Prevention Funding Allocation Model
Strategic Plan

Division of Mental Health and Substance Abuse Services
Office of Prevention Services
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LIST OF ACRONYMS

ADMH	Alabama Department of Mental Health
AEOW	Alabama Epidemiology Outcomes Workgroup
ALSDE	Alabama State Department of Education
ASAIS	Alabama Substance Abuse Information System
AYP	Adequate Yearly Progress
CAPT	Center for the Application of Prevention Technology
CHS	Center for Health Statistics
CSAP	Center for Substance Abuse Prevention
DMHSAS	Division of Mental Health and Substance Abuse Services Division
EBP	Evidence-Based Process
EBPP	Evidence-Based Program and Practices
MVA	Motor Vehicle Accidents
OBC	Office of Billing and Contracts
OCP	Office of Contracts and Purchasing
OIT	Office of Information Technology
OP	Office of Prevention
PP	Prevention Plans
RFP	Request for Proposal
SAIPE	Small Area Income and Poverty Estimates
SAMHSA	Substance Abuse and Mental Health Services
SABG	Substance Abuse Prevention and Treatment block grant
SIG	State Incentive Grant

SMVF	Service Members, Veterans, and Their Families
SPAB	State Prevention Advisory Board
SPF	Strategic Prevention Framework
SPF-SIG	Strategic Prevention Framework-State Incentive Grant
SSA	Single State Agency
TBD	To Be Determined
T/TA	Training & Technical Assistance

Abstract

The Alabama Department of Mental Health (ADMH), Division of Mental Health and Substance Abuse Services (DMHSAS), Office of Prevention (OP) presents this strategic plan for substance abuse prevention in Alabama. The strategic plan will serve as the guidance document for implementation of a system's change for funding allocation for substance abuse prevention programs that seek to receive Substance Abuse Prevention and Treatment Block Grant funds (SABG) to address the state's prevention needs. A hybrid funding allocation approach utilizing county population [1] and need as determined by multiple factors is indicated. The purpose for this system's change is typified in the following targets for change.

Alabama's substance abuse prevention system seeks to:

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

Utilizing the Strategic Prevention Framework (SPF), this document details how the OP seeks to utilize a competitive bid process to disperse SABG monies, expand its prevention system, positively impact workforce development, and address a diverse array of outcomes.

This document was developed by the OP with guidance from the Alabama Epidemiology Outcomes Workgroup (AEOW) and the State Prevention Advisory Board (SPAB).

[1] Utah utilizes a population distribution based on 40% as well as New Jersey. Similarly, Oregon provides a base amount to all counties with consideration of 'larger' counties in distribution.

Introduction

At the state level, prevention services are managed through the ADMH. The ADMH was established by Alabama Acts 1965, No. 881, Section 22-50-2. Act 881 defines "mental health services" as the diagnosis of, treatment of, rehabilitation for, follow-up care of, prevention of and research into the causes of all forms of mental or emotional illness, including but not limited to, alcoholism, drug addiction, or epilepsy in combination with mental illness or intellectual disability. Among its designated powers, ADMH is authorized to plan, supervise, coordinate, and establish standards for all operations and activities of the State of Alabama, including the provision of services, related to intellectual disability and mental health.

ADMH is designated as the Single State Agency (SSA) in Alabama authorized to receive and administer any and all funds available from any source to support the provision of services and other activities within the scope of its statutory authority. However, ADMH does not operate any substance abuse prevention, treatment, or recovery support programs or directly provide any related services.

ADMH is also charged with the receipt and administration of the Mental Health and SABG provided by the Substance Abuse and Mental Health Services Administration (SAMHSA). The SABG provided by SAMHSA is the primary funding source for Alabama's public system of substance abuse services. Alabama expends block grant funds to maintain a continuum of substance abuse services. Eighty percent of the SABG funds are devoted to treatment services. Twenty percent of the SABG funds are spent on primary prevention programs for individuals who do not require treatment for substance abuse, specifying the activities proposed for each of the six strategies to include Information Dissemination, Education, Alternatives, Problem Identification and Referral, Community-based Process and Environmental.

ADMH certifies thirty-three (33) substance abuse service prevention providers and provides SABG funding to twenty-nine (29) of these providers (as of October 2013). Current OP staff have worked in the respective area for eight years and during the tenure of these staff prevention funding has always been determined as 'historical funding.' It is not known how the original funding decisions were made. What is known is that these funding decisions have continued throughout the existence of the funding cycle. Therefore, it is necessary to explore a funding allocation model that is grounded in a data driven approach.

Assessment

The assessment step provides a clearer understanding of how the OP deemed it necessary to seek a system's change for funding its statewide prevention system.

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

- Not all areas of the State are being reached, and not all citizens have access to prevention services;
- Stabilize and strengthen the State's prevention system—including funding and other resources;
- Leverage resources to build the capacity of providers;
- Prioritize current high needs areas and emerging issues when making funding decisions;
- Need to demonstrate significant improvements in reducing the problems and consequences related to substance abuse;
- Current funding structure and allocation processes make it difficult to achieve population-level outcomes;
- The SSA uses a primarily historical approach for allocating prevention funds to direct services providers. This approach hinders the SSA's ability to foster the development of outcome-based performance resource allocation and expand the use of population-based strategies and environmental approaches. Additionally, these strategies may not reach the people in the greatest need;
- Expand the reach of prevention funds. The SSA's ability to achieve its desired goal of positive population-level change and reduce high substance use rates would be enhanced by an analysis of how the reach of prevention funds could be broadened;
- Align funding with needs by moving away from school-based services to more community and environmental approaches. The prevention system would be enhanced by further aligning funding with established need, which would include moving from school-based direct services to more community and environmental strategies; and
- Rethink the resource allocation process, possibly moving away from historical funding. The SSA's ability to expand the use of population-based strategies and environmental approaches to address substance abuse prevalence rates and corresponding problems would be enhanced by the creation of a phased plan for transitioning the provider system away from historical funding to outcome-based performance resource allocation.

The review assessed how the state's prevention system addresses state needs against its ability to improve substance abuse indicators and outcomes measured by SAMSHA's National Outcome Measures. As a result of this review and its feedback it was determined that Alabama needed to address its historical funding approach to align closer with a needs based approach that could incorporate outcome-based performance resource allocation. The following addresses further how assessment was utilized.

Assessment provides a clearer understanding of substance use and factors related to substance use in Alabama's counties in order to best address their problems. The establishment and identification of state and national data sources will enhance substance abuse prevention efforts across the state. This section

includes information about the data selection process for data sources and indicators, analysis of data, and usage of data for funding purposes.

Four resource allocation planning models adapted by SAMHSA/CSAP were reviewed for consideration for the funding allocation model. The selected model will guide how funding is dispensed to address the prevention needs in the state of Alabama. A description of the models is provided below.

> Equity- Dictates equitable distribution of funds across all sub-State communities. The same amount of money is awarded to each community without applying other criteria. For example, underage drinking levels being widely distributed across a State.
>
> Highest-Contributor- Concentrates funding within a subset of communities or regions that contribute the highest number of cases to a State's total. For example, a State prioritizing substance abuse-related motor vehicle accidents (MVAs) to identify regions/communities with the highest number of MVA cases.
>
> Highest-Need- Directs funding to those communities or regions that have the highest rate (e.g., 32.2 cases per 100,000) of substance-use pattern or substance-related consequence. For example, using county data from the PRIDE survey indicating the rate of youth reporting any drinking or binge drinking in the last 30 days compared to the rate on a Statewide basis.
>
> Hybrid- Concentrates funding on "hot-spot" problem areas as defined by both prevalence numbers and rates. For example, combining the Highest-Contributor and Highest-Need models in an urban community within a State to address non-medical prescription use.

The Office of Prevention staff met on a number of occasions to review and discuss the models. From these meetings and review of the models as well as from guidance provided through CSAP's State Information Request it was determined that a hybrid approach would be selected to support the funding allocation model. The hybrid approach would combine equity resource allocation and need. The approach selected utilizes existing 310 Catchment Areas with considerations of population for each catchment area.

A. Data Selection Process

Information gathered from state and national sources provided preliminary data from which the needs assessment took direction. Counties were analyzed based on population and need.

The first component used in the allocation of funding was population. Population statistics are often used in determining federal and state program funding allocations. The formula, such as using total population, population for specific age groups or setting aside a portion of funding based off population, varies from program to program depending on the objectives of the program. For Alabama's funding allocation process, the total population estimates from the United States Census Bureau, 2013 Population Estimates will be used. Alabama consists of sixty-seven counties which comprise 22 310 catchment areas. The 22 catchment areas are compiled as seen below:

Table 1. 310 Catchment Areas Distribution by County

310 Catchment Area	County Currently Funded	County Not Currently Funded
M-1	Lauderdale, Colbert	Franklin
M-2	Limestone, Morgan	Lawrence
M-3	Madison	
M-4	Fayette, Lamar, Marion, Walker, Winston	
M-5	Jefferson,	Blount, St. Clair
M-6	DeKalb, Cherokee, Etowah	
M-7	Calhoun	Cleburne
M-8	Pickens, Tuscaloosa	Bibb,
M-9	Talladega,	Clay, Randolph, Coosa
M-10	Choctaw, Hale, Marengo, Sumter	Greene,
M-11	Chilton, Shelby	
M-12	Lee,	Chambers, Tallapoosa, Russell
M-13	Dallas,	Perry, Wilcox
M-14	Montgomery,	Autauga, Elmore, Lowndes
M-15	Pike	Macon, Bullock
M-16	Mobile	Washington
M-17		Clarke, Conecuh, Escambia, Monroe
M-18	Crenshaw	Butler, Coffee, Covington
M-19	Geneva, Henry, Houston	Dale, Barbour
M-20	Jackson, Marshall	
M-21	Baldwin	
M-22	Cullman	

The second component used in the allocation of funding was need. The first step of assessing the counties in Alabama was to determine the criteria for inclusion for need. To help determine need in relation to substance abuse the OP looked at substance abuse indicators as well as social and economic indicators within a county. The process for choosing indicators was determined by:

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

Based off the criteria, the following indicators were selected to assess Epidemiological Need:

- Alcohol and/or Drug Related Motor Vehicle Crashes
- Substance Abuse Treatment Admission[2]
- Graduation Rates
- Poverty[3]
- Suicides[4]

[2] New Jersey and Louisiana use this data element.
[3] Louisiana uses this data element.

B. Brief Profile of Selected Indicators

The following is a brief summary of the indicators selected to determine need:

Alcohol and/or Drug Related Motor Vehicle Crashes

Drunk/drugged driving is often the symptom of a larger problem of alcohol/drug misuse or abuse. Also, driving under the influence of alcohol and/or drugs not only puts the driver at risk, but also passengers and other people who share the road. In 2011, 6853 alcohol and/or drug related motor vehicle crashes occurred in Alabama. In 2010, there were 495 alcohol related crashes by causal drivers age 16 to 20.

Substance Abuse Treatment Admissions

In 2013, there were 21,607 treatment admissions that report to the Alabama Substance Abuse Information System (ASAIS) in Alabama. The primary substance for treatment admissions [5]for Alabama in 2013 was alcohol followed by marijuana then other opiates.

Graduation Rates

Poor school achievement and low school bonding is a risk factor in the early use of alcohol and/or drugs. The early onset of alcohol and/or drug use is a risk factor for developing alcohol and drug related problems later in life. In 2013, the graduation rate for Alabama was 80% (Alabama State Dept. of Education). SAMHSA states in the report, *Substance Use Among 12th Grade Aged Youths by Dropout Status*, that in the US, "Dropouts had higher overall levels of current alcohol use than students (41.6 percent versus 35.3 percent) and higher rates of current binge drinking (32.3 percent versus 23.8 percent)."[6]

Poverty

Financial means, whether through health insurance and/or income, is important to the access of substance abuse treatment. The Census Bureau uses a set of money income thresholds that vary by family size and composition to determine who is in poverty. If a family's total income is less than the family's threshold, then that family and every individual in it is considered in poverty (US Census). In 2012, the poverty rate was 19% for all ages in Alabama while the poverty rate was 27.6% for ages 0-17.

Suicides

Alcohol and other substance use disorders are a risk factor for suicide. In 2012, 721 people committed suicide in Alabama. The suicide rate for Whites males was 30.5 per 100,000 population while black and other males was 11.3 per 100,000 population. The suicide rate for White females was 7.4 per 100,000 population while black and other females was 1.4 per 100,000 population. In Alabama, 74 youth (age 24

[4] As determined by Alabama Department of Public Health's Center of Health Statistics. This indicator does not include overdose deaths.
[5] This represents treatment admissions for all ages.
[6] This is based on US data due to the limitation of ALSDE data addressing substance abuse and dropouts

and younger) suicides occurred in 2012, and 85% were males of all races. In 2012, the suicide rate (15.0) is much higher than the homicide rate (6.7) in Alabama. (Alabama Dept. of Public Health).

C. Prioritization Process

Once each indicator was selected and county-level data collected, the second step was to standardize the indicators by calculating z-scores for each indicator. Z-score is an individual test score expressed as the deviation from the mean score of the group in units of standard deviation (Merriam-Webster.com). Z-score allows for standardization of each indicator to the county average for the state. Microsoft Excel was used to calculate z-score by utilizing the formula (See Appendix 6):

$$Z = \frac{\textit{(County Value) – (Average of Counties in the Mental Health Region)}}{\textit{(Standard Deviation of Counties in the Mental Health Region)}}$$

Note while each indicator has a negative effect on substance use in a county, an increase in graduation rates has a positive effect. When calculated graduation rate z-score, the process was reversed by multiplying it scores by a negative one so higher scores reflect a negative effect.

Finally, after the z-scores for each measure was calculated, the z-score was multiplied by its respective weight then added together in order to develop a composite score (need score) for each county. The overall need score is a weighted composite of five indicators: Alcohol and/or Drug Related Motor Vehicle Crashes (30%), Substance Abuse Treatment Admissions (30%), Suicide (20%), Graduation Rates (10%), and Poverty Rates (10%). The weights added together equal 100%. Each indicator was assigned weights based off the following criteria:

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

The composite scores were listed from highest to lowest scores within each mental health region.

As data is updated and becomes available, evaluation efforts will monitor increases and/or decreases in substance abuse and associated factors. The goal is to see a decrease in substance abuse within counties through effective prevention efforts.

Capacity Building

A. Areas Needing Strengthening

Alabama's state-level planning and implementation efforts have historically focused on the management of our provider network rather than the management of our prevention service system as a whole. It is the intent of this strategic plan to serve as a guidance document in the development of capacity building in the prevention service area throughout the state.

The following are system issues that have been identified in Alabama, and are clear indicators of our need to enhance our infrastructure. Below, Table 2 illustrates a summary of Alabama's identified gaps as well as solutions to address the gaps.

Table 2. Alabama Identified Gaps and Solutions

Identified Gaps	Solutions
State and local level services tend to overlap resulting in redundancies.	Establish additional state and local collaborative venues to enhance communication and awareness of the left and right hands. The venue can be incorporated within the existing prevention provider network.
Alabama prevention providers often fail to engage in activities that focus on community change. Critical activities such as community mobilization, capacity building, and environmental strategies are not given adequate chance to succeed.	Technical assistance will orient prevention providers as to the essential elements of an effective organization affecting community change. Increased training in the areas of community mobilization, capacity building, environmental strategies and the integral role the components play will be incorporated.
Funding streams are not coordinated and often lead to service redundancies.	Encourage and promote coordination of prevention efforts, to include funding, in respective prevention regional areas to eliminate or reduce service duplication.
There is a need for increased evaluation and monitoring so that more reliable program participation reporting methods are developed.	Implementation of program evaluation, to include *on-site monitoring as well as quarterly reporting, to be conducted to measure program service delivery, and determine program effectiveness so that dysfunctional programs are improved or replaced, and service redundancies are eliminated. *The purpose of the on-site monitoring visit is to assess the coalition's compliance with federal and/or state regulations and to help the coalition and community improve established prevention systems. Coalition membership status, coalition meetings, capacity, accomplishments, barriers, will be reviewed during the visit. The results of the visit will be reviewed with Coalition designee at the conclusion of the visit, followed up by a written report within 5 business working.
There is a need to increase the number of programs that target economically disadvantaged populations. For example, some providers under serve rural	Biannual review of the data obtained from the prevention provider network plan highlights the disparity in populations served. The Evidence-Based Practice (EBP) Workgroup

(isolated populations), urban (inner city) populations, and economically disadvantaged youth and adults.	will use this review data to aid in the identification of appropriate evidence-based programs, policies, and practices to best address this target population. Training in the areas of capacity building and collaboration will be employed to broaden the scope of service areas.
Since Strategic Prevention Framework (SPF) encourages addressing prevention across life spans, and framework is incorporated into state prevention standards, we need to begin efforts to reach college and pre-school students, which traditionally are two of our larger underserved populations.	Utilization of the existing collaboration with the Alabama Department of Education to assist with best approaches and ideologies in reaching pre-school and college-aged individuals.
Gender specific programs should be utilized where appropriate.	Employ training that will provide awareness, knowledge and strategies to foster a culturally competent environment. The EBP Workgroup will partner with T/TA providers to align training that will best provide awareness, knowledge, and strategies to support gender specific programs.
Many of our service providers only began using Evidence-Based Program and Practices in 2003 during our State Incentive Grant (SIG) project period, thus, there is a need for ongoing training and technical assistance to ensure Evidence-Based Program and Practices (EBPP) institutionalization.	Employment of Best Practices in Evidence Based Program for Substance Abuse Prevention training for the provider network. T/TA may be of benefit on EBPP to expand provider knowledge base of the EBPP that currently exist that they might not be aware of. Due to funding constraints ADMH has not been able to support the level of continuing education opportunities that it has been able to in the past which has tremendously limited providers' ability to learn of new and innovative EBPP's. Thus, the EBP workgroup will be paramount in assisting this process.
The continuum of services should be expanded to include children under age five and the elderly. Both populations are underserved and are at risk of developing substance abuse problems.	Utilization of the existing collaboration with the Alabama Department of Human Resources and relationship establishment with the Alabama Department of Senior Services to assist with best approaches and ideologies in reaching children under five and elderly populations.
Local planners should examine the ethnic makeup of their programs and compare them to the ethnic makeup of their target community. Programs should perform additional outreach and needs assessment among these ethnic groups to understand how they can better meet their prevention needs.	Employ training that will provide planners with general knowledge and skills on needs assessment design and methodologies in order for them to conduct their local assessment and strategic plan; interpret the results while maintaining cultural integrity.

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

B. State- and Community-Level Activities

1. State Capacity Building Activities

Internally, the OP staff will take advantage of training opportunities that expand upon the knowledge base in respect to the science and practice of prevention, the SPF model, data collection and use, underage drinking, prescription drug and illicit drug use. When possible, new staff members will have priority selection for training opportunities. When this is not available, webinars, teleconference, state information request, etc. will be utilized. DMHSAS will continue to provide training to the prevention provider network and various community entities. Extensive training and technical assistance will be provided to communities statewide to build prevention capacity at both the state and local level. Trainings will support the development and implementation of community-based prevention planning and programming. DMHSAS will provide on-going TA so that the prevention provider network and local communities collaboratively have the necessary resources and infrastructure to adequately employ effective prevention practices.

The OP will provide T/TA to ensure that prevention providers will be capable to:

- Engage community stakeholders
- Distinguish and understand the relevancy of direct and indirect services and their impact on communities
- Train service providers and stakeholders
- Conduct sustainability planning
- Implement their strategic plan using appropriate EBPs
- Collaborate with prevention-related coalitions to prevent duplication

Training topics will include cultural competency, sustainability, evaluation, EBPs, environmental strategies, grant writing, needs assessment, strategic planning, and logic modeling. Additionally, we will continue to utilize national and regional TA resources such as the CAPT and various prevention consultants. Program evaluation, to include on-site monitoring as well as quarterly reporting, will be conducted to measure the program service delivery, and to determine program effectiveness so that programs are improved or replaced, and service redundancies are eliminated.

Our needs assessment efforts will involve comprehensive and culturally competent reviews of risk and protective factor data, service gaps, and community resources to determine how best to allocate limited prevention resources. A funding allocation approach will be utilized to ensure that prevention dollars are not customarily disseminated, but rather distributed based on identified need.

2. Community Capacity Building Activities

    a. Collaboration & Communication

Community collaborative efforts will assist in ensuring that there is adequate representation from various interrelated entities to enhance the goals, objectives and resources of the prevention provider. Representation of an entire community such as school officials, law enforcement, clergy, parents, etc. will establish an all-encompassing decision-making forum that will enhance the existing prevention infrastructure. The forum will allow diverse community representatives to dialogue to determine who, what, and how needs are addressed in their communities. With the familiarity of the community provider network and the network's knowledge on best logistics and cultural practices, facilitation will lend to increased community involvement and buy-in regarding capacity-building efforts. Participatory stakeholder dialogue

will focus on both direct and indirect services. Discussion will include items such as establishing a community outlet for youth (indirect) or teaching youth in an after-school program (direct).

b. Training

Table 3. Training Timeline

TRAINING/TECHNICAL	DEVELOPMENT	TIMELINE	TRAINER
Welcome to Prevention – Newcomer's Orientation -This training will serve as an overview of Alabama's prevention system.	Training length: 6hrs Target delivery date: Quarterly Estimate development time: TBD hours of adaptation, already developed Developer: Prevention Director/Prevention Consultants	This training should be implemented quarterly to programs/individuals interested and/or seeking prevention certification/service delivery in the State of Alabama.	Prevention Consultants
Environmental Strategies - Interactive session which will explain structural interventions as aiming to modify social, economic, and political structures and systems in which we live. These interventions may affect legislation, media, health care, marketplace and more.	Training length: 8hrs Target delivery date: TBD Estimate Development time: 80 hours Developer: CAPT	This training could be implemented during an existing conference as a two-day session; Or, could serve as a stand-alone session.	This training could be conducted by CAPT, or, use a train the trainer model where the prevention consultants are trained and in turn they implement the training with providers.
Needs Assessment-This training will provide participants with general knowledge and skills on needs assessment design and methodologies in order for them to conduct their local assessment and strategic plan. It will also include data interpretation strategies.	Training length: 2hrs Target delivery date: TBD Estimate Development time: 40 hours Developer: AEOW/Epidemiologist/Evaluator	This training could be implemented during the Prevention Provider Network quarterly meeting.	AEOW Epidemiologist Evaluator
Program Evaluation-This training will introduce participants to the basic principles of process and outcome evaluation and its applicability to the implementation of their local strategic plan, best practice intervention and cross site evaluation.	Training length: 2hrs Target delivery date: TBD Estimate Development time: TBD Developer: Evaluator	This training could be implemented during the Prevention Provider Network quarterly meeting for ADMH certified prevention providers. Follow-up by individualized technical assistance and training.	Evaluator
Decision Making Models-This training will provide participants with skills to establish healthy leadership models.	Training length: 4 hrs Target delivery date: TBD Estimate Development time: 40 hours Developer: CAPT	This training could be implemented during an existing conference as a two-day session; Or, could serve as a stand-alone	This training could be conducted by the CAPT during a designated prevention provider meeting, or, a train-the-trainer model could be employed with Prevention Consultants and

TRAINING/TECHNICAL	DEVELOPMENT	TIMELINE	TRAINER
		session.	training could be conducted at Individual TA sessions.
Strategic Planning-This training will introduce the strategic planning model. It will include the SPF-SIG framework as referenced in the prevention standards.	Training length: 2hrs Target delivery date: TBD Estimate Development time: 80 hours Developer: CAPT/AEOW/ Epidemiologist/Evaluator	This training could be implemented both individually and with all prevention providers.	This training could be conducted by CAPT, or, the use of a train the trainer model where the Prevention Management Team and Prevention Consultants are trained and in turn they implement the training with prevention providers.
Logic Modeling-This workshop will provide participants with skills to develop logic models that will illustrate the strategies prevention providers want to implement.	Training length: 4hrs Target delivery date: TBD Estimate Development time: 20 hours Developer: CAPT	This training could be implemented both individually and with all prevention providers.	This training could be conducted by CAPT if done as training with all prevention providers.
Best Practices in Evidence Based Program for Substance Abuse Prevention	Training length TBD Target delivery date: TBD Estimate Development time: TBD Developer: TBD	This training could be implemented during an existing conference.	TBD
TRAINING/SUSTAINABILITY	**DEVELOPMENT**	**TIMELINE**	**TRAINER**
Organizational/Partnership/Leadership Development- Help prevention providers examine their organization and partnerships and assess their organizational readiness to begin the task at hand. It will also orient them as to the essential elements of an efficient organization, as well as effective partnerships, leadership identification, and guide them towards the redesign or the strengthening of their organization, partnerships, leadership and coalition through an action plan.	Training length: 12 hrs Target delivery date: TBD 4 three-hour sessions Estimate Development time: 40 hours Developer: Prevention Management Team	This training could be implemented during the Prevention Provider Network quarterly meeting. Follow-up by individualized technical assistance and training.	These trainings will be conducted by Prevention Management Team. Prevention Newcomer's will obtain training during the orientation meeting. Subsequent sessions will take place either during individual TA sessions or during other prevention provider meetings.
Cultural Competence-This training will provide participants with awareness, knowledge and strategies to foster a culturally competent environment in their agency and community.	Training length: 4 hr initial training with ongoing increments of 3hrs Target delivery date: TBD Estimate Development time: 80 hours Developer: CAPT/SPF SIG Coordinator	This training could be implemented during an existing conference as a two-day session; Or, could serve as a stand-alone session.	This training could be conducted by SPF-SIG Project Coordinator and CAPT if done as a training with all funded programs or regionally OR At individual TA sessions.
Youth Involvement- This training will provide participants with guiding principles and strategies to create meaningful partnerships between adults and young people.	Training length: TBD Target delivery date: TBD Estimate Development time: TBD Developer: TBD	This training could be implemented during an existing conference as a two-day session; Or, could serve as a stand-alone session.	This training could be conducted by CAPT if done as a training with all funded programs or regionally or incorporated into the state's annual Alabama School of Alcohol and other Drug Studies.
COMMUNICATION STRATEGIES Advocacy- This workshop would introduce participants to	Developer: Training length: TBD Target delivery date: TBD	This training could be implemented	This training could be conducted by CAPT if done

TRAINING/TECHNICAL	DEVELOPMENT	TIMELINE	TRAINER
basic advocacy principles and strategies that could be used to further the structural changes prevention providers will implement. **Media**- This workshop will provide participants with basic skills to engage the media in their efforts to implement structural change.	Estimate Development time: TBD Developer: TBD	during an existing conference as a two-day session; Or, could serve as a stand-alone session.	as a training with all funded programs or regionally or incorporated into the state's annual Alabama School of Alcohol and other Drug Studies.
Grant Writing/Funding- This workshop will provide participants with basic information regarding strategies to secure long-term funding for the program's activities	Training length: TBD Target delivery date: TBD Estimate Development time: TBD Developer: CAPT/Prevention Director/SPF SIG Coordinator	This training could be implemented during an existing conference as a two-day session; Or, could serve as a stand-alone session.	This training could be conducted by Prevention Director, SPF-SIG Project Coordinator and CAPT if done as a training with all funded programs or regionally.

Planning

A. State Planning Model for Allocating Funds

The epidemiological data provided by the epidemiologist would be used to determine the priority and the allocation model. Substance abuse consequences and consumption patterns are the foundation of data utilized in the epidemiological profile for Alabama.

CSAP outlines four potential planning and allocation models. The four funding models are based on highest rate/need areas, highest-contributor, and equitable distribution across Alabama, or a hybrid model where two or more of these are blended. A descriptive detail of each of these models is provided in the Assessment section of this plan. After careful consideration, Alabama selected the Hybrid Model. The Hybrid Resource-Allocation Planning Model will use a combination of the approaches mentioned above. In addition, the hybrid model was chosen to ensure a statewide effect is created while providing additional funding to areas based on the burden of substance abuse.

B. Description of community-based activities

Beginning fiscal year 2012 all contracted prevention providers in the state were required by prevention standard 580-9-47-.04 to utilize the SPF model. Recipients of SABG funding through contract with the ADMH are subject to adherence to these standards. To ensure adherence to these standards, staff of the OP along with the Office of Certification conduct unannounced site visits to check compliance with the standards. Similarly, this standard requires providers to embed the SPF into their prevention plans that are submitted every two years and updated on a minimum of every year. This process will include the completion of a local needs assessment designed to identify local causal factors associated with the identified priority outcomes.

Each funded community will follow a standardized procedure as set forth by the OP for their local needs assessment and gather data to further examine the risk in their jurisdiction for the identified priority outcomes. Additional data will be gathered to determine the presence of key risk and protective factors that affect the identified priority outcomes. Communities will be made well aware of data requirements through forums, e-mail notifications, trainings, etc. and will have data access via the ADMH website. Service Members, Veterans, and Their Families (SMVF) are special populations that sub recipients will be encouraged to find data on.

A prerequisite for the success of the SPF is mobilization efforts. As a result of each sub-recipient conducting its own needs assessment, the following community level activities are suggested to assist this process. Various methods for mobilization will be used, including a SPF SIG forum and town meeting approaches. Town hall meetings allow for education and suggest the democratic process. During these open discussions a group of citizens are gathered, sharing a common vision, willing to work, supporting community goals, and seeking plan accomplishments. This shared vision and goal perspective will allow sub recipients and non-sub recipients to identify as allies and link likeminded interests and needs. Furthermore, these meetings will provide an opportunity for networking and building relationships that could potentially encourage the growth and development of the local planning committee. Funded organizations will be required to develop a strategic plan that outlines the community-level factors identified and appropriate evidence-based practices they will implement. The local plans will also include steps to sustain

the efforts when the grant funding ends. Included in the strategic plan will be a description of local evaluation efforts.

C. Allocation Approach

According to the selected planning model, a Hybrid Resource-Allocation Planning Model will direct funding to all currently funded counties throughout the state. Through the assessment process, the OP, AEOW and SPAB determined that the unit of analysis would be counties which are combined into their respective 310 catchment area. [7]This decision was based on the fact that the SPF program encourages community-led planning activities. The OP determined that the following indicators would best measure the need:

- Alcohol and/or Drug Related Motor Vehicle Crashes
- Substance Abuse Treatment Admission
- Graduation Rates[8]
- Poverty
- Suicides

Five percent ($221,820.02) of the available funding is set aside for incentives and for a separate contract for evaluation services. The remaining available balance is to be utilized for the funding allocation model. Funding allocation ($4,260,990.18) will be based on the 22 310 catchment areas with each counties within a catchment area having an amount required to be spent in the respective county. Awardees must spend for each county at least the required county spending amount out of the total catchment allocation.

Example: If you apply for 310 catchment area 20 (Jackson, Marshall), the allocation amount you can apply for is $137,601.98. If awarded 310 catchment area you are required to spend $55,492.74 in Jackson and $82,109.24 in Marshall.

Appendix 5 displays the funding allocation for each 310 catchment area with the required spending amounts for each county in the 310 catchment area. The 310 catchment area were proportion based on the 2013 census estimates and the five need indicators found above for the funding amounts as seen below. The aforementioned funding amount is derived from FY14 SABG. Actual FY16 funding will be determined by the FY16 SABG so amounts are subject to slight change. All decisions were agreed upon by the OP, AEOW and the SPAB.

Table 4. Funding Allocation Based on 310 Catchment Area Distribution

310 Catchment Area	Total Allocation
Catchment Area 1	$209,277.55
Catchment Area 2	$180,851.13
Catchment Area 3	$66,139.34
Catchment Area 4	$315,259.13
Catchment Area 5	$185,642.10

[7] Oklahoma uses a catchment type approach.
[8] South Dakota utilizes similar outcomes.

310 Catchment Area	Total Allocation
Catchment Area 6	$202,250.80
Catchment Area 7	$134,514.47
Catchment Area 8	$235,148.79
Catchment Area 9	$220,054.57
Catchment Area 10	$227,211.75
Catchment Area 11	$120,886.82
Catchment Area 12	$267,964.27
Catchment Area 13	$176,060.16
Catchment Area 14	$312,467.06
Catchment Area 15	$156,470.41
Catchment Area 16	$128,232.97
Catchment Area 17	$217,392.92
Catchment Area 18	$194,289.80
Catchment Area 19	$382,439.18
Catchment Area 20	$137,601.98
Catchment Area 21	$71,462.64
Catchment Area 22	$119,372.34

Based upon the selected funding allocation model the OP plans to utilize a Request for Proposal (RFP) process to distribute SABG funds beginning FY16.

Implementation

Implementation Activities

To accomplish the hybrid (equity resource allocation and need based) funding allocation model for the state of Alabama the following are the intended implementation activities.

A. RFP Process for Sub-Grantees

Utilizing the RFP approach, the OP will modify a previously developed Prevention Services RFP as the foundation for implementation. The modification of the RFP is slated for September 2014 and will be developed by the Director of Prevention with feedback from the OP staff. Upon completion of the developed RFP, it will be sent for review and feedback to the Associate Commissioner of the Division of Mental Health and Substance Abuse Services. During this review period the OP will make contact with the Office of Contracts and Purchasing (OCP) to alert them of the forthcoming RFP and the magnitude of the RFP so that the office has the capacity to field the number of RFP responses that will be received. Upon review and necessary edit consideration, the RFP will be submitted to the OCP along with a completed form C-2 from the DMHSAS Office of Billing and Contracts (OBC) for publication in October 2014. The RFP will be published on the ADMH website and all certified prevention providers and vendors will receive a notification of the RFP. Additionally, the RFP will be advertised through print media in the dominant local newspapers for the state. During this open period, RFP specific questions will be fielded by the OCP. Questions outside the scope of the OCP will be forwarded to the Director of Prevention from the OCP to respond to. Those responses will be submitted to the OCP who will in turn send the response to the individual who inquired. The RFP process is a competitive process. Allocations to each county will be based upon the funding allocation model. The RFP is anticipated to be open through February 2015.

Upon closure of the RFP, the OCP will designate the reviewers for the RFP with suggestion from the OP. An overview to the RFP and the expectations for scoring will be provided to the OCP and/or the designated reviewers prior to the review. Proposals will be evaluated and scored in accordance with Alabama Bid Laws. Final scores will be provided by the OCP to the OP. The OP will review the recommendations from the score sheet for final approval.

Contract Execution Process

Upon final approval, the OP will secure a form C-1 from the OBC as well as submit the contract language, award amount, and dates of the contract to the OBC. This information is then forwarded from the OBC to the OCP. The OCP notifies the designated applicants who will then become sub-recipients of their selection for funding. The OCP also notifies those who were not selected for funding.

B. Prevention Plans and Budgets

Subsequent to the RFP and contract execution process. Prevention plans (PP) of the sub-recipient will be submitted to the OP with a date to be determined. The PPs will be reviewed by the OP for any necessary edits prior to FY16 implementation of services. Sub-recipients will submit an edited budget to the OP as a result of the PP edits. These budgets will be reviewed by OP staff and necessary edits addressed with the sub-recipient prior to setting them up in the system by the OBC.

Upon final approval of the PP and the budget, sub-recipients will make the necessary updates in the management information system (ASAIS) prior to the start of FY16.

Funding will be distributed on a reimbursement basis up to twice a month based on data entry submissions into ASAIS as well as based on submission of contract field vouchers to the OCB.

C. Technical Assistance

As technical assistance (TA) needs are identified by the sub-recipient's those needs will be communicated to the Prevention Consultants who will deliver technical assistance via phone call, email correspondence, or face-to-face meeting. Addressing the TA needs will be ongoing. The Prevention Consultants have a well-established long standing relationship with providers and are accustom to addressing their TA needs with and through them. The Prevention Consultants work in concert with the OP to address these needs. When needs are global, TA may take on the form of a targeted presentation at the quarterly prevention provider meetings that are coordinated by the OP throughout the state. Once the RFP is released, no TA will be provided with relation to the RFP or any of its components.

D. Community-level Implementation Monitoring

The Director of Prevention will monitor the implementation process against the timeline deliverables. Sub-recipients will submit to ASAIS at least on a monthly basis along with submissions to the OCB for reimbursement consideration. At least on a yearly basis the Epidemiologist will run data against the need measures. Equally the OP will randomly pull data to see who is eligible based on the data to receive an incentive.

Incentive opportunities will be utilized for the first time in the history of the OP. A portion of the SABG (2.615% - $123,789) will be allocated towards incentives. The qualifiers for incentive consideration are site visit score (4 points), sustainability effort (3 points), and workforce development (3 points). A 10 point Incentive Award system will be utilized to determine prospective incentive award amount based on the qualifiers. The 10 point Incentive Award System is illustrated in the table (5) below.

Site visit scores must fall within the one and two year certification range to be eligible. Those receiving certification for two years based on the site visit score will receive 4 points. Those receiving certification for one year based on the site visit score will receive 1 point. The sustainability qualifier is tied to sub-recipient's ability to secure prevention specific funding from national and state entities outside of the SABG as demonstrated by notice of award at time the data is randomly pulled by the OP. If this qualifier is met then 3 points are awarded. The workforce development qualifier which accounts for 3 points is tied to the sub-recipient's ability to demonstrate prevention internships, award scholarships or educational incentives to staff pursuing certification, degree's, continuing education, and demonstrable relationships / partnerships with adjacent higher educational institutions that serve as catalysts of creating and sustaining prevention career paths.

Providers must have a total of 3-10 points to potentially qualify. Awards will be made based upon the number of counties the provider provides services to (as identified through their approved prevention plan and by their contract) as demonstrated in the table below. The incentive recipient's contract will be amended to add the award. The award can be utilized towards workforce development; specifically, conference attendance, credentials, or tuition assistance (specific to pursuit of a degree, education, or

credential related to the field of prevention); award can be utilized for additional supplies and/or equipment for prevention staff or used toward additional monies for execution of prevention strategies. Incentives will not be available to those who have had a contract reduction due to lack of service utilization within the last year or to those who have chargebacks.

Table 5. Incentive Distribution

Accumulated Points	Counties (1-3)	Counties (4-6)	Counties (7+)
8-10	$5,250/$15,750	$6,250/$18,750	$7,250/$21,750
5-7	$3,250/$9,750	$4,250/$12,750	$5,250/$15,750
3-4	$2,250/$6,750	$3,250/$9,750	$4,250/$12,750
Total Potential	$32,250	$41,250	$50,250

Up to three (3) awards per category

Implementation Activities

Table 6. Implementation Activity Timeline

Implementation Activity	Responsible	Timeline
Strategic Plan Submission (external) – Draft plan will be submitted to the AEOW/SPAB for review and input.	Office of Prevention AEOW SPAB	October 2014
Strategic Plan & RFP Submission (internal) – Draft plan and RFP will be submitted to the Associate Commissioner for review and input.	Office of Prevention Associate Commissioner	October 2014
Edits to Strategic Plan & RFP Submission (internal) – Edits to the plan based on the internal review will be accomplished.	Office of Prevention Associate Commissioner	October 2014
RFP planning – Consult with the OCP regarding forthcoming actions i.e. mass RFP, demand for scores, ability to educate scorers prior to scoring, etc.	Office of Prevention Office of Contracts & Purchasing	Ongoing
RFP release – Submit the RFP to the OCB for generation of Form C2. OCB submit the RFP along with the C2 to OCP for release.	Office of Prevention Office of Contracts & Billing Office of Contracts & Purchasing	October 2014
RFP Scoring – OCP secures scorers for the RFP. Scorers are educated by the OP on essentials to look for during review of proposals.	Office of Prevention Office of Contracts & Purchasing	February 2015 April 2015 (scoring complete)
Score Sheets – OCP provides the score sheets of the scored RFP's to the OP. OP review the submissions and ask the OCP for copy of budget and proposals of the highest scorers for each county. OP reviews the submissions to identify TA issues to address.	Office of Prevention Office of Contracts & Purchasing	April 2015
Contract Execution – the OP develops contract exhibit pages and sends those pages along with a list of the sub-recipient's, award amount, dates of award to the OCB. OCB develops a form C1 and submits the contract and the form to the OCP who notifies the sub-recipients.	Office of Prevention Office of Contracts & Billing Office of Contracts & Purchasing	May 2015

Implementation Activity	Responsible	Timeline
Prevention Plans – Sub-recipients submit plans and budgets to the OP.	Sub-recipients	TBA (To be announced post scoring completion)
Prevention Plan Reviews – OP reviews prevention plans and budgets.	OP	TBD
ASAIS training – Office of Information Technology (OIT) provides training as necessary based on identification of need determined by the OP.	Office of Prevention OIT	September 2015
Services – contracted services begin.	Sub-recipient's	October 2015

The OP will support the implementation activities as it has the full responsibility for the successful implementation. Maintenance of open communication will be an integral component of support. Thus, responsible parties will be communicated with in advance of activity and timeline. As much as possible and without infringing upon other responsible parties, the OP will ensure all required documentation is completed and submitted in a timely manner within its office and impress upon other entities the need to do the same.

Training and technical needs will be determined post RFP process for the sub-recipients. Determination will be made by review of the originally submitted prevention plans and budgets contained within the RFP proposals. Data reporting to ASAIS will be another means to identify needs. Equally, review of reimbursement vouchers will offer insight on needs. At a minimum, an annual progress report will be submitted by the sub-recipient's which will guide additional need identification.

Evaluation

The funding allocation model evaluation will include assessment of the implementation of the process, the outcomes, and long-terms impacts to the prevention system in the state. To establish evaluation of the process, the OP will develop an RFP for evaluation services. Upon conclusion of the RFP process and selection of an evaluator, the evaluator will design an evaluation plan for the state that is inclusive of the funding allocation process. During design and development of the evaluation plan, the OP will provide the evaluator with continuous feedback. Additionally, the need funding factors will help guide a portion of the evaluation to assess the prevention system's ability to impact change on the indicated factors i.e. treatment admissions, poverty rates, graduation rates, and suicide completions. It is anticipated that the sub-recipient awards would be for a minimum of four years to effectively measure change across the indicated factors.

A. Target for Change

The OP seeks to:

- Eradicate historic funding in Alabama's prevention system;
- designate a funding allocation model for the state prevention system;
- develop measures (reduction in treatment admissions, decrease in poverty rates, increase in graduation rates, and reduction in suicide completions) for delivery of prevention strategies;
- establish incentives for prevention providers; and
- fund prevention services throughout all counties in the state of Alabama.

The OP, the state Epidemiologist, the Evaluator, and the AEOW/SPAB will plan, coordinate, and manage evaluation processes. Evaluation components will include:

- Process evaluation;
- Outcome evaluation;
- Review of implementation effectiveness; and
- Development of recommendations for program improvement.

B. The Process Evaluation

A newly secured Evaluator will conduct the process evaluation to answer the major process evaluation question:

To what degree was the Funding Allocation effectively implemented?

This question will be addressed through collection and analysis of a variety of data sources to be determined and potentially developed by the Evaluator. It may include but not be limited to interviews, site visits, and training and technical assistance evaluation surveys. This array of required and appropriate data sources will provide a robust collection of data designed to collect qualitative and quantitative data relevant to these questions:

1. Did the implementation of the Funding Allocation match the plan?
2. What types of deviations from the plan occurred?

3. What led to the deviations?
4. What impact did the deviations have on implementation and desired targets for change?

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

1. The extent to which increased statewide prevention capacity is observed by the number of counties funded for and delivering prevention strategies;
2. Reduction in treatment admissions as measured by the total number of admissions per year (fiscal or calendar) by county as determined through ASAIS;
3. Decrease in poverty rates by county as measured by the estimate of poverty for the total population within a county per year determined through US Census Small Area Income and Poverty Estimates;
4. Increase in graduation rates as measured by cohort graduation rate by county per year as determined through ALSDE;
5. Reduction in suicide completions as measured by the total number of completions per year (fiscal or calendar) by county as determined through ADPH data;
6. Increased units of service across all prevention strategies per year (fiscal or calendar) by state as determined through ASAIS;
7. Increased workforce development for preventionist by year (fiscal or calendar) across the state as determined by workforce development monitoring tool (TBD), prevention budgets, and prevention balance sheets;
8. Increased use of evidence-based practices, as measured by the number of EBP employed by providers throughout the state as determined by prevention plan an annual outcomes monitoring tool (TBD);
9. Increased retention of preventionist determined by dividing the total number of agency preventionist by the number of preventionist leaving the agency.

C. The Outcome Evaluation

State level outcomes will be monitored for increases in capacity building and strengthening of the substance abuse prevention system.

State level outcomes will be collected as deemed by the state Evaluator and may include a combination of quantitative and qualitative outcome data. At a minimum, the following outcome measures will be collected with respect to the NOMs:

- Abstinence from Drug Abuse/Alcohol Use
- Return to/Stay in School
- Decreased Criminal Justice Involvement
- Cost-Effectiveness of Services (Average Cost)
- Use of Evidence-Based Practices

Changes in risk factors and protective factors; community practices, norms, and attitudes are expected at the community level as a result of the expansion in the statewide prevention system. Qualitative data

collected through the evaluation process will be utilized to measure these changes. Review of pre and post test administered at the community level through sub-recipients may be a resource for reporting these findings.

The outcome evaluation seeks to answer these questions:

1. Were substance use and its related problems, prevented or reduced?
2. Did Alabama achieve the targets for change?
3. Was prevention capacity and infrastructure for the state improved?

D. Variables to be Tracked

Program variables to be tracked include:

- the National Outcome Measures (NOMs);
- the total number of evidence-based programs;
- strategies employed;
- targeted substance;
- priority(ies);
- race;
- ethnicity;
- gender;
- age;
- community type;
- community size;
- hearing status;
- domain(s);
- IOM group identifier; and
- Other (LGBTG, homeless, students in college, military families, underserved racial & ethnic minorities, high risk youth, youth in tribal communities).

Additional variables may be identified once an evaluator is secured and/or based on updates to required data elements.

E. Evaluation Activities

The evaluator will determine the necessary evaluation activities to track the breadth of information currently collected as well as information that is yet to be collected. At a minimum frequency of yearly, the evaluator will evaluate accomplishment of prevention plan objectives.

Cross-Cutting Components and Challenges

The following are challenges that may be encountered in attempting to operationalize the funding allocation model.

- Organizational inertia and the tendency for providing agencies to be content with current trajectories could pose potential challenges.
- The allotted time frame of the award may imply a lower performance due to the restriction of data capturing and reporting in a timely manner.
- Internal infrastructure to support a timely implementation process (ADMH).
- The number of prevention providers across the state may decrease while the number of counties having prevention services increases as a result of providers addressing multiple counties which could result in a monopoly of sorts.
- The reliance on data from agencies outside of ADMH may affect ability to measure progress due to an agency making systematic changes to the data collection and analysis methodology and data availability for any indicator/variable.

References

Robert Wood Johnson Foundation & University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps, Retrieved from http://www.countyhealthrankings.org/. Accessed 2013.

Appendix 1 - Office of Prevention Organization Chart

Appendix 2 – Alabama Epidemiological Outcomes Workgroup Members 2014

Name	Agency Affiliation	Sector	Region Representation
1. Anderson, Ronada	*Viral Hepatitis Prevention Coordinator* Department of Public Health	State Partner	III
2. Brown, Maranda	*Director of Prevention Services* Department of Mental Health, Division of Mental Health & Substance Abuse Services	State Partner	III
3. Blanding, Lauren	*SPF-SIG Consultant* Department of Mental Health, Division of Mental Health & Substance Abuse Services	State Partner	III
4. Burks, Henry	*Chief Drug Inspector* Alabama Board of Pharmacy	State Partner	II
5. Burleson, Erin	*Prevention Consultant* Department of Mental Health, Division of Mental Health & Substance Abuse Services	State Partner	III
6. Deavers, Penny	*President* Southern Prevention Associates, LLC	State-level Substance Abuse Prevention Partner	II
7. Douglass, Charon	*Prevention Consultant* Department of Mental Health, Division of Mental Health & Substance Abuse Services	State Partner	II
8. English, Tafeni	*SPF-SIG Consultant* Department of Mental Health, Division of Mental Health & Substance Abuse Services	State Partner	III
9. Folks, Brandon	*Prevention Associate* Department of Mental Health, Division of Mental Health & Substance Abuse Services	State Partner	III
10. James, Catina	*Epidemiologist* Department of Mental Health, Division of Mental Health & Substance Abuse Services	State Partner	III
11. Johnson, Beverly	*SPF-SIG Coordinator* Department of Mental Health, Division of Mental Health &	State Partner	III

Name	Agency Affiliation	Sector	Region Representation
	Substance Abuse Services		
13. Means, Cesily	*Outreach Specialist* Governor's Office, Faith-Based and Community Initiatives	State Partner	III
14. Nelson, Loretta	*Representative* Department of Revenue	State Partner	III
15. Oakes, Robert	*Assistant Executive Director* Pardons and Parole	State Partner	III
16. Pendergast, Pat	*Screening and Placement Coordinator* Department of Youth Services	State Partner	III
17. Quinn, Michael	*Program Coordinator* Department of Rehabilitation	State Partner	III
18. Reese, Sondra	*Representative* Department of Public Health	State Partner	III
19. Shanks, Bill	(*Resource Provider*) Department of Public Safety	State Partner	III
20. Toney, Jim	*Representative* Prevention and Support Services Section, Alabama State Department of Education	State Partner	III
21. Winningham, Janet	*Representative* Department of Human Resources	State Partner	III
22. Wright, Bennet	*Representative* Sentencing Commission	State Partner	III

Appendix 3 – State Prevention Advisory Board Members 2014

Name	Membership Category	Sector
1. Blanding, Lauren	*SPF-SIG Consultant* Department of Mental Health, Division of Mental Health & Substance Abuse Services	State Partner
2. Deavers, Penny	*President* Southern Prevention Associates, LLC	State-level Substance Abuse Prevention Partner
3. Dunaway, Candace	*Associate Director* *Partnership for a Drug Free Community*	State-level Substance Abuse Prevention Partner
4. English, Tafeni	*SPF-SIG Consultant* Department of Mental Health, Division of Mental Health & Substance Abuse Services	State Partner
5. Forbes, Laura	*Assistant Professor of Health Education* Department of Human Studies	State-level Substance Abuse Prevention Partner
6. Foster-Payne, Pamela, M,D.	*Deputy Director* Rural Health, University of Alabama-Tuscaloosa	State-level Substance Abuse Prevention Partner
7. Garrison, Ruby	*Human Resource Manager* Big Lots Distribution Center, Inc. (Retail)	State-level Substance Abuse Prevention Partner
8. Goodwin, Kathy	*Substance Abuse Director* 310 Board Representative	Prevention Provider
9. Jones, Anne-Marie	*Prevention Coordinator*, Cherokee County Substance Abuse Council (Advocacy)	Prevention Provider
10. Keith, Jamie	*Executive Director* Alabama Campaign to Prevent Teen Pregnancy	State-level Substance Abuse Prevention Partner
11. Kelly, Emily	*Community Projects Director* Alabama Coalition against Domestic Violence (ACADV)	State-level Substance Abuse Prevention Partner
12. Long-Cohen, Leigh	*Behavior Intervention Coordinator* Homewood City Schools	State-level Substance Abuse Prevention Partner
13. Myles, Lori	*Sheriff's Assistant for Public Affairs* Mobile County Sheriff's Office	State-level Substance Abuse Prevention Partner
15. Pierre, Vandlyn	*Director* South Regional Clearinghouse, Drug Education Council, Inc.	Prevention Provider

Name	Membership Category	Sector
16. Selase, Seyram	*Director* Agency for Substance Abuse Prevention	Prevention Provider
17. Robertson, Tom	HIV Prevention Education	State Partner
18. Robinson-Cooper, Vickie	*Division Director* Department of Human Resources	State Partner
19. Schaffer, Tonia	CSAP	State Partner
20. Soule, Deborah	*Executive Director* Partnership for a Drug-free Community, Non-profit	State-level Substance Abuse Prevention Partner
21. Stapleton, Danita	Seraaj Family Homes, Inc	Substance Abuse Prevention Partner
22. Summerville, Curtis	*State Trooper* Department of Public Safety	State Partner
23. Thompson, James	*Executive Director* Alabama Association of Child Care Agencies (AACCA) Brewer-Porch Children's Center	State-level Substance Abuse Prevention Partner
24. Toney, Jim	*Education Specialist* Prevention and Support Services Section, Alabama State Department of Education	State Partner
25. Warren, Earl	*Director, Office of Institutional Development* Jacksonville State University	State-level Substance Abuse Prevention Partner
26. Watson, Gay	*Associate State Director of AARP in Alabama* Non-profit, Financial Agency	State-level Substance Abuse Prevention Partner
27. Zook, Louis	*Law Enforcement Coordinator* Office of the Attorney General	State-level Substance Abuse Prevention Partner

Appendix 4 - Data Sources

Population Estimates – US Census, QuickFacts 2013 Population Estimates

QuickFacts tables are summary profiles of the nation, states, counties, and places showing frequently requested data items from various Census Bureau programs. QuickFacts contains statistics about population, business, and geography for an area.

Alcohol and/or Drug Related Motor Vehicle Crashes – University of Alabama, Center for Advanced Public Safety; Alabama Department of Public Safety

The Center for Advanced Public Safety is a research and development center at The University of Alabama dedicated to the use of information technology to positively impact society. The research and development activities have been centered on the application of novel technology to public and transportation safety, but the work transcends these areas into health care and social services. The number of alcohol and/or drug related crashes includes where there was a positive alcohol or drug test, or the officers opinion was "yes for alcohol, drug or both.

Graduation Rate – Alabama State Department of Education**,** Accountability Reporting System

The Alabama State Department of Education (ALSDE) serves over 741,000 K-12 students in 132 public school systems. The Accountability team in the Office of Education Information and Accountability is responsible for managing and developing the state accountability program as it pertains to Adequate Yearly Progress (AYP) determinations and reporting. The Accountability Reporting System provides reports related to Cohort, AYP, Status of Systems, and Assessment Exams

Poverty Rates – US Census, Small Area Income and Poverty Estimates

The US Census Bureau, with support from other federal agencies, created the Small Area Income and Poverty Estimates (SAIPE) program to provide more current estimates of selected income and poverty statistics than those from the most recent decennial census. Estimates are created for school districts, counties, and states. These estimates combine data from administrative records, intercensal population estimates, and the decennial census with direct estimates from the American Community Survey to provide consistent and reliable single-year estimates. Poverty rate estimates for 2012 was used which was released in December 2013.

Suicides – Alabama Department of Public Health, Center for Health Statistics, Mortality Statistical Query System

The Center for Health Statistics (CHS) collects and tabulates health-related statistical data and operates the vital records system for the State of Alabama. The Statistical Analysis Division in the Center for Health Statistics conducts studies and provides analysis of health data for public health policy and surveillance. The division prepares various statistical analyses of natality, pregnancy, general mortality, infant mortality, causes of death, marriage, divorce, and other demographic and health-related data for the state and its geographical regions. The CHS houses the Mortality Statistical Query System which provides a means to

create tables showing frequencies of Alabama resident deaths for 1990 through 2012 by county, race, sex, age group, and cause of death.

Substance Abuse Treatment Admissions – Alabama Department of Mental Health, Alabama Substance Abuse Information System

Alabama Substance Abuse Information System (ASAIS), is a web-based management information system that will assist the Substance Abuse Services Division in achieving the goal of providing the highest level of client care with the funds we have available. It provides substantial built-in electronic medical record components for case management, outcomes management, financial management, and provider network management resulting in streamlined processes, increased communication, and improved access to information.

Category	Measure	Impact	Data Source	Year of Data	Weight (%)
Substance Use	Alcohol and/or Drug Related Motor Vehicle Crashes	Negative	University of Alabama, Center for Advanced Public Safety	2011	30
Substance Use	Substance Abuse Treatment Admissions	Negative	Alabama Department of Mental Health, Alabama Substance Abuse Information System	2013	30
Mental Illness	Suicide Rate	Negative	Alabama Department of Public Health, Center for Health Statistics, Mortality Statistical Query System	2012	20
Social & Economic	High School Graduation	Positive	Alabama State Department of Education, Accountability Reporting System	2013 (Graduation Cohort)	10
Social & Economic	Poverty Rate	Negative	US Census, Small Area Income and Poverty Estimates	2012	10

Appendix 5 – Funding Allocation Amounts per 310 Catchment and County

310 Catchment Area	County	Population 2013	Need	Tier	Identified Need/Population Allocation	Minimum Allocation	Required County Spending Amount	Total Catchment Allocation
1	Lauderdale	92,797	25	Need – Mid/Low Population - Highest	79,849.50	39522.84	**119,372.34**	**209,277.55**
	Franklin	31,532	46	Need – Lower Bottom Population – Mid/Low	4,471.57	39522.84	**43,994.41**	
	Colbert	54,520	57	Need – Lowest Population – Mid/High	6,387.96	39522.84	**45,910.80**	
2	Morgan	119,787	36	Need – Lower Population - Highest	42,586.40	39522.84	**82,109.24**	**180,851.13**
	Lawrence	33,587	55	Need – Lowest Population – Mid/Low	3,726.31	39522.84	**43,249.15**	
	Limestone	88,845	63	Need – Bottom Tier Population - Highest	15,969.90	39522.84	**55,492.74**	

Appendix 5 – Funding Allocation Amounts per 310 Catchment and County

310 Catchment Area	County	Population 2013	Need	Tier	Identified Need/Population Allocation	Minimum Allocation	Required County Spending Amount	Total Catchment Allocation
3	Madison	346,892	53	Need – Lowest Population – Highest	26,616.50	39522.84	**66,139.34**	**66,139.34**
4	Fayette	16,909	2	Need – High Population –Low	21,293.20	39522.84	**60,816.04**	**315,259.13**
	Lamar	14,236	4	Need – High Population – Lowest	15,969.90	39522.84	**55,492.74**	
	Walker	65,998	17	Need – Mid Population - High	63,879.60	39522.84	**103,402.44**	
	Marion	30,334	18	Need – Mid Population – Mid/Low	14,905.24	39522.84	**54,428.08**	
	Winston	24,146	62	Need – Bottom Tier Population - Low	1,596.99	39522.84	**41,119.83**	
5	Jefferson	659,479	42	Need – Lower Bottom Population – Highest	37,263.10	39522.84	**76,785.94**	**185,642.10**

Appendix 5 – Funding Allocation Amounts per 310 Catchment and County

310 Catchment Area	County	Population 2013	Need	Tier	Identified Need/Population Allocation	Minimum Allocation	Required County Spending Amount	Total Catchment Allocation
	St. Clair	86,308	56	Need – Lowest Population – Highest	21,293.20	39522.84	**60,816.04**	
	Blount	57,872	59	Need – Lowest Population – Mid/High	8,517.28	39522.84	**48,040.12**	
6	Etowah	103,931	35	Need – Low Population - Highest	47,909.70	39522.84	**87,432.54**	**202,250.80**
	Cherokee	26,203	47	Need – Lower Bottom Population - Low	3,832.78	39522.84	**43,355.62**	
	DeKalb	71,013	50	Need – Lower Bottom Population – Highest	31,939.80	39522.84	**71,462.64**	
7	Calhoun	116,736	26	Need – Lower Population – Highest	53,233.00	39522.84	**92,755.84**	**134,514.47**

Appendix 5 – Funding Allocation Amounts per 310 Catchment and County

310 Catchment Area	County	Population 2013	Need	Tier	Identified Need/Population Allocation	Minimum Allocation	Required County Spending Amount	Total Catchment Allocation
	Cleburne	14,994	44	Need – Lower Bottom Population – Lowest	2,235.79	39522.84	**41,758.63**	
8	Tuscaloosa	200,821	19	Need – Mid Population – Highest	106,466.00	39522.84	**145,988.84**	**235,148.79**
	Pickens	19,401	23	Need – Mid/Low Population – Low	6,387.96	39522.84	**45,910.80**	
	Bibb	22,512	45	Need – Lower Bottom Population – Low	3,726.31	39522.84	**43,249.15**	
9	Coosa	10,898	8	Need – High Population – Lowest	11,498.33	39522.84	**51,021.17**	**220,054.57**
	Talladega	81,096	34	Need – Low Population - Highest	47,909.70	39522.84	**87,432.54**	
	Randolph	22,727	61	Need – Bottom Tier Population – Low	1,596.99	39522.84	**41,119.83**	

Appendix 5 – Funding Allocation Amounts per 310 Catchment and County

310 Catchment Area	County	Population 2013	Need	Tier	Identified Need/Population Allocation	Minimum Allocation	Required County Spending Amount	Total Catchment Allocation
	Clay	13,486	64	Need – Bottom Tier Population - Lowest	958.19	39522.84	**40,481.03**	
10	Sumter	13,361	7	Need – High Population –Low	11,498.33	39522.84	**51,021.17**	**227,211.75**
	Greene	8,744	11	Need – Mid Population - Lowest	8,623.75	39522.84	**48,146.59**	
	Marengo	20,155	31	Need – Low Population – Low	4,790.97	39522.84	**44,313.81**	
	Hale	15,406	38	Need – Lower Population – Low	3,406.91	39522.84	**42,929.75**	
	Choctaw	13,426	58	Need – Lowest Population – Lowest	1,277.59	39522.84	**40,800.43**	
11	Chilton	43,951	15	Need – Mid Population – Mid	25,871.24	39522.84	**65,394.08**	**120,886.82**

Appendix 5 – Funding Allocation Amounts per 310 Catchment and County

310 Catchment Area	County	Population 2013	Need	Tier	Identified Need/Population Allocation	Minimum Allocation	Required County Spending Amount	Total Catchment Allocation
	Shelby	204,180	67	Need – Bottom Tier Population – Highest	15,969.90	39522.84	**55,492.74**	
12	Russell	59,585	13	Need – Mid Population – Mid/High	57,491.64	39522.84	**97,014.48**	**267,964.27**
	Chambers	34,162	29	Need – Lower Population – Mid/Low	7,452.62	39522.84	**46,975.46**	
	Tallapoosa	41,203	40	Need – Lower Population – Mid	7,665.55	39522.84	**47,188.39**	
	Lee	150,933	41	Need – Lower Bottom Population – Highest	37,263.10	39522.84	**76,785.94**	
13	Dallas	41,996	1	Need – High Population – Mid/Low	47,909.70	39522.84	**87,432.54**	**176,060.16**

Appendix 5 – Funding Allocation Amounts per 310 Catchment and County

310 Catchment Area	County	Population 2013	Need	Tier	Identified Need/Population Allocation	Minimum Allocation	Required County Spending Amount	Total Catchment Allocation
	Wilcox	11,307	14	Need – Mid Population – Lowest	8,623.75	39522.84	**48,146.59**	
	Perry	10,020	65	Need – Bottom Tier Population - Lowest	958.19	39522.84	**40,481.03**	
14	Lowndes	10,703	5	Need – High Population – Lowest	15,969.90	39522.84	**55,492.74**	**312,467.06**
	Montgomery	226,659	24	Need – Mid/Low Population – Highest	79,849.50	39522.84	**119,372.34**	
	Elmore	80,902	32	Need – Low Population – Highest	47,909.70	39522.84	**87,432.54**	
	Autauga	55,246	51	Need – Lowest Population – Mid/High	10,646.60	39522.84	**50,169.44**	

Appendix 5 – Funding Allocation Amounts per 310 Catchment and County

310 Catchment Area	County	Population 2013	Need	Tier	Identified Need/Population Allocation	Minimum Allocation	Required County Spending Amount	Total Catchment Allocation
15	Pike	33,339	9	Need – High Population – Mid/Low	26,829.43	39522.84	**66,352.27**	**156,470.41**
	Macon	19,688	20	Need – Mid Population – Low	8,517.28	39522.84	**48,040.12**	
	Bullock	10,639	39	Need – Lower Population – Lowest	2,555.18	39522.84	**42,078.02**	
16	Mobile	414,079	33	Need – Low Population - Highest	47,909.70	39522.84	**87,432.54**	**128,232.97**
	Washington	16,877	66	Need – Bottom Tier Population – Low	1,277.59	39522.84	**40,800.43**	
17	Escambia	37,983	3	Need – High Population – Mid/Low	42,586.40	39522.84	**82,109.24**	**217,392.92**
	Conecuh	12,887	10	Need – High Population – Lowest	11,498.33	39522.84	**51,021.17**	

Appendix 5 – Funding Allocation Amounts per 310 Catchment and County

310 Catchment Area	County	Population 2013	Need	Tier	Identified Need/Population Allocation	Minimum Allocation	Required County Spending Amount	Total Catchment Allocation
	Monroe	22,236	54	Need – Lowest Population – Low	2,661.65	39522.84	**42,184.49**	
	Clarke	25,207	60	Need – Lowest Population – Low	2,555.18	39522.84	**42,078.02**	
18	Covington	37,886	16	Need – Mid Population – Mid	17,034.56	39522.84	**56,557.40**	**194,289.80**
	Butler	20,265	21	Need – Mid/Low Population – Low	7,984.95	39522.84	**47,507.79**	
	Coffee	50,938	49	Need – Lower Bottom Population – Mid/High	9,581.94	39522.84	**49,104.78**	
	Crenshaw	13,986	52	Need – Lowest Population – Lowest	1,596.99	39522.84	**41,119.83**	
19	Geneva	26727	6	Need – High Population – Mid/Low	22,996.66	39522.84	**62,519.50**	**382,439.18**
	Houston	103,668	12	Need – Mid Population – Highest	143,729.10	39522.84	**183,251.94**	

Appendix 5 – Funding Allocation Amounts per 310 Catchment and County

310 Catchment Area	County	Population 2013	Need	Tier	Identified Need/Population Allocation	Minimum Allocation	Required County Spending Amount	Total Catchment Allocation
	Henry	17,296	27	Need – Lower Population – Low	4,258.64	39522.84	**43,781.48**	
	Barbour	27,076	28	Need – Lower Population – Mid/Low	6,387.96	39522.84	**45,910.80**	
	Dale	49,884	43	Need – Lower Bottom Population – Mid/High	7,452.62	39522.84	**46,975.46**	
20	Jackson	52,951	30	Need – Lower Population – High	15,969.90	39522.84	**55,492.74**	**137,601.98**
	Marshall	94,760	37	Need – Lower Population - Highest	42,586.40	39522.84	**82,109.24**	
21	Baldwin	195,540	48	Need – Lower Bottom Population – Highest	31,939.80	39522.84	**71,462.64**	**71,462.64**

Appendix 5 – Funding Allocation Amounts per 310 Catchment and County

310 Catchment Area	County	Population 2013	Need	Tier	Identified Need/Population Allocation	Minimum Allocation	Required County Spending Amount	Total Catchment Allocation
22	Cullman	80,811	22	Need – Mid/Low Population – Highest	79,849.50	39522.84	**119,372.34**	**119,372.34**

Appendix 6 - Z-Score Calculation Example

- This data is not factual. It is only for explanation purposes.

Step 1. Collect your data

Autauga	77
Bullock	85
Chambers	67
Choctaw	65
Dallas	74
Elmore	59
Greene	73
Hale	81
Lee	58
Lowndes	82
Macon	75

Step 2. Find the mean of the counties.
a. Add all the values together and divide the number of counties used
77+85+67+65+74+59+73+81+58+82+75 = 796
796/11= 72.36

Step 3. Calculate the standard deviation of the counties.
Represents how tightly or loosely the values are grouped around the mean. In this example, the standard deviation of the set of data is 9.091455.

Step 4. Calculate the Z score.
For this example purposes Autauga county sample was used to calculate Z-score

$$Z = \frac{\text{(County Value) – (Average of Counties in the Region)}}{\text{(Standard Deviation of Counties in the Region)}}$$

$$Z = \frac{77-72.36}{9.09} = 0.51$$

The result of that formula is the Z score of the chosen sample, indicating how many standard deviations away from the mean the chosen sample lies. For this example the Z-score indicates how many standard deviations above the mean the sample lays.

Step 5. Multiple by Weight
For this example purposes, a weight of 20% was give for the factor above.

Z-score *weight = 0.51*.20 = 0.102