Prevention Funding Allocation Model Strategic Plan

Division of Mental Health and Substance Abuse Services
Office of Prevention Services
January 2019

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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
PPT	Prevention Plan Template
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 the implementation sustainability of 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. The purpose of the funding allocation is to sustain a model that is grounded in a data driven approach, which aligns with the original system's change (2014)[1]. A hybrid funding allocation approach utilizing county population and need as determined by multiple factors is indicated.

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, originally guided by the efforts of the Alabama Epidemiology Outcomes Workgroup (AEOW) and the State Prevention Advisory Board (SPAB), has been updated to reflect the most up-to-date relevant information.

[1]Prevention Funding Allocation Model Strategic Plan 2014 http://www.mh.alabama.gov/SAPV/?sm=c_f

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 twenty-four (24) substance abuse service prevention providers and provides SABG funding to fifteen (15) of these providers (as of January 2019).

Assessment

During the introduction and implementation of the 2014 needs-based approach, the following areas of Alabama's prevention system were strengthened:

- Access to prevention services was made available to all 67 counties within the State of Alabama;
- The State's prevention system was stabilized and strengthened, to include funding and other resources;
- Resources were leveraged to build the capacity of providers;
- Current high need areas and emerging issues were prioritized when making funding decisions;
- Established the need to demonstrate significant improvements in reducing the problems and consequences related to substance abuse;
- Provided avenues to achieve population-level outcomes;
- Increased the SSA's ability to foster the development of outcome-based performance resource allocation and expand the use of population-based strategies, environmental approaches, and strategies that reach people in the greatest need;
- Expanded prevention funds;
- Allowed the alignment of funding with needs by moving away from school-based services to more community and environmental approaches; and
- Enhanced the SSA's ability to address substance abuse prevalence rates and corresponding problems.

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 and determine if any changes deemed necessary. From these meetings and review of the models, it was determined that the hybrid approach would be the continued approach 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, 2016 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	Counties 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, St. Clair, Blount
M-6	DeKalb, Cherokee, Etowah
M-7	Calhoun, Cleburne
M-8	Pickens, Tuscaloosa, Bibb
M-9	Talladega, Coosa, Randolph, Clay
M-10	Choctaw, Hale, Marengo, Sumter, Greene
M-11	Chilton, Shelby
M-12	Lee, Russell, Chambers, Tallapoosa
M-13	Dallas, Wilcox, Perry
M-14	Montgomery, Lowndes, Elmore, Autauga
M-15	Pike, Macon, Bullock
M-16	Mobile, Washington

M-17	Escambia, Conecuh, Monroe, Clarke
M-18	Crenshaw, Covington, Butler, Coffee
M-19	Geneva, Henry, Houston, Barbour, Dale
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:

- Persons Killed & Highest Driver Blood Alcohol Concentration (.08+) in Crash
- Substance Abuse Treatment Admission[1,4]
- High School Graduate or Higher
- Poverty[2]
- Suicides[3]

B. Brief Profile of Selected Indicators

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

Persons Killed & Highest Driver Blood Alcohol Concentration (BAC) in Crash

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 2016, 27% of persons killed in crashes the driver had blood alcohol concentration (.08+) in Alabama.

Substance Abuse Treatment Admissions

In 2017, there were 25,185 treatment admissions that report to the Alabama Substance Abuse Information System (ASAIS) in Alabama. The primary substance for treatment admissions [4]for Alabama in 2013 was marijuana/hashish followed by alcohol.

[1] New Jersey and Louisiana use this data element.
[2] Louisiana uses this data element.
[3] As determined by Alabama Department of Public Health's Center of Health Statistics. This indicator does not include overdose deaths.
[4] This represents treatment admissions for all ages.

High School Graduate or Higher

In 2012-2016, the percentage of high school graduates or higher was 83.4% for persons 25 years old or older. The 2012-2016 American Community Survey 5-year estimates include results from both the American Community Survey and the Puerto Rico Community Survey. The statistics presented describe the entire data collection period, from January 1, 2012 to December 31, 2016. The 2012-2016 ACS 5-year data products include estimates of demographic, social, housing and economic characteristics for people living in housing units and group quarters.

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 2016, the poverty rate was 17.2% for all ages in Alabama.

Suicides

Alcohol and other substance use disorders are a risk factor for suicide. In 2015, 748 people committed suicide in Alabama. In 2016, more than 79% of all Alabama suicides were males of all races. The suicide rate 16.2 is much higher than the homicide rate (11.2), both in Alabama and in the U.S. as a whole. (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: Persons Killed & Highest Driver Blood Alcohol Concentration (.08+) in Crash (20%), Substance Abuse Treatment Admissions (20%), Suicide (20%), % High School Graduate or Higher, Age 25 years + (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 of Improvement

Within the past three years, Alabama's state-level planning and implementation efforts have shifted focus from the management of our provider network to the management of our statewide prevention service system. A primary goal for the OP is to build prevention capacity and infrastructure at the state and community levels. Increased capacity allows Alabama to support effective substance abuse prevention services at both the state and local levels.

The following are system issues that were identified in Alabama prior to the introduction of the current planning process, the needs identified to enhance our infrastructure, and associated outcomes.

Table 2. Previously Alabama Identified Gaps and Outcomes

Identified Gaps	Outcomes
There was a need to build capacity and buy-in for environmental strategies that previously were invested heavily in school-based programming.	Training opportunities were employed to emphasize the importance of individual and environmental intervention strategies and fully understanding the necessity for broader approaches as it relates to changing conditions within communities that may lead to substance use. Currently, 91% of Alabama's counties are inclusive of environmental intervention strategies.
There was a need for an increased understanding of appropriately defining CSAP strategies, particularly environmental.	Increased technical assistance assisted prevention providers in the identification, selection and implementation of the six CSAP strategies. FY'18 technical assistance increased 10.5%.
There was a need to expand collaboration and coordination at the state and local levels across agencies and subrecipients.	Explored opportunities to increase coordination among prevention efforts at the substate level, both individually with subrecipients as well as in partnership with other state agencies and stakeholder organizations and their prevention subrecipients.
There was a need for formal, proactive efforts to build the capacity of volunteers and community and coalition members to enhance the effectiveness of community-led prevention efforts.	Technical assistance allowed prevention providers to obtain knowledge of the essential elements of an effective organization affecting community change. In addition to in-state technical assistance, coordinated efforts with Community Anti-Drug Coalitions of America (CADCA), assisted Alabama with technical assistance to sufficiently orient the prevention network to community mobilization, capacity building, and environmental strategies.
Funding streams were not coordinated and often lead to service redundancies.	Encouraged and promoted coordination of prevention efforts, to include strategic funding distribution, to eliminate or reduce service duplication.
There was a need for increased evaluation and monitoring so that more reliable program	Implementation of program evaluation included on-site monitoring as well as quarterly reporting to measure

participation reporting methods are developed.	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/agency's compliance with federal and/or state regulations and to help the coalition, provider and community improve established prevention systems.
There was a need for the selection of prevention strategies or to target priority issues or populations to be data driven.	The utilization of data and evidence-based strategies as priority for decision-making and strategy implementation are an expectation and pivotal to effective programmatic service provision.
There was a need to increase the number of programs that target economically disadvantaged populations. For example, some providers underserved rural (isolated populations), urban (inner city) populations, and economically disadvantaged youth and adults.	Addressing disparity in populations is immersed into prevention planning efforts. Training in the areas of capacity building and collaboration are employed to broaden the scope of service areas. To date, four (4) health disparity trainings have been conducted.
Since Strategic Prevention Framework (SPF) encourages addressing prevention across life spans, and framework is incorporated into state prevention standards, we needed to begin efforts to reach college and pre-school students, which traditionally are two of our larger underserved populations.	Implementation of the Community College Initiative within the four regions of the state, afforded the opportunity to reach and expand efforts to college students. Utilization of the existing collaboration with the Alabama Higher Education Partnership will continue to assist with best approaches and ideologies in reaching college-aged individuals. In addition, the continued partnerships with the Alabama Department of Education will assist with pre-school efforts.
Gender specific programs should be utilized where appropriate.	Efforts are currently underway to employ trainings that will provide awareness, knowledge and strategies to foster a culturally competent environment as it relates to gender specific programs.
There was a need to utilize community engagement strategies to build support for implementation of evidence-based strategies	The introduction of the newly revised Prevention Plan Template (PPT) and technical assistance, effective FY'19, will assist with exploring how the base of popular local support incurred through community engagement activities (e.g., talent shows, youth ATOD prevention commercials) can be leveraged to build support for the corollary implementation of prevention strategies that have strong evidence of effectiveness in reducing local ATOD-related problems.
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 the Alabama Department of Senior Services to assist with best approaches and ideologies in reaching children under five and elderly populations. Technical assistance has been received by the State Prevention Advisory Board (SPAB), to include the Alabama Department of Senior Services, as well as the prevention provider network to explore best approaches and practices to reach older populations. Stakeholders have convened as it relates to the expansion

	of service provision zero to five and technical assistance will be employed.
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.	Specific training that provides 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 was employed.
Many of our service providers have difficulty with program data as it relates to the numbers and characteristics of persons served, thus, there is a need for ongoing training and technical assistance to ensure the necessary information for reporting purposes is captured.	Efforts were employed to strengthen and revise subrecipient process evaluation protocols to ensure the ability to track and report all federal program information required to include building the capacity of providers to use ASAIS and other program data for process evaluation and management purposes. Based on the Substance Abuse Prevention and Synar Site Visit Report (2016), ADMH reported that age was not known for 71.7 percent of persons served by individual-based programs and strategies, and age was not known for 43.5 percent of persons served by population-based programs and strategies. ADMH OP provided on-site provider technical assistance and as a result FY'19 SABG report submitted, age was not known for 1.6 percent of persons served by individual-based programs and strategies and 1 percent age was not known of persons served by population-based programs and strategies.

B. State- and Community-Level Activities

1. State Capacity Building Activities

Internally, the OP staff will continue to 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 continue to 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 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

TRAINING/TECHNICAL	DEVELOPMENT	TIMELINE	TRAINER
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: TA Provider	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 TA Provider, 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: TA Provider	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 the TA Provider during a designated prevention provider meeting, or, a train-the-trainer model could be employed with Prevention Consultants and 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: TA Provider/AEOW/ Epidemiologist/Evaluator	This training could be implemented both individually and with all prevention providers.	This training could be conducted by TA Provider, or, the use of a train the trainer model where the Prevention Management Team and Prevention

TRAINING/TECHNICAL	DEVELOPMENT	TIMELINE	TRAINER
			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: TA Provider	This training could be implemented both individually and with all prevention providers.	This training could be conducted by TA Provider 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: TA Provider/Prevention Director	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 and TA Provider 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 TA Provider if done as a training with all funded programs or regionally or incorporated into the state's annual Alabama School of Alcohol and other Drug Studies.
COMMUNICATION STRATEGIES Advocacy- This workshop would introduce participants to basic advocacy principles and strategies that could be 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.	Developer: 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 TA Provider if done as a training with all funded programs or regionally or incorporated into the state's annual Alabama School of Alcohol and other Drug Studies.
Grant Writing/Funding- This workshop will	Training length: TBD	This training could	This training could be

TRAINING/TECHNICAL	DEVELOPMENT	TIMELINE	TRAINER
provide participants with basic information regarding strategies to secure long-term funding for the program's activities	Target delivery date: TBD Estimate Development time: TBD Developer: TA Provider/Prevention Director	be implemented during an existing conference as a two-day session; Or, could serve as a stand-alone session.	conducted by Prevention Director and TA Provider 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 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 SPF 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. [5]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:

- Persons Killed & Highest Driver Blood Alcohol Concentration (.08+) in Crash
- Substance Abuse Treatment Admission[6]
- High School Graduate or Higher
- Poverty[7]
- Suicides

Five percent ($230,930) 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 ($4,387,646.28) 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 $306,169.68. If awarded 310 catchment area you are required to spend $106,531.84 in Jackson and $199,637.84 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 2016 census estimates and the five need indicators found above for the funding amounts as seen below. The aforementioned funding amount is derived from FY19 SABG. Actual FY20 funding will be determined by the FY20 SABG so amounts are subject to slight change. All decisions were agreed upon by the OP, AEOW and the SPAB.

[5] Oklahoma uses a catchment type approach.
[6] New Jersey and Louisiana use this data element.
[7] Louisiana uses this data element.

Table 4. Funding Allocation Based on 310 Catchment Area Distribution

310 Catchment Area	Total Allocation
Catchment Area 1	$180,700.52
Catchment Area 2	$178,279.52
Catchment Area 3	$91,046.84
Catchment Area 4	$341,830.20
Catchment Area 5	$264,703.52
Catchment Area 6	$320,093.52
Catchment Area 7	$121,324.68
Catchment Area 8	$170,963.52
Catchment Area 9	$236,314.36
Catchment Area 10	$260,183.20
Catchment Area 11	$131,440.68
Catchment Area 12	$211,279.36
Catchment Area 13	$162,615.52
Catchment Area 14	$239,412.36
Catchment Area 15	$162,702.52
Catchment Area 16	$151,658.68
Catchment Area 17	$196,050.36
Catchment Area 18	$165,875.36
Catchment Area 19	$335,040.20
Catchment Area 20	$306,169.68
Catchment Area 21	$86,046.84
Catchment Area 22	$73,914.84

Based upon the selected funding allocation model the OP plans to utilize a Request for Proposal (RFP) process to distribute SABG funds beginning FY20.

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

The issuance of the RFP is slated for January 2019 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 February 2019. 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 March 2019.

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 FY20 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 FY20.

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 continue to be utilized. A portion of the SABG (2.679% - $123,750) 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. *Note: Additional incentives and methods of distribution may be incorporated if additional funding becomes available. If this occurs, providers will be notified of the opportunity and specifications to receive additional funding will be communicated accordingly.*

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	January 2019
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	January 2019
Edits to Strategic Plan & RFP Submission (internal) – Edits to the plan based on the internal review will be accomplished.	Office of Prevention Associate Commissioner	January 2019
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	January 2019
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	March 2019 May 2019 (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	May 2019
Contract Execution – the OP develops contract exhibit pages and sends those pages along with a list of the sub-	Office of Prevention Office of Contracts & Billing	June 2019

Implementation Activity	Responsible	Timeline
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 Contracts & Purchasing	
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 2019
Services – contracted services begin.	Sub-recipient's	October 2019

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 support evaluation of the process, the OP will develop an RFP for the continuation of 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:

- sustain 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 and 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 (LGBTQ, homeless, students in college, military families, underserved racial & ethnic minorities, high risk youth, youth in tribal communities).

Additional variables may be identified by the evaluator and/or based on updates to required data elements.

E. Evaluation Activities

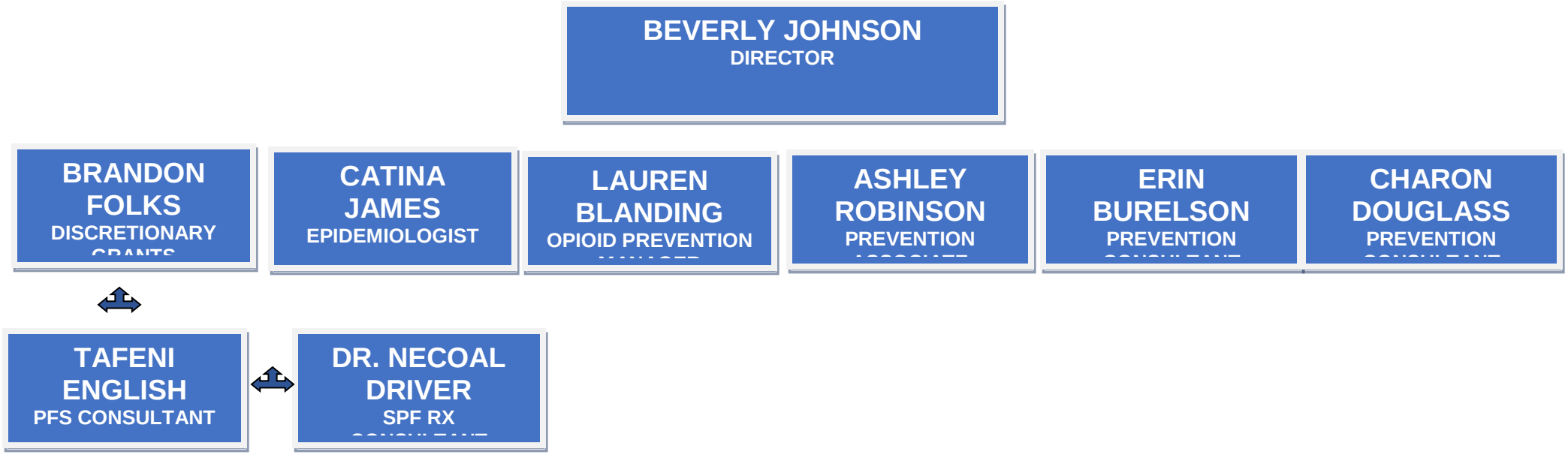
The evaluator will determine the necessary evaluation activities to track the breadth of information currently collected as well as information that is yet to be collected. At a minimum frequency of yearly, the evaluator will evaluate accomplishment of prevention plan objectives.

Cross-Cutting Components and Challenges

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

- 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.

Appendix 1 - Office of Prevention Organization Chart



Appendix 2 – Alabama Epidemiological Outcomes Workgroup Members

Member	Organization/Community Sector Organization Role/Title	Member Contribution/Responsibility
James, Catina	Alabama Department of Mental Health	Chairwoman – Epidemiologist Chairs the AEOW meetings, organizes the AEOW's activities and agenda, reviews identified needs and priorities as it relates to AEOW.
Johnson, Beverly	Alabama Department of Mental Health	Director, Prevention Services Provide updates on statewide initiatives as it relates to substance abuse prevention and assist with priority and need identification
Folks, Brandon	Alabama Department of Mental Health	Coordinator, Discretionary Grants Provide updates on statewide initiatives as it relates to current discretionary grants and assist with priority and need identification
Anderson, Ronada	Alabama Department of Public Health Hepatitis Coordinator	Provide updates on current trends in HIV prevalence and incidences based on ADPH research, surveillance, assessments and analysis and assist with identifying current and/or emerging SA risk factors among HIV/AIDS populations to include county and state-wide data.
Burleson, Erin	ADMH Office of Prevention Services Prevention Consultant	Ex-officio member, Provides updates related to occurring at the community level and related to working directly with providers.
Winningham, Janet	Alabama Department of Human Resources	Provides updates related to effects on children and services target to children.
Douglass, Charon	ADMH Office of Prevention Services Prevention Consultant	Ex-officio member, Provides updates related to occurring at the community level and related to working directly with providers.
Nightengale, Julie	Alabama Department of Public Health Epidemiologist	Assist with identifying correlating infectious disease such as STI's with SA risk factors, developing common themes and trends among youth in an effort to effectively select youth intervention models for prevention service delivery and activities. Also assist with identifying substance use rate data to show where rates are changing in the state.
Reese, Sondra	Alabama Department of Public Health	Assist with updates related to Synar and chronic diseases
Nelson, Loretta	AL Department of Revenue	Provides updates on others funding outside of the Dept. of Mental Health are distributed to other organization for substance abuse prevention.
Wilcox, Dr. Delynne	UA Office of Wellness & Promotion Assistant Director of Health Planning & Prevention	Assist with identifying, analyzing data on college-age youth and utilizing outcomes to prioritize prevention efforts on college campuses statewide. Provide recommendations on best practices for collecting and/or accessing university data.
Renita Ward	High Intensity Drug Trafficking Area (HIDTA)	Assists with data on drug enforcement

Appendix 3 – State Prevention Advisory Board Members

Sector	Member	Organization/Community Sector Organization Role/Title	Member Contribution/Responsibility
	Schaffer, Tonia	SAMHSA-Center for Substance Abuse Prevention	Federal Project Officer
Provider	Selase, Seyram, Chair agencyabuse@gmail.com	Agency for Substance Abuse Prevention (ASAP) Executive Director	Provide community level feedback, assist members in understanding of political processes, how to advocate, engage and collaborate within local political systems. Share successes, barriers and outcomes on community-level prevention service delivery.
Community Provider/Non-Profit Public Health	Parker-Merriweather, Elana, Vice Chair	Director of Behavioral Health for Medial AIDS Outreach/Copeland Care Center/Public Health/Minority Health	Responsible for the integration of behavioral health services including substance abuse and mental health services. Develops the administrative, programmatic and clinical infrastructure for the integration of comprehensive behavioral health services to patients with co-occurring disorders. Provide information on state-wide issues and initiatives as it relates to a Public Health Model and the relationship of Substance Use and Health Disparities among substance users, SA risk factors associated with health disparities, recommendations for integrating cultural responsiveness and sensitivity into prevention delivery and assist in identification of key public health contacts and resources on new and emerging trends in SA from a public health perspective as well as engaging minority populations in prevention activities.
Community Organization	Kimble, Bruce, Secretary	Alabama Alcohol and Drug Abuse Association (AADAA) President Elect	Provide recommendations for Prevention Professional certification standards, update on current trends in substance use, misuse and/or abuse, and provide clinical expertise

			related to the identifying of signs, symptoms and progressive stages of addiction to promote early intervention and prevention practice.
State/Government	Butler, Dr. Erica	Alabama State Department of Education (ALSDE) School Safety and Crisis Management-Prevention and Support Services	Assist with navigation of ALSDE Website to access current data, provide updates on current trends and policies in school systems statewide to assist providers in selection of EB interventions and best practices relative to bullying, truancy, promoting positive behavior and positive school climates and etc.
Community Member	Douglass, Gerald	Retired Educator	Provide community level feedback, recommendations on working with local school systems, understanding family dynamics relating to teen/parent relationships and assist with recommending development of and dissemination of resources to providers relative to facilitation of groups and integrating cultural sensitivity in prevention program implementation.
Community Organization (Mental Health)	Moore, Michelle	Prevention Director	Provide community level feedback with specific regard to working with psychiatric and mental health services for adults, children and adolescents. Provides feedback on co-occurring substance abuse treatment and prevention services.
Community Organization	Hernandez, Jean	AIDS Alabama Latino Outreach Coordinator	Community Level Feedback with specific regard to immigrant populations as it relates to health disparities and access to services and care including cultural and language barriers and provide recommendations to improve such.
Education 4-Yr College	Hinton, Vincent	Alabama State University Counseling Faculty	Assist with the identification of common themes and trends among college-aged youth substance use/misuse and abuse and provide recommendations on new and emerging trends and initiative from a collegiate perspective as well as

			assist with providing recommendation on engaging college-aged youth in prevention activities and collaborating with universities to promote prevention efforts on campuses.
State/Government (Law Enforcement/Public Safety)	Leonard, Corporal Cedric	Law Enforcement- Montgomery County Sheriff's Office Administrative	Provide community level feedback, best practices and recommendations for collaborating and engaging with law enforcement, assist with access to local data sources and provide updates on policies regarding youth offender management regarding substance use and abuse.
Education (k-12)	Long-Cohen, Leigh	Homewood City Schools Intervention Coordinator	Provide K-12 level feedback and expertise on EB prevention practices utilized within K-12 school systems and provide recommendations and updates on theory and trends in youth social-emotional development and behavioral performance. Also, provide insight on promoting parental involvement in youth prevention activities.
Counseling LPC	Malone, Deegan	Healthy Sexual Solutions, LLC Federal Defenders Office, Northern District	Provide community level feedback, best practices and recommendations for collaborating and engaging with professionals providing services to sexually reactive children and transgender populations. Also provides insight regarding assessment and evaluation of sexually reactive children. In addition, also provides insight regarding Mental Health/General Counseling and expertise on EB prevention practices utilized in counseling with the adolescent transgender community.
Education (4-Yr College)	Mitchell, Dr. Q'Shequilla	University of Alabama Department of Psychology & Education	Provide collegiate level feedback and perspectives on SA among college-aged youth, provide relevant updates on college-wide SA prevention initiatives and how to engage and/or recruit college-aged students in prevention activities.
Provider	Pierre, Vandlynn	South Regional	Provide community level feedback

		Clearinghouse-Drug Ed Council	and recommendations on allocation of resources promoting clearinghouses and recommendations for marketing and dissemination of materials related to ATOD. Share successes, barriers and outcomes on community-level prevention service delivery.
State/Government Criminal Justice/Law Enforcement	Pinkston, Honorable Patrick	Elmore County District Judge	Provide relevant information as it relates to substance abuse in the criminal justice system, including, but not limited to legalizing marijuana, punishment, substance to crime correlation, alternative sentencing and the impact on families and communities and make recommendations for early intervention and best practices in prevention service delivery.
Community Organization	Stapleton, Danita	Foster Care Family Preservation	Provide community level feedback with specific regard to risks factors associated with youth in foster care and best recommendations for developing and/or adapting prevention services for youth in foster care.
Education 4-Yr College	Yarbers-Allen, Dr. Anneice	Auburn University at Montgomery	Assist with the improvement and enhancement of the prevention workforce through the implementation of a prevention certification program offered at the collegiate level, provide collegiate level feedback and provide recommendations on how to engage and collaborate with universities in the area of substance abuse prevention and administration.
Education 4-Yr College	Tyre, Dr. Yulanda	Auburn University at Montgomery	Assist with training and development to improve and enhance prevention workforce, provide collegiate level feedback and provide recommendations on how to engage and collaborate with universities
State/Governmentt Criminal Justice/Corrections	TyTell, Dr. David	Alabama Department of Corrections (DOC) Chief Psychologist Office of Health Services	Provide information on understanding impact on the family of youth whose parents have substance abuse, mental health and/or co-occurring

			disorders, identifying early warning signs of behavioral health or substance abuse disorders and assist with recommendations of EBP's and best practices to promote early intervention and prevention services.
Education 4-Yr College	Wilcox, Delynne	Health Planning & Prevention Assistant Director University of Alabama Department of Health Promotion and Wellness	Provide collegiate-level feedback on student and staff perspectives and expertise regarding poor lifestyle choice and environmental influences in an effort to create healthier cultures and well-being in the workplace. Also, provide information and recommendation on new trends in SA among college-aged youth and university prevention efforts and initiatives.
Community Organization	Crews, Ebony	Spectracare Health Systems Director of Community Programs, Prevention	Provides community based feedback on mental health, intellectual disabilities and substance abuse prevention services.
Community Organization	Finch, Shereda	Council on Substance Abuse-NCADD Executive Director	Provides community-based feedback on substance abuse preventions, behavioral health and mental illness. Provides feedback on sustainability, funding and grant writing.
Community Organization	Howard, Gloria	Aletheia House Chief Operating Officer	Provides community-based feedback on substance abuse treatment and prevention services to individuals.
State Government/Public Health	Reese, Sondra	Alabama Department of Public Health Epidemiologist	Chronic Disease Epidemiologist
Community Organization	McKenley, Lantana	AltaPoint Health Systems	Provides community-based feedback on prevention, specifically underage drinking and PFS efforts. Also provides feedback on behavioral healthcare system that promotes the wellness and recovery of people living with mental illness and substance use disorders
Community Organization	Williams, Carol	Compact 2020 Prevention Director	Provides community level feedback on substance abuse, underage drinking, prescription drugs and opioids. Also serves as a reviewer for the EBP workgroup. Provides feedback on evidence-based

			curriculums. Also provides feedback on coalition building and sustainability, grant writing and evaluations.
Community Organization	Osborne, Derek	Pride of Tuscaloosa Executive Director	Provides community level feedback on substance abuse, prescription drugs and opioids.

Appendix 4 - Data Sources

Population Estimates – US Census, QuickFacts 2016 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.

Persons Killed & Highest Driver Blood Alcohol Concentration (.08+) in Crash – National Highway Traffic Safety Administration, Fatality Analysis Reporting System.

The Fatality Analysis Reporting System (FARS) contains data on all reported vehicle crashes in the United States that occur on a public roadway and involve a fatality. This FARS Query System provides interactive public access to fatality data through this web interface. FARS is a nationwide census providing National Highway Traffic Safety Administration (NHTSA), Congress and the American public yearly data regarding fatal injuries suffered in motor vehicle traffic crashes.

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 2016 was used.

% High School Graduate or Higher, Age 25 years + – US Census, American Community Survey (ACS), 5-Year Estimates, 2012-2016

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.

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 2015 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	Substance Abuse Treatment Admissions	Negative	Alabama Department of Mental Health, Alabama Substance Abuse Information System	2017	20
Substance Use	Persons Killed & Highest Driver Blood Alcohol Concentration (.08+) in Crash	Negative	National Highway Traffic Safety Administration, Fatality Analysis Reporting System.	2016	20
Mental Illness	Suicide Rate	Negative	Alabama Department of Public Health, Center for Health Statistics, Mortality Statistical Query System	2015	20
Social & Economic	Poverty Rate	Negative	US Census, Small Area Income and Poverty Estimates	2016	10
Social & Economic	% High School Graduate or Higher, Age 25 years +	Positive	Alabama Department of Public Health, Center for Health Statistics, Mortality Statistical Query System	2015	10

Appendix 5 – Funding Allocation Amounts per 310 Catchment and County

310 Catchment Area	County	Population 2016	Need	Tier	Identified Need/Population Allocation	Minimum Allocation	Required County Spending Amount	Total Catchment Allocation
1	Lauderdale	92,319	35	Need – Mid/Low Population - Highest	19,571.00 >70,000 +16,996	39522.84	**76,089.84**	**180,700.52**
	Franklin	31,577	19	Need – Mid High Population – Mid/Low	6,089.00 Need – 19 +9,690	39522.84	**55,301.84**	
	Colbert	54,520	25	Need – Mid High Population – Mid/High	9,786.00	39522.84	**49,308.84**	
2	Morgan	118,819	54	Need – Lower Population - Highest	10,873.00 >100,000 +24,100	39522.84	**74,495.84**	**178,279.52**
	Lawrence	33,232	58	Need – Lower Population – Mid/Low	1,218.00	39522.84	**40,740.84**	
	Limestone	92,920	64	Need – Lowest Population - Highest	6,524.00 >70,000 +16,996	39522.84	**63,042.84**	

Appendix 5 – Funding Allocation Amounts per 310 Catchment and County

310 Catchment Area	County	Population 2016	Need	Tier	Identified Need/Population Allocation	Minimum Allocation	Required County Spending Amount	Total Catchment Allocation
3	Madison	356,312	62	Need – Lowest Population – Highest	6,524.00 >300,000 +45,000	39522.84	**91,046.84**	**91,046.84**
4	Fayette	16,538	2	Need – High Population –Low	8,698.00 Need – 2 +34,391	39522.84	**82,611.84**	**341,830.20**
	Lamar	13,949	18	Need – Mid Population – Lowest	2,609.00 Need – 18 +9,690	39522.84	**51,821.84**	
	Walker	65,998	16	Need – Mid Population - High	31,314.00 Need – 16 +9,690	39522.84	**80,526.84**	
	Marion	29,922	10	Need – High Population – Low	9,394.00 Need – 10 +24,391	39522.84	**73,307.84**	
	Winston	23,887	17	Need – Mid High Population - Low	4,349.00 Need – 17 +9,690	39522.84	**53,561.84**	
5	Jefferson	659,479	46	Need – Low Population – Highest	13,047.00 >600,000 +100,000	39522.84	**152,569.84**	**264,703.52**

Appendix 5 – Funding Allocation Amounts per 310 Catchment and County

310 Catchment Area	County	Population 2016	Need	Tier	Identified Need/Population Allocation	Minimum Allocation	Required County Spending Amount	Total Catchment Allocation
	St. Clair	86,308	55	Need – Low Population – Highest	10,873.00 >70,000 +16,996	39522.84	**67,391.84**	
	Blount	57,562	50	Need – Low Population – Mid/High	5,219.00	39522.84	**44,741.84**	
6	Etowah	102,726	44	Need – Lower Population - High	15,222.00 >100,000 +24,100	39522.84	**78,844.84**	**320,093.52**
	Cherokee	25,766	40	Need – Lower Population - Low	2,088.00	39522.84	**41,610.84**	
	DeKalb	71,216	4	Need – High Population – High	108,728.00 >70,000 +16,996 Need – 4 +34,391	39522.84	**199,637.84**	
7	Calhoun	114,980	37	Need – Mid Low Population – Highest	17,396.00 >100,000 +24,100	39522.84	**81,018.84**	**121,324.68**

Appendix 5 – Funding Allocation Amounts per 310 Catchment and County

310 Catchment Area	County	Population 2016	Need	Tier	Identified Need/Population Allocation	Minimum Allocation	Required County Spending Amount	Total Catchment Allocation
	Cleburne	14,873	47	Need – Low Population – Lowest	783.00	39522.84	**40,305.84**	
8	Tuscaloosa	206,282	60	Need – Low Population – Highest	8,698.00 >200,000 +40,000	39522.84	**88,220.84**	**170,963.52**
	Pickens	20,315	43	Need – Mid/Low Population – Low	1,522.00	39522.84	**41,044.84**	
	Bibb	22,663	30	Need – Mid High Population – Low	2,175.00	39522.84	**41,697.84**	
9	Coosa	10,809	11	Need – Higher Population – Lowest	3,523.00 Need – 11 +14,391	39522.84	**57,436.84**	**236,314.36**
	Talladega	80,386	29	Need – Mid High Population - Highest	21,746.00 >70,000 +16,996	39522.84	**78,264.84**	
	Randolph	22,498	14	Need – High Population – Low	5,871.00 Need – 14 +14,391	39522.84	**59,784.84**	

Appendix 5 – Funding Allocation Amounts per 310 Catchment and County

310 Catchment Area	County	Population 2016	Need	Tier	Identified Need/Population Allocation	Minimum Allocation	Required County Spending Amount	Total Catchment Allocation
	Clay	13,410	28	Need – Mid High Population - Lowest	1,305.00	39522.84	**40,827.84**	
10	Sumter	12,932	22	Need – Mid High Population – Lowest	1,957.00	39522.84	**41,479.84**	**260,183.20**
	Greene	8,488	34	Need – Mid Low Population - Lowest	1,218.00	39522.84	**40,740.84**	
	Marengo	19,505	42	Need – Low Population – Low	1,218.00	39522.84	**40,740.84**	
	Hale	14,847	7	Need – High Population – Lowest	4,697.00 Need – 7 +24,391	39522.84	**68,610.84**	
	Choctaw	13,050	9	Need – High Population – Lowest	4,697.00 Need – 9 +24,391	39522.84	**68,610.84**	
11	Chilton	43,830	23	Need – Mid Population – Mid Low	5,871.00	39522.84	**45,393.84**	**131,440.68**

Appendix 5 – Funding Allocation Amounts per 310 Catchment and County

310 Catchment Area	County	Population 2016	Need	Tier	Identified Need/Population Allocation	Minimum Allocation	Required County Spending Amount	Total Catchment Allocation
	Shelby	211,073	67	Need – Lowest Population – Highest	6,524.00 >200,000 +40,000	39522.84	**86,046.84**	
12	Russell	58,177	49	Need – Low Population – Mid/High	5,219.00	39522.84	**44,741.84**	**211,279.36**
	Chambers	33,717	20	Need – Mid High Population – Mid/Low	6,089.00 Need – 20 +9,690	39522.84	**55,301.84**	
	Tallapoosa	40,574	57	Need – Lower Population – Mid	1,566.00	39522.84	**41,088.84**	
	Lee	150,933	63	Need – Lowest Population – Highest	6,524.00 >100,000 +24,100	39522.84	**70,146.84**	
13	Dallas	40,081	15	Need – High Population – Mid/Low	10,568.00 Need – 15 +14,391	39522.84	**64,481.84**	**162,615.52**

Appendix 5 – Funding Allocation Amounts per 310 Catchment and County

310 Catchment Area	County	Population 2016	Need	Tier	Identified Need/Population Allocation	Minimum Allocation	Required County Spending Amount	Total Catchment Allocation
	Wilcox	10,875	32	Need – Mid Low Population – Lowest	1,174.00	39522.84	**40,696.84**	
	Perry	9,570	12	Need – High Population - Lowest	3,523.00 Need – 12 +14,391	39522.84	**57,436.84**	
14	Lowndes	10,241	27	Need – Mid High Population – Lowest	1,305.00	39522.84	**40,827.84**	**239,412.36**
	Montgomery	226,716	52	Need – Low Population – Highest	10,873.00 >200,000 +40,000	39522.84	**90,395.84**	
	Elmore	81,240	59	Need – Low Population – Highest	8,698.00 >70,000 +16,996	39522.84	**65,216.84**	
	Autauga	55,278	56	Need – Low Population – Mid/High	3,479.00	39522.84	**43,001.84**	

Appendix 5 – Funding Allocation Amounts per 310 Catchment and County

310 Catchment Area	County	Population 2016	Need	Tier	Identified Need/Population Allocation	Minimum Allocation	Required County Spending Amount	Total Catchment Allocation
15	Pike	33,215	48	Need – Low Population – Mid/Low	1,827.00	39522.84	**41,349.84**	**162,702.52**
	Macon	19,072	39	Need – Mid Low Population – Low	1,392.00	39522.84	**40,914.84**	
	Bullock	10,441	1	Need – High Population – Lowest	6,524.00 Need – 1 +34,391	39522.84	**80,437.84**	
16	Mobile	414,852	51	Need – Low Population - Highest	10,873.00 >400,000 +60,000	39522.84	**110,395.84**	**151,658.68**
	Washington	16,877	26	Need – Mid High Population – Low	1,740.00	39522.84	**41,262.84**	
17	Escambia	37,476	31	Need – Lower Population – Mid/Low	3,131.00	39522.84	**42,653.84**	**196,050.36**
	Conecuh	12,515	21	Need – Mid High Population – Lowest	1,957.00	39522.84	**41,479.84**	

Appendix 5 – Funding Allocation Amounts per 310 Catchment and County

310 Catchment Area	County	Population 2016	Need	Tier	Identified Need/Population Allocation	Minimum Allocation	Required County Spending Amount	Total Catchment Allocation
	Monroe	21,572	6	Need – High Population – Low	7,828.00 Need – 6 +24,391	39522.84	**71,741.84**	
	Clarke	24,350	65	Need – Lowest Population – Low	652.00	39522.84	**40,174.84**	
18	Covington	37,886	36	Need – Mid Low Population – Mid Low	2783.00	39522.84	**42,305.84**	**165,875.36**
	Butler	20,265	53	Need – Low Population – Low	1,087.00	39522.84	**40,609.84**	
	Coffee	50,938	66	Need – Lowest Population – Mid/High	1,957.00	39522.84	**41,479.84**	
	Crenshaw	13,907	24	Need – Mid High Population – Lowest	1,957.00	39522.84	**41,479.84**	
19	Geneva	26,516	8	Need – High Population – Low	9,394.00 Need – 8 +24,391	39522.84	**73,307.84**	**335,040.20**

Appendix 5 – Funding Allocation Amounts per 310 Catchment and County

310 Catchment Area	County	Population 2016	Need	Tier	Identified Need/Population Allocation	Minimum Allocation	Required County Spending Amount	Total Catchment Allocation
	Houston	104,173	13	Need – High Population – Highest	58,713.00 >100,000 +24,100 Need – 13 +14,391	39522.84	**136,726.84**	
	Henry	17,092	33	Need – Mid Low Population – Low	1,566.00	39522.84	**41,088.84**	
	Barbour	25,774	45	Need – Lower Population –Low	1,827.00	39522.84	**41,349.84**	
	Dale	49,228	41	Need – Lower Population – Mid/High	3,044.00	39522.84	**42,566.84**	
20	Jackson	52,049	3	Need – High Population – High	32,618.00 Need – 3 +34,391	39522.84	**106,531.84**	**306,169.68**
	Marshall	95,403	5	Need – High Population - High	108,728.00 >70,000 +16,996 Need – 5 +34,391	39522.84	**199,637.84**	

Appendix 5 – Funding Allocation Amounts per 310 Catchment and County

310 Catchment Area	County	Population 2016	Need	Tier	Identified Need/Population Allocation	Minimum Allocation	Required County Spending Amount	Total Catchment Allocation
21	Baldwin	207,509	61	Need – Lowest Population – Highest	6,524.00 >200,000 +40,000	39522.84	**86,046.84**	**86,046.84**
22	Cullman	82,322	38	Need – Mid/Low Population – Highest	17,396.00 >70,000 +16,996	39522.84	**73,914.84**	**73,914.84**

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