I: State Information

State Information

I. State Agency for the Block Grant

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III. Expenditure Period

State Expenditure Period

From	10/1/2011
To	9/30/2012

Block Grant Expenditure Period

From	10/1/2009
To	9/30/2011

IV. Date Submitted

Submission Date	12/3/2012 5:11:05 PM
Revision Date	

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Footnotes:

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Table 2 - State Priorities

Number	Title	Description
1	Compliance with SABG Statutory Requirements	Enhance access to services and service delivery for intravenous drug users as according to 45CFR 96 126. Ensure priority access to evidence-based substance abuse treatment, in conjunction with access to prenatal care and other services needed to support recovery and family strengthening. Ensure TST resources are available to assist with the provision of TB services. Ensure formally establish agreements exist for the provision of TB services as outlined in 45 CFR 96.127. Ensure access to HIV/AIDS counseling, education, and referral services at all programs serving pregnant women and IV drug users in accordance with 45 CFR 96.121, 96.126, and 96.131.
2	Diversification of Service Populations	Increase access to culturally competent care in rural communities. Improve access to care and increase service delivery for veterans and their families at programs funded by ADMH. Increase participation of LGBTG individuals and organizations in ADMH planning processes for substance abuse prevention, treatment, and recovery support services.
3	Health Care Reform	Enhance Alabama's public substance abuse services delivery system readiness for changes in health care delivery.
4	Adolescent/Young Adult Services	Implement a strength-based approach to addressing underage drinking in Alabama. Identify, increase, track, and incentivize use of EBP/BP within adolescent programs.
5	Linguistic and Culturally Competent Services	Establish a substance abuse prevention, treatment, and recovery support service system that is responsive to the needs of a culturally and linguistically diverse client population. Develop reporting processes which will allow the Division to determine with precision the numbers of people who are limited English proficient (including people are who are deaf and use American Sign Language) and what language assistance is provided to them per Executive Order 13166.
6	Suicide Prevention	Actively promote suicide prevention in Alabama.
7	Community Populations for Environmental Prevention Activities	Strengthen community mobilization efforts to address Environmental change be viewed as a community wide effort to address the health and social well-being of the community at large.
8	Workforce Development	Recruit and retain a qualified workforce to meet the growing needs of individuals seeking substance abuse services within the state.
9	Information Technology	Develop a comprehensive behavioral information system that allows Alabama to assess needs, improve quality, and fill gaps across the service delivery system.
10	Implementation of a Good and Modern Service System	Expand SBIRT initiative. Ensure current SBIRT providers are still vested in the initiative and are not experiencing barriers to utilizing SBIRT. Enhance the billable service options for substance abuse prevention, treatment, and recovery support funded in full or in-part by ADMH. To support sustained recovery for those with substance use disorders. To improve the health and wellness of individuals and families. Increase the utilization of evidence-based trauma informed treatment services in programs funded by ADMH. Integrate Mental Health Promotion and Wellness into the prevention community services.

Footnotes:
Please see Table 2 Attachment for Alabama Priority updates referenced in Table 3.

Alabama
2012/13 SABG Behavioral Health Assessment and Plan
Table 2
(As revised July 13, 2012 in response to SPO revision request)

Number	State Priority Title	State Priority Detailed Description
1	Injection Drug Users (IDUs)	Enhance access to services and service delivery for injection drug users in Alabama as according to 45 CFR 96.126.
2	Pregnant and Parenting Women	Ensure priority access to substance abuse treatment for pregnant women and women with dependent children that incorporates (a) evidence-based practices; (b) prenatal care; (c) HIV/AIDS prevention education, counseling, and referral for related services; (d) services for dependent children; and (e) other gender responsive services needed to minimize barriers to treatment, support recovery, and strengthen the family.
3	Tuberculosis Services for Substance Abuse Treatment Program Participants	Ensure resource availability and the establishment of formal agreements for the provision of TB services as outlined in 45 CFR 96.127 for all substance abuse treatment programs funded by ADMH.
4	Rural Populations	Increase access to culturally competent substance abuse prevention and treatment services in rural Alabama communities.
5	Veterans	Improve access to trauma informed care and increase service delivery for veterans and their families at programs funded by ADMH.
6	LGBTQ Individuals	Alabama will increase outreach and training opportunities to serve LGBTQ individuals.
7	Health Care Reform	Enhance Alabama's public substance abuse services delivery system readiness for changes in health care delivery.
8	Underage Drinking	Facilitate implementation of a strength-based approach to addressing underage drinking in Alabama.
9	Linguistic and Culturally Competent Services	Improve the state's substance abuse prevention, treatment, and recovery support service system so that it is more responsive to the needs of a culturally and linguistically diverse client population.
10	Suicide Prevention	Actively participate in efforts to combat the state's increase of deaths by suicide and promote suicide prevention in Alabama.
11	Community Populations for Environmental Prevention Activities	Enhance efforts throughout the state to address the health and social well-being of the community at large through implementation of environmental change processes.
12	Workforce Development	Recruit and retain a qualified workforce to meet the growing needs of individuals seeking substance abuse services within the state.
13	Information Technology	Develop a comprehensive behavioral information system that allows Alabama to assess needs, improve quality, and fill gaps across the service delivery system.
14	Implementation of a Good and Modern Services System	Alabama will enhance the available substance abuse service array. Alabama will actively promote implementation of a Recovery Oriented System of Care. Alabama will integrate Mental Health Promotion and Wellness (MHPW) into community prevention services. Alabama will increase access to Trauma Informed Services.

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Table 3 - Objectives, Strategies and Performance Indicators

Start Year:

End Year:

Priority	Goal	Strategy	Performance Indicator	Description of Collecting and Measuring Changes in Performance Indicator	Achieved	Proposed Changes	Reason Not Achieved
Compliance with SABG Statutory Requirements	Injection Drug Users (IDU)	1. Work in conjunction with community partners to review evidence-based outreach models and identify at least three models for use in conjunction with or by treatment programs. 2. Monitor implementation of outreach activities.	IDU admissions to ADMH funded treatment programs will increase by 10% by the end of FY 14.	1. Staff assigned to manage this goal will obtain end of the year reports of IDU admissions from ASAIS and provide a report of such to the Executive Staff and the Division's Associate Commissioner. REVISION REQUEST: Description of Collecting and Measuring Changes in Performance Indicator 1. Staff assigned to manage this goal will develop an end of the year progress report that shows the IDU admissions from ASAIS.	In Progress		
		1. Identify and implement strategies to more effectively publicize the availability of treatment for pregnant women. 2. Develop and implement strategies to promote the use of SBIRT in the Medicaid Maternity Care Network. 3. Survey programs serving pregnant women to establish baseline data on utilization of evidence-based practices. On the basis of the survey's results, develop and implement strategies to increase use. 4. Policies to reduce barriers to treatment and recovery support for parenting individuals will be implemented in 50% of the programs		1. Staff assigned to manage this goal will obtain quarterly reports of the number of admissions of pregnant women and women with dependent children to ADMH funded treatment programs and provide a report of such to the Executive Staff and the Division's Associate Commissioner. 2. Program monitoring reports will be modified to capture information on the use of evidence-base practices in specialize women's programs. Assigned monitoring staff will prepare reports on the use of evidence-based practices. REVISION REQUEST: Performance Indicators 1. From October 1, 2011 thru September 30, 2012, data collection and analysis will establish a baseline level of performance by ADHM contract substance			

Compliance with SABG Statutory Requirements	Pregnant Women & Women with Dependent Children	funded by ADMH. REVISION REQUEST: Ensure priority access to substance abuse treatment for pregnant women and women with dependent children that incorporate (a) evidence-based practices; (b) prenatal care; (c) services for dependent children; and (d) other gender responsive services needed to minimize barriers to treatment, support recovery, and strengthen the family. Strategies: 1. Identify and implement strategies to more effectively publicize the availability of treatment for pregnant women and women with dependent children. 2. Develop and implement strategies to promote the use of Screening Brief Intervention and Referral to Treatment in the Alabama Medicaid Maternity Care Network. 3. Modify the ADMH substance abuse services contract billing manual and contract language to comply with 45 CFR 96.121, 96.126, and 96.131. 4. Provide provider training and make available technical assistance to support compliance with contract requirements. 5. Monitor provider compliance with contract requirements. 6. FY 2012 the Division of Mental Health and Substance Abuse Services will hire a central office staff designated for Special Women's Services to provide technical assistance, training and monitor provider compliance with contractual requirement regarding special women services. 7. The coordinators will also work with Alabama Medicaid	Admissions of pregnant women and women with dependent children to ADMH funded treatment programs will increase by 10%. All programs serving pregnant women and women with dependent children will utilize evidence-based practices by September 30, 2013.	abuse treatment providers that provides a distinct, unduplicated count of the number of: (a) Admissions of pregnant women. (b) Admission of women with dependent children. 2. By September 30, 2013, admission to ADMH funded treatment programs by pregnant women and by women with dependent children will increase, respectively, by 20% from the baseline level established on September 30, 2012. 3. By September 30, 2013, the number of ADMH contract programs that provide substance abuse treatment for pregnant women and women with dependent children that incorporates: (a) Evidence-based practices as part of the treatment process will increase by 20% over the baseline established in September 2012. (b) Access to prenatal care children will increase by 20% over the baseline established in September 2012. (d) Services for dependent children will increase by 20% over the baseline established in September 2012. (e) Gender responsive services to minimize barriers to treatment, support recovery, and strengthen the family will increase by 20% over the baseline established in September 2012. 4. By September 30, 2013, policies to reduce barriers to treatment and recovery support for parenting individuals will be implemented in 50% of the programs funded by ADMH, an increase of twenty eight (28) organizations more than in FY 11, during which there no formal program policies in place for this purpose. Description of Collecting and Measuring Changes in Performance Indicator: 1. The Special Women's Coordinator will submit a final report including, number of	In Progress

		to develop funding opportunities for special women's programs.		admission of pregnant women and women with dependent children to ADMH funded programs and progress made to attain the performance indicators listed.	
Compliance with SABG Statutory Requirements	Tuberculosis Services	1. The Substance Abuse Office of Treatment Services will identify how recent ADPH TST changes are affecting providers. 2. The Substance Abuse Office of Treatment Services will develop a sample template as an example for providers to use for the provision of TB services.	The SA Office of Treatment Services will document providers affected by ADPH TST changes. Formal memorandum of understanding and / or letter of agreement are on file with each provider agency for the provision of TB services as outlined in 45 CFR 96.127.	1. A document listing the providers affected by the ADPH TST changes along with the proposed plan to ensure TST resources are available will be developed by the Substance Abuse Office of Treatment Services. 2. The Substance Abuse Office of Treatment Services will conduct SAPTBG monitoring compliance visits on a scheduled rotation, that will yield evidence of compliance specific to 45 CFR 96.127, tracked on the SAPTBG Program Compliance Monitoring Survey. This survey will yield evidence of compliance, no evidence of compliance, or partial evidence of compliance. REVISION REQUEST: Performance Indicator 1. By September 30, 2012, at least 25% of the 50 contractual SA treatment providers will report to the SA Office of Treatment Services on the existence of gaps in the provision of TB services as the result of ADPH TST changes. 2. By September 30, 2012 the SA Office of Treatment Services will develop and disseminate to 100% of SA treatment providers a sample memorandum of understanding and / or letter of agreement as a guide for providers to use for the provision of TB services as outlined in 45 CFR 96.127. 3. By September 30, 2013, 100% of SA treatment providers will submit documentation detailing the provision of TB services for their agency in accordance with 45 CFR 96.127.	In Progress
				Staff will be assigned responsibility to lead efforts for implementation of this	

Diversification of Service Populations	LGBTQ Individuals	1. Identify and initiate contact with organizations whose primary mission is to support or otherwise address the needs of LGBTG individuals. 2. Facilitate meetings with identified organizations to explore collaborative opportunities and develop strategies for implementation at the state and local level in Alabama. 3. Initiate invitations for qualified organizations to formally serve on appropriate ADMH planning bodies.	Individuals and organizations serving LGBTQ will be formally involved in ADMH planning activities.	strategy, document efforts to engage LGBTG individuals and organizations in ADMH planning efforts, and to make quarterly reports of such to the Associate Commissioner and to the MISA Executive Staff Committee. REVISION REQUEST: Performance Indicator 1. ADMH will partner with the Alabama School of Alcohol and Other Drug Studies to provide a course titled Gay, Lesbian, Bisexual, Transgender (GLBT) and Behavioral Health Issues at the conference in March 2012. 2. ADMH will work to offer a course on the Council of Community Mental Health Center conference in May of 2012.	In Progress	
Diversification of Service Populations	Rural Populations	1. Engage medical providers in rural communities to participate in SBIRT. 2. Collaborate with existing rural community providers (exa. FQHC's) and current/prospective SA service providers to integrate services. 3. Explore grant opportunities through the Office of Rural Health. 4. Opportunities for Telehealth	Activities implemented that engage medical providers, existing rural community providers, and current/prospective SA providers. Participation in SBIRT. Use of SBIRT billing code. Grants and/or request for proposals (RFP) specific to rural communities.	1. Documentation of activities that engaged medical providers, existing rural community providers, and current/prospective SA providers. 2. # Of new SBIRT enrollee's. 3. Utilization rates of SBIRT billing code. 4. # of grants and/or RFP's applied for / published. 5. # of new service providers and / or levels of care within rural communities. REVISION REQUEST: Performance Indicator 1. By September 30, 2012, establish a baseline to determine the number of activities implemented that engage medical providers, existing rural community providers, and current/prospective SA providers. 2. By September 30, 2013, increase the number of targeted activities implemented that engage medical providers, existing rural community providers, and current/prospective SA providers by 20%. 3. By September 30, 2013, increase the current number of SBIRT providers (18) by 20%. 4. By September 30, 2013, increase the current use of the SBIRT billing code	In Progress	

				(currently billed $7,000) by 20%. 5. By September 20, 2013, seek out and apply for (1) grant and/or request for proposal (RFP) specific to rural communities.	
Health Care Reform	Health Care Reform	1. Provide opportunities for providers' self assessment of readiness to adapt to changes in the country's health care delivery system. 2. Seek resources for and promote the use of electronic health records by ADMH not-for-profit contractors. 3. Establish and implement a process for routine dissemination of information on health care reform related funding opportunities' 4. Collaborate with state agency partners in development of the behavioral health benefit options to be provided through the Alabama Health Insurance Exchange. 5. Collaborate with state agency partners to maximize opportunities for individuals with substance use disorders to benefit from Alabama's Health Insurance Exchange. 6. Provide technical assistance and education activities for ADMH staff and for providers to support implementation and compliance with the Affordable Care Act and related changes in the health care.	Self assessments will be completed by at least 50% of ADMH's contract providers. Resource development, information dissemination, and technical assistance activities will be documented. Participation in collaborative state activities will be documented.	Staff will be assigned responsibility to lead efforts for implementation of this strategy, document efforts taken to implement strategies, and to make written quarterly reports of such, along with recommendations relative to progress toward attainment of benchmarks, to the Associate Commissioner and to the MISA Executive Staff Committee. REVISION REQUEST: Performance Indicator 1. By September 30, 2013, self assessments will be completed by at least 50% of ADMH substance abuse treatment contract providers; twenty eight (28) organizations more than in FY 2011during which no contract providers had conducted self assessments to establish readiness for impending changes in the health care delivery system. 2. By September 30, 2013, at least 50% of ADMH substance abuse treatment contract providers will be able to document formal staff participation in resource development and technical assistance activities to address needs identified through self-assessment; twenty eight (28) organizations more than in FY 2011 during which no contract providers had formally participated in such activities. 3. By September 30, 2013, ADMH will be able to document formal participation in at least four (4) collaborative activities with state and quasi-state agencies that will enhance the public treatment system's readiness for changes in health care delivery; this represent an increase of 150%	In Progress

				over the FY 2011 participation rate during which there was formal participation in two (2) collaborative activities. 4. ADMH will partner with the SCATTC to offer at least two (2) Leadership Summits in 2012 for Executive Staff of all provider agencies to help prepare them for Heath Care Reform.	
Adolescent/Young Adult Services	Evidence-Based Practices	1. Require use of EBP/BP 2. Develop and promote effective clinical professional practices. 3. Change requirements for funding certified facilities to become smoke-free or incentivize those who do.	The Substance Abuse Certification standards initiated by the SA Office of Treatment Services will require the use of EBP/BP. 2. The SA Office of Treatment Services will recommend incentives for use of EBP/BP to the Associate Comm of SA and MH.	1. The Division of Substance Abuse and Mental Illness will implement Substance Abuse certification standards by August 2012. These standards will be disseminated to all certified substance abuse providers. 2. Documentation of ongoing efforts to adopt incentives for use of EBP/BP may include but not limited to email correspondence, meeting agenda, RFP language, contractual language, etc. 3. The number of providers receiving incentives for use of EBP/BP as evidenced by reimbursement rate or structure beginning no later than FY2014. REVISION REQUEST: Performance Indicator 1. By September 30, 2012, 100% of SA treatment providers will be required to use EBP/BP. 2. By September 30, 2013, the SA Office of Treatment Services will incorporate at least 1 incentive for use of EBP/BP.	In Progress
		1. Collaborate with community partners to identify and			

Adolescent/Young Adult Services	Underage Drinking	develop key practical solutions that demonstrate sound Prevention practice that would build on existing strengths of communities and individuals; 2. Integrate Prevention programming and practice with other available services to promote mental health promotion and other alternatives to healthier choices for underage youth; 3. Demonstrate sound application of data to inform where and how to provide applicable services to those whom experience underage drinking; 4. Apply principles of didactic learning, adult learning skills to facilitate effective underage drinking awareness and education to promote community buy in and community collaboration; 5. Develop a system (tools) to facilitate the alignment of data, proposed strategies, desired impacts and outcomes on the state and community level; and 6. Integrate substance abuse prevention efforts within mental health promotion, primary health care when relevant to underage drinking risks.	Increase in the number of coalitions/collaborative efforts in Alabama that lead local coalition/task force efforts. 2. Increase and/or implementation of policies or procedures related to underage drinking.	Alabama Coalitions, as well as prevention collaborative efforts with various entities such as Department of Education, Public Safety, Human Resources, etc., will serve as the basis of collecting quarterly Underage Drinking measures. The coalition and collaborative effort reports will be reviewed and analyzed quarterly to determine progress or lack of progress regarding the effects of activities, policies, and procedures that address underage drinking. This data will be utilized as a means of future strategic planning for the assessment and approach of underage drinking. REVISON REQUEST: Performance Indicator 1. By September 30, 2012, the Office of Prevention Services in collaboration with Drug Free Communities/coalitions will establish a baseline with coalitions/collaborative to determine the number of existing policies or procedures related to underage drinking. 2. By September 30, 2013, increase the number of established coalitions (55) collaborative efforts in Alabama by 20%.	In Progress	
Adolescent/Young Adult Services	Veterans	1. Identify, initiate contact, and establish collaborative relationships with veteran serving organizations throughout the state. 2. Research, develop, and implement effective outreach and engagement strategies for veterans and their families. 3. Promote the implementation	Services to Veterans or members of their family by ADMH funded programs will increase by 20% in FY 2013.	Staff will be assigned responsibility to lead efforts for implementation of this strategy, document efforts to implement the identified strategies, and submit an end of the year report to the Associate Commissioner. REVISION REQUEST: Performance Indicator 1. The number veterans receiving services from ADMH funded substance abuse treatment programs will increase by 20% from 1044 individuals in FY 2011 to 1253 individuals in FY 2013. 2. ADMH will partner	In Progress	

		of engagement and outreach strategies by programs funded by ADMH. 4. Promote the implementation of SBIRT in veteran serving organizations throughout the state.		with the Alabama School of Alcohol and Other Drug Studies to bring a speaker to conduct the following trainings: After the War…Hidden Wounds, Myths, and Realities; Those Left Behind: The Military Family Experience There and Back Again; and Readjusting to Life after Deployment at the conference in March 2012 for all providers in the state.	
Linguistic and Culturally Competent Services	Linguistic and Culturally Competent Services	Develop reporting processes which will allow the Division to determine with precision the numbers of people who are limited English proficient (including people are who are deaf and use American Sign Language) and what language assistance is provided to them per Executive Order 13166. 1. Revise data fields to capture language of preference and hearing status in reportable form. 2. Revise reporting from providers to capture expenditure for language assistance.	Report number and language preference of any consumer who is LEP. Report number of hours of free language assistance provided.	Monthly reports of hearing status and language of preference will be made to Office of Deaf Services for analysis against known prevalence rates. REVISION REQUEST: Performance Indicator 1.By September 30, 2013, client records failing to indicate the client's language of preference will decrease from the FY 2011 level of 100% to less than 10%. 2. By September 30, 2013, client records failing to show notification of free language assistance will decrease from the FY 2011 level of 100% to less than 25%. 3. By September 30, 2013, client records failing to indicate hearing status of clients will decrease from the FY 2011 level of 17% to less than 5%. Description of Collecting and Measuring Changes in Performance Indicator 1.Assigned staff will monitor implementation of tasks assigned for implementation of the stated strategies and submit an end of the year report listing the findings as they relate to the stated indicators to the Associate Commissioner. 2. ADMH Office of Deaf Services will offer at a minimum four (4) trainings around the state including at least two (2) state conferences on working with this challenging population in 2012.	In Progress
				1. Bi-monthly performance reports developed by assigned	

				ADMH personnel and disseminated to the cultural competence advisory committee and Associate Commissioner. REVISION REQUEST: Performance Indicator 1. From October 1, 2011 thru September 30, 2012, data collection and analysis will establish a baseline level of performance (percentage) by ADHM contract substance abuse treatment providers for the following indicators: a. Clients served by race and identified culture. b. Access to care by county. b. Services received in comparison to service need. No baseline data was available during FY 2011 to support assessment of goal attainment. 2. By September 30, 2012, 100% of ADMH contract substance abuse treatment providers, fifty-seven (57) more than in FY 2011, will begin receipt of quarterly program specific reports of the following indicators: a. Clients served by race and identified culture. b. Access to care by county. c. Services received in comparison to service need. No baseline data was available during FY 2011 to support assessment of goal attainment. 3. By September 30, 2013, participation of cultural and linguistic minorities within Alabama's public substance abuse service delivery system will increase by 10% over baseline figures established September, 30 2012. 4. By September 30, 2013, the state's public substance abuse treatment system's performance will document a 10% performance increase from baseline figures established September 30, 2012 for the following indicators: a. Clients served by race and identified culture b. Access to care by county. c. Services received in comparison
Linguistic and Culturally Competent Services	Linguistic and Culturally Competent Services	Establish a substance abuse prevention, treatment, and recovery support service system that is responsive to the needs of a culturally and linguistically diverse client population. 1. Gather community-based information on needs and concerns of cultural groups regarding substance abuse services. 2. Assess the staff and service capacity of the public substance abuse system to serve the identified groups. 3. Assess the policies and procedures provider organizations to address the needs of cultural groups. 4. Conduct trainings to improve competence skill sets for the public workforce.	Service outcomes regarding access, receipt of services, quality of care, and client satisfaction. Training provided and results of training evaluations.		In Progress

				to service need. Description of Collecting and Measuring Changes in Performance Indicator: ADMH will assign a staff member to monitor the performance indicators during FY2011-2012 and preparean end of the year progress report for the block grant.	
Suicide Prevention	Actively promote suicide prevention in Alabama	1. Actively collaborate with federal, state, and local agencies in the development and implementation of a statewide plan to prevent suicide. 2. Develop an internal suicide prevention plan that complements the statewide plan, but clarifies ADMH's role in relation to other agencies addressing this problem and identifies specific internal strategies, policies and procedures to be implemented on a continuous basis. 3. Examine the feasibility of implementation and promotion of Mental Health First Aid in Alabama as an adjunct to ADMH's suicide prevention plan.	ADMH workgroup established. ADMH's documented participation in federal, state and local collaborative efforts. Development of an ADMH specific plan. 4. Strategy implementation, including steps taken to determine feasibility of Mental Health First Aid.	Staff will be assigned responsibility to lead efforts for implementation of this strategy, document efforts taken to implement strategies, and to make written quarterly reports of such, along with recommendations relative to progress toward attainment of benchmarks, to the Associate Commissioner and to the MISA Executive Staff Committee. REVISION REQUEST: Performance Indicator 1. By September 30, 2013 ADMH will document active participation in at least four (4) sustainable activities with state and local partners that support suicide prevention for individuals who have substance use and co-occurring substance use and mental disorders, a 300% increase from involvement in one (1) initiative in FY 2011. 2. Staff will be assigned responsibility to lead efforts for implementation of this strategy, document efforts taken to implement strategies, and formulate an end of the year progress report submit to the Associate Commissioner.	In Progress
		Strengthen community mobilization efforts to address Environmental change be viewed as a community wide effort to address the health and social well-being of the community at large. 1. Promote local ownership and decision making on			

Community Populations for Environmental Prevention Activities	Community Populations for Environmental Prevention Activities	alcohol and tobacco as a health issue opposed to a cultural norm; 2. Encourage and incentivize collaboration between individuals and organizations; 3. Provide a framework (Strategic Prevention Framework) for prevention planning and implementation efforts; 4. Show community models of success whereas new energy and outcomes were facilitated by community buy-in and support; 5. Create and ensure a conduit to have a public presence and pressure to change laws, policies and practices-progress that can not be made by one individual or one organization; 6. Increase the awareness and education on cross-sector collaboration and existing monetary benefits of all parties; 7. Individualize what “capacity building” means to communities before an attempt is made to ensure prevention activities and outcomes are finalized based solely on funding; 8. Support communities to utilize comprehensive approached to effective prevention practices that include multiple components and address a wide range of risks and protective factors of the target populations; 9. Utilize the principles of effective prevention programs by using various teaching methods, applying the sufficient dosage, having concrete theory and scientific justification, foster strong stable relationships and are appropriately timed to have	Increase in the number of coalitions/prevention collaborative efforts in Alabama that lead to an increase and/or implementation of policies or procedures relative to Environmental prevention activities utilizing the Strategic Prevention Framework process.	The prevention services coordinator will monitor the implementation of strategies and develop quarterly reports of increased coalition activities in the state and changes in the development of environmental policy reports. REVISION REQUEST: Performance Indicator 1. By September 30, 2012, the Office of Prevention Services in collaboration with Drug Free Communities/coalitions will establish a baseline to determine the number of policies and procedures relative to Environmental prevention activities utilizing the Strategic Prevention Framework process. 2. By September 30, 2013, increase the number of coalitions/prevention collaborative efforts relative to Environmental prevention activities utilizing the Strategic Prevention Framework process by 20%. 3. ADMH will partner with the Alabama School of Alcohol and Other Drug Studies to bring in national speakers from CAPT ASSOCIATES to train the course titled Substance Abuse Prevention Skills Training (SAPST): A Behavioral Health Workforce Development Curriculum for prevention providers at the conference in March 2012.	In Progress

		maximal impact in a participant's life; 10. Practices and programs should be tailored to express the cultural beliefs and norms of the community; 11. Develop a user friendly system to retrieve outcome evaluation necessary to determine if the strategy worked; 12. Assist with a community approach to sustaining training, support and supervision; and 13. Ensure that adolescent messages on substance use are consistent and are delivered across the domains (family, school, parents, peers and the community).			
Workforce Development	Workforce Development	Recruit and retain a qualified workforce to meet the growing needs of individuals seeking substance abuse services within the state. 1. Increase cooperative relationships with universities whereby students complete the internship/practicum portion of their degrees within mental health disciplines. 2. Expand use of telemedicine. 3. Identification of successful strategies	Documented relationships with universities for internship/practicum placement. Address licensing laws and reciprocity with the Alabama Board of Medical Examiners. Research and pursue opportunities to expand use of telemedicine.	1. The Substance Abuse Office of Treatment Services will query providers about the # of internship/practicum students hired and/or retained post degree attainment on an annual basis through use of a survey administered by FY2013. 2. The ADMH's documentation of communication with ABME. 3. # of opportunities pursued by the ADMH to expand use of telemedicine. REVISION REQUEST: Performance Indicator 1. By September 30, 2012, the SA Office of Treatment Services will disseminate the SA Provider directory to 100% of the educational institutions within the state that have master's level counseling programs to foster opportunities for students to complete internship/practicum placement within mental health facilities. 2. By September 30, 2013 the Mental Health and Substance Abuse Division will ensure the inclusion of the topic of addressing licensing laws and reciprocity with the Alabama Board of Medical Examiners on its Mental Health	In Progress	

	used by other states.	Substance Abuse Coordinating Subcommittee meeting agenda. 3. By September 30, 2012 the SA Office of Treatment Services will establish a baseline to determine the number of SA treatment providers who utilize telemedicine. 4. By September 30, 2013, increase the number of SA treatment providers utilizing telemedicine by 20%. 5. ADMH will partner with the Alabama School for Alcohol and Other Drug Studies in March and other state conferences throughout FY 2011-2012 to offer courses that will continue to build our workforce skills.	
		1. Analysis of current information system infrastructure completed. The Department will complete a comprehensive analysis of current information system infrastructure and identify goals and strategies that will need to be implemented to create a cohesive structure for all data the department maintains. 2. Development of an ongoing process involving user groups in identifying new technologies and engaging the service delivery system in their use. We will establish and help to facilitate at least five groups on various types of technology where there is identified interest. These groups will each have team leaders and be assisted by staff from the division, but be composed of providers who have an interest in that particular technology. All meetings will be available to all,	

Information Technology	Information Technology	Develop a comprehensive behavioral information system that allows Alabama to assess needs, improve quality, and fill gaps across the service delivery system. 1. Analyze ADMH's current information system infrastructure to identify gaps and determine ways to be more efficient in collection and access to data from the service delivery system. 2. Develop a mechanism to identify new technologies that would be helpful to improve service quality and consumer engagement, and a process for organized dissemination of these technologies throughout the state.	ADMH will develop an analysis of its current info. system infrastructure identifying strengths, needs, and gaps and present it to the Comm. & to the Exe. Staff. ADMH will develop user groups for a variety of new technologies for which there is interest	whether by teleconference or in-person and the groups will report out to relevant bodies as appropriate. REVISION REQUEST: Performance Indicator By September 30, 2013, there will be four (4) IT user groups functioning to support ADMH in the identification of infrastructure strengths, needs, gaps, and new technology critical for development of a comprehensive behavioral information system. This is an increase of 400% over the FY 2011 level of operations during which there were no functioning user groups. Description of Collecting and Measuring Changes in Performance Indicator 1. Analysis of current information system infrastructure completed. The Department will complete a comprehensive analysis of current information system infrastructure and identify goals and strategies that will need to be implemented to create a cohesive structure for all data the department maintains. 2. Development of an ongoing process involving user groups in identifying new technologies and engaging the service delivery system in their use. We will establish and help to facilitate at least four (4) IT user groups on various types of technology where there is identified interest. These groups will each have team leaders and be assisted by staff from the division, but be composed of providers who have an interest in that particular technology. All meetings will be available to all, whether by teleconference or in-person and the groups will report out to relevant bodies as appropriate.	In Progress
				Assigned staff will monitor	

Implementation of a Good and Modern Service System	Enhancement of Substance Abuse Service Array	1. Conduct interviews and focus groups with providers to identify barriers to implementation of expanded service array. 2. Incorporate CPT service codes previously identified and defined for use in ADMH funded programs into the agency's contract billing manual and management information system. 3. Develop guidelines and related training to assist providers in moving to an environment of billing for services rather than levels of care. 4. Provide technical assistance as needed to address issues of over and/or under service utilization. 5. Develop process for evaluation of utility and provider satisfaction with expanded service array.	All programs funded by ADMH will have access to and utilize an expanded array of services to address the needs of their identified clientele. Increase revenue for providers.	implementation of tasks assigned for implementation of the stated strategies and report quarterly findings as they relate to each identified indicator. REVISION REQUEST: Performance Indicator By September 30, 2013, there will be at least sixty (60) authorized billable service options available for providers to use in providing treatment services for individuals who have substance use disorders, a 93% increase from the thirty one (31) billable service options available in FY 2011. Description of Collecting and Measuring Changes in Performance Indicator: Staff will be assigned responsibility to lead efforts for implementation of this strategy, document efforts taken to implement strategies, and to complete a written end of the year report along with recommendations to the Associate Commissioner.	In Progress
				The number of consumers and families who report that they were present and involved in their individual service plan. 2. Number of service plans reviewed that reflect that services and support are consistent with individual need and preference. 3. Review of recovery support services and early intervention services submitted for payment. REVISION REQUEST: Performance Indicator 1. By September 30, 2012, data collection and analysis will establish a baseline level of performance by ADHM contract substance abuse treatment providers that specifies the number: a. Employing trained and certified Peer Support Specialists. b. Utilizing client self-directed care	

Implementation of a Good and Modern Service System	Implementation of a Recovery Oriented Systems of Care	1. Collaborate and enhance program planning to promote recovery oriented system of care via expanding and increasing access to Prevention awareness and information technology to promote cross-discipline information exchange-treatment-mental illness-prevention; 2. Promote a interoperable system (Prevention, Mental Illness, Treatment) to utilize data and needs assessment information that supports data driven decisions across all three disciplines; 3. Maximize choice and control for consumers and families to self-direct care and treatment with a focus on recovery and support. 4. Intervene early with individuals with alcohol and other drug issues. 5. Promote evidence-based practices and co-occurring training at the state level.	Consumers & families are actively involved in planning their services & supports. Consumers & families receive services based on their needs & preferences as identified in their placement assessment. The # of certified service providers reporting ROSC.	strategies. c. Providing the level of care assessed as needed for each client admitted into the program. d. Providing co-occurring enhanced services. No baseline data was available during FY 2011 to support assessment of goal attainment. 2. By September 30, 2013, at least five (5) contract substance abuse treatment providers more than the baseline number established on September 30, 2012 will hire at least one (1) certified and trained Peer Support Specialist to provide peer-run services. 3. Use of client self-directed care strategies by contract substance abuse treatment providers will increase from the base-line level established on September 30, 2012 at least 15% by September 30, 2013. 4. Clients admitted to treatment at the level of care needed based upon their ASAM placement assessment will increase at least 10% by September 30, 2013 from the baseline level established on September 12, 2012. 5. By September 30, 2013, at least five (5) contract substance abuse treatment providers more than the baseline number established on September 12, 2012 will be providing ADMH certified co-occurring enhanced treatment programs. which will allow consumers to access services through any door and obtain services where they live. 6. ADMH will partner with the Alabama School of Alcohol and Other Drug Studies to offer a course titled Certified Peer Specialist Training and bring a national speaker to train a course titled The Client -Directed, Outcome-Informed Movement Increase Motivation, Engagement and Retention at the conference in March 2012 for providers in the state.	In Progress
		1. Support early				

Implementation of a Good and Modern Service System	Mental Health Promotion and Wellness	childhood services to support children and families whom already have risk factors; 2. Target mental health promotional activities that target vulnerable groups/populations; 3. Work toward the intersection of Prevention with Mental Health promotion messages that are consistent and clear to improve how individuals receive Information Dissemination to problem solve with difficult situations; 4. Assess further exploration on how Prevention and Promotion may overlap and complement each other at the state and community levels; 5. Facilitate further exploration on combining prevention and promotion programs in mental health via public health strategies to reduce stigma and increase cost effectiveness; 6. Integrate cultural influences that are predominant in communities that may enable and support Mental Health promotion and messaging;	Establish the integration and utilization of mental health promotion within the prevention discipline.	Assigned staff will monitor implementation of tasks assigned for implementation of the stated strategies and report quarterly findings as they relate to the stated indicator to the Associate Commissioner and to the MISA Executive Staff Committee. REVISION REQUEST: Performance Indicator 1. By September 30, 2012, the Office of Prevention Services will establish a baseline rubric to determine the number of existing efforts integrating and utilizing mental health promotion within the prevention discipline. 2. By September 30, 2013, increase the number of efforts integrating and utilizing mental health promotion within the prevention discipline by 10%. 3. ADMH will partner with the Alabama School of Alcohol and Other Drug Studies to offer the Mental Health First Aid training at the conference in March 2012 for all state providers.	In Progress	
Implementation of a Good and Modern Service System	SBIRT	1. The Substance Abuse Office of Treatment Services will promote awareness of SBIRT to increase new enrollee's. 2. The Substance Abuse Office of Treatment Services will engage in dialogue with current SBIRT providers.	The SA Office of Treatment Services will monitor the number of activities implemented that raise awareness of SBIRT. As a result of engaging current SBIRT providers, the SA Office of Treatment Services will see increased use of SBIRT billing code.	1. The Substance Abuse Office of Treatment Services will document activities that raised awareness of SBIRT each fiscal year. 2. The Substance Abuse Office of Treatment Services will document dialogue with current SBIRT providers. REVISION REQUEST: Performance Indicator 1. By September 30, 2012, the SA Office of Treatment Services will highlight SBIRT through publication of at least one (1) informational piece on the ADMH website and/or within an ADMH publication to raise awareness of SBIRT. 2. By September 30, 2013, increase the current number of SBIRT providers (18) by 20%. 3. By September 30, 2013, increase the	In Progress	

				current use of the SBIRT billing code (currently billed $7,000) by 20%.	
Implementation of a Good and Modern Service System	Trauma Informed Services	1. Develop opportunities for community providers to obtain trauma training for all staff, including administrative and support personnel. 2. Establish a process for provider self assessment to determine if internal policies and procedures are supportive of the needs of trauma survivors. 3. Collaborate with state and community partners to develop resources to support access to trauma specific services.	A process for self assessment will be developed and completed by all ADMH treatment providers. Access to trauma specific services will be available to all ADMH funded treatment programs.	Assigned staff will monitor implementation of tasks assigned for implementation of the stated strategies and report quarterly findings as they relate to the stated indicator to the Associate Commissioner and to the MISA Executive Staff Committee. REVISION REQUEST: Performance Indicator From October 1, 2011 thru September 30, 2012, data collection and analysis will establish a baseline level of performance (number) of ADHM contract substance abuse treatment providers that integrate trauma informed care into their treatment protocol. 2. By September 30, 2013, the number of ADMH contract providers who have integrated trauma informed care into their treatment protocol will increase by 25% from the baseline performance level established on September 30, 2012. 3. ADMH will partner with SCATTC and the School of Alcohol and Other Drug Studies to bring a national speaker to conduct a course titled What the Heck is Trauma-Informed Care, Why Do We Need To Do It, and How Do We Do It? At the conference in March 2012.	In Progress

Footnotes:

Please see Table 3 Attachment for report of objectives "In Progress."

ALABAMA TABLE 3 ATTACHMENT FY 2013 SABG Behavioral Health Report Report of Objectives "In Progress"		
Priority		**Progress**
1.	Injection Drug Users	This goal is on target for accomplishment by September 30, 2013. In 2013 the State will continue to work to implement strategies approved by the SPO in July 2012 when, at the same time, this goal was revised with "Injection Drug Users" becoming the planning Priority, and the following Goal established: "Enhance access to services and service delivery for injection drug users in Alabama as according to 45 CFR 96.126." Progress toward increasing IDU treatment admissions by 10% was made in FY 2012 as follows: 1. ADMH's substance abuse treatment staff reviewed and established the three evidenced-based Outreach Service Models (The Standard Intervention Model, The Health Education Model, and the Indigenous Leader Model) recommended by SAMHSA as the authorized outreach models for use by contract providers in community outreach efforts. 2. The requirement for 45CFR 96.126 was included in the ADMH Substance Abuse Services Contract Billing Manual. 3. A new billing code for outreach services was developed and incorporated in the Substance Abuse Services Contract Billing Manual to support implementation of this activity. 4. ADMH's substance abuse staff continued to actively conduct on-site SABG provider monitoring visits on a scheduled basis to evaluate each agency's compliance with 45 CFR 96.126.
2.	Pregnant Women & Women With Dependent Children	This goal is on target for accomplishment by September 30, 2013. In 2013 the State will continue to work to implement strategies approved by the SPO in July 2012 when, at the same time, this goal was revised with "Pregnant and Parenting Women" becoming the planning Priority, and the following Goal established: "Ensure priority access to substance abuse treatment for pregnant women and women with dependent children that incorporates (a) evidence-based practices; (b) prenatal care; (c) HIV/AIDS prevention education, counseling, and referral for related services; (d) services for dependent children; and (e) other gender responsive services needed to minimize barriers to treatment, support recovery, and strengthen the family." Progress toward increasing the number of pregnant and parenting women admitted to treatment by 10%, and increasing the use of evidence-based strategies utilized by programs serving this population was made in FY 2012 as follows: 1. Baseline data was established for programs serving pregnant and parenting women in regard to the number of women served, use of evidence-based practices, access to pre-natal care; HIV/AIDS prevention education, counseling, and referral; and services for dependent children. 2. Plans were initiated to hire a full-time individual whose duties would be to work exclusively with programs serving women, adolescents, and children. Plans were delayed due to funding constraints, but authorization to proceed with the new hire had been granted as of

		September 30, 2012. 3. ADMH's program certification standards were modified and placed into administrative code to include rules governing services for pregnant women and women with dependent children that mirror federal regulations. These rules represent the state's first standards for women's services. 4. ADMH's substance abuse staff continued to actively conduct on-site SABG provider monitoring visits on a scheduled basis to evaluate each women serving agency's compliance with 45 CFR 96.121; 96.124; 96.126; and 96.131.
3.	Tuberculosis Services	This goal is on target for accomplishment by September 30, 2013. In 2013 the State will continue to work to implement strategies approved by the SPO in July 2012 when, at the same time, this goal was revised with "Tuberculosis Services for Substance Abuse Treatment Program Participants" becoming the planning Priority, and the following Goal established: "Ensure resource availability and the establishment of formal agreements for the provision of TB services as outlined in 45 CFR 96.127 for all substance abuse treatment programs funded by ADMH." Progress was made toward goal attainment in FY 2012 as follows: 1. ADMH substance abuse staff initiated development of a document that shows, by name, which contracted agencies were affected by the change in funding for TB Services delivered by the Alabama Department of Public Health. Staff will request information (by way of an agency survey) and a plan, as needed, from each certified SA treatment provider detailing how they are currently meeting the requirement to provide TB Services. 2. A "Sample MOU" was developed for dissemination to all certified substance abuse treatment providers to support collaboration with other agencies for the provision of local TB Services. 3. ADMH continued to actively conduct on-site SABG provider monitoring visits on a scheduled basis to evaluate each agency's compliance with 45 CFR 96.127.
4.	LGBTQ	This goal is on target for accomplishment by September 30, 2013. In 2013 the State will continue to work to implement strategies approved by the SPO in July 2012 when, at the same time, this goal was revised with "LGBTQ Individuals" becoming the planning Priority, and the following Goal established: "Alabama will increase outreach and training opportunities to serve LGBTQ individuals." Progress was made toward goal attainment in FY 2012 as follows: 1. ADMH incorporated LGBTQ individuals as a target population for which needs were assessed as part of the agency's formal needs assessment that was initiated in March 2012. LGBTQ individuals were surveyed and data gathered in regard to the behavioral health needs of this population. 2. ADMH partnered with the Alabama School of Alcohol and Drug Studies for the provision of a course entitled "Gay, Lesbian, Bisexual, Transgender, and Behavioral Health Issues" in March, 2012. 3. Staff identified community resources to assist in the development of

		formal planning partnerships with organizations serving LGBTQ individuals.
5.	Rural Populations	This goal is on target for accomplishment by September 30, 2013. In 2013 the State will continue to work to implement strategies approved by the SPO in July 2012 when, at the same time, this goal was revised with "Rural Populations" becoming the planning Priority, and the following Goal established: "Increase access to culturally competent substance abuse prevention and treatment services in Rural Alabama communities." Progress was made toward goal attainment in FY 2012 as follows: 1. All executive directors of ADMH contract providers participated in technical assistance to enhance collaborative efforts with Federally Qualified Health Centers (FQHCs) located prominently throughout Alabama's rural counties. 2. SBIRT, Screening and brief intervention, HCPC codes, staffing requirements, and service guidelines were incorporated in the Medicaid State Plan Amendment developed by ADMH staff for Rehabilitation Services. 3. SBIRT billing guidelines were developed for the Medicaid Maternity Care Waiver Program.
6.	Health Care Reform	This goal is on target for accomplishment by September 30, 2013. In 2013 the State will continue to work to implement strategies approved by the SPO in July 2012 when, at the same time, this goal was revised as follows: "Enhance Alabama's public substance abuse services delivery system readiness for changes in health care delivery." Substantial progress was made toward goal attainment in FY 2012 as follows: 1. ADMH secured technical assistance from national consultant David Lloyd which enabled 90% of its substance abuse contract providers to complete self-assessments. 2. Plans were made to provide additional technical assistance by David Lloyd in FY 2013 to support improved provider readiness for operating in an integrated primary care-behavioral health care service delivery system. 3. ADMH had permanent substance abuse staff representation on the Alabama Health insurance Exchange (HIE) Advisory Committee, who worked to assure this body appropriately considered and addressed the needs of individuals with behavioral health disorders in its plans for the HIE. 4. Substance abuse staff collaborated with staff of the Alabama Primary Care Association for the development of training on behavioral health and primary care integration targeting ADMH contract providers and Administrators of Federally Qualified Health Centers.
7.	Evidence-Based Practices	This goal is on target for accomplishment by September 30, 2013. In 2013 the State will continue to work to implement strategies approved by the SPO in July 2012 when, at the same time, this goal was revised and incorporated into the following Priority: "Implementation of a Good and Modern System," and Goal: "Alabama will actively promote implementation of a Recovery Oriented System of Care." Progress was made toward goal attainment in FY 2012 as follows:

		1. Treatment standards reflecting principles of evidence-based practices were established by ADMH substance abuse staff and published in Alabama's Administrative Code. 2. ADMH partnered with the Southern Coast ATTC for the provision of on-site training and ongoing teleconferencing for substance abuse contract providers with Dr. David Mee-Lee in regard to implementation of the ASAM levels of care, person-centered care, and best practice treatment for co-occurring disorders.
8.	Underage Drinking	This goal is on target for accomplishment by September 30, 2013. In 2013 the State will continue to work to implement strategies approved by the SPO in July 2012. Substantial progress was made toward goal attainment in FY 2012 as follows: 1. Underage drinking was identified as a priority for prevention efforts in the FY13 prevention plan template that was the information collection tool used to identify targets for CSAP strategy implementation. 2. Underage drinking was identified as a priority for prevention efforts and communicated as such to prevention providers. An underage drinking video was developed along with an underage drinking fact sheet. 3. Progress was made to identify the need for underage drinking services through the dissemination of county-level Alcohol Beverage Control (ABC) compliance data to prevention providers by county, which shows establishments where underage individuals were allowed to purchase alcohol. 4. Statewide underage drinking public education efforts began through dissemination of our underage drinking video via website. Additionally, an underage drinking fact sheet has been developed and is in the process of being disseminated through publication on our website. 5. Collaboration with community partners to promote the implementation of effective prevention practices relative to underage drinking began through the reinstitution of quarterly prevention provider meetings. During these meetings prevention providers have an opportunity to share information and practices through presentations that highlight successful strategy implementation.
9.	Veterans	This goal is on target for accomplishment by September 30, 2013. In 2013 the State will continue to work to implement strategies approved by the SPO in July 2012, when, at the same time, this goal was revised with "Veterans" becoming the planning Priority and the following Goal established: "Improve access to trauma informed care and increase service delivery for veterans at programs funded by ADMH." Progress was made toward goal attainment in FY 2012 as follows: 1. The Alabama Department of Mental Health has been a recipient of Service Members Veterans and Families (SMVF) technical assistance from SAMHSA. As a result, during FY 12 the agency remained engaged in quarterly meeting with various veteran serving community agencies to address issues related to the care and

		treatment of this special population. 2. ADMH partnered with Army One Source to conduct an initiative using public media to see if behavioral health professionals would get involved with web-based training opportunities aimed at improving access to appropriate care for soldiers and sailors. 3. ADMH partnered with the 2012 Alabama School of Alcohol and Drug Studies for the provision of veteran specific training for contract substance abuse providers. 4. Staff has planned veteran specific PTSD training for ADMH providers in three (3) different areas of the state for April, May, and June 2013.
10.	Linguistic and Culturally Competent Services	This goal is on target for accomplishment by September 30, 2013. In 2013 the State will continue to work to implement strategies approved by the SPO in July 2012 when, at the same time, this goal was revised combining Goals 10 and 11 under this Priority into one Goal as follows: "Improve the state's substance abuse prevention, treatment, and recovery support services system so that it is more responsive to the needs of a culturally and linguistically diverse population." Progress was made in FY 2012 toward goal attainment as follows: 1. Assessment was conducted of the needs of various cultural groups in Alabama in regard to substance abuse services, as part of the division's comprehensive needs assessment project which began in March 2012. Surveys, focus groups, and key informant interviews provided information to assist in better planning for the needs of African Americans, Hispanics, Native Americans, Asians and Pacific Islanders, Multi-Racial Individuals, as well as, individuals who are deaf and hard of hearing. 2. Revision of the agency's reporting procedures and MIS to capture language reportable information from providers relative to clients' language of preference, hearing status, and data to provider expenditures for language assistance was completed. 3. Training was conducted throughout the state to improve competence skill sets of providers who work with deaf and hard of hearing clients. 4. Preparation began for continued work during FY2013 to assess the staff and service capacity of substance abuse provider agencies to adequately address the needs of a culturally diverse clientele and to identify resources to address deficits identified.
11.	Linguistic and Culturally Competent Services	Progress as reported for Goal 10.
12.	Suicide Prevention	This goal is on target for accomplishment by September 30, 2013. In 2013 the State will continue to work to implement strategies approved by the SPO in July 2012 when, at the same time, this goal was revised to read: "Actively participate in efforts to combat the state's increase of deaths by suicide and promote suicide prevention in Alabama." Progress was made toward goal attainment in FY 2012 as follows: 1. ADMH substance abuse prevention and treatment staff participated in Mental Health First Aid training and began development of community-wide implementation strategies. 2. Substance abuse staff began development of an ADMH internal plan

		for suicide prevention.
13.	Community Populations for Environmental Prevention Activities	This goal is on target for accomplishment by September 30, 2013. In 2013 the State will continue to work to implement strategies approved by the SPO in July 2012 when, at the same time, this goal was revised to read as follows: "Enhance efforts throughout the state to address the health and social well-being of the community at large through implementation of environmental change processes." Progress was made toward goal attainment in FY 2012 as follows: 1. Environmental prevention strategies were identified as a priority for prevention efforts in ADMH's FY13 prevention plan template that served as the information collection tool used to identify targets for CSAP prevention strategy implementation. 2. A study of the ADMH's reimbursement methodology for environmental strategies took place, resulting in its modification. The reimbursement rate for this strategy is now among the highest of the prevention strategies and serves as an additional incentive to support provider implementation of this strategy.
14.	Workforce Development	This goal is on target for accomplishment by September 30, 2013. In 2013 the State will continue to work to implement strategies approved by the SPO in July 2012 when, at the same time, this goal was revised to read: "Recruit and retain a qualified workforce to meet the growing needs of individuals seeking substance abuse services within the state." Progress was made toward goal attainment in FY 2012 as follows: 1. ADMH substance abuse staff worked with the Director of Instruction and Special Projects for the Alabama Commission on Higher Education to obtain an email list serve and mailing addresses for members of the Alabama Council of Graduate Deans, which includes the deans of each of the institutions in Alabama. Preparation of correspondence to all deans of these higher education institutions began, that will include a list of all substance abuse provider agencies in the state that could be used as possible sites for internships and/or practicum placements. 2. ADMH substance abuse staff began development of a survey to send to all substance abuse providers to inquire about the number of internship/practicum students hired and or retained post degree. 3. Plans were made to contact career centers or student services officers at various universities within each of the four ADMH planning regions to seek opportunities for ADMH's participation in a number of career fairs. 4. ADMH Medical Director is actively involved in this initiative and outlined the following strategies to reach the stated goal in 2013: a. Actively communicate with Southeastern medical/osteopathic school training directors, psychiatric residency and fellowship training directors regarding the great need for training retention of public psychiatrists and NPs. b. Meet with residency classes of at least 4 psychiatric training programs in the southeast to directly recruit psychiatrists to our state. c. Engage with training programs within the state of Alabama to

		support training and retention of mental health professionals, including provision of time for direct training opportunities (i.e. lectures, supervision). d. Develop clear strategies for addressing barriers to licensure reciprocity in Alabama and request a meeting with the licensure board to present and discuss these strategies. 5. The substance abuse staff began development of a survey to establish the baseline number of substance abuse treatment providers who currently utilize interactive communication technology as a part of the treatment process.
15.	Information Technology	This goal is on target for accomplishment by September 30, 2013. In 2013 the State will continue to work to implement strategies approved by the SPO in July 2012 when, at the same time, this goal was revised to read: "Develop a comprehensive behavioral information system that allows Alabama to assess needs, improve quality, and fill gaps across the service delivery system." Progress was made toward goal attainment in FY 2012 as follows: 1. ADMH analyzed its current information system infrastructure and identified gaps as well as areas for improvement in collection and assessing data from our service delivery system. We are adding some additional indicators as well as providing additional provider feedback reports to attempt to address issues with our data reporting and improve the accuracy of information we collect in the future. 2. Initial steps were taken but no formal process has yet been put in place to identify new technologies. 3. A process was developed to engage user groups in the process of identifying strategies to implement new technologies.
16.	Enhancement of Substance Abuse Service Array	This goal is on target for accomplishment by September 30, 2013. In 2013 the State will continue to work to implement strategies approved by the SPO in July 2012 when, at the same time, this goal was revised to read: "Alabama will enhance the available substance abuse service array." Progress was made toward goal attainment in FY 2012 as follows: 1. Through provider interviews conducted, increasing services without an increase of funding was identified as a major barrier to adoption of an expanded service array. 2. Strategies to increase funding have been promoted which include obtaining Medicaid provider status. 3. Service definitions were fully developed along with staff qualifications for eighteen (18) new services. 4. A Medicaid state plan amendment was developed which incorporates fifteen (15) new substance abuse service options and submitted to the Alabama Medicaid agency. 5. The process of modification of the substance abuse contract billing manual to incorporate the new service definitions and requirements was started. 6. Collaboration with the Alabama Medicaid Agency was initiated to promote adoption of ADMH's recommendations for the Medicaid Rehabilitation Option State Plan Amendment.

17.	Implementation of a Recovery Oriented System of Care	This goal is on target for accomplishment by September 30, 2013. In 2013 the State will continue to work to implement strategies approved by the SPO in July 2012 when, at the same time, this goal was revised to read: "Alabama will actively promote implementation of a Recovery Oriented System of Care." The ADMH substance abuse staff made progress toward goal attainment in FY 2012 as follows: 1. Collaborated with treatment providers, faith-based community organizations, client advocacy groups, clients, and their families to gain input to guide development of a recovery oriented system of care. 2. Established a written philosophical framework for a recovery oriented system of care. 3. Collaborated with the Southern Coast ATTC and the Alabama School of Alcohol and Drug studies to sponsor training for contract providers on "Recovery Oriented Systems of Care." 4. Provided funding to a statewide advocacy organization to provide peer support training.
18.	Mental Health Promotion and Wellness	This goal is on target for accomplishment by September 30, 2013. In 2013 the State will continue to work to implement strategies approved by the SPO in July 2012 when, at the same time, this goal was revised to read: "Alabama will integrate Mental Health Promotion and Wellness (MHWP) into community prevention services." Progress was made toward goal attainment in FY 2012 as follows: 1. ADMH prevention services staff began exploration of best practices for embedding mental health wellness activities within the state's prevention services through the vision of Mental Health America's promotion of mental wellness. The prevention services director initiated a State Information Request (SIR) in this regard to Alabama's technical assistance project manager. 2. Goals for Mental Health Promotion and Wellness were embedded into ADMH's FY 13-18 Prevention Services Plan. 3. ADMH's prevention services staff participated in SAMHSA sponsored Mental Health First Aid training.
19.	SBIRT	This goal is on target for accomplishment by September 30, 2013 through its integration with the "Rural Populations" and "Pregnant and Parenting Women" priorities as indicated in the state's revised Table 3, as approved by the SPO in July 2012. In 2013 the State will continue to work to implement strategies approved for SBIRT expansion within the stated priorities.
20.	Trauma Informed Services	This goal is on target for accomplishment by September 30, 2013. In 2013 the State will continue to work to implement strategies approved by the SPO in July 2012 when, at the same time, this goal was revised to read: "Alabama will increase access to Trauma Informed Services." Progress was made toward goal attainment in FY 2012 as follows: 1. Developed a survey to access the use of evidence-based practices, including trauma informed care, by contract providers. 2. Collaborated with Alabama School of Alcohol Studies to sponsor training on trauma informed care.

III: Expenditure Reports

Table 4a - State Agency Expenditure Report

Expenditure Period Start Date: 10/1/2011 Expenditure Period End Date: 9/30/2012

Activity	A. SA Block Grant	B. MH Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other
1. Substance Abuse Prevention and Treatment	$ 18,023,710	$	$ 3,562,045	$ 83,251	$ 14,462,510	$	$
2. Primary Prevention	$ 4,786,442	$	$	$	$	$	$
3. Tuberculosis Services	$	$	$	$	$	$	$
4. HIV Early Intervention Services	$	$	$	$	$	$	$
5. State Hospital	$	$	$	$	$	$	$
6. Other 24 Hour Care	$	$	$	$	$	$	$
7. Ambulatory/Community Non-24 Hour Care	$	$	$	$	$	$	$
8. Administration (Excluding Program and Provider Level)	$ 1,122,056	$	$	$	$ 1,045,755	$	$
9. Subtotal (Rows 1, 2, 3, 4, and 8)	$23,932,208	$	$3,562,045	$83,251	$15,508,265	$	$
10. Subtotal (Rows 5, 6, 7, and 8)	$1,122,056	$	$	$	$1,045,755	$	$
11. Total	$23,932,208	$	$3,562,045	$83,251	$15,508,265	$	$

Please indicate the expenditures are actual or estimated.

( ) Actual ( ) Estimated

Footnotes:

III: Expenditure Reports

Table 4b - State Agency SABG Expenditure Compliance Report

Expenditure Period Start Date: 10/1/2009 Expenditure Period End Date: 9/30/2011

Category	FY 2010 SAPT Block Grant Award
1. Substance Abuse Prevention* and Treatment	$18023710.00
2. Primary Prevention	$4786442.00
3. Tuberculosis Services	$0.00
4. HIV Early Invervention Services**	$0.00
5. Administration (excluding program/provider level)	$1122056.00
6. Total	$23932208.00

*Prevention other than Primary Prevention
**HIV Designated States

Footnotes:

III: Expenditure Reports

Table 5 - SAPT Block Grant Expenditure By Service

Expenditure Period Start Date: 10/1/2011 Expenditure Period End Date: 9/30/2012

Service	Unduplicated Individuals	Units	Expenditures
Healthcare Home/Physical Health			$0.00
General and specialized outpatient medical services	0	0	$0.00
Acute Primary care	0	0	$0.00
General Health Screens, Tests and Immunizations	0	0	$0.00
Comprehensive Care Management	0	0	$0.00
Care coordination and Health Promotion	0	0	$0.00
Comprehensive Transitional Care	0	0	$0.00
Individual and Family Support	0	0	$0.00
Referral to Community Services Dissemination	0	0	$0.00
Prevention (Including Promotion)			$0.00
Screening, Brief Intervention and Referral to Treatment	0	0	$0.00
Brief Motivational Interviews	0	0	$0.00
Screening and Brief Intervention for Tobacco Cessation	0	0	$0.00
Parent Training	0	0	$0.00
Facilitated Referrals	0	0	$0.00
Relapse Prevention/Wellness Recovery Support	0	0	$0.00
Warm Line	0	0	$0.00
Engagement Services			$1320812.13
Assessment	11151	12209	$1305236.63
Specialized Evaluations (Psychological and Neurological)	0	0	$0.00
Service Planning (including crisis planning)	0	0	$0.00
Consumer/Family Education	185	6459	$15575.50

Outreach	0	0	$0.00
Outpatient Services			$1329713.17
Individual evidenced based therapies	5780	27841	$905682.65
Group therapy	71	1833	$21634.00
Family therapy	836	13579	$401640.04
Multi-family therapy	4	102	$756.48
Consultation to Caregivers	0	0	$0.00
Community Support (Rehabilitative)			$0.00
Parent/Caregiver Support	0	0	$0.00
Skill building (social, daily living, cognitive)	0	0	$0.00
Case management	0	0	$0.00
Behavior management	0	0	$0.00
Supported employment	0	0	$0.00
Permanent supported housing	0	0	$0.00
Recovery housing	0	0	$0.00
Therapeutic mentoring	0	0	$0.00
Traditional healing services	0	0	$0.00
Other Supports (Habilitative)			$0.00
Personal care	0	0	$0.00
Homemaker	0	0	$0.00
Respite	0	0	$0.00
Supported Education	0	0	$0.00
Transportation	0	0	$0.00
Assisted living services	0	0	$0.00
Recreational services	0	0	$0.00
Trained behavioral health interpreters	0	0	$0.00

Interactive communication technology devices	0	0	$0.00
Intensive Support Services			$9145106.25
Substance abuse intensive outpatient (IOP)	8779	489835	$9145106.25
Partial hospital	0	0	$0.00
Assertive Community Treatment	0	0	$0.00
Intensive home based services	0	0	$0.00
Multi-systemic therapy	0	0	$0.00
Intensive Case Management	0	0	$0.00
Out-of-Home Residential Services			$6274528.49
Crisis residential/stabilization	3418	59313	$4809419.28
Clinically Managed 24 Hour Care (SA)	0	0	$0.00
Clinically Managed Medium Intensity Care (SA)	0	0	$0.00
Adult Substance Abuse Residential	591	32836	$1465109.21
Adult Mental Health Residential	0	0	$0.00
Youth Substance Abuse Residential Services	0	0	$0.00
Children's Residential Mental Health Services	0	0	$0.00
Therapeutic foster care	0	0	$0.00
Acute Intensive Services			$873092.36
Mobile crisis	0	0	$0.00
Peer based crisis services	0	0	$0.00
Urgent care	0	0	$0.00
23 hr. observation bed	0	0	$0.00
Medically Monitored Intensive Inpatient	704	4533	$873092.36
24/7 crisis hotline services	0	0	$0.00
Recovery Supports			$0.00
Peer Support	0	0	$0.00
Recovery Support Coaching	0	0	$0.00

Recovery Support Center Services	0	0	$0.00
Supports for Self Directed Care	0	0	$0.00
Medication Services			$372455.59
Medication management	0	0	$0.00
Pharmacotherapy (including MAT)	138	37713	$372455.59
Laboratory services	0	0	$0.00
Other			$0.00

Footnotes:

III: Expenditure Reports

Table 6a - Primary Prevention Expenditures Checklist

Expenditure Period Start Date: 10/1/2011 Expenditure Period End Date: 9/30/2012

Strategy	IOM Target	SAPT Block Grant	Other Federal	State	Local	Other
Information Dissemination	Selective	$	$	$	$	$
Information Dissemination	Indicated	$	$	$	$	$
Information Dissemination	Universal	$	$	$433,520	$	$
Information Dissemination	Unspecified	$	$	$	$	$
Information Dissemination	Total	$	$	$433,520	$	$
Education	Selective	$	$	$	$	$
Education	Indicated	$	$	$	$	$
Education	Universal	$	$	$	$	$
Education	Unspecified	$1,227,899	$	$	$	$
Education	Total	$1,227,899	$	$	$	$
Alternatives	Selective	$	$	$	$	$
Alternatives	Indicated	$	$	$	$	$
Alternatives	Universal	$	$	$	$	$
Alternatives	Unspecified	$989,657	$	$	$	$
Alternatives	Total	$989,657	$	$	$	$
Problem Identification and Referral	Selective	$	$	$	$	$
Problem Identification and Referral	Indicated	$100,000	$	$	$	$
Problem Identification and Referral	Universal	$	$	$	$	$
Problem Identification and Referral	Unspecified	$	$	$	$	$
Problem Identification and Referral	Total	$100,000	$	$	$	$
Community-Based Process	Selective	$	$	$	$	$

Community-Based Process	Indicated	$	$	$	$	$
Community-Based Process	Universal	$493,777	$	$135,795	$	$
Community-Based Process	Unspecified	$	$	$	$	$
Community-Based Process	Total	$493,777	$	$135,795	$	$
Environmental	Selective	$	$	$	$	$
Environmental	Indicated	$	$	$	$	$
Environmental	Universal	$1,975,109	$	$	$	$
Environmental	Unspecified	$	$	$	$	$
Environmental	Total	$1,975,109	$	$	$	$
Section 1926 Tobacco	Selective	$	$	$	$	$
Section 1926 Tobacco	Indicated	$	$	$	$	$
Section 1926 Tobacco	Universal	$	$	$	$	$
Section 1926 Tobacco	Unspecified	$	$	$	$	$
Section 1926 Tobacco	Total	$	$	$	$	$
Other	Selective	$	$	$	$	$
Other	Indicated	$	$	$	$	$
Other	Universal	$	$	$	$	$
Other	Unspecified	$	$	$	$	$
Other	Total	$	$	$	$	$

Footnotes:

III: Expenditure Reports

Table 6b - Primary Prevention Expenditures by IOM Category

Expenditure Period Start Date: 10/1/2011 Expenditure Period End Date: 9/30/2012

Activity	SAPT Block Grant	Other Federal	State	Local	Other
Universal Direct	$ 1227899.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00
Universal Indirect	$ 2468886.00	$ 0.00	$ 569315.00	$ 0.00	$ 0.00
Selective	$ 989657.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00
Indicated	$ 100000.00	$ 0.00	$ 0.00	$ 0.00	$ 0.00
Column Total	$4,786,442.00	$0.00	$569,315.00	$0.00	$0.00

Please indicate whether expenditures on resource development activities are actual or estimated.

Actual Estimated

Footnotes:

III: Expenditure Reports

Table 7 - Resource Development Expenditure Checklist

Resource Development Expenditures Checklist						
Activity	A. Prevention-MH	B. Prevention-SA	C. Treatment-MH	D. Treatment-SA	E. Combined	F. Total
1. Planning, Coordination and Needs Assessment						$0.00
2. Quality Assurance						$0.00
3. Training (Post-Employment)						$0.00
4. Program Development						$0.00
5. Research and Evaluation						$0.00
6. Information Systems						$0.00
7. Education (Pre-Employment)						$0.00
8. Total	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

Please indicate whether expenditures on resource development activities are actual or estimated

b Actual c Estimated

Footnotes:

Table 8 - Statewide Entity Inventory

Expenditure Period Start Date: 10/1/2009 Expenditure Period End Date: 9/30/2011

Entity Number	I-SATS ID (for SABG)	Area Served (Statewide or SubState Planning Area)	Provider / Program Name	Street Address	City	State	Zip	SAPT Block Grant - A. Block Grant Funds	SAPT Block Grant - B. Prevention (other than primary prevention) and Treatment Services	SAPT Block Grant - C. Pregnant Women and Women with Dependent Children	SAPT Block Grant - D. Primary Prevention	SAPT Block Grant - E. Early Intervention Services for HIV	CMHS Block Grant - F. Adults serious mental illness	CMHS BLock Grant - G. Children with a serious emotional disturbance
0001	AL750405	99	Alcohol and Drug Abuse Treatment Centers Inc.	2701 Jefferson Avenue SW	Birmingham	AL	35211	$2,789,509.00	$2,637,035.00	$1,043,716.00	$152,474.00	$0.00		
0002	AL300037	99	Aletheia House Inc.	201 Finley Avenue West	Birmingham	AL	35204	$1,850,001.00	$1,655,709.00	$421,201.00	$194,292.00	$0.00		
0005	AL900547	02	Agency for Substance Abuse Prevention	1302 Noble Street, Lyric Square Suite 3-B	Anniston	AL	36201	$135,223.00	$0.00	$0.00	$135,223.00	$0.00		
0006	AL750561	04	Baldwin County Mental Health Center	372 South Greeno Road	Fairhope	AL	36532 -1905	$419,273.00	$256,978.00	$0.00	$162,295.00	$0.00		
0007	AL900091	02	Bibb-Pickens-Tuscaloosa Mental Health Center					$847,363.00	$609,194.00	$129,560.00	$238,169.00	$0.00		
0008	AL302108	03	Cahaba Mental Health Center	912 J L Chestnut Jr Boulevard	Selma	AL	36701	$430,743.00	$351,634.00	$161,466.00	$79,109.00	$0.00		
0009	AL900109	02	Calhoun-Cleburne Mental Health Center	1640 Coleman Road	Anniston	AL	36203	$254,737.00	$254,737.00	$0.00	$0.00	$0.00		
0010	AL900604	03	Chemical Addictions Program	1153 Air Base Boulevard	Montgomery	AL	36108	$1,349,766.00	$1,349,766.00	$0.00	$0.00	$0.00		
0012	AL900570	01	Cherokee-Etowah-Dekalb Mental Health Center	425 5th Avenue NW	Attalla	AL	35954	$336,788.00	$119,968.00	$0.00	$216,820.00	$0.00		
0013	AL750272	01	Central Alabama Council	100 Commerce Street, Suite 800	Montgomery	AL	36104	$291,548.00	$0.00	$0.00	$291,548.00	$0.00		
0014	AL900620	99	Cheaha Mental Health Center	1721 Old Birmingham Highway	Sylacauga	AL	35150	$776,885.00	$623,310.00	$0.00	$153,575.00	$0.00		
0016	AL750090	02	Chilton-Shelby Mental Health Center					$425,568.00	$191,243.00	$0.00	$234,325.00	$0.00		
0017	AL901362	04	Dauphin Way Lodge	1009 Dauphin Street	Mobile	AL	36604	$891,438.00	$891,438.00	$0.00	$0.00	$0.00		
0018	AL100551	04	Drug Education Council					$426,596.00	$0.00	$0.00	$426,596.00	$0.00		
0019	AL900612	03	East Alabama Mental Health Center					$716,834.00	$468,857.00	$146,594.00	$247,977.00	$0.00		
0020	AL302371	03	East Central Alabama Mental Health Center	200 Cherry Street	Troy	AL	36081	$143,431.00	$98,373.00	$0.00	$45,058.00	$0.00		
0021	AL100106	02	Family and Child Services					$132,787.00	$0.00	$0.00	$132,787.00	$0.00		
0022	AL750058	02	Fellowship House Birmingham	1625 12th Avenue South	Birmingham	AL	35205	$430,439.00	$430,439.00	$0.00	$0.00	$0.00		
0023	AL100502	04	Franklin Memorial Health Center	1055 Dauphin Street	Mobile	AL	36604	$65,778.00	$0.00	$0.00	$65,778.00	$0.00		
0024	AL750074	02	Jefferson County Commission for Economic Opportunity	228 2nd Avenue North	Birmingham	AL	35204	$302,539.00	$204,523.00	$0.00	$98,016.00	$0.00		
0026	AL301407	03	Lighthouse Counseling Center	1415 East South Boulevard	Montgomery	AL	36116	$569,913.00	$508,186.00	$144,276.00	$61,727.00	$0.00		

0028	AL900786	01	Marshall/Jackson Mental Health Center	22165 U.S. Highway 431	Guntersville	AL	35976	$1,096,457.00	$937,617.00	$0.00	$158,840.00	$0.00		
0025	AL900737	01	Mental Health Center of Madison County	4040 Memorial Parkway SW, Suite C	Huntsville	AL	35802-1396	$747,149.00	$441,475.00	$0.00	$305,674.00	$0.00		
0029	AL901206	04	Mobile Mental Health Center	4211 Government Boulevard	Mobile	AL	36693	$808,130.00	$808,130.00	$140,137.00	$0.00	$0.00		
0030	AL100429	02	Oakmont Center	2008 21st Street Ensley	Birmingham	AL	35218	$196,188.00	$61,633.00	$0.00	$134,555.00	$0.00		
0032	AL900117	01	North Central Alabama Mental Health Center	4110 U.S. Highway 31 South	Decatur	AL	35603-1644	$707,545.00	$476,119.00	$230,298.00	$231,426.00	$0.00		
0033	AL750199	01	Northwest Alabama Mental Health Center	1100 7th Avenue	Jasper	AL	35501	$427,610.00	$257,840.00	$0.00	$169,770.00	$0.00		
0034	AL900653	01	Pathfinder	3104 Ivy Avenue SW	Huntsville	AL	35805	$4,040.00	$4,040.00	$0.00	$0.00	$0.00		
0036	AL900778	01	Riverbend Mental Health Center	635 West College Street	Florence	AL	35630	$689,305.00	$472,442.00	$0.00	$216,863.00	$0.00		
0037	AL750140	04	South Central Mental Health Center	150 Hospital Drive, P. O. Drawer 700	Luverne	AL	36049	$535,196.00	$535,196.00	$0.00	$0.00	$0.00		
0038	AL900513	04	Southwest Alabama Mental Health Center					$343,390.00	$294,502.00	$101,921.00	$48,888.00	$0.00		
0044	AL100668	01	Substance Abuse Council of Northwest Alabama	54 Wheeler Hills Road, P.O. Box 1020	Rogersville	AL	35652	$299,911.00	$299,911.00	$299,911.00	$0.00	$0.00		
0040	AL302330	01	The Bridge	3232 Lay Springs Road	Gadsden	AL	35904	$434,888.00	$434,888.00	$0.00	$0.00	$0.00		
0041	AL100049	02	University of Alabama in Birmingham Drug Free Treatment Program	401 Beacon Parkway West, Suite 270	Birmingham	AL	35209	$1,006,521.00	$837,772.00	$141,007.00	$168,749.00	$0.00		
0042	AL900687	03	West Alabama Mental Health Center	1215 South Walnut Avenue	Demopolis	AL	36732	$144,051.00	$60,768.00	$0.00	$83,283.00	$0.00		
0043	AL750124	04	Wiregrass Mental Health Board	831 John D Odom Road	Dothan	AL	36303	$1,541,039.00	$1,314,595.00	$0.00	$226,444.00	$0.00		
0101	X	01	Recovery Services	301 Godfrey Avenue SE	Fort Payne	AL	35967	$1,266.00	$1,266.00	$0.00	$0.00	$0.00		
0120	X	01	Cullman Mental Health Authority	1909 Commerce Avenue NW	Cullman	AL	35055	$185,746.00	$96,477.00	$0.00	$89,269.00	$0.00		
0059	X	02	Hope House	1002 2nd Avenue East	Montgomery	AL	36104	$37,648.00	$37,648.00	$0.00	$0.00	$0.00		
0067	X	03	SAY NO Inc	492 South Court Street Suite 1	Montgomery	AL	36104	$16,911.00	$0.00	$0.00	$16,911.00	$0.00		
Total								$22,810,150.00	$18,023,709.00	$2,960,087.00	$4,786,441.00	$0.00		

Footnotes:
Alabama's sub-state planning areas for substance abuse services are defined in terms of the state's sixty-seven (67) counties as follows: Region 1: Cherokee; Colbert; Cullman; DeKalb; Etowah; Fayette; Franklin; Jackson; Lamar; Lauderdale; Lawrence; Limestone; Madision; Marion; Marshall; Morgan; Walker; Winston.

Region 2: Bibb; Blount; Calhoun: Chilton; Clay; Cleburne; Coosa; Jefferson; Pickens; Randolph; Shelby; St. Clair; Talladega; Tuscaloosa.

Region 3: Autauga; Bullock; Chambers; Choctaw; Dallas; Elmore; Greene; Hale; Lee; Lowndes; Macon; Marengo; Montgomery; Perry; Pike; Russell; Sumter; Tallapoosa; Wilcox.

Region 4: Baldwin; Barbour; Butler; Clarke; Coffee; Conecuh; Covington; Crenshaw; Dale; Escambia; Geneva; Henry; Houston; Mobile; Monroe; Washington.

III: Expenditure Reports

Table 9a - Maintenance of Effort for State Expenditures for SAPT

Did the State or Jurisdiction have any non-recurring expenditures for a specific purpose which were not included in the MOE calculation?

Yes _____ No X

If yes, specify the amount and the State fiscal year: _____

Did the State or Jurisdiction include these funds in previous year MOE calculations?

Yes _____ No _____

When did the State submit an official request to the SAMHSA Administrator to exclude these funds from the MOE calculations? _____

Total Single State Agency (SSA) Expenditures for Substance Abuse Prevention and Treatment		
Period (A)	Expenditures (B)	B1(2010) + B2(2011) 2 (C)
SFY 2010 (1)	$16,608,336	
SFY 2011 (2)	$15,194,169	$15,901,253
SFY 2012 (3)	$16,120,891	

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

SFY 2010 Yes X No _____

SFY 2011 Yes _____ No X

SFY 2012 Yes X No _____

If estimated expenditures are provided, please indicate when actual expenditure data will be submitted to SAMHSA: _____

Footnotes:

III: Expenditure Reports

Table 9b - Base and Maintenance of Effort for State Expenditures for TB

State Expenditures for Tuberculosis Services to Individuals in Substance Use Disorder Treatment BASE				
Period	Total of All State Funds Spent on TB Services (A)	% of TB Expenditures Spent on Individuals in Substance Use Disorder Treatment (B)	Total State Funds Spent on Individuals in Substance Use Disorders Treatment (A x B) (C)	Average of Column C1 and C2 $\frac{C1+C2}{2}$ (MOE BASE) (D)
SFY 1991 (1)	$2,470,000	6%	$148,200	
SFY 1992 (2)	$2,470,000	6%	$148,200	$148,200

State Expenditures for Tuberculosis Services to Individuals in Substance Use Disorder Treatment MAINTENANCE				
Period	Total of All State Funds Spent on TB Services (A)	% of TB Expenditures Spent on Individuals in Substance Use Disorder Treatment (B)	Total State Funds Spent on Individuals in Substance Use Disorders Treatment (A x B) (C)	Average of Column C1 and C2 $\frac{C1+C2}{2}$ (MOE BASE) (D)
SFY 2012 (3)	$4,904,300	6.0000%	$294,258	

Footnotes:

By October 1, 1992, initial contacts had been made by the Division of Substance Abuse Services with the Tuberculosis Control Branch of the Alabama Department of Public Health. Planning meetings began in early November with the focus being to deliberately address preventing and treating tuberculosis for those accessing the substance abuse service system while making implementation of testing procedures of minimal disruption to programs. Immediately the issues of staff health, confidentiality regulations and consistent reporting were identified. As a result of discussions, the decision was made to train supervisors separately from clinicians and nurses in order to address administrative considerations. All staff would need training on tuberculosis and reporting procedure, etc., however, for those programs with nursing staff, retraining on placing and reading the skin test would be advisable.

Once the dilemma of both departments honoring separate sets of confidentiality regulations was identified, a detailed comparison of the laws was compiled. The end result was to find the laws basically the same with no significant areas of conflict. Both however, required individual client releases to be signed if information was to be divulged to another agency not covered under their law. Since both agencies are advocates of the client, a cooperative agreement could be developed to omit the need for releases. Another problem in this area related to the contracting arrangement with local substance abuse service providers, meaning the cooperative agreements used by the state departments would not cover substance abuse program communications to the local Health Department. To resolve this issue, a sample local interagency agreement at state level is reinforced by local agreements resulting in the elimination of individual releases when reporting the need for test results and other basic information between substance abuse and public health agencies on behalf of clients requesting services.

In order to maximize the resources of both agencies, the Division of Substance Abuse Services agreed to use the current Public Health tuberculosis reporting system and develop guidelines for all substance abuse providers in fulfilling the TB requirements. The Department of Public Health provides all supplies and equipment needed for testing except alcohol swabs and needed disposal boxes. For those programs with nursing staff, the Public Health local TB managers are available to assist on questionable test results and following up on positive results. For those programs without nursing staff, cooperative arrangements can be made for TB managers to come to the program when testing is needed by a number of clients.

Programs are also strongly encouraged to do testing of staff, although this is not a stated requirement within the Block Grant. The need for a staff testing system was obvious to the planners, along with policies and procedures of how staff TB status/issues would be accommodated.

Between February 2 and April 6, 1993, training was conducted in the four Substance Abuse Services
Regions to three audiences: administrative, clinicians and nurses. The training was segmented based on the informational needs and prominent concerns of each group. The training team was made up of the
SASD Chiefs of the Office of Training and the Office of Treatment Improvement along with the Director of the Public Health Department's Tuberculosis Control Branch, his assistant RN and a consultant M.D.

All Alabama / SAPT FY2011 /programs were given the option of attending any of the scheduled events, however, local Tuberculosis managers were available at meetings encompassing their district of supervision only. 56 administrators, 42 clinicians, and 54 nurses, totaling 152 participants attended the training. The training was approved for CEU credit hours for nurses, psychologists, social workers and counselors. After all training was completed a list of programs not represented at any event was compiled. The list was given to local TB managers for personal contact and technical assistance in adhering to the Block Grant testing requirements and state guidelines. Substance abuse programs have also been encouraged to contact the Division of Substance Abuse Services or the Tuberculosis Control Branch of Public Health regarding problems that are experienced in fulfilling the grant requirements while serving clients in the most time efficient manner.

Modifications were made in Alabama's approach to TB testing based on data collected by the Department of Public. From October 1, 1993, to September 30, 1995, the Department of Public Health screened 13,556 substance abuse clients for TB. A total of two new cases of TB were discovered. The Department of Public Health recommended that due to the very low number of new cases and the very high cost of testing every admission that Alabama cut back on the requirement for testing all admissions and provide TB tests only for those clients who show symptoms.
The Alabama Substance Abuse Services Division implemented a policy beginning October 1, 1995, requiring that intake clinicians observe and refer only those clients who show symptoms.
Since the implementation of the change beginning in October 1995, most of the community programs are only testing the clients that show symptoms of TB, however, some of the programs still test all admissions.

The programs that still require tests of all admissions provide testing on site using trained staff. It is the professional opinion of the staff with the Health Department and the substance abuse community treatment programs that the current approach will adequately detect TB infected clients receiving substance abuse treatment.

The Alabama Public Health Department estimates that approximately 6% of state funds expended for tuberculosis services are attributable to substance abusers. Therefore, the estimate of state TB expenditures for substance abusing citizens is calculated by multiplying the state expenditures, reported by the Public Health Department’s Tuberculosis Branch, by 6%. In addition to these state expenditures the

Alabama Department of Mental Health and Mental Retardation, Substance Abuse Services Division spends state funding to pay for screening/assessments for adolescents that include TB screening. The inclusion of these expenditures was approved.

TB EXPENDITURES
Alabama received a Center for Substance Abuse Treatment Core Review in April 2008. The following represents a modification to the T. B. State Expenditure Table that was prepared in consultation with the review team.

FFY 1991 $2,470,000 x .06 $148,200 0 $148,200
FFY 1992 $2,470,000 x .06 $148,200 0 $148,200
FFY 1993 $2,880,000 x .06 $172,800 0 $172,800
FFY 1994 $2,600,000 x .06 $156,000 0 $156,000
FFY 1995 $2,600,000 x .06 $156,000 0 $156,000
FFY 1996 $2,675,905 x .06 $160,554 0 $160,554
FFY 1997 $2,739,148 x .06 $164,348 0 $164,348
FFY 1998 $2,740,997 x .06 $164,459 0 $164,459
FFY 1999 $1,400,665 x .06 $ 84,039 + $130,537 = $214,576
FFY 2000 $1,552,233 x .06 $ 93,134 + $140,560 = $233,694
FFY 2001 $1,827,974 x .06 $109,678 + $147,760 = $257,438
FFY 2002 $2,012,030 x .06 $120,721 + $147,640 = $268,361
FFY 2003 $1,767,116 x .06 $106,026 + $132,905 = $238,931
FFY 2004 $2,609,454 x .06 $156,567 + $128,987 = $284,987
FFY 2005 $2,450,783 x .06 $147,046 + $144,815 = $291,861
FFY 2006 $2,873,796 x .06 $172,427 + $118,795 = $246,440
FFY 2007 $2,159,415 x .06 $129,564 + $ 88,219 = $217,784
FFY 2008 $2,119,052 x .06 $127,143 + $246,734 = $373,877
FFY 2009 $2,147,343 x .06 $128,840 + $162,177 = $291,017
FFY 2010 $2016,201 x .06 $120,972 + $206,033 = $327,005
FFY 2011 $1874,620 X .06 $112477 + $185640 = $298,117

FFY 2012 $2,050,905 X .06 $123054 + $171204 = $294258

III: Expenditure Reports

Table 9c - Base and Maintenance of Effort for Expenditures for HIV Early Intervention Services

Enter the year in which your State last became a designated State, Federal Fiscal Year _. Enter the 2 prior years' expenditure data in A1 and A2. Compute the average of the amounts in boxes A1 and A2. Enter the resulting average (MOE Base) in box B2.

State Expenditures for HIV Early Intervention Services to Individuals in Substance Use Disorder Treatment BASE		
Period	Total of All State Funds Spent on Early Intervention Services for HIV (A)	Average of Columns A1 and A2 A1+A2 / 2 (MOE Base) (B)
(1) SFY 1991	$0	
(2) SFY 1992	$0	$0

Statewide Non-Federal Expenditures for HIV Early Intervention Services to Individuals in Substance Use Disorder Treatment MAINTENANCE	
Period	Total of All State Funds Spent on Early Intervention Services for HIV (A)
(3) SFY 2012	$0

Footnotes:

III: Expenditure Reports

Table 9d - Expenditures for Services to Pregnant Women and Women with Dependent Children

Expenditures for Services to Pregnant Women and Women with Dependent Children		
Period	Total Women's Base (A)	Total Expenditures (B)
SFY 1994	$1,366,290	
SFY 2010		$2,556,405
SFY 2011		$2,556,405
SFY 2012		$2,533,488
Enter the amount the State plans to expend in SFY 2012 for services for pregnant women and women with dependent children (amount entered must be not less than amount entered in Table IV Maintenance - Box A (1994)): $ 2533488.00		

Footnotes:

IV: Populations and Services Reports

Table 10 - Prevention Strategy Report

Column A (Risks)	Column B (Strategies)	Column C (Providers)
No Risk Assigned	1. Information Dissemination	
	1. Clearinghouse/information resources centers	2
	5. Radio and TV public service announcements	2
	6. Speaking engagements	20
	7. Health fairs and other health promotion, e.g., conferences, meetings, seminars	20
	2. Education	
	1. Parenting and family management	12
	2. Ongoing classroom and/or small group sessions	20
	3. Peer leader/helper programs	5
	3. Alternatives	
	2. Youth/adult leadership activities	5
	4. Community service activities	5
	4. Problem Identification and Referral	
	2. Student Assistance Programs	1
	5. Community-Based Process	
	1. Community and volunteer training, e.g., neighborhood action training, impactor-training, staff/officials training	10
	2. Systematic planning	5
	3. Multi-agency coordination and collaboration/coalition	20
	6. Environmental	
	1. Promoting the establishment or review of alcohol, tobacco, and drug use policies in schools	10
	2. Guidance and technical assistance on monitoring enforcement governing availability and distribution of alcohol, tobacco, and other drugs	5
	3. Modifying alcohol and tobacco advertising practices	10

Footnotes:

IV: Populations and Services Reports

Table 11 - Treatment Utilization Matrix

Expenditure Period Start Date: 10/1/2011 Expenditure Period End Date: 9/30/2012

Level of Care	Number of Admissions ≥ Number of Persons Served		Costs per Person		
	Number of Admissions (A)	Number of Persons Served (B)	Mean Cost of Services (C)	Median Cost of Services (D)	Standard Deviation of Cost (E)
DETOXIFICATION (24-HOUR CARE)					
1. Hospital Inpatient	0	0	$0.00	$0.00	$0.00
2. Free-Standing Residential	681	681	$1282.07	$1230.00	$521.06
REHABILITATION/RESIDENTIAL					
3. Hospital Inpatient	0	0	$0.00	$0.00	$0.00
4. Short-term (up to 30 days)	4164	4164	$2348.65	$2352.69	$1717.30
5. Long-term (over 30 days)	1811	1811	$4260.48	$3161.34	$5063.36
AMBULATORY (OUTPATIENT)					
6. Outpatient	2232	2232	$612.47	$394.00	$646.65
7. Intensive Outpatient	13372	13372	$1161.60	$600.00	$1553.99
8. Detoxification	0	0	$0.00	$0.00	$0.00
OPIOID REPLACEMENT THERAPY					
9. Opioid Replacement Therapy	956	956	$2466.58	$2610.03	$1479.68
10. ORT Outpatient	0	0	$0.00	$0.00	$0.00

Footnotes:

Table 12 - Unduplicated Count of Persons

Expenditure Period Start Date: 10/1/2011 Expenditure Period End Date: 9/30/2012

Age	A. Total	B. WHITE		C. BLACK OR AFRICAN AMERICAN		D. NATIVE HAWAIIAN / OTHER PACIFIC ISLANDER		E. ASIAN		F. AMERICAN INDIAN / ALASKA NATIVE		G. MORE THAN ONE RACE REPORTED		H. Unknown		I. NOT HISPANIC OR LATINO		J. HISPANIC OR LATINO	
		Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
1. 17 and Under	3739	1384	644	1190	269	2	1	5	1	11	3	34	12	151	32	2763	953	15	8
2. 18 - 24	3864	1060	1220	737	430	1	1	4	3	2	3	16	23	200	164	1998	1825	22	19
3. 25 - 44	7720	2645	1879	1656	543	1	3	5	6	17	7	26	11	480	441	4780	2874	50	16
4. 45 - 64	3232	1114	535	994	199	0	0	0	0	10	3	5	1	246	125	2357	862	12	1
5. 65 and Over	137	55	12	50	4	0	0	0	0	0	0	0	0	12	4	117	20	0	0
6. Total	18692	6258	4290	4627	1445	4	5	14	10	40	16	81	47	1089	766	12015	6534	99	44
7. Pregnant Women	262		166		49		2		0		0		1		44		260		2
Number of persons served who were admitted in a period prior to the 12 month reporting period		4524																	
Number of persons served outside of the levels of care described on Table 11		0																	

Footnotes:

IV: Populations and Services Reports

Table 14 - HIV Designated States Early Intervention Services

Expenditure Period Start Date: 10/1/2011 Expenditure Period End Date: 9/30/2012

Early Intervention Services for Human Immunodeficiency Virus (HIV)		
1. Number of SAPT HIV EIS programs funded in the State	Statewide: 0	Rural: 0
2. Total number of individuals tested through SAPT HIV EIS funded programs	0	
3. Total number of HIV tests conducted with SAPT HIV EIS funds	0	
4. Total number of tests that were positive for HIV	0	
5. Total number of individuals who prior to the 12-month reporting period were unaware of their HIV infection	0	
6. Total number of HIV-infected individuals who were diagnosed and referred into treatment and care during the 12-month reporting period	0	
Identify barriers, including State laws and regulations, that exist in carrying out HIV testing services:		

Footnotes:

IV: Populations and Services Reports

Table 15 - Charitable Choice

Expenditure Period Start Date: 10/1/2011 Expenditure Period End Date: 9/30/2012

Notice to Program Beneficiaries - Check all that apply:

- þ Used model notice provided in final regulation.
- ¢ Used notice developed by State (please attach a copy to the Report).
- þ State has disseminated notice to religious organizations that are providers.
- þ State requires these religious organizations to give notice to all potential beneficiaries.

Referrals to Alternative Services - Check all that apply:

- þ State has developed specific referral system for this requirement.
- þ State has incorporated this requirement into existing referral system(s).
- þ SAMHSA's Treatment Facility Locator is used to help identify providers.
- ¢ Other networks and information systems are used to help identify providers.
- ¢ State maintains record of referrals made by religious organizations that are providers.
- ¢ _____ Enter total number of referrals necessitated by religious objection to other substance abuse providers ("alternative providers"), as defined above, made in previous fiscal year. Provide total only; no information on specific referrals required.

Brief description (one paragraph) of any training for local governments and faith-based and community organizations on these requirements.

Footnotes:

V: Performance Indicators and Accomplishments

Table 16 - Treatment Performance Measure Employment/Education Status (From Admission to Discharge)

Most recent year for which data are available

From: 1/1/2011

To: 12/31/2011

Short-term Residential(SR)

Employment/Education Status – Clients employed or student (full-time and part-time) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of clients employed or student (full-time and part-time) [numerator]	828	708
Total number of clients with non-missing values on employment/student status [denominator]	3090	3090
Percent of clients employed or student (full-time and part-time)	26.8 %	22.9 %

Long-term Residential(LR)

Employment/Education Status – Clients employed or student (full-time and part-time) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of clients employed or student (full-time and part-time) [numerator]	146	434
Total number of clients with non-missing values on employment/student status [denominator]	1058	1058
Percent of clients employed or student (full-time and part-time)	13.8 %	41.0 %

Outpatient (OP)

Employment/Education Status – Clients employed or student (full-time and part-time) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of clients employed or student (full-time and part-time) [numerator]	691	808
Total number of clients with non-missing values on employment/student status [denominator]	1899	1899
Percent of clients employed or student (full-time and part-time)	36.4 %	42.5 %

Intensive Outpatient (IO)

Employment/Education Status – Clients employed or student (full-time and part-time) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of clients employed or student (full-time and part-time) [numerator]	3016	3482

Total number of clients with non-missing values on employment/student status [denominator]	7302	7302
Percent of clients employed or student (full-time and part-time)	41.3 %	47.7 %

State Conformance To Interim Standard

States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described.

The information is collected in the Alabama Substance Abuse Information System (ASAIS) at the assessment and at discharge through an assessment screen and discharge summary screen that is individual to each client. The information is either directly entered into ASAIS or uploaded from existing provider systems through an Electronic Data Interchange (EDI) interface.

Data Source

What is the source of data for table 16? (Select all that apply)

- [x] Client self-report

Client self-report confirmed by another source:

- [ ] Collateral source
- [ ] Administrative data source
- [ ] Other, Specify

Episode of Care

How is the admission / discharge basis defined for table 16? (Select one)

- (•) Admission is on the first date of service, prior to which no service has been received for 30 days AND discharge is on the last date of service, subsequent to which no service has been received for 30 days.
- ( ) Admission is on the first date of service in a Program/Service Delivery Unit and Discharge is on the last date of service in a Program/Service Delivery Unit.
- ( ) Other, Specify

Discharge Data Collection

How was discharge data collected for table 16? (Select all that apply)

- [ ] Not applicable, data reported on form is collected at time period other than discharge.
  - ( ) In-Treatment data days post admission
  - ( ) Follow-up data months post 6
  - ( ) Other, Specify
- [x] Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment.
- [ ] Discharge data is collected for a sample of all clients who were admitted to treatment.
- [ ] Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment.
- [ ] Discharge records are not collected for approximately % of clients who were admitted for treatment.

Record Linking

Was the admission and discharge data linked for table 16? (Select all that apply)

- [x] Yes, all clients at admission were linked with discharge data using an Unique Client Identifier (UCID).

Select type of UCID: Master Client Index or Master Patient Index, centrally assigned 6

- [ ] No, State Management Information System does not utilize UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohorts basis) or State relied on other data sources for post admission data.
- [ ] No, admission and discharge records were matched using probabilistic record matching.

If Data Is Unavailable

If data is not reported, why is State unable to report? (Select all that apply)

- [ ] Information is not collected at admission.
- [ ] Information is not collected at discharge.

- Information is not collected by the categories requested.
- State collects information on the indicator area but utilizes a different measure.

Data Plans If Data Is Not Available

State must provide time-framed plans for capturing employment/education status data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.

Footnotes:

V: Performance Indicators and Accomplishments

Table 17 - Treatment Performance Measure Stability of Housing (From Admission to Discharge)

Most recent year for which data are available

From: 1/1/2011

To: 12/31/2011

Short-term Residential(SR)

Stability of Housing – Clients reporting being in a stable living situation (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of clients in a stable living situation [numerator]	3133	3071
Total number of clients with non-missing values on living arrangements [denominator]	3319	3319
Percent of clients in stable living situation	94.4 %	92.5 %

Long-term Residential(LR)

Stability of Housing – Clients reporting being in a stable living situation (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of clients in a stable living situation [numerator]	961	1055
Total number of clients with non-missing values on living arrangements [denominator]	1115	1115
Percent of clients in stable living situation	86.2 %	94.6 %

Outpatient (OP)

Stability of Housing – Clients reporting being in a stable living situation (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of clients in a stable living situation [numerator]	2173	2215
Total number of clients with non-missing values on living arrangements [denominator]	2233	2233
Percent of clients in stable living situation	97.3 %	99.2 %

Intensive Outpatient (IO)

Stability of Housing – Clients reporting being in a stable living situation (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of clients in a stable living situation [numerator]	7332	7412

Total number of clients with non-missing values on living arrangements [denominator]	7630	7630
Percent of clients in stable living situation	96.1 %	97.1 %

State Conformance To Interim Standard

States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described.

The information is collected in the Alabama Substance Abuse Information System (ASAIS) at the assessment and at discharge through an assessment screen and discharge summary screen that is individual to each client. The information is either directly entered into ASAIS or uploaded from existing provider systems through an Electronic Data Interchange (EDI) interface.

Data Source

What is the source of data for table 17? (Select all that apply)

- [x] Client self-report

Client self-report confirmed by another source:

- [ ] Collateral source
- [ ] Administrative data source
- [ ] Other, Specify

Episode of Care

How is the admission / discharge basis defined for table 17? (Select one)

- (•) Admission is on the first date of service, prior to which no service has been received for 30 days AND discharge is on the last date of service, subsequent to which no service has been received for 30 days.
- ( ) Admission is on the first date of service in a Program/Service Delivery Unit and Discharge is on the last date of service in a Program/Service Delivery Unit.
- ( ) Other, Specify

Discharge Data Collection

How was discharge data collected for table 17? (Select all that apply)

- [ ] Not applicable, data reported on form is collected at time period other than discharge.
  - ( ) In-Treatment data days post admission
  - ( ) Follow-up data months post 6
  - ( ) Other, Specify
- [x] Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment.
- [ ] Discharge data is collected for a sample of all clients who were admitted to treatment.
- [ ] Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment.
- [ ] Discharge records are not collected for approximately % of clients who were admitted for treatment.

Record Linking

Was the admission and discharge data linked for table 17? (Select all that apply)

- [x] Yes, all clients at admission were linked with discharge data using an Unique Client Identifier (UCID).

Select type of UCID: Master Client Index or Master Patient Index, centrally assigned 6

- [ ] No, State Management Information System does not utilize UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohorts basis) or State relied on other data sources for post admission data.
- [ ] No, admission and discharge records were matched using probabilistic record matching.

If Data Is Unavailable

If data is not reported, why is State unable to report? (Select all that apply)

- [ ] Information is not collected at admission.
- [ ] Information is not collected at discharge.

- Information is not collected by the categories requested.
- State collects information on the indicator area but utilizes a different measure.

Data Plans If Data Is Not Available

State must provide time-framed plans for capturing stability of housing data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.

Footnotes:

V: Performance Indicators and Accomplishments

Table 18 - Treatment Performance Measure Criminal Justice Involvement (From Admission to Discharge)

Most recent year for which data are available

From: 1/1/2011

To: 12/31/2011

Short-term Residential(SR)

Employment/Education Status – Clients employed or student (full-time and part-time) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of Clients without arrests [numerator]	2502	3224
Total number of Admission and Discharge clients with non-missing values on arrests [denominator]	3288	3288
Percent of clients without arrests	76.1 %	98.1 %

Long-term Residential(LR)

Employment/Education Status – Clients employed or student (full-time and part-time) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of Clients without arrests [numerator]	739	1067
Total number of Admission and Discharge clients with non-missing values on arrests [denominator]	1086	1086
Percent of clients without arrests	68.0 %	98.3 %

Outpatient (OP)

Employment/Education Status – Clients employed or student (full-time and part-time) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of Clients without arrests [numerator]	1759	2135
Total number of Admission and Discharge clients with non-missing values on arrests [denominator]	2221	2221
Percent of clients without arrests	79.2 %	96.1 %

Intensive Outpatient (IO)

Employment/Education Status – Clients employed or student (full-time and part-time) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of Clients without arrests [numerator]	6321	7270

Total number of Admission and Discharge clients with non-missing values on arrests [denominator]	7552	7552
Percent of clients without arrests	83.7 %	96.3 %

State Conformance To Interim Standard

States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described.

The information is collected in the Alabama Substance Abuse Information System (ASAIS) at the assessment and at discharge through an assessment screen and discharge summary screen that is individual to each client. The information is either directly entered into ASAIS or uploaded from existing provider systems through an Electronic Data Interchange (EDI) interface.

Data Source

What is the source of data for table 18? (Select all that apply)

- [x] Client self-report

Client self-report confirmed by another source:

- [ ] Collateral source
- [ ] Administrative data source
- [ ] Other, Specify

Episode of Care

How is the admission / discharge basis defined for table 18? (Select one)

- (•) Admission is on the first date of service, prior to which no service has been received for 30 days AND discharge is on the last date of service, subsequent to which no service has been received for 30 days.
- ( ) Admission is on the first date of service in a Program/Service Delivery Unit and Discharge is on the last date of service in a Program/Service Delivery Unit.
- ( ) Other, Specify

Discharge Data Collection

How was discharge data collected for table 18? (Select all that apply)

- [ ] Not applicable, data reported on form is collected at time period other than discharge.
  - ( ) In-Treatment data days post admission
  - ( ) Follow-up data months post 6
  - ( ) Other, Specify
- [x] Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment.
- [ ] Discharge data is collected for a sample of all clients who were admitted to treatment.
- [ ] Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment.
- [ ] Discharge records are not collected for approximately % of clients who were admitted for treatment.

Record Linking

Was the admission and discharge data linked for table 18? (Select all that apply)

- [x] Yes, all clients at admission were linked with discharge data using an Unique Client Identifier (UCID).

Select type of UCID: Master Client Index or Master Patient Index, centrally assigned 6

- [ ] No, State Management Information System does not utilize UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohorts basis) or State relied on other data sources for post admission data.
- [ ] No, admission and discharge records were matched using probabilistic record matching.

If Data Is Unavailable

If data is not reported, why is State unable to report? (Select all that apply)

- [ ] Information is not collected at admission.
- [ ] Information is not collected at discharge.

- Information is not collected by the categories requested.
- State collects information on the indicator area but utilizes a different measure.

Data Plans If Data Is Not Available

State must provide time-framed plans for capturing criminal justice involvement data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.

Footnotes:

V: Performance Indicators and Accomplishments

Table 19 - Treatment Performance Measure Change in Abstinence - Alcohol Use (From Admission to Discharge)

Short-term Residential(SR)

A. ALCOHOL ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)
Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol [numerator]	316	410
All clients with non-missing values on at least one substance/frequency of use [denominator]	453	453
Percent of clients abstinent from alcohol	69.8 %	90.5 %

B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL USERS AT ADMISSION
Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		102
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	137	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		74.5 %

C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL ABSTINENT AT ADMISSION
Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		308
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	316	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		97.5 %

Notes (for this level of care):	
Number of CY 2011 admissions submitted:	1,539
Number of CY 2011 discharges submitted:	1,114
Number of CY 2011 discharges linked to an admission:	456
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	453
Number of CY 2011 linked discharges eligible for this calculation (non-missing values):	453

Source: SAMHSA/CBHSQ TEDS CY 2011 admissions file and CY 2011 linked discharge file
[Records received through 5/2/2012]

Long-term Residential(LR)

A. ALCOHOL ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)
Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol [numerator]	0	1
All clients with non-missing values on at least one substance/frequency of use [denominator]	1	1
Percent of clients abstinent from alcohol	0.0 %	100.0 %

B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL USERS AT ADMISSION
Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		1
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	1	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		100.0 %

C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL ABSTINENT AT ADMISSION
Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		0
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	0	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		0.0 %

Notes (for this level of care):	
Number of CY 2011 admissions submitted:	941
Number of CY 2011 discharges submitted:	378
Number of CY 2011 discharges linked to an admission:	1
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	1
Number of CY 2011 linked discharges eligible for this calculation (non-missing values):	1

Source: SAMHSA/CBHSQ TEDS CY 2011 admissions file and CY 2011 linked discharge file
[Records received through 5/2/2012]

Outpatient (OP)

A. ALCOHOL ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)
Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol [numerator]	13	15
All clients with non-missing values on at least one substance/frequency of use [denominator]	16	16
Percent of clients abstinent from alcohol	81.3 %	93.8 %

B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL USERS AT ADMISSION
Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		3
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	3	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		100.0 %

C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL ABSTINENT AT ADMISSION
Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		12
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	13	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		92.3 %

Notes (for this level of care):	
Number of CY 2011 admissions submitted:	456
Number of CY 2011 discharges submitted:	278
Number of CY 2011 discharges linked to an admission:	32
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	16
Number of CY 2011 linked discharges eligible for this calculation (non-missing values):	16

Source: SAMHSA/CBHSQ TEDS CY 2011 admissions file and CY 2011 linked discharge file
[Records received through 5/2/2012]

Intensive Outpatient (IO)

A. ALCOHOL ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)
Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol [numerator]	550	744

All clients with non-missing values on at least one substance/frequency of use [denominator]	821	821
Percent of clients abstinent from alcohol	67.0 %	90.6 %

B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL USERS AT ADMISSION

Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		213
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	271	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		78.6 %

C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL ABSTINENT AT ADMISSION

Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		531
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	550	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		96.5 %

Notes (for this level of care):	
Number of CY 2011 admissions submitted:	3,848
Number of CY 2011 discharges submitted:	2,915
Number of CY 2011 discharges linked to an admission:	859
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	848
Number of CY 2011 linked discharges eligible for this calculation (non-missing values):	821

Source: SAMHSA/CBHSQ TEDS CY 2011 admissions file and CY 2011 linked discharge file
[Records received through 5/2/2012]

Footnotes:

V: Performance Indicators and Accomplishments

Table 20 - Treatment Performance Measure Change in Abstinence - Other Drug Use (From Admission to Discharge)

Short-term Residential(SR)

A. DRUG ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)
Drug Abstinence – Clients with no Drug use at admission vs. discharge, as a percent of all clients (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs [numerator]	228	374
All clients with non-missing values on at least one substance/frequency of use [denominator]	453	453
Percent of clients abstinent from drugs	50.3 %	82.6 %

B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG USERS AT ADMISSION
Clients abstinent from Drug at discharge among clients using Drug at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		162
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	225	
Percent of clients abstinent from drugs at discharge among clients using Drug at admission [#T2 / #T1 x 100]		72.0 %

C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG ABSTINENT AT ADMISSION
Clients abstinent from Drug at discharge among clients abstinent from Drug at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		212
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	228	
Percent of clients abstinent from drugs at discharge among clients abstinent from Drug at admission [#T2 / #T1 x 100]		93.0 %

Notes (for this level of care):	
Number of CY 2011 admissions submitted:	1,539
Number of CY 2011 discharges submitted:	1,114
Number of CY 2011 discharges linked to an admission:	456
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	453
Number of CY 2011 linked discharges eligible for this calculation (non-missing values):	453

Source: SAMHSA/CBHSQ TEDS CY 2011 admissions file and CY 2011 linked discharge file
[Records received through]

Long-term Residential(LR)

A. DRUG ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)
Drug Abstinence – Clients with no Drug use at admission vs. discharge, as a percent of all clients (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs [numerator]	0	0
All clients with non-missing values on at least one substance/frequency of use [denominator]	1	1
Percent of clients abstinent from drugs	0.0 %	0.0 %

B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG USERS AT ADMISSION
Clients abstinent from Drug at discharge among clients using Drug at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		0
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	1	
Percent of clients abstinent from drugs at discharge among clients using Drug at admission [#T2 / #T1 x 100]		0.0 %

C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG ABSTINENT AT ADMISSION
Clients abstinent from Drug at discharge among clients abstinent from Drug at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		0
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	0	
Percent of clients abstinent from drugs at discharge among clients abstinent from Drug at admission [#T2 / #T1 x 100]		0.0 %

Notes (for this level of care):	
Number of CY 2011 admissions submitted:	941
Number of CY 2011 discharges submitted:	378
Number of CY 2011 discharges linked to an admission:	1
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	1
Number of CY 2011 linked discharges eligible for this calculation (non-missing values):	1

Source: SAMHSA/CBHSQ TEDS CY 2011 admissions file and CY 2011 linked discharge file
[Records received through]

Outpatient (OP)

A. DRUG ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)
Drug Abstinence – Clients with no Drug use at admission vs. discharge, as a percent of all clients (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs [numerator]	8	12
All clients with non-missing values on at least one substance/frequency of use [denominator]	16	16
Percent of clients abstinent from drugs	50.0 %	75.0 %

B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG USERS AT ADMISSION
Clients abstinent from Drug at discharge among clients using Drug at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		5
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	8	
Percent of clients abstinent from drugs at discharge among clients using Drug at admission [#T2 / #T1 x 100]		62.5 %

C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG ABSTINENT AT ADMISSION
Clients abstinent from Drug at discharge among clients abstinent from Drug at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		7
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	8	
Percent of clients abstinent from drugs at discharge among clients abstinent from Drug at admission [#T2 / #T1 x 100]		87.5 %

Notes (for this level of care):	
Number of CY 2011 admissions submitted:	456
Number of CY 2011 discharges submitted:	278
Number of CY 2011 discharges linked to an admission:	32
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	16
Number of CY 2011 linked discharges eligible for this calculation (non-missing values):	16

Source: SAMHSA/CBHSQ TEDS CY 2011 admissions file and CY 2011 linked discharge file
[Records received through]

Intensive Outpatient (IO)

A. DRUG ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)
Drug Abstinence – Clients with no Drug use at admission vs. discharge, as a percent of all clients (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs [numerator]	527	722

All clients with non-missing values on at least one substance/frequency of use [denominator]	821	821
Percent of clients abstinent from drugs	64.2 %	87.9 %

B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG USERS AT ADMISSION

Clients abstinent from Drug at discharge among clients using Drug at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		219
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	294	
Percent of clients abstinent from drugs at discharge among clients using Drug at admission [#T2 / #T1 x 100]		74.5 %

C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG ABSTINENT AT ADMISSION

Clients abstinent from Drug at discharge among clients abstinent from Drug at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		503
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	527	
Percent of clients abstinent from drugs at discharge among clients abstinent from Drug at admission [#T2 / #T1 x 100]		95.4 %

Notes (for this level of care):	
Number of CY 2011 admissions submitted:	3,848
Number of CY 2011 discharges submitted:	2,915
Number of CY 2011 discharges linked to an admission:	859
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	848
Number of CY 2011 linked discharges eligible for this calculation (non-missing values):	821

Source: SAMHSA/CBHSQ TEDS CY 2011 admissions file and CY 2011 linked discharge file
[Records received through]

Footnotes:

V: Performance Indicators and Accomplishments

Table 21 - Treatment Performance Measure Change in Social Support Of Recovery (From Admission to Discharge)

Most recent year for which data are available

From: 1/1/2011

To: 12/31/2011

Short-term Residential(SR)

Social Support of Recovery – Clients attending Self-help Programs (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of clients attending self-help programs [numerator]	255	1318
Total number of clients with non-missing values on self-help attendance [denominator]	1543	1543
Percent of clients attending self-help programs	16.5 %	85.4 %
Percent of clients with self-help attendance at discharge minus percent of clients with self-help attendance at admission Absolute Change [%T2-%T1]	68.9 %	

Long-term Residential(LR)

Social Support of Recovery – Clients attending Self-help Programs (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of clients attending self-help programs [numerator]	352	876
Total number of clients with non-missing values on self-help attendance [denominator]	886	886
Percent of clients attending self-help programs	39.7 %	98.9 %
Percent of clients with self-help attendance at discharge minus percent of clients with self-help attendance at admission Absolute Change [%T2-%T1]	59.1 %	

Outpatient (OP)

Social Support of Recovery – Clients attending Self-help Programs (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of clients attending self-help programs [numerator]	9	33
Total number of clients with non-missing values on self-help attendance [denominator]	134	134
Percent of clients attending self-help programs	6.7 %	24.6 %
Percent of clients with self-help attendance at discharge minus percent of clients with self-help attendance at admission Absolute Change [%T2-%T1]	17.9 %	

Intensive Outpatient (IO)

Social Support of Recovery – Clients attending Self-help Programs (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of clients attending self-help programs [numerator]	205	593
Total number of clients with non-missing values on self-help attendance [denominator]	1272	1272
Percent of clients attending self-help programs	16.1 %	46.6 %
Percent of clients with self-help attendance at discharge minus percent of clients with self-help attendance at admission Absolute Change [%T2-%T1]	30.5 %	

State Conformance To Interim Standard

States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described.

The information is collected in the Alabama Substance Abuse Information System (ASAIS) at the assessment and at discharge through an assessment screen and discharge summary screen that is individual to each client. The information is either directly entered into ASAIS or uploaded from existing provider systems through an Electronic Data Interchange (EDI) interface.

Data Source

What is the source of data for table 21? (Select all that apply)

- [x] Client self-report

Client self-report confirmed by another source:

- [ ] Collateral source
- [ ] Administrative data source
- [ ] Other, Specify

Episode of Care

How is the admission / discharge basis defined for table 21? (Select one)

- (•) Admission is on the first date of service, prior to which no service has been received for 30 days AND discharge is on the last date of service, subsequent to which no service has been received for 30 days.
- ( ) Admission is on the first date of service in a Program/Service Delivery Unit and Discharge is on the last date of service in a Program/Service Delivery Unit.
- ( ) Other, Specify

Discharge Data Collection

How was discharge data collected for table 21? (Select all that apply)

- [ ] Not applicable, data reported on form is collected at time period other than discharge.
  - ( ) In-Treatment data days post admission
  - ( ) Follow-up data months post 6
  - ( ) Other, Specify
- [x] Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment.
- [ ] Discharge data is collected for a sample of all clients who were admitted to treatment.
- [ ] Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment.
- [ ] Discharge records are not collected for approximately % of clients who were admitted for treatment.

Record Linking

Was the admission and discharge data linked for table 21? (Select all that apply)

- [x] Yes, all clients at admission were linked with discharge data using an Unique Client Identifier (UCID).

Select type of UCID: Master Client Index or Master Patient Index, centrally assigned 6

- No, State Management Information System does not utilize UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohorts basis) or State relied on other data sources for post admission data.
- No, admission and discharge records were matched using probabilistic record matching.

If Data Is Unavailable

If data is not reported, why is State unable to report? (Select all that apply)

- Information is not collected at admission.
- Information is not collected at discharge.
- Information is not collected by the categories requested.
- State collects information on the indicator area but utilizes a different measure.

Data Plans If Data Is Not Available

State must provide time-framed plans for capturing change in social support data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.

Footnotes:

V: Performance Indicators and Accomplishments

Table 22 - Retention - Length of Stay (in Days) of Clients Completing Treatment

Manually Enter Data

Level of Care	Average (Mean)	25th Percentile	50th Percentile (Median)	75th Percentile
DETOXIFICATION (24-HOUR CARE)				
1. Hospital Inpatient	0	0	0	0
2. Free-Standing Residential	24	9	29	36
REHABILITATION/RESIDENTIAL				
3. Hospital Inpatient	0	0	0	0
4. Short-term (up to 30 days)	151	29	101	212
5. Long-term (over 30 days)	43	43	43	43
AMBULATORY (OUTPATIENT)				
6. Outpatient	163	42	120	208
7. Intensive Outpatient	230	106	176	261
8. Detoxification	0	0	0	0
OPIOID REPLACEMENT THERAPY				
9. Opioid Replacement Therapy	0	0	0	0

Level of Care	2011 TEDS discharge record count	
	Discharges submitted	Discharges linked to an admission
DETOXIFICATION (24-HOUR CARE)		
1. Hospital Inpatient	0	0
2. Free-Standing Residential	71	46
REHABILITATION/RESIDENTIAL		
3. Hospital Inpatient	0	0

4. Short-term (up to 30 days)	1114	456
5. Long-term (over 30 days)	378	1
AMBULATORY (OUTPATIENT)		
6. Outpatient	278	16
7. Intensive Outpatient	2915	859
8. Detoxification	0	0
OPIOID REPLACEMENT THERAPY		
9. Opioid Replacement Therapy	0	0

Source: SAMHSA/CBHSQ TEDS CY 2010 linked discharge file
[Records received through 5/2/2012 12:00:00 AM]

Footnotes:

Table 23 - Prevention Performance Measures - Reduced Morbidity-Abstinence from Drug Use/Alcohol Use; Measure: 30 Day Use

A. Measure	B. Question/Response	C. Pre-populated Data	D. Approved Substitute Data
1. 30-day Alcohol Use	Source Survey Item: NSDUH Questionnaire. "Think specifically about the past 30 days, that is, from [DATEFILL] through today. During the past 30 days, on how many days did you drink one or more drinks of an alcoholic beverage?[Response option: Write in a number between 0 and 30.] Outcome Reported: Percent who reported having used alcohol during the past 30 days.		
	Age 12 - 17 - FFY 2009	12	
	Age 18+ - FFY 2009	47	
2. 30-day Cigarette Use	Source Survey Item: NSDUH Questionnaire: "During the past 30 days, that is, since [DATEFILL], on how many days did you smoke part or all of a cigarette?[Response option: Write in a number between 0 and 30.] Outcome Reported: Percent who reported having smoked a cigarette during the past 30 days.		
	Age 12 - 17 - FFY 2009	8	
	Age 18+ - FFY 2009	30	
3. 30-day Use of Other Tobacco Products	Survey Item: NSDUH Questionnaire: "During the past 30 days, that is, since [DATEFILL], on how many days did you use [other tobacco products][1]?[Response option: Write in a number between 0 and 30.] Outcome Reported: Percent who reported having used a tobacco product other than cigarettes during the past 30 days, calculated by combining responses to questions about individual tobacco products (snuff, chewing tobacco, pipe tobacco).		
	Age 12 - 17 - FFY 2009	7	
	Age 18+ - FFY 2009	12	
4. 30-day Use of Marijuana	Source Survey Item: NSDUH Questionnaire: "Think specifically about the past 30 days, from [DATEFILL] up to and including today. During the past 30 days, on how many days did you use marijuana or hashish?[Response option: Write in a number between 0 and 30.] Outcome Reported: Percent who reported having used marijuana or hashish during the past 30 days.		
	Age 12 - 17 - FFY 2009	5	
	Age 18+ - FFY 2009	5	
5. 30-day Use of Illegal Drugs Other Than Marijuana	Source Survey Item: NSDUH Questionnaire: "Think specifically about the past 30 days, from [DATEFILL] up to and including today. During the past 30 days, on how many days did you use [any other illegal drug]?[2] Outcome Reported: Percent who reported having used illegal drugs other than marijuana or hashish during the past 30 days, calculated by combining responses to questions about individual drugs (heroin, cocaine, stimulants, hallucinogens, inhalants, prescription drugs used without doctors'orders).		
	Age 12 - 17 - FFY 2009	6	
	Age 18+ - FFY 2009	3	

[1]NSDUH asks separate questions for each tobacco product. The number provided combines responses to all questions about tobacco products other than cigarettes.
[2]NSDUH asks separate questions for each illegal drug. The number provided combines responses to all questions about illegal drugs other than marijuana or hashish.

Footnotes:

V: Performance Indicators and Accomplishments

Table 24 - Prevention Performance Measures - Reduced Morbidity-Abstinence from Drug Use/Alcohol Use; Measure: Perception Of Risk/Harm of Use

A. Measure	B. Question/Response	C. Pre-populated Data	D. Approved Substitute Data
1. Perception of Risk From Alcohol	Source Survey Item: NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they have five or more drinks of an alcoholic beverage once or twice a week?[Response options: No risk, slight risk, moderate risk, great risk] Outcome Reported: Percent reporting moderate or great risk.		
	Age 12 - 17 - FFY 2009	78	
	Age 18+ - FFY 2009	77	
2. Perception of Risk From Cigarettes	Source Survey Item: NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they smoke one or more packs of cigarettes per day?[Response options: No risk, slight risk, moderate risk, great risk] Outcome Reported: Percent reporting moderate or great risk.		
	Age 12 - 17 - FFY 2009	91	
	Age 18+ - FFY 2009	90	
3. Perception of Risk From Marijuana	Source Survey Item: NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they smoke marijuana once or twice a week?[Response options: No risk, slight risk, moderate risk, great risk] Outcome Reported: Percent reporting moderate or great risk.		
	Age 12 - 17 - FFY 2009	84	
	Age 18+ - FFY 2009	70	

Footnotes:

V: Performance Indicators and Accomplishments

Table 25 - Prevention Performance Measures - Reduced Morbidity-Abstinence from Drug Use/Alcohol Use; Measure: Age of First Use

A. Measure	B. Question/Response	C. Pre-populated Data	D. Approved Substitute Data
1. Age at First Use of Alcohol	Source Survey Item: NSDUH Questionnaire: "Think about the first time you had a drink of an alcoholic beverage. How old were you the first time you had a drink of an alcoholic beverage? Please do not include any time when you only had a sip or two from a drink.?[Response option: Write in age at first use.] Outcome Reported: Average age at first use of alcohol.risk.		
	Age 12 - 17 - FFY 2009	13	
	Age 18+ - FFY 2009	17	
2. Age at First Use of Cigarettes	Source Survey Item: NSDUH Questionnaire: "How old were you the first time you smoked part or all of a cigarette?[Response option: Write in age at first use.] Outcome Reported: Average age at first use of cigarettes.		
	Age 12 - 17 - FFY 2009	13	
	Age 18+ - FFY 2009	16	
3. Age at First Use of Tobacco Products Other Than Cigarettes	Source Survey Item: NSDUH Questionnaire: "How old were you the first time you used [any other tobacco product][1]?[Response option: Write in age at first use.] Outcome Reported: Average age at first use of tobacco products other than cigarettes.		
	Age 12 - 17 - FFY 2009	12	
	Age 18+ - FFY 2009	18	
4. Age at First Use of Marijuana or Hashish	Source Survey Item: NSDUH Questionnaire: "How old were you the first time you used marijuana or hashish?[Response option: Write in age at first use.] Outcome Reported: Average age at first use of marijuana or hashish.		
	Age 12 - 17 - FFY 2009	14	
	Age 18+ - FFY 2009	18	
5. Age at First Use of Illegal Drugs Other Than Marijuana or Hashish	Source Survey Item: NSDUH Questionnaire: "How old were you the first time you used [other illegal drugs][2]?[Response option: Write in age at first use.] Outcome Reported: Average age at first use of other illegal drugs.		
	Age 12 - 17 - FFY 2009	13	
	Age 18+ - FFY 2009	22	

[1]The question was asked about each tobacco product separately, and the youngest age at first use was taken as the measure.
[2]The question was asked about each drug in this category separately, and the youngest age at first use was taken as the measure.

Footnotes:

V: Performance Indicators and Accomplishments

Table 26 - Prevention Performance Measures - Reduced Morbidity-Abstinence from Drug Use/Alcohol Use; Measure: Perception of Disapproval/Attitudes

A. Measure	B. Question/Response	C. Pre-populated Data	D. Approved Substitute Data
1. Disapproval of Cigarettes	Source Survey Item: NSDUH Questionnaire: "How do you feel about someone your age smoking one or more packs of cigarettes a day?[Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] Outcome Reported: Percent somewhat or strongly disapproving.		
	Age 12 - 17 - FFY 2009	89	
2. Perception of Peer Disapproval of Cigarettes	Source Survey Item: NSDUH Questionnaire: "How do you think your close friends would feel about you smoking one or more packs of cigarettes a day?[Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] Outcome Reported: Percent reporting that their friends would somewhat or strongly disapprove.		
	Age 12 - 17 - FFY 2009	86	
3. Disapproval of Using Marijuana Experimentally	Source Survey Item: NSDUH Questionnaire: "How do you feel about someone your age trying marijuana or hashish once or twice?[Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] Outcome Reported: Percent somewhat or strongly disapproving.		
	Age 12 - 17 - FFY 2009	86	
4. Disapproval of Using Marijuana Regularly	Source Survey Item: NSDUH Questionnaire: "How do you feel about someone your age using marijuana once a month or more?[Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] Outcome Reported: Percent somewhat or strongly disapproving.		
	Age 12 - 17 - FFY 2009	86	
5. Disapproval of Alcohol	Source Survey Item: NSDUH Questionnaire: "How do you feel about someone your age having one or two drinks of an alcoholic beverage nearly every day?[Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] Outcome Reported: Percent somewhat or strongly disapproving.		
	Age 12 - 17 - FFY 2009	88	

Footnotes:

V: Performance Indicators and Accomplishments

Table 27 - Prevention Performance Measures - Employment/Education; Measure: Perception of Workplace Policy

A. Measure	B. Question/Response	C. Pre-populated Data	D. Approved Substitute Data
Perception of Workplace Policy	Source Survey Item: NSDUH Questionnaire: "Would you be more or less likely to want to work for an employer that tests its employees for drug or alcohol use on a random basis? Would you say more likely, less likely, or would it make no difference to you?[Response options: More likely, less likely, would make no difference] Outcome Reported: Percent reporting that they would be more likely to work for an employer conducting random drug and alcohol tests.		
	Age 18+ - FFY 2009	52	
	Age 12 - 17 - FFY 2009		

Footnotes:

V: Performance Indicators and Accomplishments

Table 28 - Prevention Performance Measures - Employment/Education; Measure: Average Daily School Attendance Rate

A. Measure	B. Question/Response	C. Pre-populated Data	D. Approved Substitute Data
Average Daily School Attendance Rate	Source: National Center for Education Statistics, Common Core of Data: *The National Public Education Finance Survey* available for download at http://nces.ed.gov/ccd/stfis.asp. Measure calculation: Average daily attendance (NCES defined) divided by total enrollment and multiplied by 100.		
	FFY 2009	96	

Footnotes:

V: Performance Indicators and Accomplishments

Table 29 - Prevention Performance Measures - Crime and Criminal Justice; Measure: Alcohol-Related Traffic Fatalities

A. Measure	B. Question/Response	C. Pre-populated Data	D. Approved Substitute Data
Alcohol-Related Traffic Fatalities	Source: National Highway Traffic Safety Administration Fatality Analysis Reporting System Measure calculation: The number of alcohol-related traffic fatalities divided by the total number of traffic fatalities and multiplied by 100.		
	FFY 2009	39	

Footnotes:

V: Performance Indicators and Accomplishments

Table 30 - Prevention Performance Measures - Crime and Criminal Justice; Measure: Alcohol and Drug Related Arrests

A. Measure	B. Question/Response	C. Pre-populated Data	D. Approved Substitute Data
Alcohol- and Drug-Related Arrests	Source: Federal Bureau of Investigation Uniform Crime Reports Measure calculation: The number of alcohol- and drug-related arrests divided by the total number of arrests and multiplied by 100.		
	FFY 2009	16	

Footnotes:

V: Performance Indicators and Accomplishments

Table 31 - Prevention Performance Measures - Social Connectedness; Measure: Family Communications Around Drug and Alcohol Use

A. Measure	B. Question/Response	C. Pre-populated Data	D. Approved Substitute Data
1. Family Communications Around Drug and Alcohol Use (Youth)	Source Survey Item: NSDUH Questionnaire: "Now think about the past 12 months, that is, from [DATEFILL] through today. During the past 12 months, have you talked with at least one of your parents about the dangers of tobacco, alcohol, or drug use? By parents, we mean either your biological parents, adoptive parents, stepparents, or adult guardians, whether or not they live with you.?[Response options: Yes, No] Outcome Reported: Percent reporting having talked with a parent.		
	Age 12 - 17 - FFY 2009	60	
2. Family Communications Around Drug and Alcohol Use (Parents of children aged 12-17)	Source Survey Item: NSDUH Questionnaire: "During the past 12 months, how many times have you talked with your child about the dangers or problems associated with the use of tobacco, alcohol, or other drugs?[1][Response options: 0 times, 1 to 2 times, a few times, many times] Outcome Reported: Percent of parents reporting that they have talked to their child.		
	Age 18+ - FFY 2009	94	

[1]NSDUH does not ask this question of all sampled parents. It is a validation question posed to parents of 12- to 17-year-old survey respondents. Therefore, the responses are not representative of the population of parents in a State. The sample sizes are often too small for valid reporting.

Footnotes:

V: Performance Indicators and Accomplishments

Table 32 - Prevention Performance Measures - Retention; Measure: Percentage of Youth Seeing, Reading, Watching, or Listening to a Prevention Message

A. Measure	B. Question/Response	C. Pre-populated Data	D. Approved Substitute Data
Exposure to Prevention Messages	Source Survey Item: NSDUH Questionnaire: "During the past 12 months, do you recall [hearing, reading, or watching an advertisement about the prevention of substance use][1]? Outcome Reported: Percent reporting having been exposed to prevention message.		
	Age 12 - 17 - FFY 2009	87	

[1]This is a summary of four separate NSDUH questions each asking about a specific type of prevention message delivered within a specific context having been exposed to prevention message.

Footnotes:

V: Performance Indicators and Accomplishments

Table 33-37 - Reporting Period - Start and End Dates for Information Reported on Tables 33, 34, 35, 36, and 37

Reporting Period Start and End Dates for Information Reported on Tables 33, 34, 35, 36 and 37
Please indicate the reporting period (start date and end date totaling 12 months by the State) for each of the following forms:

Tables	A. Reporting Period Start Date	B. Reporting Period End Date
1. Table 33 - Prevention Performance Measures - Individual-Based Programs and Strategies; Measure: Number of Persons Served By Age, Gender, Race, And Ethnicity	10/1/2011	9/30/2012
2. Table 34 - Prevention Performance Measures - Population-Based Programs And Strategies; Measure: Number of Persons Served By Age, Gender, Race, And Ethnicity	10/1/2011	9/30/2012
3. Table 35 - Prevention Performance Measures - Number of Persons Served by Type of Intervention	10/1/2011	9/30/2012
4. Table 36 - Prevention Performance Measures - Number of Evidence-Based Programs by Types of Intervention	10/1/2011	9/30/2012
5. Table 37 - Prevention Performance Measures - Total Number of Evidence-Based Programs and Total SAPTBG Dollars Spent on Evidence-Based Programs/Strategies	10/1/2011	9/30/2012

Question 1: Describe the data collection system you used to collect the NOMs data (e.g., MDS, DbB, KIT Solutions, manual process).

The Alabama Substance Abuse Information System (ASAIS)

Question 2: Describe how your State's data collection and reporting processes record a participant's race, specifically for participants who are more than one race.
Indicate whether thes State added those participants to the number for each applicable racial category or whether the State added all those partipants to the More Than One Race subcategory.

The participants were all added to the more than one race subcategory.

Footnotes:

V: Performance Indicators and Accomplishments

Table 33 - Prevention Performance Measures - Individual-Based Programs and Strategies; Measure: Number of Persons Served By Age, Gender, Race, And Ethnicity

Category	Total
Age	
0-4	0
5-11	9987
12-14	4714
15-17	875
18-20	70
21-24	47
25-44	109
45-64	53
65 and over	11
Age Not Known	230
Gender	
Male	7834
Female	8063
Gender Unknown	199
Race	
White	6110
Black or African American	8518
Native Hawaiian/Other Pacific Islander	1
Asian	57
American indian/Alaska Native	41
More Than One Race (not OMB required)	362

Race Not Known or Other (not OMB required)	1007
Ethnicity	
Hispanic or Latino	779
Not Hispanic or Latino	15317

Question 1: Describe the data collection system you used to collect the NOMs data (e.g., MDS, DbB, KIT Solutions, manual process).

The Alabama Substance Abuse Information System collected this data from each provider on a quarterly basis.

Question 2: Describe how your State's data collection and reporting processes record a participant's race, specifically for participants who are more than one race.
Indicate whether thes State added those participants to the number for each applicable racial category or whether the State added all those partipants to the More Than One Race subcategory.

We record race information exactly as it is displayed here. Those with more than one race only show up in the More than One Race column.

Footnotes:

V: Performance Indicators and Accomplishments

Table 34 - Prevention Performance Measures - Population-Based Programs And Strategies; Measure: Number of Persons Served By Age, Gender, Race, And Ethnicity

Category	Total
Age	
0-4	24994
5-11	36930
12-14	16697
15-17	20317
18-20	22200
21-24	25324
25-44	108677
45-64	98973
65 and over	77526
Age Not Known	1402316
Gender	
Male	331313
Female	36315
Gender Unknown	1139326
Race	
White	484737
Black or African American	252920
Native Hawaiian/Other Pacific Islander	62
Asian	6539
American indian/Alaska Native	3866
More Than One Race (not OMB required)	5721

Race Not Known or Other (not OMB required)	1080109
Ethnicity	
Hispanic or Latino	14194
Not Hispanic or Latino	1819760

Footnotes:

V: Performance Indicators and Accomplishments

Table 35 - Prevention Performance Measures - Number of Persons Served by Type of Intervention

Number of Persons Served by Individual- or Population-Based Program or Strategy

Intervention Type	A. Individual-Based Programs and Strategies	B. Population-Based Programs and Strategies
1. Universal Direct	24385	N/A
2. Universal Indirect	N/A	True
3. Selective	663	N/A
4. Indicated	151	N/A
5. Total	25199	1798736

Footnotes:

V: Performance Indicators and Accomplishments

Table 36 - Prevention Performance Measures - Number of Evidence-Based Programs by Types of Intervention

1. Describe the process the State will use to implement the guidelines included in the above definition.

We require all programs to use evidence-based strategies, but have given waivers in cases where there is promising evidence that the program could meet the evidence-based definition in a short time span.

2. Describe how the State collected data on the number of programs and strategies. What is the source of the data?

The information was entered by prevention providers into the Alabama Substance Abuse Information System (ASAIS) as part of their quarterly reporting process.

Table 36 - SUBSTANCE ABUSE PREVENTION Number of Evidence-Based Programs and Strategies by Type of Intervention

	A. Universal Direct	B. Universal Indirect	C. Universal Total	D. Selective	E. Indicated	F. Total
1. Number of Evidence-Based Programs and Strategies Funded	67	17	84	15	1	100
2. Total number of Programs and Strategies Funded	68	25	93	15	1	109
3. Percent of Evidence-Based Programs and Strategies	98.53 %	68.00 %	90.32 %	100.00 %	100.00 %	91.74 %

Footnotes:

V: Performance Indicators and Accomplishments

Table 37 - Prevention Performance Measures - Total Number of Evidence-Based Programs and Total SAPTBG Dollars Spent on Evidence-Based Programs/Strategies

	Total Number of Evidence-Based Programs/Strategies for IOM Category Below	Total SAPT Block Grant Dollars Spent on evidence-based Programs/Strategies
Universal Direct	Total # 67	$ 1227899.00
Universal Indirect	Total # 17	$ 2468886.00
Selective	Total # 15	$ 989657.00
Indicated	Total # 1	$ 100000.00
	Total EBPs: 100	Total Dollars Spent: $4786442.00

Footnotes:

V: Performance Indicators and Accomplishments

Prevention Attachments

Submission Uploads

FFY 2013 Prevention Attachment Category A:		Browse...	Upload
FFY 2013 Prevention Attachment Category B:		Browse...	Upload
FFY 2013 Prevention Attachment Category C:		Browse...	Upload
FFY 2013 Prevention Attachment Category D:		Browse...	Upload

Footnotes: