

SAMHSA FY20-21
Alabama Mental Health Block Grant Application

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Overview of the Public Mental Health Service Delivery System

The Alabama Department of Mental Health (ADMH) was created under Act 881 of the 1965 legislature, Section 22-50-2. ADMH was charged with the responsibility of establishing a public mental health system. ADMH is responsible for mental illness, intellectual disability, and substance abuse services. ADMH serves as both the Single State Authority (SSA) for the Substance Abuse Prevention and Treatment Block Grant, as well as the State Mental Health Authority (SMHA) for the Community Mental Health Services Block Grant (SAPT/CMHS). ADMH is responsible for operating state psychiatric facilities, establishing standards for community services, and is empowered to contract for services. The Commissioner of ADMH, and other Departmental staff, coordinate services with other state agencies such as the Department of Human Resources (child welfare – adult and child protective agency), Department of Youth Services (juvenile justice), Department of Corrections, Department of Public Health, and Medicaid. ADMH is involved in coordinating services with these agencies through multiple committees, workgroups, and daily contacts. Services are coordinated both for individuals and for systems of care.

The Commissioner of the ADMH is a cabinet member appointed by the Governor. ADMH is comprised of three unique divisions: (1) Administration, (2) Developmental Disabilities, and (3) Mental Health and Substance Abuse Services. Each division operates under the direction and control of its own Associate Commissioner who is appointed by and reports directly to the ADMH Commissioner. A Board of Trustees, appointed by the Governor, serves in an advisory capacity to the Commissioner.

Since January 2011, ADMH has had six Commissioners. Upon taking office in January 2011, newly elected Governor Robert Bentley appointed Zelia Baugh as the Commissioner for ADMH which dismissed the standing Commissioner, John Houston. Commissioner Baugh changed many of her executive staff positions, to include the Associate Commissioner of Mental Illness (Acting Dr. Beverly Bell-Shambley), Associate Commissioner of Substance Abuse (Dr. Tammy Peacock), and Associate Commissioner of Developmental Disabilities (Ann White-Spunner).

Commissioner Baugh set forth a new vision which included merging the long separated Mental Illness Division and Substance Abuse Division. Historically the ADMH Division of Mental Illness, under the direction of the Associate Commissioner, has responsibility for operation of state psychiatric hospitals and the development and coordination of the system of community treatment services for mental illness. This responsibility includes contracting for services with local providers and monitoring those service contracts, evaluation, and certification of service programs in accordance with statutory standards, implementation of a joint hospital and community Performance Improvement Plan, and planning for the development of needed services. In addition to the Offices of Community Programs, Certification, and Performance Improvement, the Division of Mental Illness includes an Office of Consumer Relations and an Office of Deaf Services.

With the merging of the Division of Mental Illness and the Division of Substance Abuse Services, ADMH went from having three service divisions (MI/SA/DD) to two services divisions – the Mental Health Substance Abuse Services Division and the Developmental Disabilities Services Division. The newly appointed Associate Commissioner, Dr. Tammy Peacock, became the Associate Commissioner of the Mental Health Substance Abuse Services (MHSA) Division. Much work occurred to break down “service silos” that have long existed between the traditionally separate Mental Illness and Substance Abuse Divisions while at the same time providing better recovery-oriented services for those individuals with mental illnesses, substance use disorders, and co-occurring disorders.

On June 2012, Commissioner Zelia Baugh tendered her resignation with this being effective June 30, 2012, as well as the departure of two of the Associate Commissioners, Ann White-Spunner – Developmental Disabilities Service Division and Dr. Tammy Peacock – Mental Health and Substance Abuse Services Division. Governor Bentley appointed as the new Commissioner of Mental Health Jim Reddoch, effective July 2012. Commissioner Reddoch appointed three new positions

– Associate Commissioner of the Developmental Disabilities Division, Courtney Tarver; Associate Commissioner of Mental Health Substance Abuse Services Division, Dr. Beverly Bell-Shambley; and General Counsel of ADMH, Tommy Klinner.

On July 1, 2015, Commissioner Jim Reddoch retired, and the Governor appointed James V. Perdue as the Commissioner of ADMH. Commissioner Perdue maintained the executive staff of Associate Commissioner of the Developmental Disabilities Division, Courtney Tarver; Associate Commissioner of Mental Health Substance Abuse Services Division, Dr. Beverly Bell-Shambley; and General Counsel of ADMH, Tommy Klinner. In September 2016, Dr. Bell-Shambley retired and Diane Baugher was appointed by Commissioner Perdue as the Associate Commissioner of the MHS Division.

On April 10, 2017, Robert Bentley resigned as Governor for the State of Alabama. Lt. Governor Kay Ivey was sworn in on this same date as Alabama's Governor. On Tuesday, April 11, 2017, Governor Ivey asked for the resignations of all staffers and cabinet members. In July 2017, Governor Ivey accepted Commissioner Perdue's resignation, with his last day being July 7th. In July 2017, Governor Ivey appointed as the new Commissioner of Mental Health Lynn Beshear. Commissioner Beshear maintained the executive staff of Associate Commissioner of the Developmental Disabilities Division, Courtney Tarver; Associate Commissioner of Mental Health Substance Abuse Services Division, Diane Baugher; and General Counsel of ADMH, Tommy Klinner.

With ADMH being the designated single state agency (SSA) in Alabama, it is authorized to receive and administer any and all funds available from any source to support the provision of services and other activities within the scope of its statutory authority. This responsibility includes receipt and administration of the Mental Illness and Substance Abuse Block Grants provided by the Substance Abuse and Mental Health Services Administration (SAMHSA). ADMH's decision to submit separate SAMHSA block grant applications for mental illness and substance abuse services, respectively, for FY 20 – FY 21 allows for more realistic planning based upon currently identified needs, than does submission of a combined application.

Organization of Alabama's Mental Health Service Delivery System:

In FY10, there were six state-run adult mental illness inpatient treatment facilities serving adults in Alabama. Bryce Hospital in Tuscaloosa operated an acute unit and an extended care unit. Two other facilities operate in Tuscaloosa: Taylor Hardin Secure Medical Facility providing services for Alabama's male forensic psychiatric population and the Mary Starke Harper Geriatric Psychiatric Center, providing specialty geriatric services. Searcy Hospital in Mt. Vernon (near Mobile) operated an acute care unit and an extended care unit. North Alabama Regional Hospital in Decatur, AL operated acute care units. Greil Hospital in Montgomery, AL operated acute care units.

Due to severe budget reductions and a decrease in state dollars for ADMH by approximately \$40 million over a four year period of time, FY12 provided unique planning opportunities for ADMH and its long-standing partners (consumer and family advocate groups, providers, judges, hospitals, etc.). Through two ADMH Administrations, much direct focus and planning was given to determining to most effective way to move toward a transformed system that could be provided with such funding cuts. This planning process led to a restructuring in how ADMH would provide post commitment care to consumers civilly committed (Probate Court commitments) to ADMH and the process would have to occur over a multiple year process to achieve true statewide restructuring. However to address the budget demands in FY12, most all of the efforts of ADMH was focused on the closure of two state-run mental illness inpatient treatment facilities serving adults in Alabama. To accomplish this meant building an infrastructure within communities of Region 3 and Region 4 (both in the southern portion of Alabama) which included an array of services to include Designated Mental Health Facilities (DMHF) to provide post-commitment care that would replace this service being provided in a state-run psychiatric hospital. By implementing this process, ADMH was able to close Searcy Hospital in Mt. Vernon (near Mobile) operating an acute care unit and an extended care unit and Greil Hospital (in Montgomery) operating acute care units.

In FY13, ADMH expanded the restructuring of the process for serving civilly committed patients and focused our efforts on the other regions which primarily utilized Bryce State Hospital and North Alabama Regional Hospital. ADMH experienced some shifting in the budget that allowed for some expansion dollars to be utilized to implement a similar process in the mid to northern part of the state as we had done with the southern end of the state. This effort was primarily

of importance as Bryce Hospital was preparing to enter into a new, state of the art, facility with a much smaller bed capacity. The new Bryce became operational in July 2014. By October 1, 2014, the two regions involved with this process had achieved their restructuring goals by utilizing DMHFs in their areas to serve committed patients. In January 2015, ADMH announced the intent to close North Alabama Regional State Hospital and all efforts were made to achieve this goal in coordination with community providers, family members, advocates, and the consumers receiving treatment at this state hospital. North Alabama Regional State Hospital had the last patient served there June 17, 2015.

As of July 2015, there are three state-run mental illness inpatient treatment facilities serving adults in Alabama:

- Bryce Hospital in Tuscaloosa operates an acute unit and an extended care unit.
- Taylor Hardin Secure Medical Facility in Tuscaloosa operates units for Alabama's male forensic psychiatric population.
- Mary Starke Harper Geriatric Psychiatric Center in Tuscaloosa operates units providing specialty geriatric services.

Through the **Juvenile Code** in Alabama, the courts have the authority to commit adolescents to ADMH for psychiatric stabilization in cases where the criteria outlined in the juvenile law is met. As these are adolescents, through the Juvenile Commitment, the minor is placed in the custody of ADMH for the purposes of providing psychiatric treatment. Once the committed youth has met maximum benefit from commitment to ADMH, the court releases ADMH from commitment and re-establishes custody with an entity other than ADMH. Prior to October 2010, the care for committed youth was provided in a state-run mental illness inpatient treatment facility serving adolescents at Bryce Hospital in Tuscaloosa. With appropriate amendments to the Juvenile Code in 2010, the Commissioner of ADMH was provided the authority to have such committed youth served in a state-run mental illness inpatient treatment facility or with a contracted inpatient treatment facility. On October 1, 2010, ADMH contracted with the University of Alabama Department of Psychiatry and Behavioral Neurobiology in Birmingham (UAB) to operate the Adolescent Unit that was formerly operated by Bryce Hospital. This adolescent unit became known as the ADMH Adolescent Psychiatric Unit at UAB. This was a shift from a 20 bed unit to a 10 bed unit. In the fall of 2015, ADMH and UAB mutually agreed to sever its contractual agreement. ADMH issued a Request for Proposals (RFP) for the ADMH Adolescent Psychiatric Unit and this proposal was awarded to East Alabama Medical Center (EAMC) in Opelika, Alabama. On April 1, 2016, ADMH contracted with EAMC to operate the Adolescent Unit that was formerly operated by UAB. This adolescent unit became known as the ADMH Adolescent Psychiatric Unit at EAMC. This was a shift from a 10 bed unit to a 9 bed unit.

The **public community mental health services system** was originally based upon 22 service areas. In April 2014, two of the community mental health providers (AltaPointe and Baldwin) merged. In August 2016, two more community mental health centers (AltaPointe and Cheaha) merged. In October 2017, two more community mental health centers (Wellstone and Cullman) merged. This produced 19 service areas. There are now 19 public, non-profit regional mental health boards (called 310 Boards based on ACT 310 of the 1967 Regular Session of the Alabama Legislature). There are 24 community mental health centers in the 19 service areas, 19 being the 310 Board community mental health centers (CMHC) and 5 being community mental health centers that are operational under a 310 Board CMHC. The Birmingham area has a regional 310 Board and four mental health centers under contract. The Tuscaloosa area has a regional 301 Board with one community mental health center under contract. Outside of the Birmingham area, the mental health centers are organized with a main center in the most populous county or city in their catchment area and satellite offices in outlying counties/areas. The mental health centers provide a continuum of services to all ages with a focus on adults who have a serious mental illness and youth who have a severe emotional disturbance. In some areas, the mental health center also provides services for those who have intellectual disabilities and/or substance use disorders. In addition to the community mental health centers, two of these CMHCs are specialty child and adolescent service providers: 1) Brewer-Porch in Tuscaloosa and 2) Glenwood, Inc. in Birmingham.

Community services are funded through a mix of resources including federal MH Block Grant funds, state funds, Medicaid, Medicare, other third party (insurance), local government, donations, and client fees generated under a sliding fee scale.

The level of city and county support for these providers varies significantly across the state. In addition to contracting with ADMH, providers may also enter local arrangements with the Department of Human Resources, the Department of Youth Services, and local education agencies. In FY 2020, block grant funds will account for approximately 3% of ADMH contracts for Community Mental Health services while state sources such as the General Fund, Special Mental Health Fund and other state sources accounted for 61% of total resources. Medicaid reimbursements and other federal funding account for an additional 36% of the ADMH Community Mental Health budget. This does not include support that is provided by local sources, the proportion of which varies greatly from center to center.

310 Board CMHC (20); attached CMHCs (6)	MI	SA	DD
AltaPointe	X	X	X
Cahaba	X	X	X
Highland Health System (formerly Calhoun- Cleburne)	X	X	X
CED	X	X	
Chilton-Shelby	X	X	X
Cullman	X	X	
East Alabama	X	X	X
East Central	X	X	X
Huntsville (dba Wellstone)	X	X	
Indian Rivers	X	X	X
Brewer Porch*	X		
J.B.S.	X		
Eastside*	X		
Western *	X		
UAB*	X		
Capitol Care*	X		
Glenwood*	X		X
Mountain Lakes	X	X	
Montgomery	X		
Northwest	X	X	X
North Central	X		
Riverbend	X	X	
South Central	X	X	X
Southwest	X	X	X
Spectracare	X	X	X
West Alabama	X		

Hospitalization

(Downsizing effort for community integration)

Adults

In 1970 Alabama faced a lawsuit, Wyatt vs. Stickney, which brought the “right to treatment” for state psychiatric hospital patients into the foreground. This litigation significantly influenced fundamental changes in architectural features of this States’ mental health service delivery system. Upon the filing of the suit, one of the longest running mental health lawsuit in US history, ADMH started shifting focus from providing mental health treatment within the confines of large- scale institutional walls towards creating a new vision and thus, constructing the foundation necessary for community based mental health treatment. The 1999 Olmstead “integration mandate” decision further inspired the pursuit of building more appropriate and effective mental health service models within the community mental health landscape. As ADMH continues pursuing the development and expansion of new and enhanced community supports, great effort and commitment to reflect the desires of consumer partners and to be guided by the voices of those we serve, remain at the core of its design.

ADMH has moved steadily towards less reliance upon state psychiatric inpatient services by shifting funding to less costly, but more effective community services and supports. Since 1971, the census at Bryce alone dropped from over 5,000 patients to less than 400 in 2004. In order to meet the requirements of the Wyatt settlement, ADMH made provisions to utilize a census reduction model in which the care of individuals housed within the States’ extended care wards would be transferred to the community provider network. Moreover, strides to better serve consumers outside of inpatient settings continued beyond those prompted by the settlement leading to a statewide reduction in hospital census as well as closures of state operated facilities. Through the dedicated efforts of state psychiatric hospitals and community partners, ADMH can boast nearly a 52% statewide reduction in total state psychiatric hospital census from FY09 to June 2015.

In 2007, with the establishment of an appointed taskforce, transferring acute care operations from state hospital admission units to the community was the primary focus. Four regional planning groups composed of consumers, family members, mental health centers, state hospital directors, Probate Judges, and private providers, developed “acute care plans” for the establishment of new services. Increased funding in FY07 and FY08 supported the recommendations of the four regional planning groups specifically to reduce use of state psychiatric hospitals as well as to promote system transformation. Whenever possible, local providers work with hospitals to secure local psychiatric inpatient services for indigent consumers. Probate judges can also make involuntary commitments to local inpatient units or residential programs that request and receive ‘designated mental health facility’ status per the 1991 commitment law. These additions to the service array included purchase of additional local inpatient care, increased psychiatric time, and development of a psychiatric assessment center:

- Inpatient – Twelve centers proposed some type of local inpatient/psychiatric emergency service to increase/enhance local inpatient or acute care services (the Psychiatric Emergency Room proposed for Birmingham was eliminated in FY09 due to budget cuts - it had not opened)
- Residential – 325 new residential beds ranging from apartments to specialized medical homes (24 Supportive Housing units that had not opened were eliminated due to budget cuts)
- Assertive Community Treatment Teams – six new teams
- Community Support Specialists – five positions designed to assist consumers with development of daily living skills
- Adult In-home Intervention Teams – ten new two person teams
- Bridge Teams – two new teams in the Mobile area
- Psychiatric Assessment Center- Montgomery

In 2010, ADMH again pursued the implementation of a census reduction model to address critical overages in state hospitals with a primary focus on Regions 2 and 4. The initial planning for the “Downsizing Project” started during FY09 at which time residents of Bryce and Searcy who were living in Extended Care units or who had a length of stay greater than 90 days were evaluated in order to determine what community services would be needed to promote discharge from the hospital. The evaluation teams were composed of hospital staff, community staff, and advocates. Based on the evaluation and the input of the consumer, community services were proposed to support discharge of these individuals. The planning process continued into FY10 and was incorporated into planning for the sale of Bryce Hospital to the University of Alabama and subsequent construction of a smaller state of the art hospital. Final plans were developed and approved by the Bryce Consumer Transitioning Work Group, the Mental Illness Coordinating Subcommittee, and the Commissioner. Nontraditional financial models were utilized such as incentive and risk bearing contracts based on regional outcomes and performance. The community provider network in Regions 2 and 4 established Board of Supervisor groups for the purposes of promoting service coordination and monitoring of project goals at a regional level. New services began in June 2010 in Region 2 (Bryce) and in August 2010 in Region 4 (Searcy).

The plans included the development of the following community services in the Bryce Hospital area (Region 2):

- 84 Supportive Housing Units
- 60 Medication, Observation, and Meals (MOM) beds
- 30 Augmented existing residential beds
- 12 beds in 3 bed group homes
- Peer Bridger Team
- Clinical Support Team
- Flex Funds for Support

The plans for community services in the Searcy area (Region 4) included the following:

- 60 Supportive Housing Units
- 40 Medication, Observation, and Meals (MOM) beds
- 56 Augmented existing residential beds
- 12 beds in 3 bed group homes
- 16 Assisted Living Beds in scattered sites
- Peer Bridger Team
- Flex Funds for Support

In May 2011, the maximum capacity for Bryce’s and Searcy’s extended care units were formally reduced further underscoring ADMH’s commitment to operate smaller inpatient facilities and shift budgetary funds traditionally from state hospitals, to the expansion of services and supports better constructed to promote independence and inclusion into the community for consumers. As a result of the Downsizing Project, there was a reduction of the census at Bryce Hospital by 116 from a FY09 baseline average daily census of 318 to 202, exceeding the target goal of 222; and a reduction in the census at Searcy by 70 from a baseline average daily census of 351 to 245 exceeding the project target of 255.

In the wake of the above described initiatives, the financial atmosphere of FY11/12 and desire to advance a more responsive system of care prompted an acceleration of ADMH’s goals to further reduce the number of acute care psychiatric beds and to bring about the closure of selected state operated facilities. The 2012 Hospital Closure Project resulted in ADMH closures of Greil Memorial Psychiatric Hospital (Montgomery County) August 31, 2012 and Searcy Hospital (Mobile County) October 31, 2012. Collectively, these two hospitals served a total of 1,231 individuals in FY11. Over ninety percent of Greil and Searcy’s inpatient capacity has been shifted to local communities. As a means of supporting this shift, an innovative framework for processing inpatient commitments was born from the Hospital Closure

Project. The dedicated and unprecedented cooperation between state government, local provider agencies, and local probate courts resulted in a new Department of Mental Health Commitment Procedure specifically for Regions 3 and 4 and for which the success of this project hinged. A pivotal element to the newly established commitment procedure was the development of the Gateway System which permits for the tracking of probate committed individuals to be served within the community at a Designated Mental Health Facility or Willing Hospital Participant locales. This process allows for ongoing flexibility, customization, and movement within less restricted levels of care outside of state operated institutions.

The plans included the expansion and/or development of the following community services in the Region 3 area (with closure of Greil Hospital):

- Local inpatient psychiatric treatment provided in a hospital setting for either pre/post-commitment care.
- Medication cost provision for indigent population with loss of IDP.
- One ER screening system with partnership between a community mental health center and local hospital.
- Two Crisis Residential treatment facilities (31 beds) to provide psychiatric stabilization treatment in a ADMHF non-hospital setting for either pre/post commitment care.
- Psychiatric access and care
- One probate liaison
- 24 Supportive Housing Units
- 22 Medication, Observation, and Meals (MOM) beds
- 2 Respite beds
- 3 crisis mobile teams

The plans included the expansion and/or development of the following community services in the Region 4 area (with closure of Searcy Hospital):

- Local inpatient psychiatric treatment provided in a hospital setting for either pre/post-commitment care.
- Four Crisis Residential treatment facilities (64 beds) to provide psychiatric stabilization treatment in a ADMHF non-hospital setting for either pre/post commitment care.
- Psychiatric access and care
- 60 Supportive Housing Units
- 25 Medication, Observation, and Meals (MOM) beds
- One Centralized Service system with a community mental health center.

During FY13 and FY 14, ADMH pursued similar efforts for Regions 1 and 2 in which the utilization of community inpatient capacity will supplement or supplant acute care functions at North Alabama Regional Hospital (NARH) and Bryce Memorial Hospital respectively. This initiative is referred to as the “Hospital Repurposing Project.” In FY12, prior to project implementation, NARH, located in Region 1, served 728 individuals with an acute inpatient bed capacity of 74 and Bryce, located in Region 2, served 897 individuals with an acute and extended care inpatient bed capacity of 268.

The Hospital Repurposing Project proposed plans included the expansion and/or development of the following community services for the following Regions:

Region 1 area:

- Local inpatient psychiatric treatment provided in a hospital setting for either pre/post-commitment care.
- Four Crisis Residential treatment facilities (64 beds) to provide psychiatric stabilization treatment in a DMHF non-hospital setting for either pre/post commitment care.
- One augmented residential care home (12 beds)

Region 2 area:

- Local inpatient psychiatric treatment provided in a hospital setting for either pre/post-commitment care.
- Medication cost provision for indigent population with loss of IDP.
- One preventive urgent behavioral health care facility
- 16 beds in a Specialized Medical group home
- 30 beds dedicated to the care of forensic consumers
- 21 beds in 3 bed group homes (15 positioned in Region 1)
- 36 Supportive Housing Units
- 5 crisis mobile teams

On July 20, 2014, patients located at Bryce Psychiatric Hospital were relocated to a new location commonly referred to as the “new Bryce.” The facility was constructed with state-of-the-art design and purpose. Hospital wards were reduced in capacity to allow for increased patient privacy and sense of community. In total, the new hospital operates with a 268 bed capacity. During FY15, ADMH was able to attain another significant milestone with the closure of NARH which occurred on June 17th, 2015.

The accumulative effects of statewide efforts to reduce hospital census is generating significant results. The number of patients in residence at end of the year, the number of admissions/readmission, and the total served by state hospitals all show reductions. In FY09, prior to the implementation of the latest series of census reduction projects, the statewide average daily census for all state operated facilities serving adult geriatric, forensic, extended care, and acute care populations totaled 1,054. Compared to this FY09 baseline end of year average daily census, ADMH reduced the total statewide hospital census in FY12 by nearly 24%, in FY13 by 44%, and in FY14 by 50%. ADMH demonstrated nearly a 52% statewide reduction in total state psychiatric hospital census from FY09 to June 2015.

With the closure of three state psychiatric hospitals (Searcy, Greil, and NARH) and the reduction of the footprint of Bryce Psychiatric Hospital, ADMH successfully reduced the number of state psychiatric hospitals to three, with all being located in Tuscaloosa, Alabama. All three are unique in their specialty populations. In 2015, ADMH focused its hospital efforts on expanding the statewide system of care to more closely unite the efforts between community care and hospital care. The importance of including state psychiatric hospitals in the system of care would ensure removing the silo approach and transforming into a more seamless care coordination model with a focus on least restrictive care environments. This process began with the implementation of the DMH Civil Commitment Protocol process. This process was developed to shift the civil commitment system from reactive to proactive. This process requires community providers to become actively engaged with an individual’s care at the time a petition for commitment is filed. Historically, most individuals committed were not known to the community providers and their professional involvement occurred after a DMH commitment and placement in a state psychiatric hospital. The implementation of this new process forced direct involvement with the probate courts and an opportunity for development of a coordination system with the involved parties to include the consumer, family members, private inpatient acute hospitals, jails/detention facilities, nursing homes, etc. It also allowed for diversion of inappropriate commitments linked to social reasons.

Another key component was the development of a centralized admission to state psychiatric hospitals process. The DMH Admission Coordinator (DAC) was implemented and this position was placed in DMH Central Office under the supervision of the Office of Mental Illness Community Programs. This became a bridge position for the system of care. This position ensures the monitoring and linking of movement of committed patients, the renewal of commitments, the securing of clinical summaries, and the release from commitment processes.

Also, the Gateway web-based system was developed to track a committed patient across the system, whether served in a Designated Mental Health Facility (DMHF) or state psychiatric hospital. This allowed for a shift in the Community Mental Health Center (CMHC) Responsible. Traditionally, this had been the county of commitment. With the implementation of

the DMH Civil Commitment Protocol process, this changed to county of residence. With such a shift, it allowed for care coordination to remain with the home county of the committed individual. It also developed a need for CMHCs work bidirectional for utilization of statewide resources and care management.

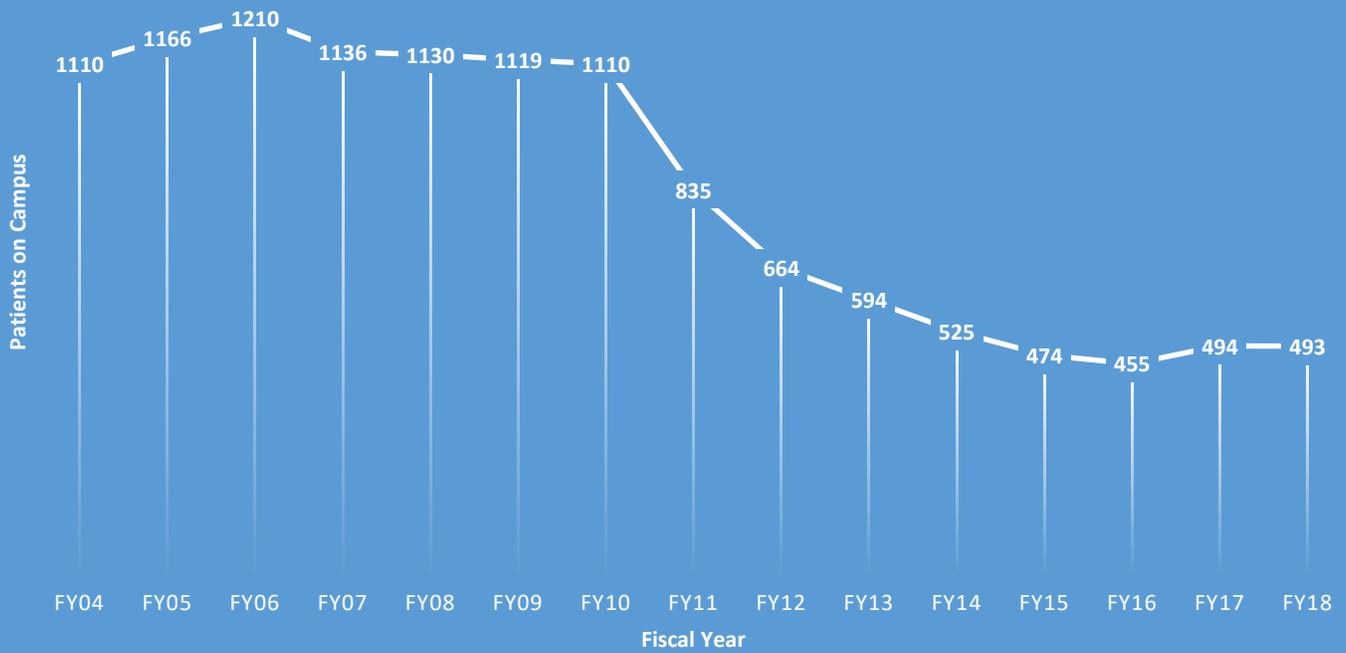
To ensure the development of a statewide system, in December 2016, a monthly statewide staffing, centered on committed patients in Bryce, was implemented. The monthly staffing is an expansion of the treatment team process. It allows the committed patient's social worker to staff the case with representatives from every CMHC covering the entire state. The social worker can then bridge the information to the treatment team. This process allows for expanded communication and planning to better ensure security of recommended resources are in place for a smooth transition into the community upon the release from the commitment. This monthly staffing will expand to the two other state hospitals by October 1, 2017. Data is being collected and has shown the specialty populations that exist within the state hospitals. This will provide an opportunity to develop and enhance relationships within our system of care with our providers, as well as outside our system of care such as the areas of nursing homes. Continued efforts will be a focus on re-aligning regional areas, implementing a utilization process within those regions, implementing a utilization process at the time of a commitment, and implementation of a statewide pilot project with a private hospital in the Birmingham area.

In October 2016, a lawsuit was filed against ADMH alleging that ADMH violated the Plaintiffs Fourteenth Amendment due process rights by failing to provide the Plaintiffs timely competency restoration treatment. The ACLU of Alabama and Alabama Disabilities Advocacy Program (ADAP) filed the lawsuit against ADMH on behalf of three inmates who have been declared incompetent to stand trial due to mental illness. Incompetent and mentally ill inmates transfer to the ADMH, which operates one hospital for patients involved in the criminal justice system, Taylor Hardin Secure Medical Facility. The average wait for a bed at Taylor Hardin has grown to more than eight months, according to the lawsuit. Federal judges have declared waits of more than 14 days to be unconstitutional per ADAP. ADMH worked with ACLU and ADAP to work out a settlement agreement that requires ADMH to meet specified timelines in evaluation and restoration. ADMH developed a DMH Forensic Commitment Protocol Process, which will include entering Forensic committed patients to the Gateway database system, as well as the statewide monthly treatment team staffing process. To meet the criteria outlined in the Forensic Settlement Agreement, ADMH has separated the Forensic Outpatient evaluation process from the work needed within the inpatient setting of Taylor Hardin Secured Medical State Hospital. As part of the Forensic Settlement Agreement, ADMH had to expand the state hospital beds within Taylor Hardin Secured Medical State Hospital by 40 beds which occurred in FY17.

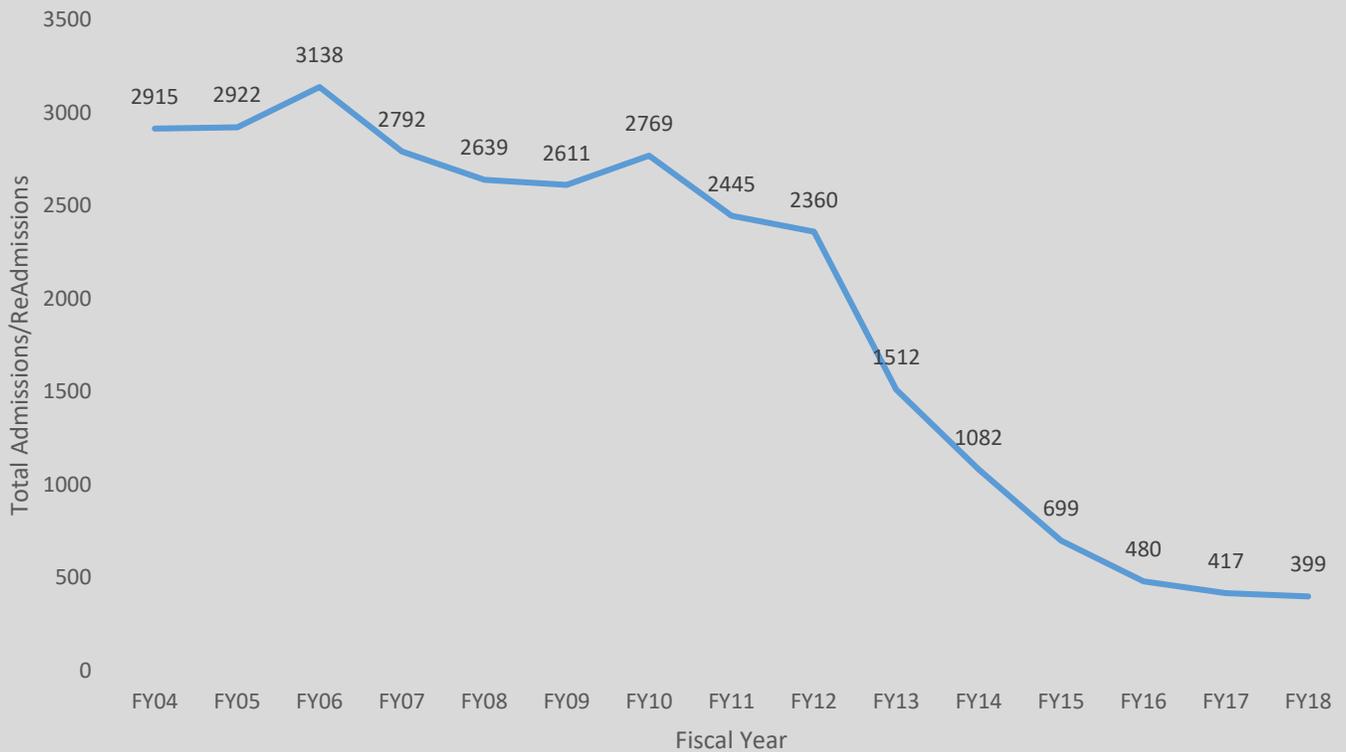
PATIENTS SERVED IN MI STATE HOSPITALS



ALL MI PATIENTS AT THE END OF THE FISCAL YEAR



Admissions & Readmissions To MI State Hospitals

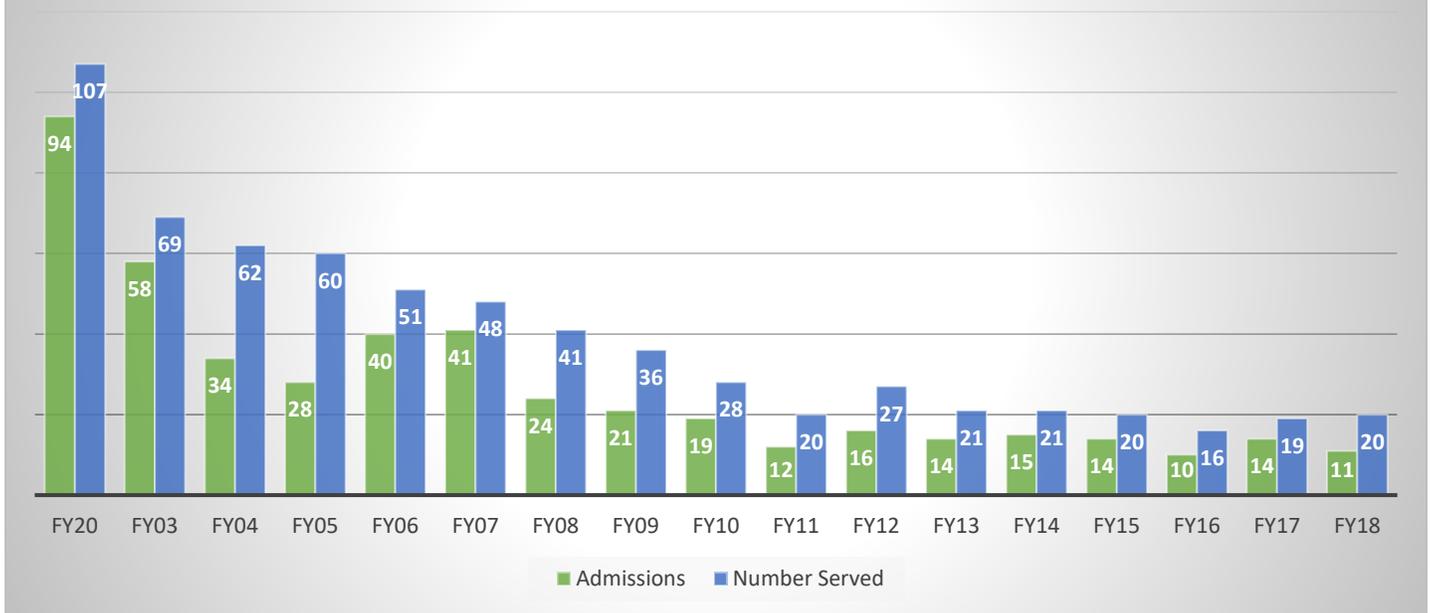


ADOLESCENTS

In regard to adolescents, the inpatient beds operated by the Mental Health system in Alabama for adolescents were located at Bryce State Hospital Adolescent Unit serving the state's child and adolescent population. In March of 2004, the original 40 bed unit for adolescents at Bryce Hospital was reduced to a 20 bed unit. While this reduction was in part a cost saving measure, it was possible because of the significant census reduction experienced by the unit. A total of 19 adolescents were admitted and 28 served at the Adolescent Unit at Bryce Hospital during FY10. This number represented a decrease in total number admitted and in total number served from the previous years. The unit remained below capacity. The ability to keep census below capacity is attributed to the expansion of community services and the development of a service referred to as a Juvenile Court Liaison. Juvenile Court Liaisons work closely with the state child and adolescent services staff, with the sole mission of appropriately diverting mental health and juvenile court commitments in lieu of more appropriate community based services. Children or adolescents are not placed in out-of-state programs by ADMH, Division of Mental Illness and Substance Abuse Services.

During the FY09 legislative session, an amendment to the Juvenile Code was passed and subsequently signed by the Governor in May 2009. This amendment affirmed the ADMH Commissioner's ability to designate a hospital/facility outside of ADMH to provide services to minors and children with SMI or intellectual disabilities and to place these minors and children who have been committed to ADMH in said hospital/facility. These changes were in line with the recommendations of the Child and Adolescent Workgroup of the Systems Reconfiguration Task Force. A contract transferring the operation of the ADMH Psychiatric Adolescent Unit from Bryce Hospital into a smaller (10 bed) unit at the University of Alabama in Birmingham Department of Psychiatry and Behavioral Neurobiology was signed. The transfer was effective in October, 2010. With the movement to a new location at UAB, the unit continued to remain at or below capacity most of the time, even though the number of beds was half of that at the Bryce Adolescent Unit. On April 1, 2016, ADMH contracted with EAMC to operate the Adolescent Unit that was formerly operated by UAB. This adolescent unit became known as the ADMH Adolescent Psychiatric Unit at EAMC. This was a shift from a 10 bed unit to a 9 bed unit. This contractor has also been successful in remaining at or below capacity most of the time. This has been due to continued success in expanding and improving access to less-restrictive community-based treatment options for children and adolescents, and continued effective collaboration between child-serving agencies at the state and local level.

ADMH Adolescent Unit -Admissions and Number Served



Activities Leading to Reduction of Hospitalization

All services and resources within the system of care for our target populations of SMI adults and SED kids are geared to the reduction of hospitalization. It is vital to have a system of care of resources to reduce the need for hospitalization, as well as the inappropriate use of hospitalization for respite, residential, and/or homelessness. It is vital to have training at the local, community, regional and state level of these resources. Community Mental Health Centers (CMHCs) train their local community partners, such as, but not limited to, schools, courts, detention facilities, and child-welfare, on services and resources for diversion. Such diversion services include certified peer specialists, intensive care coordinators, in-home teams, ACT teams, court liaisons, school-based mental health collaboration, drop-in centers, supported employment programs, and FEP team. Staff are trained in engagement and outreach, so they can be the front line in actively engaging with the sites of potential hospitalization diversion such as emergency rooms, courts, detention facilities, and private inpatient acute units. All CMHCs have funded Juvenile Court Liaisons (JCL) who work directly with the courts to divert kids that come to the courts attention to the most appropriate resources. In circumstances when hospitalization is warranted, the JCL serves as a care coordinator and remains involved with the youth consumer and their family and the program in which they are receiving inpatient care to assist with the care coordination back to the community and with the needed resources for a smooth transition. With the closures of three state psychiatric hospitals from 2012-2015, a similar process for adults with SMI was implemented. Since the number of SMI adults served is significantly higher, the efforts for reduction of hospitalization is carried out at a local, regional, and state level. At the local level, each CMHC has a point person for the involved entities. There are also four UR Coordinators, one assigned to each region. Through the DMH Mental Illness Community Programs, staff work with key partners and the DMH Civil Commitment Protocol Process as implemented. Starting in December 2016, ADMH staff, State Hospital Staff, and CMHC staff participate in a monthly care coordination process of an extended treatment planning process in which all committed individuals placed in the three state hospitals are staffed. This is approximately 500 consumers. The goal of this project is to increase discharges from the state hospitals, which has been successful. Also, there is a review process of the waiting list to ensure diversion to the most appropriate and least restrictive setting. ADMH is working with the Alabama Hospital Association to initiate a similar process within the private inpatient settings. Much of the work that has been at the forefront of ADMH's focus since 2011 has been on reduction of hospitalization.

Community Based Mental Health Services

The services eligible for reimbursement for the adults who are severely mentally ill (SMI) and children and adolescents who are severely emotionally disturbed (SED) throughout the state, via contractual relationships between ADMH and the 310 Boards, are shown below. Many of these service categories apply to both adult and child populations. The contract eligibility criteria specify that funds should be used to serve individuals who cannot afford to pay, are not insured, and who meet the criteria for Serious Mental Illness and Severe Emotional Disturbance as well as those individuals presenting in an emergency situation.

Mental Illness Ambulatory Services

1. *Intake/Evaluation*
2. *Diagnostic Testing*
3. *Individual Counseling/Psychotherapy*
4. *Group Counseling/Psychotherapy*
5. *Family Counseling/Psychotherapy*
6. *Crisis Intervention and Resolution*
7. *Pre-Hospitalization Screening/Court Screening*
8. *Physician/Medical Assessment and Treatment (to include telemedicine)*
9. *Medication Administration*
10. *Medication Monitoring (Non-Physician)*
11. *Partial Hospitalization Program (adults only)*
12. *Adult Intensive Day Treatment*
13. *Adult Rehabilitative Day Program*
14. *Child and Adolescent Mental Illness Day Treatment*
15. *Adult In-Home Intervention*
16. *Child and Adolescent In-Home Intervention*
17. *Assertive Community Treatment (ACT) (adults only)*
18. *Program for Assertive Community Treatment (PACT) (adults only)*
19. *Mental Illness Basic Living Skills*
20. *Psychoeducation/Family Support Education*
21. *Treatment Plan Review*
22. *Mental Health Care Coordination*
23. *Certified Peer Services – Adults*
24. *Certified Peer Services – Youth*

25. *Certified Peer Services – Parents*
26. *Therapeutic Mentoring*
27. *Nursing Assessment and Care*
28. *Psychosocial Rehabilitation Services – Working Environment*

Case Management Services

29. *Case Management – Adults*
30. *Low Intensity Care Coordination – C&A*
31. *High Intensive Care Coordination – C&A*

Residential - Housing

32. *Adult Small Capacity (3 bedroom) Residential Care Home*
33. *Adult Residential Care Home*
34. *Adult Residential Care Home with Specialized Basic Services*
35. *Adult Residential Care Home with Specialized Medical Services*
36. *Adult Residential Care Home with Specialized Behavioral Services*
37. *Adult Therapeutic Group Home*
38. *Child/ Adolescent Residential Care Program*
39. *Child/ Adolescent Residential Care Program – Intensive*
40. *Child/ Adolescent Diagnostic and Evaluation Residential Care Program*
41. *Transitional Age Residential Care Program*
42. *Medication/Observation/Meals (MOM) Program (adults only)*

Residential – Stabilization

43. *Intermediate Care Program (adults only)*
44. *Crisis Residential Program (adults only)*
45. *Psychiatric Assessment Center (adults only)*

Minimum Continuum of Care

Expectations for providing minimum continuum of care services for a community mental health provider or a community mental health center is outlined fully in the Alabama Department of Mental Health Mental Illness Community Programs within the Administrative Code – Chapter 580-2-9, Program Standards. A provider that meets the respective requirements will be issued one of two types of certificates depending upon the number and type of services delivered by the provider.

(a) **Mental Health Services Provider** – A provider may be certified as a Mental Health Services provider if it provides one or more (but not all) of the services as listed below in compliance with the ADMH standards.

- General Outpatient
- Child and Adolescent In-Home Intervention
- Adult In-Home Intervention
- Emergency Services
- Partial Hospitalization Program

- Adult Intensive Day Treatment
- Adult Rehabilitative Day Program
- Child and Adolescent Day Treatment
- Case Management
- Residential Services
- Designated Mental Health Facility
- Consultation And Education
- Assertive Community Treatment
- Program for Assertive Community Treatment
- Child and Adolescent Seclusion and Restraint
- Adult Seclusion and Restraint
- Therapeutic Individualized Rehabilitation Services

(b) **Community Mental Health Center** – A provider will be certified as a Community Mental Health Center (CMHC) if the requirements listed below are met. The requirements are designed to assure that any provider certified as a CMHC provides the array of services defined below either directly or through specific arrangement with another agency/individual to a broad array of recipients in an identified service area without regard to age, race, language of preference, sex, and degree of psychiatric disability. The services must be coordinated in a manner that assures access to inpatient and residential care and to community supports for adults with serious mental illness and children and adolescents severe emotional disturbance.

The provider must provide the following services directly through its employees. In addition to the specific criteria listed below, the provider must also comply with the applicable sections of the program standards for each program element.

- Emergency Services.
- Outpatient Services (to include specialty services for children and elderly),
- Consultation and Education Services,
- Specialty services for persons discharged from an inpatient psychiatric setting and for persons with a serious mental illness/severe emotional disturbance and must include the following:
 - Evaluation and medication monitoring by a psychiatrist.
 - Outreach capability to provide services to consumers in their usual living situation.
 - Provision of case management services in accordance with the program standards either directly or through an arrangement approved by ADMH.
 - Screening for admission to state psychiatric hospitals as evidenced by a written agreement with the local 310 Board (if not a 310 Board), relative to coordination of screening petitions for involuntary inpatient commitment for consumers of the CMHC.
- Partial Hospitalization/Intensive Day Treatment/ Rehabilitative Day Program, **and**
- Must provide residential services either directly through its employees or through agreement with other certified providers.

Because Community Mental Health Centers are expected to offer a broad array of services to a demographically and psychiatrically diverse population, the following additional requirements regarding the overall operation of the agency must be met:

- Staff capable of providing specialty outpatient services to children, adolescents, adults, and older adults.
- Should be able to demonstrate community outreach efforts designed to promote access from all age groups with particular emphasis on those who are seriously mentally ill or severely emotionally disturbed.

- The number of recipients both total and by service type and the services provided are acceptable for the time period that the agency has been operational and are roughly proportionate to the number of consumers and types of services provided by agencies similarly certified.
- The provider can demonstrate appropriate response to consumers for whom a petition for involuntary commitment has been issued and/or who have been hospitalized at a state psychiatric hospital.
- At the end of the first year of operation, the agency must have served at least 100 consumers and the services provided should be proportionate to the average of those agencies that are similarly certified.

Child and Adolescent Development of Continuum of Care

The Levels approach to a minimum continuum of care for mental health services delineated in 1985 by the Alabama CASSP Definition Committee and revised in 1998 and 2004 by the Strategic Plan Workgroup provides a sound framework for prioritizing service development and expansion. The structure (by delineating statewide, regional, and local levels) intends to strike a realistic balance between a minimal service set, economy of scale, and fiscal reality. It is assumed that ADMH, in conjunction with the community mental health centers, will not necessarily create and/or operate the total system, but will exhibit the leadership necessary to assure development, effective operation, and coordination. The continuum as envisioned is as follows:

Level I: (Community/County-Based)

Diagnosis and Evaluation (screening)

Intake/Psychosocial Assessment

Outpatient (Individual, Group, Family)

Psychoeducation/Family Support (Consultation, education, training, networking to build a support system)

Level II: (Community/Catchment Area-Based) Diagnosis and Evaluation (comprehensive)

Case Management/Care Coordination

Day Treatment

In-Home Intervention

Child and Adolescent Psychiatric Services

Respite Care Beds

Level IV: (Statewide)

Residential Treatment

Short Term Treatment and Evaluation Program (STTEP)

Private Acute Inpatient Hospitalization

ADMH Psychiatric Adolescent Unit at EAMC

Mental Health and Rehabilitation Services

Alabama continues to develop a comprehensive system of care for children and adolescents with serious emotional disturbances that extend across the state. In addition to the main offices in the 24 community mental health centers,

services are available in most of the state's 67 counties through the satellite programs of the CMHCs. The services available vary across the catchment areas (See table below).

Children and Adolescent MI Services by County (Survey Conducted by ADMH) ----July 2019

PROVIDER	Out-patient	JCL	Case Mgt	In-Home	Day Tx	Respite	Tele-med	Resid	SBMH Collab	FEP Team	Youth Peer Spt Spec	Family Peer Spt Spec	Crisis
<u>AltaPointe</u>													
Mobile	X	X	X	X	C/A/SC/SA	X	X	X	X				X
Washington	X	X					X		X				X
Baldwin	X	X	X	X	C/A/SC/SA		X		X				X
Clay	X	X	X	X			X		X				X
Coosa	X	X	X	X	C/A/SC/SA								X
Randolph	X	X	X				X		X				X
Talladega	X	X	X	X	C/A/SC/S		X		X				X
<u>Brewer-Porch</u>	X				C			X					X
<u>Cahaba MHC</u>													
Dallas	X	X	X	X			X		X				X
Perry	X	X	X				X						X
Wilcox	X	X	X	X			X						X
<u>Calhoun-Cleburne (Highland Health)</u>													
Calhoun	X	X	X	X	P/SP/C/SC		X		X				X
Cleburne	X	X	X	X			X		X				X
PROVIDER	Out-patient	JCL	Case Mgt	In-Home	Day Tx	Respite	Tele-med	Resid	SBMH Collab	FEP Team	Youth Peer Spt Spec	Family Peer Spt Spec	Crisis
<u>CED MHC</u>													
Cherokee	X	X	X	X			X		X				X
Etowah	X	X	X	X			X		X				X
Dekalb	X	X	X				X		X				X
<u>Capitol Care South</u>	X												
<u>Chilton-Shelby MHC</u>													
Chilton	X	X	X	X			X		X				X
Shelby	X	X	X	X	C (x2)/SC		X		X				X

East Alabama MHC														
Chambers	X	X	X	X					X					X
Lee	X	X	X	X	AC/SC	X	X		X					X
Russell	X	X	X	X					X					X
Tallapoosa	X	X	X	X					X					X
East Central MHC														
Bullock	X	X	X	X										X
Macon	X	X	X	X										X
Pike	X	X	X	X	Summer	X			X					X
Eastside MHC	X				C		X							
Glenwood MH	X							X						
Indian Rivers MHC														
Bibb	X	X	X	X				X						X
Pickens	X	X		X				X						X
Tuscaloosa	X	X	X	X				X						X
J-B-S MHA	X	X	X	X		X				X	X	X	X	X
Montgomery Area														
Autauga	X	X	X	X					X					X
Elmore	X	X	X	X					X					X
Lowndes	X	X	X	X										X
Montgomery	X	X	X	X					X					X
Mountain Lakes														
Jackson	X	X	X	X	AC/SC		X							X
Marshall	X	X	X	X			X							X
PROVIDER	Out-patient	JCL	Case Mgt	In-Home	Day Tx	Respite	Tele-med	Resid	SBMH Collab	FEP Team	Youth Peer Spt Spec	Family Peer Spt Spec	Crisis	
North Central MHC														
Lawrence	X	X	X	X	P/SP/SC/SA		X							X
Limestone	X	X	X	X	SC/SA		X							X
Morgan	X	X	X	X	SC/SA		X		X					X
Northwest MHC														
Fayette	X	X	X	X	P/AC		X							X
Lamar	X	X	X	X	AC		X							X

Marion	X	X	X	X	P		X						X
Walker	X	X	X	X	P/C/A		X						X
Winston	X	X	X				X		X				X
Riverbend MHC													
Colbert	X	X	X	X	SC/SA				X				X
Franklin	X	X	X	X	SC/SA				X				X
Lauderdale	X	X	X	X	P/SC/SA				X				X
South Central MHC													
Butler	X	X	X	X	AC		X		X				X
Coffee	X	X	X	X	AC		X		X				X
Covington	X	X	X	X	AC		X		X				X
Crenshaw	X	X	X	X	AC		X						X
Southwest MHC													
Clarke	X	X					X						X
Conecuh	X	X		X			X						X
Escambia	X	X	X	X			X		X				X
Monroe	X	X	X				X						X
SpectraCare MHC													
Barbour	X	X	X	X			X						X
Dale	X	X	X	X			X						X
Geneva	X	X	X	X			X						X
Henry	X	X	X	X			X						X
Houston	X	X	X	X			X		X				X
UAB MHC	X												X
PROVIDER	Out-patient	JCL	Case Mgt	In-Home	Day Tx	Respite	Tele-med	Resid	SBMH Collab	FEP Team	Youth Peer Spt Spec	Family Peer Spt Spec	Crisis
WellStone													
Madison	X	X	X	X	P/SC				X				X
Cullman	X	X	X	X			X		X				X
West Alabama MHC													
Choctaw	X	X					X						X
Green	X	X	X	X			X						X
Hale	X	X					X						X

Marengo	X	X	X	X			X		X				X
Sumter	X	X	X				X						X
<u>Abbreviations</u>													
Outpatient - Individual/Family Therapy			Day Tx – Day Treatment				SP-Summer Preschool						
Resid – MI Residential			P – Preschool				SC-Summer Child						
Case Mgt – MI Case Management			C – Child				SA-Summer Adolescent						
JCL – Juvenile Court Liaison			A – Adolescent				AC-After School DTx Child						
Telemed. – Telemedicine			In-Home – In-Home Intervention Team				SBMH Collab-School-Based Mental Health Collaboration						
Youth Peer Spt Spec-Youth Peer Support Specialist							Family Peer Spt Spec-Family Peer Support Specialist						
--- For Informational Use Only ---													

Case Management

Through the implementation and evaluation of two federal Community Support Program (CSP) grants which provided brokerage type case management services to adults who were seriously mentally ill (1983), and adults who were homeless and seriously mentally ill (1987), and an Office of Substance Abuse Program (OSAP) local demonstration grant which focused on case management to children and adolescents with serious emotional disturbances (1987), the Alabama ADMH was ready in FY88 to begin statewide implementation of case management services. The demonstration grants provided expertise and techniques to organize and deliver effective case management services, as well as staff with the training skills to disseminate the service statewide.

Two events converged to give impetus to the development of case management services in FY88. One was the funding of a CSP systems development grant which provided funding support for training 100 new case managers in the state. The other critical event was the addition of the Targeted Case Management Option to the Alabama Medicaid Plan beginning on October 1, 1988. Optional Targeted Case Management provided a new funding source specifically for services to adults who are seriously mentally ill (SMI), and children and adolescents who have serious emotional disorder (SED).

The mental health centers work with a variety of public and private resources to obtain services and supports needed by SMI and SED consumers in the community. Case Management services are essential to successful maintenance of persons who have SMI and SED in the community. Adult case managers and supervisors are trained either locally through an approved training curriculum or at training sessions provided by Jefferson-Blount-St. Clair Mental Health/Mental Retardation Authority (JBS). All Child and Adolescent case managers and their supervisors are trained through an ADMH and Medicaid approved training curriculum. ADMH contracts with JBS Mental Health Authority to provide these trainings. These sessions held by JBS, to include C&A In-Home Intervention, occur about every two months. The certification standards require successful completion of this training prior to provision of services. In FY18, 9,888 adults and 3,697 children and adolescents had received case management services. Every community mental health center has case management services for adults and children and adolescents.

The following services must be delivered within the Case Management Program:

- a) A systematic determination of the specific human service needs of each consumer.
- b) The development of a systematic consumer coordinated written plan that is developed within 30 days of first face-to-face case management service unless services terminate earlier and that lists the actions necessary to meet the needs of each consumer.
- c) Assisting the consumer through crisis situations and/or arranging for the provision of such assistance by other professional/personal caregivers.

- d) The direct delivery, or the arrangement for, transportation to needed services if the consumer is unable to transport him or herself.
- e) Establishing links between the consumer and service providers or other community resources.
- f) Advocating for and developing access to needed services on the consumer's behalf when the consumer himself is unable to do so alone.
- g) Monitoring of the consumer's access to, linkage with, and usage of necessary community supports as specified in the case plan.
- h) Systematic reevaluation (at 6 months after the original case plan was developed and intervals of 12 months thereafter) of the consumer's human service needs and the consumer's progress toward planned goals so that the established plans can be continued or revised.

Case Management Services must be provided by a staff member with a Bachelor's Degree and who has completed a ADMH approved Case Manager Training Program and infection control training. Case managers who work with consumers who are deaf must complete training focusing on deafness and mental illness by ADMH Office of Deaf Services. Case Management Services for consumers who are deaf or who have limited English proficiency must be provided in a linguistically appropriate manner by staff fluent in the consumer's preferred language, or through the use of a qualified interpreter who achieves at least an Intermediate Plus level on the Sign Language Proficiency Interview. Adult Case Management Services are supervised by either a staff member who has a Master's degree and 2 years of post-master's clinical experience and has successfully completed a ADMH approved case management supervisor training program, or a staff member who has a master's degree which included a clinical practicum, has 2 years of experience as a case manager regardless of whether the experience occurred pre-or-post master's degree, and has successfully completed a ADMH approved case management training program. Child and Adolescent Case Management Services are supervised by a staff member with a Master's Degree and two years of post-Master's clinical experience and who has successfully completed an approved child and adolescent case management training program. Case Managers must possess a current driver's license valid in Alabama. Most Case Management Services and activities will occur on an outreach basis.

RESIDENTIAL CARE

Adult community residential is a key service within the continuum of care. Residential services support discharges and diversions from state psychiatric hospitals. The table below shows the current availability of residential treatment and housing programs for adults listed on the Mental Illness Community Residential Placement System (MICRS) by community service area and by type of program. Overall, residential slots have increased from 1,253 in FY1991 to 2,808 units to date.

Community Residential Capacity - July 2019											
	Stabilization		Congregate Living					Independent/Supported Housing			
CMHC	CRISIS	INTMD CARE	FOSTER	RCH	RCSPEC	3 BED	THOME	MOM	EBP SHP	SEMINT/SHOUS	TOTAL
AltaPointe	-	32	71	14	199	9	-	-	72	151	548
Cahaba	-	-	-	-	26	3	12	-	-	41	82
CED	-	-	73	-	-	-	20	-	12	-	105
Chilton-Shelby	-	-	-	-	46	-	-	-	36	-	82
East Alabama	11	-	2	-	30	-	16	-	-	24	83
East Central	15	-	11	14	60	-	-	-	-	-	100
Highlands	16	-	-	-	14	3	-	-	-	16	49
Huntsville	42	-	33	22	-	-	-	-	12	95	204

<u>Indian Rivers</u>	<u>10</u>	-	-	<u>17</u>	<u>16</u>	<u>3</u>	-	<u>20</u>	<u>12</u>	<u>52</u>	<u>130</u>
<u>JBS</u>	<u>16</u>	-	<u>41</u>	-	<u>80</u>	<u>24</u>	<u>30</u>	<u>92</u>	<u>36</u>	<u>91</u>	<u>410</u>
<u>Montgomery Area</u>	<u>32</u>	-	<u>10</u>	-	<u>54</u>	<u>3</u>	<u>10</u>	<u>12</u>	<u>12</u>	<u>82</u>	<u>215</u>
<u>Mt. Lakes</u>	-	-	<u>49</u>	<u>12</u>	<u>3</u>	<u>3</u>	-	-	<u>12</u>	<u>8</u>	<u>87</u>
<u>North Central</u>	-	-	-	-	<u>34</u>	<u>3</u>	-	<u>9</u>	-	-	<u>46</u>
<u>Northwest</u>	<u>16</u>	-	-	-	<u>113</u>	<u>3</u>	<u>16</u>	-	-	<u>66</u>	<u>214</u>
<u>Riverbend</u>	-	-	-	-	<u>16</u>	<u>9</u>	-	<u>11</u>	-	<u>39</u>	<u>75</u>
<u>South Central</u>	-	<u>16</u>	-	-	<u>10</u>	<u>3</u>	-	-	<u>24</u>	-	<u>53</u>
<u>Southwest</u>	-	-	-	-	<u>14</u>	-	-	<u>25</u>	<u>24</u>	-	<u>63</u>
<u>SpectraCare</u>	-	<u>16</u>	<u>27</u>	<u>32</u>	<u>48</u>	-	-	-	<u>60</u>	-	<u>183</u>
<u>West Alabama</u>	-	-	-	-	<u>26</u>	-	-	-	<u>12</u>	<u>41</u>	<u>79</u>
<u>TOTAL</u>	<u>158</u>	<u>64</u>	<u>317</u>	<u>111</u>	<u>789</u>	<u>66</u>	<u>104</u>	<u>169</u>	<u>324</u>	<u>706</u>	<u>2808</u>

THOME = Therapeutic Group Home, RCH = Residential Care Home, RCSPEC = Residential Care Home with Specialized Services, CRISIS = Crisis Residential, SEMINT= Semi-independent living with intensive supervision, SPHOUS = Supported Housing, FOSTER = Foster Care Facility, INTMD= Intermediate Care, MOM=Medication, Observation, and Meals, EBP SHP= Permanent Supportive Housing

This list represents the number of housing options for seriously mentally ill adults that are provided by community mental health centers (CMHC) or are under contract with CMHCs. In FY18, 4,052 adults were served within the residential programs. It is important to note that there are also numerous individuals who reside in housing supported with Section 8 Rental Assistance and Alabama Housing Finance Authority units, nursing home beds, and assisted living facility beds which are not operated by community mental health centers and, thus, are not captured in the above chart. In FY 18, 290 individuals were served in in nursing homes under contract with the local community mental health center via subcontract with the ADMH. Also, a small pilot program initiated in FY07 to purchase local Assisted Living Facility (ALF) for individuals being placed out of the state geriatric psychiatric hospital which expanded in FY12. The ALF project served 61 individuals in FY18.

For ***Children and Adolescents***, residential services do not exist in all catchment areas. However, there is access statewide to the following components:

Short Term Treatment and Evaluation Program

A 10 bed short-term treatment and evaluation program fills gaps in the service system for comprehensive evaluation outside of inpatient psychiatric hospitals. STTEP offers comprehensive diagnostic and evaluation services and short-term (7-90 days) residential treatment to the statewide population of children and adolescents, ages 5-12 years, with a serious emotional disturbance. This program is jointly funded by ADMH and the Department of Human Resources (DHR).

Children’s Residential Treatment

Two intensive residential programs, located in Birmingham, serves children with serious emotional disturbances from across the state, ages six through fourteen. Contract beds are jointly funded by the ADMH and DHR. An intensive residential program located in Mobile has 8 contract ADMH beds and serves children and adolescents with serious emotional disturbances from across the state. A transitional age residential program, located in Mobile, serves consumers age 17-22. The 10 contract ADMH bed group home has as its priority population young adults who currently need transitional placement from the state hospitals.

SUPPORT SERVICES

As described earlier, a comprehensive system of community mental health services is being developed for adults with serious mental illness and children and adolescents with serious emotional disturbances. The primary mental health service that ties consumers to other needed services is case management. Case managers, through their assessment of consumer needs, development of comprehensive service plans, and linkage of consumers to needed services through referral, active assistance and advocacy, and monitoring of service utilization, are responsible for assuring access to the broad range of needed community services.

Consumer outcome research conducted as part of the program evaluations of demonstration case management programs for adult SMI, homeless SMI, and SED children and adolescents in the state have all found case managers to be successful in significantly increasing the use of the broad range of services needed by consumers. Research results also suggest that the level of functioning of consumers increased with the increased use of services. These outcomes suggest that increased participation in a variety of needed services not only improve the quality of life of consumers, but can also increase the adaptive functioning of consumers in areas of everyday life that are critical to their community tenure. The following are the types of housing, health, rehabilitation, employment, education, medical, dental, and support services that, in addition to mental health services described earlier, are needed in order for consumers to function in their home communities.

Housing Services

Housing is one of the State's critical gaps. It is the ADMH's goal that "all services will be provided from a person-centered treatment planning perspective driven by family and consumer needs and ds that consumers will receive, not only high quality treatment services, but the necessary supports to achieve independent living in safe and decent housing, employment or a sense of purpose, , and inclusion through meaningful social interactions with friends, family, and the community."

Alabama is the sixth poorest state in the nation with a population of 4.86 million (2016 Census estimate). Nearly 1 in 6 Alabamians live below the federal poverty line as cited in the Poverty and Shared Households by State: *(2011 American Community Survey Briefs)*. The availability of safe and affordable housing remains a challenge for consumers with mental illness and limited or no income. According to the National Low-Income Housing Coalition 2017 State Housing Profile, Alabama has a shortage of over 69,000 available and affordable rental homes for extremely low-income earners with 65% spending more than half of their income. "Severely cost burdened poor households are more likely than other renters to sacrifice other necessities like healthy food and healthcare to pay the rent, and to experience unstable housing situations like evictions."

The 2017 Out of Reach report indicates that an individual relying on federal SSI in 2017 can afford monthly rent of no more than \$221. About 8.3 million individuals receive SSI nationwide because they are elderly, blind, or have another disability, and have few other economic resources *(2014 Out of Reach Report)*.

ADMH conducted a housing needs analysis in 2007 and in 2015. A statewide supportive housing plan was developed in 2007 and updated in 2015 through the efforts of two housing expert consultants. Building upon this foundational work, in 2017, ADMH secured the services of Navigant Consulting and the Technical Assistance Collaborative (TAC) to assist with launching a comprehensive strategic planning process to update the 2015 Alabama Supportive Housing Plan. Over the course of a year, Navigant and TAC facilitated a strategic planning process that organized and convened key stakeholders to develop an updated plan. The processes to draft the plan included: 1) Convening a Housing Leadership Group and

stakeholder workgroups; 2) Conducting a permanent supportive housing (PSH) gaps analysis by interviewing stakeholders and reviewing critical documents; and 3) Holding consumer focus groups.

The Housing Leadership Group and four workgroups (two focused on housing and two focused on services) met regularly from October 2017 to February 2018 to discuss key issues and formulate the goals and objectives. Workgroup members included but were not limited to representatives from ADMH, Alabama Medicaid, Alabama Housing Finance Authority, community mental health centers (CMHCs) and other mental health service providers, facility services providers, mental health services advocacy organizations, peer services organizations, Continuums of Care (CoCs), Public Housing Authorities (PHAs), various housing associations such as the Low Income Housing Coalition (ALIHCA) and Alabama Department of Economic and Community Affairs (ADECA), and family and consumer representatives.

A gaps analysis was conducted to project the unmet need for PSH units for persons with a serious mental illness. Findings from this analysis show a shortfall of 2,246 (low-end estimate) to 3,134 (high-end estimate) of community-based housing for persons in the ADMH targeted and eligible population including needs for PSH. *(The Executive Summary for the full Alabama Permanent Supportive Housing Plan can be found in the attachments)*

The Low-Income Housing Coalition of Alabama (LIHCA) is a statewide coalition consisting of housing advocates, elected officials, banking institutions, nonprofit service providers, legal services groups, and low-income persons and whose mission is to increase housing opportunities for individuals with the greatest financial need. In 2017, LIHCA and the Alabama Alliance to End Homelessness (ALEHA) merged. This merger allows for one unified voice to advocate on behalf of affordable housing and services for the homelessness. LIHCA released **LIHCA's 2016 Red Book** which includes a series of county housing profiles identifying housing affordability, housing availability, number of homeowners/renters, available housing units and various community, household, and special needs factors. The special needs category includes the number of individuals living with a disability, HIV/AIDs, and serious mental illness.

LIHCA observed that Alabama has historically relied solely on federal funding for the development of affordable housing and that public funding is critical for the future development of affordable housing. LIHCA advocated for passage of the National Housing Trust Fund and campaigned for the establishment of an Alabama Housing Trust Fund. In May 2012, House Bill 110 established a state housing trust fund. This trust fund is meant to be a flexible source of funding for use in developing and maintaining safe and decent rental and ownership options for families, elderly, persons with disabilities, and others who cannot afford housing. However, Alabama is one of six states to have created housing trust funds legislatively but do not currently have public revenues committed to the funds.

Due to stigma and limited housing options available for citizens with serious mental illness, especially those with limited or no income transitioning from institutions or from homelessness, ADMH has historically relied on expansion of housing programs within its' own continuum of care in an attempt to meet this need. Currently, ADMH contracts roughly 49.7 million dollars with the community mental health provider network to provide approximately 2,808 beds for various living arrangements for adults such as group homes, semi-independent apartments and supportive housing. Comparisons of 2007 MICRS data to 2019, reveals significant changes in the number and type of community living alternatives for persons with mental illness to include those who are homeless. Although some types of housing programs used within the mental health continuum, such as foster homes and therapeutic group homes, have decreased, overall housing programs have increased by 37.2%. This represents an increase by 760 community beds of various types. Most notably, evidence-based permanent supportive housing, first adopted in 2007, increased significantly in 2013. To date, there are 324 permanent supportive housing units in operation consistent with the evidence-based model. The original 108 pilot units are directly supported by ADMH funds. The remaining numbers of units are supported by "bridge funds" obtained from the 2009 downsizing project and, most recently, the hospital closure project in which funds used to support hospitals were transferred to expand community services. Even with this effort, housing opportunities fall short of the projected numbers estimated to meet the needs of our consumer populations.

Additionally, ADMH continues to maintain \$250,000 Housing Support Funds, available statewide for mental health providers to use in order to assist consumers with obtaining and maintaining more independent and stable housing.

ADMH continues a partnership with the Alabama Housing Finance Authority (AHFA) to focus attention on the housing needs of persons ADMH serves. AHFA established HOME and Low-Income Tax Credit 477 set-aside units with reduced rental rates. Housing is also available at reduced rental rates through USDA Farmers Home developments. A Housing Advocate employed by ADMH works to ensure that priority for vacancies as they develop are given to individuals with serious mental illness, developmental disabilities, or substance abuse disorders. In February 2011, a new program, Hardest Hit Alabama (HHA), provided \$162 million to the Alabama Housing Finance Authority to assist Alabama's unemployed homeowners in the prevention of foreclosures. This program was considered an important step in the prevention of homelessness due to widespread unemployment and risk of foreclosures in Alabama.

HUD remains a dedicated supporter to ADMH. In 2011, upon hearing of the plan to close state facilities, the Alabama HUD Field Office located in Birmingham extended an offer to assist ADMH in efforts to transition persons from institutions. As a result, a series of meetings transpired with key leadership from HUD, Fair Housing, and Public Housing Authorities. In March 2012, ADMH participated in HUD's Community Planning and Development Statewide panel discussion as a first step of many to create a framework from which to build collaborations at a local level as well as state level. ADMH is the grantee for two HUD Sponsor-based Rental Assistance Programs (legacy Shelter plus Care grants), the first of which has been longstanding within the urban area of Mobile. The FY18 annual performance report for Mobile demonstrated 51 homeless individuals were served. In 2011, ADMH was awarded rural based Shelter plus Care grant allowing rural based mental health providers the opportunity to expand housing in their rural service area. The FY18 annual performance report for this project demonstrated 5 individuals served.

Collaborative Solutions, Inc. (CSI), an approved technical assistance consultant of the Alabama HUD Field Office. ADMH has partnered with CSI to pursue Rural Housing and Economic Development (RHED) grants. CSI is the state lead for Rural Supportive Housing Initiative (RSHI) and established Peer Networks as a way to link emerging community-based organizations interested in the provision of supportive housing with experienced supportive housing developers. Through the Peer Network, CSI provides the leadership, support, and training necessary to help providers address the affordable housing challenges in their communities.

As part of the overall Housing initiative, it is anticipated that a small number of housing units may be identified and developed to assist with transition services from child and adolescent services to adult services (17-22 years of age). Due to the unique developmental, social, and educational/vocational needs of the 17–22-year-old consumer population, it makes sense to offer residential services that are designed to address these needs programmatically.

ADMH service delivery system recognizes adults at 18 years of age. A consumer is eligible for all adult services if they also meet the SMI criteria. At present, there is a gap in the service delivery system around residential and day treatment needs. This appears to be not one of eligibility on the part of the young consumer, but rather a perceived inappropriateness based on the developmental issues of each consumer population. This transitional population (17 – 22) presents with additional challenges regarding legal status. Often these consumers may be under the jurisdiction of a juvenile court until they are 21, or in the legal custody of the Department of Human Resources. System wide accommodation will take some time. Until then, consumers who have needs greater than outpatient and case management are handled on an individual basis.

ADMH acknowledges the lack of adequate affordable housing stock for Alabama residents and the need for a statewide policy and strategy to address this issue. ADMH representatives will continue to work in all venues to access new housing resources for individuals we serve.

Transitional Age Service

An emerging issue for child and adolescent mental health services is the unique unmet needs of those adolescents transitioning from the child mental health system and entering the very different adult mental health system. To better address these needs, a work group was developed by the Child and Adolescent Task Force, which included adult advocates and mental health professional and planners from adult services. In FY07, recommendations were made by this

workgroup, adopted by the Child and Adolescent Task Force, and approved by the Mental Illness Coordinating Sub-Committee to RFP for a Transitional Age Group Home, a Transitional Age In-Home team, and a Transitional Age Case Manager, all within a Pilot Demonstration Site. These services were operational by fall 2008. The workgroup continued its efforts on the development of parameters for the Transitional Age Supporting Housing Model and other outpatient/community based Transitional services. In FY09, due to budget cuts, the Transitional Age Supported Housing project lost its funding. Based on these models, the information was utilized to develop standards around Transitional Age Residential and standards were incorporated in the revised MI Certification Standards that became effective in October 2010.

Outreach to Homeless Individuals

In 2018, ADMH served a total of 104,642 people statewide through community programs. Of that number 72,232 were adults and 32,410 were children and adolescents. Of the total population served, 1,338 of people reported as living in a shelter or as homeless at time of admission to community mental health services. The highest concentrations of these individuals were in the most populated areas of the state with the Birmingham area comprising 37% of the statewide total adults receiving community mental health services.

ADMH is a recipient of SAMHSA's Projects for Assistance in Transition from Homelessness (PATH) Formula Grant Program for which the 2019 award is anticipated to be \$613,144 in funds allocated to support five community mental health providers located in the most metropolitan areas reflecting the highest homeless point in time counts within the state. PATH funds are the only source of dedicated funding specifically targeted to serving homeless individuals who are seriously mentally ill and/or co-occurring mental illness and substance abuse disorders. In FY18, a total of 505 individuals were served by PATH programs. PATH grant funds permit providers to offer an assortment of specialized services, primarily through outreach methods and case management for individuals who are PATH eligible with the end goal of securing stable housing and transitioning them into mainstream services and supports. PATH outreach workers/case managers are charged with assisting individuals eligible for PATH by creating a person-centered plan to obtain and coordinate needed services including those related to daily living activities, peer support, personal finance and benefits acquisition, transportation, habilitation and rehabilitation services, prevocational and employment services, housing assistance and referrals necessary to promote full recovery. PATH services delivery for enrolled consumers are detailed in the graph below (Source: 2019 Annual PATH Report)

Services to Enrolled Client

505 Number of active, enrolled PATH clients receiving community mental health services through any funding source at any point during the reporting period [Q16]

Services Provided to Enrolled PATH Clients (unduplicated) [Q17]



Services Provided

In less populous regions of the state not receiving PATH funds, regular case management is offered to those who are homeless and have a serious mental illness and/or co-occurring disorder.

According to PATH Annual Report Data, in fiscal year 2018, of the providers who reported the total number of persons who were outreach/contacted, over **32% of those contacted were identified as chronically homeless and over 21% were unsheltered and 40.6% stayed in homeless shelters.** ADMH projects that 1,270 individuals will be contacted through PATH outreach during fiscal year 2019 using PATH funded services. Of those contacted, 53% are anticipated to meet the definition of literally homeless and 406 are anticipated to become new enrollees into PATH services.

In December 2013, Executive Order creating Alabama Executive Network for Service Members, Veterans and Their Families (AlaVetNet). One of the priority areas addressed in the AlaVetNet’s Strategic Plan is veteran’s homelessness.

ADMH is supportive of all 8 instate Continua of Care in Alabama. Continua stationed in Montgomery, Mobile, and Birmingham have published local plans to address homelessness and are in various stages of implementation. The State PATH contact serves on the Boards for the Alabama Rural Coalition for the Homeless (ARCH)). As an ARCH board member, state level coordination of homeless services targeted for individuals in rural areas can be accomplished. As published on the Housing and Urban Development’s Exchange, in 2018, HUD’s Continuum of Care Homeless Assistance Programs Point-In-Time Counts reflected 3,434 individuals and families were identified as homeless statewide with 70.6% in shelters and 29.4% unsheltered. Of this total population, 15.7% were identified as chronically homeless, 24.9% identified as seriously

mentally ill, 15% as having a chronic substance use condition, 1.3% with HIV/AIDS, 8.1% as victims of domestic violence, and 9.9% as veterans.

In 2017, the Alabama Alliance to End Homelessness (ALAEH) merged with the Low-Income Housing Coalition of Alabama (LIHCA). Both boards agreed the merger would allow for a unified voice when advocating on behalf of housing and homelessness. The LIHCA board configuration was augmented to ensure representation of the HUD Coc's. LICHCA partners with Collaborative Solutions, Inc. co-sponsor an annual conference targeted towards service providers and individuals with lived experience.

Alabama has implemented SSI/SSDI Outreach, Access and Recovery (SOAR) training statewide in the past. More recently, providers have utilized the on-line SOAR training option. SOAR has been instrumental in providing the skills needed for service providers to directly impact homelessness and to move forward in accomplishing the overall arching goal of the States' Plan to End Homelessness and the States' Comprehensive Mental Health Service plan.

It should be noted that children and adolescents are served, when part of a homeless family, by PATH case managers and by specialized children's case managers in the mental health regions, which have dedicated children's case management. The major provider of homeless services for children and adolescents is the Department of Human Resources (DHR), the child welfare agency. Runaway youth are also identified and referred for other mental health services, including case management, by runaway shelters located across the state. The ADMH staff also participates in the training of the state's law enforcement personnel. Since the police are frequently the first to encounter runaway youth, a considerable amount of time is allocated for discussion of identification and referral for mental health services.

Medical, Dental, and Health Services

For consumers who are Medicaid or Medicare eligible, almost every type of medical care is provided. Very often the only barrier to service is finding providers who serve Medicaid consumers. Other, non-Medicaid eligible clients have typically exhausted health care resources such as insurance, and must rely on health care available in their community on an indigent basis. Typically, local Public Health departments and community health clinics are the main referral resources used by case managers to meet the primary health care needs of their consumers. Local hospitals provide a very limited amount of inpatient care to indigent consumers. Because of historical practices among indigent consumers, many emergency rooms provide the only primary health care some consumers get. Individuals with mental illness have wrestled with the health care issue for years and in general this is one of the few areas where children and adolescents fare better than the adults. For example, Medicaid benefits for persons under 21 can exceed usual limits when indicated by the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. Children and adolescents in the care of DHR and DYS receive medical care from these agencies, as well as through school nurses where available. In addition to coverage by Medicaid, dental services are covered by AllKids, Alabama's SCHIP program.

The importance of improving coordination and collaboration with primary medical providers is underscored by the finding that persons with mental illness die on the average 25 years earlier than the general population, due in large part to un- or under-treated primary medical conditions. ADMH received a Transformation Transfer Initiative Grant in FY08 and in FY10 to support efforts to improve integration of primary and mental health care. The following partners were convened to assist in planning grant activities: Alabama Medicaid Agency, Department of Public Health, Alabama Hospital Association, Alabama Academy of Family Physicians, Alabama Primary Health Care Association and American Academy of Pediatrics – Alabama Chapter. In FY08 ten regional meetings were conducted to obtain ideas from both primary and mental health providers relative to barriers and opportunities to improve collaboration. The findings from the regional meetings provided the foundation for the efforts funded in FY10. There are three elements to the current grant: 1) expert panels of physicians to discuss their perspectives on collaboration; 2) provide grants to six areas to develop written plans for improving collaboration locally; and 3) support for the Child and Adolescent Psychiatric Institute focusing on primary care collaboration.

Consumers who are in state hospitals are provided medical care as part of their involuntary confinement where there is no insurance or other source of coverage for medical expenses. The state hospitals became tobacco-free on January 1, 2010. Consumers who have no health insurance and who reside in ADMH community residential programs have minor medical services paid by the provider. There is a limited statewide fund for residents of foster homes to pay for incidental medical expenses when there is no other source of revenue.

Most of the adults with serious mental illness and youth with serious emotional disturbances have Medicaid coverage for medical and dental services. However, it is a challenge to find providers in some areas who will accept Medicaid. Case managers provide a vital service by linking consumers to individual practitioners who will accept Medicaid or who will agree to see consumers on a sliding scale or no fee basis. Community mental health providers routinely receive training in universal precautions. Consumers in day treatment and residential programs receive health education on general nutrition, personal hygiene, exercise, and healthy lifestyle, as well as receiving health monitoring and general health advice from staff nurses. Individuals in outpatient, day treatment, and residential services who are also receiving medication services routinely have vital signs monitored with referrals for necessary medical care. Recommendations for routine health screenings are incorporated in all services. Community resources such as health fairs, free blood pressure checks, flu vaccines, etc. are utilized when available. Additionally, people are referred to school health nurses, public health clinics and Federally Qualified Health Centers, as appropriate and when available. Administration of medications prescribed by community mental health psychiatrists is coordinated with school personnel.

Access to dental care is often cited as an unmet need for consumers. The University of Alabama in Birmingham School of Dentistry also provides free clinics around the state. The waiting list for these clinics is very long. Case managers assist consumers in getting on the waiting list for any available free clinics. In some areas of the state, local dentists volunteer time for free clinics. Again, the amount of time and the range of services are limited.

In recognition of the 25 year earlier mortality rate and health disparities suffered by individuals with serious mental illness disorders, ADMH has promoted health and wellness education activities. During the last several years, the annual Alabama Institute for Recovery has provided a platform for conducting wellness screenings for a significant sample of consumers in attendance from all over the state. The 2018 Alabama Institute for Recovery had approximately 97 consumers to participate in these voluntary screenings. Screening methods included checking blood pressure for hypertension, body mass index for obesity, and blood glucose for diabetes. Due to restrictions in funding, no lipid tests were conducted to check for high cholesterol. ADMH acknowledges that the prevalence of current cigarette smoking was recently reported as 28.0% among persons with any mental illness and 18.4% among those without mental illness. Previous research has shown that people with mental illness are not only more likely to smoke, but they also smoke more frequently than people with no mental illness. Again, this year, the Fagerstrom Index was utilized to screen for nicotine dependence. Screenings were provided in partnership with Pfizer. The results of the screenings show a high degree of comorbidity with diabetes, obesity, and hypertension. Health information and smoking cessation information was disseminated at this event.

RURAL ACCESS

For purposes of classifying catchment areas as rural, the criterion was that the area not include a Standard Metropolitan Statistical Area (SMSA population \geq 50,000), in FY18, there were 7 community mental health center catchment areas, out of a total of 19 community mental health catchment areas, that met this criterion: Cahaba, East Central, Mountain Lakes, Northwest, South Central, Southwest, and West Alabama. The table below lists the seven rural mental health regions and the number of adults in the region who were SMI and children and adolescents in the region who were SED and who were served by the local mental health centers during FY18. A total of 65,934 adults who were SMI were served by the local mental health centers during FY18, and 12,867 or 19.51% were served in the seven rural regions. A total of 31,707 children and adolescents who were SED were served by the local mental health centers during FY18, and 5,019 or 15.83% were served in the seven rural regions. This relationship indicates that adult with serious mental illness and children and adolescents with serious emotional disorders in rural regions continue to have access to services. The two most frequently identified areas of need in rural areas are transportation to needed services and child and adolescent

psychiatric services. Medicaid coverage of transportation services should assist in maintaining treatment access in rural areas. Services available to children and adolescents in rural areas will be maintained, and efforts will be made during the year to increase services by equal inclusion of rural areas in the implementation of legislation for the "Multi-Need Child". Each county facilitation team receives funds under the Children’s First legislation to assist with wrap-around services for children in their county. The amounts of these vary as a function of their 2000 census for children and adolescents under 18 years of age. In regard to “mini grants” awarded to county facilitation teams under the previously funded CASSP Infrastructure Grant, all counties had equal access to grant funds.

Rural Regions	# of SMI Adults Served FY 18	# of SED C&A Served FY 18
Cahaba	1,494	361
East Central Alabama	1,779	904
Marshall – Jackson	1,515	624
North West Alabama	2,245	1,360
South Central Alabama	2,570	509
Southwest Alabama	1,922	838
West Alabama	1,342	423
Total SMI/SED Rural Served	12,867	5,019
Total SMI/SED Served	65,934	31,707
% Rural of Total SMI/SED Served Statewide	19.51%	15.707%

Medicaid coverage of the centers as providers of **Non-Emergency Transportation** assists community mental health centers to maintain/expand transportation services, particularly those in rural areas. The chart below shows the number of consumers for whom transportation services have been billed to Medicaid through for FY18.

Medicaid Transportation Units (One/Consumer/Day) for FY18

Community Mental Health Center (CMHC)	FY18 Consumers	FY18 Units
AltaPointe (Mobile)	1,034	24,543
CED	154	339
Cahaba	321	14,900

Chilton-Shelby	85	692
East Alabama	322	25,130
East Central	321	5,941
Highlands	02	42
Indian Rivers	00	00
JBS	577	37,009
North Central	338	19,222
Montgomery	203	18,559
Northwest	487	44,839
Riverbend	370	19,552
South Central	398	24,463
Southwest	00	00
Spectracare	246	23,890
Wellstone	181	7,545
West Alabama	38	4,391
Total	5,077	271,057

As part of the evolving telecommunication revolution, a vast majority of our consumers who are deaf now have videophones and or smartphones, which are much better suited to their needs than older and increasingly obsolete text-based TTY devices. These connections allow consumers who are deaf and have mental illness more rapid response to their needs and more ready access to culturally and linguistically competent therapists than they had previously. This also means greater choice in therapists, since consumers are not limited to face-to-face meetings. Through the use of telehealth and secure web-based video-conferencing platforms, consumers now have options for therapy that were not possible just a few years ago. They can choose which therapist they would like. The Office of Deaf Services (ODS) has also expanded access to qualified mental health interpreters by using the same network, allowing more rapid response. By the end of FY18, ODS has a goal of being able to fill interpreter request inside no more than a 30-minute response time for unplanned walk-ins and the ability to provide mobile teams in the community with interpreter access. ODS has a formal contract with InDemand Interpreting Service based in Seattle, Washington, for video remote interpreting to cover times and slots when staff or contract interpreters are not available. Another emerging benefit from this network is more ready access to peer support as consumers in recovery in one part of the state can mentor those in another – a tremendous advantage in a low-incident, widely dispersed population.

Increased use of telecommunication technology makes services available in more locations and decreases travel time. Many of the centers are using telecommunication equipment to participate in treatment team meetings at the state hospitals, screen hospital residents for residential placement, and to provide families an opportunity to visit. Initial poor connectivity issues have been addressed with a resulting improvement in quality of interaction. The use of telecommunication equipment has been well-accepted by most clinicians and consumers. The Medicaid Agency, based in

part on experience in the mental health system, now covers telepsychiatry under the Physician’s Program in addition to the Rehabilitation Option.

OLDER ADULTS/ELDERLY

Community based services are provided to older adults through the existing community mental health center service structure. There were 18,867 individuals aged 55 or older who had received services from a mental health center during FY18 which makes up 18% of the total population served and 26% of the adult population served. The following list shows the number of recipients aged 55 or older by service type (includes duplication):

Residential	1,377
Day Treatment	1,480
In-home Intervention	258
ACT	399
Case Management	2,599
Outpatient	17,999

Based on these numbers, older adults are receiving a variety of services through community mental health centers. During FY16, adults over 55 years of age make up 30% of the total adult population receiving Residential services and make up 40% of the total adult population receiving ACT services. Mental health centers provide both direct services to residents of nursing homes as well as case consultation to the operators.

During the second half of FY07, a small pilot project was started to purchase local Assisted Living Facility beds for individuals appropriate for this level of care who were residing in the state-operated Mary Starke Harper Geriatric Hospital. This pilot was successful enough that the pilot was expanded statewide. In FY18, a total of 61 individuals have received services through contract Assisted Living Facilities.

In July 2009, ADMH closed its 30-bed state operated psychiatric nursing facility Alice Kidd. Most of the residents were placed in the community. Those who could not be placed in the community were transferred to another state operated psychiatric facility, Mary Starke Harper Hospital, which serves geriatric patients committed to ADMH. Nursing home and Assisted Living Facilities have been used as community resources for the older residents in need of transitioning out of state hospital care. ADMH participated in planning for a Money Follows the Person grant application directed to improving discharge opportunities for residents of nursing homes and Mary Starke Harper Geriatric Hospital. ADMH continues to work closely with the Alabama Medicaid Agency on the implementation of Money Follows the Person.

Evidence-Based Practices

Evidence-based practices utilized in in Alabama are described below:

Assertive Community Treatment (ACT) and the Program for Assertive Community Treatment (PACT)

ACT and PACT have served as a critical element in the diversion of adults considered to be at high risk for readmission to a state psychiatric facility. Alabama began developing ACT and PACT services in 2001. The model used is based upon the principles of PACT as outlined in the SAMHSA Toolkit. However, when the model was adopted, the ADMH EBP Workgroup modified the national model to focus on mental health services using primarily a three member team in addition to a part-time psychiatrist. Mental Illness Program Standards require that the 3 full-time equivalent positions include at least 1 full-time master’s level clinician, at least one half time registered nurse or licensed practical nurse, and one fulltime case manager. The remaining half-time position could be filled at the agency’s discretion by a master’s level clinician, a nurse, or a case manager. The Substance Abuse Division (SA) funds SA treatment specialists for 5 of Assertive Community Treatment (ACT) Teams. The role of this specialist is to provide both direct services and expert guidance in how other team members can improve skills in the recognition of and treatment for substance abuse disorders. There are currently 16 certified ACT and 2 certified PACT programs in operation. For the consumer to staff ratio for the modified team is 1:12.

The size of the team was based on the minimum necessary to meet the treatment and support needs of consumers while maintaining conformance to the core principles. Given the predominantly rural nature of the State, there are few areas that could support a full fidelity PACT team costing approximately \$1 Million per year. The two PACT teams are currently located in our most urban city, Birmingham.

Illness Management and Recovery (IMR)

The University of Alabama Department of Psychiatry and Behavioral Neurobiology submitted the winning proposal to be a Center of Excellence to assist ADMH to implement evidence-based practices for adults with serious mental illness. The Alabama Institute for Mental Health Services (AIMHS) was created and provided training and monitoring for eight pilot sites on implementation of Illness Management and Recovery (IMR). The trainer, Patricia Scheifler, is a national expert. For a variety of reasons, the contract for the Center of Excellence was not renewed in FY10. ADMH did not have the capability to continue the training and monitoring necessary to assure acceptable fidelity to the model. For that reason, IMR services are not reported.

Permanent Supportive Housing (PSH)

As stated previously, housing continues to remain a critical gap. As a means to offer housing opportunities in a manner most in keeping with the latest evidence for best housing practices and to foster community integration, ADMH dedicated funding to support the development of evidence-based housing projects. In FY08, nine pilot sites were selected to implement Permanent Supportive Housing (PSH) projects creating housing capacity of this type by 108 beds. Additional projects have become operational as a result of the community service expansion efforts of the downsizing and closure projects resulting in a total of 324 Permanent Supportive Housing beds.

Supported Employment: Individual Placement and Supports

Employment services for consumers are not well developed within the mental illness service milieu and are identified as a system weakness. In 2018, ADMH served a total of 104,642 people statewide through community programs. Of that number 72,232 were adults and 32,410 were children and adolescents. Out of the adult population, 12.7% were employed, 21% unemployed, and 66.3% were not in the labor force due to a disability or other reasons. Individuals receiving mental health services who also reported being employed full time dropped from 8,049 in 2007. Compared to 4,578 in 2014, that represents a 43% reduction in full time employment. Consumers experiencing full-time employment in FY18 were reported at 5,912 falling short of those reported prior to the recession. The Office of MI Community Programs recognizes unemployment in the general population correlates with illness, substance abuse, domestic violence, lack of social connection, and other adverse outcomes.

ADMH and the Alabama Department of Rehabilitation Services (ADRS) have forged a longstanding collaboration to serve disabled populations. ADMH and ADRS jointly applied for the Substance Abuse Mental Health Services Administration (SAMHSA) *Supported Employment: Transforming Lives* grant. Alabama was one of seven states awarded in FY14. This 5-year grant provides an opportunity to implement evidence-based supported employment services. The program goal is to prioritize and offer full access to employment through Individual Placement and Support services for people who do not benefit from traditional vocational services. Key partners include Westat Institute, the Auburn Center for Disability Research and Services, and ADRS. Representatives from AL Medicaid actively participate on the statewide steering committee and leadership workgroups.

MICP's carefully weighed the selection of project locations. Given that over 50% of Alabama's population lives in rural counties, the inclusion of a rural location was prioritized. Grants funds supported two pilot locations: AltaPointe Health Systems (urban Mobile) and Chilton-Shelby Mental Health Center (rural). The project was expanded to a third site: Montgomery Area Mental Health Authority. Services were initiated in October 2015 for the initial sites and February 2018 for the expansion site. The two original pilot locations achieved *Exemplary Fidelity*, while the expansion site earned *Good Fidelity*. The IPS Employment Center's 25 Item Fidelity Scale is used to evaluate the programs adherence to the evidence-based practice and support of the eight (8) practice principles of IPS.

Grant activities include 1) establishing a statewide steering committee - Supported Employment Coordinating Committee (SECC) tasked with overseeing the implementation of IPS programs throughout the state, coordinating cross-agency collaborations, providing guidance to IPS policy development, and creating a financial plan to ensure sustainability; 2) creating a comprehensive IPS Supported Employment Training and Technical Assistance Program using in-person and virtual platforms; 3) implementing high fidelity IPS programs in two pilot communities, providing access to IPS for at least 450 consumers over the 5-year period, providing benefits counseling, using certified peer support specialists to engage underserved populations; and 4) Outreach to Veterans in the State of Alabama to ensure all veterans in need of mental health services who prefer to seek treatment at local community mental health centers have the opportunity to participate in IPS service from an Alabama community mental health provider. Project goals were exceeded with the addition of an expansion site and numbers served. As of June 30, 2019, a total of 501 individuals with serious mental illness have been served by IPS programs. Over 46% enrollees were employed in competitive, integrated settings and six percent were enrolled in educational programs.

As a result of the grant, state-level infrastructure was developed to support the project. ADMH established a dedicated state trainer/coordinator position. This position serves as a statewide resource for IPS implementation and is a key member of the leadership team focusing on sustainability planning. Three ADMH state-level staff have been trained as IPS fidelity reviewers. ADRS dedicated state level staff to provide leadership and support.

The Supported Employment Coordinating Committee (SECC) was established and composed multiple stakeholders to include ADRS partners, State Medicaid, Labor, statewide Peer organizations, and others. Through the dedication and work of the SECC and SECC workgroups, the following benchmarks were accomplished:

- SECC Strategic Plan developed,
- SECC IPS Marketing Plan drafted,
- ADMH IPS Reporting Codes and Service Definitions created and implemented,
- IPS Funding Crosswalk and Service Gap Analysis document drafted,
- IPS Sustainability Plan was drafted,
- A Statewide Shared Data Platform designed for ADMH, ADRS, and Alabama Medicaid data matching of shared clients across systems,
- Making a Business Case document drafted (Auburn University Collaboration)

To supplement the work of the SECC, MICP's applied for and was awarded the office of Disability Employment Policy (ODEP) Vision Quest Technical Assistance. Technical Assistance was provided in the form of access to 100 hours of time from Subject Matter Experts (SME's), Dr. Virginia Selleck and Joe Marrone, for the purposes of developing a short-term sustainability plan for the AL-IPS-SEP project. The "Bridge MOU" exemplifies the level of commitment and collaboration from the ADMH, ADRS, and IPS provider leadership. Not only does the MOU specify shared costs for the current IPS programs but promotes the alignment of ADMH and ADRS policies and practices to support IPS.

Prior to the award of the SAMHSA Supported Employment grant described above, little had been achieved in the way of developing employment services within the mental health system outside of limited funds dedicated to support the employment of certified peer specialists (CPS) within the provider network. Traditionally community mental health programs focus on job readiness training and referrals to Vocational Rehabilitative Services. Due to the lack of a devoted funding source, the means for offering evidence-based Supported Employment services as a vehicle to obtain competitive employment statewide remains undeveloped.

ADMH has been able to establish a framework from which to foster employment-based services. In FY11, ADMH received an Employment Development Initiative (EDI) grant which initiated preliminary supported employment planning activities. EDI funds supported Train the Trainer technical assistance for the end purpose of creating the capacity to conduct its in-state Certified Peer Support Specialist Training. Sponsored by EDI grant funds, experts on the **Individual Placement and Support (IPS) supported employment evidence-based** model served as keynote speakers at the EDI grant sponsored Alabama's Supported Employment kick-off event in 2011. These initial activities have uniquely positioned MI Community Programs to foster a relationship with Dartmouth IPS Supported Employment Center. Dartmouth, now Westat, continues

to provide guidance to Alabama through the IPS Learning Community and as the technical assistance provider for the SAMHSA Supported Employment grant previously described.

Within ADMH, the Division of Mental Health and Substance Abuse works closely with the Developmental Disabilities Division, which houses an employment coordinator who works primarily towards the development and expansion of integrated employment programs for the Intellectually Disabled population. Through cross Division collaboration, staff and providers within MI Community Programs are invited to access employment focused resources and training events spearheaded by the ID Division.

To affect state policy, ADMH collaborated with other state agencies to submit an Employment First Bill. The bill was introduced in the 2013 legislative session and again in 2014. Although the bill was well received, failed to reach the floor for vote. The Employment First Bill will affix “employment” as a legislatively affirmed priority. The passing of this bill will be viewed as a turning point in shaping state driven policy and funding mechanisms necessary to spark a transmutation in traditional services systems. Stakeholders continue to attempt to address concerns from some providers around employment as a priority. ODEP technical assistance has further supported the movement towards employment as a priority guiding the development of an executive order. Consumer, family, and provider input are being sought.

Consumer Operated Services

Consumer driven recovery, such as consumer run drop-in centers and support groups are seen as essential elements of the continuum of care, but these services are not covered in ADMH’s contract with community mental health centers. The Block Grant is used to support the development of consumer-operated services as well as the annual consumer conference. There are four operational drop-in centers serving on average an approximate total of 101 consumers on any given day. Within the state, there are 2 statewide consumer organizations, and 16 NAMI connection groups. The reduction in statewide consumer organizations was a result of a merger between the Alabama Peer Specialist Association (APSA) and Wings Across Alabama.

Certified Peer Specialists

ADMH has long valued the power of peers to support fellow consumers and promote recovery. ADMH first established the position of peer support specialist in 1994 at Greil Hospital and later expanded the program to all state facilities. In 2008 provisions were made to expand peer support services to the community provider network. Funding cuts restricted full expansion of peer services to every provider agency; however, due to the 2011 efforts of shifting hospital funds to community services, peer support services has once more found an opportunity to flourish. Not only has the movement towards peer services lead to the credentialing requirements for the certification of peer specialists, but it has evolved in the creation of specialty peer specialists training such as peer bridger services and peer specialists funded to assist in promoting health and wellness for consumers with chronic physical illnesses in addition to serious and persistent mental illness. Efforts to secure Medicaid funding for this service was successful as a Medicaid Rehab Option State Plan Amendment (SPA) was approved in October 2018. Current efforts are underway for implementation of Certified Peer Services in the specialty areas of Adults, Youth, and Youth Parents.

Currently there are 66 certified peer specialists employed at community mental health centers with 11 employed who are awaiting certification training, two located at state hospitals, and 16 others serving in mental health related positions, including 8 employed by mental health consumer and family organizations. Several previously employed specialists used their knowledge, experience, and skill gained from CPS training and employment to enhance their prospects and obtain higher paying positions outside of the mental health realm or to return to college.

ADMH is expanding opportunities for Certified Peer Specialists, especially with Youth Certified Peer Specialists. Jefferson, Blount, St. Clair Mental Health Authority (JBS), Hill Crest Hospital in Birmingham and ADMH piloted a project providing peer support for adolescent girls in a C&A psychiatric residential treatment facility. JBS has also established an Urgent Care Center incorporating the use of Certified Peer Specialists.

ADMH has contracted with three Supported Employment IPS sites. These are Chilton Shelby Mental Health in Calera, AltaPointe in Mobile, and Montgomery Area Mental Health Authority in Montgomery. Each team is required to include Certified Peer Specialists. ADMH has also contracted with JBS Mental Health Authority in Birmingham for a First Episode Psychosis (FEP) team. The FEP teams are required to include Certified Peer Specialists – Youth and Certified Peer Specialists – Parents.

Adults served by Evidence-Based Practices/Best Practices are outlined in the following grid:

Evidence Based Practice/Best Practice:	Estimated Number Served in FY18
Assertive Community Treatment	981
Family Psychoeducation	0
Illness Management and Recovery	0
Individual Placement and Support (IPS) -Supported Employment	248
Integrated Treatment for Co-occurring Disorders (MH/SA) *	0
Medication Management	0
Permanent Supportive Housing	293
Peer Support Services**	202

*There are four programs that identify themselves as specifically treating individuals with co-occurring disorders. Mental health centers address the co-occurring treatment needs of consumers through parallel and sequential mental illness and substance abuse services, but largely not in programs that would meet fidelity measures for co-occurring treatment.

**Although ADMH created reportable activity codes to capture the services provided by CPS/Peer Bridger’s, the number reported does not accurately reflect the actual number served and is only representative of peer activities at two mental health organizations. Eighteen community mental health centers are providing peer support services. At present, there is no incentive to report individual episodes of peer services since no reimbursement mechanism exists. The Office of Consumer and Ex-patient Relations estimates numbers served at a much higher rate than those reported in the grid above.

C&A EBPS

In regard to children and adolescents, a number of evidence-based practices (EBP) have been under consideration in Alabama. The Core Performance Indicators include Therapeutic Foster Care as one of the required EBPs for Uniform Reporting System requirements. In Alabama, Therapeutic Foster Care is funded and licensed by child welfare, the Department of Human Resources (DHR). Because ADMH cannot regulate or monitor these services, there are no goals listed below related to it. It is important to note that DHR has contracted with a Multi-Systemic Therapy (MST) provider in several areas in Alabama and DYS has contracted with a MST provider in one region. Funding services that have been demonstrated to be effective were considered by ADMH. In FY06 and FY07, the C&A EBP Workgroup worked toward formal recommendations regarding the selection and implementation of appropriate evidence-based practices. In FY07, the EBP workgroup recommended the following: Cognitive Behavior Therapy (CBT) in the form of developed models be considered for implementation. One such CBT model recommended by the workgroup was Coping Power. The EBP workgroup also recommended securing outside assistance in any implementation of a child and adolescent focused EBP and that a Center of Excellence be considered for the request for proposal process similar to the course of action currently being incorporated by ADMH with the adult SAMHSA Toolkits (this Center of Excellence no longer exists). The EBP workgroup further recommended that C&A In-Home Intervention be evaluated/assessed by a Center of Excellence as to work toward this service being recognized as a “best practice”. These recommendations were submitted to the Mental Illness Coordinating Sub-Committee. In FY08 and FY09, the EBP workgroup focused on the “A Guide for Selecting and

Adopting Evidence-Based Practices for Children and Adolescents with Disruptive Behavior Disorders” Guidelines issued by SAMHSA to assist in making further recommendations on C&A EBP’s. During the same timelines, ADMH was working with NASMHPD on the C&A EBP reporting issues and a National movement to include a New Optional Table to URS for Reporting Child and Youth EBP’s. The first priority of focus for the C&A EBP workgroup and the National workgroup that ADMH was involved was reviewing the EBP’s from the SAMHSA’s Guide which have a specific focus on treatment (versus prevention) and have demonstrated a good level of evidence. From those reviewed, the C&A EBP workgroup identified both prevention and intervention programs to be recommended. These were a smaller list than those being recommended by the NASMHPD workgroup. Because the EBP’s in the SAMHSA’s Guide primarily focused on disruptive behavior disorders, the C&A EBP Workgroup and the NASMHPD Workgroup researched other EBP’s for consideration. The C&A EBP Workgroup identified the other EBP’s for recommendation which mirror the recommendations of the NASMHPD Workgroup. The C&A EBP Workgroup encountered more difficulty around developing implementation strategies for recommended EBP’s. With C&A EBP’s, they are created and owned by an entity, usually a University. So, implementation is based on ability to work with the defined EBP entity. This has to be done with each EBP. For future implementation, the C&A Workgroup recommended to the MI Associate Commissioner the following, as funding permits:

1. Develop an ADMH approved C&A EBP menu that would allow community providers to determine which EBP works best in their community as to provide optimal movement towards transformation.
2. Contact each EBP entity approved and determine all necessary steps for implementation to include, but not limited to, training, ownership of data, certification, and all costs.
3. Consider a Center of Excellence concept similar to what has been implemented with Adult EBP’s. To properly implement C&A EBP’s, a Center of Excellence concept is what has been utilized in other states to effectively and efficiently implement EBP’s due to complex training demands, certification demands, and data/outcome demands.
4. Consider exploring avenues to have C&A In-Home Intervention evaluated/assessed as a service that could be recognized as a “promising practice” or “best practice”. To do this would only be accomplished by either working with a Center of Excellence or University.
5. As funding is the driving force for Implementation, next steps for implementation are even more complicated. Monies would have to be secured to do so either within the ADMH budget, with collaborations with other State Agencies, and/or through grant opportunities.

In FY10, efforts continued to identify and develop opportunities to implement the recommended EBPs. In FY08, ADMH partnered with the University of Alabama (UA) and Dr. John Lochman, creator of Coping Power to apply for a research grant. Dr. Lochman is the Director of the Center for the Prevention of Youth Behavioral Problems on the UA campus. Coping Power is an EBP recognized by SAMHSA. Dr. Lochman applied for a research grant that would partner with community mental health centers in the use of Coping Power. This would be in partnership with UA, ADMH and community mental health centers. The grant was submitted in July 2008 but was not awarded. Collaboration continues to work toward securing funding to demonstrate this EBP. ADMH also participated with the UA in the application of a NIH research grant. This grant opportunity would allow for the gathering of baseline data from mental health providers over a two year period of time as to assess C&A In-Home Intervention (IHI) services. This baseline data would be utilized as a platform to move toward IHI being recognized as a “promising practice”. The UA, in collaboration with ADMH, applied for this grant in June 2010 but it was not awarded. In October 2010, ADMH received notification that the SAMHSA Child Mental Health Initiative Grant (SOC) application was awarded. This grant application represented a unique opportunity to develop a system of care that would serve children with serious emotional disturbance and their families in a three county rural community. ADMH contracted with a community mental health center for the implementation with ADMH working closely with this system of care process. After year three of the SOC grant, ECCHO met sustainability. Several EBPs were being considered for implementation within this System of Care (SOC) Grant to include: Wraparound, Coping Power, Dialectic Behavioral Therapy (DBT), Positive Behavior Support (PBIS), Bright Futures, Assuring Better Child Development (ABCD), and Cognitive Behavior Therapy and Motivational Enhancement Therapy (CBT-MET). Only Coping Power had been initiated for implementation. Meetings have occurred on how to capture the data within the ADMH data system once

Coping Power is fully implemented through ECCHCO. In August of 2013, Dr. Lochman at UA applied for a three-year Patient-Centered Outcome Research Institute grant that would partner with ADMH and community mental health centers to train up to 120 mental health clinicians to implement Coping Power and establish Coping Power programs at multiple sites across the state. However, we were not awarded to grant application.

Evidence Based Practice	# Served FY18	# Served FY19	# Served FY20
	Actual	Actual	Target
Multi-systemic Therapy	0	0	0
Functional Family Therapy	0	0	0
Therapeutic Foster Care	0	0	0

Child and Adolescent Needs and Strengths (CANS)

Efforts to move toward the use of a state-wide Functional Assessment Tool became a focus of attention of the Child and Adolescent Task Force for several reasons. The use of a functional assessment tool could serve as a uniformed state-wide reporting process that would be a valuable approach for consistently capturing measurable data elements that are comparable. The use of a functional assessment tool would serve as an instrument to drive treatment planning that is individualized, family-centered, and strength-based. The use of a functional assessment tool would provide an avenue to capture data needed to assist with mandatory reporting elements. The use of a functional assessment tool would provide rich data that would enhance grant applications which is highly valuable considering the current state and federal economic conditions. Recommendations were made to the Associate Commissioner to move in this direction and, on October 1, 2010, the Child and Adolescent Needs and Strength (CANS) Functional Assessment Tool was implemented state-wide. The CANS is being used statewide for children and adolescents receiving services through the public mental health system. This transformation tool, consistent with system of care values and principles, focuses on the needs of the children and families. The CANS-Comprehensive provides a common language, objective criteria to support decisions about intervention plans and intensity of services, monitors progress through outcome measures, and supports quality improvement initiatives. Information from the CANS-Comprehensive will support decisions at multiple levels – direct services, supervision, program management, and system management. For community mental health providers, the *CANS for Alabama Comprehensive Multisystem Assessment (5 to Adulthood)* or the *EC-CANS for Alabama Comprehensive Multisystem Assessment (0 to 4 Years)* tools is being utilized. The CANS was developed by John Lyons, PhD, in collaboration with several states’ child serving systems and Dr. Lyons worked directly with ADMH on this venture. Dr. Lyons completed the “Super User” training/certification process in June 2010. Approximately 107 CANS Super Users were trained to support local implementation of the CANS-Comprehensive training, supervision, and integration into everyday practice. Alabama’s mental health public system providers were trained and certified as “Certified CANS Users”. A database, the Alabama Behavioral Health Assessment System (ABHAS), was developed to capture the CANS data and to provide a variety of reports to users at all levels of the child-serving system. ADMH Data Management Division created a web-based application in collaboration with Dr. Lyons to interface with this database, and the ABHAS website was initiated on October 1, 2010. All MI contracted providers have C&A staff trained and a CANS completed on all C&A consumers as of April 1, 2011. In 2013/2014, ADMH moved into an enhancement process for the CANS certification/re-certification process and joined a national consortium to achieve this, The Praed Foundation. By January 2015, all the mental health providers contracted with ADMH were members of the Praed Foundation under the jurisdiction of Alabama. This allowed ADMH to enhance the timeliness of certification/re-certification and the technical guidance that enriches to process of utilizing the CANS as a multi-purpose tool. In October 2018, the use of the CANS was expanded to include those providers certified through the ADMH Mental Illness Program Standards. At this time, all providers serving children and adolescents through either a contract or certification through ADMH utilize the CANS for treatment planning purposes.

School-Based Mental Health (SBMH) Collaboration

ADMH appreciates a long-standing collaboration with the Alabama State Department of Education (ALSDE) stemming back to 1999. ALSDE is responsible for educational services for children/adolescents in Alabama, and there are over one hundred school systems in the state. For numerous years, case managers, in-home intervention teams, and outpatient clinicians employed by the Community Mental Health Centers (CMHCs) have had frequent contact with the educational system on behalf of children with a serious emotional disturbance and their families. Since 1999, the two agencies have collaborated to blend funds and resources on projects that began with day treatment programs and now extended into an integrated, school based project, School-Based Mental Health (SBMH) Collaboration.

From FY 12 and FY 19 to date, sixteen of the 19 community mental health centers (CMHCs) of Alabama and close to 70 Local Education Authorities (LEAs) have conducted initial orientation meetings describing the SBMH collaborative process. Of these, 16 CMHCs and 60 School Systems have entered into formalized agreements as SBMH Collaboration Partners. The SBMH model improves access to appropriate mental health services by children who need them by placing a Master's level clinician in the school setting in a structured manner that ensures confidentiality while enhancing mental health service delivery. ADMH and ALSDE continue to jointly promote the School Based Mental Health Collaboration across the state and have presented workshops on SBMH at ALSDE's MEGA Conference and Transition Conference in FY 12 and every year thereafter through FY19. SBMH Partner CMHCs and School Systems gathered information to establish School Year 2014-2015 as the "baseline year for SBMH Data. This information is used to analyze the effectiveness of SBMH over subsequent years.

ADMH feels that by implementing this promising practice, a system can be developed that ensures a more preventive effort to integrate a seamless system of mental health care in educational settings. All of this is in an effort to provide treatment that is more holistic and, in a way, to build strength and resiliency for young people personally and with their educational successes. Initially no additional funds were provided to the CMHCs or School Systems to implement this practice. Through the dedication of CMHCs and School Systems to serve students, the initial SBMH Collaboration services were developed with existing limited resources. After the school shooting in Parkland, Florida in February 2018 and with a national focus on increased services in the school setting, the Alabama Legislature appropriated \$500,000 in FY 18. These funds assisted with the expansion to 9 additional School Systems that did not have the resources available to implement SBMH Collaboration services previously. With the continued national focus on providing proactive services in the school, ADMH continues to ask for additional funds to expand this promising practice throughout the State.

First Episode Psychosis (FEP)

ADMH has implemented the First Episode Psychosis (FEP) program, which we reference as NOVA-Alabama. This has required certain training elements in order to meet the fidelity of the model. For specific information regarding collaborative efforts with NOVA, please see Section IV, Environmental Factors and Plan: 4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside - Required MHBG.

Substance Abuse/Co-Occurring Disorders

A major gap in the current system of care for adults and children and adolescents is coordinated care for individuals with co-occurring mental illness and substance abuse problems. Often programs and services are not available due to eligibility rule-outs in their admission criteria, or complex funding requirements may hinder access to coordinated substance abuse and mental health services. As previously discussed, ADMH Administration is dedicated to making positive strides in this area and first steps were taken by combining the Mental Illness and Substance Abuse Divisions. At present within the Mental Health Substance Abuse Services Division, the executive staff works directly and in coordination with each other. There are several Offices within the Division that address MI/SA/COD such as the Office of Certification, the Office of Deaf Services, and the Office of Performance Improvement. Within all other offices, coordination of care is direct and bi-directional, to include adult and children/adolescents.

One of the major responsibilities of the Office of Children Services was the planning and development of programs and services across ADMH's three divisions: Mental Illness (MI), Developmental Disabilities (DD), and Substance Abuse (SA). The funding, in FY01 and FY02, of a Juvenile Court Liaison for each community mental health center catchment area is an example of an initial effort to improve the service capacity and flexibility in addressing co-occurring disorders. Since the juvenile court is frequently where children and adolescent with co-occurring disorders first enter the system, the Juvenile Court Liaison will assist the court in assessing the individual and make appropriate treatment recommendations. They will also be responsible for linking the youth and their family members to needed services, to include substance abuse services. With changes in the administration in FY12, the Office of Children Services was terminated and the services within that office were distributed to the two service divisions (MHSA and DD). But the integrity of the programs that served co-occurring issues remained intact with processes being developed to maintain their integrity to include the Juvenile Court Liaisons.

For FY16-17, there were not any specific co-occurring initiatives nor are there any taking place this current year. Within the Mental Health Substance Abuse Services Division, the decision was made that Co-occurring programs would fall under the ADMH SA Program Standards. In March 2014, the new substance abuse treatment regulations became fully effective. With this change, all treatment programs are under the certification of ADMH SA Program Standards are now required to be co-occurring capable, as according to the ASAM Criteria. This also makes available rules for programs to obtain a higher level of certification and designation as co-occurring enhanced. The ADMH MHSA Certification team is now surveying programs for compliance with the new rules.

Office of Planning and Resource Development (PRD)

Within ADMH, the Office of Planning and Resource Development (PRD) performs administrative operations associated with planning, coordination, and implementation of ADMH initiatives with providers, consumers, federal, state, and local agencies, and community stakeholders. Within PRD, staff provide support to ADMH Divisions with involvement in strategic planning and executing public information services to include publication, media and website development in emergency management, disaster preparedness, public education, professional development, grant management, administrative policy review, planning procedures, and program initiatives. A month-long Consumer Art Exhibit is also coordinated and held each May at the State Capitol featuring the work of individuals throughout the state.

Alabama Executive Network for Service Members, Veterans and Their Families (AlaVetNet)

ADMH received the SAMHSA Service Members, Veterans and their Families Technical Assistance award, which served as the nucleus for the development of the Alabama Executive Network for Service Members, Veterans and their Families (AlaVetNet). AlaVetNet was established through Executive Order and is co-chaired by the ADMH Commissioner along with the Commissioner of the Alabama Department of Veterans Affairs and Alabama's Adjutant General, Alabama National Guard. AlaVetNet connects Veterans with resources and services tailored to their unique needs. The website, www.alavetnet.alabama.gov, serves as a searchable database of resources allowing Veterans to browse local service providers that fit their needs as well as search for various types of services in the areas they live. The intent is to make it easy for Alabama's Veterans, Service Members, and their families to readily locate benefits and services in a unified, seamless, and systematic way. The work of AlaVetNet is completed through functional teams to address the full-spectrum of the needs of Alabama's Veterans in the following areas: Community Support Services, Education & Research, Employment & Workforce, Family & Youth, Health & Wellbeing, Legal & Justice Initiatives and Strategic Communications.

Emergency Preparedness/Disaster Response Collaboration

ADMH has standing membership with the Alabama Department of Public Health's Functional and Access Needs in Disaster (FAND) Task Force. PRD staff participate in the Alabama Department of Public Health's Medical Needs Shelter and Alabama Department of Human Resources' Mass Care Shelter planning. ADMH additionally participates in the Governor's Mass Sheltering Task Force and avails itself of training and partnering opportunities available through the Alabama Emergency

Management Agency, such as participation in Governor Kay Ivey's 2019 Hurricane Table Top Exercise in preparation for the current hurricane season. The Office of Policy and Planning is continuously collaborating with the Governor's Office of Volunteer Services, statewide colleges and universities, and non-profit organizations regarding planning and stakeholder initiatives. Additionally, staff have received Certification in Crisis Counseling Program (Grants Training) for State Mental Health Authorities from the Federal Emergency Management Agency (FEMA) and participated in partnership with the Alabama Voluntary Organizations Active in a Disaster pertaining to the coordination of emergency response, disaster training, and mitigation strategy.

SSI/SSDI Outreach, Access and Recovery (SOAR) Training

PRD coordinates the provision of SSI/SSDI Outreach, Access and Recovery (SOAR) training throughout the state through a SAMHSA technical assistance award. SOAR training is designed to facilitate the acquisition of Social Security Administration (SSA) benefits to individuals with a diagnosis of serious and persistent mental illness (SMI) and/or a co-occurring disorder of SMI and substance use. Training is geared to assist individuals who are homeless, at-risk of homelessness or living in doubled up living arrangements. The HUD Balance of State Continuum of Care, the Alabama Rural Coalition for the Homeless (ARCH), is the recent recipient of a SOAR award to serve 42 rural areas of Alabama.

Alabama Department of Public Health Collaboration

ADMH networks with the Alabama Department of Public Health (ADPH) through regularly scheduled meetings with its Office of Rural and Primary Health Care. The focus of this partnership is to explore and leverage resources to expand behavioral health services and to recruit and retain treatment professionals.

Policy Review and Strategic Planning Initiatives

PRD quarterly reviews ADMH policies, administrative code, and divisional operational guidelines providing updates, revisions, and recommendations for new policy agenda. Staff additionally compose the Executive Budget Office Quarterly (ACTUALS) Performance Reports regarding ADMH targeted populations. Currently, PRD involvement also includes the review of ADMH Stepping Up Request for Proposals for grant award selection, monitoring and renewal of ADMH System for Award Management registration for grant award funding, along with the development and implementation of ADMH Long Range Planning Scoreboards for inter-departmental strategic planning and management. PRD staff have concurrently initiated expansion activities related to the Mental Health First Aid training programs in partnership with organizations and corporations statewide while also participating within the Alabama Department of Public Health's State Child Death Review Team and Alabama's Support Team for Evidence-Based Practices in collaboration with the Alabama Legislative Services Agency.

Strengths and Needs of the service system for SMI and SED:

Strengths

- ADMH remains dedicated to maintaining state policy that persons with serious mental illness (SMI) and serious emotional disturbance (SED) are served as a top priority. While the number of individuals with SMI and SED are not expected to substantially increase, it is expected that the array and intensity of services will be enhanced through the development of new services. To the extent in which public funds are expended on persons most in need, contractual requirements to serve these priority populations will continue.
- Focus on Olmstead values and Wyatt settlement that has been the plan(s) that drives our system to be more community integrated. This has led to the closure of three state psychiatric hospitals with the responsibility of serving committed patients being provided by our certified/contracted community mental health providers.
- ADMH has a focus to move into a statewide transformation planning process that includes the process for serving committed patients, especially since the three remaining state-run psychiatric hospitals are centrally located (Tuscaloosa). The process developed will allow for continued, ongoing flexibility, customization, and movement within less restricted levels of care outside of state operated institutions.

- ADMH supports the movement to recovery supports. This is evidenced by the inclusion of person centered and recovery mandates of care in the ADMH Administrative Code for MI Program Standards; utilizing of regional planning process to expand consumer and family members involvement at all levels, gathering a consumer and family feedback through the MHSIP satisfaction survey process; continued expansion of use of Certified Peer Specialists within the community settings, created in-state capacity to provide Peer Support Certification training, maintained currently funded peer services even with the shrinkage of state dollars; work with Medicaid to secure funding for peer services, just to name a few.
- There has not been a systematic statewide effort to improve employment opportunities for people with serious mental illness. However, with the award of the SAMHSA Supported Employment IPS grant, the seeds of addressing this gap have been planted. ADMH has hired an Employment Specialist who is a resource in this process.
- Children with serious emotional disturbance and their families frequently require not only mental health services, but services from special education, child welfare, public health and/or juvenile justice. This need for multiple services from multiple agencies necessitates the integration and coordination of programs and services, not only in the service delivery arena, but also during the system planning process. The child serving agencies work very closely in a process to address these needs in a way that is more collaborative that includes blended projects such as the multiple needs process, School-Based Mental Health Collaboration, and OUR kids.
- For adolescents, much focus over the years has been on reduction of State Commitment beds, going from a 40 bed unit in 2002 to currently only having a 9 bed unit. ADMH also took strides to move away from the traditional stand-alone state hospital setting for these committed youth and achieved the legal ability to contract this psychiatric hospital function, allowing committed youth to be placed in a community hospital that could address not only their psychiatric needs but their primary health needs as well. Such efforts were only achievable due to continued development of community based specialty services, such as the Juvenile Court Liaison, as well as being a direct partner with the State Multi-needs team and strong state partnerships with other child serving agencies. Continued efforts will include utilizing the two sustained SAMHSA SOC initiatives to determine strategies to expand system of care values with statewide expansion opportunities.

Needs

- **Adequate Funding:**
 - Adequate funding remains a challenge for all publicly supported endeavors, including mental health services. The budget cuts made over the last several years have impaired the ability to fund and maintain our current mental health system, much less expand Permanent Supportive Housing, Peer Support Specialists, and other services designed to reduce the demand for acute state hospital beds. Even though the SAMHSA Mental Health Block Grant supports these endeavors, it is less than 3% of the ADMH budget and is utilized to its capacity so any expansion of necessary resources seems bleak.
 - Finding a way to reduce hospital beds, create community resources, and save money presents a formidable challenge to an already stressed system.
- **State hospital downsizing/community integration:**
 - With the dedication to shift care to the community with the state hospital downsizing/closure/restructuring projects, more committed patients are served in community settings. However, in Alabama, the state dollars continue to be cut and ADMH has been experiencing such cuts to state dollars over the past 9 years. So, the shift to committed patients being served in the community was done with a reduction of funds which meant there was an inability to expand the already stretched resources for rehabilitative services and no funds to expand into more recovery services.
- **Peers Services:**
 - There continues to be much work needed with the expansions of recovery services. ADMH current efforts does not meet the needs and gaps that are necessary to build capacity for an array of recovery supports needed. Peer Support services are not available within each of the community mental health providers. This is not even a service that exists for children and adolescents and their families. Due to budget cuts, not every mental health center was able to hire a Certified Peer Support Specialist. Drop-in centers have proven to provide engaging

socialization and empowerment, but with scarce funding, there is no way for expansion without identifying new funding sources. ADMH has worked with Alabama Medicaid to expand service packages that will allow Certified Peer Services to be included as a Medicaid reimbursable service. ADMH has financially supported the efforts of the MI Planning Council in expansion of peer services and trainings through Special Project dollars. However, with scarce funds and dwindling state dollars, concerns lie with the protection of these funds not being diverted to more traditional services.

- **Housing:**

- Alabama is the seventh poorest state in the nation, with a population of 4.7 million, one in six live below the federal poverty level. The availability of safe and affordable housing remains a challenge for consumers with mental illness and limited or no income.

- **Employment:**

- Employment services for persons with mental illness or co-occurring substance use disorders have not been adequately addressed. ADMH received approval to expand services in the Rehab Option to include Supported Employment. But it has not been developed and it is unclear if this new service will generate an adequate level of funding.

- **Evidence-based Practices (EBP's):**

- Widespread implementation of EBP's requires significant training and monitoring resources that are not currently available.

- **Workforce Development:**

- Service providers struggle in the area of employee recruitment and retention, not only of psychiatrists, but other service professionals needed to provide services to a culturally and linguistically diverse population. Third party insurance payers have credentialing requirements which often exceed those of State program and Medicaid standards. This continues with both providers and service recipients as these payer sources are not utilized for the acquisition of services.

- **Psychiatrists:**

- Alabama remains significantly below regional and national levels of psychiatrists/population. Tele-psychiatry offers opportunities to use existing psychiatrists more efficiently; however, the capacity to provide this service exists only in pockets of the state.

- **Transitional Age Services:**

- Services targeting the unique needs of youth transitioning to the adult system are not well-developed in the state. Currently services provided to these individuals are pieced together from the two existing service systems, leaving emerging issues such as early employment training and housing issues inadequately addressed. ADMH has attempted to address this need with the development of a Transitional Age 10-bed residential program and Transitional Age In-Home Intervention Team. In addition, some community mental health centers have cross-trained staff in both adult SMH and Child and Adolescent SED services to smooth the transition. However, these services are limited and need further development.

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

Cultural/subcultural competence and addressing diversity through racial, ethnic, sexual gender, American Indian/Alaskan Native, English as a second language, and other linguistic barriers, are interwoven within the statewide mental health service delivery system through various mediums. ADMH has two representatives on the State Cultural and Linguistic Competency Network.

It is imperative that the providers report mandated data. The data currently captured with demographics includes race, ethnicity, age, and gender (excluding transgender). It is important to note there is a requirement that providers report on hearing status of all consumers in general demographics (rather than "medical conditions" or Axis III). This readily allows ADMH to track consumers in the different areas outlined.

Routinely, ADMH shares data information with our providers and other stakeholder entities to include National Outcome Measures (NOMS) and results from MHSIP Satisfaction Surveys and CANS results. Funding through the Behavioral Health Services Information System State Agreement (BHSIS) has been utilized to assist with measuring, tracking, and responding to disparities in the ongoing development of a data warehouse for mental health and substance abuse services data.

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

Within the ADMH MI Program standards, providers are to provide services that are culturally competent and linguistically competent that represents the ethnic and gender needs of the community. ADMH updated the ADMH Administrative Code for MI Program Standards in 2010 that incorporates person centered and recovery mandates for care, as well as addressing the specialized needs of consumers who are deaf or hard of hearing.

Each ADMH-certified Mental Health Service Provider is required to develop Policies and Procedures that address the requirements codified in the ADMH Administrative Code. One area of focus that would capture information is trauma history, as well as information to expedite the development of individualized treatment. The “Consumer Records” Section of the Alabama ADMH Administrative Code (updated 9/30/10) requires trauma history to be obtained from every consumer and recorded in the consumer’s clinical record so that it can be considered during treatment planning. (ADMH Code 580-2-9-.06 (9)(a.)17.(b.)10.). Also, in the “Child and Adolescent Restraint and Seclusion” Section of the Code (which applies only to Day and Residential Treatment programs that are certified to employ the use of seclusion or restraint techniques) clinical staff is required to perform an initial assessment at the time of admission or intake which includes information about “Preexisting medical conditions or any physical disabilities and limitations that would place the consumer at greater risk during restraint or seclusion, including developmental age and history, psychiatric condition, and trauma history.” This Section also requires that this information be recorded in the consumer record. (ADMH Code 580-2-9-.23 (14)(b.) and –.23 (23)(d)3.) These requirements are codified with the belief that consideration of this information will help minimize the use of restraint and seclusion, and also to minimize the danger of re-traumatizing a consumer during the exercise of restraint or seclusion when it cannot be avoided.

Many ADMH policies are rooted in the provision of person-centered and individualized treatment planning as prescribed in the ADMH Administrative Code. This requirement is expressed succinctly in section 580-2-9-.08(3) entitled “General Clinical Practice,” which states, “Services must be individualized, well-planned, based on a comprehensive mental health evaluation and assessment of needed treatment and support, and should include treatment designed to enhance the consumer’s abilities to recover and function in society as normally as possible,” and also, “Each program shall provide individualized mental health care and treatment that is designed to promote Recovery and Resiliency and that represents person-centered treatment planning process.” This philosophy of care pervades all areas of service provision by ADMH certified providers. Consumers who present with histories of trauma that impact their presenting mental health conditions should be provided the best interventions available to accommodate their mental health treatment needs, including trauma-focused therapeutic interventions wherever appropriate. As a true trauma-focused system of care has not yet been achieved across the state, the types of trauma-focused therapy interventions will vary by provider agency and by individual clinician. ADMH does not have policies beyond what is provided for in the Administrative Code that require providers to deliver a specific trauma-focused intervention. Trauma-focused care is an important and growing field in mental health care, and a variety of training events and workshops have been conducted. Each provider is responsible to conduct or promote training opportunities for their clinicians and other treatment staff that will help them to develop professionally and to provide the best, most effective treatment possible for consumers of mental health services, including training and development in the area of trauma focused care.

ADMH has established an Office of Deaf Services (ODS) to serve deaf and hard-of-hearing Alabamians better. ADMH is committed to ensuring that their peers will design programs for deaf and hard-of-hearing persons to ensure services are

linguistically accessible and culturally affirmative, giving the consumer every opportunity to make progress to recovery. The ODS staff includes a director, statewide services coordinator, a statewide mental health interpreter coordinator, statewide and regional clinical staff, and regional communication access team members. ODS also provide significant communication and clinical support to Bryce, where deaf people needing inpatient care are served. ADMH has developed specific standards of care for people with hearing loss that includes, among other things, specific requirements for measurable fluency in American Sign Language for certified community programs which work with deaf consumers. Also, through contracts with ADMH, the contracted providers have access to language interpreters regardless of language and those services to assist with language needs as needed in services and care.

Alabama is home to only one federally recognized Indian Tribe. ADMH does not currently have ties with the Poarch Band of Creek Indians but understands the significance and value of pursuing such. ADMH attempted to establish and implement an ongoing relationship with the Poarch Creek Indian Tribe as to enable regular, meaningful, government-to-government consultation and collaboration in the areas of planning, operating, and funding substance abuse and mental health services in Alabama. To date, the Poarch Creek Tribal Leaders have not responded to ADMH.

Section II: Planning Steps – Step 2: Identify the unmet service needs and critical gaps within the current systems

Historically, services have been designed and implemented through a participatory planning process that includes the Mental Illness Planning Council and the Mental Illness Coordinating Subcommittee of the Management Steering Committee. Family members, consumers, advocacy organizations, other state agencies, and providers are represented on these planning bodies. A regional planning process initiated in FY08 added participants into the planning process, primarily consumer and family advocates, to address critical overages in state hospitals and system transformation.

The regional planning structure was adopted for all departmental planning beginning in FY08 and resulted in increased numbers of family members and consumers being involved in the planning process. There have been numerous participants in the regional planning process including consumers, family members, judges, public community providers, state hospitals, and local private providers. The local and regional planning process provided the foundation for ADMH's annual budget request. In FY09, the planning process was expanded to include a separate planning function for children and adolescents. This decision was based on feedback from the previous years of planning and was implemented to improve the voice of children and adolescents and their families throughout the planning process. A series of over 90 adult/children and adolescent local stakeholder planning meetings occurred in late summer and fall 2009. This provided local and regional input in determining unmet needs and critical gaps within the system at the community level. The feedback from this process was utilized within the departmental planning process as a mechanism to introduce local community input and was instrumental in the identification of needs and gaps in service. During FY 2011, ADMH leadership worked jointly with the Mental Illness Coordinating Subcommittee and Management Steering Committee to make recommendations for goal and strategy improvements. This collaboration has resulted in thorough examination of planning targets that reflect the approval of stakeholder partners while balancing the realities of ADMH fiscal parameters and magnifying the benefits of the integration efforts made within the division. This process has continued through FY 2019.

Planning for children and adolescent services is performed as a part of the overall Management Steering Committee process described above via Mental Illness Coordinating Sub-committee and the Mental Illness Planning Council.

A combination of sources was used to identify critical service gaps. For years, ADMH has monitored the utilization of public mental health services through analyzing service data reported to ADMH. This data, in conjunction with periodic survey of the providers, allowed ADMH to identify trends in service utilization by the consumers.

Other sources of data utilized by ADMH include the U.S. Bureau of Census, the National Uniform Reporting System (URS), Mental Health Statistics Improvement Program (MHSIP) Consumer Satisfaction Surveys, ADMH web-based housing

inventory (MICRS), ADMH web-based commitment system (Gateway), Child Adolescent Needs and Strengths (CANS) functional assessment tool, ADMH certification results from provider site visits, HUD Point in Time count, Housing Needs Assessments, and hospital and community Performance Improvement data sets.

Another very valuable measure ADMH has for identification of gaps in the service delivery continuum for children and adolescents is through its participation in the Case Review Committee of the Multiple Need Child Office. This staffing occurs monthly with legislatively mandated child-serving agencies charged with developing plans for children who have multiple needs and who are at risk of placement in a more restrictive setting.

ADMH has exchanged service data with other state agencies, including but not limited to the Alabama Medicaid Agency, Department of Public Health, ALL Kids, Juvenile and Adult Corrections, the Administrative Office of the Courts, Department of Education, and Department of Human Resources, to provide a comprehensive array of publicly funded services to adults and children/adolescents through memoranda of understanding, intergovernmental service agreements, or informal relationships. Also, ADMH worked with the Administrative Office of the Courts to match the ADMH mental health database with mental health court participants.

PREVALENCE

Community Programs

FY18

Overall Total Served (MI – Community and State Hospital) Unduplicated – 102,424

Overall Total Served (MI Community) Unduplicated – 101,954

Overall Total Served (MI Community) – 104,642

SMI Adult (Contract Eligible) Unduplicated – 55,402

SMI Adult (Contract Eligible) – 65,934

SED Child/Adolescent (Contract Eligible – 30,870

SED Child/Adolescent (Contract Eligible) – 31,707

The 2017 Uniform Reporting System (URS) Table 1 estimate of adults with serious mental illness (SMI) in Alabama is 203,380 and the estimate of children and adolescents with serious emotional disturbances (SED) is 73,215 people which is the upper limit of Level of Functioning equal to or less than 60.

The ADMH definition of Serious Mental Illness is more restrictive than the federal definition in that the diagnostic categories are limited. The types of functional disability are similar between the state and federal definitions. The Alabama public sector's priority population is the SMI population that requires treatment and care outside the private sector. Many children and adolescents with serious emotional disturbance are served in the private sector, by the Department of Human Resources, by the Department of Youth Services, and by educational agencies. 35.8% of the total C&A served in Alabama compared to 28.5% nationally. 64.2.0% of total adults served in Alabama compared to 71.6% nationally. The FY18 Uniform Reporting System State Report shows Alabama with a penetration rate of 21.01 per 1,000 population compared to the national rate of 23.69. The community utilization rate is 20.92 per 1,000 population compared to 22.99 nationally.

The penetration rate for adults with serious mental illness and children/adolescents with serious emotional disturbance exceeds the national rate in all age categories as follows:

00-17 years	Alabama 28.2 – National 20.2
18-20 years	Alabama 19.2 – National 17.7
21-64 years	Alabama 17.0 – National 17.3
65(+) years	Alabama 5.6 – National 4.7

The following is a description of those individuals who are contract eligible:

Alabama Department of Mental Health Mental Illness Division

DEFINITION OF SERIOUS MENTAL ILLNESS/

DESCRIPTION OF CONTRACT ELIGIBLE CLIENTS

(ADULTS)

CATEGORY A. For the purposes of this agreement, the definition of an adult is an individual, age 18 years or older, and a legal resident of the state of Alabama. Persons who meet the diagnosis and disability criteria for serious mental illness listed below in Section 1 or who meet the criteria for high risk listed below in Section 2.

Section 1: Persons who are Seriously Mentally Ill:

Diagnosis: Any ICD diagnosis listed below in combination with at least two criteria from the disability category. A primary diagnosis of a “Z” code, substance use, autism spectrum disorder, developmental/intellectual disability, organic mental disorder, or traumatic brain injury does not meet the criteria.

- *Schizophrenia and Other Psychotic Disorders (F20 – F29)*
 - With the **exclusion** of:
 1. F21 A – Schizotypal Personality D/O

- *Mood Disorders (Major): (F30 – F33.9)*
 - With the **exclusion** of:
 1. F32.0 – Mild Depressive Episode
 2. F32.8 – Premenstrual Dysphoric D/O
 3. F32.9 – Unspecified Depressive D/O

- *Severe Anxiety Disorders: (F40.00, F40.01, F40.02, F41.0, F42)*
 - With the **exclusion** of:
 1. F41.1 – Generalized Anxiety D/O
 2. F41.2 – Mixed Anxiety and Depression D/O
 3. F41.3 – Other Mixed Anxiety D/O
 4. F41.8 – Other Specified Anxiety D/O

5. F41.9 – Unspecified Anxiety D/O
6. F42.9 – Unspecified OCD
7. F40.10 – Social Anxiety D/O

Disability: (must meet at least two criteria listed below as a result of one of the above diagnoses):

1. Is unemployed, is employed with specialized employment services, or has markedly limited skills and a poor work history.
2. Shows severe inability to establish or maintain personal social support systems.
3. Shows deficits in basic living skills.
4. Exhibits inappropriate social behavior.

Section 2: High Risk (must meet one of the criteria listed below):

1. A person who has a history of DMH supported inpatient or public residential treatment as a result of a mental illness diagnosis.
2. A person who without outpatient intervention would become at imminent risk of needing inpatient hospitalization.

CATEGORY B. An individual regardless of diagnosis shall be eligible for one intake per year, as well as prehospital screening and crisis intervention as needed.

Alabama Department of Mental Health Mental Illness Division

DEFINITION OF SERIOUS EMOTIONAL DISTURBANCE/

DESCRIPTION OF CONTRACT ELIGIBLE CLIENTS

(CHILDREN AND ADOLESCENTS)

CATEGORY A. For the purposes of this agreement, the definition of a child or adolescent is an individual, age 18 years or less, and a legal resident of the state of Alabama. To be eligible for contract services he/she *must* meet the following criteria for (I & II) *or* (I & III):

I. Diagnosis

Must have a current ICD diagnosis. A primary diagnosis of a “Z” code, substance use, autism spectrum disorder, developmental/intellectual disability, organic mental disorder, or traumatic brain injury does not meet the criteria.

II. Separated from Family (Out-of-Home Placement)

Separated from family due to a child or an adolescent’s admission to, residing in, or returning from an out-of-home placement in a psychiatric hospital, a residential treatment program, therapeutic foster care home, or group treatment program as the result of a serious emotional disturbance.

III. Functional Impairments/Symptoms/Risk of Separation

Functional impairment is defined as a behavior or condition that substantially interferes with or limits a child or adolescent from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills. Functional impairments of episodic, recurrent or continuous duration are included unless they are temporary and expected responses to stressful events in the environment.

Must have A or B or C as the result of a serious emotional disturbance:

A. Functional Impairment

Must have substantial impairment in one of the following capacities to function (corresponding to expected developmental level):

1. Autonomous Functioning: Performance of the age appropriate activities of daily living, i.e., personal hygiene, grooming, mobility;
2. Functioning in the Community - i.e., relationships with neighbors, involvement in recreational activities;
3. Functioning in the Family or Family Equivalent - i.e., relationships with parents/parent surrogates, siblings, relatives;
4. Functioning in School/Work - i.e., relationships with peers/teachers/co-workers, adequate completion of school work.

B. Symptoms

Must have one of the following:

1. Features Associated with Psychotic Disorders
2. Suicidal or Homicidal Gesture or Ideation

C. Risk of Separation

Without treatment there is imminent risk of separation from the family/family equivalent or placement in a more restrictive treatment setting.

CATEGORY B. An individual regardless of diagnosis shall be eligible for one intake per year, as well as prehospital screening and crisis intervention as needed.

Services should be provided in a manner that is accessible to persons of both genders, all ages, and all races/ethnicities. The chart below shows that services are delivered to individuals in all categories.

<i>Measure</i>	FY15	FY16	FY17	FY18	FY19	FY20
	Actual	Actual	Actual	Actual	YTD	Goal
Age:						
0-17	30,424	31,201	31,718	32,410	29,133	30,000
18-20	4,790	5,100	5,215	5,343	4,919	5,000
21-64	62,928	65,984	63,386	60,724	53,064	60,000
65+	6,009	6,230	6,089	6,155	5,999	6,000
Unknown	05	27	332	10	07	
Gender:						
Female	55,202	57,606	56,470	55,095	43,834	55,000
Male	48,885	50,892	50,251	49,540	49,283	48,000
Unknown	69	44	19			

Race/Ethnicity:						
Am Ind/Al Native	322	299	295	298	274	250
Asian	189	197	225	218	189	180
Black/Afn Amn	37,991	40,828	40,251	38,861	36,010	35,000
Native Hawaiian	34	42	50	60	57	50
White	61,279	62,402	60,899	57,454	50,294	55,000
Multi-racial	1,339	1,435	1,530	1,622	1,523	1,300
Unknown	2,951	3,328	3,477	4,782	4,772	
Hispanic Origin:						
Hispanic/Latino	2,029	2,967	2,819	2,769	2,652	2,500
Not Hispanic	102,102	105,548	103,867	101,866	90,494	100,000
Unknown	25	27	54	07	07	

All of our programs are designed to treat SMI Adults and SED Children regardless of cultural or other differences. ADMH monitors this through our ADMH MI Program standards that require cultural and linguistic access and training. ADMH does contract for specialty programs around target areas that have a high impact on high utilizers and commitments to ADMH. These programs would include specialty around being SMI or SED plus Deaf, Forensic, Intellectually Disabled, to name a few.

An analysis of the unmet service needs and critical gaps within the current system

Self-Directed System of Care

Individuals with mental health issues can and do recover. Services and supports must foster the ability for self-directed recovery. Recovery benefits not only the consumer and their family, but all the community in leading to a more healthy and productive way of life. The efforts of ADMH have been to develop and enhance a continuum of care for both adults and children/adolescents that lends itself to a flexible array of services that are focused on meeting as a first priority the needs of people with a serious mental illness and serious emotional disturbance. However, this process has to be consumer driven. Consumer driven means that consumers must have a voice in decisions that affect their lives and treatment. Consumers must have choices in the services they receive and where they live. Additionally, consumer driven means that the consumer voice must be present in planning, implementing, providing, and evaluating the services and care at a local, state, and national level. Consumer input and consumer-driven should not be confused. Input is providing comment or opinion. Driven is having an impact on the direction or course of actions. As we move toward a good and modern system of care, it will be vital to incorporate the core values: community-based, consumer-driven, family-guided, culturally and linguistically competent, and individualized.

As outlined in “Section IV-Narrative Plan 16-Recovery”, efforts to move the system toward this have occurred at several levels. To try and develop infrastructure and build capacity, ADMH has engaged in the following:

- Updated the ADMH Administrative Code for MI Program Standards that incorporates person centered and recovery mandates for care, as well as addressing the specialized needs of consumers who are deaf or hard of hearing.
- Utilized a regional planning process to expand consumer and family members involvement at all levels.
- Incorporated feedback from consumers and family members in ADMH planning processes which provides the foundation for ADMH’s annual budget request.
- Gathered pertinent consumer feedback, to include client perception of care, through the MHSIP satisfaction survey. This data is reviewed to assist in informing the system for planning purposes.

- Continued to use Certified Peer Support Specialists within the community system.
- Initiated the use of Peer Bridgers for transitional services from state psychiatric hospitals to community settings.
- Created in-state capacity to provide Peer Support Certification training.
- Maintained funding for four existing drop-in centers.
- Submitted language related to Peer Support Services to Alabama Medicaid for consideration of a State Plan Amendment for the Rehab Option that would include Peer Support Services, Youth Peer Support Services, and Family Peer Support Services. In October 2018, these were approved by CMS.
- Implemented the state-wide use of the Child and Adolescent Needs and Strengths (CANS) Functional Assessment Tool.
- Have two sustained SAMHSA Children’s Mental Health Initiative System of Care (SOC) grant areas, one in the Birmingham area and the other in central Alabama which covers three rural counties. These SOC sites met local and state level sustainability and the sites are used as models for expansion across the state.
- Collaboration with the Alabama Medicaid Agency, Alabama Hospital Association, and the different consultants in regard to the multi-faceted areas of the Medicaid Reform process as to ensure that the mental health and substance abuse consumers we serve are being included for their unique and specialty needs for services and care.

However, ADMH has a long way to go in reaching self-directed care. There continues to be much work needed with the expansions of recovery services. Even though the above efforts are to be commended, it does not meet the needs and gaps that are necessary to build capacity for an array of services to assist with self-direction. Peer Support services are not available within each of the community mental health provider. This is not even a service that exists for children and adolescents and their families, outside a small project where there is one site in which Youth Certified Peer Specialists are being utilized in a residential setting, as well as the requirement to have a Youth Peer Specialist and Parent Peer Specialist on the FEP team. Drop-in centers have proven to provide engaging socialization and empowerment, but with scarce funding, there is no way for expansion without identifying new funding sources. Even though Medicaid has approved Certified Peer Services as a Rehabilitative service, implementation is in its infancy stages and it is unclear how funding will be impacted. ADMH initiated the use of the CANS functional assessment tool as a means to move the system toward strength-based, individualized treatment planning process. Even though the next steps are to initiate such an instrument for adults, it has yet to occur. ADMH has financially supported the efforts of the MI Planning Council in expansion of peer services and trainings through Special Project dollars. However, with scarce funds and dwindling state dollars, concerns lie with the protection of these funds not being diverted to more traditional services.

Community Integration

An array of services must be designed to incorporate the concept of community integration and social inclusion for individuals/families. Community integration ensures that people with behavioral health problems, disabilities and other chronic illnesses have the supports and services they need to live in a home/family/community setting. This includes services to help people live in housing of their choice and support them in school, work, families and other important relationships; both paid and unpaid community supports can help achieve these goals. This will require public purchasers to take a comprehensive look at how its policies impact the way urban, rural and frontier areas develop and how well those places support the people who live there, in all aspects of their lives—education, health, housing, employment, and transportation. This “place-based” approach should be taken to help communities work better for people.

The reforms mandated by Wyatt had a profound effect on mental illness services. The shift in emphasis from institutional care to community-based care was central to these reforms. The census at Bryce State Psychiatric Hospital dropped from over 5,000 patients in 1971 to less than 400 in 2004. Through the dedicated efforts of state psychiatric hospitals and community partners, ADMH can boast nearly a 52% statewide reduction in total state psychiatric hospital census from FY09 to June 2015. Over the 35-year term of the Wyatt case, a broad network of community providers evolved, and by

the termination of Wyatt in 2003, the public community mental health providers served approximately 100,000 Alabamians per year with offices in all 67 counties. Since then, building a continuum of care for adults and children/adolescents within the community has been the primary focus as to develop community integration. The following are continued efforts of ADMH:

The evaluations conducted in February 2009, revealed that there are significant numbers of state hospital extended care residents who can live in the community with adequate supports. There has been a prolonged and intensive planning process that began implementation in June 2010. The plans called for a reduction in census at Bryce and Searcy Hospitals by creating additional community resources. The proposed reduction in state hospital census reduced the demand for extended care beds and permitted a shift of funds from state hospital budgets to needed community services. Efforts include the use of Peer Bridgers to ease the transitional process for long-term state hospital patients, expansion of housing resources such as MOM apartments, the augmentation of existing group homes to better address the needs of this specialty population, clinical support teams to provide intensive community supports that had not existed, the use of existing Certified Peer Support Specialists to enrich the community supports provided, and flex funds to tailor individualized care.

The financial atmosphere of FY11/12 and desire to advance a more responsive system of care prompted an acceleration of the Department's goals to further reduce the number of acute care psychiatric beds and to bring about the closure of some state operated facilities. The 2012 Hospital Closure Project resulted in the Department closures of Greil Memorial Psychiatric Hospital (Montgomery County) August 31, 2012 and Searcy Hospital (Mobile County) October 31, 2012. Collectively, these two hospitals served a total of 1,231 individuals in FY11. Over ninety percent of Greil and Searcy's inpatient capacity has been shifted to local communities. As a means of supporting this shift, an innovative framework for processing inpatient commitments was born from the Hospital Closure Project. The dedicated and unprecedented cooperation between state government, local provider agencies, and local probate courts resulted in a new Department of Mental Health Commitment Procedure specifically for Regions 3 and 4 and for which the success of this project hinged. A pivotal element to the newly established commitment procedure was the development of the Gateway System which permits for the tracking of probate committed individuals to be served within the community at a Designated Mental Health Facility or Willing Hospital Participant locales.

During FY13 and FY 14, ADMH pursued a Hospital Repurposing effort in which the utilization of community inpatient capacity was further refined to supplement or supplant acute care functions at North Alabama Regional Hospital (NARH) and Bryce Memorial Hospital respectively. On July 20, 2014, patients at Bryce Psychiatric Hospital were relocated to a new smaller state-of-the-art hospital commonly referred to as the "new Bryce." As of June 17th, 2015, North Alabama Regional Hospital was closed.

In December 2016, ADMH initiated statewide transformation planning process that includes the process for serving committed patients, staffing directly with the three-remaining state-run psychiatric hospitals are centrally located (Tuscaloosa). The process developed allows for continued, ongoing flexibility, customization, and movement within less restricted levels of care outside of state operated institutions.

For adolescents, much focus over the years has been on reduction of beds, going from a 40-bed unit in 2002 to currently having only a 9-bed unit. ADMH also took strides to move away from the traditional stand-alone state hospital setting for these committed youths and achieved the legal ability to contract this psychiatric hospital function, allowing committed youth to be placed in a community hospital that could address not only their psychiatric needs but their primary health needs as well. Such efforts were only achievable due to continued development of community-based specialty services, such as the Juvenile Court Liaison, as well as being a direct partner with the State Multi-needs team and strong state partnerships with other child serving agencies and consumer/family advocate associations. Continued efforts will include utilizing the two sustained SAMHSA SOC initiatives to determine strategies to expand system of care values with statewide expansion opportunities.

Readmission rates are important measures of how effective discharge planning is as well as how effective reintegration is into the community. The 30 day and 180 day readmission rates are both National Outcome Measures (NOMs) and a state Performance Indicators.

ADMH remains dedicated to maintaining state policy that persons with serious mental illness (SMI) and serious emotional disturbance (SED) are served as a top priority. While the number of individuals with SMI and SED are not expected to substantially increase, it is expected that the array and intensity of services will be enhanced through the development of new services. To the extent in which public funds are expended on persons most in need, contractual requirements to serve these priority populations will continue.

Even with all the efforts highlighted above, ADMH continues to face critical needs and gaps in the system that negatively impacts community integration. For adults, there has not been a systematic statewide effort to improve employment opportunities for people with serious mental illness. However, with the award of the SAMHSA Supported Employment grant, the seeds of addressing this gap have been planted. Adequate funding remains a challenge for all publicly supported endeavors, including mental health services. The budget cuts made over the last several years have impaired the ability to fund Permanent Supportive Housing, Peer Support Specialists, and other services designed to reduce the demand for acute state hospital beds. In fact, in FY09, 12 mental health centers lost funding for a Peer Support Specialist. The goal is to have a Peer Support Specialist at every mental health center. The availability of safe and affordable housing remains a challenge for people with mental illness and limited incomes. Finding a way to reduce hospital beds, create community resources, and save money presents a formidable challenge to an already stressed system.

For children and adolescents, ADMH has continued to make strides in developing a comprehensive system of care for children and families who struggle with Serious Emotional Disturbances (SED). Beginning in the mid-eighties, with the awarding of a federal initiative CASSP grant that facilitated the development of a system of care for children and adolescents, ADMH has gradually moved toward strategic growth of child and adolescent services through planning and resource development. In an effort to develop a continuum of care that offers an array of services at various levels of care, an emphasis has been placed on non-traditional service delivery that truly meets the needs of the consumer, family and community. Services for children and youth are complicated by developmental variables, legal status, educational requirements, health factors, cultural factors, and living situations. The presence of a serious emotional disturbance further complicates the need for and delivery of services. Ethnicity may make a significant difference in use of mental health services, as well.

Children with serious emotional disturbance and their families frequently require not only mental health services, but services from special education, child welfare, public health and/or juvenile justice. This need for multiple services from multiple agencies necessitates the integration and coordination of programs and services, not only in the service delivery arena, but also during the system planning process. As a result, the mental health system must approach service delivery from a systems perspective. Additionally, the mental health system needs to be a component of a tightly meshed overall system of care that incorporates all child caring agencies and programs.

EBP's/Best Practices

Adoption of Evidence-based practices (EBPs) is a National Outcome measure as well as priority with ADMH. EBPs are under development in Alabama through a variety of mechanisms. There are significant gaps across the state in the availability of EBPs. For adults, there are gaps in availability of ACT and PACT teams. Less than one-half of the centers offer Permanent Supportive Housing. Seventeen centers have employed a Certified Peer Support Specialists. There has not been a systematic effort to improve employment opportunities for people with serious mental illness. ADMH has hired an Employment Specialist who is a resource to our system through our employment pilot sites. First Episode Psychosis (FEP)

concept has been introduced in Alabama, but only in one site, with expansion being implemented in two additional sites. Other adult EBPs are not being systematically implemented. Services for those experiencing co-occurring psychiatric and substance use disorders remain scarce and isolated to certain programs. EBPs for children and adolescents are not being systematically implemented at this time, primarily due to lack of funds. The MI Child and Adolescent Task Force identified and developed implementation strategies for recommended EBPs. However, the implementation is contingent on securing funding which does not currently exist. Less than 5% of what we buy conforms to national evidence-based practices (EBPs) guidelines (ACT, Supported Housing, Peer Support).

Also, the number of psychiatrists practicing in Alabama is inadequate to meet the demand in the public system. Additionally, nurse practitioners are in equally short supply. All but one of the 67 counties are designated as Psychiatric Manpower Shortage Areas. The licensing rules of the Board of Medical Examiners require that physicians moving into the state who have been out of school for more than 10 years take the general medical boards. This requirement is a disincentive for experienced psychiatrists interested in moving to Alabama. There are also restrictive parameters for nurse practitioners. ADMH was able to get a waiver for psychiatrists practicing in state hospitals and community mental health centers so that they do not have to re-take the General Medical Boards if they move from another state. This waiver will permit a larger pool of candidates for employment in the public sector. While such an exemption will be helpful, more changes are needed in the licensing law to observe reciprocity with other state licensing bodies. To further address the shortage of psychiatrists, ADMH implemented several initiatives. ADMH has provided employment for psychiatric residents graduating from University of Alabama in Birmingham (UAB) in either a state hospital or through the community mental health centers. In the past, the Mental Illness Coordinating Subcommittee approved funding six psychiatric residency training slots – three at UAB and three at the University of South Alabama (USA). But, due to budget deficits, these funds were cut. Use of telepsychiatry offers opportunities to more effectively use existing resources. ADMH supports expansion of telemedicine capability so that existing psychiatric manpower may be more efficiently used. The Bristol-Myers-Squibb Foundation Grant provided equipment to three mental health centers which have pioneered innovative uses of the equipment, including accessing psychiatric services. Through the C&A efforts, four sites participated with a C&A Telemedicine pilot demonstration, as well. The Medicaid Agency now covers telepsychiatry services under the Physician's Program in addition to the Rehab Option.

We have sufficient information about SAMHSA-recognized EBPs. We also have interest in exploring the use of recognized Best Practices. Where we need assistance is in the large-scale implementation of these practices – incorporating knowledge into practice. ADMH continues to pursue other funding avenues, such as grants and collaboration with other agencies. ADMH will increasingly rely upon EBPs and best practices to meet the needs of consumers and family members.

Determining the Unmet Service Needs and Critical Gaps

Historically, services have been designed and implemented through a participatory planning process that includes the Mental Illness Planning Council and the Mental Illness Coordinating Subcommittee of the Management Steering Committee. Family members, consumers, advocacy organizations, other state agencies, and providers are represented on these planning bodies. A regional planning process initiated in FY08 added participants into the planning process, primarily consumer and family advocates, to address critical overages in state hospitals and system transformation.

The regional planning structure was adopted for all departmental planning beginning in FY08 and resulted in increased numbers of family members and consumers being involved in the planning process. There have been numerous participants in the regional planning process including consumers, family members, judges, public community providers, state hospitals, and local private providers. The local and regional planning process provided the foundation for ADMH's annual budget request. In FY09, the planning process was expanded to include a separate planning function for children and adolescents. This decision was based on feedback from the previous years of planning and was implemented to

improve the voice of children and adolescents and their families throughout the planning process. A series of over 90 adult/children and adolescent local stakeholder planning meetings occurred in late summer and fall 2009. This provided local and regional input in determining unmet needs and critical gaps within the system at the community level. The feedback from this process was utilized within the departmental planning process as a mechanism to introduce local community input and was instrumental in the identification of needs and gaps in service. During FY 2011, ADMH leadership worked jointly with the Mental Illness Coordinating Subcommittee and Management Steering Committee to make recommendations for goal and strategy improvements. This collaboration has resulted in thorough examination of planning targets that reflect the approval of stakeholder partners while balancing the realities of ADMH fiscal parameters and magnifying the benefits of the integration efforts made within the division. This process has continued through FY 2019.

Planning for children and adolescent services is performed as a part of the overall Management Steering Committee process described above via Mental Illness Coordinating Sub-committee and the Mental Illness Planning Council.

A combination of sources was used to identify critical service gaps. For years, ADMH has monitored the utilization of public mental health services through analyzing service data reported to ADMH. This data, in conjunction with periodic survey of the providers, allowed ADMH to identify trends in service utilization by the consumers. Other sources of data utilized by ADMH include the U.S. Bureau of Census, the National Uniform Reporting System (URS), Mental Health Statistics Improvement Program (MHSIP) Consumer Satisfaction Surveys, ADMH web-based housing inventory (MICRS), ADMH web-based commitment system (Gateway), Child and Adolescent Needs and Strengths (CANS) functional assessment tool, ADMH certification results from provider site visits, HUD Point in Time count, Housing Needs Assessments, and hospital and community Performance Improvement data sets.

Another very valuable measure ADMH has for identification of gaps in the service delivery continuum for children and adolescents is through its participation in the Case Review Committee of the Multiple Need Child Office. This staffing occurs monthly with legislatively mandated child-serving agencies charged with developing plans for children who have multiple needs and who are at risk of placement in a more restrictive setting.

ADMH has exchanged service data with other state agencies, including but not limited to the Alabama Medicaid Agency, Department of Public Health, ALL Kids, Juvenile and Adult Corrections, the Administrative Office of the Courts, Department of Education, and Department of Human Resources, to provide a comprehensive array of publicly funded services to adults and children/adolescents through memoranda of understanding, intergovernmental service agreements, or informal relationships. Also, ADMH worked with the Administrative Office of the Courts to match the ADMH mental health database with mental health court participants.

ADMH works through our partnerships with our committees, consumer and family advocate groups, providers, and state and local partners to develop strategies and process to address unmet services needs and gaps. We have tackled some of this through blended funding, applying for grants, and seeking technical assistance as needed for creative solutions. Through the budgeting process, ADMH always requests for increased funds even in a financial climate where there are no new dollars, other state competing needs, and current lawsuits/settlements that demand the financial attention. The primary focus with ADMH is to keep our focus on the SMI Adults and SED Children/Adolescents as these target populations are our required target populations. ADMH has been able to implement evidence-based programs such as FEP and Supported Employment. ADMH stretches its resources and enhances our partners to braid our funds and think creatively. ADMH requires maintenance of a minimum level of care of certain required services that are outlined in the body of the MH Block Grant with the effort of meeting the needs of our target populations. The reality is that Alabama is financially stretched but will keep all efforts moving. However, with the lack of new funds and continued diminishing funds at both the state and national level, it is challenging to implement any expansion of what is currently being provided.

Section III: Table 1 - Priority Area and Annual Performance Indicators

State Priorities

#	STATE PRIORITY	STATE PRIORITY DESCRIPTION/GOAL	OBJECTIVE
1	Self-Directed System of Care	Design a comprehensive system of care that promotes access, choice, and satisfaction of consumers with SMI and SED, and their families, by providing effective treatment and care that is person-centered, consumer driven, and family-guided with a focus on recovery and resiliency.	To increase access and choice and improve satisfaction.
2	Community Integration	Building on Olmstead and Wyatt decisions, transition or divert consumers from state psychiatric inpatient care settings to integrated community settings by using effective treatment and recovery support services designed to promote Home, Health, Purpose, and Community.	To decrease the number of individuals from being committed to state hospitals.
3	EBP's/Best Practices	Develop strategies to increase capacity, implementation, and sustainability of recovery supports and evidence-based/best practices.	To develop a system of care that promotes recovery.

Section II: Planning Steps –Table 1: Priority Areas and Annual Performance Indicators

PRIORITY AREA #1: Self-Directed System of Care	
Priority Type:	MHS
Populations:	SMI, SED
GOAL: Design a comprehensive system of care that promotes access, choice, and satisfaction of consumers with SMI and SED, and their families, by providing effective treatment and care that is person-centered, consumer driven, and family-guided with a focus on recovery and resiliency.	
STRATEGIES:	
ADMH will:	
<ul style="list-style-type: none"> • <i>Continue to gather access data around age, gender, and racial/ethnic groups.</i> • <i>Maintain 80% or better of adult consumers and youth families reporting positive general satisfaction.</i> • <i>Maintain the percentage of adult consumers who report positively about function 77% or higher; and for family members of youth 67% or higher.</i> • Hold annual Alabama Institute for Recovery training. • Maintain four consumer operated drop-in centers. • Continue to fund the peer services/trainings recommended by the MI Planning Council funded with Special Project dollars. • Implement state-wide use of an adult strength-based functional assessment tool. 	
Annual Performance Indicators to Measure Goal Success	
Indicator #1:	
<ul style="list-style-type: none"> • Maintain 80% or better of adult consumers reporting positively about general satisfaction 	
Baseline Measurement:	
<ul style="list-style-type: none"> • Initial data collected during FY18. The numerator is the number of adult consumers who report positive about general satisfaction = 5,154. The denominator is the number of survey responses = 6,209. (83.01%) 	
First-year target/outcome Measurement:	
<ul style="list-style-type: none"> • Maintain 80% 	
Second-year target/outcome Measurement:	
<ul style="list-style-type: none"> • Maintain 80% 	
Data Source:	
<ul style="list-style-type: none"> • URS Table 11a 	
Description of Data:	
<ul style="list-style-type: none"> • MHSIP Survey Results 	
Data issues/caveats that affect outcome measures:	
<ul style="list-style-type: none"> • With implementation of the client level data reporting to CMHS, Alabama will be moving to the use of the adult needs and strengths assessment tool as the data source at some point in the future. 	

Indicator #2:

- Maintain 80% or better of youth families reporting positively about general satisfaction

Baseline Measurement:

- Initial data collected during FY18. The numerator is the number of youth families who report positive about general satisfaction = 1,807. The denominator is the number of survey responses = 2,121. (85.67%)

First-year target/outcome Measurement:

- Maintain 80%

Second-year target/outcome Measurement:

- Maintain 80%

Data Source:

- URS Table 11a

Description of Data:

- MHSIP Survey Results.

Data issues/caveats that affect outcome measures:

- With implementation of the client level data reporting to CMHS, Alabama will be moving to the use of the Child and Adolescent Needs and Strengths (CANS) tool as the data source.

Indicator #3:

- Maintain 77% or better of adult consumers reporting positively about functioning.

Baseline Measurement:

- Initial data collected during FY18. The numerator is the number of adult consumers who report positively about functioning = 4,639. The denominator is the number of survey responses = 6,116. (75.85%)

First-year target/outcome Measurement:

- Maintain 77%

Second-year target/outcome Measurement:

- Maintain 77%

Data Source:

- URS Table 11a

Description of Data:

- MHSIP Survey Results

Data issues/caveats that affect outcome measures:

- With implementation of the client level data reporting to CMHS, Alabama will be moving to the use of the adult needs and strengths assessment tool as the data source.

Indicator #4:

- Maintain 67% or better of family members of youth reporting positively about functioning.

Baseline Measurement:

- Initial data collected during FY18. The numerator is the number of youth family member who report positively about functioning = 1,540. The denominator is the number of survey responses = 2,116. (72.78%)

First-year target/outcome Measurement:

- Maintain 67%

Second-year target/outcome Measurement:

- Maintain 67%

Data Source:

- URS Table 11a

Description of Data:

- MHSIP Survey Results

Data issues/caveats that affect outcome measures:

With implementation of the client level data reporting to CMHS, Alabama will be moving to the use of the Child and Adolescent Needs and Strengths (CANS) tool as the data source.

PRIORITY AREA #2: Community Integration

Priority Type: MHS

Populations: SMI, SED

GOAL: *Building on Olmstead and Wyatt decisions, transition or divert consumers from state psychiatric inpatient care settings to integrated community settings by using effective treatment and recovery support services designed to promote Home, Health, Purpose, and Community.*

STRATEGIES:

ADMH will:

- *Maintain the rate of admission to state psychiatric facilities within 30 days of discharge at or below 5% for adults and adolescents; within 180 days of discharge at or below 13% (excluding forensic patients) for adults; and within 180 days of discharge at or below 10% for adolescents.*
- *Continue/expand services, as well as collaborate with state and local partners, in an effort to support consumers seeking and retaining competitive employment.*
- *Continue/expand services, as well as collaborate with state and local partners, to promote increased school attendance and positive school involvement.*
- *Continue/expand services, as well as collaborate with state and local partners, to promote reduction in criminal justice/juvenile justice involvement.*
- *Continue/expand services, as well as collaborate with state and local partners, to promote stability in housing within the community and expand access to community housing options as well as reduce homelessness.*
- *Maintain positive responses to social connectedness for adult and child/adolescent consumers.*
- *Develop infrastructure for Peer Recovery Services to include, but not limited to, certification, training, service expansion, and funding mechanisms.*

Annual Performance Indicators to Measure Goal Success**Indicator #1:**

- Increase/Maintain Employment

Baseline Measurement:

- Initial data collected during FY18. The numerator is the number of adult consumers who were employed = 7,788. The denominator is the number of adult consumer reporting on employment = 68,773. (11.32%)

First-year target/outcome Measurement:

- Maintain FY18 Baseline

Second-year target/outcome Measurement:

- Maintain FY18 Baseline

Data Source:

- URS Table 4

Description of Data:

- Central Data Repository and URS tables

Data issues/caveats that affect outcome measures:

- Due to the economic climate, employment is vastly impacted and difficult to predict particularly for our target populations.

Indicator #2:

- Improvement in school attendance

Baseline Measurement:

- Initial data collected during FY18. The numerator is the number of youth families who reported improvements in child's school attendance = 430. The denominator is the number of survey responses = 1,225. (35.10%)

First-year target/outcome Measurement:

- Maintain FY18 level.

Second-year target/outcome Measurement:

- Maintain FY18 level.

Data Source:

- URS Table 19b

Description of Data:

- MHSIP Survey Results

Data issues/caveats that affect outcome measures:

- No issues foreseen that will affect the outcomes.

Indicator #3:

- Decrease criminal justice involvement

Baseline Measurement:

- Initial data collected during FY18. The numerator is the number of adult consumers who reported decrease in criminal justice involvement = 855. The denominator is the number of adult consumer survey responses = 1,349. (63.38%)

First-year target/outcome Measurement:

- Maintain FY18 level.

Second-year target/outcome Measurement:

- *Maintain FY18 level.*

Data Source:

- *URS Table 19a*

Description of Data:

- *MHSIP Survey Results*

Data issues/caveats that affect outcome measures:

- *With implementation of the client level data reporting to CMHS, Alabama will be moving to the use of the adult needs and strengths assessment tool as the data source.*

Indicator #4:

- *Decrease juvenile justice involvement*

Baseline Measurement:

- *Initial data collected during FY18. The numerator is the number of youth who reported decrease in juvenile justice involvement = 146. The denominator is the number of survey responses = 250. (58.40%)*

First-year target/outcome Measurement:

- *Maintain FY18 level.*

Second-year target/outcome Measurement:

- *Maintain FY18 level.*

Data Source:

- *URS Table 19a*

Description of Data:

- *MHSIP Survey Results*

Data issues/caveats that affect outcome measures:

With implementation of the client level data reporting to CMHS, Alabama will be moving to the use of the Child and Adolescent Needs and Strengths (CANS) tool as the data source.

Indicator #5:

- *Increase stability in housing*

Baseline Measurement:

- *Initial data collected during FY18. The percentage of adults who report being homeless in FY16 will be less than 2% of the total adults served. The numerator is number of consumers reporting homeless/shelter at end of FY18 = 988. The denominator is 67,741. (1.46%)*

First-year target/outcome Measurement:

- *Less than 02% homeless/shelter*

Second-year target/outcome Measurement:

- *Less than 02% homeless/shelter*

Data Source:

- *The ADMH Central Data Repository*

Description of Data:

- Consumer profile demographic data collected at admission, annual review, and discharge

Data issues/caveats that affect outcome measures:

Due to the economic climate, employment is vastly impacted and difficult to predict particularly for our target populations.

Indicator #6:

- Increased Social Connectedness for adult consumers

Baseline Measurement:

- Initial data collected during FY18. The numerator is the number of adult consumers who report increased social connectedness = 4,487. The denominator is the number of survey responses = 6,100. (73.56%)

First-year target/outcome Measurement:

- Maintain FY18 baseline

Second-year target/outcome Measurement:

- Maintain FY18 baseline

Data Source:

- URS Table 11a

Description of Data:

- MHSIP Survey Results

Data issues/caveats that affect outcome measures:

With implementation of the client level data reporting to CMHS, Alabama will be moving to the use of the adult needs and strengths assessment tool as the data source.

Indicator #7:

- Increased Social Connectedness for families of youth consumers

Baseline Measurement:

- Initial data collected during FY18. The numerator is the number of youth family members who report increased social connectedness = 1,762. The denominator is the number of survey responses = 2,101. (83.86%)

First-year target/outcome Measurement:

- Maintain FY18 baseline

Second-year target/outcome Measurement:

- Maintain FY18 baseline

Data Source:

- URS Table 11a

Description of Data:

- MHSIP Survey Results

Data issues/caveats that affect outcome measures:

With implementation of the client level data reporting to CMHS, Alabama will be moving to the use of the adult needs and strengths assessment tool as the data source.

PRIORITY AREA #3: EBP's/Best Practices

Priority Type: MHS

Populations: SMI, SED

GOAL: Develop strategies to increase capacity, implementation, and sustainability of recovery supports and evidence-based/best practices.

STRATEGIES:

ADMH will:

- Maintain funding for ACT/PACT, Permanent Supportive Housing, and Certified Peer Support Specialists.
- Maintain the number of Permanent Supportive Housing units.
- Maintain/expand the number of employed Certified Peer Support Specialists.
- Continue/expand the child and adolescent (C&A) EBP of CPS and SBMH.
- Maintain/Expand FEP as outlined by SAMHSA requirements.
- Increase telehealth capacity.

Annual Performance Indicators to Measure Goal Success

Indicator #1:

- Maintain funding for Supported Housing slots

Baseline Measurement:

- Initial data collected during FY18. Funding for continuation of supported housing slots will be maintained at FY18 level = 324.

First-year target/outcome Measurement:

- Maintain FY18 level

Second-year target/outcome Measurement:

- Maintain FY18 level

Data Source:

- MICRS. CDR

Description of Data:

- ADMH maintains a web-based residential reporting system where the Supported Housing units are reported in addition to reporting data in the CDR.

Data issues/caveats that affect outcome measures:

- No issues foreseen that will affect the outcomes.

Indicator #2:

- Maintain the number of employed Certified Peer Support Specialists

Baseline Measurement:

- Initial data collected during FY18. 82 Certified Peer Support Specialist (CPS) are employed at community mental health centers

First-year target/outcome Measurement:

- Maintain 82 CPS.

Second-year target/outcome Measurement:

- Maintain 82 CPS

Data Source:

- Office of Consumer Relations

Description of Data:

- Information collected by the Office of Consumer Relations. Provider self-report. Certification site visits.

Data issues/caveats that affect outcome measures:

- Reduction in funding could cause less access in services and decrease in service staff.

		B.	C.	D.	E.	F.	G.
table2		Block Grant	Medicaid	Other Fed	State	Local Funds	Other
	2. Primary Prevention	0	0	0	0	0	0
	2b. Mental Health Primary*	NA	0	0	0	0	0
	3. Evidence-Based Practices for Early Serious Mental Illness (10 % of total award MHBG)	\$1,979,517	0	0	0	0	0
	6. State Hospital	NA	\$21,935,962	\$5,970,808	\$162,493,230	0	0
	7. Other 24 Hour Care	\$10,895,806	0	0	\$102,243,001	0	0
	8. Ambulatory/Community Non-24 Hour Care	\$6,248,592	\$249,618,352	\$4,462,600	\$196,287,713	0	0
	9. Administration (Excluding Program and Provider Level)	\$671,256	\$511,204	\$284,764	\$5,777,588	0	0
	12. Total	\$19,795,171	\$272,065,518	\$10,718,172	\$466,801,532	0	0
table 6	1. Information Systems	0					
	2. Infrastructure Support	\$562,020					
	3. Partnerships, community outreach, and needs assessment	\$1,088,406					
	4. Planning Council Activities (MHBG required, SABG optional)	\$1,530,266					
	5. Quality Assurance and Improvement	0					
	6. Research and Evaluation	0					
	7. Training and Education	\$100,350					
	8. Total	\$3,281,042					

Section IV: Environmental Factors and Plan: 1. The Health Care System, Parity and Integration - Required

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community -based mental and substance use disorders settings.

A comprehensive system of community mental health services is being developed for adults with serious mental illness; children and adolescents with serious emotional disturbances, and individuals with co-occurring mental and substance abuse disorders. The primary behavioral health service that ties consumers to other needed services is case management. Case managers, through their assessment of consumer needs, development of comprehensive service plans, and linkage of consumers to needed services through referral, active assistance and advocacy, and monitoring of service utilization, are responsible for assuring access to the broad range of needed community services.

Consumer outcome research conducted as part of the program evaluations of demonstration case management programs for adult SMI, homeless SMI, SED children and adolescents, and Co-occurring individuals in the state have all found case managers to be successful in significantly increasing the use of the broad range of services needed by consumers. Research results also suggest that the level of functioning of consumers increased with the increased use of services. These outcomes suggest that increased participation in a variety of needed services not only improve the quality of life of consumers but can also increase the adaptive functioning of consumers in areas of everyday life that are critical to their community tenure.

Medical, Dental, and Health Services

For consumers who are Medicaid or Medicare eligible, almost every type of medical care is provided. Very often the only barrier to service is finding providers who serve Medicaid consumers. Other, non-Medicaid eligible clients have typically exhausted health care resources such as insurance and must rely on health care available in their community on an indigent basis. Typically, local Public Health departments and community health clinics are the main referral resources used by case managers to meet the primary health care needs of their consumers. Local hospitals provide a very limited amount of inpatient care to indigent consumers. Because of historical practices among indigent consumers, many emergency rooms provide the only primary health care some consumers get. Individuals with mental illness have wrestled with the health care issue for years and in general this is one of the few areas where children and adolescents fare better than the adults. For example, Medicaid benefits for persons under 21 can exceed usual limits when indicated by the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. Children and adolescents in the care of DHR and DYS receive medical care from these agencies, as well as through school nurses where available. In addition to coverage by Medicaid, dental services are covered by AllKids, Alabama's SCHIP program.

The importance of improving coordination and collaboration with primary medical providers is underscored by the finding that persons with mental illness die on the average 25 years earlier than the general population, due in large part to un- or under-treated primary medical conditions. ADMH received a Transformation Transfer Initiative Grant in FY08 and in FY10 to support efforts to improve integration of primary and mental health care. The following partners were convened to assist in planning grant activities: Alabama Medicaid Agency, Department of Public Health, Alabama Hospital Association, Alabama Academy of Family Physicians, Alabama Primary Health Care Association and American Academy of Pediatrics – Alabama Chapter. In FY08 ten regional meetings were conducted to obtain ideas from both primary and mental health providers relative to barriers and opportunities to improve collaboration. The findings from the regional meetings provided the foundation for the efforts funded in FY10. There are three elements to the current grant: 1) expert panels of physicians to discuss their perspectives on collaboration; 2) provide grants to six areas to develop written plans for improving collaboration locally; and 3) support for the Child and Adolescent Psychiatric Institute focusing on primary care collaboration.

Consumers who are in state hospitals are provided medical care as part of their involuntary confinement where there is no insurance or other source of coverage for medical expenses. The state hospitals became tobacco-free on January 1, 2010. Consumers who have no health insurance and who reside in ADMH community residential programs have minor medical services paid by the provider. There is a limited statewide fund for residents of foster homes to pay for incidental medical expenses when there is no other source of revenue.

Most of the adults with serious mental illness and youth with serious emotional disturbances have Medicaid coverage for medical and dental services. However, it is a challenge to find providers in some areas who will accept Medicaid. Case managers provide a vital service by linking consumers to individual practitioners who will accept Medicaid or who will agree to see consumers on a sliding scale or no fee basis. Community mental health providers routinely receive training in universal precautions. Consumers in day treatment and residential programs receive health education on general nutrition, personal hygiene, exercise, and healthy lifestyle, as well as receiving health monitoring and general health advice from staff nurses. Individuals in outpatient, day treatment, and residential services who are also receiving medication services routinely have vital signs monitored with referrals for necessary medical care. Recommendations for routine health screenings are incorporated in all services. Community resources such as health fairs, free blood pressure checks, flu vaccines, etc. are utilized when available. Additionally, people are referred to school health nurses, public health clinics and Federally Qualified Health Centers, as appropriate and when available. Administration of medications prescribed by community mental health psychiatrists is coordinated with school personnel.

Access to dental care is often cited as an unmet need for consumers. The University of Alabama in Birmingham School of Dentistry also provides free clinics around the state. The waiting list for these clinics is very long. Case managers assist consumers in getting on the waiting list for any available free clinics. In some areas of the state, local dentists volunteer time for free clinics. Again, the amount of time and the range of services are limited.

In recognition of the 25 year earlier mortality rate and health disparities suffered by individuals with serious mental illness disorders, ADMH has promoted health and wellness education activities. During the last several years, the annual Alabama Institute for Recovery has provided a platform for conducting wellness screenings for a significant sample of consumers in attendance from all over the state. The 2018 Alabama Institute for Recovery had approximately 97 consumers to participate in these voluntary screenings. Screening methods included checking blood pressure for hypertension, body mass index for obesity, and blood glucose for diabetes. Due to restrictions in funding, no lipid tests were conducted to check for high cholesterol. ADMH acknowledges that the prevalence of current cigarette smoking was recently reported as 28.0% among persons with any mental illness and 18.4% among those without mental illness. Previous research has shown that people with mental illness are not only more likely to smoke, but they also smoke more frequently than people with no mental illness. Again, this year, the Fagerstrom Index was utilized to screen for nicotine dependence. Screenings were provided in partnership with Pfizer. The results of the screenings show a high degree of comorbidity with diabetes, obesity, and hypertension. Health information and smoking cessation information was disseminated at this event.

With all the managed care efforts, an increased focus has been on development of a system with more focus on integrated behavioral health and primary care. ADMH works closely with the Alabama Primary Health Care Association (APHCA) and we are engaged to expand and enhance the efforts of our providers around care coordination. At this time, each behavioral health provider has to ensure the linking of primary health care needs but that has been left to the local community planning process. There is a variety of avenues that behavioral health providers have implemented to meet the primary health care needs of the individuals they serve. This ranges from linking behavioral health consumers to needed providers, to co-location of primary care providers in a community provider location or a behavioral health provider in a primary health care location, to some early stages of behavioral health providers hiring their own primary health care providers, to developing a more integrated care system of behavioral health providers and primary health care providers in the same location. At present, ADMH and APHCA are exploring strategies for move toward a more integrated system that ensures the individuals our providers serve are able to receive needed care for both their mental health and primary health care needs.

Also, the work with the Alabama Medicaid Agency (AMA) remains a heightened focus, especially as it pertains to Health Homes. ADMH assisted with the development of the Medicaid Health Home state plan and it has specific processes that are designed to ensure care coordination for individuals with SMI, SED, SUD, and COD. The primary reasons for this collaboration was to ensure the inclusion of our target populations with the health home process and linkage to primary health care professionals and services. Also, AMA has implemented the Integrated Care Networks (ICN). This is the managed care of individuals who meet the level of care of a nursing home but could be maintained in a home with the appropriate level of care. This is a living at home waiver. ADMH is a partner with the ICN process as to ensure that our SMI adults are positioned for such care as appropriate. Another venture of AMA is the implementation of the Alabama Coordinated Health Networks (ACHN). ACHN is an innovative plan to transform health care provided to Medicaid recipients in Alabama. ACHN transforms the Alabama Medicaid delivery system in to a more flexible and cost-efficient effort. This effort will build off the current case management program structure. AMA and its providers will work closely with the ACHNs for the coordinated care opportunities for the consumers we serve.

2. Describe how the state provide services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, payment strategies that foster co-occurring capability.

ADMH does not operate any substance abuse prevention, treatment, or recovery support programs or directly provide any related services. ADMH has established the State’s public system of services through the execution of contractual agreements with sixty-four (64) community based private and public entities located throughout Alabama. Each of these organizations receives funds from ADMH to provide one (1) or more of fourteen (14) levels of care that together, compose the state’s treatment service continuum, funds to provide one or more of the six (6) primary preventions strategies, and/or funds to provide recovery support services.

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

For more detail, please refer to the SAMHSA SA Block Grant.

3. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through Qualified Health Plan (QHP)s?

Yes No

and Medicaid?

Yes No (ADMH does have oversight of areas of Medicaid where ADMH puts up the match, such as Rehab Option, TCM, ID Waivers, NET. Also, ADMH does monitoring through Certification, Contract review, Advocacy, and telephone calls.)

4. Who is responsible for monitoring access to M/SUD services by the QHP?

No specific responsibility has been assigned to this task by the Alabama Insurance Commission. ADMH does not have a plan for monitoring whether individuals and families have access to mental health and substance use/abuse services offered through QHPs and Medicaid. Any monitoring responsibilities in regard to activities of the QHPs falls within the authority of the Alabama Department of Insurance. At the present time, ADMH will only be involved if authorized by the Governor, and if assistance by the Alabama Department of Insurance and/or Attorney General is needed in this regard. It is important to note that Alabama is a non-expansion state.

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state?

Yes No

6. Do the behavioral health providers screen and refer for:

a) Prevention and wellness education

Yes No

b) Health risks such as

i) heart disease

Yes No

ii) hypertension

Yes No

viii) high cholesterol

Yes No

ix) diabetes

Yes No

c) Recovery supports

Yes No

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care?

Yes No (Hospital beds and claw back contracts: Also Medicaid Managed Care that is being developed)

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services?

Yes No (This role lies with the insurers such as AMA/ALL KIDS/ Insurance Commission.)

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?

Unknown at this time.

10. Does the state have any activities related to this section that you would like to highlight?

Despite previously supporting Alabama's implementation of a state-based health insurance exchange, former Governor Robert Bentley (he resigned in April 2017) announced on November 13, 2012, the state would default to a federally-facilitated exchange. The federal government assumed full responsibility for running a health insurance exchange in Alabama beginning in 2014.

Many of the states expanded Medicaid to low-income adults in the ACA, Obamacare's Affordable Care Act when it took effect, yet Alabama has not. Residents of Alabama must meet certain eligibility criteria set by the state of Alabama to apply for Medicaid. Information on this can be found at Medicaid.alabama.gov. The state CHIP program, called ALL Kids in Alabama, provides low-cost health insurance for all kids that are eligible for Alabama's Children's Health Insurance Program. ALL Kids is under the authority of the Alabama Department of Public Health (DPH). AMA and DPH coordinate their enrollment processes together.

According to the U.S. Department of Health and Human Services (HHS), over 642,000 Alabama residents are uninsured (about 16% of the state's population) and 95% of those are eligible for tax credits to supplement their insurance costs in the Affordable Care Act-enabled marketplace. Alabama has opted to let the federal government and the HHS run the health care marketplace. Residents can enroll at the official website Healthcare.gov. Insurance options include Blue Cross/Blue Shield, United Health One, Humana, and IHC Health. Income-based tax credits, as well as cost-sharing subsidies, are available through the marketplace plans. Those individuals and families who don't qualify for any financial assistance may choose to shop in the private marketplace for access to a variety of plan options and different provider networks.

As discussed within this application, Alabama is in the process of Medicaid Reform and the future of Medicaid and potential changes in its payment structures and/or services provided is unknown. Due to the complexities and infancy of the procedure with the implementation of these processes, many of the questions above cannot be fully answered. It is important to note that ADMH has a longstanding working relationship with the Alabama Medicaid Agency and other state agencies directly involved with both processes. ADMH has been and will continue to be directly involved with making recommendations on the decision-making processes. Representatives from ADMH participate on the multi-level committees and workgroups including the Commissioner of ADMH and her designated staff.

A gain in momentum to address nicotine dependence among individuals with mental health disorder over the past decade has occurred within the state hospital settings. The state hospitals became tobacco-free on January 1, 2010. All state hospitals are currently smoke-free and interventions to assist consumers with this process have been implemented. For the contracted community mental health centers, there has been progress with initiation of individual endeavors to address smoking cessation, but ADMH has not implemented a state-wide process to address this issue.

Consumers who are in state hospitals are provided medical care as part of their involuntary confinement where there is no insurance or other source of coverage for medical expenses. Consumers who have no health insurance and who reside in ADMH community residential programs have minor medical services paid by the provider. There is a limited statewide fund for residents of foster homes to pay for incidental medical expenses when there is no other source of revenue.

Most of the adults with serious mental illness and youth with serious emotional disturbances have Medicaid coverage for medical and dental services. For consumers who are Medicaid or Medicare eligible, almost every type of medical care is provided. Very often the only barrier to service is finding providers who serve Medicaid consumers. Other, non-Medicaid eligible consumers have typically exhausted health care resources such as insurance and must rely on health care available in their community on an indigent basis. Typically, local Public Health departments and community health clinics are the main referral resources used by case managers to meet the primary health care needs of their consumers. Local hospitals provide a very limited amount of inpatient care to indigent consumers. Because of historical practices among indigent consumers, many emergency rooms provide the only primary health care some consumers get. Individuals with mental illness have wrestled with the health care issue for years and in general this is one of the few areas where children and adolescents fare better than the adults. For example, Medicaid benefits for persons under 21 can exceed usual limits when indicated by the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. Children and adolescents in the care of DHR and DYS receive medical care from these agencies, as well as through school nurses where available. In addition to coverage by Medicaid, dental services are covered by ALL Kids, Alabama's SCHIP program. Case managers provide a vital service by linking consumers to individual practitioners who will accept Medicaid or who will agree to see consumers on a sliding scale or no fee basis.

Community mental health providers routinely receive training in universal precautions. Consumers in day treatment and residential programs receive health education on general nutrition, personal hygiene, exercise, and healthy lifestyle, as well as receiving health monitoring and general health advice from staff nurses. Individuals in outpatient, day treatment, and residential services who are also receiving medication services routinely have vital signs monitored with referrals for necessary medical care. Recommendations for routine health screenings are incorporated in all services. Community resources such as health fairs, free blood pressure checks, flu vaccines, etc. are utilized when available. Additionally, people are referred to school health nurses, public health clinics and Federally Qualified Health Centers, as appropriate

and when available. Administration of medications prescribed by community mental health psychiatrists is coordinated with school personnel.

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Section IV: Environmental Factors and Plan: 2. Health Disparities - Requested

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, LGBT, and age?

- a) Race Yes No
- b) Ethnicity Yes No
- c) Gender Yes No
- d) Sexual orientation Yes No
- e) Gender identity Yes No
- f) Age Yes No

2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population?

- Yes No

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers?

- Yes No

4. Does the state have a workforce-training plan to build the capacity of behavioral health providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations?

- Yes No

5. If yes, does this plan include the Culturally and Linguistically Appropriate Services (CLAS) standard?

Yes No

6. Does the state have a budget item allocated to identifying and remedialing disparities in behavioral health care?

Yes No

7. Does the state have any activities related to this section that you would like to highlight?

All community level data are collected at admission, annual update, and discharge. At or near the anniversary data of admission to the service, the client’s individual profile records are updated and uploaded to the ADMH Central Data Repository. The data currently captured with demographics includes race, ethnicity, age, and gender (excluding transgender).

It is important to note there is a requirement that providers report on hearing status of all consumers in general demographics (rather than “medical conditions” or Axis III). This readily allows ADMH to track consumers who are deaf or hard of hearing and target resources in an efficient manner. This allows ADMH to pinpoint and define the consumer characteristics of the 1,780 hard of hearing people and 228 deaf people that received services from ADMH in FY18.

ADMH has established an Office of Deaf Services (ODS) to serve deaf and hard-of-hearing Alabamians better. ADMH is committed to ensuring that their peers will design programs for deaf and hard-of-hearing persons to ensure services are linguistically accessible and culturally affirmative, giving the consumer every opportunity to make progress to recovery. The ODS staff includes a director, statewide services coordinator, a statewide mental health interpreter coordinator, statewide and regional clinical staff, and regional communication access team members. ODS also provide significant communication and clinical support to Bryce, where deaf people needing inpatient care are served. ADMH has developed specific standards of care for people with hearing loss that includes, among other things, specific requirements for measurable fluency in American Sign Language for certified community programs which work with deaf consumers. Also, through contracts with ADMH, the contracted providers have access to language interpreters regardless of language and those services to assist with language needs as needed in services and care. (See attached ODS FY18 Annual Report)

Also in ADMH MI Program standards, providers are to provide services that are culturally competent and linguistically competent and represents the ethnic and gender needs of the community. In FY14, ADMH and providers began capturing data on the client’s primary language to facilitate meeting linguistic needs of our client populations. At present, we do not capture data on transgender, sexual orientation, or tribal connection but will explore including these data elements in our data

ADMH will continue to share data information with our providers and other stakeholder entities to include National Outcome Measures (NOMS) and results from MHSIP Satisfaction Surveys and CANS results. Funding through the Behavioral Health Services Information System State Agreement (BHSIS) has been utilized to assist with measuring, tracking, and responding to disparities in the ongoing development of a data warehouse for mental health and substance abuse services data.

Section IV: Environmental Factors and Plan: 3. Innovation in Purchasing Decisions - Requested

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions?

Yes No

2. Which value based purchasing strategies do you use in your state (check all that apply):

- a) Leadership support, including investment of human and financial resources.
 - b) Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
 - c) Use of financial and non-financial incentives for providers or consumers.
 - d) Provider involvement in planning value-based purchasing.
 - e) Use of accurate and reliable measures of quality in payment arrangements.
 - f) Quality measures focus on consumer outcomes rather than care processes.
 - g) Involvement in CMS or commercial insurance value based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)). – **Health Home access through AMA.**
 - h) The state has an evaluation plan to assess the impact of its purchasing decisions.
- Monitor census of hospital/Evaluation of units of services of C&A/90% residential occupancy.**

Does the state have any activities related to this section that you would like to highlight?

ADMH has a developed process for dissemination of information within ADMH between the services divisions and ADMH specific offices. With the Divisions, primarily the program staff disseminates pertinent information, especially regarding evidence-based or promising practices. ADMH distributes information with external sources, such as the members of the MI Planning Council and Mental Illness Coordinating Sub-Committee, as well as to the provider network and state-wide consumer and family advocacy networks. This is done through list serve/distribution emails.

Many different elements of information are used in the purchasing and policy decisions involving evidence-based or promising practices. The following EBPs are in various phases of development in Alabama.

- Assertive Community Treatment (ACT)
- Integrated Treatment for Co-Occurring Disorders (COD)
- Permanent Supportive Housing
- Supported Employment
- Peer Support Services
- Coping Power
- School-Based Mental Health Collaboration
- First Episode Psychosis (FEP)

Information used was from notifications sent out by SAMHSA, NASMHPD, and other national and state entities. From the SAMHSA website, two sources that were used were the Evidence-Based Practices Tool Kits and A Guide for Selecting and Adopting Evidence-Based Practices for Children and Adolescents with Disruptive Behavior Disorders.

The information on evidence-based and promising practices have been distributed and utilized within the previously discussed committees, councils, and task forces. In all these planning groups, there are representatives from Medicaid, S-Chip, and other purchasers. In particular to mental health children and adolescent, the Child and Adolescent Task Force developed a workgroup to assist in the guidance and recommendations of evidence-

based and/or promising practices (See Section II. Step 1 for more detailed information on both adult and child/adolescent EBPs)

Evidence-Based and promising practices are part of the considerations taken into account in purchasing services. Much of the purchasing decisions are made with the Regional entities and the individual community mental health centers. Each community mental health center is expected to develop and manage a comprehensive array of mental health services with sufficient capacity for designated geographic areas.

Section IV: Environmental Factors and Plan: 4. Evidence-Based Practices for Early Intervention to Address Early Serious Mental Illness (ESMI). (10 Percent Set Aside) - Required

1. Does the state have policies for addressing early serious mental illness (ESMI)?

Yes No

2. Has the state implemented any evidence based practices (EBPs) for those with ESMI?

Yes No

If yes, please list the EBPs and provide a description of the programs that the state currently funds to implement evidence-based practices for those with ESMI.

Through much discussion, technical assistance, and consultation, ADMH decided to start with one pilot site for First Episode Psychosis (FEP). Alabama chose to implement Coordinated Specialty Care for first episode psychosis in a portion of Jefferson County, with the goal of statewide expansion of a consistent program model. The EASA Center for Excellence has been engaged for training and consultation. The name of the FEP is NOVA.

Services will include all key elements of Coordinated Specialty Care:

- Community education
- Outreach and engagement
- A transdisciplinary team including psychiatry, masters-level clinicians, peer support, supported employment and education and nursing functions.
- Individualized care including:
 - Specialized assessment,
 - Coordination across settings,
 - Family and individual psychoeducation focused on illness education, resilience, coping, and relapse prevention,
 - Counseling and case management integrating CBT and motivational interviewing, focused on mastery of symptoms, making sense of the experience and developmental progression,
 - Support for school and work following Individual Placement and Support principles

3. How does the state promote the use of evidence-based practices for individuals with a ESMI and provide comprehensive individualized treatment or integrated mental and physical health services?

ADMH promoted the use of NOVA through the study of it as a pilot demonstration. The state level advisory committee is the ADMH Mental Illness Planning Council (MIPC), the advisory committee authorized through the SAMHSA Mental Health Block Grant. The MIPC provides the oversight, assessment and approval process for the FEP site and works with ADMH for the data and evaluation, as well as statewide expansion. ADMH also participated with the Westat 10% Set-Aside Evaluation study as to appropriately implement a data collection process that can be utilized to further inform our system in effort for expansion and sustainability. ADMH hired a statewide FEP Coordinator whose primary goal is to spearhead the successes of the pilot demonstration, be the primary point person with the evaluation process, and lead the efforts for statewide promotion, training and education. ADMH is in the process of transformation efforts and moving to a system of quality measures and paying for performance. FEP is amongst the EBPs being assessed to move our system forward in a more meaningful way in purchasing outcomes. ADMH is in the process of expanding NOVA to two more sites, as well as piloting the Medicaid funding of FEP.

4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with a ESMI?

Yes No

5. Does the state collect data specifically related to ESMI?

Yes No

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI?

Yes No

7. Please provide an updated description of the state's chosen EBPs for the 10 percent set-aside for ESMI.

FEP Parameters:

The FEP Program will identify, assess and serve up to 45 adolescents and young adults at any given time who are experiencing recent changes in their thoughts, feelings, and behavior, such as unusual thoughts, distorted or heightened perceptions, ideas of special identity or abilities, suspiciousness, or odd behavior. Other changes may include reduced concentration, reduced energy, and depressed mood, sleep disturbance, withdrawal from family or friends, trouble with work or school, anxiety, or irritability.

Diagnostic Parameters:

Eligibility for participation in the FEP program is restricted to those who meet the diagnostic criteria and who have not experienced such problems before their current episode of illness or who have had only very limited previous treatment. Diagnostic eligibility consists of psychosis consistent with schizophrenia, schizoaffective or bipolar spectrum, with psychosis duration (not including prodromal) not greater than 12 months. Diagnoses include Schizophrenia, Schizoaffective or Bipolar 1 with Psychotic Features, Schizophreniform Disorder, Brief Psychotic Disorder, Psychosis Disorder NOS, and other specified or unspecified psychotic disorders.

Diagnostic categories:

Schizophrenia
Schizoaffective Disorder
Psychosis NOS
Bipolar Disorder with Psychotic features

Geographical Area:

Jefferson, Blount, St. Clair Mental Health Authority (JBS) implemented a First Episode Psychosis (FEP) Program in urban and sub-urban areas of Jefferson County which include the following cities: Birmingham City, Homewood, Vestavia, Mountain Brook, and Hoover. Residency includes either parental/permanent address, individual address if living independently or residency due to college attendance.

Age Parameters:

Ages 15-25. There are developed guidelines for flexibility for acceptance outside this age range if the person meets the other criteria and is determined to be clinically appropriate for the team

Length of Program:

Two (2) years with up to a year extension determined through a six (6) month review process.

Exclusionary Criteria:

These would include psychosis clearly due to medical condition, head injury, substance abuse and development issues, as well as IQ under 70.

Transfer Criteria:

Transfer of an individual from FEP shall occur when the individual's treatment goals have been achieved or the individual and or family declines participation in further treatment. Prior to transfer, the treatment team will identify the appropriate referral source to transfer care.

Discharge Criteria:

Discharge of an individual from FEP shall occur when the individual's treatment goals have been achieved

or the individual and or family declines participation in further treatment. Prior to discharge, the treatment team will identify the appropriate referral source to transfer care.

Program Elements:

Specific procedures and protocols were informed by a combination of EASA and OnTrack USA.

Services are delivered through a Coordinated Specialty Care Team with a caseload of no more than 1:15 across the team (1 FTE total number on the team: 15 consumers) which meets weekly and reviews treatment plan and care being provided to each client. The Coordinated Specialty Care Team is reflective of the demographic mix of the community and includes **4.83 FTE** positions as outlined below:

- 1.0 FTE Team leader/Program Coordinator who will also be lead clinician for a subgroup of consumers (Master’s degree plus two years’ experience)
- 1.0 FTE Care Coordinator (Bachelors’ Degree)
- 1.0 FTE Supported Employment and Education Specialist (Bachelors’ Degree)
- 1.0 FTE Peer support specialists (.5 family, .5 individual)
- 0.33 Psychiatrist (13 hours/week)
- 0.5 Registered Nurse (RN/LPN)

8. Please describe the planned activities for FFY 2020 and FFY 2021 for your state’s ESMI programs including psychosis?

Goal #1: Increase number of participants participating with NOVA.

- Activities:
 - Conduct ongoing staff training and participate in ongoing consultation.
 - Establish and implement ongoing training plan.
 - Expand outreach efforts.
 - Implement local level stakeholder advisory committee.
- Activities: Finalize agency policies, procedures and forms and train staff.

Goal#2: Begin to lay the infrastructure for statewide expansion.

- Activity: Train state-level position.
- Activity: Participate with Westat 10% Set-aside Evaluation Study.
- Activity: Design and implement preliminary data collection.
- Activity: Finalize ongoing fidelity self-assessment and review process to be implemented.
- Expand to two new locations

9. Please explain the state’s provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI.

At this time, ADMH is only collecting the historical data that is collected for all consumers we serve. ADMH had initially decided to follow the lead of the EPINET/PhenX planning process. Data to be collected includes, but not limited to:

- Community education activities
- Referrals and disposition of referrals
- Demographics
- Source of referral
- Duration from first psychosis to entry into the program
- Diagnosis
- School status
- Employment participation
- Insurance

- Disability system status
- Hospitalizations
- Legal involvement/arrests
- Billing claims/services received
- Discharge dates and status

We planned to also implement a fidelity self-assessment and review process. Data was to be collected on all community education activities, referrals and intakes. Quarterly demographic and functional data would also be collected. Data was to be reported longitudinally in order to set benchmarks and identify trends.

However in March 2017, ADMH was contacted by Westat about the potential for Alabama to participate in the Mental Health Block Grant 10% Set-Aside Study. Through a series of information exchange, Alabama was chosen to participate with a kick off meeting on August 25, 2017. ADMH was excited to be chosen as this opportunity allowed ADMH to ensure the appropriate data is collected, analyzed and distributed in a manner to complement our efforts.

Continuing our relationship with EASA, for consultation and technical assistance, NOVA-Birmingham participated in their first Fidelity review in 2018. Based on the review, EASA determined that the team is providing effective services in majority of the core areas of early psychosis intervention. EASA highlighted areas that they found to be needing additional development subsequently making recommendations in those areas. Additional training and oversight to help guide NOVA-Birmingham in strengthening areas necessary to become a fully developed program were provided and remain on-going.

As participants in the MHBG 10% study with Westat, NOVA-Birmingham participated in a 2-year study that included following consumers who met the criteria over a two-year period (2017-2019) as well as, participating in two process assessments and fidelity assessments. Though final study results have not yet been released by Westat Evaluators, NOVA-Birmingham's final fidelity assessment was positive. According to the assessor's report, NOVA-Birmingham achieved either good or high fidelity across most of the fidelity domains and were provided with recommendations to consider, as we prioritize to improve service delivery.

Overall, Alabama's FEP program continues to boast our teams meaningful engagement of young people and their family members/support systems, a strong individual and family peer support focus, group and community inclusion offerings for participants, supported employment and education components, rapid access and crisis response, integration of dual diagnosis treatment with trauma/grief work, all team members providing formalized psychoeducation, and a focus on program development.

10. Please list the diagnostic categories identified for your state's ESMI programs.

Diagnostic Parameters:

Eligibility for participation in the FEP program are restricted to those who meet the diagnostic criteria and who have not experienced such problems before their current episode of illness or who have had only very limited previous treatment. Diagnostic eligibility consists of psychosis consistent with schizophrenia, schizoaffective or bipolar spectrum, with psychosis duration (not including prodromal) not greater than 12 months. Diagnoses include Schizophrenia, Schizoaffective or Bipolar 1 with Psychotic Features, Schizophreniform Disorder, Brief Psychotic Disorder, Psychosis Disorder NOS, and other specified or unspecified psychotic disorders.

Diagnostic categories:

Schizophrenia
 Schizoaffective Disorder
 Psychosis NOS
 Bipolar Disorder with Psychotic features

11. Does the state have any activities related to this section that you would like to highlight?

Alabama's First Episode of Psychosis program is established and operated by JBS Mental health center and is commonly known as NOVA-Birmingham. The FEP program has remained committed to empowering youth and young adults while providing compassionate and comprehensive treatment, utilizing the evidenced-based practices that the program is founded upon. Beginning August 2016-2017 (the first year of the program) NOVA-Birmingham received 15 referrals, and successfully accepted and treated 3 individuals, as they met the diagnostic criteria, were in the specified catchment area, and met the age requirements. Appropriate resources and referrals were provided to others who were screened out of FEP services through Nova-Birmingham, as per the need for continued care. Year 2017-2018 NOVA-Birmingham received 20 referrals, while 6 of those met the before-mentioned criteria and were accepted and received treatment. Utilizing the flexibility to carve out specific recovery-focused services of the Coordinated Specialty Care (CSC) evidenced-based practice, it has made a great impact on the experiences of the target population. The present year 2018-2019 NOVA-Birmingham has exceeded our previous referral count at 29 referrals, with 14 of those meeting the criteria. The program has made significant progress in the areas of outreach and engagement which continues to positively affect the overall expected outcomes.

At present, ADMH is working with two community mental health centers to expand NOVA. Initial orientation meetings have occurred and ADMH is working to expand to AltaPointe Health Systems, which will create NOVA-Mobile, and Wellstone, Inc., which will create NOVA-Madison.

Section IV: Environmental Factors and Plan: 5. Person Centered Planning (PCP) – Required

1. Does your state have policies related to person centered planning?

Yes No

2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.

3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.

ADMH supports a model for assessment, service planning, and service delivery that is person-centered, strength based, consumer-driven, and family-focused. Efforts to move the system toward this have occurred at several levels. To try and develop infrastructure and build capacity, ADMH has engaged in the following:

- Updated the ADMH Administrative Code for MI Program Standards that incorporates person centered and recovery mandates for care. Person-centered treatment planning is outlined. Addressing the specialized needs of consumers who are deaf or hard of hearing was integrated in every level. So that consumers and their families can be informed of the quality of care of the provider, ADMH implemented having certification scores being posted on the ADMH website as a "report card". Consumer, family and advocacy representatives are direct and active members of the committees that review, develop, and make recommended changes to the ADMH Administrative Code for MI Program Standards.
- A regional planning structure was adopted for all departmental planning beginning in FY08 and resulted in increased numbers of family members and consumers being involved in the planning process. During FY09, there were numerous participants in the regional planning process including consumers, family members, Probate Judges, public community providers, state hospitals, and local private providers. In FY09, the planning process was expanded to separate local planning for adults from local planning for children and adolescents. This decision was based on feedback from the previous years of planning with the intent to improve the voice of children and adolescents and their families throughout the planning process. A series of local stakeholder planning meetings occurred in late summer and fall 2009. This provided an avenue to have local and regional input in determining unmet needs and critical gaps within the system at the community level. The local and regional planning process provides the foundation for the Department's annual budget request.
- ADMH implemented the state-wide use of the Child and Adolescent Needs and Strengths (CANS) Functional Assessment Tool effective October 1, 2010 in order to address the concerns about the special individualized needs of child and adolescent consumers and their family members. This strengths-based assessment instrument has cultural subscales that guide service providers in assessing cultural strengths and helping families to select services that are

culturally relevant to them. The CANS is linked directly to the treatment plan as to ensure the treatment is individualized, strength based, family-driven, and youth-guided. ADMH developed a statewide web-based application for the CANS as a means to gather data for NOMs and to measure performance and outcomes. It is anticipated that ADMH will implement such an instrument for the adult system. The adoption of the CANS was recommended by the statewide DMH Child and Adolescent Task Force (CATF) who has youth consumers, family members, and advocates as members who recommended the implementation of this assessment tool.

- ADMH is working closely with Alabama Medicaid in efforts to expand coverage to those peer related services that would enhance a self-directed care system. ADMH has submitted language for consideration of a State Plan Amendment for the Rehab Option that would include Peer Support Services, Youth Peer Support Services, and Family Peer Support Services. Work continues on these efforts as other funding stream enhancements are being explored.

4. Describe the person-centered planning process in your state.

Many ADMH policies are rooted in the provision of person-centered and individualized treatment planning as prescribed in the ADMH Administrative Code. This requirement is expressed succinctly in section 580-2-9-.08(3) entitled "General Clinical Practice," which states, "Services must be individualized, well-planned, based on a comprehensive mental health evaluation and assessment of needed treatment and support, and should include treatment designed to enhance the consumer's abilities to recover and function in society as normally as possible," and also, "Each program shall provide individualized mental health care and treatment that is designed to promote Recovery and Resiliency and that represents person-centered treatment planning process." This philosophy of care pervades all areas of service provision by ADMH certified providers. Consumers who present with histories of trauma that impact their presenting mental health conditions should be provided the best interventions available to accommodate their mental health treatment needs, including trauma-focused therapeutic interventions wherever appropriate. As a true trauma-focused system of care has not yet been achieved across the state, the types of trauma-focused therapy interventions will vary by provider agency and by individual clinician. ADMH does not have policies beyond what is provided for in the Administrative Code that require providers to deliver a specific trauma-focused intervention. Trauma-focused care is an important and growing field in mental health care, and a variety of training events and workshops have been conducted. Each provider is responsible to conduct or promote training opportunities for their clinicians and other treatment staff that will help them to develop professionally and to provide the best, most effective treatment possible for consumers of mental health services, including training and development in the area of trauma focused care.

Person-centered treatment planning has been adopted as the philosophy for ADMH through which consumers are assisted in articulating their vision and hope for how their lives will be changed for the better. Person-centered treatment planning training sessions have ongoing for several years in state facilities and with community mental health providers. A training manual has been developed for use by mental health professionals. Community mental health providers are expected to provide ongoing training on person-centered treatment planning and consumer directed services. In 2009, refresher training sessions were provided in four locations across the state related to the focus on improving recovery and resiliency capability of the system. Alabama's Administrative Code promotes the use of person centered treatment planning throughout.

Alabama currently has no formal policy on participant-directed services. Within ADMH, the Mental Illness Division has relied on a traditional community mental health center system of care. This has provided limited choices to the community providers of what services are offered. However, within the community mental health system at a local level, individuals have choice to what services they will accept, therapist within that system to provide the service, and individualized treatment planning. The efforts of ADMH have been to develop and enhance a continuum of care for both adults and children/adolescents that lends itself to a flexible array of services that are focused on meeting as a first priority the needs of people with a serious and persistent mental illness, particularly those who have been in a state psychiatric hospital. However, this is within the community mental health center itself and to develop a seamless system of care from hospital to community. All services are designed to be provided from a person-centered treatment planning perspective driven by

family and consumer needs. Consumers receive not only high quality treatment services, but receive the necessary supports to achieve the highest degree possible of independent living in safe and decent housing, to be employed, to receive necessary medical care in a coordinated manner, and to engage in social interaction with friends and family. The struggle with expanding the provider network is the balancing of care coordination and collaboration necessary to maintain consumer recovery and foster resiliency.

Section IV: Environmental Factors and Plan: 6. Program Integrity - Required

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

Yes No

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with programs requirements, including quality and safety standard?

Yes No

3. Does the state have any activities related to this section that you would like to highlight?

The program integrity process involves a number of ADMH administrative tools including the ADMH MI Program Standards, ADMH Administrative Division Finance Bureau Audit Guidelines Manual, ADMH contracts, and ADMH Mental Illness Contract Service Delivery Manual. ADMH expends most of the Community Mental Health Services Block Grant (MHBG) through the community mental health centers and state-wide consumer/family advocacy entities. ADMH policy on the use of state and federal funds is expressed in the above listed tools.

The ADMH MISA Services Division conducts on-site visits as indicated in ADMH MI Program Standards (administrative code) for all programs certified either as a community mental health center or as a community mental health provider. The purpose of these on-site certification reviews is to evaluate program plans and services delivered to ensure consistency and conformance with services definitions, state regulations, and policies governing mental health programming. The on-site certification reviews are conducted every two years or sooner.

Under the FY20 contracts, ADMH expects the centers to develop and manage a comprehensive array of mental health services with sufficient capacity as outlined in ADMH MI Program Standards. In developing and managing this continuum of services, the centers are expected to include in their planning the federal mandates under the SAMHSA Mental Health Block Grant (MHBG). Within the contracts, language exists that outlines that the contractor has an affirmative responsibility to pursue any third-party payment (e.g., Medicaid, Medicare, etc.) and that ADMH is the payor of last resort. The contract also outlines that the contractor agrees it will comply with all applicable terms, conditions, provisions, and requirements delineated in the current ADMH Audit Guidelines Manual and subsequent amendments.

MHBG budget review monitoring and oversight responsibilities on the state budget appropriation level are primarily assigned to the staff within the ADMH Bureau of Finance, primarily the office of accounting. The Bureau of Finance manages the accounting, financial reporting, budgeting, purchasing, payroll, and accounts payable functions for the department. In addition, it is responsible for the financial management of the department's contracts and federal awards. The assigned staff provides quarterly projections of MHBG award balances to ADMH MISA Division MI Financial Data Analysis.

A funding plan for the MHBG is reviewed annually with the MI Planning Council. In addition, the same funding plan is reviewed and approved by the Associate Commissioner of ADMH MISA Services Division. Any substantial change in these plans are also reviewed and approved by the same parties. The Division has also developed a standard uniform excel budget sheet for all contracts awarded under the MHBG. These individual budgets are reviewed and approved by the MI Financial Data Analyst, Director of MI Community Programs, Associate Commissioner of the Division, and ADMH Office of

Accounting. The purpose of the review is to assure that all contract expenditures as described in narrative format, are consistent with the purpose of each contract, the planned expenditures Block Grant requirements and rules.

Alabama does not use insurance claims model for distributing Block Grant funding. Instead individual contracts are utilized to distribute block grant funding. Questions of payment processes under these contracts are addressed by Division managers, ADMH Bureau of Finance staff, and Division's Financial Data Analyst.

On a quarterly basis, the ADMH's Office of Accounting produces an excel spreadsheet summary of the financial status of all block grant-funded contracts that is distributed to the MI Financial Data Analyst and Director of MI Community Programs. The report notes if individual block grant contracts have failed to expend funding in a timely manner. On a quarterly basis, the ADMH Office of Account updates obligation spreadsheets that detail the planned contract and operational expenditures for each block grant award, the contracts obligated, and contracts expended. These obligation spreadsheets are reviewed by the Division's MI Financial Data Analyst, Director of MI Community Programs, and Associate Commissioner. Utilization and performance analysis reports are created to analyze block grant funded agency. These reports are reviewed by the providers, the Division MI Financial Data Analysis, and the Division Director of MI Community Programs.

Agencies receiving block grant contract awards of \$500,000 or more are required to submit single audit reports to Department staff that include a review of adherence to federal block grant requirements on an annual basis. These agencies are responsible for resolving audit findings, questioned costs, practices, etc., in accordance with applicable laws and regulations (e.g., Single Audit Act, OMB Circular A-133, Medicaid requirements), and/or to ADMH's satisfaction within six (6) months from the issue date of the respective report(s). This same responsibility and resolution period apply to the entity for any/all audit findings, questioned amounts, and/or practice of the entity's subcontractors/recipients that received funds through any ADMH contract, grant, and/or agreement. ADMH has oversight responsibility to coordinate and ensure that all audit findings and questions that could or do affect ADMH funding are satisfactorily resolved within the required time limit. These reports are reviewed by personnel in the ADMH Office of Contracts under the Bureau of Finance. Any findings of significance are passed along to Division's MI Financial Data Analyst. These findings are discussed with the Director of MI Community Programs and the Division's Associate Commissioner. Appropriate ADMH staff lead an investigation of the findings and develop a corrective action or response plan. If the agency succeeds in adequately addressing the finding issues and is approved, the Commissioner has final authority only within ADMH on the resolution of all audit findings. The details of the process are outlined in the ADMH Administrative Division Finance Bureau Audit Guidelines Manual.

The Division has concentrated the majority of its MHBG funding on non-direct services other 24-hour care. In addition, the primary focus of funding for direct services under the MHBG is serving populations that are not likely to be eligible for Medicaid or private insurance eligible and/or would not have the services paid through ADMH support paid by Medicaid or private insurance. As the Affordable Care Act is implemented, ADMH will evaluate its monitoring tools and determine appropriate adjustments to the new health insurance coverage expectations.

Section IV: Environmental Factors and Plan: 7. Tribes - Requested

1. How many consultation sessions has the state conducted with federally recognized tribes? – None
2. What specific concerns were raised during the consultation session(s) noted above? - NA
3. Does the state have any activities related to this section that you would like to highlight?

Alabama is home to only one federally recognized Indian Tribe. Operating as a sovereign nation since 1984, the Poarch Band of Creek Indians consists of descendants of a segment of the original Creek Nation which once covered almost all of the state, as well as, Georgia. The Poarch Creeks have lived together for almost

200 years in and around the reservation, which is located fifty-seven (57) miles from Mobile in Poarch, Alabama.

The Alabama Department of Mental Health (ADMH) does not currently have ties with the Poarch Band of Creek Indians but understands the significance and value of pursuing such. Unsuccessful attempts have been made to establish and implement a relationship that would enable regular, meaningful, government-to-government consultation and collaboration in the areas of planning, operating, and funding substance abuse and mental health services in Alabama.

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

Section IV: Environmental Factors and Plan: 9. Statutory Criterion of MHBG – Required MHBG

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occurring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Community Based Mental Health Services

The services eligible for reimbursement for the adults who are severely mentally ill (SMI) and children and adolescents who are severely emotionally disturbed (SED) throughout the state, via contractual relationships between ADMH and the 310 Boards, are shown below. Many of these service categories apply to both adult and child populations. The contract eligibility criteria specify that funds should be used to serve individuals who cannot afford to pay, are not insured, and who meet the criteria for Serious Mental Illness and Severe Emotional Disturbance as well as those individuals presenting in an emergency situation.

Mental Illness Ambulatory Services

- 1. Intake/Evaluation*
- 2. Diagnostic Testing*
- 3. Individual Counseling/Psychotherapy*
- 4. Group Counseling/Psychotherapy*
- 5. Family Counseling/Psychotherapy*
- 6. Crisis Intervention and Resolution*
- 7. Pre-Hospitalization Screening/Court Screening*
- 8. Physician/Medical Assessment and Treatment (to include telemedicine)*
- 9. Medication Administration*
- 10. Medication Monitoring (Non-Physician)*
- 11. Partial Hospitalization Program (adults only)*
- 12. Adult Intensive Day Treatment*

13. *Adult Rehabilitative Day Program*
14. *Child and Adolescent Mental Illness Day Treatment*
15. *Adult In-Home Intervention*
16. *Child and Adolescent In-Home Intervention*
17. *Assertive Community Treatment (ACT) (adults only)*
18. *Program for Assertive Community Treatment (PACT) (adults only)*
19. *Mental Illness Basic Living Skills*
20. *Psychoeducation/Family Support Education*
21. *Treatment Plan Review*
22. *Mental Health Care Coordination*
23. *Certified Peer Services – Adults*
24. *Certified Peer Services – Youth*
25. *Certified Peer Services – Parents*
26. *Therapeutic Mentoring*
27. *Nursing Assessment and Care*
28. *Psychosocial Rehabilitation Services – Working Environment*

Case Management Services

29. *Case Management – Adults*
30. *Low Intensity Care Coordination – C&A*
31. *High Intensive Care Coordination – C&A*

Residential - Housing

46. *Adult Small Capacity (3 bedroom) Residential Care Home*
47. *Adult Residential Care Home*
48. *Adult Residential Care Home with Specialized Basic Services*
49. *Adult Residential Care Home with Specialized Medical Services*
50. *Adult Residential Care Home with Specialized Behavioral Services*
51. *Adult Therapeutic Group Home*
52. *Child/ Adolescent Residential Care Program*
53. *Child/ Adolescent Residential Care Program – Intensive*
54. *Child/ Adolescent Diagnostic and Evaluation Residential Care Program*
55. *Transitional Age Residential Care Program*
56. *Medication/Observation/Meals (MOM) Program (adults only)*

Residential – Stabilization

- 57. *Intermediate Care Program (adults only)*
- 58. *Crisis Residential Program (adults only)*
- 59. *Psychiatric Assessment Center (adults only)*

Minimum Continuum of Care

Expectations for providing minimum continuum of care services for a community mental health provider or a community mental health center is outlined fully in the Alabama Department of Mental Health Mental Illness Community Programs within the Administrative Code – Chapter 580-2-9, Program Standards. A provider that meets the respective requirements will be issued one of two types of certificates depending upon the number and type of services delivered by the provider.

(a) **Mental Health Services Provider** – A provider may be certified as a Mental Health Services provider if it provides one or more (but not all) of the services as listed below in compliance with the ADMH standards.

- General Outpatient
- Child and Adolescent In-Home Intervention
- Adult In-Home Intervention
- Emergency Services
- Partial Hospitalization Program
- Adult Intensive Day Treatment
- Adult Rehabilitative Day Program
- Child and Adolescent Day Treatment
- Case Management
- Residential Services
- Designated Mental Health Facility
- Consultation And Education
- Assertive Community Treatment
- Program for Assertive Community Treatment
- Child and Adolescent Seclusion and Restraint
- Adult Seclusion and Restraint
- Therapeutic Individualized Rehabilitation Services

(b) **Community Mental Health Center** – A provider will be certified as a Community Mental Health Center (CMHC) if the requirements listed below are met. The requirements are designed to assure that any provider certified as a CMHC provides the array of services defined below either directly or through specific arrangement with another agency/individual to a broad array of recipients in an identified service area without regard to age, race, language of preference, sex, and degree of psychiatric disability. The services must be coordinated in a manner that assures access to inpatient and residential care and to community supports for adults with serious mental illness and children and adolescents severe emotional disturbance.

The provider must provide the following services directly through its employees. In addition to the specific criteria listed below, the provider must also comply with the applicable sections of the program standards for each program element.

- Emergency Services.
- Outpatient Services (to include specialty services for children and elderly),
- Consultation and Education Services,
- Specialty services for persons discharged from an inpatient psychiatric setting and for persons with a serious mental illness/severe emotional disturbance and must include the following:

- Evaluation and medication monitoring by a psychiatrist.
- Outreach capability to provide services to consumers in their usual living situation.
- Provision of case management services in accordance with the program standards either directly or through an arrangement approved by ADMH.
- Screening for admission to state psychiatric hospitals as evidenced by a written agreement with the local 310 Board (if not a 310 Board), relative to coordination of screening petitions for involuntary inpatient commitment for consumers of the CMHC.
- Partial Hospitalization/Intensive Day Treatment/ Rehabilitative Day Program, **and**
- Must provide residential services either directly through its employees or through agreement with other certified providers.

Because Community Mental Health Centers are expected to offer a broad array of services to a demographically and psychiatrically diverse population, the following additional requirements regarding the overall operation of the agency must be met:

- Staff capable of providing specialty outpatient services to children, adolescents, adults, and older adults.
- Should be able to demonstrate community outreach efforts designed to promote access from all age groups with particular emphasis on those who are seriously mentally ill or severely emotionally disturbed.
- The number of recipients both total and by service type and the services provided are acceptable for the time period that the agency has been operational and are roughly proportionate to the number of consumers and types of services provided by agencies similarly certified.
- The provider can demonstrate appropriate response to consumers for whom a petition for involuntary commitment has been issued and/or who have been hospitalized at a state psychiatric hospital.
- At the end of the first year of operation, the agency must have served at least 100 consumers and the services provided should be proportionate to the average of those agencies that are similarly certified.

Child and Adolescent Development of Continuum of Care

The Levels approach to a minimum continuum of care for mental health services delineated in 1985 by the Alabama CASSP Definition Committee and revised in 1998 and 2004 by the Strategic Plan Workgroup provides a sound framework for prioritizing service development and expansion. The structure (by delineating statewide, regional, and local levels) intends to strike a realistic balance between a minimal service set, economy of scale, and fiscal reality. It is assumed that ADMH, in conjunction with the community mental health centers, will not necessarily create and/or operate the total system, but will exhibit the leadership necessary to assure development, effective operation, and coordination. The continuum as envisioned is as follows:

Level I: (Community/County-Based)

Diagnosis and Evaluation (screening)

Intake/Psychosocial Assessment

Outpatient (Individual, Group, Family)

Psychoeducation/Family Support (Consultation, education, training, networking to build a support system)

Level II: (Community/Catchment Area-Based) Diagnosis and Evaluation (comprehensive)

Case Management/Care Coordination

Day Treatment

In-Home Intervention

Child and Adolescent Psychiatric Services

Respite Care Beds

Level IV: (Statewide)

Residential Treatment

Short Term Treatment and Evaluation Program (STTEP)

Private Acute Inpatient Hospitalization

ADMH Psychiatric Adolescent Unit at EAMC

SUPPORT SERVICES

As described earlier, a comprehensive system of community mental health services is being developed for adults with serious mental illness and children and adolescents with serious emotional disturbances. The primary mental health service that ties consumers to other needed services is case management. Case managers, through their assessment of consumer needs, development of comprehensive service plans, and linkage of consumers to needed services through referral, active assistance and advocacy, and monitoring of service utilization, are responsible for assuring access to the broad range of needed community services.

Consumer outcome research conducted as part of the program evaluations of demonstration case management programs for adult SMI, homeless SMI, and SED children and adolescents in the state have all found case managers to be successful in significantly increasing the use of the broad range of services needed by consumers. Research results also suggest that the level of functioning of consumers increased with the increased use of services. These outcomes suggest that increased participation in a variety of needed services not only improve the quality of life of consumers but can also increase the adaptive functioning of consumers in areas of everyday life that are critical to their community tenure. The following are the types of housing, health, rehabilitation, employment, education, medical, dental, and support services that, in addition to mental health services described earlier, are needed in order for consumers to function in their home communities.

Housing Services

Housing is one of the State’s critical gaps. It is the ADMH’s goal that “all services will be provided from a person-centered treatment planning perspective driven by family and consumer needs and ds that consumers will receive, not only high quality treatment services, but the necessary supports to achieve independent living in safe and decent housing, employment or a sense of purpose, , and inclusion through meaningful social interactions with friends, family, and the community.”

Alabama is the sixth poorest state in the nation with a population of 4.86 million (2016 Census estimate). Nearly 1 in 6 Alabamians live below the federal poverty line as cited in the Poverty and Shared Households by State: (2011 American Community Survey Briefs). The availability of safe and affordable housing remains a challenge for consumers with mental illness and limited or no income. According to the National Low-Income Housing Coalition 2017 State Housing Profile, Alabama has a shortage of over 69,000 available and affordable rental homes for extremely low-income earners with 65% spending more than half of their income. “Severely cost burdened poor households are more likely than other renters to sacrifice other necessities like healthy food and healthcare to pay the rent, and to experience unstable housing situations like evictions.”

The 2017 Out of Reach report indicates that an individual relying on federal SSI in 2017 can afford monthly rent of no more than \$221. About 8.3 million individuals receive SSI nationwide because they are elderly, blind, or have another disability, and have few other economic resources (*2014 Out of Reach Report*).

ADMH conducted a housing needs analysis in 2007 and in 2015. A statewide supportive housing plan was developed in 2007 and updated in 2015 through the efforts of two housing expert consultants. Building upon this foundational work, in 2017, ADMH secured the services of Navigant Consulting and the Technical Assistance Collaborative (TAC) to assist with launching a comprehensive strategic planning process to update the 2015 Alabama Supportive Housing Plan. Over the course of a year, Navigant and TAC facilitated a strategic planning process that organized and convened key stakeholders to develop an updated plan. The processes to draft the plan included: 1) Convening a Housing Leadership Group and stakeholder workgroups; 2) Conducting a permanent supportive housing (PSH) gaps analysis by interviewing stakeholders and reviewing critical documents; and 3) Holding consumer focus groups.

The Housing Leadership Group and four workgroups (two focused on housing and two focused on services) met regularly from October 2017 to February 2018 to discuss key issues and formulate the goals and objectives. Workgroup members included but were not limited to representatives from ADMH, Alabama Medicaid, Alabama Housing Finance Authority, community mental health centers (CMHCs) and other mental health service providers, facility services providers, mental health services advocacy organizations, peer services organizations, Continuums of Care (CoCs), Public Housing Authorities (PHAs), various housing associations such as the Low Income Housing Coalition (LIHC) and Alabama Department of Economic and Community Affairs (ADECA), and family and consumer representatives.

A gaps analysis was conducted to project the unmet need for PSH units for persons with a serious mental illness. Findings from this analysis show a shortfall of 2,246 (low-end estimate) to 3,134 (high-end estimate) of community-based housing for persons in the ADMH targeted and eligible population including needs for PSH. (*The Executive Summary for the full Alabama Permanent Supportive Housing Plan can be found in the attachments*)

The Low-Income Housing Coalition of Alabama (LIHCA) is a statewide coalition consisting of housing advocates, elected officials, banking institutions, nonprofit service providers, legal services groups, and low-income persons and whose mission is to increase housing opportunities for individuals with the greatest financial need. In 2017, LIHCA and the Alabama Alliance to End Homelessness (ALEHA) merged. This merger allows for one unified voice to advocate on behalf of affordable housing and services for the homelessness. LIHCA released [LIHCA's 2016 Red Book](#) which includes a series of county housing profiles identifying housing affordability, housing availability, number of homeowners/renters, available housing units and various community, household, and special needs factors. The special needs category includes the number of individuals living with a disability, HIV/AIDs, and serious mental illness.

LIHCA observed that Alabama has historically relied solely on federal funding for the development of affordable housing and that public funding is critical for the future development of affordable housing. LIHCA advocated for passage of the National Housing Trust Fund and campaigned for the establishment of an Alabama Housing Trust Fund. In May 2012, House Bill 110 established a state housing trust fund. This trust fund is meant to be a flexible source of funding for use in developing and maintaining safe and decent rental and ownership options for families, elderly, persons with disabilities, and others who cannot afford housing. However, Alabama is one of six states to have created housing trust funds legislatively but do not currently have public revenues committed to the funds.

Due to stigma and limited housing options available for citizens with serious mental illness, especially those with limited or no income transitioning from institutions or from homelessness, ADMH has historically relied on expansion of housing programs within its' own continuum of care in an attempt to meet this need. Currently, ADMH contracts roughly 49.7 million dollars with the community mental health provider network to provide approximately 2,808 beds for various living arrangements for adults such as group homes, semi-independent apartments and supportive housing. Comparisons of 2007 MICRS data to 2019, reveals significant changes in the number and type of community living alternatives for persons with mental illness to include those who are homeless. Although some types of housing programs used within the mental

health continuum, such as foster homes and therapeutic group homes, have decreased, overall housing programs have increased by 37.2%. This represents an increase by 760 community beds of various types. Most notably, evidence-based permanent supportive housing, first adopted in 2007, increased significantly in 2013. To date, there are 324 permanent supportive housing units in operation consistent with the evidence-based model. The original 108 pilot units are directly supported by ADMH funds. The remaining numbers of units are supported by “bridge funds” obtained from the 2009 downsizing project and, most recently, the hospital closure project in which funds used to support hospitals were transferred to expand community services. Even with this effort, housing opportunities fall short of the projected numbers estimated to meet the needs of our consumer populations.

Additionally, ADMH continues to maintain \$250,000 Housing Support Funds, available statewide for mental health providers to use in order to assist consumers with obtaining and maintaining more independent and stable housing.

ADMH continues a partnership with the Alabama Housing Finance Authority (AHFA) to focus attention on the housing needs of persons ADMH serves. AHFA established HOME and Low-Income Tax Credit 477 set-aside units with reduced rental rates. Housing is also available at reduced rental rates through USDA Farmers Home developments. A Housing Advocate employed by ADMH works to ensure that priority for vacancies as they develop are given to individuals with serious mental illness, developmental disabilities, or substance abuse disorders. In February 2011, a new program, Hardest Hit Alabama (HHA), provided \$162 million to the Alabama Housing Finance Authority to assist Alabama's unemployed homeowners in the prevention of foreclosures. This program was considered an important step in the prevention of homelessness due to widespread unemployment and risk of foreclosures in Alabama.

HUD remains a dedicated supporter to ADMH. In 2011, upon hearing of the plan to close state facilities, the Alabama HUD Field Office located in Birmingham extended an offer to assist ADMH in efforts to transition persons from institutions. As a result, a series of meetings transpired with key leadership from HUD, Fair Housing, and Public Housing Authorities. In March 2012, ADMH participated in HUD’s Community Planning and Development Statewide panel discussion as a first step of many to create a framework from which to build collaborations at a local level as well as state level. ADMH is the grantee for two HUD Sponsor-based Rental Assistance Programs (legacy Shelter plus Care grants), the first of which has been longstanding within the urban area of Mobile. The FY18 annual performance report for Mobile demonstrated 51 homeless individuals were served. In 2011, ADMH was awarded rural based Shelter plus Care grant allowing rural based mental health providers the opportunity to expand housing in their rural service area. The FY18 annual performance report for this project demonstrated 5 individuals served.

Collaborative Solutions, Inc. (CSI), an approved technical assistance consultant of the Alabama HUD Field Office. ADMH has partnered with CSI to pursue Rural Housing and Economic Development (RHED) grants. CSI is the state lead for Rural Supportive Housing Initiative (RSHI) and established Peer Networks as a way to link emerging community-based organizations interested in the provision of supportive housing with experienced supportive housing developers. Through the Peer Network, CSI provides the leadership, support, and training necessary to help providers address the affordable housing challenges in their communities.

As part of the overall Housing initiative, it is anticipated that a small number of housing units may be identified and developed to assist with transition services from child and adolescent services to adult services (17-22 years of age). Due to the unique developmental, social, and educational/vocational needs of the 17–22-year-old consumer population, it makes sense to offer residential services that are designed to address these needs programmatically.

ADMH service delivery system recognizes adults at 18 years of age. A consumer is eligible for all adult services if they also meet the SMI criteria. At present, there is a gap in the service delivery system around residential and day treatment needs. This appears to be not one of eligibility on the part of the young consumer, but rather a perceived inappropriateness based on the developmental issues of each consumer population. This transitional population (17 – 22) presents with additional challenges regarding legal status. Often these consumers may be under the jurisdiction of a juvenile court until they are 21, or in the legal custody of the Department of Human Resources. System wide

accommodation will take some time. Until then, consumers who have needs greater than outpatient and case management are handled on an individual basis.

ADMH acknowledges the lack of adequate affordable housing stock for Alabama residents and the need for a statewide policy and strategy to address this issue. ADMH representatives will continue to work in all venues to access new housing resources for individuals we serve.

Transitional Age Service

An emerging issue for child and adolescent mental health services is the unique unmet needs of those adolescents transitioning from the child mental health system and entering the very different adult mental health system. To better address these needs, a work group was developed by the Child and Adolescent Task Force, which included adult advocates and mental health professional and planners from adult services. In FY07, recommendations were made by this workgroup, adopted by the Child and Adolescent Task Force, and approved by the Mental Illness Coordinating Sub-Committee to RFP for a Transitional Age Group Home, a Transitional Age In-Home team, and a Transitional Age Case Manager, all within a Pilot Demonstration Site. These services were operational by fall 2008. The workgroup continued its efforts on the development of parameters for the Transitional Age Supporting Housing Model and other outpatient/community based Transitional services. In FY09, due to budget cuts, the Transitional Age Supported Housing project lost its funding. Based on these models, the information was utilized to develop standards around Transitional Age Residential and standards were incorporated in the revised MI Certification Standards that became effective in October 2010.

Medical, Dental, and Health Services

For consumers who are Medicaid or Medicare eligible, almost every type of medical care is provided. Very often the only barrier to service is finding providers who serve Medicaid consumers. Other, non-Medicaid eligible clients have typically exhausted health care resources such as insurance, and must rely on health care available in their community on an indigent basis. Typically, local Public Health departments and community health clinics are the main referral resources used by case managers to meet the primary health care needs of their consumers. Local hospitals provide a very limited amount of inpatient care to indigent consumers. Because of historical practices among indigent consumers, many emergency rooms provide the only primary health care some consumers get. Individuals with mental illness have wrestled with the health care issue for years and in general this is one of the few areas where children and adolescents fare better than the adults. For example, Medicaid benefits for persons under 21 can exceed usual limits when indicated by the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. Children and adolescents in the care of DHR and DYS receive medical care from these agencies, as well as through school nurses where available. In addition to coverage by Medicaid, dental services are covered by AllKids, Alabama's SCHIP program.

The importance of improving coordination and collaboration with primary medical providers is underscored by the finding that persons with mental illness die on the average 25 years earlier than the general population, due in large part to un- or under-treated primary medical conditions. ADMH received a Transformation Transfer Initiative Grant in FY08 and in FY10 to support efforts to improve integration of primary and mental health care. The following partners were convened to assist in planning grant activities: Alabama Medicaid Agency, Department of Public Health, Alabama Hospital Association, Alabama Academy of Family Physicians, Alabama Primary Health Care Association and American Academy of Pediatrics – Alabama Chapter. In FY08 ten regional meetings were conducted to obtain ideas from both primary and mental health providers relative to barriers and opportunities to improve collaboration. The findings from the regional meetings provided the foundation for the efforts funded in FY10. There are three elements to the current grant: 1) expert panels of physicians to discuss their perspectives on collaboration; 2) provide grants to six areas to develop written plans for improving collaboration locally; and 3) support for the Child and Adolescent Psychiatric Institute focusing on primary care collaboration.

Consumers who are in state hospitals are provided medical care as part of their involuntary confinement where there is no insurance or other source of coverage for medical expenses. The state hospitals became tobacco-free on January 1, 2010. Consumers who have no health insurance and who reside in ADMH community residential programs have minor medical services paid by the provider. There is a limited statewide fund for residents of foster homes to pay for incidental medical expenses when there is no other source of revenue.

Most of the adults with serious mental illness and youth with serious emotional disturbances have Medicaid coverage for medical and dental services. However, it is a challenge to find providers in some areas who will accept Medicaid. Case managers provide a vital service by linking consumers to individual practitioners who will accept Medicaid or who will agree to see consumers on a sliding scale or no fee basis. Community mental health providers routinely receive training in universal precautions. Consumers in day treatment and residential programs receive health education on general nutrition, personal hygiene, exercise, and healthy lifestyle, as well as receiving health monitoring and general health advice from staff nurses. Individuals in outpatient, day treatment, and residential services who are also receiving medication services routinely have vital signs monitored with referrals for necessary medical care. Recommendations for routine health screenings are incorporated in all services. Community resources such as health fairs, free blood pressure checks, flu vaccines, etc. are utilized when available. Additionally, people are referred to school health nurses, public health clinics and Federally Qualified Health Centers, as appropriate and when available. Administration of medications prescribed by community mental health psychiatrists is coordinated with school personnel.

Access to dental care is often cited as an unmet need for consumers. The University of Alabama in Birmingham School of Dentistry also provides free clinics around the state. The waiting list for these clinics is very long. Case managers assist consumers in getting on the waiting list for any available free clinics. In some areas of the state, local dentists volunteer time for free clinics. Again, the amount of time and the range of services are limited.

In recognition of the 25 year earlier mortality rate and health disparities suffered by individuals with serious mental illness disorders, ADMH has promoted health and wellness education activities. During the last several years, the annual Alabama Institute for Recovery has provided a platform for conducting wellness screenings for a significant sample of consumers in attendance from all over the state. The 2018 Alabama Institute for Recovery had approximately 97 consumers to participate in these voluntary screenings. Screening methods included checking blood pressure for hypertension, body mass index for obesity, and blood glucose for diabetes. Due to restrictions in funding, no lipid tests were conducted to check for high cholesterol. ADMH acknowledges that the prevalence of current cigarette smoking was recently reported as 28.0% among persons with any mental illness and 18.4% among those without mental illness. Previous research has shown that people with mental illness are not only more likely to smoke, but they also smoke more frequently than people with no mental illness. Again, this year, the Fagerstrom Index was utilized to screen for nicotine dependence. Screenings were provided in partnership with Pfizer. The results of the screenings show a high degree of comorbidity with diabetes, obesity, and hypertension. Health information and smoking cessation information was disseminated at this event.

Evidence-Based Practices

Evidence-based practices utilized in in Alabama are described below:

Assertive Community Treatment (ACT) and the Program for Assertive Community Treatment (PACT)

ACT and PACT have served as a critical element in the diversion of adults considered to be at high risk for readmission to a state psychiatric facility. Alabama began developing ACT and PACT services in 2001. The model used is based upon the principles of PACT as outlined in the SAMHSA Toolkit. However, when the model was adopted, the ADMH EBP Workgroup modified the national model to focus on mental health services using primarily a three member team in addition to a part-time psychiatrist. Mental Illness Program Standards require that the 3 full-time equivalent positions include at least 1 full-time master's level clinician, at least one half time registered nurse or licensed practical nurse, and one fulltime case manager. The remaining half-time position could be filled at the agency's discretion by a master's level clinician, a nurse, or a case manager. The Substance Abuse Division (SA) funds SA treatment specialists for 5 of Assertive Community Treatment (ACT) Teams. The role of this specialist is to provide both direct services and expert guidance in how other

team members can improve skills in the recognition of and treatment for substance abuse disorders. There are currently 16 certified ACT and 2 certified PACT programs in operation. For the consumer to staff ratio for the modified team is 1:12. The size of the team was based on the minimum necessary to meet the treatment and support needs of consumers while maintaining conformance to the core principles. Given the predominantly rural nature of the State, there are few areas that could support a full fidelity PACT team costing approximately \$1 Million per year. The two PACT teams are currently located in our most urban city, Birmingham.

Illness Management and Recovery (IMR)

The University of Alabama Department of Psychiatry and Behavioral Neurobiology submitted the winning proposal to be a Center of Excellence to assist ADMH to implement evidence-based practices for adults with serious mental illness. The Alabama Institute for Mental Health Services (AIMHS) was created and provided training and monitoring for eight pilot sites on implementation of Illness Management and Recovery (IMR). The trainer, Patricia Scheifler, is a national expert. For a variety of reasons, the contract for the Center of Excellence was not renewed in FY10. ADMH did not have the capability to continue the training and monitoring necessary to assure acceptable fidelity to the model. For that reason, IMR services are not reported.

Permanent Supportive Housing (PSH)

As stated previously, housing continues to remain a critical gap. As a means to offer housing opportunities in a manner most in keeping with the latest evidence for best housing practices and to foster community integration, ADMH dedicated funding to support the development of evidence-based housing projects. In FY08, nine pilot sites were selected to implement Permanent Supportive Housing (PSH) projects creating housing capacity of this type by 108 beds. Additional projects have become operational as a result of the community service expansion efforts of the downsizing and closure projects resulting in a total of 324 Permanent Supportive Housing beds.

Supported Employment: Individual Placement and Supports

Employment services for consumers are not well developed within the mental illness service milieu and are identified as a system weakness. In 2018, ADMH served a total of 104,642 people statewide through community programs. Of that number 72,232 were adults and 32,410 were children and adolescents. Out of the adult population, 12.7% were employed, 21% unemployed, and 66.3% were not in the labor force due to a disability or other reasons. Individuals receiving mental health services who also reported being employed full time dropped from 8,049 in 2007. Compared to 4,578 in 2014, that represents a 43% reduction in full time employment. Consumers experiencing full-time employment in FY18 were reported at 5,912 falling short of those reported prior to the recession. The Office of MI Community Programs recognizes unemployment in the general population correlates with illness, substance abuse, domestic violence, lack of social connection, and other adverse outcomes.

ADMH and the Alabama Department of Rehabilitation Services (ADRS) have forged a longstanding collaboration to serve disabled populations. ADMH and ADRS jointly applied for the Substance Abuse Mental Health Services Administration (SAMHSA) *Supported Employment: Transforming Lives* grant. Alabama was one of seven states awarded in FY14. This 5-year grant provides an opportunity to implement evidence-based supported employment services. The program goal is to prioritize and offer full access to employment through Individual Placement and Support services for people who do not benefit from traditional vocational services. Key partners include Westat Institute, the Auburn Center for Disability Research and Services, and ADRS. Representatives from AL Medicaid actively participate on the statewide steering committee and leadership workgroups.

MICP's carefully weighed the selection of project locations. Given that over 50% of Alabama's population lives in rural counties, the inclusion of a rural location was prioritized. Grants funds supported two pilot locations: AltaPointe Health Systems (urban Mobile) and Chilton-Shelby Mental Health Center (rural). The project was expanded to a a third site: Montgomery Area Mental Health Authority. Services were initiated in October 2015 for the initial sites and February 2018 for the expansion site. The two original pilot locations achieved *Exemplary Fidelity*, while the expansion site earned *Good Fidelity*. The IPS Employment Center's 25 Item Fidelity Scale is used to evaluate the programs adherence to the evidence-based practice and support of the eight (8) practice principles of IPS.

Grant activities include 1) establishing a statewide steering committee - Supported Employment Coordinating Committee (SECC) tasked with overseeing the implementation of IPS programs throughout the state, coordinating cross-agency collaborations, providing guidance to IPS policy development, and creating a financial plan to ensure sustainability; 2) creating a comprehensive IPS Supported Employment Training and Technical Assistance Program using in-person and virtual platforms; 3) implementing high fidelity IPS programs in two pilot communities, providing access to IPS for at least 450 consumers over the 5-year period, providing benefits counseling, using certified peer support specialists to engage underserved populations; and 4) Outreach to Veterans in the State of Alabama to ensure all veterans in need of mental health services who prefer to seek treatment at local community mental health centers have the opportunity to participate in IPS service from an Alabama community mental health provider. Project goals were exceeded with the addition of an expansion site and numbers served. As of June 30, 2019, a total of 501 individuals with serious mental illness have been served by IPS programs. Over 46% enrollees were employed in competitive, integrated settings and six percent were enrolled in educational programs.

As a result of the grant, state-level infrastructure was developed to support the project. ADMH established a dedicated state trainer/coordinator position. This position serves as a statewide resource for IPS implementation and is a key member of the leadership team focusing on sustainability planning. Three ADMH state-level staff have been trained as IPS fidelity reviewers. ADRS dedicated state level staff to provide leadership and support.

The Supported Employment Coordinating Committee (SECC) was established and composed multiple stakeholders to include ADRS partners, State Medicaid, Labor, statewide Peer organizations, and others. Through the dedication and work of the SECC and SECC workgroups, the following benchmarks were accomplished:

- SECC Strategic Plan developed,
- SECC IPS Marketing Plan drafted,
- ADMH IPS Reporting Codes and Service Definitions created and implemented,
- IPS Funding Crosswalk and Service Gap Analysis document drafted,
- IPS Sustainability Plan was drafted,
- A Statewide Shared Data Platform designed for ADMH, ADRS, and Alabama Medicaid data matching of shared clients across systems,
- Making a Business Case document drafted (Auburn University Collaboration)

To supplement the work of the SECC, MICP's applied for and was awarded the office of Disability Employment Policy (ODEP) Vision Quest Technical Assistance. Technical Assistance was provided in the form of access to 100 hours of time from Subject Matter Experts (SME's), Dr. Virginia Selleck and Joe Marrone, for the purposes of developing a short-term sustainability plan for the AL-IPS-SEP project. The "Bridge MOU" exemplifies the level of commitment and collaboration from the ADMH, ADRS, and IPS provider leadership. Not only does the MOU specify shared costs for the current IPS programs but promotes the alignment of ADMH and ADRS policies and practices to support IPS.

Prior to the award of the SAMHSA Supported Employment grant described above, little had been achieved in the way of developing employment services within the mental health system outside of limited funds dedicated to support the employment of certified peer specialists (CPS) within the provider network. Traditionally community mental health programs focus on job readiness training and referrals to Vocational Rehabilitative Services. Due to the lack of a devoted funding source, the means for offering evidence-based Supported Employment services as a vehicle to obtain competitive employment statewide remains undeveloped.

ADMH has been able to establish a framework from which to foster employment-based services. In FY11, ADMH received an Employment Development Initiative (EDI) grant which initiated preliminary supported employment planning activities. EDI funds supported Train the Trainer technical assistance for the end purpose of creating the capacity to conduct its in-state Certified Peer Support Specialist Training. Sponsored by EDI grant funds, experts on the **Individual Placement and Support (IPS) supported employment evidence-based** model served as keynote speakers at the EDI grant sponsored

Alabama's Supported Employment kick-off event in 2011. These initial activities have uniquely positioned MI Community Programs to foster a relationship with Dartmouth IPS Supported Employment Center. Dartmouth, now Westat, continues to provide guidance to Alabama through the IPS Learning Community and as the technical assistance provider for the SAMHSA Supported Employment grant previously described.

Within ADMH, the Division of Mental Health and Substance Abuse works closely with the Developmental Disabilities Division, which houses an employment coordinator who works primarily towards the development and expansion of integrated employment programs for the Intellectually Disabled population. Through cross Division collaboration, staff and providers within MI Community Programs are invited to access employment focused resources and training events spearheaded by the ID Division.

To affect state policy, ADMH collaborated with other state agencies to submit an Employment First Bill. The bill was introduced in the 2013 legislative session and again in 2014. Although the bill was well received, failed to reach the floor for vote. The Employment First Bill will affix "employment" as a legislatively affirmed priority. The passing of this bill will be viewed as a turning point in shaping state driven policy and funding mechanisms necessary to spark a transmutation in traditional services systems. Stakeholders continue to attempt to address concerns from some providers around employment as a priority. ODEP technical assistance has further supported the movement towards employment as a priority guiding the development of an executive order. Consumer, family, and provider input are being sought.

Consumer Operated Services

Consumer driven recovery, such as consumer run drop-in centers and support groups are seen as essential elements of the continuum of care, but these services are not covered in ADMH's contract with community mental health centers. The Block Grant is used to support the development of consumer-operated services as well as the annual consumer conference. There are four operational drop-in centers serving on average an approximate total of 101 consumers on any given day. Within the state, there are 2 statewide consumer organizations, and 16 NAMI connection groups. The reduction in statewide consumer organizations was a result of a merger between the Alabama Peer Specialist Association (APSA) and Wings Across Alabama.

Certified Peer Specialists

ADMH has long valued the power of peers to support fellow consumers and promote recovery. ADMH first established the position of peer support specialist in 1994 at Greil Hospital and later expanded the program to all state facilities. In 2008 provisions were made to expand peer support services to the community provider network. Funding cuts restricted full expansion of peer services to every provider agency; however, due to the 2011 efforts of shifting hospital funds to community services, peer support services has once more found an opportunity to flourish. Not only has the movement towards peer services lead to the credentialing requirements for the certification of peer specialists, but it has evolved in the creation of specialty peer specialists training such as peer bridge services and peer specialists funded to assist in promoting health and wellness for consumers with chronic physical illnesses in addition to serious and persistent mental illness. Efforts to secure Medicaid funding for this service was successful as a Medicaid Rehab Option State Plan Amendment (SPA) was approved in October 2018. Current efforts are underway for implementation of Certified Peer Services in the specialty areas of Adults, Youth, and Youth Parents.

Currently there are 66 certified peer specialists employed at community mental health centers with 11 employed who are awaiting certification training, two located at state hospitals, and 16 others serving in mental health related positions, including 8 employed by mental health consumer and family organizations. Several previously employed specialists used their knowledge, experience, and skill gained from CPS training and employment to enhance their prospects and obtain higher paying positions outside of the mental health realm or to return to college.

ADMH is expanding opportunities for Certified Peer Specialists, especially with Youth Certified Peer Specialists. Jefferson, Blount, St. Clair Mental Health Authority (JBS), Hill Crest Hospital in Birmingham and ADMH piloted a project providing

peer support for adolescent girls in a C&A psychiatric residential treatment facility. JBS has also established an Urgent Care Center incorporating the use of Certified Peer Specialists.

ADMH has contracted with three Supported Employment IPS sites. These are Chilton Shelby Mental Health in Calera, AltaPointe in Mobile, and Montgomery Area Mental Health Authority in Montgomery. Each team is required to include Certified Peer Specialists. ADMH has also contracted with JBS Mental Health Authority in Birmingham for a First Episode Psychosis (FEP) team. The FEP teams are required to include Certified Peer Specialists – Youth and Certified Peer Specialists – Parents.

Adults served by Evidence-Based Practices/Best Practices are outlined in the following grid:

Evidence Based Practice/Best Practice:	Estimated Number Served in FY18
Assertive Community Treatment	981
Family Psychoeducation	0
Illness Management and Recovery	0
Individual Placement and Support (IPS) -Supported Employment	248
Integrated Treatment for Co-occurring Disorders (MH/SA) *	0
Medication Management	0
Permanent Supportive Housing	293
Peer Support Services**	202

*There are four programs that identify themselves as specifically treating individuals with co-occurring disorders. Mental health centers address the co-occurring treatment needs of consumers through parallel and sequential mental illness and substance abuse services, but largely not in programs that would meet fidelity measures for co-occurring treatment.

**Although ADMH created reportable activity codes to capture the services provided by CPS/Peer Bridger’s, the number reported does not accurately reflect the actual number served and is only representative of peer activities at two mental health organizations. Eighteen community mental health centers are providing peer support services. At present, there is no incentive to report individual episodes of peer services since no reimbursement mechanism exists. The Office of Consumer and Ex-patient Relations estimates numbers served at a much higher rate than those reported in the grid above.

C&A EBPS

In regard to children and adolescents, a number of evidence-based practices (EBP) have been under consideration in Alabama. The Core Performance Indicators include Therapeutic Foster Care as one of the required EBPs for Uniform Reporting System requirements. In Alabama, Therapeutic Foster Care is funded and licensed by child welfare, the Department of Human Resources (DHR). Because ADMH cannot regulate or monitor these services, there are no goals listed below related to it. It is important to note that DHR has contracted with a Multi-Systemic Therapy (MST) provider in several areas in Alabama and DYS has contracted with a MST provider in one region. Funding services that have been demonstrated to be effective were considered by ADMH. In FY06 and FY07, the C&A EBP Workgroup worked toward formal recommendations regarding the selection and implementation of appropriate evidence-based practices. In FY07, the EBP workgroup recommended the following: Cognitive Behavior Therapy (CBT) in the form of developed models be considered for implementation. One such CBT model recommended by the workgroup was Coping Power. The EBP workgroup also recommended securing outside assistance in any implementation of a child and adolescent focused EBP and that a Center of Excellence be considered for the request for proposal process similar to the course of action currently being incorporated by ADMH with the adult SAMHSA Toolkits (this Center of Excellence no longer exists). The EBP

workgroup further recommended that C&A In-Home Intervention be evaluated/assessed by a Center of Excellence as to work toward this service being recognized as a “best practice”. These recommendations were submitted to the Mental Illness Coordinating Sub-Committee. In FY08 and FY09, the EBP workgroup focused on the “A Guide for Selecting and Adopting Evidence-Based Practices for Children and Adolescents with Disruptive Behavior Disorders” Guidelines issued by SAMHSA to assist in making further recommendations on C&A EBP’s. During the same timelines, ADMH was working with NASMHPD on the C&A EBP reporting issues and a National movement to include a New Optional Table to URS for Reporting Child and Youth EBP’s. The first priority of focus for the C&A EBP workgroup and the National workgroup that ADMH was involved was reviewing the EBP’s from the SAMHSA’s Guide which have a specific focus on treatment (versus prevention) and have demonstrated a good level of evidence. From those reviewed, the C&A EBP workgroup identified both prevention and intervention programs to be recommended. These were a smaller list than those being recommended by the NASMHPD workgroup. Because the EBP’s in the SAMHSA’s Guide primarily focused on disruptive behavior disorders, the C&A EBP Workgroup and the NASMHPD Workgroup researched other EBP’s for consideration. The C&A EBP Workgroup identified the other EBP’s for recommendation which mirror the recommendations of the NASMHPD Workgroup. The C&A EBP Workgroup encountered more difficulty around developing implementation strategies for recommended EBP’s. With C&A EBP’s, they are created and owned by an entity, usually a University. So, implementation is based on ability to work with the defined EBP entity. This has to be done with each EBP. For future implementation, the C&A Workgroup recommended to the MI Associate Commissioner the following, as funding permits:

6. Develop an ADMH approved C&A EBP menu that would allow community providers to determine which EBP works best in their community as to provide optimal movement towards transformation.
7. Contact each EBP entity approved and determine all necessary steps for implementation to include, but not limited to, training, ownership of data, certification, and all costs.
8. Consider a Center of Excellence concept similar to what has been implemented with Adult EBP’s. To properly implement C&A EBP’s, a Center of Excellence concept is what has been utilized in other states to effectively and efficiently implement EBP’s due to complex training demands, certification demands, and data/outcome demands.
9. Consider exploring avenues to have C&A In-Home Intervention evaluated/assessed as a service that could be recognized as a “promising practice” or “best practice”. To do this would only be accomplished by either working with a Center of Excellence or University.
10. As funding is the driving force for Implementation, next steps for implementation are even more complicated. Monies would have to be secured to do so either within the ADMH budget, with collaborations with other State Agencies, and/or through grant opportunities.

In FY10, efforts continued to identify and develop opportunities to implement the recommended EBPs. In FY08, ADMH partnered with the University of Alabama (UA) and Dr. John Lochman, creator of Coping Power to apply for a research grant. Dr. Lochman is the Director of the Center for the Prevention of Youth Behavioral Problems on the UA campus. Coping Power is an EBP recognized by SAMHSA. Dr. Lochman applied for a research grant that would partner with community mental health centers in the use of Coping Power. This would be in partnership with UA, ADMH and community mental health centers. The grant was submitted in July 2008 but was not awarded. Collaboration continues to work toward securing funding to demonstrate this EBP. ADMH also participated with the UA in the application of a NIH research grant. This grant opportunity would allow for the gathering of baseline data from mental health providers over a two-year period of time as to assess C&A In-Home Intervention (IHI) services. This baseline data would be utilized as a platform to move toward IHI being recognized as a “promising practice”. The UA, in collaboration with ADMH, applied for this grant in June 2010 but it was not awarded. In October 2010, ADMH received notification that the SAMHSA Child Mental Health Initiative Grant (SOC) application was awarded. This grant application represented a unique opportunity to develop a system of care that would serve children with serious emotional disturbance and their families in a three-county rural community. ADMH contracted with a community mental health center for the implementation with ADMH working closely with this system of care process. After year three of the SOC grant, ECCHO met sustainability. Several EBPs were being considered for implementation within this System of Care (SOC) Grant to include: Wraparound, Coping Power,

Dialectic Behavioral Therapy (DBT), Positive Behavior Support (PBIS), Bright Futures, Assuring Better Child Development (ABCD), and Cognitive Behavior Therapy and Motivational Enhancement Therapy (CBT-MET). Only Coping Power had been initiated for implementation. Meetings have occurred on how to capture the data within the ADMH data system once Coping Power is fully implemented through ECCHCO. In August of 2013, Dr. Lochman at UA applied for a three-year Patient-Centered Outcome Research Institute grant that would partner with ADMH and community mental health centers to train up to 120 mental health clinicians to implement Coping Power and establish Coping Power programs at multiple sites across the state. However, we were not awarded to grant application.

Evidence Based Practice	# Served FY18 Actual	# Served FY19 Actual	# Served FY20 Target
Multi-systemic Therapy	0	0	0
Functional Family Therapy	0	0	0
Therapeutic Foster Care	0	0	0

Child and Adolescent Needs and Strengths (CANS)

Efforts to move toward the use of a state-wide Functional Assessment Tool became a focus of attention of the Child and Adolescent Task Force for several reasons. The use of a functional assessment tool could serve as a uniformed state-wide reporting process that would be a valuable approach for consistently capturing measurable data elements that are comparable. The use of a functional assessment tool would serve as an instrument to drive treatment planning that is individualized, family-centered, and strength-based. The use of a functional assessment tool would provide an avenue to capture data needed to assist with mandatory reporting elements. The use of a functional assessment tool would provide rich data that would enhance grant applications which is highly valuable considering the current state and federal economic conditions. Recommendations were made to the Associate Commissioner to move in this direction and, on October 1, 2010, the Child and Adolescent Needs and Strength (CANS) Functional Assessment Tool was implemented state-wide. The CANS is being used statewide for children and adolescents receiving services through the public mental health system. This transformation tool, consistent with system of care values and principles, focuses on the needs of the children and families. The CANS-Comprehensive provides a common language, objective criteria to support decisions about intervention plans and intensity of services, monitors progress through outcome measures, and supports quality improvement initiatives. Information from the CANS-Comprehensive will support decisions at multiple levels – direct services, supervision, program management, and system management. For community mental health providers, the *CANS for Alabama Comprehensive Multisystem Assessment (5 to Adulthood)* or the *EC-CANS for Alabama Comprehensive Multisystem Assessment (0 to 4 Years)* tools is being utilized. The CANS was developed by John Lyons, PhD, in collaboration with several states’ child serving systems and Dr. Lyons worked directly with ADMH on this venture. Dr. Lyons completed the “Super User” training/certification process in June 2010. Approximately 107 CANS Super Users were trained to support local implementation of the CANS-Comprehensive training, supervision, and integration into everyday practice. Alabama’s mental health public system providers were trained and certified as “Certified CANS Users”. A database, the Alabama Behavioral Health Assessment System (ABHAS), was developed to capture the CANS data and to provide a variety of reports to users at all levels of the child-serving system. ADMH Data Management Division created a web-based application in collaboration with Dr. Lyons to interface with this database, and the ABHAS website was initiated on October 1, 2010. All MI contracted providers have C&A staff trained and a CANS completed on all C&A consumers as of April 1, 2011. In 2013/2014, ADMH moved into an enhancement process for the CANS certification/re-certification process and joined a national consortium to achieve this, The Praed Foundation. By January 2015, all the mental health providers contracted with ADMH were members of the Praed Foundation under the jurisdiction of Alabama. This allowed ADMH to enhance the timeliness of certification/re-certification and the technical guidance that enriches to process of utilizing the

CANS as a multi-purpose tool. In October 2018, the use of the CANS was expanded to include those providers certified through the ADMH Mental Illness Program Standards. At this time, all providers serving children and adolescents through either a contract or certification through ADMH utilize the CANS for treatment planning purposes.

School-Based Mental Health (SBMH) Collaboration

ADMH appreciates a long-standing collaboration with the Alabama State Department of Education (ALSDE) stemming back to 1999. ALSDE is responsible for educational services for children/adolescents in Alabama, and there are over one hundred school systems in the state. For numerous years, case managers, in-home intervention teams, and outpatient clinicians employed by the Community Mental Health Centers (CMHCs) have had frequent contact with the educational system on behalf of children with a serious emotional disturbance and their families. Since 1999, the two agencies have collaborated to blend funds and resources on projects that began with day treatment programs and now extended into an integrated, school based project, School-Based Mental Health (SBMH) Collaboration.

From FY 12 and FY 19 to date, sixteen of the 19 community mental health centers (CMHCs) of Alabama and close to 70 Local Education Authorities (LEAs) have conducted initial orientation meetings describing the SBMH collaborative process. Of these, 16 CMHCs and 60 School Systems have entered into formalized agreements as SBMH Collaboration Partners. The SBMH model improves access to appropriate mental health services by children who need them by placing a Master's level clinician in the school setting in a structured manner that ensures confidentiality while enhancing mental health service delivery. ADMH and ALSDE continue to jointly promote the School Based Mental Health Collaboration across the state and have presented workshops on SBMH at ALSDE's MEGA Conference and Transition Conference in FY 12 and every year thereafter through FY19. SBMH Partner CMHCs and School Systems gathered information to establish School Year 2014-2015 as the "baseline year for SBMH Data. This information is used to analyze the effectiveness of SBMH over subsequent years.

ADMH feels that by implementing this promising practice, a system can be developed that ensures a more preventive effort to integrate a seamless system of mental health care in educational settings. All of this is in an effort to provide treatment that is more holistic and, in a way, to build strength and resiliency for young people personally and with their educational successes. Initially no additional funds were provided to the CMHCs or School Systems to implement this practice. Through the dedication of CMHCs and School Systems to serve students, the initial SBMH Collaboration services were developed with existing limited resources. After the school shooting in Parkland, Florida in February 2018 and with a national focus on increased services in the school setting, the Alabama Legislature appropriated \$500,000 in FY 18. These funds assisted with the expansion to 9 additional School Systems that did not have the resources available to implement SBMH Collaboration services previously. With the continued national focus on providing proactive services in the school, ADMH continues to ask for additional funds to expand this promising practice throughout the State.

First Episode Psychosis (FEP)

ADMH has implemented the First Episode Psychosis (FEP) program, which we reference as NOVA-Alabama. This has required certain training elements in order to meet the fidelity of the model. For specific information regarding collaborative efforts with NOVA, please see Section IV, Environmental Factors and Plan: 4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside - Required MHBG.

Substance Abuse/Co-Occurring Disorders

A major gap in the current system of care for adults and children and adolescents is coordinated care for individuals with co-occurring mental illness and substance abuse problems. Often programs and services are not available due to eligibility rule-outs in their admission criteria, or complex funding requirements may hinder access to coordinated substance abuse and mental health services. As previously discussed, ADMH Administration is dedicated to making positive strides in this area and first steps were taken by combining the Mental Illness and Substance Abuse Divisions. At present within the Mental Health Substance Abuse Services Division, the executive staff works directly and in coordination with each other.

There are several Offices within the Division that address MI/SA/COD such as the Office of Certification, the Office of Deaf Services, and the Office of Performance Improvement. Within all other offices, coordination of care is direct and bi-directional, to include adult and children/adolescents.

One of the major responsibilities of the Office of Children Services was the planning and development of programs and services across ADMH's three divisions: Mental Illness (MI), Developmental Disabilities (DD), and Substance Abuse (SA). The funding, in FY01 and FY02, of a Juvenile Court Liaison for each community mental health center catchment area is an example of an initial effort to improve the service capacity and flexibility in addressing co-occurring disorders. Since the juvenile court is frequently where children and adolescent with co-occurring disorders first enter the system, the Juvenile Court Liaison will assist the court in assessing the individual and make appropriate treatment recommendations. They will also be responsible for linking the youth and their family members to needed services, to include substance abuse services. With changes in the administration in FY12, the Office of Children Services was terminated and the services within that office were distributed to the two service divisions (MHSA and DD). But the integrity of the programs that served co-occurring issues remained intact with processes being developed to maintain their integrity to include the Juvenile Court Liaisons.

For FY16-17, there were not any specific co-occurring initiatives nor are there any taking place this current year. Within the Mental Health Substance Abuse Services Division, the decision was made that Co-occurring programs would fall under the ADMH SA Program Standards. In March 2014, the new substance abuse treatment regulations became fully effective. With this change, all treatment programs are under the certification of ADMH SA Program Standards are now required to be co-occurring capable, as according to the ASAM Criteria. This also makes available rules for programs to obtain a higher level of certification and designation as co-occurring enhanced. The ADMH MHSA Certification team is now surveying programs for compliance with the new rules.

Office of Planning and Resource Development (PRD)

Within ADMH, the Office of Planning and Resource Development (PRD) performs administrative operations associated with planning, coordination, and implementation of ADMH initiatives with providers, consumers, federal, state, and local agencies, and community stakeholders. Within PRD, staff provide support to ADMH Divisions with involvement in strategic planning and executing public information services to include publication, media and website development in emergency management, disaster preparedness, public education, professional development, grant management, administrative policy review, planning procedures, and program initiatives. A month-long Consumer Art Exhibit is also coordinated and held each May at the State Capitol featuring the work of individuals throughout the state.

Alabama Executive Network for Service Members, Veterans and Their Families (AlaVetNet)

ADMH received the SAMHSA Service Members, Veterans and their Families Technical Assistance award, which served as the nucleus for the development of the Alabama Executive Network for Service Members, Veterans and their Families (AlaVetNet). AlaVetNet was established through Executive Order and is co-chaired by the ADMH Commissioner along with the Commissioner of the Alabama Department of Veterans Affairs and Alabama's Adjutant General, Alabama National Guard. AlaVetNet connects Veterans with resources and services tailored to their unique needs. The website, www.alavetnet.alabama.gov, serves as a searchable database of resources allowing Veterans to browse local service providers that fit their needs as well as search for various types of services in the areas they live. The intent is to make it easy for Alabama's Veterans, Service Members, and their families to readily locate benefits and services in a unified, seamless, and systematic way. The work of AlaVetNet is completed through functional teams to address the full-spectrum of the needs of Alabama's Veterans in the following areas: Community Support Services, Education & Research, Employment & Workforce, Family & Youth, Health & Wellbeing, Legal & Justice Initiatives and Strategic Communications.

Emergency Preparedness/Disaster Response Collaboration

ADMH has standing membership with the Alabama Department of Public Health's Functional and Access Needs in Disaster (FAND) Task Force. PRD staff participate in the Alabama Department of Public Health's Medical Needs Shelter and Alabama Department of Human Resources' Mass Care Shelter planning. ADMH additionally participates in the Governor's Mass Sheltering Task Force and avails itself of training and partnering opportunities available through the Alabama Emergency Management Agency, such as participation in Governor Kay Ivey's 2019 Hurricane Table Top Exercise in preparation for the current hurricane season. The Office of Policy and Planning is continuously collaborating with the Governor's Office of Volunteer Services, statewide colleges and universities, and non-profit organizations regarding planning and stakeholder initiatives. Additionally, staff have received Certification in Crisis Counseling Program (Grants Training) for State Mental Health Authorities from the Federal Emergency Management Agency (FEMA) and participated in partnership with the Alabama Voluntary Organizations Active in a Disaster pertaining to the coordination of emergency response, disaster training, and mitigation strategy.

SSI/SSDI Outreach, Access and Recovery (SOAR) Training

PRD coordinates the provision of SSI/SSDI Outreach, Access and Recovery (SOAR) training throughout the state through a SAMHSA technical assistance award. SOAR training is designed to facilitate the acquisition of Social Security Administration (SSA) benefits to individuals with a diagnosis of serious and persistent mental illness (SMI) and/or a co-occurring disorder of SMI and substance use. Training is geared to assist individuals who are homeless, at-risk of homelessness or living in doubled up living arrangements. The HUD Balance of State Continuum of Care, the Alabama Rural Coalition for the Homeless (ARCH), is the recent recipient of a SOAR award to serve 42 rural areas of Alabama.

Alabama Department of Public Health Collaboration

ADMH networks with the Alabama Department of Public Health (ADPH) through regularly scheduled meetings with its Office of Rural and Primary Health Care. The focus of this partnership is to explore and leverage resources to expand behavioral health services and to recruit and retain treatment professionals.

Policy Review and Strategic Planning Initiatives

PRD quarterly reviews ADMH policies, administrative code, and divisional operational guidelines providing updates, revisions, and recommendations for new policy agenda. Staff additionally compose the Executive Budget Office Quarterly (ACTUALS) Performance Reports regarding ADMH targeted populations. Currently, PRD involvement also includes the review of ADMH Stepping Up Request for Proposals for grant award selection, monitoring and renewal of ADMH System for Award Management registration for grant award funding, along with the development and implementation of ADMH Long Range Planning Scoreboards for inter-departmental strategic planning and management. PRD staff have concurrently initiated expansion activities related to the Mental Health First Aid training programs in partnership with organizations and corporations statewide while also participating within the Alabama Department of Public Health's State Child Death Review Team and Alabama's Support Team for Evidence-Based Practices in collaboration with the Alabama Legislative Services Agency.

2. Does your state provide the following services under comprehensive community-based mental health service systems?

- a) Physical Health
 Yes No
- b) Mental Health
 Yes No
- c) Rehabilitation services
 Yes No

Employment services

Yes No

e)

Housing services

Yes No

f)

Educational Services

Yes No

g)

Substance misuse prevention and SUD treatment services

Yes No

h)

Medical and dental services

Yes No

i)

Support services

Yes No

j)

Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)

Yes No

k)

Services for persons with co-occurring M/SUDs

Yes No

Please describe as needed (for example, best practices, service needs, concerns, etc)

Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)

Services are coordinated through several different mechanisms, primarily with a care coordination focus. All consumers served within the community mental health system has a primary professional responsible for the plan of care. This ranges from case managers, In-Home, ACT/PACT, FEP, peer specialists, and specialty program staff. The person-centered treatment planning drives the determination of areas that need care coordination within the mental health system and with partners outside that continuum of care as to ensure our consumers are linked into the system of care in their communities and across the state.

3. Describe your state's case management services

Case Management/Care Coordination

Through the implementation and evaluation of two federal Community Support Program (CSP) grants which provided brokerage type case management services to adults who were seriously mentally ill (1983), and adults who were homeless and seriously mentally ill (1987), and an Office of Substance Abuse Program (OSAP) local demonstration grant which focused on case management to children and adolescents with serious emotional disturbances (1987), the Alabama ADMH was ready in FY88 to begin statewide implementation of case management services. The demonstration grants provided expertise and techniques to organize and deliver effective case management services, as well as staff with the training skills to disseminate the service statewide.

Two events converged to give impetus to the development of case management services in FY88. One was the funding of a CSP systems development grant which provided funding support for training 100 new case managers in the state. The other critical event was the addition of the Targeted Case Management Option to the Alabama Medicaid Plan beginning on October 1, 1988. Optional Targeted Case Management provided a new funding source specifically for services to adults who are seriously mentally ill (SMI), and children and adolescents who have serious emotional disorder (SED).

The mental health centers work with a variety of public and private resources to obtain services and supports needed by SMI and SED consumers in the community. Case Management services are essential to successful maintenance of persons who have SMI and SED in the community. Adult case managers and supervisors are trained either locally through an approved training curriculum or at training sessions provided by Jefferson-Blount-St. Clair Mental Health/Mental Retardation Authority (JBS). All Child and Adolescent case managers and their supervisors are trained through an ADMH and Medicaid approved training curriculum. ADMH contracts with JBS Mental Health Authority to provide these trainings. These sessions held by JBS, to include C&A In-Home Intervention, occur about every two months. The certification standards require successful completion of this training prior to provision of services. In FY18, 9,888 adults and 3,697 children and adolescents had received case management services. Every community mental health center has case management services for adults and children and adolescents.

The following services must be delivered within the Case Management Program:

- i) A systematic determination of the specific human service needs of each consumer.
- j) The development of a systematic consumer coordinated written plan that is developed within 30 days of first face-to-face case management service unless services terminate earlier and that lists the actions necessary to meet the needs of each consumer.
- k) Assisting the consumer through crisis situations and/or arranging for the provision of such assistance by other professional/personal caregivers.
- l) The direct delivery, or the arrangement for, transportation to needed services if the consumer is unable to transport him or herself.
- m) Establishing links between the consumer and service providers or other community resources.
- n) Advocating for and developing access to needed services on the consumer's behalf when the consumer himself is unable to do so alone.
- o) Monitoring of the consumer's access to, linkage with, and usage of necessary community supports as specified in the case plan.
- p) Systematic reevaluation (at 6 months after the original case plan was developed and intervals of 12 months thereafter) of the consumer's human service needs and the consumer's progress toward planned goals so that the established plans can be continued or revised.

Case Management Services must be provided by a staff member with a Bachelor's Degree and who has completed a ADMH approved Case Manager Training Program and infection control training. Case managers who work with consumers who are deaf must complete training focusing on deafness and mental illness by ADMH Office of Deaf Services. Case Management Services for consumers who are deaf or who have limited English proficiency must be provided in a linguistically appropriate manner by staff fluent in the consumer's preferred language, or through the use of a qualified interpreter who achieves at least an Intermediate Plus level on the Sign Language Proficiency Interview. Adult Case Management Services are supervised by either a staff member who has a Master's degree and 2 years of post-master's clinical experience and has successfully completed a ADMH approved case management supervisor training program, or a staff member who has a master's degree which included a clinical practicum, has 2 years of experience as a case manager regardless of whether the experience occurred pre-or-post master's degree, and has successfully completed a ADMH approved case management training program. Child and Adolescent Case Management Services are supervised by a staff member with a Master's Degree and two years of post-Master's clinical experience and who has successfully completed an approved child and adolescent case management training program. Case Managers must possess a current driver's license valid in Alabama. Most Case Management Services and activities will occur on an outreach basis.

4. Describe activities intended to reduce hospitalizations and hospital stays.

Hospitalization

(Downsizing effort for community integration)

Adults

In 1970 Alabama faced a lawsuit, Wyatt vs. Stickney, which brought the “right to treatment” for state psychiatric hospital patients into the foreground. This litigation significantly influenced fundamental changes in architectural features of this States’ mental health service delivery system. Upon the filing of the suit, one of the longest running mental health lawsuit in US history, ADMH started shifting focus from providing mental health treatment within the confines of large- scale institutional walls towards creating a new vision and thus, constructing the foundation necessary for community based mental health treatment. The 1999 Olmstead “integration mandate” decision further inspired the pursuit of building more appropriate and effective mental health service models within the community mental health landscape. As ADMH continues pursuing the development and expansion of new and enhanced community supports, great effort and commitment to reflect the desires of consumer partners and to be guided by the voices of those we serve, remain at the core of its design.

ADMH has moved steadily towards less reliance upon state psychiatric inpatient services by shifting funding to less costly, but more effective community services and supports. Since 1971, the census at Bryce alone dropped from over 5,000 patients to less than 400 in 2004. In order to meet the requirements of the Wyatt settlement, ADMH made provisions to utilize a census reduction model in which the care of individuals housed within the States’ extended care wards would be transferred to the community provider network. Moreover, strides to better serve consumers outside of inpatient settings continued beyond those prompted by the settlement leading to a statewide reduction in hospital census as well as closures of state operated facilities. Through the dedicated efforts of state psychiatric hospitals and community partners, ADMH can boast nearly a 52% statewide reduction in total state psychiatric hospital census from FY09 to June 2015.

In 2007, with the establishment of an appointed taskforce, transferring acute care operations from state hospital admission units to the community was the primary focus. Four regional planning groups composed of consumers, family members, mental health centers, state hospital directors, Probate Judges, and private providers, developed “acute care plans” for the establishment of new services. Increased funding in FY07 and FY08 supported the recommendations of the four regional planning groups specifically to reduce use of state psychiatric hospitals as well as to promote system transformation. Whenever possible, local providers work with hospitals to secure local psychiatric inpatient services for indigent consumers. Probate judges can also make involuntary commitments to local inpatient units or residential programs that request and receive ‘designated mental health facility’ status per the 1991 commitment law. These additions to the service array included purchase of additional local inpatient care, increased psychiatric time, and development of a psychiatric assessment center:

- Inpatient – Twelve centers proposed some type of local inpatient/psychiatric emergency service to increase/enhance local inpatient or acute care services (the Psychiatric Emergency Room proposed for Birmingham was eliminated in FY09 due to budget cuts - it had not opened)
- Residential – 325 new residential beds ranging from apartments to specialized medical homes (24 Supportive Housing units that had not opened were eliminated due to budget cuts)
- Assertive Community Treatment Teams – six new teams
- Community Support Specialists – five positions designed to assist consumers with development of daily living skills
- Adult In-home Intervention Teams – ten new two person teams
- Bridge Teams – two new teams in the Mobile area
- Psychiatric Assessment Center- Montgomery

In 2010, ADMH again pursued the implementation of a census reduction model to address critical overages in state hospitals with a primary focus on Regions 2 and 4. The initial planning for the “Downsizing Project” started during FY09

at which time residents of Bryce and Searcy who were living in Extended Care units or who had a length of stay greater than 90 days were evaluated in order to determine what community services would be needed to promote discharge from the hospital. The evaluation teams were composed of hospital staff, community staff, and advocates. Based on the evaluation and the input of the consumer, community services were proposed to support discharge of these individuals. The planning process continued into FY10 and was incorporated into planning for the sale of Bryce Hospital to the University of Alabama and subsequent construction of a smaller state of the art hospital. Final plans were developed and approved by the Bryce Consumer Transitioning Work Group, the Mental Illness Coordinating Subcommittee, and the Commissioner. Nontraditional financial models were utilized such as incentive and risk bearing contracts based on regional outcomes and performance. The community provider network in Regions 2 and 4 established Board of Supervisor groups for the purposes of promoting service coordination and monitoring of project goals at a regional level. New services began in June 2010 in Region 2 (Bryce) and in August 2010 in Region 4 (Searcy).

The plans included the development of the following community services in the Bryce Hospital area (Region 2):

- 84 Supportive Housing Units
- 60 Medication, Observation, and Meals (MOM) beds
- 30 Augmented existing residential beds
- 12 beds in 3 bed group homes
- Peer Bridger Team
- Clinical Support Team
- Flex Funds for Support

The plans for community services in the Searcy area (Region 4) included the following:

- 60 Supportive Housing Units
- 40 Medication, Observation, and Meals (MOM) beds
- 56 Augmented existing residential beds
- 12 beds in 3 bed group homes
- 16 Assisted Living Beds in scattered sites
- Peer Bridger Team
- Flex Funds for Support

In May 2011, the maximum capacity for Bryce's and Searcy's extended care units were formally reduced further underscoring ADMH's commitment to operate smaller inpatient facilities and shift budgetary funds traditionally from state hospitals, to the expansion of services and supports better constructed to promote independence and inclusion into the community for consumers. As a result of the Downsizing Project, there was a reduction of the census at Bryce Hospital by 116 from a FY09 baseline average daily census of 318 to 202, exceeding the target goal of 222; and a reduction in the census at Searcy by 70 from a baseline average daily census of 351 to 245 exceeding the project target of 255.

In the wake of the above described initiatives, the financial atmosphere of FY11/12 and desire to advance a more responsive system of care prompted an acceleration of ADMH's goals to further reduce the number of acute care psychiatric beds and to bring about the closure of selected state operated facilities. The 2012 Hospital Closure Project resulted in ADMH closures of Greil Memorial Psychiatric Hospital (Montgomery County) August 31, 2012 and Searcy Hospital (Mobile County) October 31, 2012. Collectively, these two hospitals served a total of 1,231 individuals in FY11. Over ninety percent of Greil and Searcy's inpatient capacity has been shifted to local communities. As a means of supporting this shift, an innovative framework for processing inpatient commitments was born from the Hospital Closure Project. The dedicated and unprecedented cooperation between state government, local provider agencies, and local probate courts resulted in a new Department of Mental Health Commitment Procedure specifically for Regions 3 and 4 and for which the success of this project hinged. A pivotal element to the newly established commitment procedure was the development of the Gateway System which permits for the tracking of probate committed individuals to be served

within the community at a Designated Mental Health Facility or Willing Hospital Participant locales. This process allows for ongoing flexibility, customization, and movement within less restricted levels of care outside of state operated institutions.

The plans included the expansion and/or development of the following community services in the Region 3 area (with closure of Greil Hospital):

- Local inpatient psychiatric treatment provided in a hospital setting for either pre/post-commitment care.
- Medication cost provision for indigent population with loss of IDP.
- One ER screening system with partnership between a community mental health center and local hospital.
- Two Crisis Residential treatment facilities (31 beds) to provide psychiatric stabilization treatment in a ADMHF non-hospital setting for either pre/post commitment care.
- Psychiatric access and care
- One probate liaison
- 24 Supportive Housing Units
- 22 Medication, Observation, and Meals (MOM) beds
- 2 Respite beds
- 3 crisis mobile teams

The plans included the expansion and/or development of the following community services in the Region 4 area (with closure of Searcy Hospital):

- Local inpatient psychiatric treatment provided in a hospital setting for either pre/post-commitment care.
- Four Crisis Residential treatment facilities (64 beds) to provide psychiatric stabilization treatment in a ADMHF non-hospital setting for either pre/post commitment care.
- Psychiatric access and care
- 60 Supportive Housing Units
- 25 Medication, Observation, and Meals (MOM) beds
- One Centralized Service system with a community mental health center.

During FY13 and FY 14, ADMH pursued similar efforts for Regions 1 and 2 in which the utilization of community inpatient capacity will supplement or supplant acute care functions at North Alabama Regional Hospital (NARH) and Bryce Memorial Hospital respectively. This initiative is referred to as the “Hospital Repurposing Project.” In FY12, prior to project implementation, NARH, located in Region 1, served 728 individuals with an acute inpatient bed capacity of 74 and Bryce, located in Region 2, served 897 individuals with an acute and extended care inpatient bed capacity of 268.

The Hospital Repurposing Project proposed plans included the expansion and/or development of the following community services for the following Regions:

Region 1 area:

- Local inpatient psychiatric treatment provided in a hospital setting for either pre/post-commitment care.
- Four Crisis Residential treatment facilities (64 beds) to provide psychiatric stabilization treatment in a DMHF non-hospital setting for either pre/post commitment care.
- One augmented residential care home (12 beds)

Region 2 area:

- Local inpatient psychiatric treatment provided in a hospital setting for either pre/post-commitment care.

- Medication cost provision for indigent population with loss of IDP.
- One preventive urgent behavioral health care facility
- 16 beds in a Specialized Medical group home
- 30 beds dedicated to the care of forensic consumers
- 21 beds in 3 bed group homes (15 positioned in Region 1)
- 36 Supportive Housing Units
- 5 crisis mobile teams

On July 20, 2014, patients located at Bryce Psychiatric Hospital were relocated to a new location commonly referred to as the “new Bryce.” The facility was constructed with state-of-the-art design and purpose. Hospital wards were reduced in capacity to allow for increased patient privacy and sense of community. In total, the new hospital operates with a 268 bed capacity. During FY15, ADMH was able to attain another significant milestone with the closure of NARH which occurred on June 17th, 2015.

The accumulative effects of statewide efforts to reduce hospital census is generating significant results. The number of patients in residence at end of the year, the number of admissions/readmission, and the total served by state hospitals all show reductions. In FY09, prior to the implementation of the latest series of census reduction projects, the statewide average daily census for all state operated facilities serving adult geriatric, forensic, extended care, and acute care populations totaled 1,054. Compared to this FY09 baseline end of year average daily census, ADMH reduced the total statewide hospital census in FY12 by nearly 24%, in FY13 by 44%, and in FY14 by 50%. ADMH demonstrated nearly a 52% statewide reduction in total state psychiatric hospital census from FY09 to June 2015.

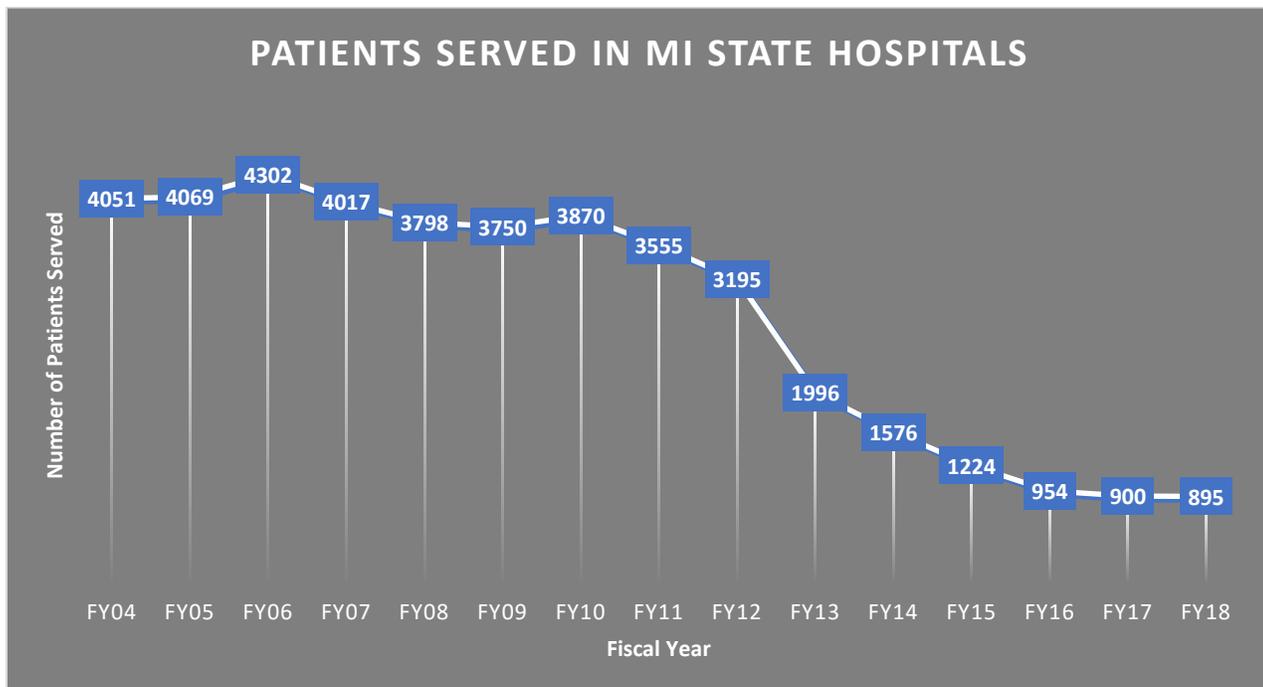
With the closure of three state psychiatric hospitals (Searcy, Greil, and NARH) and the reduction of the footprint of Bryce Psychiatric Hospital, ADMH successfully reduced the number of state psychiatric hospitals to three, with all being located in Tuscaloosa, Alabama. All three are unique in their specialty populations. In 2015, ADMH focused its hospital efforts on expanding the statewide system of care to more closely unite the efforts between community care and hospital care. The importance of including state psychiatric hospitals in the system of care would ensure removing the silo approach and transforming into a more seamless care coordination model with a focus on least restrictive care environments. This process began with the implementation of the DMH Civil Commitment Protocol process. This process was developed to shift the civil commitment system from reactive to proactive. This process requires community providers to become actively engaged with an individual’s care at the time a petition for commitment is filed. Historically, most individuals committed were not known to the community providers and their professional involvement occurred after a DMH commitment and placement in a state psychiatric hospital. The implementation of this new process forced direct involvement with the probate courts and an opportunity for development of a coordination system with the involved parties to include the consumer, family members, private inpatient acute hospitals, jails/detention facilities, nursing homes, etc. It also allowed for diversion of inappropriate commitments linked to social reasons.

Another key component was the development of a centralized admission to state psychiatric hospitals process. The DMH Admission Coordinator (DAC) was implemented and this position was placed in DMH Central Office under the supervision of the Office of Mental Illness Community Programs. This became a bridge position for the system of care. This position ensures the monitoring and linking of movement of committed patients, the renewal of commitments, the securing of clinical summaries, and the release from commitment processes.

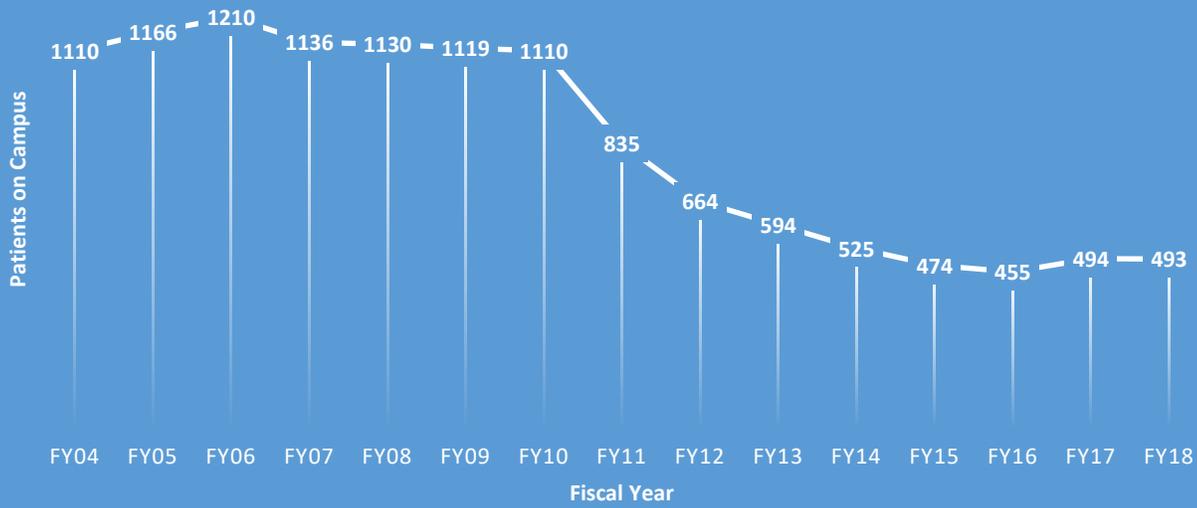
Also, the Gateway web-based system was developed to track a committed patient across the system, whether served in a Designated Mental Health Facility (DMHF) or state psychiatric hospital. This allowed for a shift in the Community Mental Health Center (CMHC) Responsible. Traditionally, this had been the county of commitment. With the implementation of the DMH Civil Commitment Protocol process, this changed to county of residence. With such a shift, it allowed for care coordination to remain with the home county of the committed individual. It also developed a need for CMHCs work bidirectional for utilization of statewide resources and care management.

To ensure the development of a statewide system, in December 2016, a monthly statewide staffing, centered on committed patients in Bryce, was implemented. The monthly staffing is an expansion of the treatment team process. It allows the committed patient’s social worker to staff the case with representatives from every CMHC covering the entire state. The social worker can then bridge the information to the treatment team. This process allows for expanded communication and planning to better ensure security of recommended resources are in place for a smooth transition into the community upon the release from the commitment. This monthly staffing will expand to the two other state hospitals by October 1, 2017. Data is being collected and has shown the specialty populations that exist within the state hospitals. This will provide an opportunity to develop and enhance relationships within our system of care with our providers, as well as outside our system of care such as the areas of nursing homes. Continued efforts will be a focus on re-aligning regional areas, implementing a utilization process within those regions, implementing a utilization process at the time of a commitment, and implementation of a statewide pilot project with a private hospital in the Birmingham area.

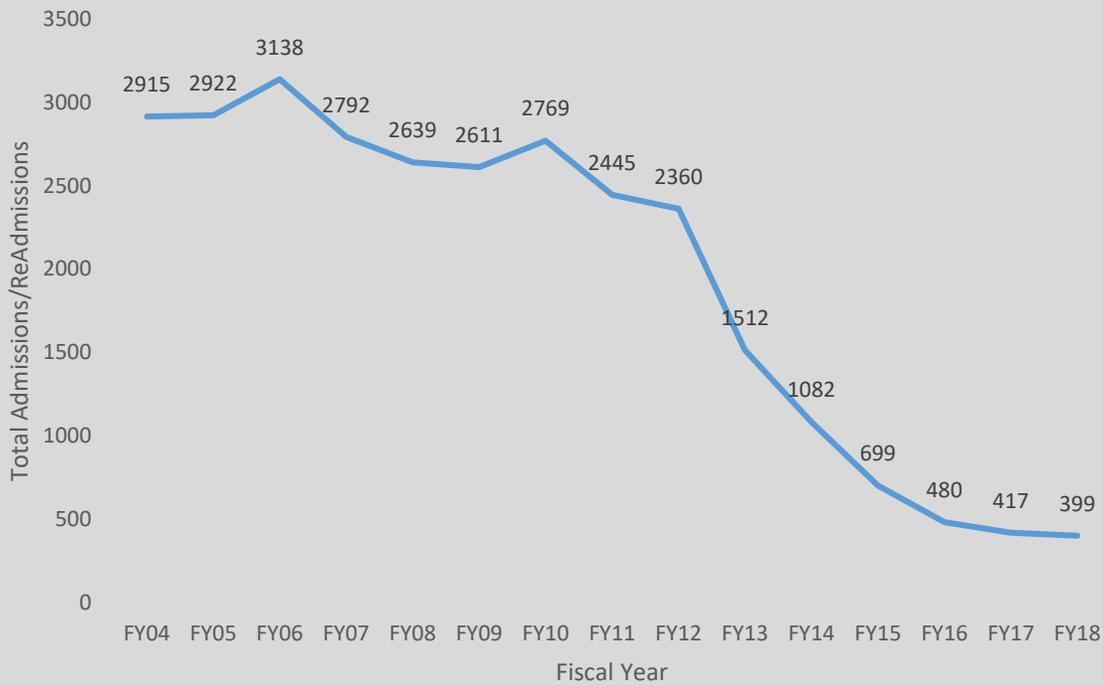
In October 2016, a lawsuit was filed against ADMH alleging that ADMH violated the Plaintiffs Fourteenth Amendment due process rights by failing to provide the Plaintiffs timely competency restoration treatment. The ACLU of Alabama and Alabama Disabilities Advocacy Program (ADAP) filed the lawsuit against ADMH on behalf of three inmates who have been declared incompetent to stand trial due to mental illness. Incompetent and mentally ill inmates transfer to the ADMH, which operates one hospital for patients involved in the criminal justice system, Taylor Hardin Secure Medical Facility. The average wait for a bed at Taylor Hardin has grown to more than eight months, according to the lawsuit. Federal judges have declared waits of more than 14 days to be unconstitutional per ADAP. ADMH worked with ACLU and ADAP to work out a settlement agreement that requires ADMH to meet specified timelines in evaluation and restoration. ADMH developed a DMH Forensic Commitment Protocol Process, which will include entering Forensic committed patients to the Gateway database system, as well as the statewide monthly treatment team staffing process. To meet the criteria outlined in the Forensic Settlement Agreement, ADMH has separated the Forensic Outpatient evaluation process from the work needed within the inpatient setting of Taylor Hardin Secured Medical State Hospital. As part of the Forensic Settlement Agreement, ADMH had to expand the state hospital beds within Taylor Hardin Secured Medical State Hospital by 40 beds which occurred in FY17.



ALL MI PATIENTS AT THE END OF THE FISCAL YEAR



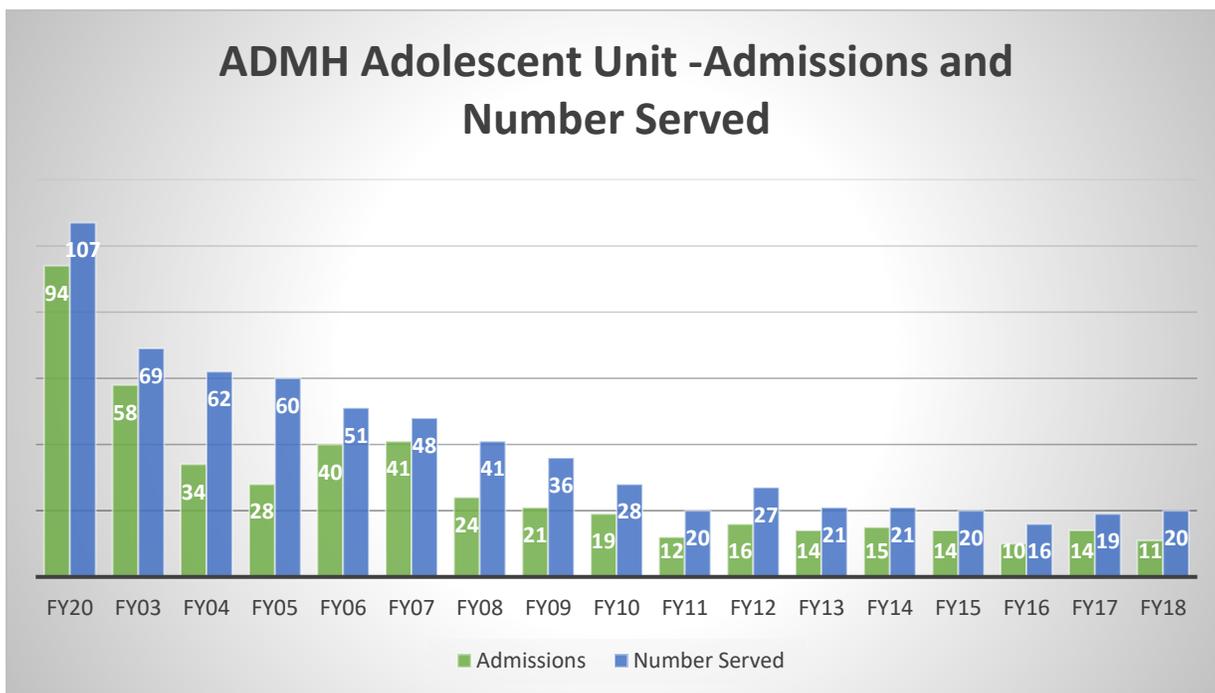
Admissions & Readmissions To MI State Hospitals



ADOLESCENTS

In regard to adolescents, the inpatient beds operated by the Mental Health system in Alabama for adolescents were located at Bryce State Hospital Adolescent Unit serving the state’s child and adolescent population. In March of 2004, the original 40 bed unit for adolescents at Bryce Hospital was reduced to a 20 bed unit. While this reduction was in part a cost saving measure, it was possible because of the significant census reduction experienced by the unit. A total of 19 adolescents were admitted and 28 served at the Adolescent Unit at Bryce Hospital during FY10. This number represented a decrease in total number admitted and in total number served from the previous years. The unit remained below capacity. The ability to keep census below capacity is attributed to the expansion of community services and the development of a service referred to as a Juvenile Court Liaison. Juvenile Court Liaisons work closely with the state child and adolescent services staff, with the sole mission of appropriately diverting mental health and juvenile court commitments in lieu of more appropriate community based services. Children or adolescents are not placed in out-of-state programs by ADMH, Division of Mental Illness and Substance Abuse Services.

During the FY09 legislative session, an amendment to the Juvenile Code was passed and subsequently signed by the Governor in May 2009. This amendment affirmed the ADMH Commissioner’s ability to designate a hospital/facility outside of ADMH to provide services to minors and children with SMI or intellectual disabilities and to place these minors and children who have been committed to ADMH in said hospital/facility. These changes were in line with the recommendations of the Child and Adolescent Workgroup of the Systems Reconfiguration Task Force. A contract transferring the operation of the ADMH Psychiatric Adolescent Unit from Bryce Hospital into a smaller (10 bed) unit at the University of Alabama in Birmingham Department of Psychiatry and Behavioral Neurobiology was signed. The transfer was effective in October, 2010. With the movement to a new location at UAB, the unit continued to remain at or below capacity most of the time, even though the number of beds was half of that at the Bryce Adolescent Unit. On April 1, 2016, ADMH contracted with EAMC to operate the Adolescent Unit that was formerly operated by UAB. This adolescent unit became known as the ADMH Adolescent Psychiatric Unit at EAMC. This was a shift from a 10 bed unit to a 9 bed unit. This contractor has also been successful in remaining at or below capacity most of the time. This has been due to continued success in expanding and improving access to less-restrictive community-based treatment options for children and adolescents, and continued effective collaboration between child-serving agencies at the state and local level.



Activities Leading to Reduction of Hospitalization

All services and resources within the system of care for our target populations of SMI adults and SED kids are geared to the reduction of hospitalization. It is vital to have a system of care of resources to reduce the need for hospitalization, as well as the inappropriate use of hospitalization for respite, residential, and/or homelessness. It is vital to have training at the local, community, regional and state level of these resources. Community Mental Health Centers (CMHCs) train their local community partners, such as, but not limited to, schools, courts, detention facilities, and child-welfare, on services and resources for diversion. Such diversion services include certified peer specialists, intensive care coordinators, in-home teams, ACT teams, court liaisons, school-based mental health collaboration, drop-in centers, supported employment programs, and FEP team. Staff are trained in engagement and outreach, so they can be the front line in actively engaging with the sites of potential hospitalization diversion such as emergency rooms, courts, detention facilities, and private inpatient acute units. All CMHCs have funded Juvenile Court Liaisons (JCL) who work directly with the courts to divert kids that come to the courts attention to the most appropriate resources. In circumstances when hospitalization is warranted, the JCL serves as a care coordinator and remains involved with the youth consumer and their family and the program in which they are receiving inpatient care to assist with the care coordination back to the community and with the needed resources for a smooth transition. With the closures of three state psychiatric hospitals from 2012-2015, a similar process for adults with SMI was implemented. Since the number of SMI adults served is significantly higher, the efforts for reduction of hospitalization is carried out at a local, regional, and state level. At the local level, each CMHC has a point person for the involved entities. There are also four UR Coordinators, one assigned to each region. Through the DMH Mental Illness Community Programs, staff work with key partners and the DMH Civil Commitment Protocol Process as implemented. Starting in December 2016, ADMH staff, State Hospital Staff, and CMHC staff participate in a monthly care coordination process of an extended treatment planning process in which all committed individuals placed in the three state hospitals are staffed. This is approximately 500 consumers. The goal of this project is to increase discharges from the state hospitals, which has been successful. Also, there is a review process of the waiting list to ensure diversion to the most appropriate and least restrictive setting. ADMH is working with the Alabama Hospital Association to initiate a similar process within the private inpatient settings. Much of the work that has been at the forefront of ADMH's focus since 2011 has been on reduction of hospitalization.

Criterion 2

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's behavioral health system

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1. Adults with SMI	203,380	17.0
2. Children with SED	73,215	28.2

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

ADMH gets this data from the SAMHSA URS System, State Mental Health Measures.

Historically, services have been designed and implemented through a participatory planning process that includes the Mental Illness Planning Council and the Mental Illness Coordinating Subcommittee of the Management Steering Committee. Family members, consumers, advocacy organizations, other state agencies, and providers are represented on

these planning bodies. A regional planning process initiated in FY08 added participants into the planning process, primarily consumer and family advocates, to address critical overages in state hospitals and system transformation.

The regional planning structure was adopted for all departmental planning beginning in FY08 and resulted in increased numbers of family members and consumers being involved in the planning process. There have been numerous participants in the regional planning process including consumers, family members, judges, public community providers, state hospitals, and local private providers. The local and regional planning process provided the foundation for ADMH's annual budget request. In FY09, the planning process was expanded to include a separate planning function for children and adolescents. This decision was based on feedback from the previous years of planning and was implemented to improve the voice of children and adolescents and their families throughout the planning process. A series of over 90 adult/children and adolescent local stakeholder planning meetings occurred in late summer and fall 2009. This provided local and regional input in determining unmet needs and critical gaps within the system at the community level. The feedback from this process was utilized within the departmental planning process as a mechanism to introduce local community input and was instrumental in the identification of needs and gaps in service. During FY 2011, ADMH leadership worked jointly with the Mental Illness Coordinating Subcommittee and Management Steering Committee to make recommendations for goal and strategy improvements. This collaboration has resulted in thorough examination of planning targets that reflect the approval of stakeholder partners while balancing the realities of ADMH fiscal parameters and magnifying the benefits of the integration efforts made within the division. This process has continued through FY 2019.

Planning for children and adolescent services is performed as a part of the overall Management Steering Committee process described above via Mental Illness Coordinating Sub-committee and the Mental Illness Planning Council.

A combination of sources was used to identify critical service gaps. For years, ADMH has monitored the utilization of public mental health services through analyzing service data reported to ADMH. This data, in conjunction with periodic survey of the providers, allowed ADMH to identify trends in service utilization by the consumers.

Other sources of data utilized by ADMH include the U.S. Bureau of Census, the National Uniform Reporting System (URS), Mental Health Statistics Improvement Program (MHSIP) Consumer Satisfaction Surveys, ADMH web-based housing inventory (MICRS), ADMH web-based commitment system (Gateway), Child Adolescent Needs and Strengths (CANS) functional assessment tool, ADMH certification results from provider site visits, HUD Point in Time count, Housing Needs Assessments, and hospital and community Performance Improvement data sets.

Another very valuable measure ADMH has for identification of gaps in the service delivery continuum for children and adolescents is through its participation in the Case Review Committee of the Multiple Need Child Office. This staffing occurs monthly with legislatively mandated child-serving agencies charged with developing plans for children who have multiple needs and who are at risk of placement in a more restrictive setting.

ADMH has exchanged service data with other state agencies, including but not limited to the Alabama Medicaid Agency, Department of Public Health, ALL Kids, Juvenile and Adult Corrections, the Administrative Office of the Courts, Department of Education, and Department of Human Resources, to provide a comprehensive array of publicly funded services to adults

and children/adolescents through memoranda of understanding, intergovernmental service agreements, or informal relationships. Also, ADMH worked with the Administrative Office of the Courts to match the ADMH mental health database with mental health court participants.

Criterion 3

Provides for a system of integrated services in order for children to receive care for their multiple needs. Does your state integrate the following services into a comprehensive system of care?

a)

Social Services

Yes No

b)

Educational services, including services provided under IDEA

Yes No

c)

Juvenile justice services

Yes No

d)

Substance misuse prevention and SUD treatment services

Yes No

e)

Health and mental health services

Yes No

f)

Establishes defined geographic area for the provision of services of such system

Yes No

Criterion 4

A: Describe your state's targeted services to rural population:

RURAL ACCESS

For purposes of classifying catchment areas as rural, the criterion was that the area not include a Standard Metropolitan Statistical Area (SMSA population \geq 50,000), in FY18, there were 7 community mental health center catchment areas, out of a total of 19 community mental health catchment areas, that met this criterion: Cahaba, East Central, Mountain Lakes, Northwest, South Central, Southwest, and West Alabama. The table below lists the seven rural mental health regions and the number of adults in the region who were SMI and children and adolescents in the region who were SED and who were served by the local mental health centers during FY18. A total of 65,934 adults who were SMI were served by the local mental health centers during FY18, and 12,867 or 19.51% were served in the seven rural regions. A total of 31,707 children and adolescents who were SED were served by the local mental health centers during FY18, and 5,019 or 15.83% were served in the seven rural regions. This relationship indicates that adult with serious mental illness and children and adolescents with serious emotional disorders in rural regions continue to have access to services. The two most frequently identified areas of need in rural areas are transportation to needed services and child and adolescent psychiatric services. Medicaid coverage of transportation services should assist in maintaining treatment access in rural areas. Services available to children and adolescents in rural areas will be maintained, and efforts will be made during the year to increase services by equal inclusion of rural areas in the implementation of legislation for the "Multi-Need Child". Each county facilitation team receives funds under the Children's First legislation to assist with wrap-around services for children in their county. The amounts of these vary as a function of their 2000 census for children and adolescents under 18 years of age. In regard to "mini grants" awarded to county facilitation teams under the previously funded CASSP Infrastructure Grant, all counties had equal access to grant funds.

Rural Regions	# of SMI Adults Served FY 18	# of SED C&A Served FY 18
Cahaba	1,494	361
East Central Alabama	1,779	904
Marshall – Jackson	1,515	624
North West Alabama	2,245	1,360
South Central Alabama	2,570	509
Southwest Alabama	1,922	838
West Alabama	1,342	423
Total SMI/SED Rural Served	12,867	5,019
Total SMI/SED Served	65,934	31,707
% Rural of Total SMI/SED Served Statewide	19.51%	15.707%

B. Describe your state’s targeted services to the homeless population:

Outreach to Homeless Individuals

In 2018, ADMH served a total of 104,642 people statewide through community programs. Of that number 72,232 were adults and 32,410 were children and adolescents. Of the total population served, 1,338 of people reported as living in a shelter or as homeless at time of admission to community mental health services. The highest concentrations of these individuals were in the most populated areas of the state with the Birmingham area comprising 37% of the statewide total adults receiving community mental health services.

ADMH is a recipient of SAMHSA’s Projects for Assistance in Transition from Homelessness (PATH) Formula Grant Program for which the 2019 award is anticipated to be \$613,144 in funds allocated to support five community mental health providers located in the most metropolitan areas reflecting the highest homeless point in time counts within the state. PATH funds are the only source of dedicated funding specifically targeted to serving homeless individuals who are seriously mentally ill and/or co-occurring mental illness and substance abuse disorders. In FY18, a total of 505 individuals were served by PATH programs. PATH grant funds permit providers to offer an assortment of specialized services, primarily through outreach methods and case management for individuals who are PATH eligible with the end goal of securing stable housing and transitioning them into mainstream services and supports. PATH outreach workers/case managers are charged with assisting individuals eligible for PATH by creating a person-centered plan to obtain and coordinate needed services including those related to daily living activities, peer support, personal finance and benefits acquisition, transportation, habilitation and rehabilitation services, prevocational and employment services, housing assistance and referrals necessary to promote full recovery. PATH services delivery for enrolled consumers are detailed in the graph below (Source: 2019 Annual PATH Report)

Services to Enrolled Client

505 Number of active, enrolled PATH clients receiving community mental health services through any funding source at any point during the reporting period [Q16]

Services Provided to Enrolled PATH Clients (unduplicated) [Q17]



Services Provided

In less populous regions of the state not receiving PATH funds, regular case management is offered to those who are homeless and have a serious mental illness and/or co-occurring disorder.

According to PATH Annual Report Data, in fiscal year 2018, of the providers who reported the total number of persons who were outreached/contacted, over **32% of those contacted were identified as chronically homeless and over 21% were unsheltered and 40.6% stayed in homeless shelters.** ADMH projects that 1,270 individuals will be contacted through PATH outreach during fiscal year 2019 using PATH funded services. Of those contacted, 53% are anticipated to meet the definition of literally homeless and 406 are anticipated to become new enrollees into PATH services.

In December 2013, Executive Order creating Alabama Executive Network for Service Members, Veterans and Their Families (AlaVetNet). One of the priority areas addressed in the AlaVetNet’s Strategic Plan is veteran’s homelessness.

ADMH is supportive of all 8 instate Continua of Care in Alabama. Continua stationed in Montgomery, Mobile, and Birmingham have published local plans to address homelessness and are in various stages of implementation. The State PATH contact serves on the Boards for the Alabama Rural Coalition for the Homeless (ARCH)). As an ARCH board member, state level coordination of homeless services targeted for individuals in rural areas can be accomplished. As published on the Housing and Urban Development’s Exchange, in 2018, HUD’s Continuum of Care Homeless Assistance Programs Point-In-Time Counts reflected 3,434 individuals and families were identified as homeless statewide with 70.6% in shelters and 29.4% unsheltered. Of this total population, 15.7% were identified as chronically homeless, 24.9% identified as seriously

mentally ill, 15% as having a chronic substance use condition, 1.3% with HIV/AIDS, 8.1% as victims of domestic violence, and 9.9% as veterans.

In 2017, the Alabama Alliance to End Homelessness (ALAEH) merged with the Low-Income Housing Coalition of Alabama (LIHCA). Both boards agreed the merger would allow for a unified voice when advocating on behalf of housing and homelessness. The LIHCA board configuration was augmented to ensure representation of the HUD Coc's. LICHCA partners with Collaborative Solutions, Inc. co-sponsor an annual conference targeted towards service providers and individuals with lived experience.

Alabama has implemented SSI/SSDI Outreach, Access and Recovery (SOAR) training statewide in the past. More recently, providers have utilized the on-line SOAR training option. SOAR has been instrumental in providing the skills needed for service providers to directly impact homelessness and to move forward in accomplishing the overall arching goal of the States' Plan to End Homelessness and the States' Comprehensive Mental Health Service plan.

It should be noted that children and adolescents are served, when part of a homeless family, by PATH case managers and by specialized children's case managers in the mental health regions, which have dedicated children's case management. The major provider of homeless services for children and adolescents is the Department of Human Resources (DHR), the child welfare agency. Runaway youth are also identified and referred for other mental health services, including case management, by runaway shelters located across the state. The ADMH staff also participates in the training of the state's law enforcement personnel. Since the police are frequently the first to encounter runaway youth, a considerable amount of time is allocated for discussion of identification and referral for mental health services.

C. Describe your state's targeted services to the older adult population:

OLDER ADULTS/ELDERLY

Community based services are provided to older adults through the existing community mental health center service structure. There were 18,867 individuals aged 55 or older who had received services from a mental health center during FY18 which makes up 18% of the total population served and 26% of the adult population served. The following list shows the number of recipients aged 55 or older by service type (includes duplication):

Residential	1,377
Day Treatment	1,480
In-home Intervention	258
ACT	399
Case Management	2,599
Outpatient	17,999

Based on these numbers, older adults are receiving a variety of services through community mental health centers. During FY16, adults over 55 years of age make up 30% of the total adult population receiving Residential services and make up 40% of the total adult population receiving ACT services. Mental health centers provide both direct services to residents of nursing homes as well as case consultation to the operators.

During the second half of FY07, a small pilot project was started to purchase local Assisted Living Facility beds for individuals appropriate for this level of care who were residing in the state-operated Mary Starke Harper Geriatric Hospital. This pilot was successful enough that the pilot was expanded statewide. In FY18, a total of 61 individuals have received services through contract Assisted Living Facilities.

In July 2009, ADMH closed its 30-bed state operated psychiatric nursing facility Alice Kidd. Most of the residents were placed in the community. Those who could not be placed in the community were transferred to another state operated psychiatric facility, Mary Starke Harper Hospital, which serves geriatric patients committed to ADMH. Nursing home and Assisted Living Facilities have been used as community resources for the older residents in need of transitioning out of state hospital care. ADMH participated in planning for a Money Follows the Person grant application directed to improving discharge opportunities for residents of nursing homes and Mary Starke Harper Geriatric Hospital. ADMH continues to work closely with the Alabama Medicaid Agency on the implementation of Money Follows the Person.

Criterion 5

Describe your state's management systems.

The Alabama Department of Mental Health (ADMH) has collected demographic and service event data at the client level for all recipients receiving community mental health services since 1995 through the Alabama Community Services Information System (ACSIS). Client level demographic and service event data is stored in a Central Data Repository (CDR) located in the ADMH Central Office for all recipients and is refreshed once a month by data uploaded electronically through a secure web portal from each of 24 community mental health providers with whom ADMH contracts to provide services. Each provider has implemented or begun implementation of an electronic medical record system which has the capacity to report client level demographic and service event data to the CDR. The upload files conform to a standard file structure with data elements and standard codes specified by ADMH and required by contract. Uploads are due by the 16th of the month following the month of service, admission, discharge or a change in client profile status. ADMH has reported all required URS Tables and NOMs beginning with fiscal year 2006. In addition to client level data, data can also be aggregated at the program and provider level.

The CARES management information system is an Admission/Transfer/Discharge used by state operated mental health hospitals since 1991 to track admissions, discharges, transfers, client demographics, diagnoses, and selected clinical information at the client level and is updated in real time. CARES and ACSIS systems are linked each year using the client's Social Security Number to complete the URS tables with unduplicated counts. ADMH began implementation of an electronic health record (EHR) in September 2015 in a single state psychiatric hospital. The EHR is operational in all three state psychiatric hospitals as of September 2018 and will replace CARES and allow us to continue client level reporting for the state hospital population. CARES and EHR data can be aggregated by programs/units within the facility, and by facility.

ADMH utilizes the Alabama Substance Abuse Services Information System (ASAIS) to collect client level demographic and service event data for recipients of substance abuse services. Data can also be aggregated at the program and provider level. The system is a web-based system hosted by a third party and used by all substance abuse services providers. TEDS data is reported from this system. Recipients from the ASAIS, ACSIS systems can be linked to report both MI and SA services. ADMH has strived to keep data element coding structures for the community behavioral health systems compatible with each other to enable better reporting.

The Alabama Behavioral Health Assessment System (ABHAS) was developed by ADMH resources to administer and monitor the Child and Adolescent Needs and Strengths (CANS) assessment tool. The assessment is administered at admission, discharge, and regular intervals during the year to all children and adolescents receiving MH services from an ADMH contract MH service provider. The tool enables ADMH to look at school attendance, juvenile justice involvement, family and client satisfaction on a client level basis as well as assess the needs and strengths of a recipient which is used to develop an individualized plan of care. ADMH can use CANS data to assess outcomes for school attendance, juvenile justice involvement, client and family satisfaction at the individual level. This data can also be aggregated at the program and provider level.

The Alabama Legal Commitment Gateway System (LCGateway) was developed with ADMH resources to provide a web-based state-wide tracking system for community-based inpatient commitments. The system captures basic consumer

hearing outcome, commitment, commitment renewal and placement information. ACSIS and LCGateway data are linked each year to provide adolescent commitment data for URS and CLD reporting with unduplicated counts.

Section IV: Environmental Factors and Plan: 11. Quality Improvement Plan - Requested

1. Has your state modified its CQI plan from FFY 2016-FFY 2017?

Yes No

Does the state have any activities related to this section that you would like to highlight?

The Alabama Department of Mental Health, Division of Mental Health and Substance Abuse Services, most recently revised the CQI plan in 2015. The CQI plan is currently under review for possible revisions. We continue to struggle with Substance Use Provider, Substance Use Family Member, Substance Use Consumer, and other Recovery Oriented Advocacy group participation in the State Performance Improvement (PI) Committee. We are making a concerted effort to engage all stakeholders in the PI Committee meeting process and are looking at different ways to attract and retain Substance Use representatives.

The Office of Performance Improvement, in the Division of Mental Health and Substance Abuse Services, officially changed its name to the Office of Quality Improvement and Risk Management (QIRM) in 2018. We have converted to a new electronic incident reporting system, Therap, as of March 14, 2019. The system is being used by all MHSA Providers and has facilitated easier access to key PI data, enhanced our ability to track outcomes and performance, and identified trends in our certified providers. Therap offers a Business Intelligence module that will be used to create meaningful aggregate data reports and dashboards that allow for identification of trends. This tool will also allow comparison of data across providers and programs.

In FY 18 and FY 19, the MI Performance Improvement Committee met four times in each FY to review data and conduct PI business. Community Provider data that was reported and reviewed through the ADMH Performance Improvement Process includes Safety measures (critical incidents), Rights measures (complaints, grievances, and abuse/neglect allegations), Continuity of Care measures, and Outcome measures. The current active community provider PI measures are listed in Appendix B of the attached State CQI Plan. The community reporting procedures are included in Part B of the Incident Management Plan. Statewide training on Part B of the Incident Management Plan was offered to all MHSA Providers in May and June 2019. For those Providers that were unable to attend in May or June, a makeup training is being offered August 29, 2019, in Montgomery, AL. Safety measures listed below are reported to the ADMH in accordance with the published reporting procedures. These procedures describe the process for responding and reporting incidents and/or critical incidents. The Alabama Administrative Code also includes requirements for responding to complaints and grievances in accordance with the ADMH Internal Advocacy Program.

The following outlines the measures that were reported/reviewed each quarter/annually for the MI Community Programs:

Safety Measures

Death

Injury

Suicide attempts

Seclusion/Restraint use and any associated injuries

Medication Errors

Elolements

Rights Measures

Abuse/Neglect Allegations

Advocacy Monitoring (complaints/grievances/rights violations)

Continuity of Care Measures

Hospitalization

Outcome Measures

Adult Consumer Perception of Care/Youth Family Perception of Care (MHSIP Surveys – Annual Measures)

The following outlines the key Community performance improvement initiatives for the Committee this year:

- State CQI Plan revision
- Drill down on Seclusion – Restraint reporting

2018 - 2019 MHSIP Survey Process (Consumer Satisfaction Surveys)

The MI PI Committee provided oversight to the Community MHSIP Survey process which was conducted for the sixteenth time in April of 2018 and the seventeenth time in April of 2019. A total of twenty-four (24) agencies participated in the 2018 and 2019 MHSIP Survey Process. The Adult MHSIP and Youth Services Family surveys were administered in April 2018 and April 2019. Survey data for 2018 was sent to each CMHC late August 2018 along with state and national comparison numbers for each domain. Survey data for 2019 was received August 1, 2019, and our office is in the process of reviewing the data and compiling comparative reports to be sent to each Community Mental Health Center Executive Director.

Peer Review Child & Adolescent 2018

The Office of Quality Improvement and Risk Management, Division of Mental Health and Substance Abuse Services, coordinated and participated in an independent peer review of the *AltaPointe Health Systems School-Based Mental Health Collaboration* on September 20, 2018. AltaPointe Health Systems served as the host site while Jefferson, Blount, and St. Clair Mental Health Authority (JBS), Eastside Mental Health Center, UAB Community Psychiatric Program, and Capitol Care South served as reviewers. The purpose of peer review is to share ideas, best practices, and other innovative treatment strategies so that other centers may take this information back to their program and improve consumer services. Other areas covered during the Peer Review included:

- Goals of the Program
- Eligibility Criteria for the Program
- Admission Criteria for the Program
- Penetration Rate
- Assessment
- Treatment Planning
- Training
- Supervision
- Process Monitoring
- Outcomes Monitoring
- Quality Assurance
- Client Choice
- Barriers
- Things that have helped make the program a success

Peer Review Adult 2018

The Office of Quality Improvement and Risk Management, Division of Mental Health and Substance Abuse Services, coordinated and participated in an independent peer review of the *Individual Placement and Support Employment Program*, on August 23, 2018. Chilton Shelby Mental Health Center served as the host while Jefferson, Blount, and St. Clair Mental Health Authority (JBS), SpectraCare, Indian Rivers Mental Health Center, and Cahaba Mental Health Center served as reviewers. The purpose of peer review is to share ideas, best practices, and other innovative treatment strategies so that other centers may take this information back to their program and improve consumer services. Other areas covered during the Peer Review included:

- Goals of the Program
- Eligibility Criteria for the Program
- Admission Criteria for the Program
- Penetration Rate
- Assessment
- Treatment Planning
- Training
- Supervision
- Process Monitoring
- Outcomes Monitoring
- Quality Assurance
- Client Choice
- Barriers
- Things that have helped make the program a success

Peer Review Child & Adolescent 2019

The 2019 Child & Adolescent Peer Review will be held on Tuesday, September 10, 2019, at the Jefferson, Blount, St. Clair Mental Health Authority (JBS) NOVA site, located in Birmingham, Alabama. The focus of the peer review will be *First Episode Psychosis*.

Peer Review Adult 2019

The 2019 Adult Services Peer Review will be held Tuesday, September 24, 2019, at Wellstone Behavioral Health in Huntsville, Alabama. The focus of the peer review will be the *UR Regional Process*.

Inpatient Services

HBIPS is an acronym for Hospital Based Inpatient Psychiatric Services (HBIPS) core measure set. Free-standing psychiatric hospitals with an average daily census greater than ten inpatients will be required to participate using a Joint Commission-listed vendor and submit data to The Joint Commission on all applicable measures that comprise the HBIPS core measure set. Joint Commission accredited free standing psychiatric hospitals impacted by this requirement will be deemed to have met their ORYX core measure reporting requirements through submission of data on the HBIPS core measure set alone. The HBIPS measures monitored by Alabama Department of Mental Health hospitals are as follows:

- **Screening for metabolic disorders**

Definition: Percentage of discharges from an IPF for which a structured metabolic screening for 4 elements was completed in the past year. Weighted mean is the sum of all HCOs' numerators divided by the sum of all HCOs' denominators.

- **Transition record with specified elements received by discharged Patients**

Definition: Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care, or their caregiver(s), who received a transition record. Weighted mean is the sum of all HCOs' numerators divided by the sum of all HCOs' denominators.

- **Timely transmission of transition record**

Definition: Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designate for follow-up care within 24 hours of discharge. Weighted mean is the sum of all HCOs' numerators divided by the sum of all HCOs' denominators.

- **SUB 2 – Brief Intervention Provided or Offered**

Definition: Patients who screened positive for unhealthy alcohol use who received or refused a brief intervention during the hospital stay. Weighted mean is the sum of all HCOs' numerators divided by the sum of all HCOs' denominators.

- **SUB 2a – Brief Intervention Received**

Definition: Patients who screened positive for unhealthy alcohol use who received a brief intervention during the hospital stay. Weighted mean is the sum of all HCOs' numerators divided by the sum of all HCOs' denominators.

- **Sub3- Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge**

Definition: Patients who are identified with alcohol or drug use disorder who receive or refuse at discharge a prescription for FDA-approved medications for alcohol or drug use disorder, OR who receive or refuse a referral for addictions treatment.

- **Sub3a- Alcohol and Other Drug Use Disorder Treatment Provided (a subset of SUB3)**

Definition: Patients who are identified with alcohol or drug disorder who receive a prescription for FDA-approved medications for alcohol or drug use disorder OR a referral for addictions treatment.

- **TOB-2 TOBACCO USE TREATMENT PROVIDED or OFFERED**

Definition: Hospitalized patients who received counseling AND medication as well as those who received counseling & had reason for not receiving the medication. Weighted mean is the sum of all HCOs' numerators divided by the sum of all HCOs' denominators.

- **TOB3-TOBACCO USE TREATMENT PROVIDED or OFFERED at Discharge**

Definition: Patients identified as tobacco product users within the past 30 days who were referred to or refused evidence-based outpatient counseling AND received/refused a FDA-approved cessation medication upon discharge. Weighted mean is the sum of all HCOs' numerators divided by the sum of all HCOs' denominators.

- **TOB3a-TOBACCO USE TREATMENT at DISCHARGE**

Definition: Patients who were referred to evidence-based outpatient counseling AND received a prescription for FDA approved cessation medication upon discharge as well as those who were referred to outpatient counseling & had reason for not receiving a prescription for medication. Weighted mean is the sum of all HCOs' numerators divided by the sum of all HCOs' denominators.

- **IMM-2 INFLUENZA IMMUNIZATION**

Definition: Inpatients, age 6 months and older, **discharged each year from October 1 through March 31**, who are screened for influenza vaccination status and vaccinated prior to discharge. Weighted mean is the sum of all HCOs' numerators divided by the sum of all HCOs' denominators.

Retired Measures for 2019:

TOB-1

SUB-1

Section IV: Environmental Factors and Plan: 12. Trauma - Requested

1. Does the state have a plan or policy for M/SUD providers that guide how they will address individuals with trauma-related issues?

Yes No

2. Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers?

Yes No

3. Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care?

Yes No

4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations?

Yes No

5. Does the state have any activities related to this section that you would like to highlight.

Each ADMH-certified Mental Health Service Provider is required to develop Policies and Procedures that address the requirements codified in the ADMH Administrative Code. The "Consumer Records" Section of the Alabama ADMH Administrative Code (updated 9/30/10) requires trauma history to be obtained from every consumer and recorded in the consumer's clinical record so that it can be considered during treatment planning. (ADMH Code 580-2-9-.06 (9)(a).17.(b.)10.). Also, in the "Child and Adolescent Restraint and Seclusion" Section of the Code (which applies only to Day and Residential Treatment programs that are certified to employ the use of seclusion or restraint techniques) clinical staff is required to perform an initial assessment at the time of admission or intake which includes information about "Preexisting medical conditions or any physical disabilities and limitations that would place the consumer at greater risk during restraint or seclusion, including developmental age and history, psychiatric condition, and trauma history." This Section also requires that this information be recorded in the consumer record. (ADMH Code 580-2-9-.23 (14)(b.) and – .23 (23)(d)3.) These requirements are codified with the belief that consideration of this information will help minimize the use of restraint and seclusion, and also to minimize the danger of re-traumatizing a consumer during the exercise of restraint or seclusion when it cannot be avoided.

Many ADMH policies are rooted in the provision of person-centered and individualized treatment planning as prescribed in the ADMH Administrative Code. This requirement is expressed succinctly in section 580-2-9-.08(3) entitled "General Clinical Practice," which states, "Services must be individualized, well-planned, based on a comprehensive mental health

evaluation and assessment of needed treatment and support, and should include treatment designed to enhance the consumer’s abilities to recover and function in society as normally as possible,” and also, “Each program shall provide individualized mental health care and treatment that is designed to promote Recovery and Resiliency and that represents person-centered treatment planning process.” This philosophy of care pervades all areas of service provision by ADMH certified providers. Consumers who present with histories of trauma that impact their presenting mental health conditions should be provided the best interventions available to accommodate their mental health treatment needs, including trauma-focused therapeutic interventions wherever appropriate. As a true trauma-focused system of care has not yet been achieved across the state, the types of trauma-focused therapy interventions will vary by provider agency and by individual clinician. ADMH does not have policies beyond what is provided for in the Administrative Code that require providers to deliver a specific trauma-focused intervention. Trauma-focused care is an important and growing field in mental health care, and a variety of training events and workshops have been conducted. Each provider is responsible to conduct or promote training opportunities for their clinicians and other treatment staff that will help them to develop professionally and to provide the best, most effective treatment possible for consumers of mental health services, including training and development in the area of trauma focused care.

Section IV: Environmental Factors and Plan: 13. Criminal and Juvenile Justice - Requested

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to M/SUD services?

Yes No

2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, behavioral health provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms?

Yes No

3. Does the state provide cross-trainings for M/SUD providers and criminal/juvenile justice personnel to increase capacity for working with individuals with M/SUD issues involved in the justice system?

Yes No

4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances?

Yes No

5. Does the state have any activities related to this section that you would like to highlight?

The establishment of a secure medical facility by the Alabama Department of Mental Health (ADMH) was authorized by the Alabama Legislature in 1975. Taylor Hardin Secure Medical Facility commenced operation in November 1981. Taylor Hardin is the state’s only forensic hospital and the facility provides inpatient evaluation and treatment services throughout the judicial process. Regional evaluation programs under Taylor Hardin’s supervision also provide forensic evaluation services within the community. Pre-trial evaluations and treatment services are provided for males committed by the circuit courts of all sixty-seven (67) counties within the State of Alabama and are provided from the time of arrest through trial and sentencing. Female defendants receive inpatient evaluation and treatment services at Bryce Hospital.

Rule 11. Incompetency and mental examinations, of the Alabama Rules of Criminal Procedure, provides for the evaluation of a defendant’s mental competence to stand trial or to be sentenced if because of mental incompetence, he or she lacks the present ability to consult with counsel with a reasonable degree of rational comprehension or is unable to understand the nature of the proceedings. Once evidence exists to doubt the defendant’s competence, the procedures for ordering a mental examination through the circuit court are implemented and the court orders are received by the Community Court Liaison at Taylor Hardin and dependent upon the order, evaluations are scheduled through the community regional examiners or defendants are admitted to Taylor Hardin or Bryce for inpatient

evaluation. If a not guilty by reason of mental disease or defect defense is raised by the defendant, then the court on its own motion may order, or the defendant, the defendant's attorney, or the district attorney may move for an examination into the defendant's mental condition at the time of the offense. Orders for MSO evaluations are completed routinely on an outpatient basis by the community regional examiners or on an inpatient basis depending upon the court order. Evaluations of an individual's mental competence to waive Miranda and competence to participate in the sentencing phase are also completed as requested by the court.

The Alabama Department of Mental Health (ADMH) has for years collaborated with the Department of Corrections (DOC) for the provision of treatment for individuals with mental health disorders who are serving sentences within the DOC. Through the probate commitment process, inmates may be committed to ADMH for treatment to stabilize their condition and then returned to DOC for continued serving of the sentence. Individuals who are approaching the end of their sentence, and who have mental health disorders, and are determined to be in need of continued treatment upon release from prison can be probate committed to ADMH for inpatient treatment at the time their sentence expires. Review of the data for these type commitments over the last 9 years has shown that many of these individuals are treated and discharged to community placements after relatively brief periods of inpatient treatment. This data has led to further discussion between the two agencies to focus on planning and developing procedures where by mentally ill inmates can be triaged prior to the End of Sentence (EOS) date and linkages to community providers established for after-care and assistance with transition into the community. It is expected that this will reduce or eliminate the need for EOS commitments to state hospitals.

A Forensic Workgroup began meeting in February 2013 to evaluate forensic services throughout the hospital and community continuum and make recommendations for improvement. Formal recommendations have not yet been finalized for submission to the Commissioner, however throughout the time the Workgroup has been meeting, there have already been implemented changes for improvement of our current system. One area of discussion has been the beneficial efforts of one counties Mental Health Court and the potential for these courts to have a positive impact on diverting individuals with mental health and substance abuse disorders who have minor/misdemeanor charges, from prosecution, thus reducing the numbers of individuals who have to assert a mental state defense and be found Not Guilty by Reason of Insanity (NGI) or those who are found guilty and sentenced to the criminal justice system. Concerns with the lack of consistency in how the mental health courts operate across the state and the lack of funding for these courts was discussed and recommendations for gathering data, collaborating with the Administrative Office of Courts, and exploring funding options will be submitted to the Commissioner. Also, the process of ensuring that individuals who are released from an ADMH commitment under a Condition Release is having the appropriate follow-up care and response to the court systems. Through the assessment of the Conditional Release process, ADMH initiated the use of an ADMH Conditional Release Community Monitoring Form that mental health providers are required to complete prior to filing a petition for Revocation of a Conditional Release. This is in an attempt to improve care coordination as to confirm that all community resources have been exhausted. Through the monitoring of the data with this new process, ADMH is hopeful that consumers can be diverted to more appropriate community-based care setting. Another area of focus for the Workgroup is the revision of the Notice of Proposal for Conditional Release Order that will require community provides to send notice to ADMH of petitions for Revocations, as well of supporting documentation. The Workgroup is exploring the use of Self-Limiting orders for Conditional Releases, which would legally indicate that the Conditional Release would remain in effect for a period of one year, after which the conditions of the Defendant's release will terminate, and the individual would be Unconditionally released from ADMH custody.

Cross-trainings provided for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system

Per the State of Alabama DOC Administrative Regulation #700: The ADOC ensures that those in custody of ADOC have access to medical, dental, and mental health services and are housed in settings that can provide for their specific health care needs. It is the policy of the ADOC to ensure a continuity of care when an inmate is admitted into or released from the system. It is also the policy of ADOC to facilitate the coordination of efforts in the provision of mental health care between ADOC psychological services staff and contract mental health staff. Judges also have the ability to order substance use assessments and treatment. Individuals may enter the system through several avenues which may include probation, mental health courts, drug courts and other problem-solving courts (e.g., juvenile, veterans, and family drug courts). Individuals are assessed for appropriate care either in the detention centers at the time of entry or in the community.

- Alabama Justice Ministries Network is a non-profit faith-based organization that was founded in 2001 and works primarily with the Alabama State prison system. The goal of their mission is to provide services necessary to assist ex-offenders to best gain and retain employment opportunities. Services that are included are mentoring, educational and vocational training, life skills programming, housing and continued substance abuse treatment. They start their work with the offenders while they are still incarcerated.
 - Aid to Inmate Mothers (AIM) that was founded in 1987 and works primarily with women at Tutwiler prison, Birmingham Work Release and the Montgomery Community Based Facility. The goals of AIM are to enrich the lives of both incarcerated mothers and their families through programs that provide education and support. Care doesn't just stop once the mothers are released from prison. AIM's Project Reconnect is an aftercare program that helps them secure job and housing and provides them with essential counseling. AIM also has transitional home for women who are leaving prison.
 - As for youth, the Alabama Department of Youth Services (ADYS), they also ensure that those in custody have access to medical, dental, educational, mental health, and substance abuse services, as well as housed in setting that can provide for their specific health care needs. ADYS works bi-directionally with the community courts, educational systems, and other child serving agencies (child welfare, mental health, etc.) to divert unnecessary commitments and to coordinate efforts for effective transition for return to their community. Over the years, ADYS has set up systems to fund community diversion programs as to enrich community resources in the hopes of providing rehabilitation opportunities. One such example with ADMH is the partnership with OUR Kids.
 - Due to the belief that too many SED youth were channeled through the juvenile justice system, ADMH developed a position called the Juvenile Court Liaison (JCL) and provided funding for this position to each of the contracted community mental health centers. The JCL works directly with the court system to assist with determining appropriate treatment and care and to assist with coordination of such services and with those care agencies involved.
- Cross-trainings provided for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system:
- ADMH participates in trainings with other state agencies such as AOC, DOC and DYS. There have been collaborative grants/projects that has allowed for trainings and conferences to assist in strengthening the efforts of effective care in regard to mental health and substance use/abuse issues that focus on the use of evidence-based/best practices.
 - In addition, trainings offered by ADMH are open to anyone interested in attending. The DOC has been sending professionals to those trainings as a way of improving the quality of care offered to the offenders.
 - ADMH also offers annual training on forensic mental health issues that is open to the public and provide forensic case manager training.
 - Law enforcement officials have been receiving training in mental health first aid as part of a grant opportunity.
 - In regard to adolescents, ADMH provides annual trainings to the Juvenile Court Liaisons, as well as requested trainings by the community juvenile court systems and DHR.

- At the local level, the ADMH providers actively participate in such collaborative trainings as trainers and as participants.

Section IV: Environmental Factors and Plan: 15. Crisis Services - Requested

Please respond to the following items:

1. Crisis Prevention and Early Intervention

- a) Wellness Recovery Action Plan (WRAP) Crisis Planning
- b) Psychiatric Advance Directives
- c) Family Engagement
- d) Safety Planning
- e) Peer-Operated Warm Lines
- f) Peer-Run Crisis Respite Programs
- g) Suicide Prevention

2. Crisis Intervention/Stabilization

- a) Assessment/Triage (Living Room Model)
- b) Open Dialogue
- c) Crisis Residential/Respite
- d) Crisis Intervention Team/Law Enforcement
- e) Mobile Crisis Outreach
- f) Collaboration with Hospital Emergency Departments and Urgent Care Systems

3. Post Crisis Intervention/Support

- a) WRAP Post-Crisis
- b) Peer Support/Peer Bridges
- c) Follow-up Outreach and Support

- d) Family to Family Engagement
- e) Connection to care coordination and follow-up clinical care for individuals in crisis
- f) Follow-up crisis engagement with families and involved community members
- g) Recovery community coaches/peer recovery coaches
- h) Recovery community organization (Drop-in Centers/WINGS/NAMI/APSA)

4. Does the state have any activities related to this section that you would like to highlight?

As indicated throughout most all the sections of this application, it should be apparent that ADMH, its partners, and the system as a whole focus on a system of care that includes all levels of care, treatment, recovery, and support. A vital element at all levels is crises access, treatment, and follow-up. Care coordination is crucial to ensure all aspects are linked for coordinated continuum of treatments, services, and supports. Alabama currently participates in some level of crisis prevention and early intervention, crisis intervention/stabilization, and post crisis intervention/support services identified above, and this is documented throughout the application. ADMH is dedicated to providing and/or participating with its partners as to identify and effectively respond to, prevent, manage and assist individuals, families, and communities recover from behavioral health crises.

Section IV: Environmental Factors and Plan: 16. Recovery - Required

1. Does the state support recovery through any of the following:

- a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care?
 - Yes No
- b) Required peer accreditation or certification?
 - Yes No
- c) Block grant funding of recovery support services.
 - Yes No
- d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system?
 - Yes No

2. Does the state measure the impact of your consumer and recovery community outreach activity?

- Yes No

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

Please refer to the SAMHSA SA Block Grant application.

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

Within ADMH, consumers and their families play a crucial role in policy development, system transformation, and program implementation within every level of the service delivery network. For years, ADMH has valued consumer voice and promoted inclusion that was meaningful. Through strong alliances with the consumer and family advocate networks, ADMH has been able to drive our system of care in the direction that not only sees our consumers and their families as recipients of services but values them as vital partners at the table who serve as experts in this process.

The ADMH Office of Consumer and Ex-Patient Relations (OCER)

Over the years, the ADMH Mental Illness Division has primarily focused on designing a system of care that emphasizes a rich array of community services to complement the state hospital system of care. Much of the guiding principles were based on standards outlined in the Wyatt lawsuit. This lawsuit led to sweeping reforms in mental health systems in the state and ultimately across the nation. Developing a continuum of care within the community was the priority as to increase opportunities for consumers to live in the community with appropriate services that would minimize the need for re-institutionalization. Through this process, ADMH became increasingly aware of the value and need of consumer voice to guide the process. In 1990, the Alabama Office of Consumer Ex-Patient Relations (OCER), more commonly referenced as the Office of Consumer Relations (OCR), was established. It was the FIRST office of its kind in the nation. The purpose of OCER is to infuse the consumer perspective into the decision-making process and management of the Mental Illness Division. The director is a member of the executive management team of ADMH and directly reports to the Associate Commissioner. A primary strength of OCER is the ability to encourage recovery and hope among Alabama citizens with mental illness and their families. Additionally, the office promotes respect toward individuals with mental illness and works closely with consumer operated programs, advocacy and self-help organizations around the state.

OCER brings the mental illness experience, and its related treatment experiences, into the planning, policy making, and operations of the Division of Mental Illness Services.

The Office has four major functions:

- (1) To advocate and provide consumer insight to the senior management teams of the Division of Mental Illness Services and other agencies;
- (2) To promote, provide technical assistance and consultation in the establishment and funding of consumer self-help networks, peer operated services, including the Certified Peer Specialist/ Peer Bridgers, support/self-help groups, and consumer run drop-in centers;
- (3) To promote recovery from mental illness.
- (4) To coordinate the Alabama Certified Peer Specialist Training(s) Program.

The **Alabama Directions Council** serves as the advisory board of the Office of Consumer Relations. Its composition includes the presidents of local support groups and drop-in centers around the state, as well Wings across Alabama (Wings) and the Alabama Minority Consumer Council (AMCC). The Council meets regularly to discuss important issues and to make collective decisions about the direction of the consumer movement. The Directions Council also plays a major role in planning the annual Alabama Institute for Recovery (formerly The Alabama Recovery Conference) and the funding of local consumer run support groups. The OCER newsletter, LISTEN, has a target audience of consumers around the state and contains information on consumer issues, activities and consumer success stories. LISTEN has a circulation of 3,000.

The Directions Council membership organizations created the first official consumer statement on recovery articulated in the 2007 statewide publication Consumer Driven Recovery Focused Mental Health System: A Consumer Perspective. This document outlines what a mental health system should look like and what the concepts, principles, key components, strategies, goals, and recommendations driving the system should be. Alabama consumers defined recovery as “an individual process in which a person with mental illness reclaims a sense of who they are in mind, body, and spirit.” This definition and the specifics of the publication are in keeping with SAMHSA’s working definition of recovery: “a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential”. This document has proven an invaluable guide, leading the planning and development of mental health services and supports to promote and sustain the stated wishes and desires of “a job, a home of their own, a social life, and to contribute to society” voiced by Alabama consumers. (See attached 2007 White Paper)

The Alabama Institute for Recovery (formerly The Alabama Recovery Conference)

This annual training event is organized by the OCER and occurs in the largest venue available in the state. Approximately 700 participants attend each year with more than 600 attendees awarded scholarships that would not be able to attend otherwise. This year marked the 27th year this conference has been held. Activities during the conference include educational sessions and workshops, along with the presentation of the annual RESPECT awards, the annual Talent Show, a candlelight vigil, a watermelon social, and a dance. This three-day conference, not only offers educational and inspirational tracks, but promotes opportunities for true peer camaraderie and empowerment. The Associate Commissioner of Mental Health Substance Abuse Services, senior executive staff, and facility directors participated in the conference to assist consumers and make their stay as pleasant as possible. Medical staff from state psychiatric facilities and community mental health centers volunteer every year to be part of the Crisis Response Team. Health Screenings were offered to consumers in attendance. These screenings were initiated in 2006 and conducted every year except for 2012. (see attached 2019 AIR Conference Brochure)

Certified Peer Support Specialists

ADMH has long valued the power of peers to support fellow consumers and promote recovery. ADMH first established the position of peer support specialist in 1994 at Greil Hospital and later expanded the program to all state facilities. In 2008, the Mental Illness Coordinating Subcommittee approved allocation of \$1M in FY08 to support the equivalent of 25 full-time Peer Support positions, one to be employed at each contracted community mental health provider. Certification training based on the Georgia model was established with guidance from the National Technical Assistance Center of the National Association of State Mental Health Directors. Three trainings were initially conducted using the Depression and Bipolar Support Alliance and the Appalachian Consulting Group as trainers. When reduced budget allocations forced cuts in FY09, twelve mental health centers lost the funding for any vacant Peer Support positions. However, 2011 held more promise when grant funds allowed for the development of in-state certification training and thereby, increase the pool of certified peer specialist. With assistance from Appalachian Consulting Group, the Office Consumer Ex-Patient Relations (OCER) utilized a Train the Trainer model to create the capability to offer certification training provided by Alabama peer trainers thus reducing the dependence and cost of out of state trainers. The first two in-state trainings occurred in August and October 2012. A second Train the Trainer training was held in December 2014. OCER also coordinated two trainings for supervisors of Certified Peer Specialists. This was made possible through an approved SAMHSA TA Tracker request and OCER was able to utilize the expertise of consultants with the Appalachian Consulting group from Georgia. ADMH OCER conducted a Certified Peer Specialist Training August 22-26, 2016 and August 14-18, 2017.

Additionally, the need for specialty peer support services has provided opportunities to expand the use of peers in mental health settings. In light of the report that individuals with mental illness die 25 years younger than the general population, ADMH and a Birmingham provider participated in a NASMHPD funded pilot project in 2009 utilizing certified peer specialist to assist consumers in improving their overall physical health. In 2010, through the hospital downsizing project, the use of Peer Bridgers was initiated. Peer Bridgers concentrate efforts in assisting consumers in making the transition from the hospital to successful living in the community.

With the closures of the two state hospitals in 2012 (Greil and Searcy) and movement of treatment more focused in the community, this allowed for the expansion of the use of Certified Peer Specialists (CPS) within the continuum of care and

CPS were hired in different settings such as within group home settings and on crisis mobile teams. This was further expanded with the repurposing projects targeting NARH and Bryce State Hospital.

In March 2014, ADMH partnered with a community mental health center and an ADMH certified private C&A psychiatric residential treatment facility to introduce the use of a Youth Certified Peer Specialist when working with some of the most complex female adolescents being served in such a setting in the state of Alabama. The community mental health provider employees the Youth Certified Peer Specialist. For the FY15 SAMHSA MH Block Grant Peer Review, this project was the host for the C&A peer review as to move toward expansion into other residential programs. The Block Grant is being utilized to support the development of this project.

In addition, ADMH has implemented the First Episode Psychosis (FEP) project in one pilot location. FEP utilizes a team approach which includes 1 full-time equivalent of Certified Peer Specialists. This is achieved through hiring two youth peer specialists and two parent peer specialists. For the FY17 SAMHSA MH Block Grant Peer Review, the FEP project is the host of the C&A peer review as to move toward expansion across the state. For FY20, FEP, called NOVA, is being expanded to two additional sites. ADMH requires both Youth Peer Specialists and Parent Peer Specialists as members of the NOVA team.

Currently there are 66 certified peer specialists employed at community mental health centers with 11 others employed who are awaiting certification training, two located at state hospitals, and 16 others serving in mental health related positions, including 8 employed by mental health consumer and family organizations.

Consumer-operated services

Consumer-operated services provide alternatives for mental health consumers living in the community. Unfortunately, there is very little expansion of operations that would allow for the opportunity of choice for the consumers we serve. Consumer-driven recovery, such as consumer run drop-in centers and support groups, are seen as essential elements of the continuum of care, but these services are not covered in the Department's contract with community mental health centers. The Block Grant is used to support the development of consumer-operated services as well as the annual consumer conference. There are four operational drop-in centers serving on average an approximate total of 101 consumers on any given day. Within the state, there are two statewide consumer organizations and 16 NAMI connection groups.

Office of Deaf Services (ODS)

Among the one in five Alabamians who will need mental health services in their lifetime are more than 40,000 people who are deaf or hard of hearing. ADMH has established an Office of Deaf Services (ODS) to serve deaf and hard-of-hearing Alabamians better. ADMH is committed to ensuring that their peers will design programs for deaf and hard-of-hearing persons to ensure services are linguistically accessible and culturally affirmative, giving the consumer every opportunity to make progress to recovery. The ODS staff includes a director, statewide services coordinator, a statewide mental health interpreter coordinator, statewide and regional clinical staff, and regional communication access team members. ODS also provide significant communication and clinical support to Bryce, where deaf people needing inpatient care are served. Also, through contracts with ADMH, the contracted providers have access to language interpreters regardless of language and those services to assist with language needs as needed in services and care.

ADMH has developed specific standards of care for people with hearing loss that includes, among other things, specific requirements for measurable fluency in American Sign Language for certified community programs which work with deaf consumers. In FY14, ADMH and providers began capturing data on the client's primary language to facilitate meeting linguistic needs of our client populations. This readily allows ADMH to track consumers who are deaf or hard of hearing and target resources in an efficient manner. This allows ADMH to pinpoint and define the consumer characteristics of the 1,780 hard of hearing people and 228 deaf people that received services from ADMH in FY18.

In FY18, ODS staff provided community-based services directly to 2,008 consumers and 5,823 consumer contacts throughout the year. Technical assistance and consultation was provided to 4,291 people and programs. 8,847 hours of

interpreter services were provided for deaf consumers. Of this, 7,322 hours were provided by staff interpreters. This was in spite of having an interpreter vacancy the entire year. ODS contracts for and oversees the operation of 20 community placement beds for deaf people, all of which are staffed with people who are fluent in American Sign Language.

However, a shining gem of the Office of Deaf Services training is the nationally acclaimed Mental Health Interpreter Institute, which is annual 40-hour training for interpreters working with mentally ill deaf consumers. This training, which was initially funded by the block grant and is now self-sustaining, draws participants from all over Alabama and around the country. A website, www.mhit.org, has been set up to help provide interested people information about the project. For FY18, the Mental Health Interpreter Training Project held its 16th week-long Interpreter Institute July 30 – August 4, 2018 at Troy University at Montgomery. The annual Institute, with attendance, was "sold out" months before the opening session. Altogether 175 individuals (91 Registered Participants in the main track, 43 registered participants in the alumni track) presenters, staff and volunteers rounded out the total) participated in the training this year and over 1,300 unique individuals have been trained since its inception, an average of 74 new people every year. They have represented 49 states and 7 foreign countries.

The 11th Annual Deafness and Clinical Training event was held March 1 – 2, 2018, in Montgomery Alabama. Roger Williams, the former state director of deaf services at the South Carolina Department of Mental Health, presented on "Trauma Informed Care and the Deaf Population" at the 2018 Deafness and Clinical Training, A record-breaking 208 people attended over the two days format.

Consumer Advocacy Services

Rights Protection and Advocacy Services for persons in state facilities have long been a top priority for the ADMH. In October 1997, the ADMH greatly enhanced this effort, when the Internal Rights Protection and Advocacy Program officially expanded its role and began providing services to persons being served in community programs that were under contract with ADMH or programs which were certified by the ADMH. Services provided include: information and referral services; complaint intake, investigation and resolution services; participation in certification reviews of new community programs, as well as programs with problematic rights-related issues, to ensure standard compliance; unannounced monitoring of community residential and program areas; and rights education and training.

With a staff of 26 certified advocates working out of five service area offices across the state and in the central administrative offices, the internal advocacy program provides a non-adversarial system of rights protection and advocacy that focuses on rights awareness and prevention of rights violations. A number of the advocates are family members or consumers. Community advocates conduct random or for cause unannounced visits to community residential and day program providers, now including foster care facilities. The Office of Advocacy Services has a toll-free telephone line to address rights-related issues and also is notified of all community Serious Special Incidents.

The Office of Advocacy Services meets at least quarterly with the Advocacy Advisory Board. It is represented on the Mental Illness Coordinating Subcommittee, the MI Community Standards Committee, and other MI committees as needed. Community and facility advocacy services are integral to the quality of services and ADMH's commitment to respect and enforce consumer rights.

Wings Across Alabama

In 2003, consumers across Alabama were vocalizing the need to re-establish a consumer organization. ADMH and the Alabama Disabilities Advocacy Program (ADAP) coordinated grass roots meetings that became known as "Rekindling the Spirit". The mission was to unite consumers of mental health services statewide. In February 2004, ADMH announced an RFP to provide state-wide consumer advocacy activities and develop a state-wide consumer organization. This RFP was awarded in April 2004 and Wings Across Alabama was established. Wings is a non-profit organization for consumers of mental health services with a dedication to making positive change in the lives of consumers through education, advocacy, training, services, and technical assistance as well as through building a strong network of consumers across Alabama with the recognition that inclusion, peer support, true community involvement and participation, self-empowerment, and quality mental health services are KEY ingredients to recovery. Wings strive to improve and reform the community mental

health system, so consumers of mental health services can become effective advocates for themselves and others. The organization is run by consumers of mental health services for consumers of mental health services.

Wings and the Alabama Peer Specialist Association (APSA) merged in 2017. With the merger, Wings kept the mission of APSA and expanded to initiate Peer Support Groups regionally across Alabama.

Wing's key areas of focus around the APSA mission include:

- Promoting the expansion of peer support in Alabama.
- Educating providers on the benefits of employing Certified Peer Specialists.
- Providing a conduit for communication, support, and sharing of information, news and ideas among Peer Specialists.

Wings staff is instrumental in providing staff support to ADMH OCER with the annual Alabama Institute of Recovery and the quarterly CPS Continuing Education trainings. Wings also partners with ADMH MI Community Programs C&A staff around the annual state-wide Children's Mental Health Awareness Week and the statewide youth poster contest.

Alabama Minority Consumer Council:

The AMCC is a statewide nonprofit organization that addresses issues and advocates for issues related to minority individuals living with mental illness. They were first organized in 2001. The Alabama Minority Council promises that minorities will have a voice in the mental health movement.

National Alliance of Mental Illness – Alabama Chapter (NAMI)

NAMI Alabama is an organization comprised of local support and advocacy groups throughout the state dedicated to improving the quality of life for persons with a mental illness in Alabama. The number of such groups is growing rapidly as families become more determined to improve treatment and care for Alabamians diagnosed with a mental illness. Consumers and family members/friends affected by serious mental illness, their treatment, partners, and their supporters/allies united to advocate for a cure for severe disorders of the brain and to improve the quality of life of persons affected by serious mental illness by providing:

1. Information, support, and a sense of belonging to persons with serious mental illness and their families;
2. Advocacy for nondiscriminatory and equitable federal, state, and corporate policies;
3. Research into the causes, symptoms, and treatments for severe brain disorders; and
4. Education to eliminate the pervasive stigma toward persons affected by serious mental illness.

Wings, AMCC, and NAMI Alabama are strong advocates and primary stakeholders at the local and state levels. These organizations are intimately involved in the planning for mental health services provided to adults and children/adolescents in Alabama and have representation on ADMH's Management Steering Committee, and the Mental Illness Coordinating Committee, as well as the Mental Illness Planning Council. ADMH has a vibrant Planning Council that, not only reviews and monitors the Mental Health Services Block Grant but is also active in advocating for consumers and providing leadership in program development. The bylaws spell out the purpose of the Planning Council. Consumers and family members hold majority membership on the Council. Either a consumer or a family member has chaired the Mental Illness Planning Council for the past several years.

The Governing Body of the MI facilities and the MI Facilities Directors Committee also have consumer and family member representation. Each group formed by the Department to tackle specific problems and issues has consumer and family member representation, including the Acute Care Task Force, the four regional planning groups, the Evidence-based Practices Workgroup, the System Reconfiguration Task Force, the Financing Strategies Workgroup, and the Medicaid Managed Care Workgroup. Additionally, consumer and family involvement is guaranteed through inclusion in the

Alabama Administrative Code, which has the force and effect of law. Consumers and family members are also involved in resource allocation and service evaluation at the local community mental health center level.

Person-centered treatment planning has been adopted as the philosophy for ADMH through which consumers are assisted in articulating their vision and hope for how their lives will be changed for the better. ADMH developed a training manual about Person-Centered Treatment planning for use by mental health professionals. Community mental health providers are expected to provide ongoing training on person-centered treatment planning and consumer directed services. In 2009, ADMH sponsored refresher training sessions were provided in four locations across the state related to the focus on improving recovery and resiliency capability of the system. Alabama's Administrative Code promotes the use of a person-centered approach to treatment planning throughout its' entirety.

Alabama currently has no formal policy on participant-directed services. Within ADMH, the Mental Illness Division has relied on a traditional community mental health center system of care. This has provided limited choices to the community providers of what services are offered. However, within the community mental health system at a local level, individuals have choice to what services they will accept, therapist within that system to provide the service, and individualized treatment planning. The efforts of ADMH have been to develop and enhance a continuum of care for both adults and children/adolescents that lends itself to a flexible array of services that are focused on meeting as a first priority the needs of people with a serious and persistent mental illness, particularly those who have been in a state psychiatric hospital. However, this is within the community mental health center itself and to develop a seamless system of care from hospital to community. All services are designed to be provided from a person-centered treatment planning perspective driven by family and consumer needs. Consumers receive not only high quality treatment services, but receive the necessary supports to achieve the highest degree possible of independent living in safe and decent housing, to be employed, to receive necessary medical care in a coordinated manner, and to engage in social interaction with friends and family. The struggle with expanding the provider network is the balancing of care coordination and collaboration necessary to maintain consumer recovery and foster resiliency.

ADMH supports a model for assessment, service planning, and service delivery that is person-centered, strength based, consumer-driven, and family-focused. Efforts to move the system toward this have occurred at several levels. To try and develop infrastructure and build capacity, ADMH has engaged in the following:

- Updated the ADMH Administrative Code for MI Program Standards that incorporates person centered and recovery mandates for care. Person-centered treatment planning is outlined. Addressing the specialized needs of consumers who are deaf or hard of hearing was integrated in every level. So that consumers and their families can be informed of the quality of care of the provider, ADMH implemented having certification scores being posted on the ADMH website as a "report card".
- A regional planning structure was adopted for all departmental planning beginning in FY08 and resulted in increased numbers of family members and consumers being involved in the planning process. During FY09, there were numerous participants in the regional planning process including consumers, family members, Probate Judges, public community providers, state hospitals, and local private providers. In FY09, the planning process was expanded to separate local planning for adults from local planning for children and adolescents. This decision was based on feedback from the previous years of planning with the intent to improve the voice of children and adolescents and their families throughout the planning process. A series of local stakeholder planning meetings occurred in late summer and fall 2009. This provided an avenue to have local and regional input in determining unmet needs and critical gaps within the system at the community level. The local and regional planning process provides the foundation for the Department's annual budget request.
- ADMH implemented the state-wide use of the Child and Adolescent Needs and Strengths (CANS) Functional Assessment Tool effective October 1, 2010 in order to address the concerns about the special individualized needs of child and adolescent consumers and their family members. This strengths-based assessment instrument has cultural subscales that guide service providers in assessing cultural strengths and helping families to select services that are culturally relevant to them. The CANS is linked directly to the treatment plan as to ensure the treatment is individualized, strength based, family-driven, and youth-guided. ADMH developed a statewide web-based application

for the CANS as a means to gather data for NOMs and to measure performance and outcomes. It is anticipated that ADMH will implement such an instrument for the adult system.

- ADMH worked closely with Alabama Medicaid in efforts to expand coverage to those peer related services that would enhance a self-directed care system. ADMH submitted language for consideration of a Medicaid State Plan Amendment for the Rehab Option that was approved in October 2018 and included Adult Peer Support Services, Youth Peer Support Services, and Parent Peer Support Services.

Special Projects (Community)

A portion of the Block Grant is reserved for Planning Council Special Projects. Historically, these funds have been allocated to a variety of educational and service components. These projects have supported transformational activities by providing education/training for family and consumer advocates, direct service staff, administrators, and other interested parties. In addition, the largest part of the Special Projects funding supports drop-in centers and other consumer operated services that directly address Recovery for consumer. Funding for drop-in centers and education programs offered directly by NAMI Alabama, Wings Across Alabama, the Alabama Peer Support Association, and the Alabama Minority Consumer Council was continued as was funding for the annual Consumer Recovery Conference. The funded Special Projects (see attachment) continue to offer important training and educational opportunities for families, consumers, and service providers.

Housing (Home)

The Department acknowledges having a place to call “home” is a desire of individuals in Alabama living with mental illness conditions. Over that past several decades, housing and supports sponsored by ADMH have evolved in an effort to meet the needs and demands of mental health consumer population. As detailed in Section 2-Step 1- under Housing, the Department is committed to offering services and supports to promote individuals’ receipt of mental health treatment in the least restrictive, most integrated environment possible. Spurred by the Alabama Wyatt lawsuit and following Olmstead litigation, the state successfully increased integration efforts through hospital downsizing and closures, as well as community service expansion initiatives. As noted previously, compared to the FY09 baseline end of year average daily census, ADMH reduced the total statewide hospital census in FY12 by nearly 24%, in FY13 by 44%, and in FY14 by 50%. ADMH demonstrated nearly a 52% statewide reduction in total state psychiatric hospital census from FY09 to June 2015. The substantial portion of this success can be traced to the 2007/2008 Acute Care Project and the subsequent 2009/2010 Downsizing Project, for which systematic evaluation and analysis process was conducted with individuals residing on extended hospital wards or who had lengths of stays greater than 90 days. These evaluations were conducted by teams made up of advocates, clinical staff and peer specialists in which participants were surveyed as to their living arrangement preferences as well as service needs. This information, along with hospital treatment team assessments and recommendations, resulted in a structured plan for the development for services and housing to meet the unique needs of the target population.

Likewise, similar activities were conducted for target consumers residing in various group home and residential treatment models identified as having lengths of stays for a year or greater. Barriers to community integration were identified and served as a basis for planning housing, services, and supports necessary to address the unique requirements of this population. The specific services and program development for these projects and other integration efforts are detailed in Section 2-Step 1: Hospitalization-Downsizing Effort for Community Integration. Ongoing process of consumer needs assessment activities and community service expansion efforts have been components of subsequent Hospital Closure and Repurposing projects.

In an effort to monitor the appropriate utilization of residential treatment beds, the Department developed a web-based tool - Mental Illness Community Residential Placement System (MICRS). This system allows for Department level knowledge of residential utility, bed availability, specialized programs (i.e. medical, forensic, dual-diagnosis), and lengths of stay for current occupants. ADMH funds to support the use of Utilization Review Coordinators who are available to monitor MICRS on a regional basis and provide assistance to state psychiatric hospital staff and local mental health providers in locating the most integrated settings for individuals discharging from state psychiatric facilities as well as integrated residential treatment settings.

Wellness Promotion (Health)

In recognition of the 25 year earlier mortality rate and health disparities suffered by individuals with serious mental illness disorders, the Department has promoted health and wellness education and activities. Community mental health providers routinely receive training in universal precautions. Consumers in day treatment and residential programs receive health education on general nutrition, personal hygiene, exercise, and healthy lifestyle, as well as receiving health monitoring and general health advice from staff nurses. Individuals in outpatient, day treatment, and residential services, who are also receiving medication services routinely, have vital signs monitored with referrals to necessary medical care. Recommendations for routine health screenings are incorporated in all services. Community resources such as health fairs, free blood pressure checks, flu vaccines, etc. are utilized when available. Additionally, people are referred to school health nurses, public health clinics and Federally Qualified Health Centers, as appropriate and when available. Administration of medications prescribed by community mental health psychiatrists is coordinated with school personnel.

A gain in momentum to address nicotine dependence among individuals with mental health disorder over the past decade has occurred within the state hospital settings. The state hospitals became tobacco-free on January 1, 2010. All state hospitals are currently smoke-free and interventions to assist consumers with this process have been implemented. For the contracted community mental health centers, there has been progress with initiation of individual endeavors to address smoking cessation, but ADMH has not implemented a state-wide process to address this issue.

For more detailed information in regard Wellness Promotion, please review Section I: Step I: Assess the Strengths and Needs of the Service System to Address the Specific Populations, as well as Section IV: Environmental Factors and Plan: 1. The Health Care System and Integration

Employment and Educational Needs (Purpose)

Employment and Educational opportunities for consumers are not well developed within the mental illness service milieu and are identified as a system weakness. Alabama Department of Mental Health and the Alabama Department of Rehabilitation Services have forged a longstanding collaboration in serving disabled populations. Concerted efforts of this collaboration have targeted individuals receiving mental health services. In FY14, the Alabama Department of Mental Health (ADMH) was awarded the Substance Abuse Mental Health Services Administration (SAMHSA) *Supported Employment: Transforming Lives* grant. This grant will permit for infrastructure building and establishing the foundation necessary from which supported employment and educational services within the mental health continuum can grow. The evidenced-base model, Individual Placement and Supports (IPS) is currently practiced at two mental health provider sites with a third site identified for expansion. The principles of IPS honor a consumer's preferences for jobs and for service delivery.

In an effort to affect state policy, ADMH collaborated with other state agencies and stakeholders to try passing an Employment First Bill and establishing an Employment First Executive Order. An Employment First Bill and Executive Order will affix "employment" as a legislatively affirmed priority. The passing of this bill will be viewed as a turning point in shaping state driven policy and funding mechanisms necessary to spark a transmutation in traditional services systems.

In regard to education, this is an identified area by ADMH for ensuring foundation building in a person's life to be able to achieve resiliency, independence, and recovery. For adults, case managers and clinicians from the mental health centers work with local educational institutions and Vocational Rehabilitation Services offices to refer consumers for education and employment services. Consumers are often provided basic educational services and pre-employment services in day and residential programs. Outpatient consumers are referred to local GED classes and/or institutions of higher learning such as community colleges and universities based on the consumers' interests and abilities. Providers work with local Rehabilitation Services offices to refer people for regular rehabilitation services as well as VR supported employment. For kids, ADMH appreciates a long-standing collaboration with the Alabama State Department of Education (ALSDE) stemming back to 1999. ALSDE is responsible for educational services for children/adolescents in Alabama, and there are over one hundred school systems in the state. For numerous years, case managers, in-home intervention teams, and outpatient

clinicians employed by the Community Mental Health Centers (CMHCs) have had frequent contact with the educational system on behalf of children with a serious emotional disturbance and their families. Since 1999, the two agencies have collaborated to blend funds and resources on projects that began with day treatment programs and now extended into an integrated, school-based project, School-Based Mental Health (SBMH) Collaboration. The SBMH model improves access to appropriate mental health services by children who need them by placing a Master's level clinician in the school setting in a structured manner that ensures confidentiality while enhancing mental health service delivery. ADMH and ALSDE continue to jointly promote the School Based Mental Health Collaboration across the state and have presented workshops on SMBH at ALSDE's MEGA Conference and Transition Conference in FY 12 and every year thereafter through FY17. SBMH Partner CMHCs and School Systems gathered information to establish School Year 2014-2015 as the "baseline year for SBMH Data. This information is used to analyze the effectiveness of SBMH over subsequent years.

For more detailed information in regard Employment and Education, please review Section I: Step I: Assess the Strengths and Needs of the Service System to Address the Specific Populations, as well as Section IV: Environmental Factors and Plan: 20. Support of State Partners.

Section IV: Environmental Factors and Plan: 17. Community Living and the Implementation of Olmstead - Requested

1. Does the state's Olmstead plan include:
housing services provided.

Yes No

home and community based services.

Yes No

peer support services.

Yes No

employment services.

Yes No

2. Does the state have a plan to transition individuals from hospital to community settings?

Yes No

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

Since the United States Supreme Court decided the *Olmstead v. L.C.*, 119 S.Ct. 2176 (1999) decision regarding how persons with disabilities should be treated in the least restrictive and most integrated settings, the Alabama Department of Mental Health (ADMH) created a strategic plan that resulted in the settlement of the (at the time) thirty (30) year old *Wyatt* lawsuit. That agreement can be found as Appendix B to the court order approving the settlement and was ADMH's designated community integration plan. See, *Wyatt v. Sawyer*, 105 F.Supp.2d 1234 -1268 (M.D.Ala. 2000) (J. Thompson). ADMH substantially complied with the provisions of the settlement over a three-year period, resulting in the end of this landmark law suit that, among other things, was a precursor to the Americans with Disabilities Act that was later construed in the *Olmstead* case. See, *Wyatt v. Sawyer*, 219 F.R.D. 529 (M.D.Ala. 2004) (J. Thompson). See also, *Wyatt v. Rogers*, 985 F.Supp. 1356, 1432-33 & 1435 (M.D. Ala. 1997)(J. Thompson)(court rejected plaintiff's motion to add an ADA claim to the complaint as no additional relief was available under that statute beyond what already existed in the law of the case and the parties had already established the parameters of compliance therewith in an earlier consent decree).

During the implementation of the *Wyatt* settlement agreement, and since, ADMH has further planned and executed numerous major initiatives that effectuate the letter and spirit of *Olmstead*. For example, , the *Wyatt* settlement required a minimum of three hundred beds in extended-care psychiatric hospitals and three hundred people residing in

developmental centers (intermediate care facilities for people with mental retardation, i.e. ICF/MR) be closed and the individuals placed in community-based settings, respectively. Although ADMH declined to agree to the closure of any specific facility it operated, as it moved people with mental illness and intellectual disability to community-based settings, ADMH elected to close three developmental centers, two nursing homes (and the third and last one was closed thereafter in 2009), co-located one psychiatric hospital with another; eventually closing the relocated hospital. In 2012, ADMH embarked on further transformation efforts which led to the closures of three more state psychiatric hospitals. The 2012 Hospital Closure Project resulted in the Department closures of Greil Memorial Psychiatric Hospital (Montgomery County) August 31, 2012 and Searcy Hospital (Mobile County) October 31, 2012. Collectively, these two hospitals served a total of 1,231 individuals in FY11. During FY15, ADMH was able to attain another significant milestone with the closure of NARH which occurred on June 17th, 2015. NARH served 728 individuals with an acute inpatient bed capacity of 74 in FY12. Over ninety percent of Greil, Searcy and NARH's inpatient capacity has been shifted to local communities. ADMH also embarked on a "Hospital Repurposing Project" in FY13 with Bryce Psychiatric Hospital. In FY12, prior to project implementation, Bryce served 897 individuals with an acute and extended care inpatient bed capacity of 296. On July 20, 2014, patients located at Bryce Psychiatric Hospital were relocated to a new location commonly referred to as the "new Bryce." The facility was constructed with state-of-the-art design and purpose. Hospital wards were reduced in capacity to allow for increased patient privacy and sense of community. In total, the new hospital operates with a 268 bed capacity.

ADMH's dedication towards enhancing community services and reducing the reliance on state psychiatric hospitals, has continued to reach far beyond the initial Wyatt mandates of extended-care census reduction. Since 1971, the census at Bryce alone dropped from over 5,000 patients to less than 400 in 2004. Through the dedicated efforts of state psychiatric hospitals and community partners, ADMH can boast nearly a 52% statewide reduction in total state psychiatric hospital census from FY09 to June 2015. This was accomplished through the closure of two state operated psychiatric facilities in 2012, one downsized and moved to a new location in 2014, and another closed in 2015. At present there are three state operated facilities serving acute care, extended care, geriatric, and forensic adult populations. ADMH contracts for inpatient services for the adolescent population. Through these operations, ADMH currently carries an inpatient capacity of 489 beds. A detailed description of hospital downsizing and community expansion activities are further described in Section II- Step 1 under Hospitalization (Downsizing effort for community integration) section of this grant application.

As part of the Wyatt settlement and to foster more housing opportunities for people with serious mental illnesses or intellectual disabilities, ADMH embarked upon a partnership with the Alabama Housing Finance Authority to prioritize portions of housing developments financed through a combination of low-income housing tax credits and the Home Investment Partnership Program. These plans were approved by HUD and netted up to fifteen percent (15%) of housing units developed through funding from these two programs for the years 2000 and 2001. Under this initiative, people with mental disabilities have a priority for occupancy up to the total of reserved units and when they vacate the premises that priority remains. Only, if after working with local mental health service providers and ADMH, housing managers cannot find a person with mental disabilities to occupy the premises, many other tenants occupy that small, integrated percentage of these units. ADMH Advocacy staff assist consumers with issues that may arise with the managers of these units (and others) with problems they may have with landlords, related to the tenants' illness or condition. Further information about ADMH Housing Initiatives can be found Section II – Step 1 under Residential Care, Housing Services, and Permanent Supportive Housing of this grant application. Parallel to the implementation of the Wyatt settlement agreement, ADMH also settled a law suit filed by deaf or hard of hearing consumers in a class action, alleging violations of the Americans with Disabilities Act, among other claims. *See, Settlement Agreement, Bailey v. Alabama Department of Mental Health and Mental Retardation.*

Upon the inception of the Home and Community Based Services Expansion Project, ADMH was a member of the Olmstead Planning Core Workgroup established by the lead agency Alabama Medicaid. The workgroup comprised of state agencies, consumer and advocacy groups, and other stakeholder representatives was charged with designing a three-year strategic plan for expanding home and community-based services. Through the Wyatt settlement agreement, ADMH was required to implement a statewide community education plan, reduce institutional levels, and develop more community options.

Several workgroups comprised of ADMH Administrators and hospital staff, consumer and family members, public and private mental health providers, and advocacy groups were established to form the Wyatt Implementation Plan. This Wyatt plan and Olmstead initiatives converged to create the roadmap to drive a reduction in the use of state psychiatric institutions and expand community service options. These plans included provisions for the expansion of recovery oriented supportive services such as Peer Support Services and others. For a detailed description of support services specifically funded through hospital downsizing/community integration efforts, please refer to Section II- Step 1 under Hospitalization (Downsizing effort for community integration) section of this grant application.

Purposeful and inclusive planning supported the implementation of a census reduction, hospital downsizing, hospital closure, and hospital repurposing models in which the care of individuals housed within the States' extended care wards would be transferred to the community provider network along with the development of acute care capacity within the community. This resulted in a significant expansion of residential services many of which reflected the development of new "specialty", and small capacity (three bed) residential models to address the unique needs of extended care residents such as medical and forensic. It also resulted in the establishment of local designated mental health care facilities and local hospital partnerships. Expert training and consultation were provided through Olmstead funds and other funding sources to include deaf interpreter training, person centered discharge planning, and dual diagnosis services.

Funds continue to be dedicated for community integration and service expansion efforts though block grant dollars, general state funds, and other grant resources. Throughout the years, community integration and services expansion have been the focal point of the SAMHSA Block Grant goals and targets for mental health services. The MI Planning Council, which is the mandated body to approve the Mental Health Block Grant goals has assured this process and their guidance has steered the enhancements to this process to expand into peer directed care that is strength-based and person-centered. The MI Planning Council established guidelines for the submission and approval process for proposed uses of the stipend. Funding is dedicated to facilitate State's efforts to carry out the core values expressed under the Olmstead decision of promoting community integration for adults with serious mental illnesses and/or co-occurring substance use disorders and children with serious emotional disturbance.

For more detailed information on the State of Alabama Long Term Care Rebalancing Initiatives, please see attachment.

Section IV: Environmental Factors and Plan: 18. Children and Adolescents Behavioral Health Services – Required MHBG

11. Does the state utilize a system of care approach to support:

a) The recovery and resilience of children and youth with SED?

Yes No

b) The recovery and resilience of children and youth with SUD?

Yes No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address behavioral health needs:

a) Child welfare?

Yes No

b) Juvenile justice?

Yes No

c) Education?

Yes No

3. Does the state monitor its progress and effectiveness, around:

a) Service utilization?

Yes No

b) Costs?

Yes No

c) Outcomes for children and youth services?

Yes No

4. Does the state provide training in evidence-based:

a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families?

Yes No

b) Mental health treatment and recovery services for children/adolescents and their families?

Yes No

5. Does the state have plans for transitioning children and youth receiving services:

a) to the adult behavioral health system?

Yes No

b) for youth in foster care?

Yes No

Within ADMH, the Mental Illness Division has relied upon a traditional community mental health center system of care. Within the community mental health system at a local level, individuals are given choices in all aspects of their care to include what services they will accept and the therapist within that system they would like to provide the service. Individuals also contribute to individualized treatment planning and have direct input on the focus of their treatment. The efforts of ADMH have been to develop and enhance a continuum of care that lends itself to a flexible array of services that are focused on meeting the needs of children and adolescents with a serious emotional disturbance and their families. All services are designed to be provided from a person-centered treatment planning perspective driven by youth consumer and family needs. The importance of expanding the provider network is to achieve the balance of care coordination and collaboration necessary to maintain consumer recovery and foster resiliency. ADMH also strives to integrate services throughout all the systems that may share involvement with children and adolescents. ADMH has experience in creating a modern system of care approach to delivering mental health services to children and adolescents with serious emotional disturbance and their families. In FY 1997, ADMH received a SAMHSA Children's Mental Health Initiative System of Care (SOC) grant that covered the largest metropolitan area in Alabama – Jefferson County. The Jefferson County Community Partnership (JCCP) project focused on developing a seamless system of care for children with a serious emotional disturbance and their families. JCCP incorporated two parent coordinators which became the first parent support specialists in the children's mental health system in Alabama. All services were co-located with the system of care partners. In FY 2010, ADMH received a second SAMHSA SOC cooperative agreement that covers three rural counties in East Central Alabama. The East Central Children's Health Collaborative (ECCHCO) Project incorporates strategies around meeting the ethnic, cultural and linguistic needs of their children/adolescents they serve and their families. ECCHCO also has a full-time administrative parent/youth coordinator who addresses the diverse needs of child and adolescent consumers and their families. All services are co-located with the system of care partners. They incorporated a Family Advisory Council and a Youth Advisory Council, as well as youth and family representatives on the ECCHCO Advisory Council. The core values of system of care (community based, family-driven, youth-guided, culturally and linguistically competent) are infused at all levels within this system of care. Within the ADMH planning process, both SOC sites have been used as a laboratory of learning in the continued efforts to expand SOC core values throughout the state.

In addition to the two SOC Collaborations, efforts to integrate services throughout child-serving agencies in a system of care approach is emphasized at both the state and local levels. There is a significant focus on the importance of collaboration between child serving agencies to ensure that all agencies are working together to provide the most appropriate services that complement each other and provide consumers with optimal services to promote Recovery and excel in all settings.

At the state level, ADMH has for many years partnered with other state agencies, including but not limited to the Alabama Medicaid Agency, the Department of Public Health, Juvenile and Adult Corrections, the Administrative Office of the Courts, the Alabama State Department of Education (ALSDE), and the Department of Human Resources, to provide a comprehensive array of publicly funded services to children/adolescents through memoranda of understanding, intergovernmental service agreements or informal relationships. For specific information regarding collaborative efforts between ADMH and other state child-serving agencies, please see Section IV, Environmental Factors and Plan: 21. Support of State Partners.

In addition to these collaborative efforts, within ADMH Mental Illness Community Programs, there are three dedicated positions for child and adolescent services and both interact as state level liaisons with all the state level child serving agencies. The Coordinator of MI C&A Services works with the Alabama State Department of Education (ALSDE) on issues of policy making and expansion of services, such as the School Based Mental Health (SBMH) Collaboration. To further our efforts, a full-time Coordinator of School-Based Mental Health Services was recently added as a position with ADMH Mental Illness Community Programs to assist with the expansion of this service and to work closely with ALSDE on improving collaboration at both the local and state level. The School-Based Mental Health Collaboration is a promising practice with a focus on ensuring a more preventive approach to integrate a seamless system of mental health care in educational settings. This is part of an effort to provide treatment that is more holistic and assists young people in building strength and resiliency personally and with their educational successes. For specific information regarding collaborative efforts with SBMH, please see Section IV, Environmental Factors and Plan: 21. Support of State Partners.

The Coordinator is also a member of the State Level of MI C&A Services Multi-Needs Case Review Committee which consists of representatives from ADMH, ALSDE, the Department of Human Resources (DHR), the Department of Public Health (DPH), and the Department of Youth Services (DYS). The Case Review Committee meets monthly to discuss children and adolescents involved with two or more of these agencies who are referred from across the state in an effort to make collaborative decisions on the most appropriate resources to meet the needs of the individual. In addition, the Coordinator works closely with DHR and DYS on the OUR Kids project. OUR Kids is a joint partnership between ADMH, DHR, and DYS that funds and monitors 11 collaborative programs across the state that serve children and adolescents that may be involved or at risk of involvement with multiple agencies.

The MI C&A Resource Specialist provides mental health resources and guidance on accessing services to anyone reaching out for assistance to include the local mental health providers, educational systems, juvenile probation officers, child welfare social workers, and family members. This position ensures that the local parties identified are linked for coordination as to assure that identified children are connected to the local available mental health services.

The entire C&A staff in MI Community Programs works closely and collaboratively with the Substance Abuse Coordinator of Child and Adolescent Services. At the state level, ADMH has merged the two service divisions related to Mental Health and Substance Abuse and the staff regularly collaborate on options for individuals in need of services. The SA C&A Coordinator is also a member of the State Level Multi-Needs Case Review Committee. For more information on the efforts to integrate substance abuse services throughout a system of care, please refer to the Substance Abuse Block Grant.

At the local level, all the community mental health providers work closely with the local educational settings and most, if not all, have a current local arrangement with their LEAs to assure identified children and adolescents are connected with available mental health services. The SBMH Collaboration Program does identify a liaison for this process, both with the educational setting and the mental health provider, as well as an administrative staffing process to ensure that issues are identified and addressed in an effort to maintain and enhance the program. Another venue that allows for a liaison process to occur at the local level is through the multiple needs process. Each county has a local multi-needs team that has representatives from mental health, child welfare, juvenile court, and the educational setting(s). The multi-disciplinary staffing allows for the child serving entities to work in a multi-directional process to engage needed care for the children and their families in which they all serve. Each mental health center is also required to have a Juvenile Court Liaison (JCL). The JCL is a master's level therapist that is available to the Juvenile Court System to assess children and adolescents, provide resource options, and link to appropriate services. Some of the Juvenile Courts have provided office space allowing the JCL

to provide services at the Court and be immediately available to Juvenile Probation Officers and the Court. In other counties, the JCL is available to the court and able to provide services as needed.

7. Does the state have any activities related to this section that you would like to highlight?

Person-centered treatment planning has been adopted as the philosophy for ADMH through which children and adolescents are assisted in articulating their vision and hope for how their lives will be changed for the better. Person-centered treatment planning training sessions have been ongoing for several years in state facilities and with community mental health providers. Community mental health providers are expected to provide ongoing training on person-centered treatment planning and consumer directed services with a focus on improving recovery and resiliency capability of the system. Alabama's Administrative Code promotes the use of individualized, person centered treatment planning throughout and codifies meaningful contribution by the child/adolescent and responsible caregivers in all aspects of treatment planning and implementation.

The Child and Adolescent Needs and Strengths assessment tool (CANS) is also an instrument designed to be utilized in the person-centered treatment planning process. The CANS is linked directly to each consumer's treatment plan to ensure that treatment is individualized, strength based, family-driven, and youth-guided. ADMH developed a statewide web-based application for the CANS as a means to gather data for NOMs and to measure performance and outcomes. All MI contracted and certified providers of Child/Adolescent services have staff trained to perform the CANS assessment, and a CANS is completed on all Child/Adolescent consumers during the Intake process and at least every six months afterward. Clinicians at the local level can access outcome information on their individual consumers over time and assess progress in several different functional areas. This information is explored and discussed in treatment planning sessions with the consumer and family members and is used to help determine appropriate treatment goals and interventions during treatment. At the ADMH level, the CANS database is designed to provide accessible NOM information and is available to help in gauging the effectiveness of programming for children and adolescents. For example, the CANS data is being utilized to produce outcome information to help measure the effectiveness of the School-Based Mental Health project which is currently available in several locations around the state and is in the process of expanding with the goal of being available state-wide.

In addition, a number of different evidence-based practices (EBPs) related to various aspects of mental health prevention, treatment and recovery are utilized by different Child/Adolescent service providers. Each EBP has its own training/certification process, which is managed by the agency implementing the practice. At this time, EBPs have not been established at a state-wide level. A promising current mental health provider implementation of EBPs is the establishment of SBMHC as discussed above and the implementation with one community mental health center (CMHC) to implement the use of Youth Certified Peer Specialists. This project is located in Jefferson County and is a collaboration between a psychiatric residential treatment facility (PRTF) and the CMHC in that catchment area. The PRTF contracted with the CMHC to utilize Youth Peer Specialists within their system. This project has grown to employing four Certified Youth Peer Specialists. ADMH is utilizing this demonstration to expand the use of this EBP within the child/adolescent system. ADMH is actively working with subject matter experts to expand Youth Certified Peer Specialists and Parent Peer Specialists statewide. This includes training all supervisors on the value of peer specialists as professionals who will be providing a needed recovery service for youth and parents.

The age cut off for SED with ADMH was expanded from age 18 to age 19. ADMH has flexibility for an individual to continue with C&A services in the mental health provider system but it hinges on the ability of the provider to continue to provide the care. If a young adult is moving into the adult system, such as completing school, going to college, getting a job, there would be a transfer of services from the C&A provider network to the adult services within the provider system. The gap that is sometimes experienced is that the young adult will now need to meet the SMI criteria and there are times this is an obstacle. For young adults who are still involved with children serving life experiences, such as still in high school, involved with DHR and/or juvenile court, the provider can maintain the mental health services with the C&A service network. The one-year age increase to qualify for SED criteria will provide some increased flexibility for this age range. The primary obstacle is ensuring the staff who are providing the treatment carry necessary certification/training approvals. This is typically needed for specialty services such as case management and In-home teams. In regard to residential services, there is only one residential

treatment facility, under the certification/contract with ADMH that focuses on transitional age. The age for this program is age 17-22. The CANS was developed with a Transitional component as to allow for services and care to remain with the C&A service provider network when identified as most beneficial.

Section IV: Environmental Factors and Plan: 19. Suicide Prevention – Required

1. Have you updated your state's suicide prevention plan in the last 2 years?

Yes No

2. Describe activities intended to reduce incidents of suicide in your state.

In 2001, the Commissioner of the Alabama Department of Mental Health and the State Health Officer of the Department of Public Health (ADPH) joined forces to establish the Alabama Suicide Prevention Task Force (ASPTF). In response to identified state needs, ASPTF would function to: (1) promote recognition of suicide as a problem affecting Alabama; (2) outline a strategy for the prevention of suicide in Alabama; and (3) identify federal, state, and local resources to support implementation of Alabama's Suicide Prevention Plan. Consisting of twenty-seven (27) representatives of multidisciplinary public and private agencies, members of the faith community, as well as survivors, ASPTF published the State's first Suicide Prevention Plan in 2004. ADMH has maintained active representation on ASPTF since its inception.

The Alabama Suicide Prevention Task Force (ASPTF) reorganized during FY10. Evolving from task force status to a structured non-profit membership organization with a governing board, the ASPTF became the Alabama Suicide Prevention and Resource Coalition (ASPARC). Currently, ASPARC is coordinating efforts with ADPH as a result of the Garrett Lee Smith funding opportunity. Thus, efforts have focused on the planning and implementation of the grant which has focused on providing QPR gatekeeping training and Lay My Burdens Down (LMBD). Trainings are offered, provided and extended to agencies working with vulnerable populations to faith-based communities to anyone that seeks information and awareness as it relates to suicide prevention.

3. Have you incorporated any strategies supportive of Zero Suicide?

Yes No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments?

Yes No

5. Have you begun any targeted or statewide initiatives since the FFY 2016-FFY 2017 plan was submitted?

Yes No

If so, please describe the population targeted.

Current statewide initiatives include the following:

ADMH continues to serve as an active participant in ASPARC activities. ADMH has also extended coordinated efforts within FY'19 with ADPH to address population needs as it relates to suicide prevention. A recent report indicates the suicide rate in Alabama was 16.2 per 100,000 people in 2016, as reported by the Alabama Department of Public Health. This rate was higher than the U.S. rate of 13.9 per 100,000. The suicide rate of 16.2 exceeds the homicide rate of 11.2 in Alabama and the United States. ADMH Office of Prevention has substance abuse prevention strategies that positively impact mental health because they target associated risk and protective factors. It is expected that efforts toward the reduction of substance abuse would extend to efforts toward the reduction of suicide. The action steps that have been in progress are: participation and collaboration with the suicide prevention task force, educate the prevention system on shared risk and protective factors of suicide and substance abuse and effective practices and resources for prevention; ensure prevention plans address common risk and protective factors as it relates to substance abuse and suicide, and prevent and reduce substance-related suicides among populations at high risk. Incorporating the linkage of suicide and substance abuse as a target of focus for prevention strategy implementation allows prevention providers to address high risk and vulnerable populations for this public health issue. Forty percent of the prevention provider agencies, an increase of fifteen percent

from the previous report, addressed suicide as it relates to substance abuse in FY2019 through use of Environmental, Community Based Processes, Education, Alternatives and Information Dissemination strategies. One community example was the implementation of Mental Health First Aid. This program aims to empower adults living or working within the area to recognize signs and symptoms associated with mental health crisis, which are often increased through the use of drugs or alcohol. The Department of Human Resources reports nearly 70% of their caseload consists of families struggling with substance use, which serves as a risk factor for mental health issues in the community.

At the state level, the ADMH has continued its relationship with the suicide prevention task force with board membership, active meeting participation, and attendance at the suicide conference. In addition, ADMH is a member of the Jason Flatt Suicide Prevention Task Force. The Jason Flatt Act was signed into law in May 2016. The law requires all public schools to establish policy, curriculum, and a list of resources for suicide prevention. ADMH is involved in the assistance in development of the suicide prevention curriculum. Furthermore, ADMH continues to coordinate with the Veteran's Administration and attend workshops, trainings and conferences as it relates to suicide prevention.

The 2019 State Plan

The Alabama State Plan for Suicide Prevention provides state-specific recommendations that include Strategic Directions, Objectives and Strategies that align with the National Strategy for Suicide Prevention. The strategies outlined in this plan can be supported by ADPH, ASPARC, the Alabama Chapter of the AFSP, crisis centers, and colleges and universities throughout the state.

Strategic Direction

- Healthy and Empowered Individuals, Families, and Communities
- Clinical and Community Preventive Services
- Treatment and Support Services
- Surveillance, Research, and Evaluation

Goals

- 1) Integrate and coordinate suicide prevention activities across multiple sectors and settings.
- 2) Implement research-informed communication efforts designed to prevent suicide by changing knowledge, attitudes, and behaviors.
- 3) Increase knowledge of the factors that offer protection from suicidal behaviors and that promote wellness and recovery.
- 4) Promote responsible media reporting of suicide, accurate portrayals of suicide and mental illness in the entertainment industry, and the safety of online content related to suicide.
- 5) Develop, implement, and monitor effective programs that promote wellness and prevent suicide and related behaviors.
- 6) Provide training to community and clinical service providers on the prevention of suicide and related behaviors.
- 7) Promote suicide prevention as a core component of health care services.
- 8) Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors.
- 9) Increase the timeliness and usefulness of national surveillance systems relevant to suicide prevention and improve the ability to collect, analyze, and use this information for action.

Strategic Direction 1: Healthy and Empowered Individuals, Families, and Communities

Goal 1: Integrate and coordinate suicide prevention activities across multiple sectors and settings across the lifespan

Objective 1.1: Integrate suicide prevention into the values, culture, leadership, and work of a broad range of organizations and programs with a role to support suicide prevention activities.

Strategy 1.1.1: Conduct a stakeholder analysis and survey of suicide activities being implemented around the state.

Strategy 1.1.2: Develop a comprehensive suicide prevention and treatment resource directory for coordination purposes to assist populations in need.

Strategy 1.1.3: Convene a group of potential suicide prevention activity funders to target underserved areas.

Strategy 1.1.4: Fund, develop, and sustain public-private partnerships in identified communities.

Strategy 1.1.5: Promote R U Good? initiative with statewide media campaign.

Goal 2: Implement research-informed communication efforts designed to prevent suicide by changing knowledge, attitudes, and behaviors.

Objective 2.1: Develop, implement, and evaluate communication efforts designed to reach defined segments of the population.

Strategy 2.1.1: Disseminate a tested suicide prevention message to stakeholder organizations to use statewide.

Strategy 2.1.2: Develop a question for YRBS to determine if youth have been exposed to suicide prevention messaging.

Goal 3: Increase knowledge of the factors that offer protection from suicidal behaviors and that promote wellness and recovery.

Objective 3.1: Promote effective programs and practices that increase protection from suicide risk.

Strategy 3.1.1: Incorporate effective programs and practices in funder's proposal instructions/guidance (RFP process).

Goal 4: Promote responsible media reporting of suicide, accurate portrayals of suicide and mental illness in the entertainment industry, and the safety of online content related to suicide.

Objective 4.1: Encourage and recognize news organizations that develop and implement policies and practices addressing the safe and responsible reporting of suicide and other related behaviors.

Strategy 4.1.1: Disseminate recommendations for reporting to media outlets statewide and schools of journalism.

Strategic Direction 2: Clinical and Community Preventive Services

Goal 5: Develop, implement, and monitor effective programs that promote wellness and prevent suicide and related behaviors.

Objective 5.1: By September 2020, identify two programs that effectively promote wellness, and prevent suicide and related behaviors in youth under the age of 13.

Strategy 5.1.1: Identify research-based and best practices for wellness activities and resources for youth under the age of 13.

Strategy 5.1.2: Implement research-based and best practices for wellness activities and resources for youth under the age of 13 in schools and youth-serving organizations.

Objective 5.2: By September 2020, develop an online postvention toolkit of resources to guide the response to a suicide attempt or loss, preventing future loss and reducing contagion effects in communities.

Strategy 5.2.1: Identify local Survivors of Suicide loss support groups.

Strategy 5.2.2: Identify national guidelines and resources for suicide postvention.

Strategy 5.2.3: Adapt specific guidelines and resources for local communities from national postvention toolkits and resources.

Strategy 5.2.4: Develop and disseminate postvention toolkit to schools and youth-serving organizations.

Goal 6: Provide training to community and clinical service providers on the prevention of suicide and related behaviors.

Objective 6.1: By September 2021, increase the number of individuals trained using evidence-based suicide prevention programs by 20,000.

Strategy 6.1.1: Provide evidence-based suicide prevention programs that promote wellness and teach coping and problem-solving skills in school settings.

Strategy 6.1.2: Provide evidence-based suicide prevention programs that promote wellness and teach coping and problem-solving skills in community settings.

Strategy 6.1.3: Provide evidence-based suicide prevention programs that promote wellness and teach coping and problem-solving skills for first responders and medical personnel.

Strategy 6.1.4: Provide evidence-based suicide prevention programs that promote wellness and teach coping and problem-solving skills for higher education settings.

Strategy 6.1.5: Identify and offer services to high risk populations: LGBTQ, middle-aged men, Native Americans, and veterans.

Strategic Direction 3: Treatment and Support

Goal 7: Promote suicide prevention as a core component of health care services.

Objective 7.1: Promote timely access to assessment, intervention, and effective care for individuals with a heightened risk for suicide.

Strategy 7.1.1: Identify a behavioral health risk assessment tool for first responders and pilot.

Strategy 7.1.2: Integrate behavioral risk assessment tool for first responders as an established agency practice.

Strategy 7.1.3: Develop and pilot screening and referral program for higher education settings.

Objective 7.2: Develop collaborations between emergency departments and other health care providers to provide alternatives to emergency department care and hospitalization when appropriate and to promote rapid follow-up after discharge.

Strategy 7.2.1: Develop evidence-based protocols for referral and follow-up services.

Strategy 7.2.2: Establish formal agreements with three emergency departments or other health care providers to implement evidence-based protocols for referral and follow-up services.

Strategy 7.2.3: Promote evidence-based protocols for referral and follow-up services to emergency departments, schools, and health care providers.

Goal 8: Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors.

Objective 8.1; 8.2: (8.1.) Develop standardized protocols for use within emergency departments based on common clinical presentation to allow for more differentiated responses based on risk profiles and assessed clinical needs. **(8.2.)** Develop guidelines on the documentation of assessment and treatment of suicide risk and establish a training and technical assistance capacity to assist providers with implementation.

Strategy 8.1.1: Identify a screening tool for all providers that is inclusive of opioid abuse.

Strategy 8.2.2: Promote Zero Suicide policy implementation to hospitals and other health care providers.

Strategic Direction 4: Surveillance, Research, and Evaluation

Goal 9: Increase the timeliness and usefulness of national surveillance systems relevant to suicide prevention and improve the ability to collect, analyze, and use this information for action.

Objective 9.1: Improve and expand state and local public health capacity to routinely collect, analyze, report, and use suicide-related data to implement prevention efforts and inform policy decisions by promoting the use and sharing of national and local suicide related data.

Strategy 9.1.1: Identify 5 entities housing evidence-based suicide related data.

Strategy 9.1.2: Establish data-sharing agreements with 3 local organizations that collect and maintain a database containing suicide related data.

Strategy 9.1.3: Promote the use and sharing of national and local suicide related data through statewide informational campaign.

Strategy 9.1.4: Assess, synthesize, analyze, and disseminate survey results from suicide prevention interventions.

Strategy 9.1.5: Use syndromic surveillance and other data sources to determine the impact and effectiveness of suicide interventions in reducing suicide morbidity and mortality.

Strategy 9.1.6: Use syndromic surveillance to determine the impact and effectiveness of Zero Suicide in reducing suicide morbidity and mortality.

Section IV: Environmental Factors and Plan: 20. Support of State Partners - Required

1. Has your state added any new partners or partnerships since the last planning period?



Yes



No

2. Has your state identified the need to develop new partnerships that you did not have in place?

Yes No

If yes, with whom? **NA**

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilities Education Act.

ADMH partners with other state agencies, including but not limited to the Alabama Medicaid Agency, Department of Public Health, Juvenile and Adult Corrections, the Administrative Office of the Courts, Department of Education, Department of Corrections, and Department of Human Resources, to provide a comprehensive array of publicly funded services to adults and children/adolescents through memoranda of understanding, intergovernmental service agreements or informal relationships. As in the case of most states, Alabama has experienced fiscal challenges. Strained resources and the loss of a number of veteran state staff through accelerated retirement, downsizing and changes in state governmental leadership has increased the workload on existing staff. Moreover, there have been several changes in leadership in most departments of state government, especially with ADMH who has experienced a change in leadership of Commissioner five times since January 2011. As such, although ADMH has a good working relationship with partners, framing those relationships in a deliberate and collaborative fashion toward meeting the expectations of SAMHSA and aligning various departmental priorities with those objectives remain challenging at times. ADMH is working toward the transformation process by realigning and restructuring the process with longstanding partners and enhancing and developing the process with potentially new and less involved partners.

ADMH administers a wide range of services to adult and children/adolescent consumers in the community and at state institutions; regulates care and treatment providers; and consults with local, county, and public and non-profit agencies. The Department's responsibilities span a large number of program areas as outlined in Section II- Planning Steps - Step 1- Assess the strengths and needs. Other state departments work closely with the State Mental Health Authority on a regular basis including the following:

Primary health and mental health services

Medicaid:

The Alabama Medicaid Agency (AMA) is a state/federal program that pays for medical and long-term care services for low-income pregnant women, children, certain people on Medicare, individuals with disabilities and nursing home residents. These individuals must meet certain income and other requirements. ADMH has had a long-standing working relationship with AMA and is already fully engaged with the Medicaid Agency on planning for health care reform.

Below are areas of focus involving AMA:

Electronic Health Record:

A Web site to encourage public involvement as Alabama develops a statewide electronic health record system is now available at www.onehealthrecord.alabama.gov as well as a link on the Alabama Medicaid Agency website. The site has been established as a central point for citizens to learn about and become involved in the state's efforts to use new technology to reduce duplication, increase efficiency, improve patient health outcomes, prevent fraud and abuse, and lower health care costs. Alabama recognizes the benefits that can be achieved through a secure, interoperable exchange of electronic health information that ensures the right information will be available to the right provider at the right time which will improve the quality, safety and efficiency of health care delivered to Alabama patients. The website provides details on the state's plans for a statewide health information exchange, including the work done by the Alabama Health Information Exchange Commission and its six workgroups, links to a separate but related effort to encourage physicians and hospitals to adopt, implement or upgrade to certified information technology systems, and links to the state's federally-supported Regional Extension Center at the University of South Alabama.

Medicaid Expansion:

Former Governor Robert Bentley announced in November of 2012 that Alabama would not participate in Medicaid expansion because of funding. Governor Bentley did not believe the Affordable Care Act was a "workable solution," and reaffirmed his stand against accepting a federal offer to expand Medicaid in the state. Governor Bentley has indicated that he doesn't want to expand a broken system. He was optimistic that Medicaid reform, which he signed into law in June 2013, would go a long way toward the solutions needed in Alabama. The reform employed a managed care overlay to the system, in hopes of greatly reducing costly medical encounters by Medicaid users. In December 2014, former Governor Bentley suggested that he might be open to an alternative option for expanding Medicaid in Alabama. Governor Bentley had previously opposed expanding the state-federal insurance program but stated creating a state-designed program that uses the federal Medicaid expansion dollars may be an option for the state at some point, especially as Medicaid Reform progresses within the state of Alabama. At present date, Medicaid Expansion has not occurred on Alabama. Alabama is one of about 14 states so far that is not accepting the federal waiver for Medicaid expansion.

Medicaid Reform:

Medicaid reform legislation that would ultimately restructure the state's health care delivery system for low-income citizens (SB340) won approval in the Alabama Senate on April 25, 2013 and in the House on May 7, 2013. Former Governor Bentley held a ceremonial bill signing June 6, 2013 for Senate Bill 340, a measure that was felt would help increase efficiency in Alabama Medicaid while also helping improve patient care. The approved bill was based largely on the earlier recommendations of the Alabama Medicaid Advisory Commission which was appointed by former Governor Bentley to improve Medicaid's financial stability while also providing high-quality patient care. The Commission recommended in January 2013 that Alabama be divided into regions, and that a community-led network (RCO) coordinate the health care of Medicaid patients in each region, with networks ultimately bearing the risks of contracting with Alabama to provide that care. The Commissioner of ADMH was one of the Commission members. The previous State Health Officer chaired the Medicaid Advisory Commission and led the Medicaid transformation effort at that time.

Regional Care Organizations:

The concept of a Regional Care Organizations (RCOs) was to be locally-led managed care systems that would ultimately provide healthcare services to most Medicaid enrollees at an established cost under the supervision and approval of the Alabama Medicaid Agency. State legislation passed in 2013 and updated in 2014 created the new managed care structure to enable Medicaid to move away from a volume-based, fee-for-service environment to a payment system that incentivizes the delivery of quality health care and improved health outcomes. In October 2013, as required by law, the state established five regions. Under the new structure, Alabama Medicaid would enter into contracts with RCOs to provide certain covered services for Medicaid patients at an established cost. Implementation of full-risk RCOs was slated to begin no later than October 1, 2016, with Alabama Medicaid paying a set monthly amount to each RCO which in turn would be responsible for paying for all the RCO-covered services.

On July 27, 2017, the Commissioner for AMA issued a press release announcing that in light of known federal administration changes and potential congressional adjustments, AMA would pursue an alternative to the Regional Care Organization initiative to transform the Medicaid delivery system. Moving forward, the AMA is working with CMS to create a flexible program which builds off AMA's current case management structure as a most cost-efficient mechanism to imported recipient's healthcare outcomes. RCOs were mandated by state law in 2013 to move the Medicaid agency away from its current payment system to one that would incentivize efficient delivery of high-quality healthcare services and improve health outcomes. When RCOs were first proposed after the ACA, the plan was felt to be appropriate by AMA.

2703 Health Home State Plan Amendment (SPA):

In 2012, Medicaid partnered with the state agencies involved with Optional Medicaid services (Rehab, TCM, Waiver) to complete a 2703 Health Home State Plan Amendment (SPA). For the SPA to be approved, SAMHSA had to first approve the plan as to verify that behavioral health was written into the plan. SAMHSA conducted an interview/evaluation with

ADMH in 2012 and agreed to the components of the 2703 SPA and indicated it was one of the few applications they had reviewed that demonstrated having bi-directional mental health and substance abuse care coordination/care management at a more integrated level. The SPA remained under review with CMS until May 2013 when finally approved. ADMH reached out to AMA to set up meetings to determine how the ADMH providers would participate with the implementation of the 2703 SPA as it pertains to mental health and substance abuse care. In 2013, the entire Medicaid process became a focal point of legislative focus and the former Governor steered the state toward Medicaid Reform. It was determined that the Health Homes implemented in the four initial sites were proving to be a cost-effective process to manage both clinical care of individuals and financial cost savings. At the root of the Medicaid Reform are the goals of the Health Homes: provide quality-driven, cost effective, culturally appropriate, and person- and family-centered health home services and coordinate Primary Medical Providers (PMPs) with Behavioral Health Providers in the Region to ensure delivery of best practices for integration and care management of chronic conditions. On April 1, 2015, the Health Home program expanded statewide to be managed by six of the eleven probationary RCOs who submitted qualifying proposals for their respective regions. On October 1, 2018, the Health Home program were incorporated into the full risk RCO's operation. This interim step was designed as a building block for probationary RCOs that are working toward full certification by facilitating network development and providing resources while offering the probationary RCOs an opportunity to demonstrate that they have the resources to manage patients in their region. However, with the ending of the RCOs, the process of statewide implementation of the Health Homes was shifted to the process to implement the Alabama Coordinated Health Networks.

Alabama Coordinated Health Networks (ACHN):

With the closure of the RCO process, AMA initiated a Pivot Plan, which was the shift to build off the Health Homes and implement the Alabama Coordinated Health Networks (ACHN). AMA chose to continue to focus on managed care concepts but with a health home concept. The funding mechanism shifted to a 1915(b) waiver that was submitted on August 2, 2018 and approved on June 14, 2019. Guiding principles include paying for activity, not member, focusing on care management and health outcomes, and redirecting current expenditures to better achieve desired outcomes. The ACHN program will be implemented on October 1, 2019. The ACHN will implement a single care coordination delivery system combining Health Homes, Maternity Program, and Plan First. It replaces silos in current care coordination efforts. Care coordination services will be provided by regional Primary Care Case Management Entities (PCCM-Es), or network entities. There will be seven newly defined regions. Also, primary care physicians practicing in district comprise at least half of board. ADMH is working closely with AMA and the implementation of the ACHN to ensure that are common consumers benefit for this care coordination opportunity. There are several quality measures are that specific to mental health and substance use.

Medicaid Quality Assurance Committee:

State law required the formation of a Quality Assurance Committee comprised of practicing healthcare professionals, 60 percent of which must be physicians. ADMH has a representative on the Medicaid Quality Assurance Committee. This group approved 42 quality measures that will be used for monitoring RCOs' performance, 10 of which will be incentivized under the new managed care system. All but one of the 42 measures are nationally recognized and validated which will allow Alabama to compare its performance to other states and national benchmarks. The measures not only include metrics related to diabetes, asthma, and well-child, but mental and substance use, care coordination and if care is provided in the most appropriate location. ADMH worked closely with the committee to provide recommendations on the mental health and substance use measures. With the ending of the RCOs, the use of these quality measures in the Medicaid Reform process has shifted to the ACHN.

Integrated Care Networks (ICN):

In an effort to implement community integration for individuals who are targeted for nursing home placement, AMA worked diligently to streamline the coordinated efforts of several nursing home waivers. The Alabama's Integrated Care Network (ICN) program, based on a concept paper released by the Alabama Medicaid Agency in March 2018, was implemented. The ICN program establishes a new Medicaid long-term care program focusing on a person-centered

approach to care delivery using the Primary Care Case Management (PCCM) Entity delivery model, with implementation on October 1, 2018.

Alabama's current long-term services and supports (LTSS) system covers approximately 23,000 qualified elderly and disabled adults. The ICN program, in an effort to fix the fragmentation in the LTSS delivery system and to create a more fiscally sustainable system, will introduce managed care components, including a strong emphasis on case management, outreach, and an effort to increase home and community-based services (HCBS) utilization over institutional care. The PCCM model was chosen after the state deemed that a full-risk, capitated model would be more costly compared to the current Medicaid program.

AMA will continue to process claims and pay for all Medicaid-covered services on a fee-for-service (FFS) basis, with the exception of HCBS case management services for the Elderly and Disabled and ACT waivers. AMA will also be responsible for maintaining the Medicaid fee-for-service provider network as well as operation of a call center, provision of satisfaction surveys, and a grievance and appeals system. The ICN will be responsible for education, outreach, and case management services. It will be the primary source of contact for Medicaid LTSS. The ICN will educate eligible beneficiaries about nursing facility and HCBS waiver options and coordinate with hospitals on educational resources related to community options. ICN clinical staff will coordinate all services for members to support overall health, not just long-term care needs. The ICN will contract with the statewide network of local Area Agencies on Aging (AAAs) to deliver HCBS waiver case management services for the first two years of the program. The ICN will reimburse the AAAs at a minimum rate equal to the prevailing Medicaid fee-for-service payment schedule. It will be held accountable for increasing the percentage of members in HCBS settings. The ICN will also be required to have coordinating agreements with nursing facilities to share information, recommend medical interventions to avoid hospital admissions and emergency room visits, and suggest quality improvements in the care-planning process. Additionally, the ICN will be responsible for data management, quality improvement, and other administrative functions.

The following individuals will be eligible to participate in the ICN program:

- Medicaid beneficiaries receiving care within a nursing facility
- Medicaid beneficiaries receiving care through select HCBS waiver programs
- Elderly and Disabled Waiver – targeting individuals who are frail or physically disabled
- Alabama Community Transition (ACT) Waiver – targeting individuals currently residing in institutional long-term care who seek to transition to an HCBS setting

Dual eligibles who qualify based on the above criteria will be included in the program. Approximately 85 percent of the ICN enrollment is expected to be duals.

The following populations will be excluded from the ICN program and continue to be administered on a fee-for-service basis by the state:

- State of Alabama Independent Living (SAIL) waiver participants
- Technology Assisted (TA) waiver participants
- Participants in either of the two waivers serving individuals with intellectual and developmental disabilities (I/DD)
- Individuals in Alabama's Program for All Inclusive Care for the Elderly (PACE)
- Individuals living in an intermediate care facility
- Individuals receiving Medicaid-funded hospice room and board in a nursing facility or Medicaid-funded hospice in the community

Each ICN's performance will be evaluated by the ICN Quality Assurance Committee (QAC) based on the following quality measures:

- Clinical
- Long-Term Care
- Service Delivery and Effectiveness
- Person-Centered Planning and Coordination
- Choice and Control
- Community Inclusion
- Holistic Health and Functioning
- System Performance and Accountability

The ICN was implemented on October 1, 2018. The ICN Statewide provider is Alabama Select Network (which is under Blue Cross/Blue Shield). ADMH has been working closely with AMA and Alabama Select to secure a Letter of Commitment as to provide opportunity for much needed care coordination.

Medicaid Reform impact on ADMH:

ADMH has work directly with members of the Alabama Medicaid Agency, Alabama Hospital Association, the State Health Officer, the different consultants, ADMH providers, and ADMH internal committees, as well as the Disability Leadership Coalition, in regard to the multi-faceted areas of the Medicaid Reform process as to ensure that the mental health and substance use consumers we serve are being included for their unique and specialty needs for services and care. ADMH continues to share our willingness to partner and collaborate with the Medicaid Reform as to provide the expertise and guidance as it pertains to the consumers with severe mental illness, serious emotional disturbances, and substance use issues that we serve. The consumers currently with MI needs, that have traditionally been served by ADMH MI certified and contracted providers, were to be impacted by these changes in the system as they were included in the Medicaid Managed Care process. It is ADMH’s belief that SMI and SED will remain a target population of focus with Medicaid Managed Care and AMA realizes ADMH’s strong desire to be a partner in any future avenues pursued that impacts our mission and the consumers we serve.

ADMH determined that having the voices of our consumers, family members, providers, and other stakeholders (to include Medicaid) was vital to provide instrumental feedback and guidance in these areas of Medicaid Reform. Through the ADMH Associate Commissioner’s two coordinating sub-committees (Mental Illness and Substance Abuse), several committees were formulated to include a MICS MI Planning Committee. This committee will continue to focus on managed care concepts and transformation efforts pertaining to ADMH and the target populations of SMI and SED. Areas of current focus include care for committed patients, housing, meaningful day, outreach services, and quality measures. ADMH has contracted with a consultation group to assist in this process. These efforts are ongoing and the changes with AMA underscore the importance of this work. Future meetings will focus on the legal mandates of ADMH, dollars necessary to meet ADMH statutory requirements, and the impact of the consumers we serve with SMI/SED who are uninsured. Through the Medicaid Reform process, it has provided a platform for ADMH reform as well as to ensure that as the state of Alabama moves to a more coordinated system, the process does not develop an unintentional unhinging of the ADMH mental health system of care that has been developed over the past decades.

Medicaid Emergency Psychiatric Demonstration: In 2012, ADMH partnered with Medicaid and the Alabama Hospital Association in the Medicaid application for a 3 year CMS demonstration grant around the allowance of Medicaid payment for psychiatric care in a free standing psychiatric private hospital unit (IMD). ADMH provided the state match dollars for this demonstration. There were four inpatient psychiatric hospitals participating in the demonstration. In March/April 2015, the Alabama Medicaid Agency was contacted by CMS that the project would close 2.5 months early due to federal funding issues. There is a SB in Congress to secure approval for these demonstration states to continue for the next 2 years while CMS is completing is review of the demonstration. ADMH worked with AMA and ALAHA on sustainability documentation required by CMS. Once CMS completed its process, they determined they could not meet cost neutrality. The decision was made by CMS that the long-term sustainability of this demonstration would not be funded.

Medicaid State Plan Amendments:

- **Medicaid Rehab Option:** ADMH has worked with the AMA for the last 8 years on making updates to the Rehab Option requested by ADMH. Due to issues with CMS, this was temporarily delayed. ADMH continues to express our need for this update as to expand Rehab service options that could include peers as professionals and employment opportunities. In May 2014, CMS made contact with AMA to get closure on the outstanding issues. A series of calls have occurred, and AMA is hopeful for resolution. In February 2015, the state agencies that participate with Rehab Option came together to discuss the needed financial changes being mandated by CMS. AMA compiled and brought the state agencies back together for review and submission to CMS. The Rehab SPA was approved in October 2018 and a revision approved in June 2019. This is vital to ADMH and the transformation work it is trying to achieve as we progress our recovery system.
- **Targeted Case Management (TCM):** ADMH has worked with the AMA for the last 7-8 years on ADMH requested changes to TCM Target 1 (SMI Adults) and Target 3 (SED Kids). ADMH requested and provided proposed language to add a new target – Target 9 for Substance Abuse Adults and Kids. With the ADAP ESPDT Settlement agreement requiring the implementation of Intensive Care Coordination (ICC), a new Target (10) was developed and the TCM SPA was approved in June 2019. This incorporated the changes requested in all the AMDH targets and the development of a new Target 10.
- **Medicaid Non-Emergency Transportation (NET):** In June 2012, Medicaid decided to issue an RFP for transitioning the Non-Emergency Transportation Program from the current administrative model to a broker model. Under the broker model, Medicaid would contract with a broker to arrange a pay for NET services. This process excluded the ADMH NET program. Under the Medicaid arrangement with ADMH, ADMH pays state share (50%). The RFP process occurred in June 2012 for vendors to submit proposals. Medicaid submitted the SPA in January/February 2013. CMS wanted to change how ADMH was addressing the Transportation process which would mean changing from an Administrative Claims process to a Service Claims process, which is ADMH's preference. ADMH and Medicaid finalized the process which began April 1, 2014 for the Substance Abuse NET billing process and June 1, 2014 for the Mental Illness NET billing process. AMA did not initiate the new NET process yet and will await to address with the Medicaid Reform efforts.

Alabama Department of Public Health (ADPH):

The purpose of the ADPH is to provide caring, high quality and professional services for the improvement and protection of the public's health through disease prevention and the assurance of public health services to resident and transient populations of the state regardless of social circumstances or the ability to pay. The ADPH works closely with the community to preserve and protect the public's health, to provide caring, quality services and serve the people of Alabama by assuring conditions in which they can be healthy. The ADMH works collaboratively with the following programs within ADPH.

- **The Office of Primary Care and Rural Health:**

The Office of Primary Care and Rural Health facilitates and participates in activities to improve access to health care services for all rural Alabamians with special concern for children, the elderly, minorities and other medically underserved vulnerable populations. They serve the following populations: Communities, Rural Health Clinics, Critical Access Hospitals, Small Rural Hospitals, Federally Qualified Health Centers, County Health Departments, Physician Practices, and Mental Health Centers. ADMH staff work closely with this Office in the designation of Health Manpower Shortage Areas and the placement of J-1 Visa physicians in mental health centers and state hospitals. ADMH partnered on a grant application that provided matching funds for placements of physicians and other mental health providers. Unfortunately, the 50% match requirement proved to be a significant barrier in times of declining funding.

- **Children's Health Insurance Program (SCHIP)/ALL Kids:**

Alabama was the first state to receive approval of their plan to implement the CHIP program under the new federal legislation. This plan was implemented in phases: (1) Medicaid Expansion of the SOBRA coverage for youth ages 14-19, effective February 1, 1998, (2) Benchmark Health Insurance for children, ages 0-19, in families between 100% and 200% of poverty, effective September 1, 1998, and (3) a self-insured "special needs" package of services. The third phase was implemented by a coalition of agencies – Public Health, Mental Health, Children's Rehabilitation Services, and BC/BS. The mental health component of the Children's Health Insurance Program, referred to as ALL Kids, was

expanded in December 2002 and now mirrors the services available through the Rehab Option for those eligible for Medicaid. CHIP was reauthorized in April 2009. Through the provisions included in the Children's Health Insurance Reauthorization Act (CHIPRA), ALL Kids expanded eligibility to include children in families with income up to 300% Federal Poverty Level. Previous income eligibility was up to 200% Federal Poverty Level. This was effective Oct. 1, 2009.

Blue Cross and Blue Shield of Alabama worked with ALL Kids to become compliant with Mental Health Parity and initiated new provisions, effective October 1, 2010. Essentially, limits for mental health related services have been removed as necessary to be comparable with medical services provided through the ALL Kids Plus benefit package which had previously been limited only to those who exceeded the Basic benefit package.

ALL Kids continues to enroll uninsured children with family income above the Medicaid limit up to 317% of the Federal Poverty Level, which is the newly established conversion threshold for Alabama per the Affordable Care Act (ACA). To prepare the state to meet the various changes required by the ACA, ALL Kids has partnered with Medicaid and other sister agencies in the development of a new joint eligibility and enrollment system which was implemented in October 2013.

As required by the ACA, effective January 1, 2014, 22,939 ALL Kids enrollees were transitioned to Medicaid. This group is referred to as MCHIP. ADMH participated in the transition planning process to ensure transitioning enrollees received needed behavioral health services without interruption. This MCHIP group covers uninsured children from 6 to 19 years of age with family income between 107 and 146 percent of the federal poverty level.

ALL Kids is Mental Health Parity compliant as well as meets the ACA preventive services requirements.

Primary Health Collaborations:

Alabama Primary Health Care Association (APHCA):

The APHCA was established in 1985 as a non-profit, professional trade association whose mission is to strengthen and expand Alabama's community health center network through service, technology, partnerships, advocacy and education so that Alabamians have access to quality primary health care. APHCA is governed by a Board of Directors comprised of one voting delegate from each organizational member and four non-voting representatives from the associate membership. As the voice for Alabama's community health centers (CHC), medically underserved and uninsured populations, APHCA is dedicated to the promotion of high-quality, family-oriented, culturally competent health care. APHCA represents the program, policy, and operational interests of more than 120 community-based health care centers providing almost one million primary care visits to over 300,000 individuals across Alabama. Alabama's community health centers had an overall economic impact of \$150 million and supported 2000 jobs.

Over the last couple of years, staff of the APHCA has met with ADMH staff, the Executive Directors, and Clinical Directors of the provider networks to initiate the collaborative process. Additionally, information regarding the new Health Resources and Services Administration Access Point and Capacity Expansion grants has been shared with mental health centers who are encouraged to work with the local Federally Qualified Health Center (FQHC) to develop joint applications. APHCA was a primary partner in the development and implementation of the Transformation Transfer Initiative, the foundation of which was improved collaboration between primary and mental health partners. Meetings continue to occur between FQHCs and CMHCs Executive Directors for the purposes of strengthening collaborations at a local level.

In FY11, through a USDA grant, the University of Alabama, School of Medicine, Tuscaloosa Campus partnered with rural clinics to provide telemedicine services and distance learning. One of the sites is Capstone Rural Health Center which provides primary health care, health promotion, disease prevention and managed care to all surrounding rural areas and have partnered with a local mental health center to the benefit of 6,000 mental health consumers. In addition, the College of Community Health Sciences and the Institute for Rural Health Research at the University of Alabama was also able to

access grant funds to promote the use of telemedicine and offer educational opportunities for mental health employees through distance learning on various topics and to serve as a bridge between the mental health provider and the University of Alabama Autism Spectrum Disorders clinic.

American Academy of Pediatrics – Alabama Chapter (ALAAP):

The ALAAP is the only statewide member organization of pediatricians, with 650 members across the state, representing both academic and community pediatricians in both urban and rural areas. Alabama's pediatricians serve as the first line of healthcare for children across the state and are many times the only professionals that many of the state's children come in contact with during their formative years. ALAAP Chapter members have an active voice on every state committee or collaborative effort whose mission is to serve the interests of children. The organization is a non-profit 501(c) 3 organization, operated by a volunteer board of directors and executive staff located at a central office in Montgomery.

ADMH has had a long-standing collaborative relationship with ALAAP. Throughout the past several years, ALAAP and ADMH, along with other state and community partners, have directly collaborated on several initiatives.

- Telemedicine – Due to the fact that more than 25 percent of Alabama's children receiving services in the public mental health system are prescribed psychotropic medications and are in need of ongoing care and monitoring, yet there is a significant shortage of child and adolescent Psychiatrists, in 2004, a telemedicine pilot project was launched in a rural MHC catchment area where this service previously did not exist. This project was a collaborative effort by ADMH, Children's Hospital, a local pediatrician, ALAAP, and the community mental health center and provided child and adolescent psychiatric services via the teleconferencing system set up at the local hospital. An evaluation component was added to provide necessary data to determine future goals and needs. This evaluation data led to the Alabama Medicaid Agency adding telemedicine to the Rehabilitation Option. Over the next several years, several C&A telepsychiatry projects were implemented. This model was further expanded to other locations in the state for adults and children/adolescents. Since 2010, the Medicaid Agency, based in part on experience in the mental health system, now covers telepsychiatry under the Physician's Program in addition to the Rehabilitation Option. The use of telepsychiatry continues to expand in the state with mental health centers reporting a total of 52 counties and 71 telemedicine sites in use for child/adolescent services as of July 2019.
- Child and Adolescent Psychiatric Institute (CAPI) - Collaboration also occurred between ADMH, pediatricians, ALAAP, and community mental health psychiatrists concerning appropriate child and adolescent psychiatric care, which led to a partnership with the Department of Public Health to allow for expansion of the Child and Adolescent Psychiatric Training Institute (CAPI) to include pediatricians. This partnership occurred for seven CAPIs, allowing community mental health psychiatrists and pediatricians the opportunity to receive continuing education training on best practices information regarding the treatment of children and adolescents with severe emotional disturbances. Attendees included community mental health center psychiatrists, pediatricians, acute care psychiatrists, and ADMH-certified residential treatment care facility psychiatrists. From these training institutes, several local communities have begun collaborative relationships and have co-located and/or integrated care, initiated the use or screening instruments, developed local resource guides, and explored other creative wrap services. Sadly, due to the budget deficits, funds for this training was eliminated.
- In early 2015, ALAAP began a five-year partnership with ADMH and the Alabama Partnership for Children as a sub-grantee for Project LAUNCH (Linking Actions for Unmet Needs in Children's Health). The purpose of Project LAUNCH is to promote the wellness of young children from birth to eight years by addressing the physical, social, emotional, cognitive and behavioral aspects of their development. Alabama's Project LAUNCH is building on the vision of the Early Childhood Comprehensive Systems (ECCS) plan (Blueprint for Zero to Five), and other successful collaborative efforts to integrate programs that provide a complete range of developmentally supportive services

to families with young children, and to expand and enhance evidence-based programs related to children's healthy development. The local implementation area is Tuscaloosa County. The core strategies include:

- screening and assessment of young children – through the state Help Me Grow initiative training and support for primary providers (health care, early education, and home visiting) to use the ASQ-3/SE at regular intervals; develop a single point of referral and information and improve the roadmap for referrals; enhance 2-1-1 and Parenting Assistance Line for seamless and appropriate referrals; gather and analyze data to improve referral systems and identify service barriers
- integration of behavioral health into primary care settings – expanding the use of Social and Emotional Foundations of Early Learning materials and resources; technical assistance, training, and mentoring; training and resources to implement the ASQ-3/SE and appropriate referrals in primary care settings
- mental health consultation in early care and education, including training and mentoring for diverse early learning settings; improved access to needed interventions; and broad understanding of the social and emotional needs of young children and the negative impact of adverse childhood experiences
- enhanced home visiting with focus on social and emotional well-being by providing training and mentoring to existing and new home visitation programs; expanding evidence-based family strengthening and parent skills training – expanding and enhancing the Strengthening Families Initiative to the local implementation area including community training and resources; parent cafes; improved access to resources; parent leadership training and engagement; building family and community strengths to improve resiliency.

The Alabama Child Health Improvement Alliance (ACHIA) Steering Committee:

ACHIA evolved from a concept at a June 2013 meeting organized by the Alabama Chapter of the American Academy of Pediatrics to an established state-wide alliance. ACHIA is a collaboration of public and private partners that uses measurement-based efforts and a systems approach to improve the quality of children's health. The mission of ACHIA is to improve health outcomes by fostering a culture of continuous quality improvement through partnerships with practitioners, payers, families and organizations that deliver care to Alabama children. One of the main areas of focus is the collaboration with providers in the medical and mental health areas. ACHIA has explored implementing early social-emotional screening, adolescent depression screening, and the treatment of ADHD in pediatric practices. In Spring of 2016, ACHIA reached out to ADMH as a collaborative partner, recognizing the benefits of working together to meet all the health needs, both medical and mental, of children in Alabama. ADMH serves as a member of the ACHIA Steering Committee and is an active participant in identifying future ACHIA projects and areas of collaboration.

Alabama Hospital Association (ALAHA):

Founded in 1921, the Alabama Hospital Association (ALAHA) is a statewide trade organization that assists member hospitals in effectively serving the health care needs of Alabama, through advocacy, representation, education and service. Members of the association include primarily hospitals and health systems, as well as other companies and organizations related to health care. The Alabama Hospital Association provides advocacy and representation for its more than 100 hospital members, promoting a stable and cost-effective environment for hospitals and their patients.

Over the last several years, staff of the ALAHA has met with ADMH staff, the Executive Directors, and Clinical Directors of the provider networks to initiate the collaborative process. ADMH primarily works with the Psychiatric Section of ALAHA and has focused on developing a care coordination system that would bridge the private and public sector, bridge outpatient and inpatient care, and improve coordination with DMH Commitments. ADMH and ALAHA have partnered through the state hospital closure process and have been direct partners with some of their members choosing to contract

with ADMH's contract community mental health centers to serve committed patients. ADMH and ALAHA have worked especially close on all the areas of Medicaid Managed Care as the hospitals are the primary drivers of this system. ADMH is currently working with ALAHA and its members to implement a utilization process linked to committed patients and appropriate resources needed for diversion. Also, ADMH is in discussion with ALAHA around contracting for Detox beds. ADMH looks forward to this continued close working relationship as AMA pivots into a new path around Medicaid Managed Care.

Interagency Collaboration

ADMH works collaboratively with other local and state adult and child serving agencies to develop systems that would integrate social services, education and criminal and juvenile justice with mental health services as to develop a more comprehensive system of care in the community. A variety of avenues have been utilized in the ongoing attempts to provide a system of integrated services. For child and adolescent services, in 1986, an interagency agreement creating the Interagency Council on Youth (ICOY) was signed by all five-state child-serving agencies to cooperate on improving services to children. From that time, several noteworthy interagency collaborations have been created not only between ADMH and a singular state agency, but with multiple agencies collaborating in conjunction. The early foundation of interagency collaboration seems to have paved a path that has allowed for expansion and enhancement of mental health services in a more creative process. However, the recognition is that much more is needed in the area of interagency collaboration to move to true transformation and restructuring of a system of care for adults, children/adolescents, and their families.

Criminal Justice Services

ADMH fosters collaborations with those in law enforcement, judiciary, and corrections at both state and local levels. ADMH was the recipient of a Bureau of Justice Assistance grant to improve coordination of services. Dr. Ron Cavanaugh, the Director of Treatment for Alabama Department of Corrections has engaged ADMH and the Council of Community Mental Health Boards to discuss the service needs and resources of prisoners who have reached end of sentence or who qualify for parole. In FY11, the Community Mental Health Clinical Directors hosted a number of Dr. Cavanaugh's treatment staff to address issues around access and care coordination for inmates being released from prison. One challenge faced by both DOC and ADMH are inmates who are at end of sentence but for whom DOC feels are too symptomatic to be maintained in the community. Many individuals who fall within this description often end up being admitted into the State Psychiatric System and often pose barriers to community integration due to criminal history, sex offender status, and/or limited or no financial resources.

In FY12, the ADMH and DOC Commissioners brought together key decision makers of their staff to explore avenues to strengthen the care coordination and transition between our systems. The primary area of focus was on End of Sentence (EOS). There are two distinct paths that involves mental health inmates: 1) Re-entry 2) EOS ADMH Commitment. In regard to EOS ADMH Commitment, through the probate commitment process, inmates may be committed to ADMH for treatment to stabilize their condition and then returned to DOC for continued serving of the sentence. Individual who are approaching the end of their sentence, and who have mental health disorders, and are determined to be in need of continued treatment upon release from prison can be probate committed to ADMH for inpatient treatment at the time their sentence expires. Review of the data for these type commitments over the last 9 years has shown that many of these individuals are treated and discharged to community placements after relatively brief periods of inpatient treatment. This data review has led to the development of a protocol process that can streamline this process and make better use of community resources where by mentally ill inmates can be triaged prior to the End of Sentence (EOS) date and linkages to community providers established for after-care and assistance with transition into the community. It is expected that this will reduce or eliminate the need for EOS commitments to state hospitals. In regard to Re-entry, ADMH has involved the community providers in this effort and this remains an area that needs further assessment as to strengthen and develop a more formalized process.

One of the areas identified that was vital in the care coordination between the Justice entities and the Mental Health entities was the need for appropriate and accurate data. In 2013, ADMH partnered with both Department of Corrections and Pardons and Paroles to develop two separate Bureau of Justice Administration grant proposals. ADMH, DOC, and P&P

submitted a proposal to create the Alabama Secure Sharing Utility for Recidivism Elimination (ASSURE) web-portal through which will authorize personnel from ADMH, ABPP and DOC to retrieve supervision information regarding clients/inmates collected by other agencies. ASSURE will also include information from the risk and needs assessments conducted by each of the partner agencies as well as supervision information where applicable. ADMH also partnered with Pardons and Paroles to develop a BJA proposal that would implement a Substance Abuse and Mental Health Activities supporting Recovery Team (SMART) in order to reduce individuals with mental illness from further involvement from the criminal justice system and to improve the safety of the community at large. SMART will address the lack of coordinated training and cross systems communication as it relates to individuals with mental illness or co-occurring disorders involved in the justice system.

With the Department of Correction lawsuit and Alabama's focus on Prison Reform, ADMH has been working with DOC and the Alabama Board of Pardons and Parole (ABPP) on areas that pertain to mental illness and substance abuse. Key staff within ADMH from both mental illness and substance abuse worked within a workgroup that focused on several tasks. One task that got approved with the use of statewide screening tools. The UNCOPE was approved for substance abuse. The Correctional Mental Health Screen (CMHS) was approved for mental illness. There are two versions as to focus on gender specific – Correctional Mental Health Screen for Men (CMHS-M) and the Correctional Mental Health Screen for Women (CMHS-W). ADMH staff agreed to train all adult probation officers on the use of these approved screening tools, as well as mental health and substance use/abuse services and resources. Three trainings have been conducted in 2017.

Another focus area of the Prison Reform work was on improved coordination of care. A significant aspect of Alabama's prison reform effort involves the expansion of access to community-based, behavioral health services for supervised felony offenders who have mental illnesses and substance use disorders. To achieve this expansion, ADMH and ABPP collaborated to publish a Request for Proposals (RFP). This targeted select Alabama counties that lack adequate access to behavioral health services. The RFP is currently under review with hopes of implementation by the end of the 2017 calendar year.

Juvenile Justice/Alabama Department of Youth Services (DYS):

In 1987, an interagency agreement was negotiated and signed with the state's juvenile justice system, Department of Youth Services (DYS). This agreement governed the referral and assessment of problematic cases, which in the past had frequently resulted in protracted legal battles.

ADMH and DYS have been collaborating for many years. Collaborations have included, but are not limited to, the following:

- An Interagency task force called the Commission on Girls and Women in the Criminal Justice System. Established by a joint legislative resolution in 2006, the commission is studying the conditions, needs, issues, and problems of the criminal justice system in Alabama as it affects girls and women. The commission issued its recommendations in October 2007. In 2008, a Phase II/New Legislative Resolution occurred to extend the work of the Taskforce so that this group could oversee the implementation of recommendations.
- In 2007, an effort was made to continue to implement the strategic plan of the 2004 National Policy Academy on Improving Services for Youth with Mental Health and Co-Occurring Substance Abuse Disorders and bring together the efforts of other such initiatives currently underway in Alabama. ADMH partnered with DYS and two local counties (Jefferson and Morgan) to make application for the Models for Change Mental Health/Juvenile Justice Action Network sponsored by the MacArthur Foundation and coordinated by the National Center for Mental Health and Juvenile Justice. This grant application was not selected.
- For the past decade, the Annie E. Casey Foundation and counties around the country have focused on investing in a process called the Juvenile Detention Alternatives Initiative (JDAI). They set out to show that local jurisdictions could establish more effective and efficient systems that could safely reduce reliance on secure detention. The JDAI model has proven to be cost effective, improve public safety, improve efficiency, and promote good administration. JDAI is a process, not a conventional program, whose goal is to make sure that locked detention is used only when necessary. In pursuing that goal, JDAI restructures the surrounding systems to create improvements that reach far beyond detention alone. JDAI's primary target is youth who are in detention or at-risk to be detained in the future. With the vision of key leaders in Alabama, to include the previous Governor and

previous Chief Justice, as well as strong advocacy from DYS, Annie E. Casey Foundation entered a partnership to strengthen juvenile justice in the state. In April 2007, a team of experts from the Casey Strategic Consulting Group provided technical assistance in Alabama. The introduction of JDAI in Alabama started in four counties – Jefferson, Montgomery, Mobile, and Tuscaloosa. In 2008, ADMH was invited by the two of the four local JDAI sites (Jefferson and Montgomery) to participate on the Executive Committee.

- In 2017, Alabama formulated the Alabama Juvenile Justice Task Force. The charge of the Task Force is to develop proposals for reform. The priorities of will be to promote public safety and hold juvenile offenders accountable; control taxpayer costs; and improve outcomes for youth, families, and communities in Alabama. The Task Force's recommendation will be used as the foundation for statutory, budgetary, and administrative changes during the 2018 legislative session. One of the Task Force members is the Commissioner of ADMH and her designee. The Pew-MacArthur Charitable Trust was invited into Alabama to assist with this process. Prior to entering Alabama, Pew had completed a similar process with Juvenile Justice focus in seven other states. June 2017 was when the first meeting of the Task Force convened and there will be a total of six meetings. DYS is the lead and they are conducting a series of roundtable discussions around the state. One such roundtable included subject matter experts from community mental health providers and ADMH mental illness children staff. The final report was completed in November 2017.

Administrative Office of the Courts (AOC):

AOC is charged with providing centralized, state-level administrative support necessary for the operation of the State's court system; the development of procedures and systems to enhance the operational capacity of the courts; and the collection and dissemination of information necessary for the development of policies to promote the more efficient operations of the courts. The major programs for which the Administrative Office of Courts assumes responsibility are: finance; personnel services; judicial education; legal research and assistance; automated program design and site implementation; imaging; inventory control; records and space management; judicial assignments; jury and case management; time standards and statistical data; uniform traffic ticket and complaint supply and accountability; magistrate appointment and education; trial court assistance; child support enforcement; Juvenile Court assistance; court referral programs; drug court and other problem-solving specialty courts and court planning.

ADMH and AOC have been collaborating for many years. Collaborations have included, but are not limited to, the following:

- In 2006, ADMH partnered with the AOC and received a grant to establish an Adult and Adolescent Mental Health/Juvenile Task Force. The task force(s) completed a needs assessment on the state and a gap analysis that led to the development of recommendations in a strategic plan. Many of the participants of the 2004 National Policy Academy participated on the Juvenile Task Force of this initiative. This grant ended in November 2007. However, the state applied for a Phase II funding for the Justice and Mental Health Collaboration Program which was submitted by ADMH This application was not awarded.
- In FY06, there was a proposed revision to the Alabama Juvenile Code of 1975. In April 2006, the Bill did not make it out of legislative committee. However, a Juvenile Code Legislative Subcommittee was appointed, with the development of specialized subcommittees to include a Mental Health Subcommittee. Primarily, the proposed revisions were to provide updates and clarify old terminology with emphasis on the delinquent statutes being in line with Federal regulations. In the 2007 Regular Legislative Session, a revised bill was introduced. That bill came out of committee, but, like most of the bills introduced during that session, did not reach a vote in either House. During 2007, a concerted effort was made to again review the bill with all of the interested groups and entities, along with the Alabama Law Institute. During this period, the bill's provisions were again revisited and revised to meet the concerns of the different groups and interests. In 2008, the draft legislation was once again presented and the Juvenile Justice Act of 2008 was signed into law by the Governor on May 8, 2008. While most of the changes in the law are procedural or involve only reorganization and clarification of current law, there are some changes that may impact each of the respective agencies (mental health, child welfare, education, juvenile justice). In an effort to assist partnering agencies, AOC organized meetings to discuss different state agency's training needs and ways that AOC may assist in meeting those needs. These efforts continued into FY09 with

identified training needs developed and implemented to ensure agencies and communities were aware of changes as the Act became effective in two phases, January 2009 and October 2009.

- Also during the FY09 legislative session, HB 559, the amendment to the Juvenile Code, was signed by the Governor on May 21, 2009. This Act affirms the ADMH Commissioner's ability to designate a hospital/facility outside of the Department to provide services to minors and children with SMI or intellectual disabilities and to place these minors and children who have been committed to the department in said hospital/facility. It would also clarify the timeframe intended in the code as the necessary amount of time needed in notifying the department of final commitment hearings. These changes are in line with the recommendations of the Child and Adolescent Workgroup of the Systems Reconfiguration Task Force. An internal workgroup has been charged with drafting recommended language for a Request for Proposals process by the MI Associate Commissioner and ADMH Commissioner as to work toward complying with recommendations of the System's Reconfiguration Request for Proposals (RFP) regarding Bryce Adolescent Unit was issued August 2009. University of Alabama-Birmingham (AUB) Hospital's RFP was selected. A contract transferring the operation of the Adolescent Unit from Bryce Hospital to the University of Alabama in Birmingham Department of Psychiatry and Behavioral Neurobiology was signed. The transfer was effective in October 2010.
- ADMH submitted a joint application with AOC for a Department of Justice Planning and Implementation grant in 2009. The proposal focus was to establish design and outcome criteria for Juvenile Mental Health Courts. There has been increasing interests in mental health courts for juveniles and a few counties in Alabama have begun to provide diversion and alternative mental health programming through such mechanisms. The grant proposal would attempt to bring uniformity in the operation of these and any new courts so that their effectiveness can be compared and generalized across Alabama. In FY10, ADMH received this Planning and Implementation Grant from the Bureau of Justice Administration (BJA) to develop an evaluation component mechanism to evaluate mental health courts (adult and juvenile) in Alabama. The grant provided training and technical assistance opportunities to the state and various jurisdictions on public safety and treatment outcomes of individuals involved in mental health courts. The grant supported the development of a toolkit for courts and treatment providers to use and improved capacity to collect relevant data to determine outcomes within and across jurisdictions. The collaboration hosted the two-statewide mental health court conferences in 2010 and in November of 2011.

Education, Rehabilitation, and Employment:

Alabama Department of Rehabilitation Services (ADRS):

The mission of ADRS is "to enable Alabama's children and adults with disabilities to achieve their maximum potential." Created by the Alabama Legislature in 1994, the Alabama Department of Rehabilitation Services (ADRS) is the state agency that serves people with disabilities from birth to old age through a "continuum of services." As such, ADRS is a valued partner.

- Case managers and clinicians from the mental health centers work with local educational institutions and Vocational Rehabilitation Services offices to refer consumers for education and employment services. Consumers are often provided basic educational and pre-employment services in day and residential programs. Outpatient consumers are referred to local GED classes and/or institutions of higher learning such as community colleges and universities based on the consumers' interests and abilities. Providers work with local the Rehabilitation Services office to refer people for regular rehabilitation services as well as VR supported employment.
- The Department acknowledges employment is an essential element to Recovery. The Intellectual/Developmental Disabilities Division houses an Employment Coordinator dedicated to employment models for the Intellectual Disabilities population. The MHSA Division staff enjoys a close and collaborative relationship with the ID/DD Division benefiting from his expertise. This Employment Coordinator is a former career professional with the Alabama Department of Rehabilitation Services. His connections with ADRS and expertise in supported employment have well served the staff of MI Community programs.
- The Office of MI Community programs has partnered with ADRS to in an effort to promote employment within the mental health continuum. Preliminary work in this area was provided by an Employment Development

Initiative grant. Activities supported by the EDI grant included consumer and provider survey's as to barriers towards employment, Peer Support Specialist Train the Trainer training, a statewide stakeholder supported employment planning event, and a series of educational and motivational workshops: Work Works: An Essential Component to Recovery, conducted by George V. Nostrand, self-advocate and professional Employment Counselor. In 2014, ADMH was awarded the SAMHSA Transforming Lives through Supported Employment grant. This grant funds Supported Employment Trainer/Coordinator dedicated to the implantation of the evidence-based supported employment model (Individual Placement & Supports) at pilot locations. This model focuses on creating competitive employment opportunities for individuals with serious mental illness. Each pilot site employs, at a minimum, 2 Employment Specialists, 1 Peer Specialist, and 1 Benefits Specialist. In addition to providing services to consumers enrolled in the program, the IPS team engages in recruitment and education activities directed at consumers of the host mental health agency, their families, and the clinical staff of the agency for the purposes of promoting employment and education as integral to the recovery process. ADMH and ADRS work cooperatively to identify and develop practices and policies necessary for the appropriate implementation of the IPS model.

- ADMH chairs the Employment First Leadership Network Taskforce to further the principles and concepts of Employment First. Representatives for this network include ADRS, the Alabama Department of Economic and Community Affairs (ADECA), Alabama Medicaid, Post-Secondary Education, and Workforce Development participate. This interagency collaboration assures a coordinated effort to affect state policy as well as advocated for Employment First legislation.

Alabama State Department of Education (ALSDE):

ALSDE is responsible for educational services for children/adolescents in Alabama, and there are over one hundred school systems in the state. For numerous years, case managers, in-home intervention teams, and outpatient clinicians employed by the Community Mental Health Centers (CMHCs) have had frequent contact with the educational system on behalf of children with a serious emotional disturbance and their families.

- In FY99, the educational system identified a portion of At-Risk funding to develop school day treatment programs in conjunction with community mental health centers. This initiative enabled 10 additional community-based child and adolescent day treatment programs to be established statewide. Further efforts for training have occurred around educational laws, with special focus on Individual with Disabilities Education Act (IDEA). All day treatment programs had to undergo necessary training, education, and adaptations. Also, case managers, Juvenile Court Liaisons, and mental health clinicians are provided in-depth training around IDEA and special education laws provided by the Alabama Disabilities Advocacy Program (ADAP).
- Through the C&A Evidence-Based Practices (EBP) Workgroup, several EBPs have been researched and recommended for consideration, to include school based EBPs. Efforts have been initiated over the last several years to secure funding to initiate these EBPs to include budget requests and applications for grants both with ALSDE and with the University of Alabama. Also, the Department was granted a SAMHSA System of Care grant that involved three rural counties. Coping Power, a mental health/education EBP, was written into this grant as to implement this EBP in two of the three counties, as well as Positive Behavior Supports (PBS).
- Case managers and CMHC clinical staff assess their consumer's educational strengths and deficits and link consumers to training and other services necessary to enhance their educational and employment status. A variety of services are available to meet the individual educational and employment needs of adolescents transitioning into adulthood including adult education, literacy training, pre-employment services in day treatment programs, and specialized vocational and training services provided by the Department of Vocational Rehabilitation Services (VRS). For children and adolescents with a serious emotional disturbance, case managers and clinical staff have available the array of special education services provided within the educational system, as well as day-treatment programs which also contain a school component, or alternative school programs provided in other settings by mental health centers, the Department of Youth Services and some private, non-profit agencies. Case managers and clinicians work with the Rehabilitation Services office to refer people for regular rehabilitation services, as well as supported employment. Education and employment are key aspects of recovery for many consumers.
- In FY09, ADMH was invited to be a member of ALSDE's State Interagency Transition Team through the Special Education Division. The Interagency Transition Team is responsible for the development of a strategic plan that

addresses issues surrounding transitional planning concerning special education students. In FY09, ADMH participated as presenters in the Auburn University's Annual Transition Conference. This was a panel discussion of the service array provided by each Division within ADMH and how these potential resources could be beneficial to the transition process. In FY10, ADMH was invited to present again. A panel presentation, with representatives from ADMH, a local provider, and two youth consumers, was conducted that focused on helping young people with mental health needs face individual and institutional challenges in transition. ADMH also presented similar information at ALSDE's MEGA Conference (Alabama Special Education) in July 2010 on similar transition issues for youth with SED. In May 2010, ADMH presented at the Educational hosted Annual Health and Human Resources Leadership Day, presenting on mental health resources with focus on the continuum of care.

- In FY11, key administrative staff from ADMH and ALSDE met to discuss potential collaborative opportunities in light of health reform and budgetary issues. ADMH and ALSDE identified the need for a deliberate strategy aimed at improving service quality within and continuity between the two departments. The aim is to achieve greater integration of mental health services between the mental health providers and the public schools and to increase the utilization of evidence-based practices. The integration of these services fosters continuity of care and ensures sustained gains in academic and developmental domains for children, youth and their families. A School-Based Mental Health Services (SBMH) workgroup was established to facilitate this collaboration. The goal of the School-Based Mental Health Services (SBMH) collaboration between ADMH and ALSDE and their local entities is to ensure that children and adolescents, both general and special education, enrolled in local school systems have access to high quality mental health prevention and treatment services.
- From FY 12 and FY 19 to date, sixteen of the 19 community mental health centers (CMHCs) of Alabama and over 70 Local Education Authorities (LEAs) have conducted initial orientation meetings describing the SBMH collaborative process. Of these, 16 CMHCs and 60 School Systems have entered into formalized agreements as SBMH Collaboration Partners. The SBMH model improves access to appropriate mental health services by children who need them by placing a Master's level clinician in the school setting in a structured manner that ensures confidentiality while enhancing mental health service delivery. ADMH and ALSDE continue to jointly promote the School Based Mental Health Collaboration across the state and have presented workshops on SMBH at ALSDE's MEGA Conference and Transition Conference in FY 12 and every year thereafter through FY9. SBMH Partner CMHCs and School Systems are currently gathering information to establish School Year 2014-2015 as the "baseline year for SBMH Data. This information will be used to analyze the effectiveness of SBMH over subsequent years.
- In 2013, ADMH started participation in an interagency workgroup of the Alabama State Department of Education (ALSDE) to promulgate proposed regulations for "State-Supported Schools." These schools provide educational services for students who are located in facilities that provide treatment and care to children in both Special Education and General Education. Responsibility for the oversight of these programs and the student's educational progress has historically fallen to the state and not the Local Educational Agencies (LEA). These regulations, if approved by the ALSDE Board, will vest responsibility and oversight in the Local Education Authority (LEA) where the facility is located. This was an important collaboration since ADMH has certification authority for many of the treatment programs identified under "State-Supported". Academic achievement for children with serious emotional disturbances is a significant component in their treatment and a protective factor against all risks as they transition into adulthood.
- In 2018, the Governor's Office created an interagency SAFE (Securing Alabama's Facilities of Education) Council in response to the February 2018 school shooting in Parkland, Florida and a nationwide focus on safety in schools. The focus of the SAFE Council was to address safety concerns in schools statewide and develop recommendations on proactive steps to secure schools. Both ADMH and ALSDE were active participants in this endeavor. Regional trainings for school staff occurred statewide. Topics covered included SBMHC, as well as Mental Health First Aid (MHFA) and the Colorado Threat Assessment and related safety responses.

Social Services/Department of Human Resources (DHR):

The Social Service agency in Alabama is the Department of Human Resources (DHR). Collaboration with DHR occurs at the local and state level to include direct care, blended services, training efforts, coordination, and planning. Social services

provided for this population does include in-home and community-based care that can be provided by or linked by In-Home Intervention Teams and case management services.

- In 1988, ADMH entered into an agreement with DHR to jointly fund three Family Integration Network Demonstration Projects (FIND). These projects consisted of in-home intervention and case management operated through a CMHC. The FIND programs serve children with serious emotional disturbances and their families who are generally involved with multiple agencies. Currently, there are 51 C&A In-Home Intervention teams across the state. At present, every community mental health center catchment area has a least one designated children's case manager. Children and adolescents may also receive case management from qualified CMHC staff who has been cross-trained in the delivery of case management to both adults and youth.
- Since this first cooperative funding venture with DHR in 1988, the two agencies (ADMH and DHR) have jointly funded the Brewer Porch Short Term Treatment and Evaluation Program (STTEP) and Glenwood's Daniel House. STTEP is designed to provide evaluation and short-term treatment for children who had previously been hospitalized or were at risk of hospitalization. Glenwood Daniel House provides residential treatment for children who would frequently have been placed in an inpatient unit or in a residential program that would not encourage family involvement. In 2007, ADMH and DHR re-crafted this joint collaboration to allow for the contracting of beds in three of Glenwood's premier programs. Daniel House I and Daniel II are residential treatment programs that continue to serve the most severe SED youth and their families, ranging from age six to fourteen. The contract changes also allowed for contract beds in the short-term assessment program, Glenwood Drummond Center II. This 90-day assessment program alleviated the overuse of acute units for inpatient assessment needs and provided thorough recommendations as to assist family members and communities in providing more appropriate treatment. Admissions to these programs are jointly screened by the agencies involved. In FY09, due to budget issues and restructuring of their service system, Glenwood Drummond Center II was closed but the collaboration continued with the other programs.
- ADMH had a contractual collaboration with DHR involving a partnership with a special project of the former First Lady of Alabama; Mrs. Patsy Riley, with the Parenting Assistance Line (PAL). PAL is a collaborative service of the University of Alabama Child Development Resources and the Alabama Children's Trust Fund. When callers call the toll-free number, a parenting resource specialist will answer the phone, listen to the caller, and then offer helpful information and support. Callers can also request free literature about their specific parenting concerns. Due to the high volume of calls involving PTSD linked to the Hurricanes of 2005, ADMH became a partner with this project providing funds for a state-wide media campaign through billboards, radio, and television to raise awareness of traumatic issues, especially Post Traumatic Stress Disorder. This media campaign started in May 2007. PAL remains operational. However, ADMH no longer participates with funding due to lack of monies.

State Multiple Needs Childs Office:

A Joint Task Force of DHR and ADMH was established in 1991 to address problematic interagency issues. The Task Force established subcommittees to work on conflict resolution procedures, cross-agency training, promotion of coordination at the local level, and planning for future needs. In 1993, the Alabama Legislature passed the amendments to the Juvenile Justice Act, otherwise known as the Multi-need Child Legislation. Patterned after the "clusters" in Ohio, the Act required the establishment of a State Facilitation Team, and facilitation teams in each of Alabama's 67 counties. At a minimum, the agencies mandated to participate include Education, Human Resources (child welfare), Public Health, Mental Health, and Youth Services (juvenile justice). The Multiple Needs Child Act is for children who need services from two or more agencies and are at risk of out-of-home placement or movement into a more restrictive environment. These children's needs are often multifaceted and require intensive collaborative efforts and service coordination from the child care agencies. Currently, the local teams and the state team meet monthly to discuss programmatic and funding issues in an effort to effectively serve the neediest children in the state. The local Multineeds teams utilize the provision of social services to assist the consumer and their family with maintaining community level of care in the efforts to avoid out of home placement. The Mental Illness Division continues to support maintenance of effort of \$544,000 each year; with ADMH providing \$1 million total to cover MI/SA/ID youth through the multiple needs process.

OUR Kids

The OUR Kids Initiative which began in 2002 is a collaboration between the departments of DYS, ADMH, and DHR to serve children and families that have needs that cross each agency's area of responsibility. Our Kids has become an example of Interagency Collaboration to serve children and adolescents in their communities. The OUR Kids initiative has been noted by federal reviewing authorities from each department as a good example of interagency collaboration. (Ex. Child and Family Services Review, Mental Health Block Grant, SAMSHA, and the National Center for Mental Health and Juvenile Justice.)

The three state agencies comprising the initiative pool funds together (most of it Children First Dollars) and issue a joint competitive Request for Proposal (RFP) across the state. In order to respond and be eligible for funding, a provider must demonstrate the need for a specific service, the coordination and support of the partners in the county or area, and assure it is not duplicative of other services in the area.

Since 2002, specialized services, not previously available, to targeted populations have been provided through this initiative. The departments have supported community-based programs for children identified as CHINs; Aftercare services for children discharged from DYS with mental health needs; Intensive in-home and psychiatric services for children with mental health and DHR involvement; Intensive In-home services for children with lower cognitive functioning.

Today the OUR Kids Initiative supports 11 different programs across the state with a budget of 860,000 dollars. Since 2002, the initiative has averaged serving over 1300 youth per year, for a total of over 12,000 children and adolescents in their communities. These programs have become a valuable resource for County Multiple Needs Teams and other state and local agencies.

MI Planning Council:

Representatives from many of these organizations are members of, and actively participate on, the Alabama Mental Illness Planning Council (Please see Application Section: Environmental Factors: 22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application and the Application Section: Behavioral Health Advisory Council Members - for Planning Council membership details). The MI Planning Council is tasked with the following responsibilities:

- Advise and assist in the development of the Mental Health Block Grant plans and reports.
- Reviewing and monitoring the Mental Health Block Grant and submitting to ADMH any recommendations for modifications.
- Prepare and submit a separate annual report of progress to the Governor.
- Promote and advocate for improved and innovative services for individuals in Alabama with serious mental illness.
- Participating in improving mental health services within the State.
- Monitoring the portion of the MHBG dollars reserved for Planning Council Special Projects.

To meet the requirements of providing a letter of support indicating agreement with the description of their role and collaboration with the SMHA, attached is letter of support from the MI Planning Council which represents the membership of collaborative partners.

Section IV: Environmental Factors and Plan: 21. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application - Required

1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g. meeting minutes, letters of support, etc...)

a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?

In regard to Substance Abuse, ADMH has historically included consumers, families, and advocates in all aspects of its planning processes. The SA Coordinating Subcommittee, ADMH's primary planning body for its substance abuse service delivery system, meets bi-monthly. The committee consists of various substance abuse stakeholders from around the state (consumers, advocates, individuals who represent family members, community council representatives, and family members of children with substance use disorders, provider organizations and ADMH staff). For more details, please refer to the SAMHSA SA Block Grant application.

Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into i

Yes No

2. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?

Yes No

3. Please indicate the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

The MI Planning Council has a strong, positive relationship with the ADMH. ADMH does not currently have an integrated MI and SA (behavioral health) Planning Council. ADMH Substance Abuse representatives responsible for the SA Block Grant have actively engaged appropriate SA providers and consumer/family representatives to assist in the development of the SABG.

In previous years, ADMH responded to a BRSS TACS grant to assist with moving toward a single Behavioral Health Planning Council but was not awarded. Also, ADMH representatives and MI Planning Council President has attended SAMHSA Block Grant TA Conferences to determine the most beneficial avenues to achieve an integrated Behavioral Health Planning Council process and was impacted by the information that most states that have effectively achieved such an effective process has done so over a multiple year process. At present, ADMH has been awarded a BRSS TACS grant but the primary focus is on infrastructure building of SA peer resources. ADMH continues to utilize the MI Planning Council for the SAMHSA Mental Health Block Grant.

The Council strives to ensure that its members is diverse with its membership. The Council relies on the statewide advocacy organizations (WINGS, NAMI, AFT, AYM, AMCC, APSA) and Office of Consumer Relations to nominate the consumer and family representatives on the Council. The Council has 51 members. Twenty-five of the members are either consumers or family members. Of the twenty-five members, thirteen are consumer representatives, with two of these representatives being in individuals with lived youth experience of SED. In regard to family representatives, there are three parents of children with SED. Within the state employee representatives, there are both adult and youth representatives, as well as the Director of Deaf Services (who is deaf) and the Director of Consumer Relations (an individual with lived experience). The Associate Commissioner and Commissioner are also members of the Council. The other members of the Council are providers of mental health services (public and private) and a single representative from each of the following state agencies: education, child welfare, housing, corrections, youth services, vocational rehabilitation, Medicaid, S-Chip (ALL Kids), as well as two university representatives. There are also legislative representatives, judge representatives, and a member from the Alabama Hospital Association. Currently, the Council membership includes representation of African American members, older adults, consumer and family members of SMI and SED, and members from rural and urban areas.

Appointments to the MI Planning Council are made in several ways (depending on the membership requirements). For consumers, family members, service providers, and legislative representatives, nominations are received, and the MI Planning Council’s workgroup makes recommendations that are brought back to the full Council for approval. The Council submits a letter of recommendations to the Associate Commissioner who determines if the nominee will be appointed. Each Council member serves a term of three years. Any current member can be re-nominated. Council member terms are reviewed during the November/December meetings. During this time, members with expiring term will be identified and member recommendations are made. Re-appointments and new appointments will be based on participation, mandated representation, and willingness of Council members to serve on the Council. The Council meets at a minimum on a quarterly basis.

The MI Planning Council is very active and participates with other advocacy entities in the expansion of consumer and family voice with the ever-changing health climate and Medicaid Reform occurring in Alabama. The planning council participates throughout the year with all phases of Block Grant work to include the review and recommendations for the Block Grant application, the details involved with the goals, priorities, strategies, and performance indicators. They have met several times to review and provide recommendations that led to the creation of the FY20-21 Block Grant application. Each year, they complete mid-year goal review and discuss the data and performance indicators. The MI Planning Council truly guides and steers the planning process. Its members are also vital representatives on the other committees/task forces/councils within ADMH as to maintain a coordinated effort.

The Council develops a letter annually to accompany the MHBG application (see attachment). The letter identifies the activities and accomplishments of the council during the year, as well as challenges and issues that face Alabama’s public mental health systems.

Updated Per June 2019 Recommendations

October 2019

ALABAMA MENTAL ILLNESS PLANNING COUNCIL (51 Members)

Family Members – Children and Adolescents				
			Current term	Proposed
1.	Youth Family Member	Mary Murphy	12/18	12/21
2.	Youth Family Member	Teresa Kidd	12/17	12/20
3.	Youth Family Member	Brenda Reagan	12/18	12/21
Family Members – Adults				
1.	Family Member	Wendy Harris	12/18	12/21
2.	Family Member	Zina May	12/17	12/20
3.	Family Member	Allen Harris	12/18	12/21
4.	Family Member	Melissa Schilling	12/17	12/20
5.	Family Member	Mary Ann Hatcher	12/17	12/20
6.	Family Member	Klieta Bagwell	12/17	12/20

7.	Family Member	Jackie Hambrick	12/18	12/21
8.	NAMI Ex. Director or Designee	Kelly Emerson	Designated	Designated
9.	NAMI President or Designee	Jimmy Walsh	Designated	Designated
Consumers				
1.	Wings Ex. Director or Designee	Thomson McCorkle	Designated	Designated
2.	Wings President or Designee	Marie Holliday	Designated	Designated
3.	Primary Consumer	Vickie Pierson	12/18	12/21
4.	Primary Consumer	Mike Herring	12/17	12/20
5.	Primary Consumer	Lewis Fincher	12/18	12/21
6.	Primary Consumer	Christi Collins	12/17	12/20
7.	Primary Consumer	Ibriel Isom	12/18	12/21
8.	Primary Consumer	William Ruff	12/18	12/21
9.	Primary Consumer	Merna Dukes	12/17	12/20
10.	Dir. Consumer Relations	Mike Autrey	Designated	Designated
11.	AL Minority Consumer Council	Fannie Hicks	Designated	Designated
12.	Adolescent Consumer	Audrey Trippe	12/17	12/20
13.	Adolescent Consumer	Brian Flucker	12/18	12/21
State Employees/University Representatives				
1.	Commissioner	Lynn Beshear	Designated	Designated
2.	Associate Commissioner	Diane Baugher	Designated	Designated
3.	Dept of Educ. Spec. Ed	Tina Sanders	Designated	Designated
4.	Dir. of Comm. Programs	Kim Hammack	Designated	Designated
5.	House Fin. Authority	David Young	Designated	Designated
6.	Human Resources	Starr Stewart	Designated	Designated
7.	Public Health	Cathy Caldwell	Designated	Designated
8.	Rehabilitation Services	James Myrick	Designated	Designated
9.	Youth Services/Correctional Agency	Alesia Allen	Designated	Designated
10.	University Affiliated	Elizabeth Caine	12/17	12/20
11.	Medicaid Agency	Karen Watkins-Smith	Designated	Designated

12.	University Affiliated	Ross Grimes, Ph.D.	12/17	12/20
13.	State Coordinator of Deaf Svs.	Steve Hamerdinger	Designated	Designated
14.	Department of Corrections	Ruth Naglich	Designated	Designated
Providers				
1.	Council of Community of MH Boards representative	Richard Craig, Ph.D.	12/17	12/20
2.	Behavioral Healthcare Alliance of Alabama	Don Schofield	12/18	12/21
3.	Private Provider	Emmett Poundstone	12/17	12/20
4.	Private Provider	Derek Johnson	12/18	12/21
Others				
1.	AL House	Pebblin Warren	12/17	12/20
2.	AL House	Paul Beckman	12/17	12/20
3.	AL Senate	Vivian Figures	12/17	12/20
4.	AL Senate	Tom Whatley	12/17	12/20
5.	Law Enforcement	Judge James Anderson	12/18	12/21
6.	MHA Exec. Dir.	Brittany Wiggins	Designated	Designated
7.	MHA President	Will O'Rear	Designated	Designated
8.	Probate Judge	Judge Steve Norman	12/18	12/21

FY20-21 Environmental Factors and Plan: Behavioral Health Council Composition by Member Type

The MI Planning Council is extremely active with ADMH in many avenues to include the SAMHSA MH Block Grant. The planning council participates throughout the year with all phases of Mental Health Block Grant work to include the review and recommendations for the Block Grant application, the details involved with the goals, priorities, strategies, and performance indicators. They have met several times to review and provide recommendations that lead to the creation of the Block Grant application. Each year, they complete mid-year goal review and discuss the data and performance indicators. They are active in the participation of each year's MI Implementation Report, as well. The MI Planning Council truly guides and steers the planning process.

Environmental Factors and Plan		
Behavioral Health Council Composition By Member Type		
FY20-21		
Type of Membership	Number	%
Total Membership	51	

Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health Services)	13	
Family Members of Individuals in Recovery (to include family members of adults with SMI)	11	
Parents of Children with SED	3	
Vacancies (Individuals and Family Members)	0	
Others (Not State employees or providers)	7	
Total Individuals in Recovery, Family Members & Others	34	66.67%
State Employees	13	
Providers	4	
Federally Recognized Tribe Representative	0	
Vacancies	0	
Total State Employees & Providers	17	33.33%
Individuals/Family Members from Diverse Racial, Ethnic, and LBGQT Populations	8	
Providers from Diverse Racial, Ethnic, and LBGQT Populations	6	
Total Individuals and Providers from Diverse Racial, Ethnic, and LBGQT Populations	14	
Persons in recovery from or providing treatment for or advocating for substance abuse services	0	

Section IV: Environmental Factors and Plan: 22. Public Comment on the State Plan - Required

The SAMHSA MHBG application public access User ID and Citizen Password have been made available as a link on the Department's website (<http://mh.alabama.gov/>). Pertinent stakeholders, including State partner agencies, members of the Mental Illness Planning Council, members of the Mental Illness Coordinating Sub-Committee, members of the Substance Abuse Coordinating Sub-Committee, members of both MI provider associations, and peer and family run organizations were notified via email, and during in-person meetings, of the availability and were encouraged to review its contents and submit comments as necessary. Each group has been encouraged to circulate the information to others who may have interest in making public comment, as well. Citizens will be able to make comments during the application process as well as post-submission.