Alabama

UNIFORM APPLICATION
FY 2022/2023 Only ApplicationBehavioral Health Assessment and Plan

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

OMB - Approved 04/19/2019 - Expires 04/30/2022
(generated on 09/28/2021 9.08.31 AM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

State Information

State Information

Plan Year

Start Year	2022
End Year	2023

State DUNS Number

Number	929956324
Expiration Date	

I. State Agency to be the Grantee for the Block Grant

Agency Name	Alabama Department of Mental Health
Organizational Unit	Mental Health and Substance Abuse Services Division
Mailing Address	100 North Union Street, Suite 420
City	Montgomery
Zip Code	36130-1410

II. Contact Person for the Grantee of the Block Grant

First Name	Tammie
Last Name	McCurry
Agency Name	Alabama Department of Mental Health, Division of Mental Health and Substance Abuse Services
Mailing Address	100 North Union Street, Suite 420
City	Montgomery
Zip Code	36130-1410
Telephone	334-242-3642
Fax	334-242-3025
Email Address	tammie.mccurry@mh.alabama.gov

III. Expenditure Period

State Expenditure Period

From	
To	

IV. Date Submitted

Submission Date	9/24/2021 7:34:57 AM
Revision Date	9/24/2021 7:35:19 AM

V. Contact Person Responsible for Application Submission

First Name	Nicole
Last Name	Walden
Telephone	334-353-7248
Fax	
Email Address	nicole.walden@mh.alabama.gov

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority

Fiscal Year 2022

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Substance Abuse Prevention and Treatment Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
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As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
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7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
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11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions

to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-construction Programs and other Certifications summarized above.

State: _____

Name of Chief Executive Officer (CEO) or Designee: _____

Signature of CEO or Designee[1]: _____

Title: _____ Date Signed: _____

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

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12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions."

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-construction Programs and other Certifications summarized above.

State: Alabama

Name of Chief Executive Officer (CEO) or Designee: KAY IVEY

Signature of CEO or Designee[1]: Kay Ivey

Title: Governor

Date Signed: 8/9/21

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL).

Standard Form LLL (click here)

Name

Title

Organization

Signature:

Date:

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

The Alabama Department of Mental Health does not undertake any lobbying activities.

Planning Steps

Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations.

Narrative Question:

Provide an overview of the state's M/SUD prevention, early identification, treatment, and recovery support systems of care, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system of care is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. The description should also include how these systems of care address the needs of diverse racial, ethnic, and sexual and gender minorities, as well as American Indian/Alaskan Native populations in the states.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

SECTION II: ALABAMA PLANNING STEPS
STEP ONE: ASSESS THE STRENGTHS AND NEEDS OF THE SERVICE SYSTEM TO ADDRESS THE SPECIFIC POPULATIONS.

A. Overview of Alabama's Substance Use Prevention, Early Intervention, Treatment, and Recovery Support System

The Alabama Department of Mental Health (ADMH) was established by Alabama Acts 1965, No. 881, Section 22-50-2. A cabinet-level state government agency, ADMH has the authority to act in any prudent way to provide mental health and intellectual disability services for the people of Alabama. Act 881 defines "mental health services" as the diagnosis of, treatment of, rehabilitation for, follow-up care of, prevention of and research into the causes of all forms of mental or emotional illnesses, including but not limited to, alcoholism, drug addiction, or epilepsy in combination with mental illness or intellectual disability.

ADMH is comprised of three unique divisions: (1) Administration, (2) Intellectual 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. The Commissioner reports directly to the Governor. A Board of Trustees, appointed by the Governor, serves in an advisory capacity to the Commissioner.

Among its designated powers, ADMH is authorized to plan, supervise, coordinate, and establish standards for all operations and activities of the State of Alabama, including the provision of services, related to intellectual disability and mental health. ADMH's two service divisions, the Intellectual Disabilities Division and the Mental Health and Substance Abuse Services Division have primary responsibility for accomplishment of these tasks.

ADMH is designated as the single state agency (SSA) in Alabama authorized to receive and administer any and all funds available from any source to support the provision of services and other activities within the scope of its statutory authority. 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 use services, respectively, for FY 22 – FY 23 allows for more realistic planning based upon currently identified needs, than does submission of a combined application that plans for a behavioral health division that remains under development.

B. Organization of Alabama's Substance Abuse Service Delivery System

1. The Role of the SSA: Alabama Department of Mental Health

The ADMH Commissioner has established Coordinating Subcommittees to facilitate the development of plans for intellectual disabilities, mental illness, and substance abuse services, respectively. The Coordinating Subcommittees, chaired by the Associate Commissioner for each departmental division, function to integrate local and regional

planning efforts with statewide planning that is consistent with the strategic directions established by the Commissioner. Plans and recommendations developed by the Coordinating Subcommittees are sent to the Commissioner for review and appropriate action. Actions and recommendations of the Management Steering Committee are advisory to the Commissioner and do not circumvent or diminish ADMH's statutory authority.

Act 881 grants ADMH statutory responsibility for operation and regulation of Alabama's public substance abuse service delivery system. Specific responsibilities, as implemented through the Division of Mental Illness and Substance Abuse Services (the Division), include:

- Planning, development, coordination, and management of a comprehensive system of prevention, treatment and recovery support services for individuals adversely impacted by, or with the potential to be adversely impacted, by alcohol, tobacco, and/or other drug use;
- Resource solicitation, development, and dissemination;
- Funding solicitation, receipt, and allocation;
- Contracting for service delivery and contract compliance monitoring;
- Development of program certification regulations, and management and implementation of a regulatory review process;
- Development and dissemination of best practice guidelines for prevention, treatment, and recovery support services;
- Collaboration with state and local government and community-based organizations to support fulfillment of its statutory responsibilities;
- Protection of patient rights, confidentiality, and privacy; and
- Collaboration with service recipients and advocates to support systems improvements and enhanced service outcomes.

For the purpose of planning for Alabama's public substance abuse service delivery system, ADMH has divided the state into four (4) regions which are defined in terms of Alabama's sixty-seven (67) counties, as listed in **TABLE 1.**

TABLE 1 **ADMH Mental Health Regions**

Region 1	Region 2	Region 3	Region 4
Cherokee	Bibb	Autauga	Baldwin
Colbert	Blount	Bullock	Barbour
Cullman	Calhoun	Chambers	Butler
De Kalb	Chilton	Choctaw	Clarke
Etowah	Clay	Dallas	Coffee
Fayette	Cleburne	Elmore	Conecuh
Franklin	Coosa	Greene	Covington
Jackson	Jefferson	Hale	Crenshaw
Lamar	Pickens	Lee	Dale
Lauderdale	Randolph	Lowndes	Escambia
Lawrence	Shelby	Macon	Geneva
Limestone	St. Clair	Marengo	Henry
Madison		Montgomery	Houston

Marion **Marshall** **Morgan** **Walker** **Winston**	**Talladega** **Tuscaloosa**	**Perry** **Pike** **Russell** **Sumter** **Tallapoosa** **Wilcox**	**Mobile** **Monroe** **Washington**

2. Service Delivery Overview

ADMH does not operate any substance abuse prevention, treatment, or recovery support programs or directly provide any related services. The agency has established the State's public system of services through the execution of contractual agreements with eighty-six (86) community based private and public entities located throughout Alabama. Each of these organizations receives funds from ADMH to provide one (1) or more of fifteen (15) 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 number of patients served by ADMH treatment services contractors in 2020 is provided in **TABLE 2**. ADMH also certifies fifteen (15) other providers with which there is no contractual relationship.

Table 2

Region	Number of Patients
1	10,780
2	13,702
3	2,396
4	5,428
Total	32,306

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, rehabilitation option programs and targeted case management program. For all three funding sources, providers are reimbursed by ADMH on a fee for service basis.

3. Treatment Services

Contract providers are required to abide by the following eligibility requirements in order to bill ADMH for treatment of individuals who have substance use disorders:

a. All potential clients must be screened for substance use and co-occurring disorders, as according to ADMH specified policies and procedures. Adolescents (under the age of 19) must be screened using the CRAFFT which is a six (6) question instrument. Adults (19 and older) must be screened using the UNCOPE which is also a six (6) question instrument. Potential co-occurring clients must be screened using an ADMH approved

screening instrument developed for such purposes.

- Each client must meet the Diagnostic and Statistical Manual of Mental Disorders, latest edition, clinical criteria of psychoactive substance use disorders, in the following order of priorities.

  (1) Drug injecting pregnant women (with diagnostic criteria).
  (2) Pregnant women (with diagnostic criteria).
  (3) Parenting women (with diagnostic criteria).
  (4) Injection drug users (6-month history of injection drug use and injection drug use within the last 30 days, with diagnostic criteria).
  (5) All other individuals who have substance use disorders.

- A need for financial assistance must be established by an individual financial assessment based upon the client's unique needs.

- Efforts must be made to collect reimbursement for the costs of providing services for individuals who are entitled to insurance benefits under the Social Security Act, including programs under title XVIII, any State compensation program, and any other public assistance program for medical expenses, any grant program, any private insurance, or any other benefit program.

- Providers may secure client payment for services in accordance with the ability to pay, which is based on an established sliding fee scale. However, the client's inability to pay cannot be a barrier to treatment access.

4. Use of Treatment Placement Criteria

Alabama has established a standardized screening process and adopted the American Society of Addiction Medicine (ASAM) Criteria for use in making decisions for appropriate referrals for treatment. Unable to find such an instrument after extensive search, staff of the ADMH Substance Abuse Services Division worked over a three-year period to develop a clinical placement assessment that would:

- Establish a need for immediate crisis intervention.
- Establish a DSM diagnosis or diagnostic impression indicating the existence of a substance use disorder.
- Screen for the presence for co-occurring mental disorders
- Collect adequate information in each of the six (6) ASAM dimensions to support client placement in a level of care appropriate to his or her needs. The ASAM dimensions include (1) Acute Intoxication and/or Withdrawal Potential; (2) Biomedical Conditions and Complications; (3) Emotional/Behavioral/Cognitive Conditions and Complications; (4) Readiness to Change; (5) Relapse, Continued Use or Continued Problem Potential; and (6) Recovery Living Environment.

- Provide for timely administration in one setting.

The resulting document, the SASD Integrated Placement Assessment, was developed in consultation with Dr. David Mee Lee, Chief Editor of the American Society of Addiction Medicine Patient Placement Criteria. The Integrated Placement Assessment incorporates the ASAM Criteria and a mental status examination to provide for a comprehensive assessment of needs to support a level of care decision.

5. Treatment Levels of Care

ADMH, in accordance with its regulatory authority, has established standards of care in the Alabama Administrative Code that are used to certify programs as eligible to provide substance abuse treatment services. Only programs that have been surveyed by ADMH and found to be in compliance with its regulatory standards are eligible to receive funding from the agency. ADMH Regulations 580-9-44-.01-.29, effective January 1, 2013, authorize the following levels of care:

a. **Medically Monitored Residential Withdrawal Management (Level 3.7-WM):** An organized service delivered by medical and nursing professionals, which provides 24-hour medically supervised evaluation and withdrawal management in a permanent facility with inpatient beds. Services are delivered under a defined set physician-approved policies and physician-monitored procedures or clinical protocols. This service level provides care to patients whose withdrawal signs and symptoms are sufficiently severe to require 24-hour inpatient care with observation, monitoring and treatment being available.

b. **Medically Monitored Residential Withdrawal Management Narcotic Treatment Program (Level 3.7-WM NTP):** An organized service delivered by medical and nursing professionals, which provides 24-hour medically supervised evaluation and withdrawal management in a permanent facility with inpatient beds. This level of care is authorized to provide withdrawal management of patients with opioid use disorders utilizing FDA approved medications, other than methadone. Services are delivered under a defined set physician-approved policies and physician-monitored procedures or clinical protocols. This service level provides care to patients whose withdrawal signs and symptoms are sufficiently severe to require 24-hour inpatient care with observation, monitoring and treatment being available.

c. **Ambulatory Withdrawal Management with Extended On-Site Monitoring (Level 2.WM):** An organized outpatient service, which may be delivered by trained clinicians who provide medically supervised evaluation, detoxification and referral services. Outpatient detoxification services shall be designed to treat the patient's level of clinical severity and to achieve safe and comfortable withdrawal from mood-altering substances and to effectively facilitate the patient's entry into ongoing treatment and recovery.

d. **Ambulatory Withdrawal Management Without On-Site Monitoring (Level 1.WM):** An organized outpatient service, which may be delivered by trained clinicians who provide medically supervised evaluation, detoxification and referral services according to a pre-determined schedule. Such services are provided in regularly scheduled sessions under a defined medical protocol. Outpatient detoxification services shall be designed to treat the patient's level of clinical severity and to achieve safe and comfortable withdrawal from mood-altering substances and to effectively facilitate the patient's entry into ongoing treatment and recovery.

e. **Medically Monitored Residential Treatment (Level 3.7):** A planned regime of 24-hour professional directed evaluation, observation, medical monitoring and addiction treatment in an inpatient setting. This Level of care is appropriate for those individuals whose sub-acute, biomedical and emotional, behavioral or cognitive problems are so severe that they require inpatient treatment, but who do not need the full resources of an acute care general hospital.

f. **Residential Treatment (Level 3.5):** Highly structured, short term, intensive chemical dependency treatment service and intensive therapeutic activities. This Level is conducted in a 24-hour supervised living arrangement operated by the facility using around the clock awake staff. The goals of treatment are to promote abstinence from substance use and antisocial behavior and to effect global change in patients' lifestyles, attitudes and values.

g. **Medium Intensity Adult Residential Treatment (Level 3.3**): A structured recovery environment in combination with medium intensity clinical services to support recovery from substance related disorders. Individuals seen at this Level are often older, cognitively impaired or developmentally delayed, or are those in whom the chronicity and intensity of the primary disease process requires a program that allows sufficient time to integrate the lessons and experiences of treatment into their daily lives.

h. **Low Intensity Residential Treatment Adult (Level 3.1):** The program offers a minimum of five (5) hours per week of low-intensity treatment of substance related disorders. Treatment is directed toward applying skills, preventing relapse, improving social functioning and ability for self-care, promoting personal responsibility, developing a social network supportive of recovery and reintegrating the individual into school, work and family life.

i. **Transitional Residential (Level 3.01) (Not a recognized ASAM Level of Care-Developed by ADMH for use in Alabama only):** A residential service that provides supportive services and therapeutic activities conducted in a residential setting designed to provide the environment conducive to recovery and to promote reintegration into the mainstream of society.

j. **Partial Hospitalization (Level 2.5):** A program that is delivered in an outpatient setting and generally features twenty (20) or more hours of clinically intensive

programming per week. There is daily or near-daily contact, as specified in the patient's service plan. Patients often have direct access to or close referral relationship with psychiatric, medical and lab services.

k. **Intensive Outpatient (Level 2.1):** A combination of time limited, goal oriented rehabilitative services designed to assist clients in reaching and maintaining a drug and alcohol-free lifestyle. The amount of time and frequency of services for Level 2.1 are established on the basis of the unique needs of each client served, but services shall be available a minimum of nine (9) hours per week for adults and a minimum of six (6) hours per week for adolescents.

l. **Outpatient Services (Level 1):** Organized outpatient treatment services, which may be delivered in a wide range of settings. Professionally qualified addiction counselors deliver directed evaluations, treatment and recovery services. Such services are provided in regularly scheduled sessions of fewer than nine (9) contact hours per week for adults and fewer than six (6) hours per week for adolescents.

m. **Early Intervention (Level 0.5):** Organized service that may be delivered in a wide variety of settings. This Level of Care is designed to explore and address problems or risk factors that appear to be related to substance use and to help the individual recognize the harmful consequences of inappropriate substance use.

n. **Opioid Treatment Programs (OTPs) (Level I-O):** An organized ambulatory treatment service for individuals with an opioid use disorder delivered by trained personnel. The nature of the services provided is determined by the individual's clinical needs, but includes case management, psychosocial treatment sessions, and daily, or other scheduled, medication visits within a structured program. Opioid Treatment Programs are provided under a defined set of policies and procedures stipulated by state and federal law and regulation.

TABLE 3

ADMH Levels of Care
Level 0.5: Early Intervention Services, consisting of:
Early Intervention Services for Adults.
Early Intervention Services for Adolescents.
Early Intervention Services for Pregnant Women and Women with Dependent Children.
Early Intervention Services for Persons with Co-Occurring Substance Use and Mental Disorders.
Level 1: Outpatient Treatment, consisting of:
Outpatient Services for Adults.
Outpatient Services for Adolescents.
Outpatient Services for Pregnant Women and Women with Dependent Children.
Outpatient Services for Pregnant Women and Women with Dependent Children.
Outpatient Services for Persons with Co-Occurring Substance Use and Mental Disorders.
Ambulatory Withdrawal Management Without Extended On-site Monitoring.
Opioid Treatment Program.
Level 2: Intensive Outpatient Services/Partial Hospital Treatment, consisting of:
Intensive Outpatient Services for Adults.
Intensive Outpatient Services for Adolescents.
Intensive Outpatient Services for Pregnant Women and Women with Dependent Children.
Intensive Outpatient Services for Persons with Co-Occurring Substance Use and Mental Disorders.

	Partial Hospital Program for Adults.
	Partial Hospital Program for Adolescents.
	Partial Hospital Program for Pregnant Women and Women with Dependent Children.
	Partial Hospital Program for Persons with Co-Occurring Substance Use and Mental Disorders.
	Ambulatory Withdrawal Management with Extended on-site Monitoring.
Level 3: Residential Treatment Services, consisting of:	
	Transitional Residential Services for Adults
	Transitional Residential Services for Adolescents.
	Clinically Managed Low Intensity Residential Programs for Adults.
	Clinically Managed Low Intensity Residential Programs for Adolescents.
	Clinically Managed Low Intensity Residential Programs for Pregnant Women and Women with Dependent Children.
	Clinically Managed Low Intensity Residential Programs for Persons with Co-occurring Substance Use and Mental Disorders.
	Clinically Managed Medium Intensity Residential Programs for Adults
	Clinically Managed Medium Intensity Residential Programs for Adolescents.
	Clinically Managed Medium Intensity Residential Programs for Pregnant Women and Women with Dependent Children.
	Clinically Managed Medium Intensity Residential Programs for Persons with Co-Occurring Substance Use and Mental Disorders.
	Clinically Managed High Intensity Residential Programs for Adults.
	Clinically Managed High Intensity Residential Programs for Pregnant Women and Women with Dependent Children.
	Clinically Managed High Intensity Residential Programs for Persons with Co-occurring Substance Use and Mental Disorders.
	Medically Monitored Intensive Residential Programs for Adults.
	Medically Monitored Intensive Residential Programs for Pregnant Women and Women with Dependent Children.
	Medically Monitored Intensive Residential Programs for Persons with Co-occurring Substance Use and Mental Disorders.
	Medically Monitored High-Intensity Residential Programs for Adolescents.
	Medically Monitored Residential Withdrawal Management Program.

The authorized levels of care are modifications of those established in the ASAM PPC-2R and updated with the 2013 ASAM Criteria. As indicated in **TABLE 3** above**,** specialty levels of care are available in Alabama for adolescents, pregnant and parenting women, and individuals who have co-occurring disorders

In addition to certifying and funding the fourteen (14) levels of care, ADMH also provides funding for the services identified in **Table 4**. Primarily, these services must be provided within the levels of care and specialized programs described above:

TABLE 4

Services Funded to Support Levels of Care	
Case Management	Individual Counseling
Diagnostic Interview	Physician Support
Family Counseling	Bed, Board, and, and Protection
Group Counseling	Ancillary Services
Basic Living Skills	Non-Emergency Transportation
Medication Monitoring	Peer Counseling
Crisis Intervention	Mental Health Consultation
Injectable Medication Administration	Oral Medication Administration
Assessment Services	Brief Intervention
Activity Therapy	Child Sitting Services

Non-Emergency Transportation	Medications for use with Opioid Use Disorders

C. SABG Priority Service Populations

1. Chapter 580-9-44-.13(9)(d) of the Alabama Department of Mental Health's Administrative Code specifies that priority access to admission for treatment will be given to the following groups in order of priority:

a. Individuals who are pregnant and have intravenous substance use disorders.
b. Individuals who are pregnant and have substance use disorders.
c. Individuals who have intravenous substance use disorders.
d. Women with dependent children.
e. Individuals who are HIV positive.
f. All others with substance use disorders.

All programs certified by ADMH must adhere to the above rule. This includes those entities under contract with ADMH, as well as, those receiving no funds from the state. Compliance is monitored during bi-annual on-site certification site visits, as well as, during annual onsite SABG compliance reviews of funded programs. In addition, the following efforts are undertaken to assure the specific needs of the SABG's priority populations are appropriately attended within ADMH's substance abuse service delivery system:

2. Pregnant Women and Women with Dependent Children

The ADMH certifies and provides SABG women's set-aside funding for comprehensive substance use programs that exclusively serve pregnant women and women with dependent children. Each of these programs is certified to provide the following Alabama modified ASAM levels of care:

- Outpatient Treatment.
- Intensive Outpatient Treatment.
- Clinically Managed Low Intensity Residential Treatment.
- Clinically Managed Medium Intensity Residential Treatment.
- Clinically Managed High Intensity Residential Treatment

Throughout ADMH's administrative code, rules addressing the specific needs of pregnant and parenting women have been published. Chapter 580-9-44-.13(11)(a)5, for example, specifies that the intake process in programs for pregnant women and women with dependent children at a minimum:

- Shall be family centered and gender responsive addressing:

  a. Assessment of primary medical care to include prenatal care, primary pediatric care and immunization for their children.
  b. Relationships.

c. Sexual & physical abuse.
d. Parenting skills and practices.
e. Childcare.

- Include assessment of children participating in treatment with their mothers which shall, at a minimum, evaluate:

  a. Developmental, emotional, and physical health functioning and needs.
  b. Sexual & physical abuse.
  c. Neglect.

- Each entity shall specify in writing the procedures to ensure:

  a. Pregnant women and/or women with dependent children are given preference in admission.
  b. Sufficient case management to include transportation, publicizing the availability of service to women through street outreach programs, ongoing public service announcements, advertisements in print media, posters and other information placed in targeted areas, frequent notification of availability of such treatment distributed to the network of community-based organizations, health care providers and social service agencies.
  c. Interim services are available and offered.

Annual onsite program reviews are conducted by ADMH's Women's Services Coordinator to assure compliance with all administrative code and contract requirements which incorporate Federal SABG requirements.

3. Injecting Drug Users

The needs of injecting drug users have taken on a renewed since of urgency since the resurgence of opioids as the primary drug of choice for many Alabamians. Admissions to the state's public service delivery system for individuals with opioid use disorders continues to exceed those for alcohol use disorders. In 2014, specific efforts to improve access to care for injecting drug users were at the forefront of ADMH initiatives, which are continued to this day, included the following:

- Annual monitoring of ADMH contractors to insure compliance with SABG Federal regulations specific to injecting drug users.
- Advocating for removal of the state's moratorium prohibiting the opening of new opioid treatment programs which was accomplished.
- The provision of clinical documentation, case management, and recovery-oriented system of care training for opioid treatment programs.
- Assigning of specific ADMH program manager to act as an advocate and liaison for the OTPs.

4. Persons with or at Risk for Tuberculosis

ADMH monitors the state's Tuberculosis infection rate through ongoing surveillance of data maintained by the Alabama Department of Public Health. In addition, the agency's Administrative Code requires each certified provider to maintain, and document compliance with a written plan for exposure control relative to infectious diseases that, at minimum, must include the following requirements:

a. The plan shall be inclusive of the entity's staff, clients, and volunteers.

b. The plan shall be consistent with protocols and guidelines established for infection control in healthcare settings by the Federal Center for Disease Control, and shall at a minimum include:

   (1) Policies and procedures to mitigate the potential for transmission and spread of infectious diseases within the agency.
   (2) The provision of TB education for all program admissions.
   (3) A formal process for screening all program admissions for TB.
   (4) TB testing for all employees prior to initiation of duties after hiring, and annually thereafter if there is known exposure or evidence of ongoing TB transmission.

c. The entity shall document compliance with all laws and regulations regarding reporting of communicable diseases to the Alabama Department of Public Health.

Program monitoring of SABG contract providers indicates 100% compliance with administrative code and contract requirements for compliance with SABG regulations specific to persons at risk for TB.

5. Persons at Risk for HIV

ADMH monitors the state's HIV infection rate through data maintained by the Alabama Department of Public Health and the Centers for Disease Control. ADMH's administrative code maintains regulations which require all certified substance abuse treatment providers to maintain, and document compliance with a written plan for exposure control relative to infectious diseases that includes:

> Provisions to offer HIV early intervention services, directly or by referral, to all clients who voluntarily accept the offer to include HIV pre-test and post-test counseling, case management and referral services, and as needed, medical care.

In addition, each ADMH service delivery contract with substance abuse treatment providers specifies, "The Contractor, and its Subcontractor(s), will provide each client receiving substance abuse treatment services pursuant to this Contract with HIV risk education, including prevention information." ADMH's treatment services staff monitors

compliance with these regulatory and contract requirements through annual onsite compliance reviews.

6. Youth in Alabama

ADMH certifies eighteen (18) adolescent substance use disorder treatment programs (See Table 5 below). Youth between the ages of 13-18 who meet DSM-V criteria are eligible for treatment services. These treatment providers offer services for youth that engage the patient and family in recovery efforts. Treatment addresses the patient's psychosocial needs along with the substance use disorder. Treatment approaches are evidenced based and modalities include residential and outpatient programs with varying intensities to meet patient needs. Services include family, group, individual counseling as well as educational sessions and other support services such as case management and peer support. Adolescent services also include in-home and school-based counseling when appropriate. Treatment providers are expected to have formal linkages with other community social service entities for referrals to ensure that individualized needs are being addressed.

ADMH utilizes the ASAM Patient Placement Criteria for the treatment of substance use disorders, which has had a positive impact on the system of care for adolescents in Alabama. All youth in need of treatment are assessed using a standardized assessment tool based on ASAM placement criteria. Based on the results of the assessment the appropriate level of care is recommended and the individual should ultimately be placed or referred to the same level of care.

ADMH has linkages with several state stakeholders whose focus is to provide greater access to quality services for youth and families in the state of Alabama. Those committees include: *Multiple Needs Case Review Committee*, which reviews referral for children in need of a more restrictive treatment environment; *State Children's Policy Council*, which is the coordinating body for the local counties' Children's Policy Councils; *Children's Justice Task Force*, which promotes the identification, assessment, and prosecution of child abuse; *State Perinatal Advisory Committee*, which advises the state health officer in the planning, organization, and evaluation of the state's perinatal program; *Fetal and Infant Mortality Review*, which is responsible for identifying critical community strengths and weaknesses as well as unique health and social issues associated with poor outcomes of pregnancy; *Statewide System Reform Program*, which is a collaboration of state agencies aiming to establish protocols to reach more families that find themselves at the crossroads of the justice system, mental health, and the child welfare system; and *Impaired Drivers Trust Fund Advisory Committee*, which facilitates a system of services for Alabamians with head and spinal cord injury.

The number of youths receiving services from ADMH funded substance abuse treatment programs for SFY 2020 was 2,195.

Table 5

Certified Adolescent Programs and LOC	
Bradford Health Services	Level 2.1, 2.5, 3.7, 3.7 WM

Bridge, Inc.	Level 0.5, 1, 2.1, 3.5
Aletheia House	Level 1, 2.1
Central Alabama Wellness	Level 1
East Alabama MHC	Level 1
Health Connect America	Level 1, 2.1
Hope House	Level 1
Montgomery Area Mental Health Authority	Level 1
Northwest Alabama MHC	Level 1, 3.5
Pinnacle Behavioral	Level 2.1 (co-occurring)
RCA Foundation	Level 1
Recovery Services	Level 1
Riverbend MHC	Level 1 (co-occurring)
Southern Wellness	Level 1
St. Clair New Day	Level 0.5, 1
TEARS	Level 0.5, 1
UAB Beacon	Level 1, 2.1
Wellstone (Nova Center)	Level 1, 2.1

7. Primary Prevention Services

ADMH, in accordance with its regulatory authority, has established service delivery rules in the Alabama Administrative Code that are used to certify programs as eligible to provide substance use prevention services. Currently certification is required only of prevention programs operated by community-based organizations that receive funding from ADMH.

ADMH does not operate substance use prevention programs, or directly provide any related services. The agency currently enlists the services of twenty-three (23) certified prevention programs across the state in this regard. ADMH has established the state's public system of services through the execution of contractual agreements with these private and public entities located throughout Alabama and include representation of all four-substance abuse regional planning areas.

ADMH utilizes twenty percent (20%) of its SABG allocation for the provision of prevention services for individuals who do not require treatment for substance use disorders. Contractors are required to:

a. Educate and counsel individuals on substance use.
b. Provide for activities to reduce the risk of such use by the individuals.
c. Give priority to populations that are at risk of developing a pattern of such use and develop community-based strategies for prevention of such use, including strategies to discourage the use of alcoholic beverages and tobacco products by individuals to whom it is unlawful to sell or distribute such beverages or products.
d. Use funds provided for the provision of comprehensive primary prevention programs that include activities and services provided in a variety of settings for both the general population, as well as targeting sub-groups who are at high risk for substance use.
e. Identify the type of target population for service provision based on the Institute of

Medicine categories: Universal, Selective, or Indicated.

f. Use a variety of strategies, as appropriate for each target group, including but not limited to the following:

(1) **Information Dissemination**: Information dissemination is a way of creating awareness and knowledge about the use, abuse and addiction of alcohol and other drugs and/or services available and is characterized by one-way communication from the source to the audience, with little or no contact between the two.

(2) **Education**: This strategy involves two-way communication and is distinguished from information dissemination by the fact that it is based on an interaction between the educator and the participants. Activities under this strategy aim to affect critical life and social skills, including decision making, refusal, and critical analysis skills. Examples of methods used are the following: classroom and small group sessions, parenting and family management classes, peer leader and peer helper programs, education programs for youth groups, and educational groups for children of substance abusers. This strategy may be used in conjunction with other strategies, practices and policies to have efficacy in communities.

(3) **Alternative Programs**: Evidence does not support the use of an alternative strategy as a sole prevention strategy with the intended target population. Alternatives are most effective when used as a part of a comprehensive plan of prevention services. The goal of this strategy is to have target populations participate in activities that are alcohol, tobacco, and other drug free in nature and incorporate educational messages. Examples of methods used in this strategy are summer recreational activities, drug free dances, youth and adult leadership activities, community service centers and mentoring programs.

(4) **Problem Identification and Referral**: This strategy aims at the general classification of those who have indulged in illegal or age-inappropriate use of tobacco or alcohol, and those who have indulged in the first use of illicit drugs, in order to assess whether the behavior can be reversed through education. It should be noted that this strategy does not include any function designed to determine whether a person needs treatment.

(5) **Community-Based Process**: The Community Based Process Strategy is aimed to enhance the ability of the community to provide more effective prevention services for substance use issues. Activities in this strategy include organizing, planning, and enhancing efficiency and effectiveness of the services being offered. Effective organizing and planning are paramount to the success of prevention practices, policies and programs. These programs consist of activities at the community level to train volunteers, parents, community action groups, school teachers, law enforcement personnel, health workers, and other professionals on topics that impact directly or indirectly alcohol, tobacco, or other drug use.

(6) **Environmental**: Environmental strategies focus on the cause and the conditions of the community environment that are:

- Changing economic conditions (How much things cost; how available things are);
- Changing social conditions (What people think; how people live);
- Changing media conditions (what people read, watch, hear, and see); and
- Changing political conditions (Who has power; who has influence)

Environmental strategies also focus on changing the norms and regulations that influence/control the social and physical contexts of the use of alcohol, tobacco and other drugs.

The majority of ADMH provided prevention funding is directed towards environmental, community-based processes, and alternative activities. A minimum of fifty percent (50%) of the contractor's ADMH SABG provided funding must be expended for implementation of Environmental Strategies. All strategies must also incorporate the utilization of evidenced-based programs from the Evidence-based Practices Resource Center.

Eligibility Criteria for Prevention Services:

Primary prevention services are provided for target populations as defined in ADMH's Office of Prevention Strategic Plan. Services must be based upon assessed community needs with priority given to programs that serve at risk individuals and communities. Contractors must identify goals and community objectives to be facilitated by all parties involved in service provision (subcontractors, fee for service and part/full time) staff members. All prevention services must be approved by ADMH prior to implementation.

Utilizing the Strategic Prevention Framework to guide the process, ADMH requires providers to submit data informed plans to ensure the needs of their diverse communities are addressed. In FY 2021, provider prevention plans focused on a comprehensive approach across the six primary strategies addressing underage drinking; prevention or reduction of illicit and prescription drug misuse, use, and abuse; and prevention across the lifespan with an emphasis on adolescents and young adults.

Strategic Prevention Framework

In 2010, the Division executed a Cooperative Agreement with SAMHSA to support implementation of the Strategic Prevention Framework (SPF) as the planning process for prevention services in Alabama. A project director was assigned responsibility for management of this State Incentive Grant and continues to work in conjunction with the State Prevention Advisory Board (SPAB) and the Alabama Epidemiological Outcomes Workgroup (AEOW) to fulfill its objectives.

The SPAB, originally appointed by Governor Bob Riley, consists of a multidisciplinary group of individuals who are interested in substance use prevention services in Alabama, and who have a range of experience (personal and professional), skills, and resources to support the successful development and implementation of the SPF. Representatives of

the office of the Department of Corrections, the Department of Children Affairs, the Department of Rehabilitation Services, the Department of Public Health, and the Department of Education serve on the SPAB, as well as, the AEOW (Alabama Epidemiological Outcomes Workgroup).

The AEOW works under the authority of the ADMH. Its membership consists of organizations and agencies that collect state specific data. The AEOW functions to support state and community efforts to prevent substance use, dependency, and related problems, collect, analyze, and disseminate data, and to describe the prevalence, consumption, and consequences of alcohol, tobacco, and other drug use in Alabama. The AEOW is chaired by the Division's Epidemiologist. The composition of the SPAB and the AEOW contribute towards the resources of the system to assist in the provision of both treatment and prevention services.

Partnerships for Success

In Fiscal Year 2016, ADMH began execution of a Cooperative Agreement with SAMHSA to sustain the Strategic Prevention Framework (SPF) initiative through the Partnerships for Success (PFS) program opportunity. The SPF project director is assigned responsibility for management of the PFS Grant and will work uniformly with the SPAB and the AEOW to fulfill its objectives.

Strategic Prevention Framework for Prescription Drugs

In Fiscal Year 2016, ADMH began execution of an additional Cooperative Agreement with SAMHSA to sustain the Strategic Prevention Framework (SPF) initiative through the Strategic Prevention Framework for Prescription Drugs (SPF Rx) program opportunity. The SPF project director is assigned responsibility for management of the SPF Rx Grant and will work uniformly with the SPAB and the AEOW to fulfill its objectives.

Opioid State Targeted Response

In Fiscal Year 2017, ADMH began execution of an additional Cooperative Agreement with SAMHSA to sustain the Strategic Prevention Framework (SPF) initiative through the Opioid State Targeted Response program opportunity. The SPF project director is assigned responsibility for management of the STR Grant and will work uniformly with the SPAB and the AEOW to fulfill its objectives.

State Opioid Response

In Fiscal Year 2019, ADMH began execution of an additional Cooperative Agreement with SAMHSA to sustain the Strategic Prevention Framework (SPF) initiative through the State Opioid Response program opportunity. The SPF project director is assigned responsibility for management of the STR Grant and will work uniformly with the SPAB and the AEOW to fulfill its objectives.

Strategic Prevention Framework for Prescription Drugs

In Fiscal Year 2021, ADMH began execution of an additional Cooperative Agreement with SAMHSA to sustain the Strategic Prevention Framework (SPF) initiative through the Strategic Prevention Framework for Prescription Drugs (SPF Rx) program opportunity. The SPF project director is assigned responsibility for management of the SPF Rx Grant and will work uniformly with the SPAB and the AEOW to fulfill its objectives.

Other Prevention Services

ADMH currently funds two coalitions dedicated to the reduction of substance use in Alabama: Council on Substance Abuse River Region Prevention Network (RRPN) formerly Montgomery Unified Prevention System (MUPS), and Elmore County Partnership for Children. Together, the coalitions annually receive a total of approximately $160,000. These coalitions consist of youth, parents, teachers, churches, civic and business leaders and others that are making positive influences and changes throughout their communities. Extensive efforts have been focused on excessive alcohol use, illicit drugs, and alcohol and tobacco ordinances, all resulting in reduction of substance use and abuse.

Alabama, also, has six (6) regular Drug-Free Community (DFC) grantees, which are community-based coalitions organized to prevent youth substance use. The philosophy behind the DFC program is that local drug problems require local solutions. Through training, technical assistance, awareness and availability of additional resources, DFC capacity is expected to be increased.

D. Recovery Support Services

In 2008, the Alabama Department of Mental Health (ADMH) developed and articulated a vision for implementation of a Recovery Oriented System of Care (ROSC) as the philosophical framework for the state's substance abuse service delivery system. Since that time, this vision has successfully guided execution of many of the agency's system improvement initiatives. Workforce development activities which encompass the systematic use of peers in service delivery for individuals who have substance use or co-occurring disorders are the primary focus of this effort at the current time, with the following goals as guidance:

1. Establish the infrastructure to support and sustain a workforce that routinely utilizes trained and certified peer specialists in the provision of services for individuals, families, and communities impacted by substance use disorders and mental illnesses.

2. Establish a well-trained and credentialed peer network, along with mechanisms to promote its use and sustain its effectiveness.

3. Establish protocols to demonstrate the effectiveness of the state's utilization of peer support specialists in expanding service access, facilitating care transitions, enhancing

treatment retention, and thereby improving the overall health and wellness of individuals, families, and communities impacted by substance use or co-occurring disorders.

ADMH has established a workgroup to guide efforts to attain the identified goals and to seek funding to support this effort. In addition, ADMH's Commissioner and its Associate Commissioner for Mental Health and Substance Abuse Services have demonstrated full support of the agency's vision for ROSC and the utilization of peers to facilitate the recovery process.

To date the agency has created a credentialing process for peers to become Certified Recovery Support Specialists and has certified over 550 peers. ADMH provides funding for the provision of peer services as part of its fee-for-service reimbursement system. The agency has worked with Alabama Medicaid to incorporate peer services as a part of its Medicaid rehabilitation service option which began in February of 2019.

In addition, ADMH has given its support to the development of the state's first recovery community centers for individuals who have substance use disorders. The two peer-run centers, one in Region 2 and the other in Region 3, opened during the summer of 2017, offering a number of recovery groups, workshops, assistance in resume development and job searches, and recreational activities for both consumers and their families. A third center opened in 2018 in Region 4 and a fourth opened in 2020.

Consumers, family members, and advocates representing both mental illnesses and substance use disorders are active participants in all ADMH strategic planning processes. This includes their membership on various standing and ad hoc committees, workgroups, and on the agency's Board of Trustees which serves in an advisory capacity to the Commissioner.

In January 2013, the ADMH hired an individual with lived substance use disorders experience to work in the position of Recovery Support Services Coordinator for the Mental Health and Substance Abuse Services Division. This individual has responsibility for managing implementation of ADMH's vision for ROSC for individuals who have substance use and co-occurring disorders and also provides training throughout the state on the fundamentals of ROSC.

E. Role of Other State Agencies in the Delivery of Substance Abuse Services

1. Alabama Medicaid Agency

The Alabama Medicaid Agency is a close collaborator of the ADMH in regard to service development and funding for the state's public system of services for substance use disorders. Through its state plan Rehabilitation Option, Medicaid has approved a broad array of covered services to support rehabilitation of individuals enrolled in ADMH sanctioned treatment programs. These services, as identified Table 6 below, may only be provided for an eligible Medicaid recipient, based upon medical necessity, by an appropriately credentialed provider working in an ADMH certified program. ADMH pays the Federal Financial Participation state match requirements for substance abuse

treatment programs that meet the staffing, certification and reporting criteria it has established for such. Medicaid also provides reimbursement nonemergency transportation services for participants in ADMH certified treatment programs.

Table 6

Intake Evaluation	Family Counseling
Physician/Medical Assessment and Treatment	Group Counseling
Diagnostic Testing	Medication Administration
Crisis Intervention	Medication Monitoring
Individual Counseling	Mental Health Consultation
Partial Hospitalization Services	Basic Living Skills
Psychoeducational Services	Opioid Use Disorder Treatment
Peer Support Services	Screening/Brief Intervention
Nursing Assessment and Care	Outpatient Detoxification

2. Other State Agencies

Although ADMH has statutory responsibility for and is the greatest contributor to the operations and development of Alabama's public substance use treatment system, other state agencies, as specified in Table 7 have, over time, created substance use treatment and prevention systems within their organizational structures to specifically address needs they have identified in the public sector.

Table 7

State Agency	Services Provided
Alabama Department of Corrections	Substance Abuse Treatment for Inmates
Alabama Department of Pardons and Parole	Substance Abuse Treatment for Parolees
Alabama Administrative Office of the Courts	DUI Early Intervention, Court Referral Services, Drug Courts
Alabama Department of Public Health	Prescription Drug Monitoring Program, Smoking Prevention and Treatment
Alabama Department of Youth Services	Substance Abuse Treatment for Youthful Offenders, Medicaid Rehabilitation Services
Alabama Community Corrections	Substance Abuse Treatment for Individuals Diverted from Correctional Settings
Alabama Department of Human Resources	Contractual Substance Abuse Treatment and Medicaid Rehabilitation Option Services
Alabama Department of Education	Substance Abuse Prevention
Alabama Department of Economic Affairs	Underage Drinking Initiatives

3. Regional, County, and Local Entities Providing Services in Alabama Service Delivery System

Entities participating as providers in Alabama's public system of substance use services are legally structured as either (a) a public not-for-profit organization operating under the authority of Alabama Acts 1967, Act 310; or (b) private not-for-profit organizations or

(c) private for-profit corporations or partnerships operating under the authority of Alabama Business and Nonprofits Entities Code, Title 10a of the Code of Alabama 1975. ADMH's relationship to these organizations is described below:

a. Public Not-For Profit Organizations

Alabama Acts 1967, Act Number 310, Sections 22-51-1 -14 provides for the formation and operation of public corporations to contract with ADMH for constructing facilities and operating programs for mental health services. Such entities are known as "310 Boards". Comprehensive 310 Boards are authorized to directly provide planning, studies, and services, for mental illness, intellectual disability, and substance abuse populations for all counties for which they are incorporated to serve. Membership of the 310 Boards consists of appointments made by local city and county governments. The executive directors of 310 Boards are significant contributors to ADMH's planning and budgeting processes, with prominent positions on the agency's Management Steering Committee and the Substance Abuse Coordinating Subcommittee.

There are nineteen (19) regional 310 Boards encompassing twenty-two (22) catchment areas in the state. ADMH certifies, contracts, and funds sixteen (16) of these Boards for the operation of substance abuse treatment and prevention programs operated by these entities. No management, monitoring or funding responsibilities of other service providers located within respective 310 regions are passed down from ADMH to the 310 Boards.

b. Free-Standing Private Not-For-Profit Organizations

Free-standing charitable agencies either contract directly with ADMH for funding to support the services they provide. These entities have their own Governing Boards and have no ties to ADMH or other governmental agencies except on a contractual basis. The mission, operational policies and procedures, and scope of services provided by these agencies are established by the entity's Board of Directors. Representatives from free-standing not-for-profit organizations participate in ADMH's planning processes by invitation or as citizen participants in open public meetings.

c. Private For-Profit Organizations

Private for-profit organization are free standing programs that operate as a for profit business entity. Privately owned, these entities contract with ADMH as Medicaid service providers. Representatives from private-for-profit organizations participate in ADMH's planning processes by invitation or as citizen participants in an open public meeting.

d. <u>Provider Participation Requirements</u>

Each entity contracting with ADMH must meet all certification, reporting, and data submission requirements as specified by the state. All claims for services provided, regardless of whether the payment source is SABG funding, state funding, Medicaid reimbursement or other grant funding, must be submitted to ADMH through its Alabama Substance Abuse Management Information System (ASAIS). Provider contacts incorporate all SABG requirements and assurances.

F. 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 substance use service delivery system through various mediums annually. In an effort to increase cultural relevancy and enhance the awareness of prevention and treatment resources available to individuals and communities served in this regard, consistent training, technical assistance and organizational collaborations incorporating and promoting diversity are provided. Substance use prevention providers are currently required to submit disparity impact statements to ensure health disparities are identified among populations and needs are met. In addition, the Mental Health and Substance Abuse Services (MHSA) Division is exploring comprehensive plans to incorporate disparity impact statements within the entire continuum. ADMH has two representatives on the State Cultural and Linguistic Competency Network that is managed by Georgetown University.

Along with these efforts, ADMH is, also, currently proposing to implement the CLAS Standards throughout each component of its service delivery system. All substance abuse providers have been offered free training on CLAS standards and given an opportunity to assess their agency as related to CLAS standards. 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.

G. Strengths and Weaknesses of the System

1. Numerous **strengths** support the operations of Alabama's public substance abuse service delivery system, including:

a. ADMH's Commissioner is one of three co-chairs for Governor Kay Ivey's Council on Opioid Overdose and Addiction.

b. Collaborative Relationships: ADMH has a history of collaboration with other agencies which supports effective and efficient use of state resources.

c. Relationship with Medicaid: ADMH's partnership with the Alabama Medicaid agency has allowed for efficient use of state dollars to expand access to care.

d. Relationship with the Alabama Department of Public Health: ADMH's partnership with the Alabama Department of Public Health enables the agency to meet many of its SABG compliance requirements, including the TB maintenance of effort.

e. The Substance Use Services Integrated Placement Assessment: SASD has developed extensive training material for implementation of the SASD Integrated Placement Assessment, established a cadre of trainers who were trained by Dr. Mee Lee and others, and provides on-site trainings a minimum of six times a year free of charge. In addition, SASD has developed criteria to guide placement in each ASAM level of care, along with operational standards for each level of care.

f. Stable Provider Base: The vast majority of the division's providers have been its providers for over thirty years.

g. Office of Deaf Services: ADMH operation of the Office of Deaf Services gives the state a unique opportunity to address an issue that is too often ignored within the substance abuse service delivery system. The director of this office provides training for behavioral health professionals all over the world.

h. ASAIS: Developed as the substance use division's management information system, ASAIS is allows for client level service reporting, supports service utilization reviews, as well as directly interfaces with the Alabama Medicaid Agency's MIS. The system is built on a platform that is capable of data sharing with the state's Health Information Exchange.

i. Substance Use Staff Qualifications and Diversity: The staff of the Division is dedicated, resourceful, and has a wealth of experience, education, and training to move the Division forward during this time of extreme system change. The staff, also, reflects the diversity of Alabama's population.

j. A strong provider compliance monitoring process.

k. Commitment of ADMH program management to systems improvement

l. Establishment of the Recovery Support Specialist credentialing process.

m. Increase in the number of providers enrolling in Medicaid, providing for more efficient utilization of state dollars.

n. A strong **Substate Prevention System** that provides stability to the statewide prevention delivery system. The prevention system in the State has many long-term staff at the local levels.

o. Coalition Readiness

(1) Increased perception of community influence on the important decisions made by the state prevention system.

(2) There is a consensus on a definition of substance use prevention that guides all participating agencies and coalitions.

(3) The state prevention system partners share a common understanding and use of evidence-based substance use prevention practices.

(4) Development of a comprehensive substance use prevention plan among state prevention partners.

(5) State prevention system activities, use of resources, and outcomes are reported to community stakeholders on a regular basis.

p. 2019 Prevention Workforce and Retention (Community-Level)

(1) Prevention is supported by community agencies.

(2) Perception of agency value of employees is positive.

(3) Agency sustainability of prevention workforce is consistent.

(4) Prevention workforce preparedness to complete job responsibilities is present.

(5) Overall enjoyment with prevention roles/responsibilities is present.

(6) Overall feeling that the role of prevention is making a difference in communities.

q. 2019 Funding Allocation (ADMH)

(1) Alabama's substance use prevention system is positioned to eradicate historic funding in Alabama's prevention system and substitute a data-driven process focusing on population/need.

(2) Alabama's prevention system has a formal funding allocation model to address resource allocation.

(3) Measures are developed for delivery of prevention strategies.

(4) Established incentives for prevention providers.

(5) All sixty-seven (67) counties within the State of Alabama have access to prevention services/funding.

(6) In addition to the components of the assessment tools, Alabama consistently employs the SPF process within all aspects of prevention services to include Assessment, Planning, Capacity, Implementation, Evaluation, Sustainability and

Cultural Competence.

2. At the same time, weaknesses have also been identified in the state's substance use service delivery system which hinder optimum operations and effectiveness. These include:

a. Treatment Data Underutilization: Throughout the years, there has been very little utilization of available data by ADMH for substance use treatment service planning purposes.

b. Access to Care: There is no organized plan for a development of a continuum of substance use treatment services within the state's planning regions. Services, basically, exist in locations that were decided upon by the program's owner or governing body in accordance with the funding available to operate the program.

c. Service Need: ADMH serves less than 10% of the estimated need for substance use treatment in Alabama.

d. Systems Change: System change has been a very slow process in Alabama. Despite advances in knowledge about substance use disorders and its prevention and treatment, evidence-based practices in that regard, innovations in technology, and changes health care delivery, few adaptations have been made within ADMH's provider base.

e. Lack of Medicaid expansion.

f. Flat state and federal funding impede the ability of the system to adequately respond to emerging community needs through implementation of evidence-based practices.

Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current M/SUD system of care as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's M/SUD system of care.
States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, SUD prevention, and SUD treatment goals at the state level.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

AEOW MEMBER ORGANIZATION & CONTRIBUTION ROSTER

Member	Organization/Community Sector Organization Role/Title	Member Contribution/Responsibility
Catina James	Alabama Department of Mental Health - Epidemiologist	Chairs the AEOW meetings, organizes the AEOW's activities and agenda, reviews identified needs and priorities as it relates to AEOW.
Beverly Johnson	Alabama Department of Mental Health – Director of Prevention Services	Provide updates on statewide initiatives as it relates to substance abuse prevention and assist with priority and need identification
Lauren Blanding	Alabama Department of Mental Health – SOR Consultant	Assists with information & data from the sub-recipients of the opioid grants, SOR & Overdose to Action (OD2A)
Erin Burleson	ADMH Office of Prevention Services Prevention Consultant	Ex-officio member, Provides updates related to occurring at the community level and related to working directly with providers.
Shalandra Rogers	ADMH Office of Prevention Services Prevention Consultant	Ex-officio member, Provides updates related to occurring at the community level and related to working directly with providers.
Maegan Ford	Alabama Department of Mental Health -	Assists with information & data related to suicide.
Reese, Sondra	Alabama Department of Public Health	Assist with information related to chronic diseases
Renita Ward	High Intensity Drug Trafficking Area (HIDTA)	Assists with data on drug enforcement
Dr. Delynne Wilcox	UA Office of Wellness & Promotion Assistant Director of Health Planning & Prevention	Assist with identifying, analyzing data on college-age youth and utilizing outcomes to prioritize prevention efforts on college campuses statewide. Provide recommendations on best practices for collecting and/or accessing university data.
OMNI Institute Team	Contracted Substance Abuse Block Grant Evaluators	Provides evaluation services for the Substance Abuse Block Grant which includes assistance with prevention planning and development of statewide survey.
Douglas Poole	Office of National Drug Control Policy - Overdose Response Strategy Analyst, Alabama	Provides intelligence bulletins/products relating to the overdose crisis in Alabama. Share timely data and pertinent intelligence.
April Knight	Northwest Alabama Mental Health Center – Director of Prevention Services	Provide the community level perspective of data needs and data sources available at a community level.
Brittney Dabney	Alabama Department of Mental Health, Office of Public Information – Public Information Specialist	Assist with providing insight on the dissemination, presentation, and marketing of the AEOW products to stakeholders.

SECTION II: ALABAMA PLANNING STEPS

STEP 2: IDENTIFY THE UNMET SERVICE NEEDS AND CRITICAL GAPS WITHIN THE CURRENT SYSTEM.

1. ASSESSMENT PROCESS

The State's Epidemiological Outcomes Workgroup is an active participant in the identification of needs and gaps in Alabama's substance abuse service delivery system. Since its establishment by the Substance Abuse Services Division of the Alabama Department of Mental Health (ADMH) in 2006, the Alabama Epidemiological Outcomes Workgroup (AEOW) has focused its efforts on the systematic assessment of alcohol, tobacco, and other drug (ATOD) use and related consequences throughout the state. The AEOW utilizes a data-driven process to ensure the availability of accurate information for the public's use in planning, programming, and service prioritization.

The AEOW functions to support state and community efforts to prevent and treat substance use and related problems; to collect, analyze, and disseminate data; and to describe the prevalence, consumption, and consequences of alcohol, tobacco, and other drug use in Alabama. The AEOW continuously contributes to ADMH's planning processes by providing ongoing system surveillance, assessment, analysis, monitoring, and dissemination of data describing ATOD consumption patterns and consequences in the state. Additional activities include ongoing review of changes in data indicators to identify improvements or gaps that need to be addressed.

The AEOW collects data at the state and community level to inform assessment of the prevalence of substance abuse issues and the impact of such in Alabama. Data includes indicators on substance use, consequences, and ATOD use risk/protective factors. Data identifying the magnitude, severity, trends, and comparison with US indicators is also collected and examined.

The AEOW's methodology for assisting ADMH in establishing SABG service priorities begins with an environmental scan of potential national and state data sources apropos for determining needs relative to ATOD use in Alabama. A data quality screening process is then conducted to identify those sources that would be appropriate for assessment purposes. Selected data sources are considered eligible for use in assessment based on the following criteria: availability, validity, consistency, and periodic collection over at least three to five past years. Data is then collected by ADMH's Epidemiologist and presented to the AEOW for discussion of consumption patterns, consequences of use, risk and protective factors, and other ATOD related needs of the people of Alabama as revealed by the data. Consensus of the AEOW, after its review and analysis of data and related information collected, results in

recommendations to ADMH for Alabama's substance abuse priority areas to address system needs and gaps.

The AEOW is chaired by ADMH's Epidemiologist and its Prevention Services Director. Through the AEOW's partnerships with state agencies, the Epidemiologist has ready access to data from several state agencies, including the Alabama Department of Public Health, Alabama State Department of Education, Alabama Law Enforcement Agency and Alabama High Intensity Drug Trafficking Area. These partnerships provide essential support for ADMH's data-driven decision making process for priority setting and service planning. The partnerships also enhance ADMH's capacity to monitor the impact of its funded services on alcohol, tobacco, and other drug use in Alabama.

The information that follows establishes the basis for Alabama's Substance Abuse Block Grant (SABG) priorities for FY 2022 and FY 2023. ADMH has identified unmet needs and critical gaps in the state's publicly funded substance abuse service delivery system through a process of review and analysis of information retrieved from data collection processes that addressed:

- Consumption of Licit and Illicit Drugs in Alabama;
- Vulnerable/Underserved Populations; and
- System Issues.

2. ALCOHOL AND OTHER DRUG USE IN ALABAMA

According to the U.S. Census Bureau, Alabama's population grew 5.1% Alabama is home to 5,024,279 individuals(U. S. Census Bureau, 2020). Alabama's population grew 5.1% since 2010 A demographic profile of the state's residents is provided in **TABLE 1** (U. S. Census Bureau, 2018).

Table 1

Age, Sex, Gender Identity	
Persons under 18 years	22.2%
Persons 65 years and over,	17.3%
Females	51.7%
Males	48.3%
Race and Hispanic Origin	
White alone	69.1%
Black or African American alone,	26.8%
American Indian and Alaska Native alone	0.7%
Asian alone	1.5%
Native Hawaiian and Other Pacific Islander alone	0.1%
Two or More Races	1.8%
Hispanic or Latino	4.6%

Families and Living Arrangements	
Households, 2015-2019	1,867,893
Persons per household, 2015-2019	2.55
Living in same house 1 year ago, percent of persons age 1 year+, 2015-2019	86.3%
Language other than English spoken at home, percent of persons age 5 years+, 2015-2019	5.3%
Income and Poverty	
Median household income (in 2019 dollars), 2015-2019	$50,536
Per capita income in past 12 months (in 2017 dollars), 2015-2019	$27,928
Persons in poverty, percent	15.5%
Children ages under 18 in poverty (2019)	21.9%

Source: Census, 2019 Population Estimates

In 2019, the state's overall poverty rate was 15.6% for all ages compared to 12.3% in the United States. For ages 5 to 17 in families, the poverty rate is 20.7% compared to 15.8% in the United States. Although data availability is not currently age-specific, the Movement Advancement Project (MAP) reports 3.1% of Alabama 18 and older population as representative of LGBTQ individuals as of 2019 as well as 147,000 individuals as the total LGBTQ population (13 and older). At this time, there are no reliable statistics on gender identity for Alabama. MAP also reports that 24% of LGBTQ individuals are raising children in the State (MAP, 2019).

In comparison to other states, Alabama's consistent ranking at or near the bottom sector of most indicators of good health and wellbeing is a major eyesore. The United Health Foundation currently ranks Alabama 47th in the nation in terms of overall health outcome (2019). This ranking is based upon analysis of the following four health determinants: (a) personal health behaviors; (b) community and environmental factors that are indicative of the reality of daily living conditions; (c) public and health policies indicative of the availability of resources to encourage and maintain health, as well as, the extent that public and health programs reach into the general population; and (d) the quality, appropriateness and cost of the clinical care received at doctors' offices, clinics and hospitals (United Health, 2020). As indicated in Table 2, the state is challenged by many health related issues.

Table 2

Alabama's 2020 Health Ranking	
Health Determinant	**National Ranking**
Obesity	44
Premature Deaths	48
Drug Deaths	19
Suicide	28
Cancer	29
Diabetes	48
Low Birthweight	48
Frequent Mental Distress	47
Frequent Physical Distress	47
Smoking	44

Mental Health Providers	50
Dentists	48
Primary Care Physicians	46
Preventable Hospitalizations	45

Alabama is not a Medicaid expansion state and its Medicaid eligibility criteria is one of the most stringent in the nation. Currently, Medicaid eligibility for non-disabled adults is limited to parents with incomes below 16% of poverty, or about $3,800 a year for a family of four. Adults without dependent children remain ineligible regardless of their income.

Alabama, also, has a significant alcohol and drug problem that both compounds and is compounded by the state's health and economic deficits. Alcohol and other drug use has been linked to poor health outcomes as those experienced in the Alabama. Long-term alcohol misuse is associated with liver disease, cancer, cardiovascular disease, and neurological damage as well as psychiatric problems such as depression, anxiety, and antisocial personality disorder. Excessive alcohol consumption is associated with approximately95,000 deaths per year (NIAAA, 2020).

Alabama's Behavioral Health Barometer published by the Substance Abuse and Mental Health Services Administration (SAMHSA, 2020), identify the following youth and young adults drug use patterns in the state:

- Among youth aged 12-17 during 2017-2019, the annual average prevalence of past-month marijuana use was 5.2% (or 19,000).

- Among young adults aged 18-25 during 2017-2019, the annual average of 7.9% (or 40,000) had illicit drug use disorder in the past year.

- Among youth aged 12-17 during 2017-2019, the annual average prevalence of past-month cigarette use was 4.8% (or 18,000).

- Among youth aged 12-17 during 2017-2019, the annual average prevalence of past-month alcohol use was 8.4% (or 31,000).

- Among youth aged 12–17 during 2017-2019, an annual average of 6.3% (or 23,000) initiated alcohol use (i.e., used it for the first time) within the year prior to being surveyed, 4.0% (or 15,000) initiated marijuana use within the year prior to being surveyed, and 3.2% (or 12,000) initiated cigarette use.

- Among people age 12 or older during 2017-2019, 5.1% (or 209,000) misused prescription pain relievers in the past year.

Of individuals aged 18 and older in Alabama, according to the 2015-2016 National Survey on Drug Use and Health:

- About 213,000 individuals in 2018–2019 had an alcohol use disorder in the past year.
- About 569,000 individuals in 2018–2019 had used marijuana in the year prior to the survey.
- About 11,000 individuals in 2018–2019 had used heroin in the year prior to the survey.
- About 72,000 individuals in 2018–2019 had used cocaine in the year prior to the survey.
- About 1,166,000 individuals in 2018–2019 had used tobacco products in the month prior to the survey.
- About 171,000 individuals in 2018–2019 had misused pain relievers in the year prior to the survey.

Alabama's 2021 Drug Threat Assessment, prepared by the Alabama Operations Center/Gulf Coast High Intensity Drug Trafficking Area (HIDTA) identified methamphetamine (meth) as the greatest drug threat by law enforcement agencies across Alabama for 2019. Heroin was ranked as the second greatest drug threat. While meth and heroin are continuing to show increases in abuse, fentanyl and controlled prescription drugs also are continuing to show a rise in abuse (AL HIDTA, 2019) According to FY2019 ADMH Treatment Admissions, marijuana, heroin & other opiates, alcohol, methamphetamine, and cocaine accounted for 96% of the admissions to the AMDH-funded substance abuse treatment system, as presented in Table 3.

Table 3

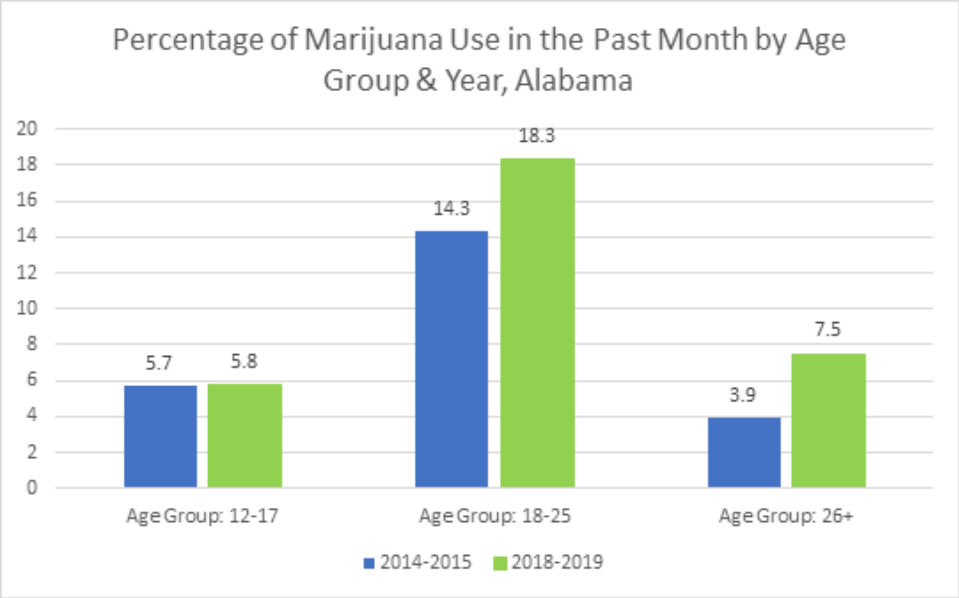
Primary Drug Used at Admission	Total
Alcohol	3,954
Cocaine (Smoked and other route)	1,174
Heroin & Other Opiates	7,372
Marijuana	4,269
Methamphetamine	3,708

Information on the top five drugs of choice at admission to treatment in Alabama is provided in below:

Marijuana

According to the AL HIDTA 2019, marijuana is second most abused drug in Alabama. High grade marijuana is available throughout the state. In the 2018-2019 NSDUH, 8.7% of individuals age 12 and older reported marijuana use in the past month compared to 10.8% in the US. Perceptions of great risk of smoking marijuana once a month is 28.2% for individuals age 12 and

older (NSDUH 2018-19). Among individuals age 18 and older, there is a statistically significant difference in marijuana use in the past year from 2017-2018 (12.8%) to 2018-2019 (15.2%). For Alabama in FY2019, there were 4,269 ADMH-funded treatment admissions for marijuana as the primary substance used among persons aged 12 years and older.



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2014, 2015, 2018, and 2019

Opioids

In the 2018-2019 NSDUH, 4.6% of individuals age 12 and older reported pain reliever misuse in Alabama in the past year compared to 3.6% in the US. Also, 0.3% of individuals age 12 and older reported heroin use in Alabama in the past year. Perceptions of great risk of trying heroin once or twice is 87.8% for individuals age 12 and older. Age group 12-17 years old (64.7%) had the lowest perception of great risk from trying heroin once or twice while 26 years old and older (91.0%) had the highest perception of great risk (NSDUH 2018-2019) . For Alabama in FY2019, there were 7,372 ADMH-funded treatment admissions for heroin and other opiates as the primary substance used among persons aged 12 years and older.

According to Alabama Department of Public Health (ADPH), based on information obtained from death certificates where known or suspected drugs were specifically provided, overdose deaths involving fentanyl and methamphetamine are on the rise and prescribed opioids are on the decline. There have been increases in overdose deaths from fentanyl statewide. From fentanyl alone the death toll statewide went from 171 in 2018 to 242 in 2019 (2021 AL HIDTA). From 2017 to 2020 in Alabama, the average rate of opioid overdose deaths increased. Like all drug-

related deaths, the number of opioid-related overdose deaths is considerably higher among males. Almost twice as many males died from drug overdose than females.

In 2015, the average rate of opioid-related deaths was 5.7 per 100,000 population while in 2016 the average rate of opioid-related deaths increased to 7.0 per 100,000 population and in 2017 the average rate of opioid-related deaths increased to 8.6 per 100,000 population. In addition, naloxone administration increased from 2015 (111.6 per 100,000 population) to 2017 (129.6 per 100,000).

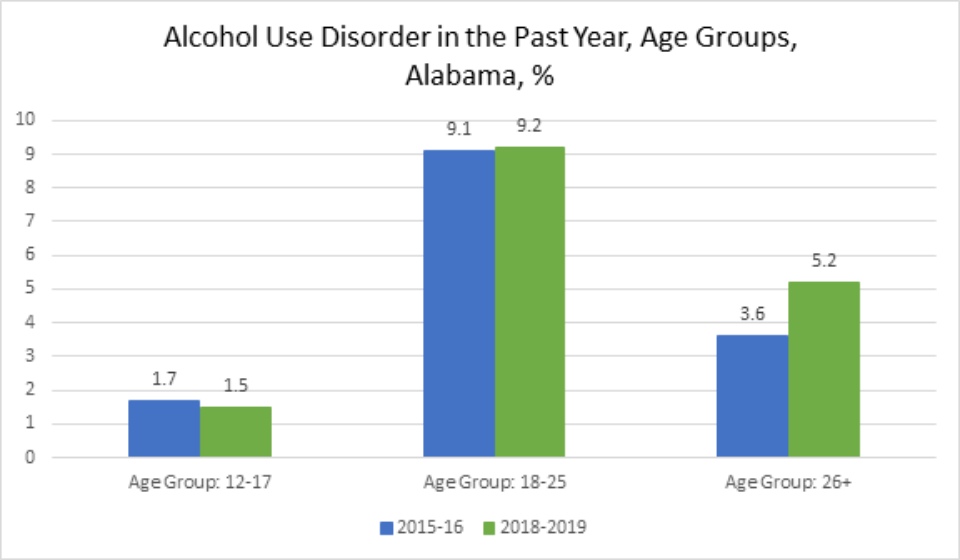
In 2018, 11,081 drug overdose-related ED visits were reported; 2,180 (19%) of those involved opioids. In most age groups, more males than females have ED visits for all drug-related overdose. Similar to all drug-related overdoses, ED visits for opioid-related overdoses occur mostly among males. In the 25-44 age groups, twice as many males than females had ED visits for opioid-related overdoses. The number of opioid-related overdose ED visits dropped slightly in the 25-44 age groups but increased slightly in the 45-64 age group from 2017-2018. The number of all drug-related overdose 911 runs was higher among males 20-49 years old.

Alcohol

According to NSDUH 2018-2019, 1,798,000 individuals in the state, age 12 and older, reported alcohol use during the month prior to the survey. For individuals aged 12 and older, 219,000 individuals reported an alcohol use disorder in the past year. Alcohol is the single most used substance in Alabama.

Binge alcohol use among male adults ages 18 and older in Alabama remained steady from 2013 (16.3%) to 2019 (16.4%) while female adults ages 18 and older increased from 2013 (6.5%) to 2019 (8.9%) (Source: BRFSS).

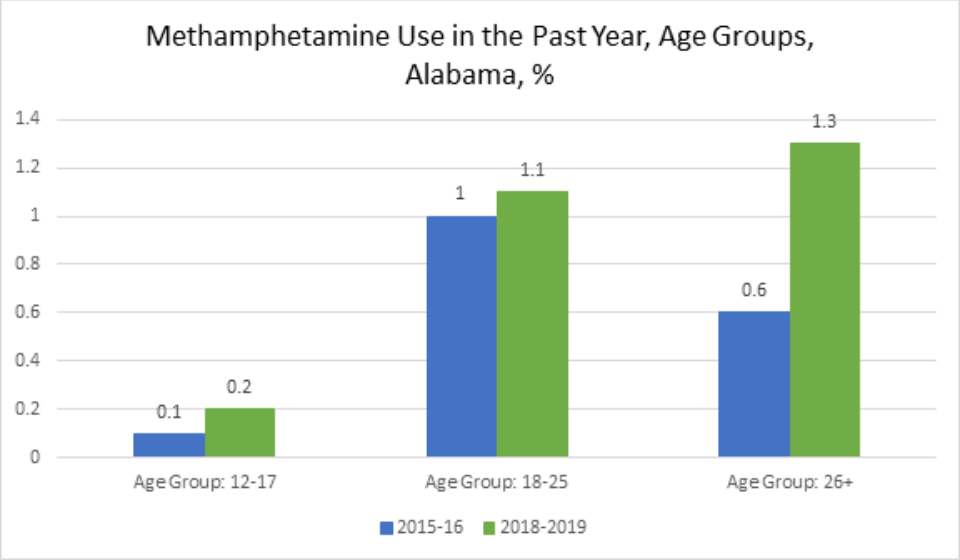
In Alabama, 30% of drivers killed in fatal crashes had a blood alcohol concentration (BAC) of .08 or higher in 2019 according to the Fatality Analysis Reporting System (FARS). In 2019, 51% of fatal crashes occurring from midnight to 2:59 am involved alcohol-impaired driving followed by 49% of fatal occurring from 9pm to 11:59 pm involved alcohol-impaired driving. In 2018, the rate of violent crimes in Alabama was 519.6 violent crimes per 100,000 inhabitants according to the Uniform Crime Reporting Program (UCR).



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015, 2016, 2018, and 2019

Methamphetamine

Methamphetamine is the greatest drug threat in the state according to law enforcement according to the 2021 AL HIDTA Drug Survey. According to NSDUH 2018-2019, 47,000 individuals in the state, age 12 and older, reported methamphetamine use in the past year.



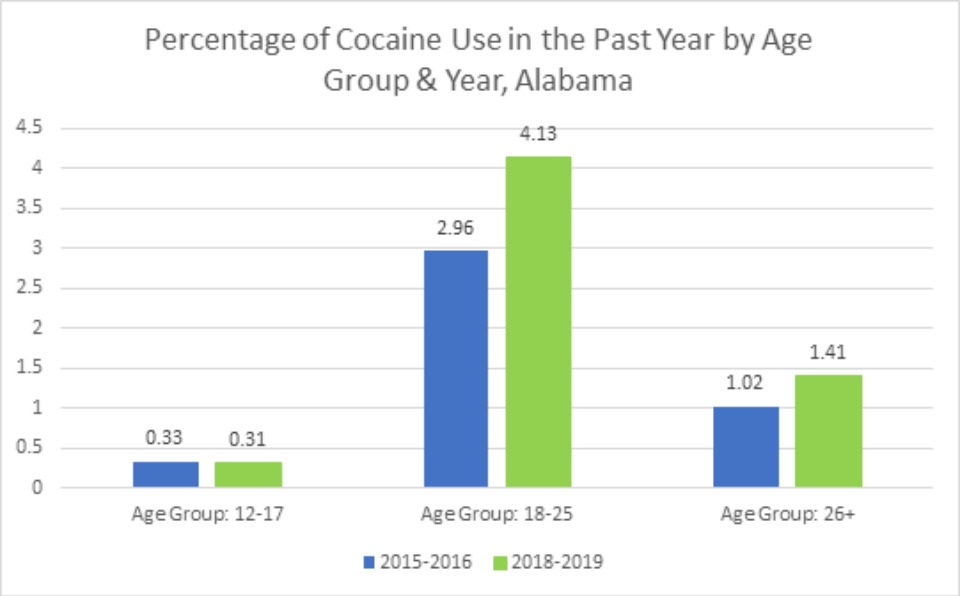
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015, 2016, 2018, and 2019

According to the 2019 AL HIDTA Drug Survey, methamphetamine was identified by law enforcement as the leading drug contributing to property crime, violent crime and amount of

resources used. There 6 meth lab seizure in Alabama for 2019 which was a decrease of labs seizures from 27 labs in 2018.

Cocaine

In the 2018-2019 NSDUH, 1.8% of individuals in Alabama, age 12 and older, reported cocaine use in the past year compared to 2.0% in the US. Cocaine has once again fallen in rank as a drug threat according to law enforcement respondents, however, it is ranked within the top three drugs responsible for both violent and property crimes (HIDTA, 2021). For Alabama in FY2019, there were 1,174 ADMH-funded treatment admissions for marijuana as the primary substance used among persons aged 12 years and older.



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015, 2016, 2018 and 2019.

3. IDENTIFICATION OF GAPS

Alabama not only has significant needs in relation to the consumption and consequences of drugs by its residents, but also has access and service delivery gaps in regard to populations in need of services.

a. High Risk Youth

The potential for problematic alcohol and/or other drug use increases as the number of risk factors experienced, as illustrated in Table 4 increases. At the same time, protective factors may reduce the risk of youth engaging in substance use that can lead to substance abuse, research shows. Protective factors associated with decreasing the likelihood of substance abuse includes parental involvement, involvement in activities, and religious beliefs

influence. The more a program reduces risk factors and increases protective factors, the more it is likely to succeed in preventing substance abuse among children and youth.

Table 4

RISK/PROTECTIVE FACTOR CHART		
DOMAIN	**RISK FACTOR**	**PROTECTIVE FACTOR**
Individual	• Rebelliousness • Friends who engage in the problem behavior • Favorable attitudes about the problem behavior • Early initiation of the problem behavior • Negative relationships with adults • Risk-taking propensity/impulsivity	• Opportunities for pro-social involvement • Rewards/recognition for pro-social involvement • Healthy beliefs and clear standards for behavior • Positive sense of self • Negative attitudes about drugs • Positive relationships with adults
Peer	• Association with delinquent peers who use or value dangerous substances • Association with peers who reject mainstream activities and pursuits • Susceptibility to negative peer pressure • Easily influenced by peers	• Association with peers who are involved in school, recreation, service, religion, or other organized activities • Resistance to peer pressure, especially negative • Not easily influenced by peers
Family	• Family history of high-risk behavior • Family management problems • Family conflict • Parental attitudes and involvement in the problem behavior	• Bonding (positive attachments) • Healthy beliefs and clear standards for behavior • High parental expectations • A sense of basic trust • Positive family dynamics
School	• Early and persistent antisocial behavior • Academic failure beginning in elementary school • Low commitment to school	• Opportunities for pro-social involvement • Rewards/recognition for pro-social involvement • Healthy beliefs and clear standards for behavior • Caring and support from teachers and staff • Positive instructional climate
Community	• Availability of drugs • Community laws, norms favorable toward drug use • Extreme economic and social deprivation • Transition and mobility • Low neighborhood attachment and community disorganization	• Opportunities for participation as active members of the community • Decreasing substance accessibility • Cultural norms that set high expectations for youth • Social networks and support systems within the community

Society	• Impoverishment • Unemployment and underemployment • Discrimination • Pro-drug-use messages in the media	• Media literacy (resistance to pro-use messages) • Decreased accessibility • Increased pricing through taxation • Raised purchasing age and enforcement • Stricter driving-while-under-the-influence laws

Risk factors associated with a potential increase in substance abuse include poverty, child abuse neglect or abuse, academic problems, and lack of parental involvement. According to data from the Child Welfare League, children in Alabama face many risks, in 2018, 12,158 children were victims of abuse or neglect in Alabama at a rate of 11.2 per 1,000 children which is an increase of 39.8% since 2013. Child deaths increased from 28 deaths (2017) to 43 deaths (2018). (Child Welfare League, 2020).

As reported in the 2019 Annie E. Casey Kids Count Profile, in 2019, 17% of Alabama's children lived in poverty while 9% of Alabama's children lived in high-poverty areas. In 2019, 26% of the state's children had parents who lacked secure employment. In 2019, 6% of teenagers between age 16 and 19 who are not enrolled in school (full-or part-time) and not employed (full- or part-time).

In 2018-2019, approximately 8,000 adolescents ages 12–17 in Alabama needed but had not received treatment at a specialty facility for illicit drug use in the past year. Approximately 54,000 adolescents ages 12-17 had a major depressive episode in the past year (NSDUH).
In Alabama, 10 suicides occurred in 2019 by individuals under the age of 15 years old (ADPH).

b. Underage Drinkers

In 2018-2019 NSDUH, 91,000 individuals aged 12- to 20- year-olds reported alcohol use in the past month. The years of potential life lost due to excessive alcohol use were 4,103 years for individuals under age 21 years. In addition, the five year average (2014 to 2018) number of drivers age 20 or younger involved in fatal crashes (FARS, 2019) is 124.

In 2019, 9th –12th Graders in Alabama reported the following information in regard to underage drinking (YRBS):

- Alcohol use prior to age 13 in 2019 – 17.2%
- Binge alcohol use during the past 30 days – 10.0%
- Had at least one drink of alcohol on at least 1 day during the past 30 days – 22.5%
- Usually obtained the alcohol they drank by someone giving it to them –35.0%
- Had at least one drink of alcohol on one day during their life – 59.8%.

c. Racial/Ethnic Minorities

Alabama is a state with a documented history of racism tension and segregation and was the site of many key events in the American civil rights movement. The state has above average poverty, unemployment, disease, death, and incarceration of males and females. During the last ten years, it has experienced a decline in population of the majority race and increases in all minority races living within its borders. The state's Hispanic or Latino population grew by 129%. Alabama's African American population significantly exceeds the national average.

Nearly 5% of the state's population report they speak a language other than English at home. These and other social, economic, biological, and cultural factors impact the belief systems of the state's residents, including, their daily conversations, the communities in which they live, who they chose as friends, and who they trust.

There is, thus, the need for cultural and linguistic competence in the delivery of health care services, including substance abuse prevention, treatment, and recovery support services. Patient-centered, cultural and linguistic competent care takes into consideration the significance of historical and socioeconomic factors that influence the norms and values of the people to be served, as well as, their response to the reality of life in their communities. It drives help-seeking behaviors and impacts service outcomes.

Table 5

Alabama Population Percentages	2000	2018
Male	**48.3**	**48.3**
Female	**51.7**	**51.7**
White	**71.1**	**69.1**
Black or African American	**26.0**	**26.8**
American Indian/Alaska Native	**0.5**	**0.7**
Asian	**0.7**	**1.5**
Native Hawaiian and Other Pacific Islander	**0**	**0.1**
Two or More Races	**1.0**	**1.8**
Hispanic or Latino (of any race)	**1.7**	**4.6**

Race, ethnicity, and religion are generally perceived as the predominant elements of culture in Alabama's public substance abuse services delivery system. Although progress has been made in regard to the incorporation of program activities that attend to these issues, organizational behavior, practices, and policies which are representative of a cultural and linguistic competent system of care still do not currently exist system-wide.

Alabama's minority race population increases are noteworthy relative to limitations within ADMH's substance abuse service delivery system to serve a growing non-white community whose primary language is something other than English. While a critical gap is evident in multilingual services for Hispanic or Latino and Asian citizens; similar concerns are evident for "African Americans who come from a different cultural environment that may use words and phrases not entirely understandable by the therapist;" but also for individuals who are deaf or hard of hearing. Alabama's predominant use of Standard English in its "health care delivery may unfairly discriminate against those from a bilingual or lower socioeconomic background and result in devastating consequences." Such inequities have been underscored by the federal government as a form of discrimination.

Alabama has a lack of multilingual therapists and other individuals working within the service delivery system which can inadvertently contributes to "inferior and damaging services to linguistic minorities." This gap presents a cultural barrier that can lend itself to ineffective service delivery and contribute to a significant number of individuals not being served or not receiving culturally competent services.

b. Intravenous Drug Users

Intravenous drug users (IDUs) face multiple health risks, including exposure to HIV and Hepatitis B and C. Drug overdose is also a major cause of death among IDUs. Alabama has seen an explosion of drug overdoses since 2010. The use of opioids throughout the state is rapidly escalating and creating major public health concerns.

Utilizing CDC data from 2017-2019, the Robert Woods Johnson Foundation identified the following drug overdose mortality rates (number of drug poisoning deaths per 100,000 population) for Alabama (RWJF, 2019). As specified in Table 7 these deaths occurred in 40 of the state's 67 counties:

TABLE 7

County	Drug Overdose Mortality Rates	County	Drug Overdose Mortality Rates
Autauga	14	Houston	43
Baldwin	82	Jackson	17
Barbour	0	Jefferson	587
Bibb	15	Lamar	0
Blount	38	Lauderdale	36
Bullock	0	Lawrence	11
Butler	0	Lee	37
Calhoun	68	Limestone	21
Chambers	11	Lowndes	0
Cherokee	13	Macon	0
Chilton	21	Madison	203
Choctaw	0	Marengo	0

Clarke	11	Marion	0
Clay	0	Marshall	49
Cleburne	0	Mobile	158
Coffee	13	Monroe	0
Colbert	16	Montgomery	43
Conecuh	0	Morgan	57
Coosa	0	Perry	0
Covington	12	Pickens	10
Crenshaw	0	Pike	0
Cullman	52	Randolph	13
Dale	10	Russell	32
Dallas	0	Shelby	103
DeKalb	63	St. Clair	76
Elmore	25	Sumter	0
Escambia	39	Talladega	34
Etowah	82	Tallapoosa	18
Fayette	11	Tuscaloosa	88
Franklin		Walker	37
Geneva	15	Washington	0
Greene	0	Wilcox	0
Hale	0	Winston	0
Henry	0		

Twenty (25) of the forty (40) Alabama counties reported in Table 7 have drug overdose mortality rates that exceed the state average of 16 per 100,000 persons from 2017 through 2019. Those counties are listed in Table 8.

TABLE 8

County	2015 Drug Mortality Rate	County	2015 Drug Mortality Rate
Baldwin	82	Lauderdale	36
Blount	38	Lee	37
Calhoun	68	Limestone	21
Chilton	21	Madison	203
Cullman	52	Marshall	49
DeKalb	63	Mobile	158
Elmore	25	Montgomery	43
Escambia	39	Shelby	103
Etowah	82	St. Clair	76
Houston	43	Talladega	34
Jackson	17	Tallapoosa	18
Jefferson	587	Tuscaloosa	88
		Walker	37

Four counties in west Alabama have been identified as high-risk for similar HIV outbreaks: Walker, Winston, Marion and Franklin. According to Dr. James Galbraith, an emergency physician at UAB Hospital, "Due to injection and unsterile needle reuse and sharing, we're seeing a Hepatitis C virus epidemic, and there is a risk of an HIV outbreak." Walker County was one of 220 counties in the nation identified as being highly vulnerable for an HIV

outbreak in a Centers for Disease Control and Prevention (CDC) report released in 2015. The county ranked 37th on the list of most at-risk counties nationally in the report.

Treatment services for IV drug users are in high demand in Alabama. Significant gaps exist in the availability of evidence-based treatment options for individuals who have limited healthcare resources in high risk areas of the state, as those identified in Table 16.

c. Pregnant Women and Parenting Women

There are many health-related risks associated with pregnancy in combination with alcohol, tobacco, and other drug use. In Alabama another alarming risk is the potential for imprisonment. Over 500 women have been arrested since enactment of the state's chemical endangerment law in 2006. Intended to protect children exposed to methamphetamine labs, the law makes it a crime, punishable by one (1) to ten (10) years in prison to expose a child to illegal drugs or drug paraphernalia. Since its enactment, efforts have been put forth in the state legislature to strengthen this law by expanding the definition of "child" to include unborn children. A challenge to the use of the existing law to prosecute pregnant women was defeated when the Alabama Court of Criminal Appeals ruled that the general term "child" in Alabama's chemical endangerment law is broad enough to encompass a "viable fetus." Alabama's chemical endangerment law has been called the most sweeping measure deployed against pregnant women in the U.S.

All programs under contract with ADMH are required to give priority admission to pregnant women and to publicize the fact that priority admission is available. Strategies implemented to increase the number of treatment admissions by pregnant women has led to a significant increase in the number served in 2018 (Table 9). Yet, as the state's opioid use disorders problem continues to soar, along with the continued practice of incarcerating pregnant women who have substance use disorders in Alabama, service accessibility must continue to improve.

Table 9

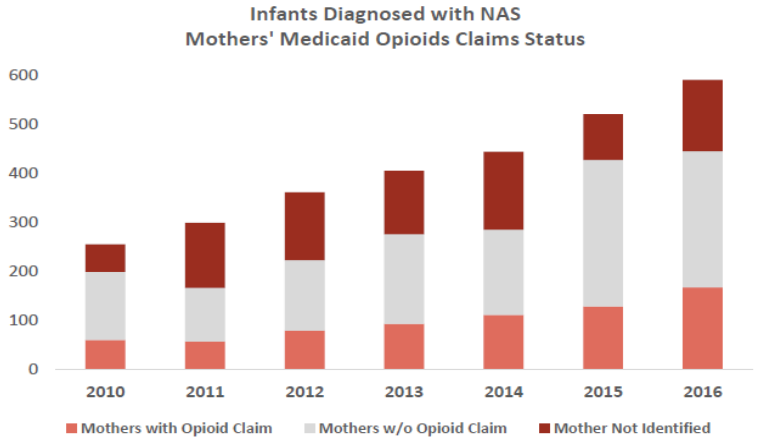
# Women Pregnant at Time of Admission ADMH Funded Substance Abuse Treatment Programs	2012	2013	2014	2015	2016	2017	2018
	275	219	245	304	484	327	465

According to the 2015 Pregnancy Risk Assessment Monitoring System (PRAMS) Surveillance Report conducted by the Alabama Department of Public Health, 13.2% of White mothers surveyed and 7.7% of the African American and other mothers surveyed reported they continued smoking during pregnancy. Cigarette smoking was significantly higher among mothers on Medicaid before, both during and after their pregnancies than non-Medicaid mothers.

Historically, according to the PRAMS, smoking decreases during pregnancy in the majority of women, only to increase again after the birth of their infants. In addition, 6.3% of White mothers in Alabama and 2.3% of African American mothers reported drinking alcoholic beverages during the last three months of pregnancy (PRAMS, 2015). Smoking and drinking places both mothers and their children at risk for adverse consequences.

Traditionally in Alabama, infant mortality for black infants is twice that of white infants. In 2016, that rate increased to nearly three times with the black infant mortality rate being 15.1 deaths per 1,000 live births compared to 6.2 deaths per 1,000 live births for white infants. The white infant mortality increased from a record low rate of 5.2 in 2015 to 6.5 in 2016. Factors contributing to Alabama's high rate of infant deaths include substance abuse that comprises smoking and neonatal abstinence syndrome.

The Alabama Medicaid Agency (AMA) pays for more births than any other entity in the state. Analysis of AMA pregnancy claims indicates the number of infants diagnosed with Neonatal Abstinence Syndrome (NAS) increased in Alabama annually between 2010 and 2016. The AMA reports that the average cost of a NAS delivery is eight times higher than a normal delivery. Ready access to treatment for women who have opioid use disorders remains an essential component of the effort to reduce NAS in Alabama (Moon, 2018).



Although admissions to treatment by pregnant women has increased, access to care continues to be identified as a barrier for women seeking substance abuse treatment. Services for pregnant and parenting women are not easily accessible in Alabama, primarily due to availability. Treatment programs that serve the public are not available in every Alabama County. Treatment programs with gender response services are even more limited. In

addition, there is only one public funded residential withdrawal management program in the state.

The adverse impact of parental substance use disorders on children is well documented in scientific literature. Alabama's child welfare agency, the Alabama Department of Human Resources, reports there were 1,605 children removed from residences in Alabama during 2017 due to parental substance use disorders compared to 1,525 in 2016. This number reflects a 19% increase in one year. (HIDTA, 2021) Drug abuse among parents has spiked as a reason for removing children from their care, according to the Alabama Department of Human Resources (DHR). The state's opioid crisis is viewed as a major factor in the increase of out-of-home placements.

f. Individuals With or at Risk for Tuberculosis

As according to requirements regarding Tuberculosis (TB) outlined in 45 CFR §96.127, the ADMH ensures that TB services are accessible for individuals receiving substance abuse treatment services. ADMH contract providers are required to maintain and implement written policies and procedures for the provision of TB services. Either directly or through arrangements with other public or nonprofit private entities, providers must make available TB services to include:

- A screening process for identification of high risk individuals;
- Referral for testing, medical evaluation and treatment, if indicated by the screening process;
- Case management, as indicated, and
- A reporting process to appropriate state agencies as required by law.

TB services are monitored through the Program Compliance Monitoring Survey (PCMS) process conducted by ADMH's Office of Substance Abuse Treatment Services. Although the rate of TB in Alabama has sharply declined (Table 10), the state's opioid crisis provides the foundation for rapid spread of this and other communicable diseases.

Table 10

TB Cases in Alabama					
1976	**1986**	**1996**	**2006**	**2016**	**2020**
824	601	423	196	112	75

The Alabama Department of Public Health (ADPH), Division of Tuberculosis Control endeavors to eliminate TB in Alabama. The number of reported tuberculosis disease was highest in Jefferson County (12 cases) followed by Montgomery County (7 cases) and Tuscaloosa County (7 cases) (ADPH, 2018).

4. UNMET SERVICE NEEDS

a. Prevention

A focus group was conducted by the State Evaluator in the beginning 2020. Information was collected from prevention providers concerning service gaps and barriers at the community-level prevention system to assess need. Two focus groups were held with 5-10 attendees in attendance at each focus group. The following gaps were identified:

Awareness & Coordination

There is coordination difficulty relative to the prevention provider network and coalition building, which often leads to capacity and community readiness issues. Alabama has a prevention infrastructure that (at the time of the Focus Group) supports fifteen (15) Substance Abuse Prevention and Treatment Block Grant providers, two (2) Discretionary Grant providers, and six (6) Drug Free Communities coalitions. While many of these providers are dually funded, in the absence of a funding initiative, many individuals are not aware of or are uncertain as to its existence and/or function. There is a state-level need for increased awareness of existing prevention coordination opportunities. Coordination and collaboration within the prevention system will reduce duplication of services – the left hand will be aware of what the right hand is doing, thereby, creating capacity to service identified underserved populations. Information sharing will serve as the basis for the coordinated effort and further development needed prevention initiatives.

Prevention providers were less clear about the identification of high risk populations, especially in rural areas and is concerned that national priorities may conflict with local priorities. There is a state-level need for increased training/technical assistance as it relates to behavioral health disparities.

Training and Technical Assistance

As mentioned earlier, there is a state-level need for increased training in the area of behavioral health disparities. Identified gaps in the area of T/TA include coalition building and sustainability and the applicability of challenges and/or barriers as it relates to rural communities.

In regards to the SPF, all prevention providers have been exposed to the SPF and have an understanding of the framework, but require more in-depth training on how to address community readiness and behavioral health disparities within their communities.

In addition, although agencies and organizations have received training on individual and environmental prevention approaches, there is a need for increased knowledge regarding the effectiveness of comprehensive approaches.

Data Collection

ADMH houses the Alabama Substance Abuse Information System (ASAIS), a web-based management information system which assists with the initial assessment, eligibility, determination and enrollment of substance abuse clients. ASAIS provides data on the number and demographic mix of clients receiving alcohol and other drug treatment.

DMHSAS requires prevention providers to submit performance data on a regular basis via ASAIS. During the focus group, it was determined that grantees did not find the data collection overly burdensome, but some of the ASAIS screens required duplicative data. There is a state-level need to review the current information system as it relates to system design/organization.

b. Treatment and Recovery Support

During the last three years, Alabama's problems with drugs have grabbed the public's attention like no other time in recent history. Fueled by a rapid rise in nonmedical use of prescription pain killers and the resurgence of heroin in both urban and rural areas, drug use across the state has reached epidemic proportions. In 2014, for the very first time, admissions to the state's public treatment service delivery system for individuals with opioid use disorders exceeded those for alcohol use disorders. At the same time, opioid-related overdoses and deaths continue to climb to record levels. Yet, access to treatment in Alabama can be quite problematic for individuals living in some areas of the state, for those with no insurance or low incomes, and for those with opioid use, as well as, other drug use disorders.

Person seeking help for an alcohol or drug problem in the state, their families, referral agencies and other advocates often seek the assistance of ADMH. These individuals and organizations have identified several indicators of the system's insufficiency, including, (a) too few levels of care to accommodate the population of need; (b) lack of recovery support service availability; (c) program admission requirements that often include admission fees; (d) waiting lists; and (e) limited operational hours of existing programs. Currently there are 457 Alabamians on the system's list awaiting an opening for substance abuse treatment.

In general, Alabama's system of care for substance use disorders is inadequately resourced to address the needs of the state's residents. The 2018-2019 National Survey on Drug Use and Health indicated 306,000 individuals, age 12 and above, in Alabama reported having a substance use disorder. The public system of substance abuse treatment services provided care for approximately 34,000 individuals during the same period, maintained consistent

waiting lists for assessments and treatment, and reported ever-increasing service demands from the state's overcrowded criminal justice system.

ADMH is currently challenged by critical needs and gaps within its system of care for opioid use disorders. The receipt of Opioid State Targeted Response (STR) funding and the State Opioid Response (SOR) funding did significantly affect the landscape of medication assisted treatment in the state. This allowed more traditional providers to start offering medication assisted treatment and it encouraged OTPs to participate in funding initiatives within the state. As identified through an assessment of Alabama's needs specific to opioid use disorders (OUDs) the state is facing the following challenges, the following items continue to be challenges that are faced in Alabama despite the opioid funding provided to the state:

(1) Opioid painkillers are prescribed at much higher rates in Alabama than most states in the nation. This continues to be true as of 2021.

(2) Alabama counties experiencing opioid problems have a preponderance of the characteristics of counties found by the Centers for Disease Control to have higher opioid prescribing, including:
   - Small cities or large towns;
   - Higher percent of white residents;
   - More people who are uninsured or unemployed; and
   - More people who have diabetes, arthritis, or disability.

(3) Widespread stigma exists among public officials, private citizens, and treatment providers surrounding medication assisted treatment for opioid use disorders.

(4) While funding for Naloxone has increased, it is not enough to meet the demand in the state. There continues to be few reporting requirements for life saving administration of Naloxone, along with limited public knowledge of its availability.

(5) There is currently a high dropout rate for individuals receiving treatment for OUDs.

(6) There is only one public funded Opioid treatment Program (OTP) within the state.

(7) Due to certificate of need regulations, only three additional OTPs may be located within the state.

(8) Minorities, veterans and persons exiting the criminal justice system are not accessing OUD treatment at levels expected in relation to population representation and OUD problems experienced.

(9) While collaboration has increased between OTPs, state-funded substance use disorder (SUD) treatment programs, primary care physicians, and office-based treatment providers, the state still has significant gaps to address.

(10) The current SUD treatment workforce is not adequately trained to provide evidence-based practices for OUD treatment and recovery support.

At the same time, gaps exist in the public service delivery system to address all drug use disorders, in addition to those presented by the present opioid crisis. A Substance Abuse Planning Committee was established in 2017. The committee consists of member from ADMH and community providers. The committee was tasked with identifying ways that the care delivery system needs to be improved. In addition, the committee continues to work on the results from a 2015 Survey which identify ways to improve access to care. The following categories were areas that were identified as needing improvement or creation:
Categorical responses were as given in **Table 11.**

Table 11

Access	% Responses	# Responses
Capacity	33.2	88
Funding	15.09	40
System Infrastructure	14.72	39
Education	13.21	35
Treatment Services	8.30	22
Insurance	6.04	16
Performance Improvement	3.02	8
Prevention Services	2.26	6
Recovery Support	1.89	5
Other	1.51	4
Workforce	.75	2

Within the above listed categories, the top 5 predominant themes for improving service access were:

(1) Capacity:
- More treatment services needed
- Particular concern for rural area services
- Particular concern for affordable services/services for people without the ability to pay
- Transportation

(2) Funding:
- More funding needed to adequately support existing resources and improve access in underserved areas.
- Funding needed to purchase services for individuals who have no insurance or ability to pay for care.
- Free substance abuse treatment.

(3) Infrastructure:
- Expand Medicaid

- Allow CRNPs to practice to the full scope of their training and education
- Establish guidelines and procedures to monitor the prescribing practices of HCPs
- Minimize state intrusion in regard to the regulation of SA programs
- Make treatment services available in lieu of incarceration

(4) Education:
- More education needed for the general public, physicians, school age children
- More advertising of available resources

(5) Treatment Services: Particular concern for:
- More detox services
- Access to medication assisted treatment
- Integrated care

The same survey asked respondents to identify the most important strategies that should be implemented in Alabama to improve the quality of services for prevention and/or treatment of substance use disorders. Categorical responses were as given in **Table 12.**

Table 12

Priority #2	% Responses	# Responses
Treatment Services	17.07	42
Performance Improvement	15.85	39
Workforce	13.01	32
System Infrastructure	12.60	31
Funding	9.35	23
Training	8.54	21
Capacity	6.50	16
Education	5.28	13
Prevention	4.47	11
Recovery Support	4.47	11
Insurance	2.85	7

Within the above listed categories, the top 5 predominant themes for improving service quality were:

(1) Treatment Services
- Integration of addiction and health care services
- Access to medication assisted services
- Evidence-based practices

(2) Performance Improvement
- More regulation of Methadone treatment and physicians prescribing pain meds.
- Certification of all treatment providers
- Publicly available performance outcomes
- Quality benchmarks

(3) Workforce

- More workers needed
- Incentives to work in mental/health substance abuse
- Incentives to work in rural areas
- Increase number of peer workers
- Increase scope of practice for nurse practitioners

(4) System Infrastructure
- Consistent prenatal care for addicted mothers
- More relaxed and easier to understand standards of care

(5) Funding
- Increase funding for all services

Flat funding for treatment and recovery support services in Alabama, with the exception of opioid use disorders, has led to little resolution of the recommendations of the governor's task force. Thus, the identified needs remain relevant in 2021.

5. ADMH FY 2022 - FY 2023 SUBSTANCE ABUSE BLOCK GRANT PRIORITIES

Based upon review and analysis of the data put forth, herein, the FY 22 – FY 23 SABG priorities have been established. These priorities are representative of some of the state's most critical gaps and needs and provide ADMH with the opportunity to enhance the lives and well-being of thousands of Alabamians impacted by the use of alcohol and other drugs.

a. Underage Drinking

Unmet Need / Gap: The Alabama Epidemiological Outcomes Workgroup has worked diligently on state Epidemiological profiles for the past six (6) years. Data clearly indicates Alabama's youth are experiencing the consequences of drinking alcohol at too early ages. Each year, young people die as a result of underage drinking; this includes deaths from motor vehicle crashes, homicides, and suicides and well as other injuries such as falls, burns and drowning. The widespread use of alcohol among adolescents continues to be problematic for communities in Alabama. Often the consequences are hidden and adults are not privy to the overall implications of use and misuse of alcohol in our communities. When youth drink, they tend to drink more intensely, often consuming four to five drinks at a time. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) defines binge drinking as a pattern of drinking alcohol that brings blood alcohol concentration (BAC) to 0.08 grams percent or above. To compare this to the adult population, men would consume five (5) or more drinks and four (4) or more for women in a two hour time span.

In Alabama, epidemiological data shows that the average age of first use for Alabama youth is nine years of age. Individuals who start to drink before the age of 15 are four times more likely to also report meeting the criteria for alcohol dependence at some point in their lives.

New research shows that serious drinking problems typically associated with middle age actually begin to appear much earlier, during young adulthood and even during the adolescence years. Those who start to drink at an early age are more than likely to start engaging in risky behaviors, including other drugs and negative behaviors.

Multiple risk factors exist within Alabama communities that present challenges and compelling barriers to decrease the prevalence of consequences for underage drinking.

b. Intravenous Drug Use

Unmet Need/Gap: Ready service availability is a widespread problem in Alabama for treatment of all substance use disorders. However, the rapid onset and escalation of opioid use in the state, in particular heroin and fentanyl, found Alabama unprepared to address the magnitude of disparities experienced by individuals who have OUDs. Far more challenges exist for this population in regard to access to appropriate care, service utilization, outcomes, and stigma, than for individuals diagnosed with other substance use disorders.

In addition, ADMH provider organizations have been slow to implement evidence-based treatment strategies appropriate for use with this population. Expansion of medication assisted treatment for opioid use disorders has expanded as a result of the federal opioid funding received within the state.

The need for more rapid access to evidence-based treatment for IVDU disorders exists in the state, efforts to combat stigma, and increased outreach for minorities and individuals without the ability to pay for care.

c. Individuals With or at Risk for Tuberculosis

Unmet Need/Gap: A 2016 Tuberculosis outbreak in Marion, Alabama located in Perry County clearly demonstrates the need for ADMH funded treatment programs in the state to continue to monitor their patients for TB. In the small County of less 10,000 individuals, 9 people were diagnosed and treated for active TB disease, 170 people were diagnosed with latent TB infection, 147 started preventive therapy, and 130 people completed preventive therapy.

Most of the state's substance abuse treatment programs accept admissions from throughout the state. This is especially true for residential treatment facilities. With individuals who have substance use disorders representing a population at high risk for TB, an outbreak, as that in Perry County, could be transmitted to another area of the state without proper ongoing surveillance. The need exists to continue to insure continuous screening, testing and referral of individuals receiving treatment for substance use disorders.

d. Pregnant and Parenting Women

Unmet Need / Gap: In 2019, there were 58,614 live births in Alabama. In order to combat both the potential health related consequences of drug use and pregnancy, along with the impact of actions in the state to criminalize pregnant and parenting women who have substance use disorders, the need exists to develop and implement strategies to strongly promote the efficacy and availability of treatment, and to improve service accessibility. There are 204 public funded treatment locations in Alabama. Of that number, four outpatient and two residential provide services to PWWDCs. Five additional programs provide services exclusively for adult women. For women with dependent children, accessing withdrawal management services is extremely difficult.

Efforts to mitigate the negative effects of parental substance abuse must be continued by ADMH. Improving access to care for pregnant women, parenting men and women, enhancing involvement of children in their parents' care, as well as, implementation of strategies to address the specific needs of the children, regardless of their parents' treatment status, represent areas in need of enhancement in Alabama.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Underage Drinking

Priority Type: SAP

Population(s): PP

Goal of the priority area:

To promote the prevention of underage drinking throughout the state.

Strategies to attain the goal:

1) Disseminate information to ADMH funded providers and community partners on evidence-based practices specific to prevention of underage drinking.
2) Develop process for incentivizing ADMH funded provider efforts to promote underage drinking.
3) Provide enhanced funding support for ADMH's community providers that incorporate the following strategies in their annual prevention plans to promote underage drinking awareness:
a. Participation in community health/wellness fairs;
b. Media campaigns;
c. Merchant education programs;
d. Establishment of city/county ordinances;
e. Utilization of evidence-based curricula;
f. Multi-agency coordination
4. Monitor the impact of promotional awareness activities on underage drinking consumption patterns and consequences through the review of provider reports and epidemiological surveillance.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The number of counties the prevention provider network services utilizing evidence-based curricula to address underage drinking as reflected in prevention plans.

Baseline Measurement: In SFY 2021, ADMH funded prevention providers identified 39 counties or 58% of the state as utilizing an evidence-based curriculum to address underage drinking.

First-year target/outcome measurement: By the end of SFY 2022, an increase of 3% of Alabama counties will be identified in prevention plans as utilizing an evidence-based curriculum to address underage drinking.

Second-year target/outcome measurement: By the end of SFY 2023, an additional increase of 2% of Alabama counties will be identified in prevention plans as utilizing an evidence-based curriculum to address underage drinking.

Data Source:

Provider prevention plans submitted to ADMH and back-up data reported from ASIAS, ADMH's management information system.

Description of Data:

The strategy designation within the prevention plan will indicate if an evidence-based curriculum is being utilized within the identified county to address underage drinking. Data from the prevention plan is also keyed into ASIAS, including programs, policies, practices, and county designation.

Data issues/caveats that affect outcome measures:

Due to the pandemic, possible coordination disruption with educational systems and/or associated entities may potentially impact intended outcomes or potentially delay outcomes.

Indicator #: 2

Indicator: The number of counties the prevention provider network services utilizing multi-agency coordination to address underage drinking as reflected in prevention plans.

Baseline Measurement: In SFY 2021, ADMH funded prevention providers identified community based processes to address underage drinking in their prevention plans in thirty-eight (38) or approximately 57% of the counties within the state.

First-year target/outcome measurement: By the end of SFY 2022, an increase of 3% of Alabama counties, funded by the SAPTBG, will be identified in prevention plans to include community based processes as it relates to underage drinking.

Second-year target/outcome measurement: By the end of SFY 2023, an additional increase of 2% of Alabama counties, funded by SAPTBG, will be identified in prevention plans to include community based processes as it relates to underage drinking.

Data Source:

Provider prevention plans submitted to ADMH.

Description of Data:

The strategy designation will indicate community based processes being utilized within the identified county to address underage drinking.

Data issues/caveats that affect outcome measures:

Due to the pandemic, possible coordination disruption with associated entities may potentially impact intended outcomes or potentially delay outcomes.

Priority #: 2

Priority Area: Improving quality and engagement in PWWDC services

Priority Type: SAT

Population(s): PWWDC

Goal of the priority area:

To enhance PWWDC services to include the use of family based interventions, doula services and recovery support services.

Strategies to attain the goal:

Offer trainings and education that focus on family based interventions and topics relative to integrated services; Implement doula services into current roster of services for PWWDCs; Assist with developing partnerships/networks that support providers of PWWDC services to address the needs of the individuals they serve.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase the number of individuals enrolling in PWWDC services

Baseline Measurement: Baseline will be established from data collected in the SAIS for FY21

First-year target/outcome measurement: By September 2022, the number of individuals receiving integrated services will increase by 3% over baseline

Second-year target/outcome measurement: By September 2023, the number of individuals receiving integrated services will increase by 5% over baseline

Data Source:

Integration of services will be tracked by client surveys and providers program curriculums will be reviewed during monitoring visits. ADMH's Substance Abuse Information System (SAIS) will also be reviewed.

Description of Data:

PWWDC receiving treatment from contracted providers will be surveyed. During block grant compliance monitoring, reviewer will review provider’s program curriculum to ensure the required and specialty services are being offered. The data set information collected in SAIS

will also be reviewed in regards to services provided, length of time to access treatment, length of stay, and drugs of use.

Data issues/caveats that affect outcome measures:

Limited services for PWWDC and current COVID pandemic will impact consumer access to care, as well as affect the number being served.

Priority #: 3

Priority Area: Improving and increasing education and other services regarding Tuberculosis (TB)

Priority Type: SAT

Population(s): TB

Goal of the priority area:

Ensure that individuals receiving SUD treatment services receive appropriate TB education, referral for TB testing, and follow up services with respect to TB.

Strategies to attain the goal:

a) Distribute CDC "Basic TB Facts" sheets, forms, and web-based information to Certified Treatment Providers in the state.
b) Assist and support the development of new provider policies for the provision of TB educational materials to individuals receiving SUD treatment to facilitate improved TB education, referral for TB testing, and follow-up services.
c) Ensure providers develop processes and thorough procedures for implementing the newly developed policies for the TB education, TB referral, and TB follow-up services provided to all individuals receiving SUD treatment.
d) Monitor the implementation of the policies and procedures developed by agencies.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The number (#) of certified treatment providers that developed and utilized appropriate TB educational materials, and policies and procedures for implementation.

Baseline Measurement: The baseline will be zero (0) as this is not currently being monitored.

First-year target/outcome measurement: By September 2022, 100% of SABG certified treatment providers will develop and utilize appropriate TB educational and counseling materials for individuals participating in SUD treatment.

Second-year target/outcome measurement: By September 2023, 100% of SABG providers will document proof of the implementation of the utilization of TB educational and materials with individuals receiving treatment and document proof of providing TB testing referral services and follow-up services to all individuals receiving SUD treatment.

Data Source:

Yearly contract compliance visits.

Description of Data:

Copies of developed training materials, policies and procedures regarding implementation of TB education, TB referral services, and documented proof of follow-up services to all individuals receiving SUD treatment.

Data issues/caveats that affect outcome measures:

No issues are currently foreseen that will affect the outcome measures.

Priority #: 4

Priority Area: Recovery Support

Priority Type:

Population(s): Other (All SUD individuals)

Goal of the priority area:

Ensure that individuals in need of recovery support services are able to access those services and that they are provided in a appropriate manner by a certified peer support specialist.

Strategies to attain the goal:

1) Organize a group of certified peers in the identified regions
2) Assist with developing a plan for the organizations(s) to meet the recovery needs of the community
3) Provide training for the new formed organization(s)
4) Establish funding and monitoring for the recovery community centers and satellite locations
5) Develop a team of peers to write guidelines for peer services

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: There will be an increase of three peer run community service centers and satellite locations.

Baseline Measurement: There are currently 4 peer run community service centers in the state.

First-year target/outcome measurement: By September 2022, there will be a new peer run community service center site in SA Planning Region 4 and a satellite location of an existing peer run organization in SA Planning Region 1.

Second-year target/outcome measurement: By September 2023, there will be a new peer run community service center site in SA Planning Region 2.

Data Source:

ADMH Peer Services Office

Description of Data:

Information on the peer run community service center will include information on non-profit status, board of directors and organizational policies and procedures.

Data issues/caveats that affect outcome measures:

Ability to finance a program may pose some difficulties

Indicator #: 2

Indicator: The submission of a set of peer certification administrative code regulations will be completed.

Baseline Measurement: The baseline for this indicator is 0 as there are no administrative code requirements around peers.

First-year target/outcome measurement: By September 2022, develop a set of peer standards for inclusion in the Administrative Code.

Second-year target/outcome measurement: By September 2023, peer standards will be filed in the Administrative Code and implemented in the system of care.

Data Source:

ADMH Office of Peer Services and Office of Certification

Description of Data:

Alabama Administrative Code

Data issues/caveats that affect outcome measures:

Time and competing priorities and concerns related to the current pandemic may interfere with the timely completion of this activity.

Priority #: 5

Priority Area: Recovery Housing

Priority Type: SAT

Population(s): Other (SUD involved individuals in need of housing)

Goal of the priority area:

The goal is to increase the number of recovery houses recognized by the Alabama Alliance for Recovery Residents (AARR), to ensure an adequate representation of quality recovery housing in the state of Alabama

Strategies to attain the goal:

a) Develop a network that fosters collaboration/networking among community recovery houses by publicizing quality living conditions to those of the recovery community; b) publicize houses that are certified through AARR; and c) educate owners of recovery houses or that hope to own a recovery house on the necessary steps toward becoming an AARR affiliate.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The percentage of providers approved by AARR to provide recovery housing

Baseline Measurement: This is not currently being measured so the number of providers will start at zero. AARR became a NARR affiliate on July 20, 2021.

First-year target/outcome measurement: By September 30, 2022, entities who are certified by AARR will be publicized through the ADMH website.

Second-year target/outcome measurement: By September 30, 2022, there will be a 20% increase of recovery houses recognized as an AARR affiliate.

Data Source:

Alabama Department of Mental Health website; AARR website

Description of Data:

Written reports of number of houses who have joined AARR

Data issues/caveats that affect outcome measures:

No issues are currently foreseen that will affect the outcome measure

Priority #: 6

Priority Area: Improving access to care and retention for People Who Inject Drugs

Priority Type: SAT

Population(s): PWID

Goal of the priority area:

The goal is to enhance the provision of services to PWIDU by expanding the knowledge and resources agency staff make available to clients upon admission into treatment.

Strategies to attain the goal:

Strategies to attain the goal will include:
(1) ADMH will provide enhanced/updated training modules on treating PWID to providers for the use of ongoing training with agency staff. Training modules will contain information on, but not limited to, the following:
• information on risks, characteristics of using person, harm reduction measures to include “clean use” and health risks, nature of OUD and other substance use disorders, signs and symptoms of overdose, overdose prevention, mixing risks, tolerance, overdose response, proper use of Narcan, accurate and reliable information on Opiate Overdose, injection sites, injection risks, etc.
(2) Contracted/Certified Agencies will develop training policy and protocols for those treating PWID.
• Agency will identify unique issues addressing PWID in their community
• Availability of Narcan at assessment
• Clean use safer use guidelines
• Harm reduction measures

• Identifying risks, risky practices, safer use strategies

(3) Agencies will increase the provision of family/support treatment services utilizing events best suited in treatment setting. These will include:
• Enhanced and continued use of Shared decision-making events
• Family support/education about PWID
• Family Therapy groups
• Individual Family therapy
• Wrap services
• Interim Treatment Service provisions aimed at overall education plan and OD prevention
• Safer use criteria

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Agencies will provide training policy/updates to AMDH to include guidelines for training staff and treating PWID. Agency will track training attendance for staff completing courses in Awareness and Education for staff treating PWID. Agency Quarterly Interim Treatment Service reports will be amended to include record of family services events provided to PWID.
Baseline Measurement:	Currently the baseline for this objective is zero as this will be a newly implemented strategy and data currently does not exist for strategies identified.
First-year target/outcome measurement:	By September 2022, 25% of all agencies will report use of enhanced training efforts outlined above and implementation of family services
Second-year target/outcome measurement:	By September 2023, 50% of all agencies will report use of enhanced training efforts outlined above and implementation of family services

Data Source:

• Provision of updated policy for improved education/training guidelines for treating PWID provided to ADMH
• Documented training attendance records for all agencies to training provided by ADMH
• Quarterly Interim Treatment Services reporting to include addition of Family Treatment Services

Description of Data:

• Agency training policies will include updates to working with PWID (compliance monitoring, and copies of updates to policy will be provided to ADMH)
• Documented training attendance for all agencies to training provided by ADMH (agency internal staff training records and compliance monitoring to assure staff are trained in recognizing needs of PWID)
• Quarterly Interim Treatment Services to include addition of Family Treatment Services (reports will include the number of family treatment service events; agencies will record progress and response of family participation to include increase in number of family support services)

Data issues/caveats that affect outcome measures:

None noted at this time

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Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2022/2023.
ONLY include funds expended by the executive branch agency administering the SABG.

Planning Period Start Date: 7/1/2021 Planning Period End Date: 6/30/2023

Activity (See instructions for using Row 1.)	Source of Funds									
	A. Substance Abuse Block Grant	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SABG)[a]	J. ARP Funds (SABG)[b]
1. Substance Abuse Prevention[c] and Treatment	$34,637,522.00		$34,228,124.00	$32,028,556.00	$35,897,626.00	$0.00	$0.00		$17,313,569.00	$14,952,628.00
a. Pregnant Women and Women with Dependent Children[c]	$2,967,190.00								$1,387,179.00	$14,952,628.00
b. All Other	$31,670,332.00		$34,228,124.00	$32,028,556.00	$35,897,626.00				$15,926,390.00	
2. Primary Prevention[d]	$9,236,672.00		$0.00	$3,118,920.00	$0.00	$0.00	$0.00		$4,328,392.00	$3,738,157.00
a. Substance Abuse Primary Prevention	$9,236,672.00			$3,118,920.00					$4,328,392.00	$3,738,157.00
b. Mental Health Primary Prevention										
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)										
4. Tuberculosis Services					$600,000.00					
5. Early Intervention Services for HIV										
6. State Hospital										
7. Other 24-Hour Care										
8. Ambulatory/Community Non-24 Hour Care										
9. Administration (excluding program/provider level) MHBG and SABG must be reported separately	$2,309,168.00		$976,500.00	$4,110,426.00	$2,060,504.00					
10. Crisis Services (5 percent set-aside)										
11. Total	**$46,183,362.00**	**$0.00**	**$35,204,624.00**	**$39,257,902.00**	**$38,558,130.00**	**$0.00**	**$0.00**	**$0.00**	**$21,641,961.00**	**$18,690,785.00**

[a] The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is July 1, 2021 – June 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between July 1, 2021 – March 14, 2023 should be entered in Column I.

[b] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is July 1, 2021 – June 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between September 1, 2021 and June 30, 2023 should be entered in Column J.

[c] Prevention other than primary prevention

[d] The 20 percent set aside funds in the SABG must be used for activities designed to prevent substance misuse.

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Planning Tables

Table 3 SABG Persons in need/receipt of SUD treatment

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
1. Pregnant Women	2,000	308
2. Women with Dependent Children	9,109	1,964
3. Individuals with a co-occurring M/SUD	156,902	1,221
4. Persons who inject drugs	50,000	3,535
5. Persons experiencing homelessness	3,434	1,022

Please provide an explanation for any data cells for which the state does not have a data source.

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Footnotes:

Column 2 numbers: #1, 3, 4 and 5 were obtained from TEDS Admission Feedback Report for Third Quarter FY2020. FY19 numbers were used from this report. #2 was obtained from ADMH's substance abuse management information system.

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

Expenditure Category	FFY 2022 SA Block Grant Award	COVID-19 Award[1]	ARP Award[2]
1 . Substance Use Disorder Prevention and Treatment[3]	$34,637,522.00	$17,313,569.00	$14,952,628.00
2 . Primary Substance Use Disorder Prevention	$9,236,672.00	$4,328,392.00	$3,738,157.00
3 . Early Intervention Services for HIV[4]	$0.00	$0.00	$0.00
4 . Tuberculosis Services	$0.00	$0.00	$0.00
5 . Administration (SSA Level Only)	$2,309,168.00	$0.00	$0.00
6. Total	**$46,183,362.00**	**$21,641,961.00**	**$18,690,785.00**

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 –September 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2021 – March 14, 2023 should be entered in this column.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 – September 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between October 1, 2021 and September 30, 2023 should be entered in this column.

[3]Prevention other than Primary Prevention

[4]For the purpose of determining which states and jurisdictions are considered "designated states" as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant (SABG); Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by the Centers for Disease Control and Prevention (CDC,), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. The most recent HIV Surveillance Report published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state's AIDS case rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SABG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would will be allowed to obligate and expend SABG funds for EIS/HIV if they chose to do so.

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Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

A		B		
Strategy	IOM Target	FFY 2022		
		SA Block Grant Award	COVID-19[1]	ARP[2]
1. Information Dissemination	Universal	$301,351	$835,667	
	Selective	$133,273	$266,667	$623,026
	Indicated			
	Unspecified			
	Total	**$434,624**	**$1,102,334**	**$623,026**
2. Education	Universal	$271,691	$200,667	
	Selective	$76,522	$266,667	$623,026
	Indicated			
	Unspecified			
	Total	**$348,213**	**$467,334**	**$623,026**
3. Alternatives	Universal	$198,739	$35,667	
	Selective	$149,634	$266,667	$623,026
	Indicated	$82,469		
	Unspecified			
	Total	**$430,842**	**$302,334**	**$623,026**
4. Problem Identification and Referral	Universal	$97,694	$35,667	
	Selective		$266,667	$623,026
	Indicated	$146,209	$800,000	
	Unspecified			
	Total	**$243,903**	**$1,102,334**	**$623,026**
	Universal	$520,646	$785,055	

5. Community-Based Process	Selective	$102,688	$266,667	$623,026
	Indicated			
	Unspecified			
	Total	**$623,334**	**$1,051,722**	**$623,026**
6. Environmental	Universal	$2,537,420	$35,667	
	Selective		$266,667	$623,027
	Indicated			
	Unspecified			
	Total	**$2,537,420**	**$302,334**	**$623,027**
7. Section 1926 Tobacco	Universal			
	Selective			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
8. Other	Universal			
	Selective			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
Total Prevention Expenditures		**$4,618,336**	**$4,328,392**	**$3,738,157**
Total SABG Award[3]		**$46,183,362**	**$21,641,961**	**$18,690,785**
Planned Primary Prevention Percentage		**27.47 %**	**58.61 %**	**67.87 %**

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023, for most states.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023.

[3]Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

Activity	FFY 2022 SA Block Grant Award	COVID-19 Award[1]	ARP Award[2]
Universal Direct			
Universal Indirect			
Selective			
Indicated			
Column Total	**$0**	**$0**	**$0**
Total SABG Award[3]	**$46,183,362**	**$21,641,961**	**$18,690,785**
Planned Primary Prevention Percentage	**0.00 %**	**0.00 %**	**0.00 %**

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023, for most states.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023.

[3]Total SABG Award is populated from Table 4 - SABG Planned Expenditures

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Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2022 and FFY 2023 SABG awards.

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

	SABG Award	COVID-19 Award[1]	ARP Award[2]
Targeted Substances			
Alcohol	☑	☐	☐
Tobacco	☑	☐	☐
Marijuana	☑	☐	☐
Prescription Drugs	☑	☐	☐
Cocaine	☑	☐	☐
Heroin	☑	☐	☐
Inhalants	☑	☐	☐
Methamphetamine	☑	☐	☐
Bath salts, Spice, K2)	☑	☐	☐
Targeted Populations			
Students in College	☑	☐	☐
Military Families	☑	☐	☐
LGBTQ	☑	☐	☐
American Indians/Alaska Natives	☑	☐	☐
African American	☑	☐	☐
Hispanic	☑	☐	☐
Homeless	☑	☐	☐
Native Hawaiian/Other Pacific Islanders	☑	☐	☐
Asian	☑	☐	☐
Rural	☑	☐	☐

Underserved Racial and Ethnic Minorities	☑	☐	☐

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 – September 30, 2023, for most states.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 – September 30, 2023.

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Planning Tables

Table 6 Non-Direct Services/System Development

Planning Period Start Date: 10/1/2021 Planning Period End Date: 9/30/2023

	FFY 2022				
Activity	A. SABG Treatment	B. SABG Prevention	C. SABG Integrated[1]	D. COVID-19[2]	E. ARP[3]
1. Information Systems					
2. Infrastructure Support	$246,000.00			$246,000.00	
3. Partnerships, community outreach, and needs assessment			$75,000.00		
4. Planning Council Activities (MHBG required, SABG optional)					
5. Quality Assurance and Improvement					
6. Research and Evaluation		$100,000.00			
7. Training and Education	$100,000.00				
8. Total	**$346,000.00**	**$100,000.00**	**$75,000.00**	**$246,000.00**	**$0.00**

[1]Integrated refers to non-direct service/system development expenditures that support both treatment and prevention systems of care.

[2]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 –September 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2021 – March 14, 2023 should be entered in Column D.

[3]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 – September 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between October 1, 2021 and September 30, 2023 should be entered in Column E.

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Environmental Factors and Plan

1. The Health Care System, Parity and Integration - Question 1 and 2 are Required

Narrative Question

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[22] Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.[23] It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.[24]

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.[25] SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.[26] For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.[27]
Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and M/SUD with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.[28]

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[29] The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and M/SUD include: developing models for inclusion of M/SUD treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.
Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.[30] Use of EHRs - in full compliance with applicable legal requirements - may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow M/SUD prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes[31] and ACOs[32] may be important strategies used by SMHAs and SSAs to foster integrated care. Training and assisting M/SUD providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.
SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.[33] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[34]
One key population of concern is persons who are dually eligible for Medicare and Medicaid.[35] Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.[36] SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who experience health insurance coverage eligibility changes due to shifts in income and employment.[37] Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with M/SUD conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.[38] SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of M/SUD conditions and work with

partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.
SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.[39] Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to M/SUD services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. The SSAs and SMHAs should collaborate with their states' Medicaid authority in ensuring parity within Medicaid programs.
SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.
Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.[40]
SAMHSA recognizes that certain jurisdictions receiving block grant funds - including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs.[41] However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

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[26] **https://www.samhsa.gov/behavioral-health-equity/quality-practice-workforce-development**

[27] **http://medical-legalpartnership.org/mlp-response/how-civil-legal-aid-helps-health-care-address-sdoh/**

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[31] Health Homes, **http://www.integration.samhsa.gov/integrated-care-models/health-homes**

[32] New financing models, **https://www.integration.samhsa.gov/financing**

[33] Waivers, **http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html**; Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders, CMS Informational Bulletin, Dec. 2012, **http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-03-12.pdf**

[34] What are my preventive care benefits? **https://www.healthcare.gov/what-are-my-preventive-care-benefits/**; Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 FR 41726 (July 19, 2010); Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 FR 46621 (Aug. 3, 2011); **http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html**

[35] Medicare-Medicaid Enrollee State Profiles, **http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateProfiles.html**; About the Compact of Free Association, **http://uscompact.org/about/cofa.php**

[36] Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies, CBO, June 2013, **http://www.cbo.gov/publication/44308**

[37] BD Sommers et al. Medicaid and Marketplace Eligibility Changes Will Occur Often in All States; Policy Options can Ease Impact. Health Affairs. 2014; 33(4): 700-707

[38] TF Bishop. Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care, JAMA Psychiatry. 2014;71(2):176-181; JR Cummings et al, Race/Ethnicity and Geographic Access to Medicaid Substance Use Disorder Treatment Facilities in the United States, JAMA Psychiatry. 2014; 71(2):190-196; JR Cummings et al. Geography and the Medicaid Mental Health Care Infrastructure: Implications for Health Reform. JAMA Psychiatry. 2013; 70(10):1084-1090; JW Boyd et al. The Crisis in Mental Health Care: A Preliminary Study of Access to Psychiatric Care in Boston. Annals of Emergency Medicine. 2011; 58(2): 218

[39] Hoge, M.A., Stuart, G.W., Morris, J., Flaherty, M.T., Paris, M. & Goplerud E. Mental health and addiction workforce development: Federal leadership is needed to address the growing crisis. Health Affairs, 2013; 32 (11): 2005-2012; SAMHSA Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues, January 2013, **https://www.cibhs.org/sites/main/files/file-attachments/samhsa_bhwork_0.pdf**; Creating jobs by addressing primary care workforce needs, **https://obamawhitehouse.archives.gov/the-press-office/2012/04/11/fact-sheet-creating-health-care-jobs-addressing-primary-care-workforce-n**

[40] About the National Quality Strategy, **http://www.ahrq.gov/workingforquality/about.htm**;

[41] Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, **http://www.cms.gov/cciio/resources/letters/index.html**; Affordable Care Act, Indian Health Service, **http://www.ihs.gov/ACA/**

Please respond to the following items in order to provide a description of the healthcare system and integration activities:

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.

ADMH's Office of Substance Abuse Treatment Services (OSATS) participates in several initiatives with goals for integration of mental health and primary care with service delivery for substance use disorders.

ADMH's commissioner is a co-chair of the Governor's Alabama Opioid Overdose and Addiction Council. It was established in 2017 and continues to be a strong presence within the state. OSATS is an active participant in every committee which provided an excellent platform for discussion of integrated care. The Treatment and Recovery Support Services Committee of the Council is chaired by the ADMH's NTN and has identified full implementation of the Mental Health and Addiction Parity Act as goal of the committee. The primary task identified has been encouraging the use of the "Six Steps Parity Compliance Guide" in order to assist insurance carriers in their compliance of act. A self-assessment tool, developed by the Kennedy forum, has been identified as tool that insurance companies can use to assess their compliance. This continues to be a focus of the committee in the upcoming year, but the committee also plans to broaden the goal by involving a member of the State Insurance Commission.

ADMH, through the annual Alabama School on Alcohol and Other Drug Studies, provides ongoing education individuals in all fields including social workers, nurses, pharmacists, counselors, physicians, etc. The purpose of the workshops is to enhance both professional growth and job performance. ADMH has made a concerted effort to ensure that topics offered will benefit the understanding and integration of mental health, primary care, and substance use services. Among the topics offered, the following is a sample: How Opioids Hijack the Brain; Tele-behavioral Health and Pandemic Fatigue; the Pharmacist's Guide to Opioid Use Disorders; HIV and Co-Occurring Disorders: Integrating Behavioral Health Services in Primary Care Clinics; Foundations of Substance Use; Trauma Informed Care and Co-Occurring Capable Care; Pregnancy and Substance Use; Dealing with Addiction and the Need to Treat Chronic Pain; and Bridging the Gap: Attacking Stigma, Barriers and Patient Center Treatment.

In June of 20I9, Alabama's Governor signed into law Senate Bill425, known as the MAT Act of 2019. A 17-member group met to establish guidelines for the use of buprenorphine in non-residential treatment programs. Two members of the group were from the Alabama Department of Mental Health. The guidelines were completed and submitted to the legislature in February 2020. However, COVID-19 derailed the guidelines being signed into law and are in a holding pattern at this point.

ADMH, in partnership with large university and funded through a SAMHSA grant, continues the promotion, expansion and integration of Screening Brief Intervention and Referral to Treatment (SBIRT) into public systems of care to increase the identification and treatment of substance use disorders and reduce the impact of related mental and physical diseases. As part of this initiative, and working with Alabama Medicaid, the SBIRT billing code has been revised to include the standardized Alabama

SBIRT screening tool as an accepted tool for SBIRT services. We also worked with Alabama Medicaid's Alabama Coordinated Health Networks (ACHNs) to increase reimbursement for those entities to cover the costs of statewide implementation of SBIRT. ADMH has also applied for a grant to implement SBIRT for adolescents in primary care settings in rural and underserved areas of the state.

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

OSATS continues to lead ADMH's efforts to provide services and supports for co-occurring substance use and mental health disorders for the last fourteen years. OSATS, in conjunction with the certification department, develops and maintains the Alabama Administrative Code for certification of the state's substance abuse treatment provider agencies. ADMH is currently in the process of updating these rules to reflect changes made to the ASAM criteria which includes treatment standards for individuals who have co-occurring mental health and substance use disorders within each ASAM level of care. Part of the updating of the administrative code includes the merging of the substance abuse code with the mental illness administrative code. This is part of ADMH's ongoing effort to merge the two departments and will benefit the area of co-occurring services.

OSATS utilizes service code modifiers to reimburse for co-occurring enhanced service delivery at a higher fee-for-service rate. The modifiers have been added to the majority of the substance abuse service codes. In addition, ADMH was able to advocate for mental health consultation to added as a substance abuse Medicaid reimbursable code in the past year.

OSATS has been able to encourage the use of qualifying EHRs by the community providers. OSATS continues to promote the ability to establish linkage with the One Health Record, Alabama's Health Information Exchange. In order to encourage the use of telehealth, ADMH applied for and received a USDA grant to buy telehealth equipment for agencies in 10 of the more rural areas of the state. Due to the pandemic and difficulty in obtaining telehealth equipment as a result of the pandemic, the implementation was delayed but is on track to be finished by the end of this fiscal year. ADMH also chose to apply for a second USDA grant to broaden the use of telehealth to other underserved areas of the state. ADMH has purchased a new substance use management information which will also be able to be used as an EHR by community providers at no cost. Medicaid Targeted Case Management has been approved for individuals who are receiving services in an ADMH certified substance abuse program.

OSATS is one of the quality improvement experts for Alabama Medicaid's new Alabama Coordinated Health Networks (ACHNs) which have replaced the former three care coordination programs used by Alabama Medicaid. In addition, Alabama Medicaid has required that an ADMH certified substance use community provider be a member of each ACHN board. ADMH is in the process of writing the 1115 demonstration waiver application in collaboration with the Alabama Medicaid agency. This joint agency effort will seek to establish a broader target population in specified geographic areas and also to remove the IMD exclusion for SUDs.

3. **a)** Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through Qualified Health Plans? ○ Yes ◉ No

b) and Medicaid? ○ Yes ◉ No

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

n/a

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state? ◉ Yes ○ No

6. Do the M/SUD providers screen and refer for:

a) Prevention and wellness education ○ Yes ◉ No

b) Health risks such as

ii) heart disease ○ Yes ◉ No

iii) hypertension ○ Yes ◉ No

iv) high cholesterol ○ Yes ◉ No

v) 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

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services? ○ Yes ◉ No

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

The sections of Alabama law relevant to parity are found in the state insurance law. There is a section about mental health coverage and a section about autism coverage. Substance use disorder services are excluded.

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

no

Please indicate areas of technical assistance needed related to this section

No technical assistance is requested at this time.

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Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

In accordance with the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**[42], **Healthy People, 2020**[43], **National Stakeholder Strategy for Achieving Health Equity**[44], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS)[45].

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the HHS Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The HHS Secretary's top priority in the Action Plan is to "assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."[46]

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status[47]. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations[48]. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBTQ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

[42] **http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf**

[43] **http://www.healthypeople.gov/2020/default.aspx**

[44] **https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_07_Section3.pdf**

[45] **http://www.ThinkCulturalHealth.hhs.gov**

[46] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[47] https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status

[48] https://www.whitehouse.gov/wp-content/uploads/2017/11/Revisions-to-the-Standards-for-the-Classification-of-Federal-Data-on-Race-and-Ethnicity-October30-1997.pdf

Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, sexual orientation, gender identity, 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 M/SUD 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) Standards? ( ) Yes (●) No

6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care? ( ) Yes (●) No

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

Substance use prevention providers are currently required to submit disparity impact statements to ensure health disparities are identified among populations and needs are met. In addition, the Mental Health and Substance Abuse Services (MHSA) Division is exploring comprehensive plans to incorporate disparity impact statements within the entire continuum

Please indicate areas of technical assistance needed related to this section

n/a

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3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, its purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality ÷ Cost, (**V = Q ÷ C**)

SAMHSA anticipates that the movement toward value based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of M/SUD systems and services.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state M/SUD authorities, legislators, and others regarding the evidence of various mental and substance misuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states' use of the block grants for this purpose. The NQF and the IOM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. SAMHSA's Evidence Based Practices Resource Center assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. SAMHSA's Evidence-Based Practices Resource Center provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General,[49] The New Freedom Commission on Mental Health,[50] the IOM,[51] NQF,and the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC).[52]. The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[53] SAMHSA and other federal partners, the HHS' Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocol Series **(TIPS)**[54] are best practice guidelines for the SUD treatment. SAMHSA draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation **(KIT)**[55] was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding M/SUD services.

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[49] United States Public Health Service Office of the Surgeon General (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

[50] The President's New Freedom Commission on Mental Health (July 2003). Achieving the Promise: Transforming Mental Health Care in America. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

[51] Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press.

[52] National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

[53] **http://psychiatryonline.org/**

[54] **http://store.samhsa.gov**

[55] **https://store.samhsa.gov/sites/default/files/d7/priv/ebp-kit-how-to-use-the-ebp-kit-10112019_0.pdf**

Please respond to the following items:

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 focused on consumer outcomes rather than care processes.
- **g)** ☐ Involvement in CMS or commercial insurance value based purchasing programs (health homes, accountable care organization, all payer/global payments, pay for performance (P4P)).
- **h)** ☐ The state has an evaluation plan to assess the impact of its purchasing decisions.

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

Please indicate areas of technical assistance needed related to this section.

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6. Program Integrity - Required

Narrative Question

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for M/SUD services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: **http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf**. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance use disorder prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for M/SUD services funded by the MHBG and SABG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of M/SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following items:

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 program requirements, including quality and safety standards? (●) Yes ( ) No

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

none

Please indicate areas of technical assistance needed related to this section

No technical assistance needed

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7. Tribes - Requested

Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the **2009 Memorandum on Tribal Consultation**[56] to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

[56] **https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf**

Please respond to the following items:

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?

n/a

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

n/a

Please indicate areas of technical assistance needed related to this section.

Receiving information on how to engage and communicate with tribes would be beneficial.

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8. Primary Prevention - Required SABG

Narrative Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification*** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based Process*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Please respond to the following items

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)? (●) Yes ( ) No

2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply) (●) Yes ( ) No

- **a)** [x] Data on consequences of substance-using behaviors
- **b)** [x] Substance-using behaviors
- **c)** [x] Intervening variables (including risk and protective factors)
- **d)** [ ] Other (please list)

3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)

- [ ] Children (under age 12)
- [x] Youth (ages 12-17)
- [x] Young adults/college age (ages 18-26)
- [x] Adults (ages 27-54)
- [x] Older adults (age 55 and above)
- [x] Cultural/ethnic minorities
- [x] Sexual/gender minorities
- [x] Rural communities
- [ ] Others (please list)

4. Does your state use data from the following sources in its Primary prevention needs assesment? (check all that apply)

- [ ] Archival indicators (Please list)

- [x] National survey on Drug Use and Health (NSDUH)
- [x] Behavioral Risk Factor Surveillance System (BRFSS)
- [x] Youth Risk Behavioral Surveillance System (YRBS)
- [ ] Monitoring the Future
- [ ] Communities that Care
- [x] State - developed survey instrument
- [ ] Others (please list)

5. Does your state use needs assesment data to make decisions about the allocation SABG primary prevention funds? (•) Yes ( ) No

If yes, (please explain)

Information gathered from state and national sources provided preliminary data from which the needs assessment took direction. Counties are analyzed based on population and need. The first component used in the allocation of funding was population. For Alabama's funding allocation process, the total population estimates from the United States Census Bureau, Population Estimates are used for Alabama's 67 counties that make up 22 catchment areas. The second component used in the allocation of funding was need. The first step is to determine the criteria for inclusion for need. To help determine need in relation to substance use the Office of Prevention looked at substance use indicators as well as social and economic indicators within a county. The process for choosing indicators was determined by: • Availability of indicators on the county level • Relative Importance • Current and Updated periodically. Based off the criteria, the following indicators were selected to assess Epidemiological Need: • Persons Killed & Highest Driver Blood Alcohol Concentration (.08+) in Crash • Substance Abuse Treatment Admission • High School Graduate or Higher • Poverty • Suicides

If no, (please explain) how SABG funds are allocated:

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification*** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Capacity Building

1. Does your state have a statewide licensing or certification program for the substance use disorder prevention workforce? (●) Yes ( ) No

If yes, please describe

Department of Mental Health, Substance Abuse Services Division, Administrative Code, Chapter 580-9-47, Prevention Standards establishes certification standards for Prevention Professionals and Prevention Agencies. In addition, the Alabama Alcohol and Drug Abuse Association is a non-profit organization that certifies Alcohol & Drug Counselors, Prevention Specialists, Criminal Justice Professionals and Clinical Supervisors. Specific criteria for Prevention Specialists can be found at https://www.aadaa.us/certification-membership-2/.

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use disorder prevention workforce? (●) Yes ( ) No

If yes, please describe mechanism used

Trainings are consistently provided to the substance use disorder workforce. Prevention professionals have an opportunity to attend the largest statewide substance use disorder professionals conference - the Alabama School of Alcohol and Other Drug Studies (ASADS) annually. In addition, there are various other trainings provided to the prevention workforce through quarterly trainings provided by ADMH Prevention Consultants, which includes a Certified Prevention Specialist. The Prevention Workforce also takes advantage of webinar offerings from the Prevention Technology Transfer Center Network (PTTC) and two annual national conferences - Community Anti-Drug Coalitions of America (CADCA) and the National Prevention Network Conference (NPN). Additional training opportunities are reviewed and explored as it relates to the substance use disorder prevention professional.

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies? (●) Yes ( ) No

If yes, please describe mechanism used

Community readiness has been assessed using the Tri- Ethnic Center model to allow communities to delve deeper into their readiness, level of knowledge, and current resources available to support the SPF process. The SPF Assessment is the first step of Alabama's SPF process. The assessment step provides guidance questions to get a clearer understanding of the problems, needs, resources and readiness of Alabama's communities to address community problems. During this process, community capacity and readiness is determined to utilize the necessary resources to address the problems in ways that can be sustained over time.

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification*** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Planning

1. Does your state have a strategic plan that addresses substance use disorder prevention that was developed within the last five years? (●) Yes ( ) No

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SABG? (N/A - no prevention strategic plan) (●) Yes ( ) No ( ) N/A

3. Does your state's prevention strategic plan include the following components? (check all that apply):

- **a)** [x] Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds
- **b)** [x] Timelines
- **c)** [x] Roles and responsibilities
- **d)** [x] Process indicators
- **e)** [x] Outcome indicators
- **f)** [x] Cultural competence component
- **g)** [x] Sustainability component
- **h)** [ ] Other (please list):
- **i)** [ ] Not applicable/no prevention strategic plan

4. Does your state have an Advisory Council that provides input into decisions about the use of SABG primary prevention funds? (●) Yes ( ) No

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SABG primary prevention funds? (●) Yes ( ) No

If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based

As a requirement, all the interventions provided must be considered “evidence based.” To truly meet the varying needs of the individual communities, SAMHSA released a publication that outlined the guidelines for deeming an intervention as evidence based. The EBP Workgroup follows these guidelines. EBP Workgroup membership was also provided with Smash’s “Identifying and Selecting Evidence-Based Interventions”. If an organization wants to ensure their program is recognized as evidence based, this guiding document serves as the basis of the approval process. The EBP follows the guidance of the Six Components of Good Fit; (1) Evidence of Effectiveness – Has the EBP shown effectiveness in the past?; (2) Conceptual Fit with the County’s Prevention Priorities – Is the EBP relevant to the intervening variables; (3) Practical Fit with the County’s Readiness and Capacity – Is the EBP

appropriate for the intervening variables?; (4) Ability to Implement with Fidelity – Can the EBP be implemented as intended?; (5) Cultural Fit within the County – Is the EBP culturally appropriate for your population?; and (6) High Likelihood of Sustainability within the County – Is the EBP sustainable in your county? The EBP Workgroup, along with the State Evaluator, will continue to ensure adequate trainings and training needs are identified and met to meet the needs of Alabama's prevention system. The role of the EBP Workgroup, as well as trainings, will be ongoing to ensure interventions are evidence-based.

Although the EBP was initiated as a result of discretionary funding, SPF processes are interwoven into SABG and as needs are identified, the EBP will be instrumental throughout all prevention processes and service provision.

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Implementation

1. States distribute SABG primary prevention funds in a variety of different ways. Please check all that apply to your state:

- **a)** ☐ SSA staff directly implements primary prevention programs and strategies.
- **b)** ☐ The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
- **c)** ☐ The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
- **d)** ☐ The SSA funds regional entities that provide training and technical assistance.
- **e)** ☐ The SSA funds regional entities to provide prevention services.
- **f)** ☐ The SSA funds county, city, or tribal governments to provide prevention services.
- **g)** ☐ The SSA funds community coalitions to provide prevention services.
- **h)** ☐ The SSA funds individual programs that are not part of a larger community effort.
- **i)** ☐ The SSA directly funds other state agency prevention programs.
- **j)** ☑ Other (please describe)

ADMH currently distributes SABG funds to fifteen (15) substance use prevention providers reflecting prevention services in all 67 counties of the state. Funding is distributed by catchment area based on 22 catchments within the state. The basic prevention system is based on Community Mental Health Centers in 22 catchment areas (currently revised to 20 catchment areas due to Community Mental Health Center merger and/or agreement, but the point of funding reflects the previous 22 catchment areas), each with its own local “310 Board” named after the Regional Mental Health Boards. Within the “310” catchment area all sixty-seven (67) counties and four (4) regions of the state are included. Some prevention providers offer prevention services in multiple catchments.

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

a) Information Dissemination:

Brochures, pamphlets, posters, & flyers
Health fairs and other health promotion
Information Lines
Radio and TV public service announcements
Speaking engagements
Media Campaigns
Clearinghouse/information resource centers
Resource Directories

b) Education:

Education programs for youth groups
Peer leader/peer helper programs
Classroom and/or small group sessions (all ages)
Children of substance users groups
Parenting and family management classes

c) Alternatives:

Community service activities
Drug free dances and parties
Youth/Adult Leadership Activities
Community Drop-In Centers

d) Problem Identification and Referral:

Employee Assistance Programs
Student Assistance Programs
Driving while under the influence/driving while intoxicated education programs

e) Community-Based Processes:

Multi-agency coordination and collaboration / coalition
Community team building activities
Community and volunteer training, e.g., neighborhood action training, training of key people in the system, staff/officials training
Systematic planning
Accessing services and funding

f) Environmental:

Promoting the establishments or review of alcohol, tobacco, and drug use policies in schools.
Modifying alcohol and tobacco advertising practices
Technical assistance to communities to maximize local enforcement procedures governing availability and distribution of alcohol, tobacco, and other drug use
Product pricing strategies

3. Does your state have a process in place to ensure that SABG dollars are used only to fund primary prevention services not funded through other means? (●) Yes ( ) No

If yes, please describe

Prevention providers are required to submit a SABG-specific Prevention Plan outlining strategies that are specifically related to the primary prevention funding received through SABG. The Prevention Plans are reviewed by contracted Prevention Consultants and ADMH Office of Prevention staff to ensure requirements and specifications are met. In addition to the Prevention Plan, prevention providers submit a detailed budget outlining expenditures relative to the strategy(y)ies of implementation. Any additional ADMH Office of Prevention funding sources require specific budgets and itemization related specifically to the designated funding source. Furthermore, ADMH Office of Prevention conducts monitoring and compliance visits, in addition to Certification Site Visits, to ensure compliance and prevent service duplication.

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Evaluation

1. Does your state have an evaluation plan for substance use disorder prevention that was developed within the last five years? (●) Yes ( ) No

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan

2. Does your state's prevention evaluation plan include the following components? (check all that apply):

- **a)** [x] Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
- **b)** [x] Includes evaluation information from sub-recipients
- **c)** [x] Includes SAMHSA National Outcome Measurement (NOMs) requirements
- **d)** [ ] Establishes a process for providing timely evaluation information to stakeholders
- **e)** [ ] Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
- **f)** [ ] Other (please list:)
- **g)** [ ] Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SABG funded prevention services:

- **a)** [x] Numbers served
- **b)** [ ] Implementation fidelity
- **c)** [ ] Participant satisfaction
- **d)** [x] Number of evidence based programs/practices/policies implemented
- **e)** [ ] Attendance
- **f)** [ ] Demographic information
- **g)** [ ] Other (please describe):

4. Please check those outcome measures listed below that your state collects on its SABG funded prevention services:

- **a)** [x] 30-day use of alcohol, tobacco, prescription drugs, etc
- **b)** [ ] Heavy use
- [x] Binge use
- [x] Perception of harm
- **c)** [x] Disapproval of use

d) ☑ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)

e) ☐ Other (please describe):

Footnotes:

Evaluation Plan

Alabama Substance Use Prevention Block Grant

Submitted to: Alabama Department of Mental Health
July 2021

Authors: Eden Griffin, Julia Ricotta, T Schweimler, Cheryl Winston, Jason Wheeler

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Sections

Evaluation Goals

Evaluation Questions

Evaluation Reporting and Analysis

Logic Model

Appendix A: Acronyms

Evaluation Goals

The goal of the Substance Use Block Grant (BG) prevention set aside is to support and advance community-driven efforts in substance use prevention. Alabama distributes BG funds to 15 prevention providers within 22 catchment areas who serve all 67 counties across the state. The State of Alabama Department of Mental Health (ADMH) has identified the following evaluation goals based on SAMHSA's Strategic Prevention Framework (SPF), the Office of Prevention Services' mission and strategic goals, and state needs.

The SABG evaluation goals are as follows:

1. Prevent and reduce underage drinking and young adult problem drinking
2. Prevent and reduce alcohol and/or drug-related motor vehicle crashes
3. Prevent and reduce prescription drug misuse
4. Prevent and reduce substance-related attempted suicides and deaths by suicide

OMNI developed this state-level evaluation plan to document all the measures that will be used to track progress towards these goals. OMNI recognizes that ADMH's priorities and prevention strategies may evolve over the course of the grant period. Thus, this plan reflects the initial evaluation activities for the first year of the funding period and will be revisited annually. Edits will be made to reflect the adjustments to the evaluation scope and ensure alignment with changing needs and priorities of ADMH, the 67 funded counties, and the SAMHSA grant requirements.

Evaluation Questions

The following process and outcome evaluation questions will be addressed throughout the course of the evaluation. These questions will help measure progress towards the five goals listed above. "Evaluation Questions" reflect the specific question to answer over the course of the grant and the goal they address (for "Outcome Evaluation Questions"). "Measures" refer to specific indicators that will be monitored over the course of the evaluation period. "Data Source and Interval" refers to the data source from which the measure is pulled and how frequently the data source will be available. For a full list of acronyms, please see Appendix A.

Process Evaluation Questions	Measures	Data Source and Interval
Which prevention services were delivered across the state? • What was the mix of services by CSAP strategy and IOM target? • Which counties prioritized which problem/priority areas? • How did those services differ across regions? • Did providers meet the requirement to deliver 50% environmental strategies?	• Number of strategies implemented in each county (of the 28 approved strategies or "Other" strategies) • Number of people served by CSAP strategy and by IOM target • Number of counties implementing specific strategies, including aggregation of strategies implemented by region.	ASAIS Data System (ongoing) County PPTs (annually) Activity Sheets (ongoing)
To what degree were prevention services effectively implemented? • Did implementation match county-level prevention plans? • Did providers meet the goals and objectives set out in their PPTs? • When/why did deviations from the plan occur and what was the result?	• Comparisons between ASAIS activities, PPTs, and prevention plan quarterly and annual progress reports • Changes to PPT or intervention workplans (can be made quarterly) • Reports of goal/objective completion by providers • Successes and barriers to progress in implementation • Qualitative data on impact of COVID-19	ASAIS Data System (ongoing) County PPTs and intervention workplans (annually) Prevention Plan Progress Reports (quarterly and annually) Qualitative data (through SPAB/AEOW meetings, QPPM, conversations with providers,

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• What were successes and barriers related to implementation of prevention services? • How did COVID-19 impact the delivery of prevention services?		and narrative components of quarterly and annual progress reports)
To what extent were prevention services able to reach populations who traditionally experience disparities in behavioral health outcomes? • Which population experiencing health disparities were targeted by prevention providers? • What adaptations were made to prevention services in order to serve selected health disparity populations?	• Number of relevant demographic subpopulations identified at the county-level through PPTs. • Number of people served by strategy stratified by relevant demographic subpopulations. • Number and type of prevention adaptations reported by providers.	ASAIS Data System (ongoing) Health disparities impact statements (annually) County PPTs and prevention workplans (annually) Prevention Plan Progress Reports (quarterly and annually)
How was prevention capacity and infrastructure strengthened at the state and county-level? • How did stakeholder engagement at the county-level change over time? • How did provider capacity change over time? • What technical assistance activities were delivered to providers and what was the perceived helpfulness of these activities?	• Number and involvement of stakeholders at the county level • Percentage of providers that report an increase in capacity • Number of technical assistance activities and trainings • Perceived helpfulness of technical assistance	Stakeholder engagement items on PPTs Capacity items on PPTs Pre- and post-surveys before and after trainings Requests for TA from Prevention Plan Progress Reports

Outcome Evaluation Questions	Measures	Data Source and Interval
To what extent did providers meet strategy-level goals and outcomes in the counties they serve? • Examples: changes in compliance checks, changes in knowledge or behavior as a result of prevention education, etc.)	• Strategy-level outcome measures and goal statements	County-level PPT and workplans
How does underage (12-20) and young adult (18-25) alcohol use change over time? • How do risk and protective factors related to underage and young adult alcohol use change over time? *(Goal 1)*	• Alcohol use in the past month • Binge alcohol use in the past month • Perceived risk of harm of alcohol use among youth • Perception of peer use of alcohol • Age of first use of alcohol among youth	NSDUH (annually) BRFSS (annually) YRBS (annually) Statewide survey (annually)
How do alcohol and/or drug related motor vehicle crashes change over time? • How do risk and protective factors related to alcohol and/or drug related motor vehicle crashes change over time? *(Goal 2)*	• Number of fatal crashes by alcohol-involved drivers • BAC level in crashes • Number of arrests for driving under the influence	Fatality Analysis Reporting System (annually) Uniform Crime Reports (annually)

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How does prescription drug misuse change over time? • How do risk and protective factors related to prescription drug misuse change over time? *(Goal 3)*	• Pain reliever misuse in the past month • Rate of prescription drug overdose deaths • Number of young adults reporting ever haven taken prescription pain medicine without a prescription or differently than how a doctor told them to use it • Perceived risk of harm of prescription drug use • Perceptions of peer use of prescription drug • Perceptions of social/community norms that promote (or do not discourage) misuse	CDC Wonder (annually) NSDUH (annually) YRBS (annually) Statewide survey (annually)
How do substance-related deaths by suicide change over time? • How do risk and protective factors related to substance-related suicide change over time? *(Goal 4)*	• Number of deaths by suicide • Number of drug-induced suicides • Number of youth or adults reporting a suicide attempt • Number of emotional and behavioral problems • Perceptions of availability of prosocial activities • Perceptions of social and community norms that perpetuate mental health stigma	CDC Wonder - National Center for Health Statistics (annually) NSDUH (annually) YRBS (annually) Statewide survey (annually)

Evaluation Reporting and Analysis

Results will be shared in a variety of formats with providers, counties, and other grant stakeholders. ADMH will utilize evaluation results to identify grant successes and challenges, community impacts, and opportunities for adjustments to future prevention strategies. Evaluation results will also be used for federal reporting requirements. The following reporting activities are planned for the first year of the grant:

- **Annual state-level report** that summarizes all grant activities, evaluation analysis results, and outcomes.
- **Ad-hoc presentations** that summarize findings for key stakeholder groups (ex. SPAB/AEOW)
- **Quarterly reporting** of evaluation activities and progress submitted by OMNI to ADMH.

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ALABAMA BLOCK GRANT PREVENTION LOGIC MODEL

	PROBLEM	TARGETED RISK FACTORS	STRATEGIES	LONG-TERM IMPACT
PROBLEM ALCOHOL USE	In 2017-18, 18.85% of Alabamians aged 12-20 reported alcohol use in the past month. (NSDUH) In 2017-18, 10.91% of Alabamians aged 12-20 reported binge alcohol use in the past month. (NSDUH) In 2018, 21% of Alabama drivers involved in fatal crashes had a BAC of .01 or higher. (FARS)	Low perceived risk of harm for alcohol use among youth Higher perception of peer use of alcohol than reality Social and community norms that promote underage use	Alabama's Block Grant funds the following prevention programs by CSAP strategy: Alternative Activities: • Alternative Programming/Summer Programming • Substance-Free Recreational Activities Community-Based Processes: • Regional or Local Capacity Building Education Programs: • Active Parenting • InShape Prevention Plus Wellness • Lifeskills Curriculum • Mental Health First Aid • Positive Action • Project Toward No Drug Abuse • Too Good For Drugs (and Violence) Environmental Strategies: • Drug Take Backs/Drug Disposal Sites • DUI Checkpoints • School Practice • School Policies on ATOD use Information Dissemination: • Compliance Checks • Media Campaigns • Lock Your Meds • Parents Who Host Lose the Most Problem Identification and Referral: • Project Magic	DECREASE IN UNDERAGE ALCOHOL USE DECREASE IN UNDERAGE BINGE DRINKING DECREASE IN ALCOHOL-RELATED DRIVING FATALITIES
PRESCRIPTION DRUG MISUSE	In 2017-18, 4.75% of Alabamians aged 18+ reported pain reliver misuse in the past month. (NSDUH) In 2019, 22.1% of Alabama youth reported ever having taken prescription pain medicine without a prescription, or differently than how a doctor told them to use it. (YRBS) In 2017, the rate of drug overdose deaths in Alabama was 19.7 per 100K. (CDC Wonder)	Low perceived risk of harm for prescription drug misuse Social availability of prescription drugs Social and community norms that promote prescription drug misuse		DECREASE IN PRESCRIPTION DRUG MISUSE AMONG ADULTS DECREASE IN PRESCRIPTION DRUG MISUSE AMONG YOUTH DECREASE IN PRESCRIPTION DRUG OVERDOSE DEATHS
SUBSTANCE-RELATED SUICIDE	In 2018, there were 16.9 deaths by suicide for every 100K Alabamians. (CDC Wonder) In 2019, 11.6% of Alabama youth and 0.54% of Alabama adults reported a suicide attempt in the past year. (YRBS & NSDUH) In 2019, there were 69 suicide deaths by alcohol or drug poisonings in Alabama. (CDC Wonder)	Emotional/behavioral problems Low availability of prosocial activities Social and community norms that perpetuate mental health stigma		DECREASE IN SUICIDE DEATHS AND ATTEMPTS AMONG ADULTS AND YOUTH DECREASE IN SUBSTANCE-RELATED DEATHS BY SUICIDE

This logic model was developed in collaboration with the Alabama Department of Mental Health by OMNI Institute as part of Block Grant evaluation services.

OMNI

Appendix A: Acronyms

Acronym	Definition
ADMH	Alabama Department of Mental Health
AEOW	Alabama Epidemiology Outcomes Workgroup
ASAIS	Alabama Substance Abuse Information System
BAC	Blood Alcohol Content
BG	Substance Use Block Grant
BRFSS	Behavioral Risk Factor Surveillance System
CSAP	Center for Substance Abuse Prevention
IOM	Institute of Medicine
NSDUH	National Survey on Drug Use and Health
PPT	Prevention Plan Templates
QPPM	Quarterly Prevention Provider Meetings
SAMHSA	Substance Abuse and Mental Health Services Administration
SPAB	State Prevention Advisory Board
SPF	Strategic Prevention Framework
YRBS	Youth Risk Behavior Survey

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FY19-22

STRATEGIC PLAN

OFFICE OF PREVENTION

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List of Acronyms

ABC	Alabama Alcoholic Beverage Control Board
ADMH	Alabama Department of Mental Health
ADPH	Alabama Department of Public Health
AEOW	Alabama Epidemiology Outcomes Workgroup
ASU	Alabama State University
CADCA	Community Anti-Drug Coalitions of America
CCI	Community College Initiative
CSAP	Center for Substance Abuse Prevention
DMHSAS	Division of Mental Health and Substance Abuse Services
EBP	Evidence Based Practices
LGBT	Lesbian, gay, bisexual, transgender
LGBTQ	Lesbian, gay, bisexual, transgender, questioning
OOP	Office of Prevention
PFS	Partnerships For Success
RFP	Request for Proposal
SAMHSA	Substance Abuse and Mental Health Services Administration
SABG	Substance Abuse Prevention and Treatment Block Grant
SIG	State Incentive Grant
SOR	State Opioid Response
SPAB	State Prevention Advisory Board
SPF	Strategic Prevention Framework
SPF Rx	Strategic Prevention Framework for Prescription Drugs
SPF-SIG	Strategic Prevention Framework-State Incentive Grant
STR	State Targeted Response
UD	Underage Drinking

Section 1: Strategic Planning

The Office of Prevention (OOP) developed a strategic planning process that enables it to carry out its mission, vision, and achieve its goals. The process is aligned closely with the office goals and deliverables process and results in a three year strategic plan that is updated annually. Beyond the annual planning process, a formal review is conducted quarterly for leadership and staff to provide status updates on the goals, objectives, and actions undertaken to accomplish the plan. Recommendations and revisions are made as needed.

This statewide strategic prevention plan was initially created as a need and in response to a Center for Substance Abuse Prevention (CSAP) Core Technical Review potential enhancement recommendation (September 2011). Specifically the state was 'encouraged to continue to develop the infrastructure plan' and to "create a comprehensive state strategic plan." The purpose of the plan is to communicate goals, action steps, distinguish responsibility, targets and metrics to guide the prevention system. This plan seeks to assist the enhancement of the prevention system in its leadership, capacity and processes. The plan incorporates: system organization; workforce development and capacity building; implementation; evaluation; and Synar. This strategic plan was informed by planning initiatives already underway such as: Substance Abuse and Mental Health Block Grant (SABG) application; Substance Abuse Mental Health Services Administration (SAMSHA) Leading Change 2.0; Alabama Epidemiological Profile: State Prevention Advisory Board (SPAB); Alabama Epidemiological Outcomes Workgroup (AEOW); Substance Abuse Prevention Workforce survey results and more. The goals of this statewide strategic prevention plan are consistent with the aforementioned documents and from input from the referenced groups and OOP staff. The plan seeks to support the mission and vision of the OOP, which are as follows:

OOP Mission

Encourage, support, and sustain culturally competent prevention prepared communities statewide for Alabamians to attain optimal health, wellness, and independence.

OOP Vision

Vision: Build emotional health, prevent or delay onset of, and mitigate symptoms and complications from substance abuse and mental illness through evidence based prevention strategies which promote healthier decisions and healthier lives for individuals and families to thrive in their communities.

This plan will allow enhancements in the prevention system organization and implementation, workforce development and capacity building, implementation, and evaluation. Through implementation of this plan, the OOP is striving to accomplish the OOP goals.

Section 2: 2015-2018 Accomplishments

By the end of FY'18, the OOP was proud to have several accomplishments that helped move forward in supporting its mission. Accomplishments include, but are not limited to:

Promote a data driven Strategic Prevention Framework (SPF)

- The SPF remains within the administrative code.
- The SPF remains within the provider prevention plan template.
- Embedded into the Prevention Newcomer's Guide.
- Educated the providers of the SPF.

Build emotional health, prevent or delay onset of, and mitigate symptoms and complications from substance abuse and mental illness through coordinated services

- Prevention provider representation is within all 67 counties with the inclusion of additional prevention funding opportunities in 20 counties via SPF-SIG; 16 counties via Opioid STR; 8 counties via PFS; 7 counties via CCI; 4 counties via SPF Rx.
- Identified distribution of prevention strategies within the Community College System.
- Increased usage of Community Based Processes and Environmental strategies.
- Developed a statewide prevention services Request for Proposals (RFP).
- Participated in and coordinated statewide National Prevention Week efforts.
- Participated in Suicide Prevention efforts.

Improve organizational business management systems at the state agency level

- Developed and implemented Intervention Work Plans.
- Developed and implemented a PFS student survey.
- Sustainability of the Funding Allocation Model guided by the SPF.
- Ensured prevention planning correlated with national efforts, SABG goals, Discretionary Grant goals, statewide needs assessment and epidemiological profile.
- Identified data gaps related to epidemiological profile and expanded data sources.
- Educated providers on data usage and needs assessment.
- Updated and disseminated an epidemiological profile.
- Updated the website for the OOP.
- Coordinated efforts with the ADMH Office of Public Information.

Prevent or reduce consequences of underage drinking

- Collaborated with and supported the Alabama Alcoholic Beverage Control Board (ABC) in execution of compliance checks and the minor operative program.
- Successfully concluded the Strategic Prevention Framework State Incentive Grant (SPF SIG) sub-recipients who implemented Underage Drinking (UD) initiatives.
- Implemented the Strategic Prevention Framework Partnerships For Success (PFS) sub-recipients who implemented Underage Drinking (UD) initiatives.
- Provided training, technical assistance, and resources to Strategic Prevention Framework Partnerships for Success (PFS) sub-recipients who implemented Underage Drinking (UD) initiatives.
- Implemented the Community College Initiative (CCI) sub-recipients who implemented Underage Drinking (UD) initiatives.
- UD was a focus of effort in prevention planning.

Coordinated services across the lifespan with an emphasis on adolescents and baby boomers

- Prevention plans took a comprehensive approach to addressing prevention across the lifespan with an emphasis on children from birth through age 25 across strategies. In addition, particular focus had been placed on the 18+ population.

Prevent or reduce illicit or prescription drug misuse, use, and abuse

- Prescription drug misuse, use, and abuse was a focus of effort in prevention planning.
- Supported, promoted, and expanded the Prescription Drug Take Back efforts.
- Developed the Strategic Prevention Framework for Prescription Drugs (SPF Rx) state strategic plan to address prescription drug misuse.
- Developed the Strategic Prevention Framework for Prescription Drugs (SPF Rx) state public education plan to address prescription drug misuse.
- Implemented the Opioid STR discretionary grant in 16 counties.
- Implemented the Strategic Prevention Framework for Prescription Drugs (SPF Rx) discretionary grant in 4 counties.
- Implemented a statewide media campaign to promote prescription drug education and awareness.
- Prescription drug and illicit opioid prevention was a focus of effort in prevention planning.

Prevent or reduce tobacco use

- Collaborated with ABC, Alabama Department of Public Health (ADHP), and the Youth Access to Tobacco Advisory.
- Supported Synar efforts to ensure submission of ASR and compliance with Synar regulations.

- Promoted tobacco-free initiatives.
- Participated with the National Council for Behavioral Health's Tobacco & Cancer Control state planning team – collaboration with ADPH.
- Tobacco prevention was a focus of effort in prevention planning.

Prevent substance-related suicides and attempted suicides

- Updated suicide prevention planning efforts to reinforce the association of primary substance abuse. (SAMHSA System Review Recommendations - 2016)
- Participated and collaborated with the Alabama State University (ASU) Suicide Prevention Task Force.
- Participated and collaborated with the Department of Education's Suicide Prevention Task Force.
- Presented at the ADPH Suicide Prevention Conference.
- Participated and facilitated Mental Health First Aid trainings.
- Educated providers on the shared risk and protective factors of substance use and suicide.
- Educated providers on National Suicide Prevention Lifeline and Question Persuade Refer training.
- Suicide prevention and its relationship to substance use was a focus of effort in prevention planning.

FY'19-22 Office of Prevention Priorities

- Promote emotional health and wellness, prevention or delay the onset of complications from substance abuse and mental illness and identify and respond to emerging behavioral health issues;
- Prevent and reduce underage drinking and young adult problem drinking, prescription drug and illicit opioid misuse and abuse;
- Prevent and reduce prescription drug and illicit opioid misuse and abuse among older adults;
- Prevent and reduce substance-related attempted suicides and deaths by suicide (emphasis on populations at high risk, especially military families, LGBTQ (lesbian, gay, bisexual, transgender, questioning) youth, and American Indians and Alaska Natives);

Section 3: Vision for 2019-2022

The OOP seeks to impact the alcohol and/or drug related motor vehicle crashes, substance abuse treatment admissions, graduation rates, poverty, and substance-related suicides through the implementation of the six CSAP strategies with focused efforts on high-risk populations, college students, transition-age youth, American Indian/Alaska Natives, ethnic minorities experiencing health and behavioral health disparities, service members i.e. veterans and their families, LGBT (lesbian, gay, bisexual and transgender) individuals, older populations, and other data driven populations through the priorities provided.

Priority

- Promote emotional health and wellness, prevention or delay the onset of complications from substance abuse and mental illness and identify and respond to emerging behavioral health issues;
- Prevent and reduce underage drinking and young adult problem drinking;
- Prevent and reduce substance-related attempted suicides and deaths by suicide (emphasis on populations at high risk, especially military families, LGBTQ (lesbian, gay, bisexual, transgender, questioning) youth, and American Indians and Alaska Natives); and/or
- Prevent and reduce prescription drug and illicit opioid misuse and abuse.

Outcomes

More specifically, this plan would allow us to achieve population level outcomes in the State of Alabama in the following ways. Beginning FY2019 with and by 2022, we attempt to:

- reduce the percentage of past year use of _____(insert substance) by 3%;
- reduce the percentage of treatment admission rates by 3%;
- reduce the alcohol and/or drug related motor vehicle crashes by 3%;
- increase the graduation rates by 3%; and
- reduce the substance-related suicide completions by 3%.

Outcomes from the previous plan (FY15) demonstrate lowered percentages among all indicators captured *(See Population Level Indicators page 14)* with the exception of the number of treatment admissions and suicides.

The increase in the number of treatment admissions could be attributed to the increase in state resources. The additional resources allow for the expansion of treatment services and offerings. In addition, the increase in promotion and awareness activities as it relates to accessing treatment services and associated resources could also be indicative of the rise.

The collaborative and planning efforts of substance abuse prevention and suicide prevention has increased to establish comprehensive strategies to address associated risk and protective factors seeking to reduce the substance-related suicide completions statewide.

The outcomes will be based on 22 catchment areas in the state representing 67 counties and the baseline are established by this configuration. *See Appendix, County Level Indicators for the State of Alabama.*

Section 4: Status of the OOP - Assessment

The SPAB assisted in the proposed priorities, outcomes, goals and deliverables through review, feedback, and identification of additions, deletions, and edits in the development of this strategic plan. The SPAB is well versed in the SPF model through training and continuous discussions about the SPF in meetings. The Prevention Director provided the draft Strategic Plan and Prevention Goals and Deliverables to the SPAB for input. Data and detail were provided from Leading Change 2.0 and the Epidemiological Profile.

The prioritization process involved a discussion of what funds and resources were already being utilized to address specific issues. In addition to that discussion, the group reviewed trends, time between implementing strategies and the impact on the issue, years of potential life loss, and readiness/political climate. OOP staff members participate regularly in the SPAB meetings and will share updates. At this point in time, the SPAB has had the opportunity to review the plan. There were no significant recommendations provided.

Alabama has identified an Evidence-based Practices (EBP) Workgroup, to use the SPF to identify needs and appropriate interventions for the communities. The EBP Workgroup is comprised of substance abuse prevention experts with backgrounds in community-level prevention, academic research, and governmental administration. The EBP Workgroup, along with sub recipients have been trained in understanding the core concepts related to selecting an EBP. The key elements are to understand the two main types of prevention strategies; Reinforce the understanding of contributing factors, intervening variables, and risk and protective factors; How to apply “good fit” components to EBPs and; Understand the Alabama SPF EBP Approval Process.

The Evidence-Based Practice Approval Process determines the legitimacy of selected EBPs. A step-by-step guide, to include an EBP Test Fit Form, has been provided to sub recipients to determine level of appropriateness. An actual flowchart has been developed to illustrate the EBP approval process.

At the State level, we require that all SPF programming and interventions have a logic model that has been submitted and approved by the SPF Management Team, EBP Workgroup and State Evaluator. These logic models are then used as tools to monitor and evaluate the programming. The State Evaluator provides continual training and technical assistance on logic modeling and ensure specific items and baselines are

identified. If adjustments are needed, the State Evaluator communicates with sub recipients and their evaluators directly. All programmatic services provided through SPF are evidence-based.

Funding Allocation Model

A hybrid funding allocation model combining population and highest need is utilized to support the prevention system in the state of Alabama. For Alabama's funding allocation process, the total population estimates from the United States Census Bureau, 2016 Population Estimates were used. Alabama consists of sixty-seven counties. These counties are contained in 22 catchment areas.

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

- Availability of indicators on the county level
- Relative Importance
- Current and Updated periodically (On at least an annual basis)

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

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

To learn in-depth about this allocation model, please refer to the Prevention Funding Allocation Model Strategic Plan which is published on our website at: https://mh.alabama.gov/wp-content/uploads/2019/01/PreventionFundingAllocationModelStrategicPlan.pdf

Section 5: Capacity

The OOP has seen tremendous growth since 2011 in personnel largely due in part to discretionary grants. Currently the office has nine full time staff and contractual evaluation services for its system. The summer of 2015 initiated our first University internship opportunity. OOP sought to expand upon the sustainability of interns and coordinated efforts with two local universities – Auburn University and Auburn University at Montgomery. The interns will assist with capacity and recruitment efforts. The core SABG staff will have responsibility and oversight of ensuring the success of this strategic plan. Specific roles and

responsibilities are outlined in personnel appraisals and within the prevention goals and deliverables. Capacity exists at the state level to engage this plan.

Community collaborative efforts will assist in ensuring adequate capacity at the community level. The prevention system RFP will facilitate a more collaborative process between historically funded agencies that will now see some mergers and contractual agreements between agencies.

Fiscal capacity is an ongoing challenge at the state and community level. The state continues to pursue discretionary grants in an attempt to support and sustain the system beyond the SABG. Since 2015, OOP has secured the following discretionary grants: Partnerships For Success (PFS) – five-year funding opportunity; Strategic Prevention Framework for Prescription Drugs (SPF Rx) – five-year funding opportunity; Opioid State Targeted Response (STR) – two-year funding opportunity; State Opioid Response (SOR) - two-year funding opportunity.

At the community level the prevention system is dependent upon the SABG, and despite continuous educational attempts to influence capacity building beyond this sole source, minimal efforts have been solidified. To further influence this, the OOP included a weighted scoring system within the prevention system RFP that rewards communities that have garnered funds outside of the SABG. OOP has acquired additional discretionary grant opportunities that extend beyond the scope of the SABG, however, there remains minimal effort within the community level prevention system to influence capacity building beyond OOP's efforts and/or offerings. In addition, OOP is coordinating efforts with Community Anti-Drug Coalitions of America (CADCA) to train and provide technical assistance to expand upon the current six (6) Drug Free Communities grant recipients within the state.

Section 6: Planning

To effectively initiate this strategic plan, it was necessary to disseminate the prevention goals and deliverables for review, additions, and edits. The plan is introduced and open to feedback from the prevention system as well as through the SPAB / AEOW. These introductions are facilitated through the quarterly meetings and through email exchange. After incorporation of those edits, the plan was finalized and OOP staff began working towards accomplishments of their roles and responsibilities. To ensure consistent engagement with the plan, the OOP on a quarterly basis updates the progress towards accomplishment of the plan. The quarterly updates are reviewed by the Prevention Director and when necessary suggestions are made toward progress. As appropriate, the progress is also aligned with SABG reporting.

Section 7: Implementation

To accomplish the OOP Strategic Plan the following are the intended implementation activities.

Implementation Activity	Responsible	Timeline
Disseminate – Strategic Plan disseminated to OOP staff, AEOW, SPAB, and posted to OOP website.	Office of Prevention AEOW SPAB	February 2019
Goals and Deliverables – Ongoing implementation with quarterly progress updates.	OOP	Ongoing
Monitoring – Site Visit; SABG & ADMH Monitoring Visit and tools	OOP	Ongoing

Section 8: Evaluation

Evaluation of this plan will include assessment of the process, the outcomes, and the long-term impacts of implementation at both the state and community levels. The current prevention infrastructure includes a Prevention System Evaluator and an evaluation plan.

Section 9: Sustainability

The OOP has been working on ways to sustain the entire prevention system. We recognize that the current system is not prepared to handle any significant reductions in SABG and discretionary grant funding as it comprises more than 90% of the funding for this office. As we continue to navigate financial changes and uncertainty, the OOP has repeatedly engaged the local communities in the SPF model, specifically addressing sustainability. Thus, the SPF model is the foundation for community ownership and collaboration. Collaborations are being established in communities with city, county officials, and various entities that should contribute to sustainability through local government allocations, existing grants, and additional grant opportunities of stakeholders. Our office apprises the prevention system of funding opportunities and support response to these opportunities through letters of support and collaboration. Further, the collection of annual data through the Annual Prevention Plan Monitoring form will allow agencies to communicate successful efforts to key groups and individuals, particularly decision makers who can allocate funding.

Section 10: 2019-2022 Strategic Goals

To achieve the OOP's vision and mission, we will strive to achieve the following strategic goals during FY2019-2022.

OOP Goals

1. With primary prevention as the focus, build emotional health, prevent or delay onset of, and mitigate symptoms and complications from substance abuse and mental illness through coordinated services;
2. Improve organizational business management systems at the state agency level;
3. Increase the capacity for workforce to address population needs;
4. Promote emotional health and wellness, prevent or delay the onset of and complications from substance abuse and mental illness, and identify and respond to emerging behavioral health issues;
5. Prevent and reduce underage drinking and young adult problem drinking;
6. Prevent and reduce prescription drug and illicit opioid misuse and abuse;
7. Prevent and reduce tobacco use;
8. Prevent and reduce substance-related attempted suicides and deaths by suicide among populations at high risk;
9. Develop a comprehensive evaluation system; and
10. Implement Synar[1] in the State of Alabama.

These goals are fully illustrated in the table that follows.

[1] Synar refers to the Synar amendment, which requires states to have laws in place prohibiting the sale and distribution of tobacco products to persons under the age of 18 and to enforce those laws effectively.

Appendices

Population Level Indicators for the State of Alabama

Indicators	Alabama
% of Illicit Drug Use in the Past Month ages 12 and older (2012-2013)	7.72
% of Alcohol Use in the Past Month ages 12 and older (2012-2013)	43.21
No. of Treatment Admissions	21607
% of Persons Killed & Driver Blood Alcohol Concentration (.08+) in Crash 2016 (FARS, 2012)	28
Poverty (U.S. Census, 2011)	19.1
No. of Suicides (2012)	721

Indicators	Alabama
% of Illicit Drug Use in the Past Month ages 12 and older (2015-2016)	7.10 (8.03 % decrease)
% of Alcohol Use in the Past Month ages 12 and older (2015-2016)	40.8 (5.58 % decrease)
No. of Treatment Admissions (ADMH, 2017)	25,185
% of Persons Killed & Driver Blood Alcohol Concentration (.08+) in Crash 2016 (FARS, 2016)	27 (3.57% decrease)
Poverty (U.S. Census, 2016)	17.2 (9.95% decrease)
No. of Suicides (2015)	748

County Level Indicators for the State of Alabama

310 Board	County	% of Treatment Admissions 2017 (ADMH)	% Persons Killed & Driver BAC (.08+) in Crash 2016 (FARS)	Prescribing Rate per 100 persons 2016 (CDC)	Suicide 2015 (ADPH)	% High School Graduate or Higher 2012-2016 (Census)	Poverty Rate 2016 (Census)
	Alabama	25185	27	121.0	748	84.8	17.2
1	COLBERT	456	18	208.1	9	83.4	16.7
1	FRANKLIN	245	8	223.3	4	75.7	20.1
1	LAUDERDALE	816	43	127.5	12	84.9	15.2
2	LAWRENCE	92	13	114.1	3	77.5	16.8
2	LIMESTONE	242	30	76.5	10	83.2	12.8
2	MORGAN	416	14	135.4	18	82.5	15.8
3	MADISON	1344	33	113.7	59	90.8	13.5
4	FAYETTE	115	35	133.3	4	79.2	20.3
4	LAMAR	96	35	104.7	1	77.4	18.6
4	MARION	246	3	182.1	7	79.9	18.5
4	WALKER	371	13	235.4	15	78.6	20.5
4	WINSTON	228	18	172.5	2	76.0	17.3
5	BLOUNT	182	28	56.9	10	80.0	14.1
5	JEFFERSON	5040	35	116.7	95	89.0	15.3
5	ST. CLAIR	274	27	114.4	15	83.5	12
6	CHEROKEE	197	24	157.7	2	81.3	16.8
6	DEKALB	725	32	114.4	12	72.6	20.5
6	ETOWAH	665	20	156.8	15	82.5	17.5
7	CALHOUN	637	26	161	24	82.3	17.1
7	CLEBURNE	48	23	44.2	1	74.2	17.2
8	BIBB	130	29	97.2	3	80.7	20.1
8	PICKENS	115	30	81.5	1	81.1	25.8
8	TUSCALOOSA	1068	26	111.2	18	88.1	17.6
9	CLAY	51	18	133.7	2	74.6	18.9
9	COOSA	32	12	25.4	3	72.9	17.5
9	RANDOLPH	45	40	108.8	6	77.3	21.8
9	TALLADEGA	285	37	138.9	20	79.8	18
10	CHOCTAW	34	37	97.8	3	78.9	22.7
10	GREENE	44	14	79.8	0	76.9	34
10	HALE	74	42	97.7	3	81.4	23.7
10	MARENGO	107	20	131.7	2	83.9	25.8
10	SUMTER	35	40	40.5	1	80.0	32.4
11	CHILTON	197	17	120.4	11	80.1	18.3

310 Board	County	% of Treatment Admissions 2017 (ADMH)	% Persons Killed & Driver BAC (.08+) in Crash 2016 (FARS)	Prescribing Rate per 100 persons 2016 (CDC)	Suicide 2015 (ADPH)	% High School Graduate or Higher 2012-2016 (Census)	Poverty Rate 2016 (Census)
11	SHELBY	650	22	100.7	33	91.6	7.9
12	CHAMBERS	259	21	140.6	5	80.3	19.9
12	LEE	603	21	64.5	17	88.7	18.3
12	RUSSELL	200	20	110.6	10	82.6	19.3
12	TALLAPOOSA	73	33	108	4	79.6	20.2
13	DALLAS	263	30	117.8	4	79.0	35.4
13	PERRY	23	50	3.6	0	76.4	35
13	WILCOX	14	33	66.4	1	79.9	31.9
14	AUTAUGA	206	31	129.6	9	87.6	13.5
14	ELMORE	260	35	117.3	13	86.8	13.5
14	LOWNDES	28	35	0.7	0	74.8	31.7
14	MONTGOMERY	1046	20	88	26	85.5	18.8
15	BULLOCK	8	88	19.8	1	66.6	32.6
15	MACON	54	12	60.1	3	80.5	30
15	PIKE	93	42	105.5	3	80.0	25.1
16	MOBILE	1704	32	133.5	66	85.8	19.5
16	WASHINGTON	33	48	44.3	3	79.7	18.2
17	CLARKE	43	10	164.7	0	81.0	29
17	CONECUH	44	40	93.9	1	79.4	28.1
17	ESCAMBIA	154	26	173.9	7	80.5	23.3
17	MONROE	59	19	135.7	8	82.0	25.7
18	BUTLER	70	16	135.4	1	81.1	24.8
18	COFFEE	77	49	129.5	5	85.1	14.4
18	COVINGTON	243	23	170.9	5	80.9	19.6
18	CRENSHAW	72	58	90.9	0	78.3	20.5
19	BARBOUR	97	20	92.7	1	73.8	29.9
19	DALE	284	13	78.7	9	85.8	20.6
19	GENEVA	203	25	50.2	5	77.7	20.9
19	HENRY	70	24	30.7	3	80.7	18.7
19	HOUSTON	993	33	142.8	21	84.9	19.4
20	JACKSON	567	18	144.6	12	79.5	17.5
20	MARSHALL	952	27	191.1	18	78.6	21
21	BALDWIN	471	28	123.8	45	90.0	11.7
22	CULLMAN	440	16	166.2	18	82.2	14.9

FY19-22 Prevention Goals and Deliverables[2]

Prevention System Organization and Implementation

Goal 1 With primary prevention as the focus, build emotional health, prevent or delay onset of, and mitigate symptoms and complications from substance abuse and mental illness through coordinated services.

Objective: Build and develop prevention prepared communities.

Action Step	Status	Primary POC	Secondary	Start Date	End Date	Total # of Days	Target Date	Metrics	Progress
1. Establish sufficient distribution of prevention strategies throughout the state.		Ashley R.	Beverly				Ongoing	Percentage distribution should be 50% Environmental followed by CBP, Alternatives, and other strategies.	
2. Increase PIDR, community-based strategies and alternative activities.		Ashley R.	Beverly				FY19-FY22	Increase the FY20 strategy distribution over the FY19 distribution.	
3. Issue RFP to ensure prevention services and strategies are represented throughout the state.		Beverly	Ashley R.				FY19	Statewide RFP issued in FY19.	

4. Promote collaborative relationships between prevention providers, coalitions, drug free communities, tribes, and multiple community sectors, including education, business, justice, housing, healthcare, and other relevant fields that are culturally representative and inclusive of the LGBTQ community, military members/veterans and their families, rural and underserved populations.		Team					FY19-22	Increase the number of of collaborations across entities and disciplines.	
5. Apply for and secure additional funding thorough grants such as PFS, SPF Rx, STR and SOR.		Beverly	Team				FY19-22	Make successful application for SOR in FY19.	
6. Increase services in		Beverly	Team				FY20	Statewide RFP issued in FY19.	

underserved areas of the state.									
7. Expand the reach of prevention funds.		Beverly	Team				FY19	Statewide RFP issued in FY19.	
8. Implement funding allocation model to assist in the distribution of SABG.		Beverly	Team				FY19	FY19 RFP scored and providers identified.	

Goal 2 Improve organizational business management systems at the state agency level.

Objective: Develop sound management practices within the Office of Prevention.

Action Step	Status	Primary POC	Secondary	Start Date	End Date	Total # of Days	Target Date	Metrics	Progress
1. Ensure prevention planning correlates with national efforts, SABG goals, results of statewide needs assessment, and epidemiological profile.		Beverly	Team				FY19-22	Prevention goals correlate with national efforts, SABG goals, results of statewide needs assessment, and epidemiological profile.	
2. Develop Continuity practical guidelines.		Team					FY19-22	Each quarter of the FY, develop at least 1 Continuity practical guideline per Office of Prevention staff member.	

Objective: Increase collaborative role of the AEOW and SPAB

Action Step	Status	Primary POC	Secondary	Start Date	End Date	Total # of Days	Target Date	Metrics	Progress

1. Promote engagement between AEOW, SPAB and their role in the prevention system.		Catina	Beverly				FY19	Increase engagements of AEOW & SPAB members with the prevention system efforts	

Objective: Produce and disseminate data/ information to appropriate audiences (e.g., community prevention planners, state and local officials, policy makers and the general public).

Action Step	Status	Primary POC	Secondary	Start Date	End Date	Total # of Days	Target Date	Metrics	Progress
1. Perform a comprehensive update of the epidemiological profile to include state and county level data. (Every two years)		Catina	AEOW				FY20	Comprehensive Epi profile published Oct. 2016 for state and inclusive of county data.	
2. Develop topic-specific fact sheets using Epidemiological profile.		Catina	AEOW				FY19	Two topic specific fact sheets each FY posted to ADMH website.	

Workforce Development and Capacity Building

Goal 1 Increase the capacity for workforce to address population needs.

Objective: Develop prevention workforce.

Action Step	Status	Primary POC	Secondary	Start Date	End Date	Total # of Days	Target Date	Metrics	Progress
1. Conduct workforce		Beverly	Ashley R.				FY19-22	Quarterly occurrence of WFD.	

development opportunities.									
2. Promote/provide prevention theory study groups for certification prep.		Consultants					FY19-22	Twelve groups conducted in a FY.	

Implementation

Goal 1 Promote emotional health and wellness, prevent or delay the onset of and complications from substance abuse and mental illness, and identify and respond to emerging behavioral health issues.

Objective: Promote emotional health and wellness within the prevention system.

Action Step	Status	Primary POC	Secondary	Start Date	End Date	Total # of Days	Target Date	Metrics	Progress
1. Educate providers on emotional health and wellness integration.		Consultants					FY19-22	Deliver 2 education sessions each FY.	
2. Ensure prevention plans take a comprehensive approach to addressing emotional health and wellness across strategies.		Consultants	Ashley R.				FY19-22	Increase the FY19 focus of effort distribution over the FY18 distribution.	
3. Prevent or delay the onset of complications of substance abuse		Team	System				FY19-22	Reduce the percentage of persons reporting substance use in the past 30 days and reporting major	

and mental illness.								depressive episodes in the year.	

Goal 2 Prevent and reduce underage drinking and young adult problem drinking.									
Objective: Promote the prevention of underage drinking and young adult problem drinking.									
Action Step	**Status**	**Primary POC**	**Secondary**	**Start Date**	**End Date**	**Total # of Days**	**Target Date**	**Metrics**	**Progress**
1. Ensure prevention plans take a comprehensive approach to addressing underage drinking across strategies to include mobilizing communities through town hall meetings.		Consultants	Ashley R.				FY19-22	Increase the FY19 focus of effort distribution over the FY18 distribution.	
2. Collaborate and support the ABC compliance checks and the minor operative program.		Beverly	Team				FY19-22	FY19-22 funding to ABC.	
3. Educate the prevention system on underage drinking and		Consultants	ABC				FY19-22	Deliver 2 education sessions each FY.	

young adult problem drinking.									
4. Prevent and reduce underage drinking and young adult problem drinking and its negative consequences.		Team	System				FY19-22	Decrease the percentage of youth aged 12-20 engaged in underage drinking and reporting alcohol use or binge drinking in the past 30 days.	
5. Enhance SPF sub-recipients sustainability, implementation and evaluation.		Brandon	Tafeni, Necoal				FY19-22	Increase the number of education sessions and TA on these topics.	

Goal 3 Prevent and reduce prescription drug and illicit opioid misuse and abuse.

Objective: Promote the prevention or reduction of illicit and prescription drug misuse and abuse.

Action Step	Status	Primary POC	Secondary	Start Date	End Date	Total # of Days	Target Date	Metrics	Progress
1. Ensure prevention plans address illicit and prescription drug misuse, use, and abuse across strategies.		Brandon/Lauren	Necoal				FY19-22	Increase the FY19 focus of effort distribution over the FY18 distribution.	
2. Support planning and implementation of prescription drug take-back program.		Beverly	Brandon				FY19-22	Sustain the # of participating agencies and/or the # of pounds collected statewide.	

3. Expand participation in prescription drug take-back program.		Brandon	Necoal				April of each fiscal year	Increase the # of participants in FY19 over FY18.	
4. Educate the prevention system on prescription drug and illicit opioid misuse and abuse.		Consultants					FY19-22	Deliver 2 education sessions each FY.	
5. Prevent and reduce prescription drug and illicit opioid misuse and abuse.		Team	System				FY19-22	Reduce the number of opioid overdoses, overdoes-related deaths, and prevalence of opioid dependence.	

Goal 4 Prevent and reduce tobacco use.

Objective: Promote the prevention of tobacco use among youth and persons with mental and substance use disorders.

Action Step	Status	Primary POC	Secondary	Start Date	End Date	Total # of Days	Target Date	Metrics	Progress
1. Collaborate with ABC, ADPH, and the Youth Access to Tobacco Advisory Board.		Beverly	Team				FY19-22	FY19-22 funding to ABC & ADPH and attendance at YATAB.	
2. Support SYNAR efforts.		Beverly	Sondra, Consultants				FY19-22	FY18 Coverage Study completion. FY19-22 ASR completion. FY Synar Workshop attendance.	
3. Promote tobacco-free initiatives in		Team					FY19-22		

mental health, substance abuse treatment, and community-based prevention efforts.									
4. Educate the prevention system on tobacco use.		Sondra	Consultants				FY19-22	Deliver 2 education sessions each FY.	
5. Prevent and reduce tobacco use among youth and persons with mental and substance use disorders.		Team	System				FY19-22	Reduce the percentage of youth aged 12-17 and persons with mental and substance use disorders reporting tobacco use in the past 30 days.	

Goal 5 Prevent and reduce substance-related attempted suicides and deaths by suicide among populations at high risk.

Objective: Promote the prevention of attempted suicides and deaths by suicide among those at high risk (white non-Hispanic males, elderly-70+, American Indian, military, etc.) for suicide.

Action Step	Status	Primary POC	Secondary	Start Date	End Date	Total # of Days	Target Date	Metrics	Progress
1. Participate and collaborate with the Suicide Prevention Task Force.		Beverly	Lauren				FY19-22	Attendance at ASPARC meetings.	
2. Educate the prevention system on suicide and effective practices and resources for the prevention of suicide as it relates to substance abuse.		Beverly	Lauren				FY19-22	Participation in 2 Information Dissemination or Education sessions each FY.	

3. Ensure prevention plans address suicide and its relationship with substance use.		Ashley R.	Consultants				FY19-22	Increase the FY19 focus of effort distribution over the FY18 distribution.	
4. Prevent and reduce substance-related suicides among populations at high risk.		Team	System				FY19-22	Reduce the number of suicide attempts and deaths by suicide.	

Evaluation

Goal 1 Develop a comprehensive evaluation system.

Objective: Utilize evaluation to inform decision making in the prevention system of Alabama.

Action Step	Status	Primary POC	Secondary	Start Date	End Date	Total # of Days	Target Date	Metrics	Progress
1. Secure evaluation services.		Beverly					FY19	Contracted Evaluator Services	
2. Develop a plan for evaluation.		Evaluator					FY19	Evaluation plan	
3. Collaborate with Evaluator and IT staff to improve collection of prevention information to include performance indicators to measure and document success.		Evaluator	IT, Ashley R.				FY19-22	Evaluator secured in FY19. Ensure performance measures established in FY19 RFP are sufficient.	

4. Develop or secure a statewide survey.		Evaluator	Team				FY20	Statewide survey	

State Synar Program Compliance

Goal 1 Implement Synar in the State of Alabama.

Objective: Achieve compliance in accordance with federal standards.

Action Step	Status	Primary POC	Secondary	Start Date	End Date	Total # of Days	Target Date	Metrics	Progress
1. Collaborate with ADPH and ABC.		Beverly	ADPH, ABC					Contract with ADPH & ABC.	
2. Support provider efforts around compliance checks.		Team						# of providers with compliance checks within strategy.	
3. Conduct coverage study.		Consultants	Catina				FY19	Completed coverage study.	
4. Develop Annual Synar Report		ADPH	Beverly				FY19-22	Submitted ASR to SAMSHA.	

[2]Quarterly updates monitor progress toward prevention goals and deliverables and provide information for midcourse adjustments, if applicable.

Environmental Factors and Plan

10. Substance Use Disorder Treatment - Required SABG

Narrative Question

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services

i)	Screening	(•) Yes ( ) No
ii)	Education	(•) Yes ( ) No
iii)	Brief Intervention	(•) Yes ( ) No
iv)	Assessment	(•) Yes ( ) No
v)	Detox (inpatient/social)	(•) Yes ( ) No
vi)	Outpatient	(•) Yes ( ) No
vii)	Intensive Outpatient	(•) Yes ( ) No
viii)	Inpatient/Residential	(•) Yes ( ) No
ix)	Aftercare; Recovery support	(•) Yes ( ) No

b) Services for special populations:

Targeted services for veterans?	(•) Yes ( ) No
Adolescents?	(•) Yes ( ) No
Other Adults?	(•) Yes ( ) No
Medication-Assisted Treatment (MAT)?	(•) Yes ( ) No

Criterion 2: Improving Access and Addressing Primary Prevention -See Narrative 8. Primary Prevention-Required SABG.

Criterion 2

Criterion 3

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability? (•) Yes ( ) No

2. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities? (•) Yes ( ) No

3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care? (•) Yes ( ) No

4. Does your state have an arrangement for ensuring the provision of required supportive services? (•) Yes ( ) No

5 Has your state identified a need for any of the following:

- **a)** Open assessment and intake scheduling (•) Yes ( ) No
- **b)** Establishment of an electronic system to identify available treatment slots (•) Yes ( ) No
- **c)** Expanded community network for supportive services and healthcare (•) Yes ( ) No
- **d)** Inclusion of recovery support services (•) Yes ( ) No
- **e)** Health navigators to assist clients with community linkages (•) Yes ( ) No
- **f)** Expanded capability for family services, relationship restoration, and custody issues? (•) Yes ( ) No
- **g)** Providing employment assistance (•) Yes ( ) No
- **h)** Providing transportation to and from services (•) Yes ( ) No
- **i)** Educational assistance (•) Yes ( ) No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

The state completes SABG contract compliance monitoring during each fiscal year with all providers who received block grant funding. The tool used for the monitoring, along with policies and procedures, are included in the attachments section.

Criterion 4,5&6

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:

- **a)** 90 percent capacity reporting requirement — (●) Yes ( ) No
- **b)** 14-120 day performance requirement with provision of interim services — (●) Yes ( ) No
- **c)** Outreach activities — (●) Yes ( ) No
- **d)** Syringe services programs, if applicable — ( ) Yes (●) No
- **e)** Monitoring requirements as outlined in the authorizing statute and implementing regulation — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Electronic system with alert when 90 percent capacity is reached — (●) Yes ( ) No
- **b)** Automatic reminder system associated with 14-120 day performance requirement — (●) Yes ( ) No
- **c)** Use of peer recovery supports to maintain contact and support — (●) Yes ( ) No
- **d)** Service expansion to specific populations (e.g., military families, veterans, adolescents, older adults)? — (●) Yes ( ) No

3. States are required to monitor program compliance related to activites and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

SABG compliance monitoring tool, along with the associated policies and procedures, are included in the attachments. Policies and procedures include information on identification and resolution of any compliance issues.

Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery? — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Business agreement/MOU with primary healthcare providers — (●) Yes ( ) No
- **b)** Cooperative agreement/MOU with public health entity for testing and treatment — (●) Yes ( ) No
- **c)** Established co-located SUD professionals within FQHCs — (●) Yes ( ) No

3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

SABG compliance monitoring tool, along with the associated policies and procedures, are included in the attachments. Policies and procedures include information on identification and resolution of any compliance issues.

Early Intervention Services for HIV (for "Designated States" Only)

1. Does your state currently have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring the service delivery? — ( ) Yes (●) No

2. Has your state identified a need for any of the following:

- **a)** Establishment of EIS-HIV service hubs in rural areas — ( ) Yes (●) No
- **b)** Establishment or expansion of tele-health and social media support services — ( ) Yes (●) No
- **c)** Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS — ( ) Yes (●) No

Syringe Service Programs

1. Does your state have in place an agreement to ensure that SABG funds are NOT expended to provide individuals with hypodermic needles or syringes(42 U.S.CÂ§ 300x-31(a)(1)F)? — (●) Yes ( ) No

2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program? ○ Yes ◉ No

3. Do any of the programs use SABG funds to support elements of a Syringe Services Program? ○ Yes ◉ No

If yes, plese provide a brief description of the elements and the arrangement

Criterion 8,9&10

Service System Needs

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Workforce development efforts to expand service access — (●) Yes ( ) No
- **b)** Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services — (●) Yes ( ) No
- **c)** Establish a peer recovery support network to assist in filling the gaps — (●) Yes ( ) No
- **d)** Incorporate input from special populations (military families, service memebers, veterans, tribal entities, older adults, sexual and gender minorities) — (●) Yes ( ) No
- **e)** Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations — (●) Yes ( ) No
- **f)** Explore expansion of services for:
  - **i)** MAT — (●) Yes ( ) No
  - **ii)** Tele-Health — (●) Yes ( ) No
  - **iii)** Social Media Outreach — (●) Yes ( ) No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person -centered and person-directed care? — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services — (●) Yes ( ) No
- **b)** Establish a program to provide trauma-informed care — (●) Yes ( ) No
- **c)** Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education — (●) Yes ( ) No

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C.§ 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449)? — (●) Yes ( ) No

2. Does your state provide any of the following:

- **a)** Notice to Program Beneficiaries — ( ) Yes (●) No
- **b)** An organized referral system to identify alternative providers? — (●) Yes ( ) No
- **c)** A system to maintain a list of referrals made by religious organizations? — ( ) Yes (●) No

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs? — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Review and update of screening and assessment instruments — (●) Yes ( ) No
- **b)** Review of current levels of care to determine changes or additions — (●) Yes ( ) No
- **c)** Identify workforce needs to expand service capabilities — ( ) Yes ( ) No

d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background — (•) Yes ( ) No

Patient Records

1. Does your state have an agreement to ensure the protection of client records? — (•) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Training staff and community partners on confidentiality requirements — (•) Yes ( ) No

b) Training on responding to requests asking for acknowledgement of the presence of clients — (•) Yes ( ) No

c) Updating written procedures which regulate and control access to records — (•) Yes ( ) No

d) Review and update of the procedure by which clients are notified of the confidentiality of their records including the exceptions for disclosure: — (•) Yes ( ) No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers? — (•) Yes ( ) No

2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C.§ 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

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3. Has your state identified a need for any of the following:

a) Development of a quality improvement plan — (•) Yes ( ) No

b) Establishment of policies and procedures related to independent peer review — (•) Yes ( ) No

c) Development of long-term planning for service revision and expansion to meet the needs of specific populations — (•) Yes ( ) No

4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds? — ( ) Yes (•) No

If Yes, please identify the accreditation organization(s)

i) [ ] Commission on the Accreditation of Rehabilitation Facilities

ii) [ ] The Joint Commission

iii) [ ] Other (please specify)

Criterion 7&11

Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program? ○ Yes ◉ No

2. Has your state identified a need for any of the following:

- **a)** Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service ○ Yes ◉ No
- **b)** Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing ○ Yes ◉ No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:

- **a)** Recent trends in substance use disorders in the state ◉ Yes ○ No
- **b)** Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services ◉ Yes ○ No
- **c)** Performance-based accountability: ◉ Yes ○ No
- **d)** Data collection and reporting requirements ◉ Yes ○ No

2. Has your state identified a need for any of the following:

- **a)** A comprehensive review of the current training schedule and identification of additional training needs ◉ Yes ○ No
- **b)** Addition of training sessions designed to increase employee understanding of recovery support services ◉ Yes ○ No
- **c)** Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services ◉ Yes ○ No
- **d)** State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort ◉ Yes ○ No

3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers (TTCs)?

- **a)** Prevention TTC? ◉ Yes ○ No
- **b)** Mental Health TTC? ○ Yes ◉ No
- **c)** Addiction TTC? ◉ Yes ○ No
- **d)** State Targeted Response TTC? ◉ Yes ○ No

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924. and 1928 (42 U.S.C.§ 300x-32 (f)).

1. Is your state considering requesting a waiver of any requirements related to:

- **a)** Allocations regarding women ○ Yes ◉ No

2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:

- **a)** Tuberculosis ○ Yes ◉ No
- **b)** Early Intervention Services Regarding HIV ○ Yes ◉ No

3. Additional Agreements

- **a)** Improvement of Process for Appropriate Referrals for Treatment ○ Yes ◉ No
- **b)** Professional Development ○ Yes ◉ No

c) Coordination of Various Activities and Services ○ Yes ◉ No

Please provide a link to the state administrative regulations that govern the Mental Health and Substance Use Disorder Programs.

http://www.alabamaadministrativecode.state.al.us/docs/mhlth/index.html

Footnotes:

Alabama Department of Mental Health
Office of Substance Abuse Treatment Services (OSATS)
Contract and SAPT Block Grant
Program Compliance Monitoring Survey

Agency: _____ Levels of Care Provided: _____

Date: _____ Reviewer Name: _____

Certain Allocations: 45 CFR 96.124 Required Services for Programs Receiving SAPTBG funds set aside for pregnant women and women with dependent children:

		Written policy and procedure	Evidence of Compliance and Implementation	Page number in P&P Manual	Comments (Including examples of implementation)
1	The program provides services to pregnant women and women with dependent children, including women who are attempting to regain custody of their children.				
2	The program treats the family as a unit and therefore admits both women and their children into treatment services, if appropriate.				
3	The program provides or arranges for:				
a.	Primary medical care for women, including prenatal care.				
b.	Childcare while the women are receiving services.				
c.	Primary pediatric care for the women's children, including immunizations.				
d.	Gender specific treatment and other therapeutic interventions for women which may address issues of relationships, sexual and physical abuse, and parenting.				
e.	Therapeutic interventions for children in custody of women in treatment which may address developmental needs, sexual/physical abuse, and neglect.				
f.	Sufficient case management and transportation to ensure that women and their children have access to services needed during the course of treatment.				
	Corrective Action Required:				
	Technical Assistance Recommended:				

Findings/Corrective Action:

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45 CFR 96.126 Capacity of treatment for intravenous substance abusers:

		Written policy and procedure	Evidence of Compliance and Implementation	Page number in P&P Manual	Comments (Including examples of implementation)
1	The program provides treatment and related therapeutic services to individuals who are IV substance abusers.				
2	No later than 7 days after reaching 90% of its capacity to admit individuals, the program notifies the agencies program manager of that fact.				
3	Each individual who requests and is in need of treatment for IV drug use is admitted not later than:				
a.	14 days after making the request for admission; or				
b.	120 days after the date of the request for admission if no such program has the capacity to admit at the time of the initial request, and				
c.	Interim services are made available no later than 48 hours after the initial request for admission.				
4	At a minimum, interim services provided by the program include:				
a.	Counseling and education about HIV and Tuberculosis;				
b.	Risks of needle sharing;				
c.	Risks of transmission to sexual partners and infants;				
d.	Steps that can be taken to ensure that HIV and Tuberculosis transmission does not occur; and				
e.	Referral for HIV or Tuberculosis treatment services if necessary.				
	In addition, interim services for pregnant substance abusers shall include:				
f.	Counseling on the effects of alcohol and drug use on the fetus; and				
g.	Referral for pre-natal care.				
5	Completion of quarterly interim service reports to OSATS office in required time frame.				
6	The program has established a formal waiting list process that includes:				
a.	A unique identifier for each injecting drug abuser seeking treatment;				
b.	A unique identifier for each injecting drug abuser receiving interim services while awaiting admission to treatment; and				
c.	Procedures for maintaining contact with individuals awaiting admission for IV drug treatment.				
7	The program consults the capacity management system (SAIS) so that patients on waiting lists are admitted at the earliest possible time to a program providing treatment within a reasonable geographic area.				
8	The program ensures that individuals actively awaiting treatment admission remain on the program's waiting list unless:				
a.	The person cannot be located for admission.				
b.	The person refuses treatment.				
c.	The person requests to be removed from the waiting list.				

continuation of **45 CFR 96.126** Capacity of treatment for intravenous substance abusers:

		Written policy and procedure	Evidence of Compliance and Implementation	Page number in P&P Manual	Comments (Including examples of implementation)
9	The program carries out formal activities to encourage individuals in need of IV drug use treatment to undergo such treatment that consists of:				
a.	Scientifically sound outreach models; or				
b.	An approach which reasonably can be expected to be an effective outreach model.				
10	All models shall require that outreach efforts include the following:				
a.	Selecting, training, and supervising outreach workers.				
b.	Contacting, communicating and following up with high-risk substance abusers, their associates, and neighborhood residents within the constraints of Federal and State confidentiality and privacy requirements, including 42 CFR Part 2, and 45 CFR Parts 160 and 164.				
c.	Promoting awareness among injecting drug abusers about the relationship between injecting drug abuse and communicable diseases such as HIV.				
d.	Recommending steps that can be taken to ensure that HIV transmission does not occur.				
e.	Encouraging entry into treatment.				
f.	Completion of outreach log and quarterly reports to OSATS office in the required time frame.				
	Corrective Action Required:				
	Technical Assistance Recommended:				

Findings/Corrective Action:

45 CFR 96.127 Requirements regarding Tuberculosis:

		Written policy and procedure	Evidence of Compliance and Implementation	Page number in P&P Manual	Comments (Including examples of implementation)
1	The program, directly or through arrangements with other public or nonprofit entities, routinely makes available the following tuberculosis services to each individual receiving treatment for substance abuse:				
a.	Counseling the individual with respect to tuberculosis.				
b.	Testing to determine whether the individual has been infected with mycobacteria tuberculosis to determine the appropriate form of treatment for the individual.				
c.	Providing for or referring the individuals infected by mycobacteria tuberculosis for appropriate medical evaluation and treatment.				
2	The program has implemented infection control procedures that are consistent with standards established by the Alabama Department of Public Health to prevent the transmission of tuberculosis and include the following:				
a.	Screening all patients who are admitted to a certified substance use program.				
b.	Identification of those individuals who are at high risk of becoming infected;				
c.	Meeting all State reporting requirements, while adhering to Federal and State confidentiality requirements, including 42 CFR Part 2, and 45 CFR parts 160 and 164 to include reporting individuals identified with active tuberculosis to the appropriate State official as required by law; and				
d.	Case management activities to ensure that individuals receive all tuberculosis services described.				
3	For individuals who are denied admission to treatment due to a lack of the program's capacity, the program refers the individual to another provider of tuberculosis services.				
4	If the program is using the ADMH TB Risk Screening Questionnaire, the program will ensure that staff are trained in the use of the tool.				
	Corrective Action Required:				
	Technical Assistance Recommended:				

Findings/Corrective Action:

45 CFR 96.128 Requirements regarding Human Immunodeficiency Virus:

		Written policy and procedure	Evidence of Compliance and Implementation	Page number in P&P Manual	Comments (Including examples of implementation)
1	The program makes available early intervention services for HIV disease to individuals undergoing treatment for substance abuse at the sites where individuals are undergoing such treatment including:				
a.	HIV/AIDS and EIS education and information.				
b.	Appropriate pre-test counseling for HIV and AIDS.				
c.	Rapid HIV on site testing which must have a CLIA Waiver.				
d.	The provision of /or referral for:				
i.	Laboratory testing to confirm the presence of the disease.				
ii.	Test to diagnose the extent of the deficiency in the immune system.				
iii.	Services to provide information on appropriate therapeutic measures for preventing and treating the deterioration of the immune system.				
iv.	Services for preventing and treating conditions arising from the disease; and				
v.	Appropriate post-test counseling.				
vi.	Case management to ensure the individuals receive all HIV services described in this section.				
vii.	Peer support to facilitate patient engagement in and adherence to recommended HIV/AIDS prevention and treatment regimens.				
2	The program has linkages with a comprehensive community resource network of HIV/AIDS related health and social services organizations to ensure a wide-based knowledge of the availability of the program's HIV early intervention services and to facilitate referrals which are demonstrated though memoranda of understandings.				
3	The program follows all procedures established by the Alabama Department of Mental Health, in cooperation with the Alabama Department of Public Health Communicable Disease Officer, in regard to the provision of HIV early intervention services.				
4	The program will ensure and document that HIV early intervention services will be undertaken voluntarily by, and with the informed consent of the individual, and undergoing such services will not be required as a condition of receiving treatment services for substance abuse or any other services.				
5	The program will formally notify all patients of the availability of HIV EIS and any terms and conditions for participation and document that such notification occurred.				

45 CFR 96.131 Treatment services for pregnant women:

		Written policy and procedure	Evidence of Compliance and Implementation	Page number in P&P Manual	Comments (Including examples of implementation)
1	The program gives preference in admission to individuals with substance use disorders in the following priority.				
a.	Pregnant individuals with intravenous (IV) substance use disorders.				
b.	Pregnant individuals with substance use disorders.				
c.	All other individuals with IV substance use disorders.				
d.	Women with substance use disorders and dependent children.				
e.	Individualls who are HIV positive.				
f.	All other individuals with substance use disorders.				
2	The program publicizes the availability of treatment services for women and the fact that pregnant women receive preference for admission which may be done by using a variety of the following mechanisms:				
a.	Street outreach programs (e.g.., jail, homeless shelters, FQHCs).				
b.	Ongoing radio/television public service announcements.				
d.	Regular advertisements in local/regional print media.				
e.	Posters placed in targeted areas.				
f.	Frequent notification of availability of such treatment distributed to a network of community-based organizations, healthcare providers, and social service agencies.				
g.	Other (e.g.., website, brochures)				
3	When the program has insufficient capacity to provide treatment services for a pregnant woman who seeks services from the facility, the program refers the woman to the Substance Abuse Services Division of the Alabama Department of Mental Health, Special Women's Coordinator, for referral to another appropriate treatment facility.				
4	When the State determines no treatment facility has the capacity to admit a pregnant woman, the program makes available interim services within forty-eight hours of the woman's request for care.				
5	The program submits data to and utilizes SAIS (the state's capacity management program) to ensure that pregnant women receive priority treatment and referral services as appropriate.				
	Corrective Action Required:				
	Technical Assistance Recommended:				

Findings/Corrective Action:

45 CFR 96.132 Additional Agreements:

		Written policy and procedure	Evidence of Compliance and Implementation	Page number in P&P Manual	Comments (Including examples of implementation)
1	The program utilizes ADMH's Substance Abuse Information System (SAIS) for capacity/waiting list management.				
2	The program follows all ADMH policies, procedures and timelines established in regards to the following:				
a.	Patients are enrolled in SAIS.				
b.	Patient admission records are established in SAIS.				
c.	Referrals for admission/continued care are made to other providers through SAIS.				
d.	Patient referral/transfer records are established in SAIS.				
e.	Patient discharge records are established in SAIS within 45 days of last service provision.				
f.	Referrals received through SAIS are managed by the program and are either accepted for or denied placement on the program's waiting list.				
g.	The program prioritizes individuals on the admissions waiting list according to established priority populations.				
h.	The program has developed and implements a formal process for maintaining contact with individuals placed on the waiting list.				
i.	The program provides interim services for patients on the waiting list.				
3	The program provides continuing education for employees according to rules established by SASD.				
4	The program coordinates the provision of treatment services with the provision of other appropriate services, including physical and mental health, social, correctional and criminal justice, educational, vocational rehabilitation, housing support and employment services through the existence of memoranda of understandings.				
5	The program has in effect a system to protect patient records from inappropriate disclosure that is in compliance with all applicable State and Federal laws and regulations, including 45 CFR Parts 160 and 164 and 42 CFR Part 2.				
6	The program provides employee education on confidentiality requirements.				
7	The program provides for employee disciplinary action upon inappropriate disclosure of patient information				
	Corrective Action Required:				
	Technical Assistance Recommended:				

Findings/Corrective Action:

45 CFR 96.135 Restrictions on Expenditures of Grant:

		Written policy	Page number in P&P Manual	Comments (Including examples of implementation)
1	The program does not expend SABG/ADMH Grant funds on the following activities:			
a.	To make cash payments to intended recipients of health services.			
b.	To purchase or improve, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment.			
c.	To satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds.			
d.	To provide financial assistance to any entity other than a public or nonprofit, private entity.			
e.	To provide individuals with hypodermic needles or syringes.			
f.	To provide treatment services in penal or correctional institutions of the State.			
g.	To pay the salary of any individual at a rate in excess of Level I of the Executive Salary Schedule for the award year.			
2	The program will not expend SABG/ADMH Block Grant funds to provide inpatient hospital substance abuse services, except in cases in which each of the following conditions have been met:			
a.	The daily rate provided to the hospital for providing services does not exceed the comparable daily rate provided by a community-based, nonhospital, residential treatment program; and			
b.	A physician makes a determination that the following conditions have been met:			
i.	The primary diagnosis of the individual is substance abuse, and the physician certifies that fact;			
ii.	The individual cannot be safely treated in a community-based, nonhospital, residential treatment program;			
iii.	The service can reasonably be expected to improve the person's condition or level of functioning; and			
iv.	The hospital-based substance abuse program follows national standards of substance abuse professional practice.			
c.	The service is provided only to the extent that it is medically necessary.			
	Corrective Action Required:			
	Technical Assistance Recommended:			

Findings/Corrective Action:

45 CFR 96.137 Payment Schedule:

		Written policy and procedure	Evidence of Compliance and Implementation	Page number in P&P Manual	Comments (Including examples of implementation)
1	The program expends SABG Grant/ADMH funds to provide services, including services for pregnant women and women with dependent children, Tuberculosis services, and HIV services, for individuals who have no other financial means of obtaining such services.				
2	The program has established the SAPT Block Grant/ADMH as payment of last resort for the provision of treatment services.				
3	The program will actively pursue and make every reasonable effort to do the following:				
a.	Collect reimbursements for the costs of providing services to persons entitled to:				
i.	Insurance under the Social Security Act, including programs under Title XVIII and Title XIX.				
ii.	Any State compensation program.				
iii.	Any other public assistance program for medical expenses				
iv.	Any grant program				
v.	Any private health insurance				
vi.	Any other benefit program				
b.	Secure from patients payments for services in accordance with their ability to pay.				
4	The program establishes a process for determining a patient's ability to pay by the use of an individual financial assessment which shall include proof of such assessment to be maintained in the patient's chart.				
5	The program will charge fees to adult patients based on a sliding fee schedule that shall include zero dollar fees, or, have a process by which the full fee can be waived.				
6	A process describing access to care for individuals who cannot pay admission or intake fees.				
7	The program does not refuse services to patients due to their inability to pay a service fee, to the extent that other resources are available for payment.				
8	The program does not bill multiple payment sources for the same patient service procedure.				
	Corrective Action Required:				
	Technical Assistance Recommended:				

Findings/Corrective Action:

42 CFR Parts 54 and 54a: Charitable Choice

	new life-website says faith based; family life says the same; the shoulder	**Written policy and procedure**	**Evidence of Compliance and Implementation**	**Page number in P&P Manual**	**Comments (Including examples of implementation)**
1	The program provides religious-based substance abuse services in addition to Federally funded substance use disorders treatment services funded by ADMH.				
2	A religious organization provides direct services for individuals enrolled in the program's ADMH certified federally funded program.				
3	The program understands and agrees to comply with the Substance Abuse and Mental Health Services Administration (SAMHSA) Charitable Choice statutes codified at sections 581-584 and 1955 of the Public Health Service Act (42 U.S.C. §§290kk, et seq., and 300x-65) and their governing regulations at 42 C.F.R. Parts 54 and 54a, respectively.				
4	The organization does not use Federal funds provided by ADMH for activities involving worship, religious instruction, or proselytization.				
5	In delivering services funded by ADMH, including outreach activities, the program does not discriminate against current or prospective program participants based on:				
a.	Religion;				
b.	Religious belief;				
c.	Refusal to hold a religious belief;				
d.	Refusal to actively participate in a religious practice.				
6	The program provides written notice to each program participant and each prospective program participant, when possible, of the individual's right to object to the religious nature of the ADMH funded program or services and to receive services from an alternative provider.				
7	Otherwise eligible participants who object to the religious character of Federally funded services are referred to alternative providers within a reasonable period of time of the objection.				
8	In making referrals as specified, the program considers any list that the State or local government makes available to entities in the geographic area that provide program services, which may include utilizing any treatment locator system developed by SAMHSA.				
9	Referrals are made in a manner consistent with all applicable privacy and confidentiality laws.				
10	Upon referring a program participant to an alternative provider, the program immediately notifies ADMH of the referral.				
11	The program ensures that the program beneficiary makes contact with the alternative provider to which he or she is referred.				
12	The organization uses generally accepted auditing and accounting principles to account for all Federal funds.				

		Written policy and procedure	Evidence of Compliance and Implementation	Page number in P&P Manual	Comments (Including examples of implementation)
13	The organization segregates Federal funds from non-Federal funds.				
14	The organization subjects Federal funds to an audit by the government.				
	Corrective Action Required:				
	Technical Assistance Recommended:				

Findings/Corrective Action:

Indigent Offenders: DMH Contract

		Written policy and procedure	Evidence of Compliance and Implementation	Page number in P&P Manual	Comments (Including examples of implementation)
1	The program provides treatment and related therapeutic services to individuals who are categorized indigent by the courts.				
a.	A court order declaring indigent status is maintained in the patient's program chart.				
b.	Ability / inability to pay is substantiated throughout the provision of services.				
c.	Waivers of fees are revoked when patient income exceeds indigent status level.				
	Corrective Action Required:				
	Technical Assistance Recommended:				

Findings/Corrective Action:

Other ADMH Requirements:

		Written policy and procedure	Evidence of Compliance and Implementation	Page number in P&P Manual	Comments (Including examples of implementation)
1	The program provides unimpeded access to patients by Department of Mental Health advocates.				
2	The program verifies U.S. citizenship for all patients for whom services are billed to ADMH.				
3	HIV risk education, including prevention information, is provided to each patient.				
4	The program routinely screens it's employees, including directors, owners and subcontractors, to establish if they have been debarred, suspended or otherwise excludeed, utilitizing the OIG website.				
5	The program maintains up to date program descriptions and provide services in accordance with the approved program descriptions that are on file at ADMH.				
6	The program cooperates with ADMH Office of Deaf Services (ODS) and informs ODS when a client who is deaf/hard of hearing presents for services and involves ODS in treatment planning for such clients.				
7	The program provides and documents clinical supervision of qualified substance abuse professionals in accordance with the following:				
a.	Clinical supervision must be based on a written supervision plan which:				
i.	Promotes professional knowledge, skills and values development;				
ii.	Models ethical standards of practice; and				
iii.	Promotes cultural competency;				
b.	Monitoring and evaluation of the supervisee's performance of service delivery to include service planning and assessment functions.				
c.	Documentation of the supervision must be recorded and contain the following information:				
i.	Date and duration of supervision;				
ii.	Identification of supervision type (group or individual);				
iii.	Content of supervision;				
iv.	Actions that the supervisee must take;				
v.	Signature and date of person providing clinical supervision; and				
vi.	Signature and date of supervisee.				
8	Clinician to patient ratio is in compliance with the requirements of the ADMH Substance Abuse Services Administrative Code.				
9	Payment(s) of Federal or State funds by ADMH to a contractor for the provisions of specific substance abuse treatment services is supported by appropriate clinical documentation.				
10	The contractor has submitted to ADMH an annual audit for the current year. For additional guidance, consult ADMH Audit Guidelines located on ADMH website.				
11	The contractor's financial policy and procedure manual supports general accepted accounting best practice guidelines that allows for the monitoring of internal management of funds and real property.				

Corrective Action Required:			
Technical Assistance Recommended:			

Findings/Corrective Action:

Recovery Oriented System of Care (ROSC)

		Written policy and procedure	Evidence of Compliance and Implementation	Page number in P&P Manual	Comments (Including examples of implementation)
1	Patients receive documented education on the nature of their behavioral health disorder.				
2	The agency implements evidence based practices and curriculums in the treatment of patients.				
3	Agency provides patients with a written menu of treatment services which includes a variety of options (e.g.., individual counseling, group therapy, psychoeducational classes, etc.).				
4	Agency offers different pathways to recovery (e.g.., clinical treatment, medications, faith based approaches, 12 step, peer support, family support, self care or other approaches) onsite or documented referral.				
5	Family education and/or therapy is offered to each patient.				
6	Peer support services are offered, documented and include the following:				
a.	Peers who provides services are certified through ADMH;				
b.	Peers offer a variety of services (e.g.., screening, basic living skills, education, connection to resources, etc.).				
8	Agency provides case management services as prescribed on the service plan and at a minimum include the following:				
a.	Documentation of referrals as needed for medical services, mental health services, etc., as found appropriate.				
b.	Documentation of recovery support services, if needed, which may include housing, employment, transportation, child care, etc.				
c.	Documented follow up on all referrals.				
9	Agency provides, either directly or through a referral process, a continuing care program for patients.				
	Corrective Action Required:				
	Technical Assistance Recommended:				

Findings/Corrective Action:

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SOR

		Written policy and procedure	Evidence of Compliance and Implementation	Page number in P&P Manual	Comments (Including examples of implementation)
1	All individuals enrolled in SOR receive a baseline GPRA interview.				
2	All individuals who received a baseline GPRA interview receive a six month follow up GPRA interview.				
3	All individuals who received a baseline GPRA interview receive a discharge GPRA tool (interview or adminstrative) within 15 days of official discharge date.				
4	All GPRA interviews are submitted to ADMH in the required time frames, in the required format and with correct information.				
5	ADMH approved locator form is completed and maintained in the patient chart at time of enrollment into SOR.				
6	Proof of Mediciad application and denial is maintained in patient chart at time of enrollment into SOR.				
7	An intake form is completed and maintained on indviduals enrolled in SOR. Patient signature is required.				
8	Individuals enrolled in SOR have a documented opioid use disorder (SOR or SOR2) or stimulant use disorder (SOR2 specific).				
9	Proof of provision of GPRA interview incentive is maintained in patient chart.				
10	Proof of contingency management incentives (for those with a stimulant use disorder) is maintained in patient chart.				
11	Drug test results (positive or negative) are discussed with patient and documented in chart. if positive, consequences are discussed and documented in chart.				
12	Patients enrolled on SOR do not remain enrolled longer than six months.				
13	Monthly reports are submitted to SOR project director in the required time frame.				
	Corrective Action Required:				
	Technical Assistance Recommended:				

Findings/Corrective Action:

Documentation

		Written policy and procedure	Evidence of Compliance and Implementation	Page number in P&P Manual	Comments (Including examples of implementation)
1	Assessment and results of screening are clearly explained to the patient and patient's family as appropriate.				
2	following:				
a	The assessment is conducted using the latest approved version of the ADMH Integrated Placement Assessment Tool; and				
b.	Completed by a QSAP I;				
c.	An appropriate Level of Care recommendation is made; and				
d.	Patient is offered a choice of providers based on the Level of Care recommendation.				
3	An individual strength based service plan and service plan revisions are completed on each patient and include, at a minimum, the following components:				
a.	Developed in partnership with the patient, the patients' family and significant others as appropriate and there is evidence that the patient is in agreement with the service plan and goals.				
b.	Has measureable goals and strategies and in words understandable to the patient.				
c.	ethnicity, development and disabilities/disorders.				
d.	Not based solely on information from the ADMH placement assessment.				
e.	clinical or medical director.				
f.	residential level of care.				
g.	administrative code.				
h.	There is evidence that a copy of the service plan and the revisions were provided to the patient.				
4	Written case reviews are completed at regular periodic intervals as defined in ADMH administrative code.				
5	care.				
6	following;				
a.	identification of the service rendered.				
b.	identification of the service recipient.				
c.	identification of the setting in which the service was rendered.				
d.	date the service was rendered.				

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Documentation continued

		Written policy and procedure	Evidence of Compliance and Implementation	Page number in P&P Manual	Comments (Including examples of implementation)
e.	start and ending time of the service.				
f.	relationship of the service to the patient's individualized service plan.				
g.	signature and credentials of the staff providing the service as well as the patient's signature.				
7	A transfer summary is completed when the level of care changes within a program.				
8	A discharge summary is completed within 5 days of discharge.				
9	Progress notes are individualized and not duplicated in any manner.				
10	Charts are current, legible and organized in a concise manner.				
11	Corrections and amendments to paper charts are made using the mark through method.				
12	Indicate below which charts were reviewed, for which levels of care, and if charts were closed or open.				
	Corrective Action Required:				
	Technical Assistance Recommended:				

Findings/Corrective Action:

On-Site Reviewer Signature and Date: _____

revised 11/02/20

FOR OFFICE USE ONLY

URICA Scoring For: 0 0 0

	Precontemplation (PC)		Contemplation (C)		Action (A)		Maintenance (M)
1	#REF!	2	#REF!	3	#REF!	6	#REF!
5	#REF!	4	Omit	7	#REF!	9	Omit
11	#REF!	8	#REF!	10	#REF!	16	#REF!
13	#REF!	12	#REF!	14	#REF!	18	#REF!
23	#REF!	15	#REF!	17	#REF!	22	#REF!
26	#REF!	19	#REF!	20	Omit	27	#REF!
29	#REF!	21	#REF!	25	#REF!	28	#REF!
31	OMIT	24	#REF!	30	#REF!	32	#REF!
TOTAL	**#REF!**	TOTAL	**#REF!**	TOTAL	#REF!	TOTAL	#REF!
AVERAGE	**#REF!**		**#REF!**		**#REF!**		**#REF!**

READINESS TO CHANGE SCORE: **#REF!**

To obtain the Readiness to Change score, first sum items from each subscale and divide by 7 to get the mean for each subscale. Then sum the means from the Contemplation, Action, and Maintenance subscales and subtract the Precontemplation mean (C + A + M - PC = Readiness).

Compare the Readiness for change score to the following group means. Choose the stage whose group average is closest to the computed Readiness Score:

Stage	**Group Average**
Precontemplation	8 or lower
Contemplation	8-11
Preparation	11-14
Maintenance	14 and above

Source: University of Maryland, Health and Addictive Behaviors lab, http://www.umbc.edu/psyc/habits/content/ttm_measures/urica/readiness.html

DEPARTMENT OF MENTAL HEALTH
SUBSTANCE ABUSE SERVICES DIVISION
MONITORING COMPLIANCE GUIDELINES
TITLE 45: OF THE CODE OF FEDERAL REGULATIONS PART 96 (45 CFR PART 196)- SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANTS; INTERIM FINAL RULE
Updated 2019/Reviewed 2021

I. SASD POLICY

These guidelines establish reasonable and minimum rules for community substance abuse prevention and treatment organizations/agencies under contract with the Department of Mental Health (DMH). The Substance Abuse Services Division of DMH as the Single-State Authority, has the responsibility and authority to appropriately monitor treatment services and activities provided by the various contracting organizations/agencies to ensure total compliance with the language spelled out in Title 45 C.F.R., Part 96 of the Substance Abuse Prevention and Treatment Federal Block Grant (SAPTBG), as well as all binding contractual language as it is written in contracts issued annually by the SSA to purchase treatment services for SA recipients.

II. GLOSSARY OF TERMS

Block Grant: Refers to the Substance Abuse and Prevention Block Grant (SAPTBG), Title 45, Part 96 U.S.C. 300x-21 to 300x-35 and 300x-51 to 300x-64.

Compliance Renewal Dates: As per the SASD current guidance, all monitoring renewal survey visits will occur within 30 days of the anniversary month of the previous monitoring survey visit. Routine monitoring visits will be scheduled at a minimum of one time per year unless otherwise warranted.

Data: Facts collected or assembled in a computer database, or a compilation of aggregate statistics or trends.

Early Intervention Services Relating to HIV:

1. Appropriate pretest counseling for the detection of HIV and AIDS;

2. Testing individuals with respect to such disease, including:
   a. Tests to confirm the presence of the disease.
   b. Tests to diagnose the extent of the deficiency in the immune system.
   c. Tests to provide information on appropriate therapeutic measures for preventing and treating the deterioration of the immune system and for preventing and treating conditions arising from the disease;

3. Appropriate post-test HIV and AIDS counseling and education to include:
   a. Risks of needle sharing
   b. Risks of transmission to sexual partners and infants; and
   c. Steps that can be taken to ensure that HIV transmission does not occur.

4. Provide the therapeutic measures described in (2) of this definition.

Evidence-Based: Based on empirical outcome and supported by clinical, scientific, or professional practices that are recognized by a majority of professionals in a field.

Financial Charge-Back: Contract dollars reimbursed to DMH for paid services that cannot be validated through reliable documentation.

Interim Substance Abuse Services: Temporary services provided for an individual in need of substance abuse treatment who has been denied admission to a program of such treatment on the basis of the lack of capacity of the program to serve the individual. Interim services for pregnant women also include counseling on the effects of alcohol and drug use on the fetus, as well as referral for prenatal care.

Monitoring Visits: Unannounced or announced visits by the staff of the DMH/SASD to ensure total provider compliance with the Federal Block Grant guidelines and State contract guidelines.

Corrective Compliance Strategy Plan: A plan detailing the action(s) that an agency/organization will take to become compliant with the Federal Block Grant and State contract requirements.

Program Compliance Monitoring Survey: The formal process complete with items to be checked, comments, and findings, used by the SASD staff to conduct State contract compliance and SAPTBG monitoring activities.

Partial Compliance Status: When an agency or entity does not meet all DMH contract and SAPTBG requirements, it may be placed in Partial Compliance Status not to exceed ninety (90) days. If the agency holds a Partial status due to compliance deficiencies following a survey, there will be an automatic one (1) year return visit scheduled.

Substance Use Disorder: The existence of a disorder that meets the criteria as described in the DSM V for the presence of a condition of substance use disorder.

Tuberculosis services:
1. Counseling and educating the individual with respect to tuberculosis; including:

2. Risks of transmission to family

3. Steps that can be taken to ensure tuberculosis transmission does not occur.

4. Testing to determine whether the individual has been infected with mycobacterium tuberculosis in order to determine the appropriate form of treatment for the individual; and

5. Providing for or referring the individual infected by mycobacterium tuberculosis appropriate medical evaluation and treatment.

III. Frequency of Compliance Review

Provider compliance monitoring of the Federal Block Grant and DMH contract will be conducted by staff from the SASD on a schedule not to exceed one (1) year. All providers receiving Federal Block Grant funds will be reviewed. In addition, SASD staff will review a representative sample of the agency's client records. The review of records will include both open and closed case files with the bulk of the records being reviewed belonging to clients meeting the special populations criteria.

IV. Compliance Review

The initial monitoring review will be initiated with a telephone call notifying the executive director of the month in which the review will occur. The reviewer will then select feasible dates for the monitoring visit with input from the executive director. A Letter of Intent, by email, will follow ten (10) days in advance of the survey informing the agency of the date and time of the monitoring survey. The letter will list the documents to be made available for the survey such as policies and procedures, program descriptions, clinical records, sliding fee scale information, etc. All subsequent reviews will occur in accordance with compliance renewal dates. The renewal date for future visit may be unannounced.

V. Unannounced Visits

DMH and/or its agents has the authority to periodically monitor contract providers continuing compliance with Federal Block Grant and DMH contract requirements as applicable to services and program operations.

VI. Compliance Review Reports

1. Within fifteen (15) days of the compliance visit, the *"SAPTBG Monitoring Survey Report"* will be sent to the agency's executive director or designee and, as applicable, a copy sent to the agency's Board of Directors.

2. The *SAPTBG Monitoring Survey Report* lists each Federal Block Grant requirement not met by the agency/organization and the report may also include comments

regarding quality improvement suggestions. Consistent failure to meet the Block Grant requirements may result in a financial charge-back to the agency and/or loss of the agency's funding contract.

VII. Contract Providers Corrective Compliance Strategy Plan

1. As the result of a monitoring survey, the agency/organization receives a "Partial Compliance Status" or is sited for being noncompliant with a particular Block Grant requirement, then the agency must submit to the SASD a *"SAPTBG Program Compliance Monitoring Provider Response"* for issues cited in the report. The Corrective Strategy Plan must be submitted within thirty (30) days after the date of receipt of the *SAPTBG Monitoring Survey Report.*

2. In the event the agency/organization receives a Partial Compliance Status and has been found to have consistently failed to meet requirements in the Block Grant, the agency/organization is required to submit to the SASD a *"SAPTBG Program Compliance Monitoring Provider Response"* that ensures the health/safety of persons served during the pending of any contract revocation.

VIII. DMH Response to Corrective Compliance Strategy Plan

1. Action taken by the SASD when the agency's *"SAPTBG Program Compliance Monitoring Provider Response"* is received may include one or more of the following:

a. Approve plan as written;
b. Request additional documentation or a supplemental Corrective Strategy Plan;
c. Provide technical assistance in deficient area(s) if requested in writing to the SASD, Director of Treatment Services;
d. Conduct a follow-up monitoring visit within ninety (90) days following the initial visit which discovered the deficiencies.

2. If the agency/organization is found to have multiple (4 or more) findings in not meeting Block Grant and DMH Contract requirements, a follow-up visit must be scheduled within ninety (90) days from receiving the agency's Corrective Strategy Plan or a recommendation must be made to the SASD Associate Commissioner for financial charge-back to the agency/organization.

IX. Loss of Contract Funding

I. If the agency/organization does not comply with Federal Block Grant and/or DMH Contract requirements for identified special populations within a specified timeframe, or if it is found to have consistently failed to meet requirements, a recommendation for loss of contract funding is made to the DMH Commissioner by the SASD Associate Commissioner. A copy of this recommendation is sent via certified mail to the Executive Director of the agency/organization and to its Board of Directors.

2. If the Commissioner notifies an agency/organization of the intent to terminate their funding contract, it may appeal the decision, or it may request a delay for up to sixty

(60) days in the Commissioner's final decision due to extenuating circumstances which must be specified in the request. It remains solely within the discretion of the DMH Commissioner to approve such a delay, based upon the type(s) and/or numbers of deficits not met. If approved, the Commissioner will notify the agency/organization of the period of time within which the agency/organization must totally comply with the Block Grant requirements.

3. If the agency/organization does not appeal the decision for contract termination or does not comply with requirements in the specified time frame, the agency/organization will lose their funding contract on the date specified by the DMH Commissioner.

X. Appeal Procedures Within DMH

A recommendation by the SASD for loss of contract funding may be appealed within fifteen (15) working days of the agency/organization receiving the report/recommendation. The appeal by the agency/organization must specify the precise reason(s) for the appeal and provide documentation to support modification of the monitoring compliance report recommending loss of contract funding.

1. The first appeal is made to the SA Director of Community Programs. The Director of Community Programs must respond in writing to the appeal within fifteen (15) working days of receipt of the appeal, upholding or revising the initial findings of the monitoring compliance survey report. If the appeal is denied:

2. The second appeal from the agency/organization is made to the SASD Associate Commissioner within fifteen (15) working days of the agency/organization's receipt of the decision on the first appeal.

3. The SASD Associate Commissioner has fifteen (15) working days to schedule a review and respond in writing to the agency/organization either upholding the denial or revising the decision.

4. The third and final appeal by the agency/organization is made to the Commissioner of the Department of Mental Health within fifteen (15) working days of receipt of the second step appeal decision by the SASD Associate Commissioner.

XI. Service Conditions on the Use of Block Grant Funds

(45 CFR, Part 96.124- Set Aside for Pregnant Women and Women with Dependent Children)

If the program receives Block Grant funds set aside for Specialized Women's Treatment Services for pregnant women and women with dependent children (including women attempting to regain custody of their children), they must comply with the following:

1. The program treats the family as a unit and, therefore, admits both women and their children into treatment services, if appropriate;

2. The program provides or arranges for primary medical care for women who are receiving substance abuse services, including prenatal care;

3. The program provides or arranges for childcare while the women are receiving services; the program arranges for Therapeutic Daycare and Early Childhood Programs for children.

4. The program provides or arranges for primary pediatric care for the women's Children, including immunization;

5. The program provides or arranges for gender-specific substance abuse treatment and other therapeutic interventions for women that may address issues of relationships, sex abuse, physical abuse, and parenting;

6. The program provides or arranges for therapeutic interventions for children in custody of women in treatment, which may among other things, address the children's developmental needs, their issues of sexual and physical abuse, as well as neglect issues;

7. The program provides or arranges for sufficient case management and transportation services to ensure that women and their children have access to the services needed during the course of treatment. These services include employment and training programs, education and special education programs and drug-free housing for women and their children.

Note: When pregnant women are referred to the SASD due to unavailability of treatment, the state must:

a. Refer them to programs with the capacity.
b. Ensure interim services, to include pre-natal care, are made available within 48 hours after women seek treatment.
c. Maintain a system for identifying the capacity for pregnant women who cannot be admitted.
d. Develop a mechanism to match such women to treatment programs with sufficient capacity.
e. Monitor programs for compliance with these requirements:

    1. SASD will routinely retrieve data through ADMH's substance abuse management information system to determine which programs currently have priority populations awaiting treatment services and if these programs are providing interim services to the client(s).

    2. This information will be compared to the Capacity Management Notices received by the SASD.

    3. If a priority population client is on the waiting list for services and interim services are not being provided, SASD will:

a. Determine why
b. Ensure interim services are extended by the provider, and/or provided by another provider within the geographic area
c. Document the rationale as to why services were refused by the client.

4. If a *Capacity Management Notice* was not completed and submitted to SASD, the program will be cited as a result and must immediately implement an action plan to ensure future incidents do not occur.

(45 CFR, Part 96.126- Capacity of Treatment for Intravenous Substance Abuse)
DMH contract programs using Block Grant funds must offer priority admission, either through immediate admission or priority placement on a waiting list, to individuals for intravenous substance abuse. The program must provide interim services to individuals for intravenous substance abuse on the waiting list and must report all services to individuals for intravenous substance abuse:

1. No later than 7 days after reaching 90% of its capacity to admit individuals, the program notifies the SASD of that fact;

2. The program admits each individual who requests and is in need of treatment for intravenous drug use no later than:
   a. 14 days after making the request for admission; or
   b. 120 days after the date of the request for admission if no such program has the capacity to admit at the time of the initial request; and
   c. Interim services are provided not later than 48 hours after the initial request for admission.

3. When applicable, the program provides interim services that include, at a minimum, the following:
   a. Counseling and education about HIV and Tuberculosis, about the risks of needle sharing, the risk of transmission to sexual partners and infants, and about steps that can be taken to ensure that HIV and Tuberculosis transmission does not occur;
   b. Referral for HIV or Tuberculosis services, if needed;
   c. Counseling on the effects of alcohol and other drug use on the fetus for pregnant women, as well as referrals for prenatal care.

4. The program has established a formal waiting list process that includes a unique patient identifier for each injecting drug user seeking treatment, including patients receiving interim services while awaiting admission to treatment.

5. The program has a mechanism that enables it to maintain contact with individuals awaiting admission for intravenous drug treatment.

6. Admit or transfer waiting list clients at the earliest possible time to an appropriate treatment program within a reasonable geographic area. The program must develop written procedures for submission of data to and utilization of the capacity management function of ADMH to admit clients into treatment for IV drug use.

7. The program removes clients awaiting treatment for intravenous substance use off the waiting list only when:
    a. Such person cannot be located for admission into treatment when services become available;
    b. Such person refuses treatment; or
    c. Such person requests to be removed from the waiting list.

8. The program ensures that outreach efforts have policies and procedures that include the following:
    a. Selecting, training, and supervising outreach workers;
    b. Contacting, communicating, and following up with high-risk substance abusers, their associates, neighborhood residents within the constraints of Federal and State confidentiality and privacy requirements including 42 CFR Part 2, and 45 CFR parts 160 and 164;
    c. Promoting awareness among injecting drug abusers about the relationship between injecting drug abuse and communicable diseases such as HIV;
    d. Recommending steps that can be taken to ensure that HIV transmission does not occur;
    e. Encouraging entry into treatment.

9. All outreach services must be rendered using outreach models that are locally applicable and scientifically sound. If there are no locally applicable scientifically sound models available, contracted programs are to use one or more of the following scientifically sound outreach models:
    a. The standard intervention model as described in the NIDA Standard Intervention Model for Injection Drug Users: Intervention Manual, National AIDS Demonstration Research (NADR) Program, National Institute on Drug Abuse, February 1992;
    b. The health education model as described in Rhodes, F. Humfleet, G. L., eta, Aids Intervention Program for Injection Drug Users: Intervention Manual, February 1992; and
    c. The indigenous leader model as described in Wiebel, W., Levin, L. B., The Indigenous Leader Model: Intervention Manual, February 1992.

(45 CFR, Part 96.127- Tuberculosis Requirements)

The program implements written policies and procedures developed in cooperation with the state or local Department of Public Health and in compliance with rules established by the Substance Abuse Services Division of DMH for the provision of tuberculosis services.

1. The program directly, or through arrangements with other public or nonprofit entities, routinely makes available the following tuberculosis services to each individual receiving treatment for substance abuse:
    a. Counseling the individual with respect to tuberculosis;
    b. Testing to determine whether the individual has been infected with mycobacterium tuberculosis to determine the appropriate form of treatment for the individual;
    c. Providing for or referring the individual infected by mycobacterium tuberculosis appropriate medical evaluation and treatment.

2. The program has implemented infection control procedures that are consistent with standards established by the Alabama DMH to prevent the transmission of tuberculosis and that address the following:
    a. Screening patients and identification of those individuals who are at high risk of becoming infected;
    b. Meeting all State reporting requirements for individuals with active TB while adhering to Federal and State confidentiality requirements 45 CFR, Part 160 & 164, Health Insurance Portability and Accountability Act (HIPPA), including 42 CFR Part 2;
    c. Case management activities to ensure that individuals receive such services.

3. For individuals who are denied admission to treatment due to a lack of the program's capacity to serve such a population, the program refers the individual to another provider of tuberculosis services.

(45 CFR, Part 96.127- Additional Requirements)

1. The program has developed and implemented a formal admission waiting list system.

2. The program utilizes the capacity management functions of ADMH's substance abuse management information system (SAIS), as required by the SASD of the Alabama DMH, for the maintenance of an admission waiting list.
    a. Clients are enrolled in the SAIS as prescribed by SASD;
    b. Client admission records are established in SAIS as prescribed by SASD;
    c. Referrals for admission/continued care are made to other providers through SAIS utilizing SASD prescribed protocol;
    d. Client referral/transfer records are established in SAIS as prescribed by SASD;
    e. Client discharge records are established in SAIS as prescribed by SASD;
    f. Referrals received through SAIS are managed by the program as prescribed by SASD and are either accepted into the program or denied placement on the program's waiting list;
    g. The program prioritizes individuals on the admissions waiting list as according to SASD established priority population;
    h. The program has developed and implements a formal process for maintaining contact with individuals placed on the waiting list;
    i. The program provides interim services for clients on their waiting list.

J. The Program provides treatment and related therapeutic services to individuals who are categorized indigent by the courts.
   1. The program keeps a court order declaring indigent status on file.
   2. The client's ability/inability to pay is substantiated throughout the provision of services.
   3. The waiver of fees is revoked when the client income exceeds indigent status level.

k. The program provides unimpeded access to clients by Department of Mental Health.

l. The program verifies U. S. citizenship for all clients for whom services are billed to the Alabama Department of Mental Health.

m. HIV risk education is provided to each client.

n. The program admits clients with co-occurring disorders who are appropriately stabilized on medications (Program Specific).

o. Program provides vocational assistance and housing support. (Correctional Programs)

3. The program provides continuing education for employees as according to rules established SASD.

4. The program coordinates the provisions of treatment services with the provision of other appropriate services, including health, social, correctional and criminal justice, educational, vocational rehabilitation, and employment services.

5. The program has in effect a system to protect client records from inappropriate disclosure, and the system:
   a. Is in compliance with all applicable State and Federal laws and regulations 45 CFR, Parts 160 and 164, as well as 42 CFR Part 2;
   b. Includes provisions for employee education on the confidentiality requirements;
   c. The program provides for employee disciplinary action upon inappropriate disclosure of client information.

(45 CFR, Part 96.128- HIV Services)

1. The program makes available early intervention services for HIV disease to individuals undergoing treatment for substance abuse at the sites where individuals are undergoing such treatment, including:

   a. Appropriate pre-test counseling for HIV and AIDS;
   b. Test for individuals with respect to such disease, including test to:
      1. Confirm the presence of the disease;
      2. Diagnose the extent of the deficiency in the immune system;
      3. Provide information on prevention and testing deterioration of the immune system;
      4. Provide information on appropriate therapeutic measures for preventing and treating conditions arising from the disease.

c. Appropriate post-test counseling;
d. Appropriate therapeutic measures for preventing and treating deterioration of the immune system, and for preventing and treating conditions arising from the disease;
e. Case management to ensure that individuals receive all HIV services described in this section.

2. The program has linkage with a comprehensive resource network of HIV/AIDS related health and social services organizations to ensure a wide-based knowledge of the availability of the program's HIV early intervention services and to facilitate referrals.

3. The program follows all procedures established by the Alabama DMH, in cooperation with the Alabama Department of Public Health Communicable Disease Officer, in regard to the provisions of HIV early intervention services.

4. The program implements written policies and procedures to ensure that: HIV early intervention services will be undertaken voluntarily by, and with the informed consent of, the individual; undergoing such services will not be required as a condition of receiving treatment for a substance abuse or any other services.

(45 CRF, Part 96.131- Treatment Services for Pregnant Women)
The program gives preference in admission to pregnant women who seek or are referred for and would benefit from Block Grant-funded treatment services.
Further, all agencies/organizations that serve women and who receive block grant funds must provide preference in the following order:

a. To pregnant women with intravenous substance use disorders;
b. To other pregnant women with substance use disorders;
c. To all other intravenous substance use disorders;
d. Women with substance use disorders and dependent children;
e. All other individuals with substance use disorders.

Agencies/organizations receiving Block Grant funds through a DMH Contract must publicize the availability of treatment services for women and the fact that pregnant women receive preference for admission. This may be done in the following ways: street outreach programs, ongoing public service announcements (radio/television), regular advertisements in local/regional print media, posters placed in targeted areas, and frequent notification of availability of such treatment distributed to the network of community-based organizations, health care providers and social service agencies.

1. The program refers pregnant women to the State (SASD) when the program has insufficient capacity to provide treatment services to any such pregnant women who seek the services of the program.

2. The program makes available interim services within 48 hours to pregnant women who cannot be admitted because of the lack of capacity.

3. The program submits data and utilizes SAIS' functionality as required to support proper working of the state's capacity management program and to ensure that pregnant women receive priority treatment and referral services as appropriate.

(45 CFR, Part 96.135- Restriction on Expenditures)

1. The program does not expend SAPT Block Grant funds on the following activities:
    a. To make cash payments to intended recipients of health services;
    b. To purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;
    c. To satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds; to provide financial assistance to any entity other than a public or nonprofit entity;
    d. To provide individuals with hypodermic needles or syringe;
    e. To provide treatment services in penal or correctional institutions of the State;
    f. To provide inpatient hospital services, except when services has been determined to be medically necessary and when it has been determined by a physician that:
        I. The primary diagnosis of the individual is substance abuse, and the physician certifies this fact;
        2. The individual cannot be safely treated in a community based, non-hospital, residential treatment program;
        3. The service can be reasonably be expected to improve an individual's condition or level of functioning;
        4. The hospital-based substance abuse program follows national standards of substance abuse professional practice.

2. In the case of an individual for whom a grant/scholarship is expected to provide inpatient hospital services, the daily rate provided by the program to the hospital does not exceed the comparable daily rate provided for Community-based, non-hospital, residential programs for substance abuse.

3. When sub-contracts are issued by the SASD Contracted Agency to purchase services using SAPTBG, the condition of first priority of services will be to pregnant women, and the reporting requirements for NOMS. These requirements will be monitored by the contracting agency. Thus, the agency should develop a policy to ensure that all vendors/sub-contractors comply with all the requirements.

(45 CFR Part 96.136- Independent Peer Review)

In addition to regularly scheduled site certification reviews, contracted providers must expect to receive Independent Peer Reviews as the SASD must provide for these. The Peer reviews address the quality, appropriateness, and efficacy of Block Grant funded treatment. Block Grant regulations define:

1. Quality as: the provision of treatment services that meet accepted standards and practices that will improve patient/client health and safety in the context of recovery.

2. Appropriateness as: the provision of treatment services consistent with each individual's identified clinical need and level of functioning.

To determine quality and appropriateness of treatment, reviewers must include examination of a representative sample of patient/client records. In reviewing client records, the reviewer will examine:

1. Admission criteria and intake processes
2. Assessments
3. Treatment planning
4. Documentation of the implementation of treatment strategies
5. Discharge and continuing care planning
6. Indications of treatment outcome

Independent Peer Reviewers must meet specific criteria. They must:

1. Be experts in the substance abuse field.
2. Represent various disciplines used by the program.
3. Be knowledgeable about the modality being reviewed and the underlying theoretical approach to addictions treatment.
4. Be sensitive to the cultural environmental issues that may influence quality of care.
5. Cannot be providers/practitioners of the program being reviewed.
6. Cannot be individuals who have oversight to make funding decisions of program under review.
7. Must review 5% of Block Grant providers each year.
8. The reviews must not be conducted in conjunction with or as a part of a certification process.

(45 CFR Part 96.137- Payment Schedule)

The program uses the Block Grant as the "payment of last resort" for services for pregnant women and women with dependent children, TB services, and HIV services and, therefore makes every reasonable effort to do the following:

1. Collect reimbursement for the costs of providing such services to persons entitled to insurance benefits under the Social Security Act, including programs under title XVIII and title XIX; any State compensation programs, any other public assistance program for medical expenses, any grant program, any private health insurance, or any other benefit program.

2. Secure from patients or clients' payments for services in accordance with their ability to pay.

The program does not use Block Grant Funds to pay salaries of senior executives more than the level on the Federal Pay Scale or $193,300 as listed in 2008.

Environmental Factors and Plan

11. Quality Improvement Plan- Requested

Narrative Question

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2020-FFY 2021? ○ Yes ◉ No

Please indicate areas of technical assistance needed related to this section.

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Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

Trauma [57] is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective M/SUD service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated M/SUD problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with. These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive M/SUD care. States should work with these communities to identify interventions that best meet the needs of these residents.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing ?business as usual.? These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[58] paper.

57 Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*
58 *Ibid*

Please consider the following items as a guide when preparing the description of the state's system:

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.

none

Please indicate areas of technical assistance needed related to this section.

none

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13. Criminal and Juvenile Justice - Requested

Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.[59]

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.[60]
A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or the Health Insurance Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

[59] Journal of Research in Crime and Delinquency: : *Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice.*Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Ren?e L. Binder. **OJJDP Model Programs Guide**
[60] **http://csgjusticecenter.org/mental-health/**

Please respond to the following items

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, M/SUD 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 ADMH Commissioner serves on the newly-formed Alabama Commission on Reentry, along with other agency executives and state leaders, which is charged with “identifying, implementing, and promoting evidence-based research, policies, strategies, and programming to support successful reentry and reintegration."

The Commission is designed to address many goals involving reentry and rehabilitation in Alabama’s criminal justice system. The goals include, but are not limited to:
• Developing and presenting a strategic plan to make communities safter by reducing recidivism and victimization.
• Assisting individuals who return from prison in becoming productive citizens and saving taxpayer dollars by lowering the direct and collateral costs of incarceration.
• Promoting partnerships and collaboration among state agencies and with local governments and organizations to effectively and cost-efficiently advance reentry and reintegration efforts and eliminate duplication of services.
• Developing strategies to expand access to educational programs and support programs upon reentry.
• Developing strategies to ensure access to health care coverage and behavioral health services upon reentry.

• Identifying and addressing other unwarranted barriers to successful reentry.

Please indicate areas of technical assistance needed related to this section.

none

Footnotes:

Environmental Factors and Plan

14. Medication Assisted Treatment - Requested (SABG only)

Narrative Question

There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], 49 [4], and 63[5].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate.

SAMHSA is asking for input from states to inform SAMHSA's activities.

TIP 40 - https://www.ncbi.nlm.nih.gov/books/NBK64245/ [ncbi.nlm.nih.gov]

TIP 43 - https://www.ncbi.nlm.nih.gov/books/NBK64164/ [ncbi.nlm.nih.gov]

TIP 45 - https://store.samhsa.gov/sites/default/files/d7/priv/sma15-4131.pdf [store.samhsa.gov]

TIP 49 - https://store.samhsa.gov/sites/default/files/d7/priv/sma13-4380.pdf [store.samhsa.gov]

TIP 63 - https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-02-01-006_508.pdf [store.samhsa.gov]

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders? (●) Yes ( ) No

2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly pregnant women? (●) Yes ( ) No

3. Does the state purchase any of the following medication with block grant funds? (●) Yes ( ) No

- **a)** [x] Methadone
- **b)** [x] Buprenophine, Buprenorphine/naloxone
- **c)** [x] Disulfiram
- **d)** [x] Acamprosate
- **e)** [x] Naltrexone (oral, IM)
- **f)** [x] Naloxone

4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately*? (●) Yes ( ) No

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

ADMH collaborates with other organizations to provide ongoing training and support to practitioners (at all clinical levels) on all aspects of MAT. The latest set of trainings (through a grant opportunity and in partnership with a large university) include the following:
1)Addressing Substance Use Stigma, 2)A Healthcare Worker's Guide to Effective Telehealth Communication, 3)Telemedicine as a Path to Primary Care Pharmacotherapy, 4)Addiction and the Brain: a New Perspective, 5)Opponent Process Therapy, 6)Buprenology, 7)Motivational Interviewing and Boundaries in Treatment, 7)Opioid Use Disorder in Pregnancy, 8)ACEs and Development of

Substance Use Disorder, 9)Implementing an Integrated Healthcare Approach, 10)Alcohol Use Disorder: Screening and Assessment, and 11)AUD Treatment. All of these are free webinars which offer CEUs and CMEs.

**Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.*

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15. Crisis Services - Required for MHBG

Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from M/SUD crises. SAMHSA has recently released a publication, Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies that states may find helpful.[61] SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with M/SUD conditions and their families. According to SAMHSA's publication, **Practice Guidelines: Core Elements for Responding to Mental Health Crises**[62],

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response.

[61] **http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848**

[62] Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. **http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427**

Please check those that are used in your state:

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)** ☑ Peer Support/Peer Bridgers
- **b)** ☑ Follow-up Outreach and Support
- **c)** ☐ Family-to-Family Engagement
- **d)** ☑ Connection to care coordination and follow-up clinical care for individuals in crisis
- **e)** ☐ Follow-up crisis engagement with families and involved community members

f) ☑ Recovery community coaches/peer recovery coaches

g) ☑ Recovery community organization

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

none

Please indicate areas of technical assistance needed related to this section.

n/a

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Footnotes:

Environmental Factors and Plan

16. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life to the greatest extent possible, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see **SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.**

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

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

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

n/a

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

In 2016, Substance Abuse peer programs and Mental Illness peer programs merged to create the new Office of Peer Programs which is staffed by peers. The office promotes recovery by coordinating the department's support for peer operated programs, trainings and educational programs.

ADMH created a credentialing process for substance abuse peers to become Certified Recovery Support Specialists. The ADMH Coordinator of Recovery Resources manages the certification process and monitors continuing education of the credentialed peers.

The Office of Peer Programs provides a minimum of four peer certification trainings each year as well as continuing education hours throughout the year.

Motivational Interviewing, conducted by Faces and Voices of Recovery, was offered specifically for peers. Peers learned what MI was, how to define reflective listening skills, how to paraphrase and summarize and how to begin developing effective skills for giving advice and providing resources. They were also taught how to apply the use of open ended and meaningful questions to build motivation and confidence.

The state has given its support to the development of recovery community centers for individuals who have substance use disorders. Currently, there are four Recovery Community Centers, one in each substance abuse planning region of the state. Each one is open 12-hours a day including holidays and weekends. The Recovery Community Centers provide a safe place for individuals seeking recovery resources including support groups, workshops, employment assistance, and recreational activities for consumers and their families. Plans are in place to open two more Recovery Community Centers within the next two years.

Currently, ADMH has 423 actively certified peers which is an increase of 167 peers since the last report. 75%, or 317 peers, are working as a peer support specialist either through a peer organization or within a treatment organization. This is an increase of 109 individuals working in the field as a peer specialist. ADMH has also stressed the importance of peers representing the population they are targeting. This includes hiring peers who are parenting or who have been to prison.

In addition to providing funding for the provision of peer services as part of its fee-for-service reimbursement system, ADMH also contracts with the two peer run organizations for the provision of outreach and engagement services. ADMH has worked with Alabama Medicaid to incorporate peer services as a part of its Medicaid rehabilitation service options. In February of 2019, providers who employed ADMH credentialed peers and were Medicaid providers, gained the ability to bill for peer support services.

Consumers, family members, and advocates representing both mental illnesses and substance use disorders are active participants in all ADMH strategic planning processes. This includes their membership on various standing and ad hoc committees, workgroups, and on the agency's Board of Trustees which serves in an advisory capacity to the Commissioner.

ADMH, through one of the peer-run organizations and with the assistance of SAMHSA grant money, opened a 24/7 Substance Abuse Helpline in July of 2019. The helpline, staffed completely by ADMH credentialed peers, was established as a mechanism for individuals who were seeking help or treatment resources. It was also designed to be a safe place to call for individuals who were interested in recovery and for their family members. Professionals are encouraged to use the line as a directory of treatment resources. The helpline receives over 780 calls per month. 85% of the call are from individuals seeking services.

The Substance Abuse Consumer Conference is a yearly educational conference for substance abuse consumers throughout Alabama. The conference offers workshops and speakers on topics and issues of interest to individuals around the state recovering from substance use disorder. Most of the presenters at the conference are themselves in recovery from substance abuse. The conference is coordinated by the Office of Peer Programs but most of the planning and execution of the conference is done by consumers. In addition to educational opportunities, the conference provides opportunities for interaction with peers, empowerment and social interaction. All of the attendees receive scholarships to attend the conference.

The Substance Abuse Peer Conference is a yearly state-wide educational conference for Certified Recovery Support Specialists. The purpose of the conference is to provide education on peer services, highlight peer accomplishments, allow peers to share combined knowledge experience working as a peer, promote the value of utilizing peer services, encourage collaborations, promote advocacy, and to encourage the development of consumer-operated services in communities. The Peer Warrior Award is given each year to a Certified Recovery Support Specialist at the annual Peer Conference. This award is a symbol of proven hard work in advocacy and peer support services to individuals with a substance use disorder. In addition, Respect Awards are given each year to individuals who are consistently respectful and supportive to individuals with mental illness. RESPECT is an acronym for the characteristics of the recipients of the Respect Award.

5. Does the state have any activities that it would like to highlight?

Substance use disorders are prevalent among pregnant and parenting women throughout the United States. Alabama is among

the states with the highest rate of Opioid prescriptions, has limited resources, and has the strictest chemical endangerment laws. This combination creates an environment that is conducive to substance use during pregnancy which leads to pregnant women not seeking services and support due to fear, judgment, and shame. The Office of Substance Abuse Treatment Services (OSATS) believes that Peer Support can help address this issue by piloting a program for our peer support specialist to become certified doulas. Doulas are non-medical persons who are trained to provide emotional, physical, and informational support to women before, during, and after childbirth. Our peer support specialist will be trained and qualified to assist with not only the recovery aspects of the women's journey, but also the birthing process; thus, providing integrated services addressing the whole person. The goal of this pilot is to provide continuous support pre and post birth, which is associated with reduced mortality rates and improved overall health of the mother and the baby. We have two peer support specialist who will begun their doula training April 2021.

Please indicate areas of technical assistance needed related to this section.

None

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Footnotes:

Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead - Requested

Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in **Olmstead v. L.C., 527 U.S. 581 (1999)**, provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with M/SUD conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with M/SUD needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights **(OCR)** cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

Please respond to the following items

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

Please indicate areas of technical assistance needed related to this section.

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18. Children and Adolescents M/SUD Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.[63]. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[64]. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death.[65].

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.[66]. Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.[67].

According to data from the 2015 Report to Congress[68] on systems of care, services:

1. reach many children and youth typically underserved by the mental health system;
2. improve emotional and behavioral outcomes for children and youth;
3. enhance family outcomes, such as decreased caregiver stress;
4. decrease suicidal ideation and gestures;
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious M/SUD needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

[63]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

[64]Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

[65]Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

[66]The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

[67]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from **https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM**

[68] **http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf**

Please respond to the following items:

1. 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 M/SUD 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 M/SUD system? ○ Yes ○ No

b) for youth in foster care? ○ Yes ○ No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

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

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

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Advisory Council Members

For the Mental Health Block Grant, **there are specific agency representation requirements** for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Health (MH) Agency.

Start Year: 2022 End Year: 2023

Name	Type of Membership	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
No Data Available				

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Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2022 End Year: 2023

Type of Membership	Number	Percentage
Total Membership	**0**	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	0	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	0	
Parents of children with SED/SUD*	0	
Vacancies (Individuals and Family Members)	0	
Others (Advocates who are not State employees or providers)	0	
Persons in recovery from or providing treatment for or advocating for SUD services	0	
Representatives from Federally Recognized Tribes	0	
Total Individuals in Recovery, Family Members & Others	**0**	**0.00%**
State Employees	0	
Providers	0	
Vacancies	0	
Total State Employees & Providers	**0**	**0.00%**
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	**0**	
Youth/adolescent representative (or member from an organization serving young people)	0	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

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Environmental Factors and Plan

22. Public Comment on the State Plan - Required

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

a) Public meetings or hearings? ○ Yes ◉ No

b) Posting of the plan on the web for public comment? ◉ Yes ○ No

If yes, provide URL:

https://mh.alabama.gov/grants/

c) Other (e.g. public service announcements, print media) ○ Yes ◉ No

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Footnotes:

The completed 2022/23 SABG Application has been posted to the ADMH website. The link and password for access to the application throughout its development process remains continuously on the ADMH website: https://mh.alabama.gov/grants/; Username: citizenal; password: citizen.

Environmental Factors and Plan

23. Syringe Services (SSP)

Narrative Question:

The Substance Abuse Prevention and Treatment Block Grant (SABG) restriction[1,2] on the use of federal funds for programs distributing sterile needles or syringes (referred to as syringe services programs (SSP)) was modified by the **Consolidated Appropriations Act**, 2018 (P.L. 115-141) signed by President Trump on March 23, 2018[3].

Section 520. *Notwithstanding any other provisions of this Act, no funds appropriated in this Act shall be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug: Provided, that such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with State and local law.*

A state experiencing, or at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, (as determined by CDC), may propose to use SABG to fund elements of an SSP other than to purchase sterile needles or syringes. States interested in directing SABG funds to SSPs must provide the information requested below and receive approval from the State Project Officer. Please note that the term used in the SABG statute and regulation, *intravenous drug user* (IVDU) is being replaced for the purposes of this discussion by the term now used by the federal government, *persons who inject drugs* (PWID).

States may consider making SABG funds available to either one or more entities to establish elements of a SSP or to establish a relationship with an existing SSP. States should keep in mind the related PWID SABG authorizing legislation and implementing regulation requirements when developing its Plan, specifically, requirements to provide outreach to PWID, SUD treatment and recovery services for PWID, and to routinely collaborate with other healthcare providers, which may include HIV/STD clinics, public health providers, emergency departments, and mental health centers[4]. SAMHSA funds cannot be supplanted, in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

In the first half of calendar year 2016, the federal government released three guidance documents regarding SSPs[5]: These documents can be found on the Hiv.gov website: **https://www.hiv.gov/federal-response/policies-issues/syringe-services-programs**,

1. **Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016** from The US Department of Health and Human Services, Office of HIV/AIDS and Infectious Disease Policy **https://www.hiv.gov/sites/default/files/hhs-ssp-guidance.pdf ,**
2. **Centers for Disease Control and Prevention (CDC)Program Guidance for Implementing Certain Components of Syringe ServicesPrograms,2016** The Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, Division of Hepatitis Prevention **http://www.cdc.gov/hiv/pdf/risk/cdc-hiv-syringe-exchange-services.pdf,**
3. **The Substance Abuse and Mental Health Services Administration (SAMHSA)-specific Guidance for States Requesting Use of Substance Abuse Prevention and Treatment Block Grant Funds to Implement SSPs http://www.samhsa.gov/sites/default/files/grants/ssp-guidance-state-block-grants.pdf ,**

Please refer to the guidance documents above and follow the steps below when requesting to direct FY 2021 funds to SSPs.

- **Step 1** - Request a Determination of Need from the CDC
- **Step 2** - Include request in the FFY 2021 Mini-Application to expend FFY 2020 - 2021 funds and support an existing SSP or establish a new SSP
  - Include proposed protocols, timeline for implementation, and overall budget
  - Submit planned expenditures and agency information on Table A listed below
- **Step 3** - Obtain State Project Officer Approval

Future years are subject to authorizing language in appropriations bills.

End Notes

[1] Section 1923 (b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-23(b)) and 45 CFR § 96.126(e) requires entities that receive SABG funds to provide substance use disorder (SUD) treatment services to PWID to also conduct outreach activities to encourage such persons to undergo SUD treatment. Any state or jurisdiction that plans to re-obligate FY 2020-2021 SABG funds previously made available such entities for the purposes of providing substance use disorder treatment services to PWID and outreach to such persons may submit a request via its plan to SAMHSA for the purpose of incorporating elements of a SSP in one or more such entities insofar as the plan request is applicable to the FY 2020-2021 SABG funds ***only*** and is consistent with guidance issued by SAMHSA.

[2] Section 1931(a(1)(F) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (42 U.S.C.§ 300x-31(a)(1)(F)) and 45 CFR § 96.135(a)(6) explicitly prohibits the use of SABG funds to provide PWID with hypodermic needles or syringes so that such persons may inject illegal drugs unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing injection drug use and the risk of HIV transmission to others. On February 23, 2011, the Secretary of the U.S. Department of Health and Human Services published a notice in the Federal Register (76 FR 10038) indicating that the Surgeon General of the United States had made a determination that syringe services programs, when part of a comprehensive HIV prevention strategy, play a critical role in preventing HIV among PWID, facilitate entry into SUD treatment and primary care, and do not increase the illicit use of drugs.

[3] Division H Departments of Labor, Health and Human Services and Education and Related Agencies, Title V General Provisions, Section 520 of the Consolidated Appropriations Act, 2018 (P.L. 115-141)

[4] Section 1924(a) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(a)) and 45 CFR § 96.127 requires entities that receives SABG funds to routinely make available, directly or through other public or nonprofit private entities, tuberculosis services as described in section 1924(b)(2) of the PHS Act to each person receiving SUD treatment and recovery services.

Section 1924(b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(b)) and 45 CFR 96.128 requires "designated states" as defined in Section 1924(b)(2) of the PHS Act to set- aside SABG funds to carry out 1 or more projects to make available early intervention services for HIV as defined in section 1924(b)(7)(B) at the sites at which persons are receiving SUD treatment and recovery services.

Section 1928(a) of Title XXI, Part B, Subpart II of the PHS Act (42 U.S.C. 300x-28(c)) and 45 CFR 96.132(c) requires states to ensure that substance abuse prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to, health services.

[5]***Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016*** describes an SSP as a comprehensive prevention program for PWID that includes the provision of sterile needles, syringes and other drug preparation equipment and disposal services, and some or all the following services:

- Comprehensive HIV risk reduction counseling related to sexual and injection and/or prescription drug misuse;
- HIV, viral hepatitis, sexually transmitted diseases (STD), and tuberculosis (TB) screening;
- Provision of naloxone (Narcan?) to reverse opiate overdoses;
- Referral and linkage to HIV, viral hepatitis, STD, and TB prevention care and treatment services;
- Referral and linkage to hepatitis A virus and hepatitis B virus vaccinations; and
- Referral to SUD treatment and recovery services, primary medical care and mental health services.

Centers for Disease Control and Prevention (CDC) Program Guidance for Implementing Certain Components of Syringe Services Programs, 2016 includes a **description of the elements of an SSP** that can be supported with federal funds.

- Personnel (e.g., program staff, as well as staff for planning, monitoring, evaluation, and quality assurance);
- Supplies, exclusive of needles/syringes and devices solely used in the preparation of substances for illicit drug injection, e.g., cookers;
- Testing kits for HCV and HIV;
- Syringe disposal services (e.g., contract or other arrangement for disposal of bio- hazardous material);
- Navigation services to ensure linkage to HIV and viral hepatitis prevention, treatment and care services, including antiretroviral therapy for HCV and HIV, pre-exposure prophylaxis, post-exposure prophylaxis, prevention of mother to child transmission and partner services; HAV and HBV vaccination, substance use disorder treatment, recovery support services and medical and mental health services;

- Provision of naloxone to reverse opioid overdoses
- Educational materials, including information about safer injection practices, overdose prevention and reversing an opioid overdose with naloxone, HIV and viral hepatitis prevention, treatment and care services, and mental health and substance use disorder treatment including medication-assisted treatment and recovery support services;
- Condoms to reduce sexual risk of sexual transmission of HIV, viral hepatitis, and other STDs;
- Communication and outreach activities; and
- Planning and non-research evaluation activities.

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Footnotes:

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Syringe Services (SSP) Program Information-Table A

If the state is planning to expend funds from the COVID-19 award, please enter the total planned amount in the footnote section.

Syringe Services Program SSP Agency Name	Main Address of SSP	Planned Dollar Amount of SABG Funds Expended for SSP	SUD Treatment Provider (Yes or No)	# Of Locations (include mobile if any)	Narcan Provider (Yes or No)
No Data Available					

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Footnotes: