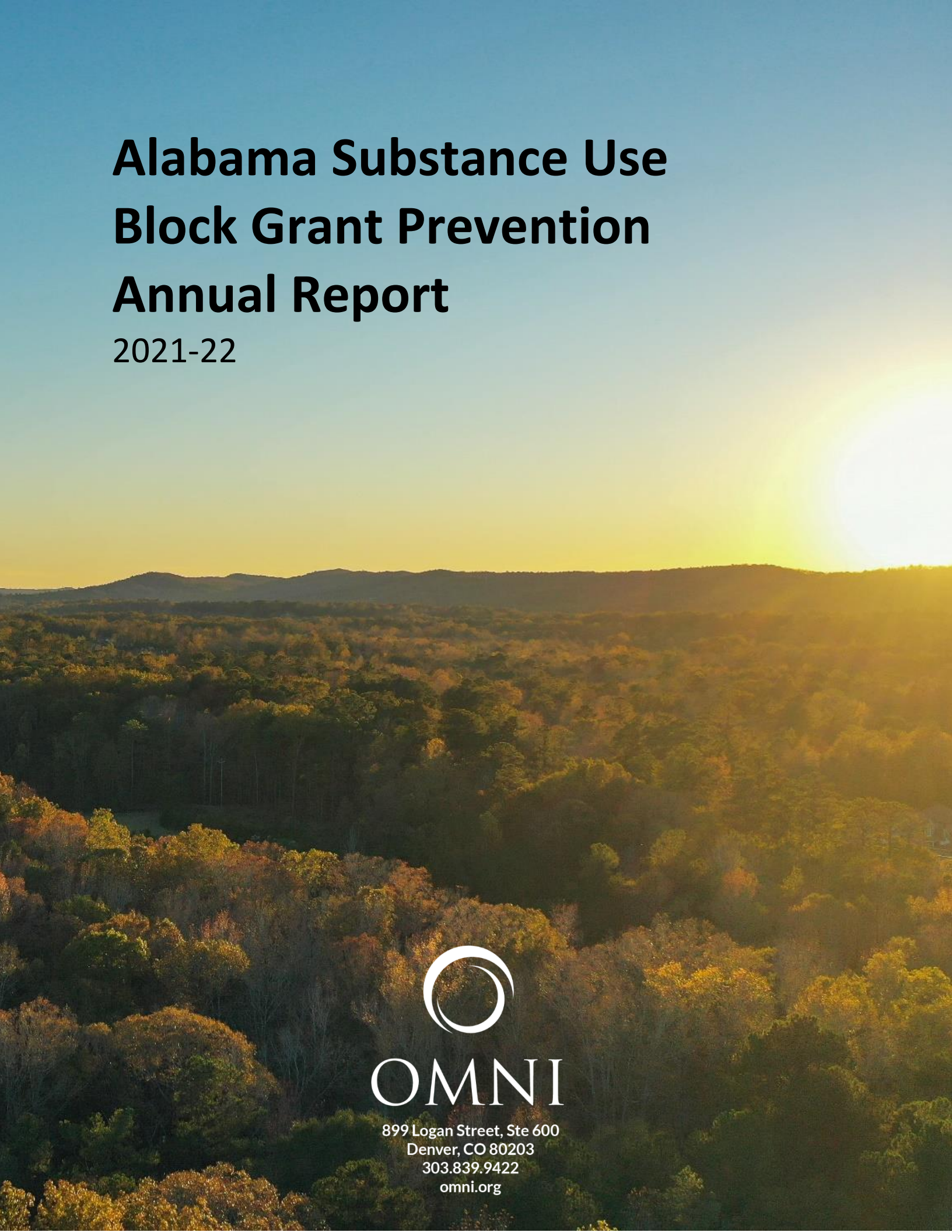
Alabama Substance Use Block Grant Prevention Annual Report

2021-22



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2021-22

Submitted to:

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Alabama Department of Mental Health
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Table of Contents

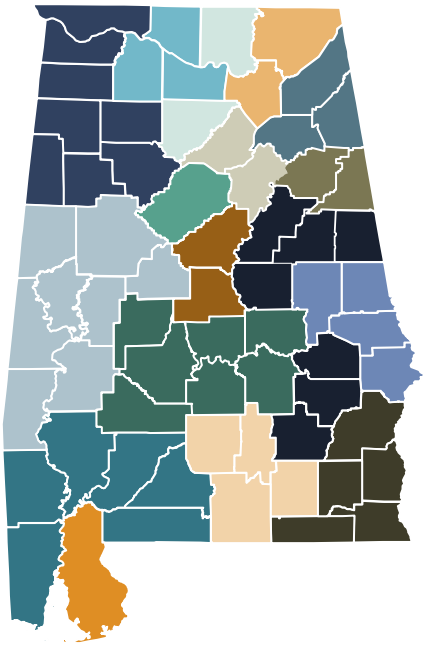
Alabama Substance Use Block Grant 2021-22 Annual Report: Executive Summary

The Substance Use Prevention, Treatment, and Recovery Services (SUPTRS) Block Grant (Formerly the Substance Abuse Prevention and Treatment [SAPT] Block Grant) is funded by the Substance Abuse and Mental Health Services Administration (SAMSHA). Alabama's Department of Mental Health (ADMH) Office of Prevention distributes grant funds to 16 prevention providers within 22 catchment areas who serve all 67 counties across the state. Providers use these funds to plan, implement and evaluate prevention strategies and activities aimed at preventing and/or decreasing substance use.

This report, prepared by OMNI Institute (OMNI), provides an overview of block grant prevention activities during the 2021-22 fiscal year (October 1, 2021 through September 30, 2022). OMNI has served as the evaluator of Alabama's BG funds since January of 2021. OMNI is a nonprofit, social science consultancy that provides integrated research and evaluation, capacity building, and data utilization services to accelerate positive social change.

Alabama's Block Grant activities are selected and implemented by providers through a data-driven approach based on the Strategic Prevention Framework (SPF) developed by SAMHSA. The SPF is made up of a set of steps and guiding principles designed to ensure effective substance use prevention services.

Each provider receiving Block Grant funding provides services to counties in their area. Alabama providers and the counties they served for the 2021-22 fiscal year are listed to the right.



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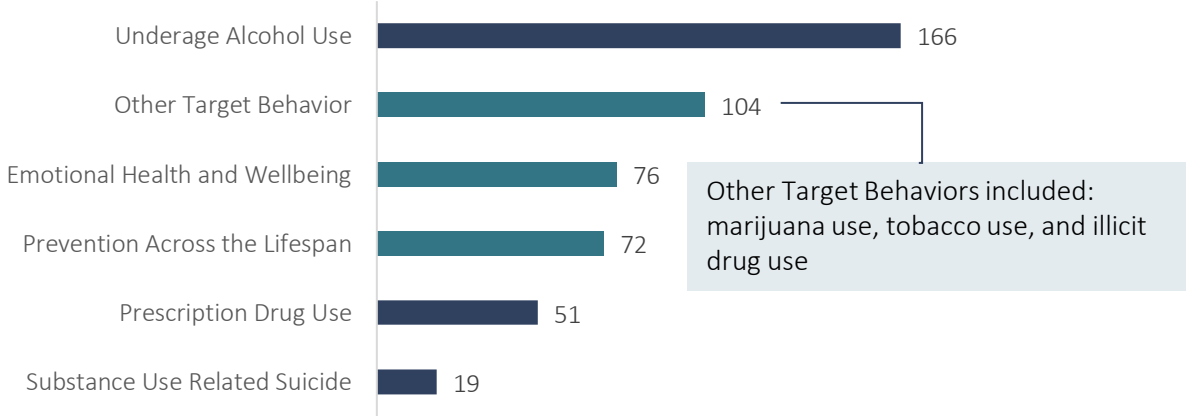
- Drug Education Council, Inc
- East Alabama Mental Health Center
- Mental Health Center of North Central Alabama
- Mountain Lakes Behavioral Health
- Northwest Alabama Mental Health Center
- P.R.I.D.E. of Tuscaloosa
- South Central Alabama Mental Health
- SpectraCare Health Systems, Inc
- Wellstone, Inc.

*Central Alabama Wellness is a subcontractor of Alcohol and Drug Abuse Treatment Center

FY22 Process Evaluation

Prevention providers selected interventions to align with statewide priority areas. The greatest number of implemented interventions targeted underage alcohol use. Providers were also able to implement other interventions that aligned with community needs, which included marijuana use, tobacco use, and illicit drug use.

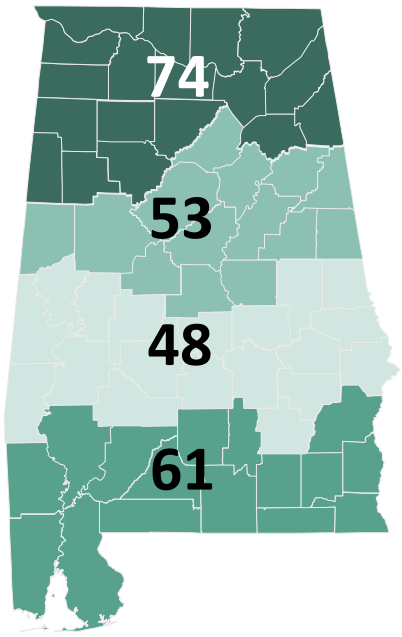


FY22 Process Evaluation

In fiscal year 2021-22 (FY22), providers implemented 236 interventions across Alabama's 67 counties, serving over 1.1 million people in Alabama.

The largest number of interventions were implemented in Region 1, followed by Region 3, Region 2, and Region 4, as shown in the map below. The number of people served by each provider is shown in the table below.

Total # of Interventions Implemented by Region



BG Provider Agency*	Numbers Served
Altapointe Health Systems	765,489
PRIDE of Tuscaloosa	246,716
Northwest Alabama MHC	93,286
South Central Alabama MHB	10,840
Drug Education Council, Inc.	7,039
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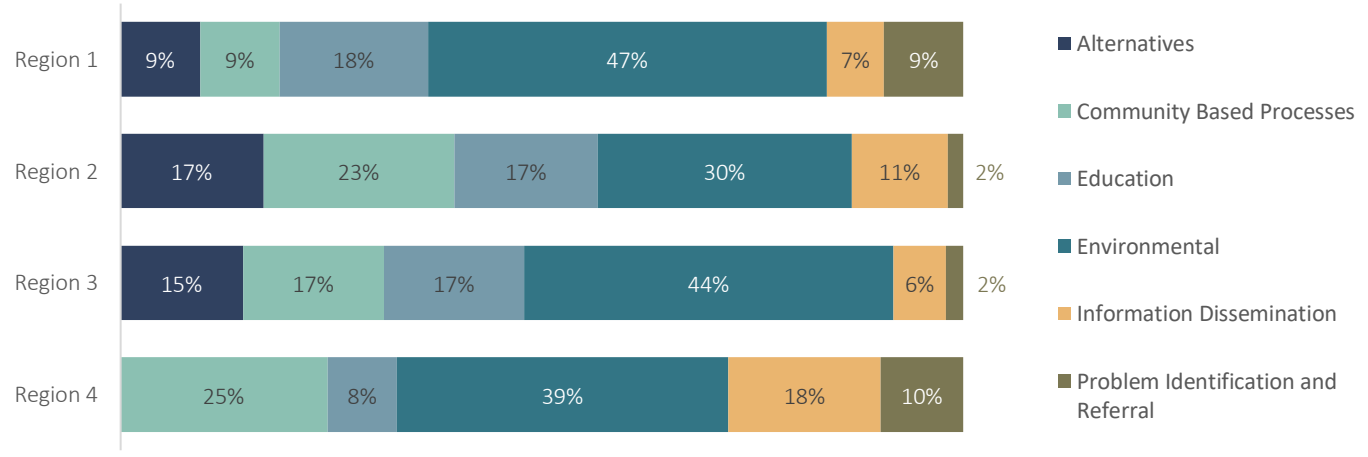
Central Alabama Wellness	4,130
Agency for Substance Abuse Prevention	3,322
SpectraCare Health Systems, Inc.	2,701
Alcohol and Drug Abuse Treatment Center	1,896
Mountain Lakes	1,467
Aletheia House	1,287
East Alabama Mental Health Center	1,143
Wellstone Inc.	606

*Data for Addiction Prevention Coalition and Mental Health Center of North Central Alabama were not available via the ASAIS data system.

Interventions fall under six Center for Substance Abuse Prevention (CSAP) strategies: Alternatives, Community-Based Processes, Education, Information Dissemination, Problem Identification and Referral, and Environmental.

Environmental strategies were the most commonly implemented strategies across all four regions.



Across Alabama the most people were served by environmental and information dissemination strategies.

747,250 served by environmental strategies

381,159 served by information dissemination strategies

21,173 served by community-based processes strategies

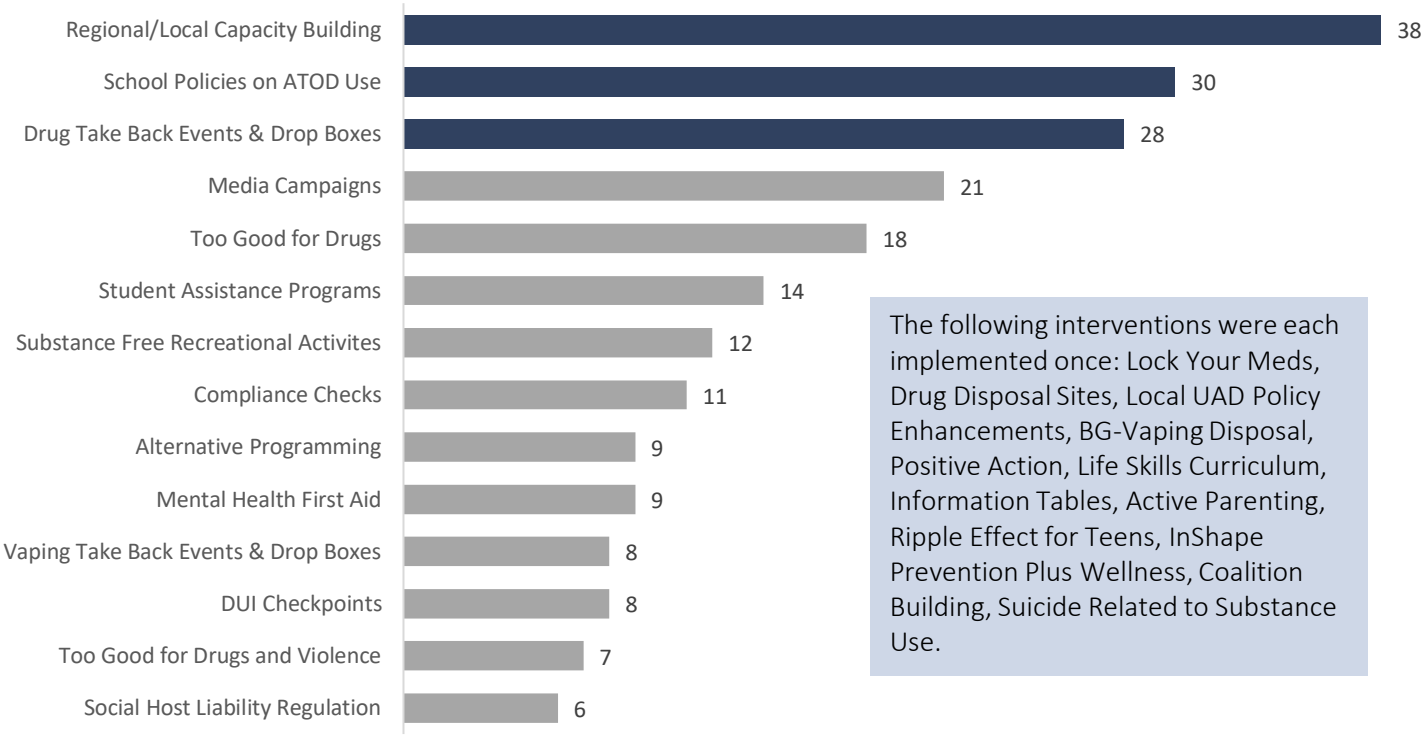
933 served by problem identification strategies

553 served by education strategies

172 served by alternative strategies

FY22 Process Evaluation

Capacity building programs, school policies on ATOD, and drug take back events and drop boxes were the most commonly implemented interventions during the 2021-22 fiscal year.



The following interventions were each implemented once: Lock Your Meds, Drug Disposal Sites, Local UAD Policy Enhancements, BG-Vaping Disposal, Positive Action, Life Skills Curriculum, Information Tables, Active Parenting, Ripple Effect for Teens, InShape Prevention Plus Wellness, Coalition Building, Suicide Related to Substance Use.

Providers shared the successes and challenges they experienced related to implementation of interventions in FY22. The themes below are listed from most to least frequently mentioned by providers.

Collaboration. A key aspect of success was provider collaboration with community partners. This was measured in number of meetings held, new connections made, and memorandums of understanding being established.

Achievement in Schools. Providers reported progress with schools regarding program implementation and substance use prevention messaging.

Outreach. Common methods associated with success while implementing prevention interventions were outreach, public education, community discussions, information dissemination, and increased and diversified social media platform engagement.

Staff Shortage. Providers reported a general lack of staff needed to successfully implement their interventions. Low internal prevention agency staff numbers, and high staff turnover contributed to lowered capacity at provider organizations.

Lack of Commitment from Partners. Collaboration with partners was very influential to successes in the past year, yet some providers mentioned that lack of support or commitment from community partners or agencies was a challenge.

Timing for Implementation of Statewide Survey. Providers noted challenges with implementing the Alabama Statewide Survey of Young Adults given the timing for implementation in late spring which conflicted with college students preparing for summer break.

FY22 Outcome Evaluation

In FY22, each prevention provider used their prevention plan template to specify short-term outcomes that they sought to reach in implementing their prevention interventions.

Providers used a variety of data sources to measure progress towards short term outcomes.

136 used pre/post evaluation tools

114 used stakeholder feedback surveys

40 used county-level data

53 used focus groups

11 documented policies enacted

In the tables below, problem area indicator data are presented along with the associated long-term outcomes desired. Changes in these key indicators from the prior year of data are discussed in more detail in the full report.

PROBLEM ALCOHOL USE

Desired Outcomes	Current Indicators
↓ Decrease in underage alcohol use	15.5% of Alabama youth ages 12-20 reported using alcohol in the past month. (NSDUH, 2018-2019)
↓ Decrease in underage binge drinking	9.8% of Alabama youth ages 12-20 reported binge alcohol use in the past month. (NSDUH, 2018-2019)
↓ Decrease in alcohol-related driving fatalities	31% of Alabama drivers involved in fatal crashes had a BAC of .01 or higher. (FARS, 2020)

PRESCRIPTION DRUG MISUSE AND OVERDOSES

Desired Outcomes	Current Indicators
↓ Decrease in prescription drug misuse among adults	4.6% of Alabamians aged 18+ reported pain reliever misuse in the past month. (NSDUH, 2018-2029)
↓ Decrease in prescription drug misuse among youth	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. (YRBSS, 2019)
↓ Decrease in prescription drug overdose deaths	22.3 per 100,000 was the rate of drug overdose deaths in Alabama in 2020. (CDC Wonder, 2020)

SUBSTANCE-RELATED SUICIDE AND DEATHS BY SUICIDE

Desired Outcomes	Current Indicators
↓ Decrease in suicide deaths and attempts in adults	16.0 per 100,000 was the rate of deaths by suicide in Alabama in 2020. (CDC Wonder, 2020)
↓ Decrease in suicide deaths and attempts in youth	11.6% of Alabama youth and 0.54% of Alabama adults reported a suicide attempt in the past year. (YRBS, 2019 & NSDUH, 2018-2019)
↓ Decrease in substance-related deaths by suicide	51 Alabamians died by suicide due to alcohol or drug poisonings in Alabama. (CDC Wonder, 2020)

Introduction

The Substance Use Prevention, Treatment, and Recovery Services (SUPTRS) Block Grant (Formerly the Substance Abuse Prevention and Treatment [SAPT] Block Grant) is funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). Alabama's Department of Mental Health (ADMH) Office of Prevention distributes grant funds to 16 prevention providers within 22 catchment areas who serve all 67 counties across the state. Providers use these funds to plan, implement, and evaluate prevention strategies and activities aimed at preventing and/or decreasing substance use.

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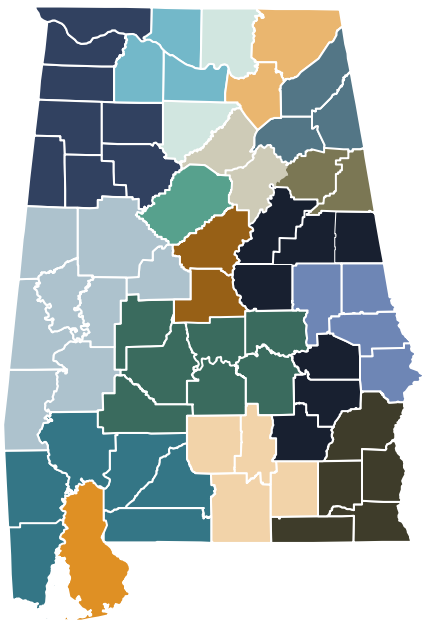
Alabama's BG activities are selected and implemented by providers through a data-driven approach based on the Strategic Prevention Framework (SPF) developed by SAMHSA.[1] The SPF is made up of a set of steps and guiding principles designed to ensure effective substance use prevention services. The steps include assessment, capacity, planning, implementation, and evaluation and are further guided by principles of sustainability and cultural competence.

Each provider completes an application for BG funding that details the counties they plan to serve with awarded funding. A list of Alabama counties and the providers that serve those counties is below.

Overview of Alabama counties and their providers for FY2021-22



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- South Central Alabama Mental Health
- SpectraCare Health Systems, Inc
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*Central Alabama Wellness is a subcontractor of Alcohol and Drug Abuse Treatment Center

[1] SAMHSA. (December 1, 2017). Applying the Strategic Prevention Framework (SPF). Retrieved from https://www.samhsa.gov/capt/applying-strategic-prevention-framework

FY22 Process Evaluation

This section of the report will summarize interventions implemented across the state in fiscal year 2021-2022 (FY22), as well as the number of people served or reached by these interventions. The section will also detail perceived successes and challenges to implementation based on progress reports.

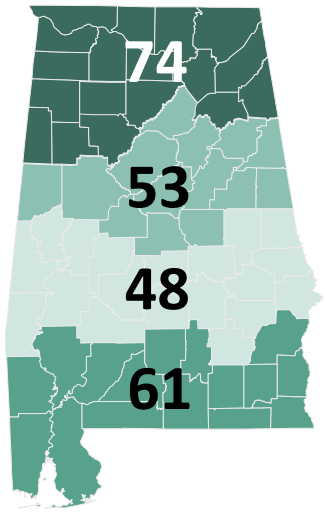
Data in this section of the report were drawn from the Alabama Substance Abuse Information System (ASAIS), Prevention Plan Templates (PPTs) for each county, and progress reports completed by providers. ASAIS data from FY22 were reviewed and analyzed to identify the number of individuals reached or served by agencies and strategies as defined by the Center for Substance Abuse Prevention (CSAP). Data collected from each county's PPT were cleaned and analyzed to identify the types of interventions that were implemented and the associated CSAP strategy. PPTs also provided qualitative data around the organizations' structures, as well as sustainability and cultural competency efforts.

For the purpose of planning for Alabama's public substance use service delivery system, the state is divided into four regions which include all 67 counties. Each region consists of from 14 to 19 counties, and regions are organized from north to south, with each region housing at least one major metropolitan area. Regions in the north of the state tend to include more urban and suburban communities, whereas regions in the south have a greater share of rural communities. Results are presented at the region level throughout this section of the report for clarity and ease of understanding. Additional results at the provider and county level are available in the appendices and are referenced throughout this section.

Prevention Interventions and Numbers Served

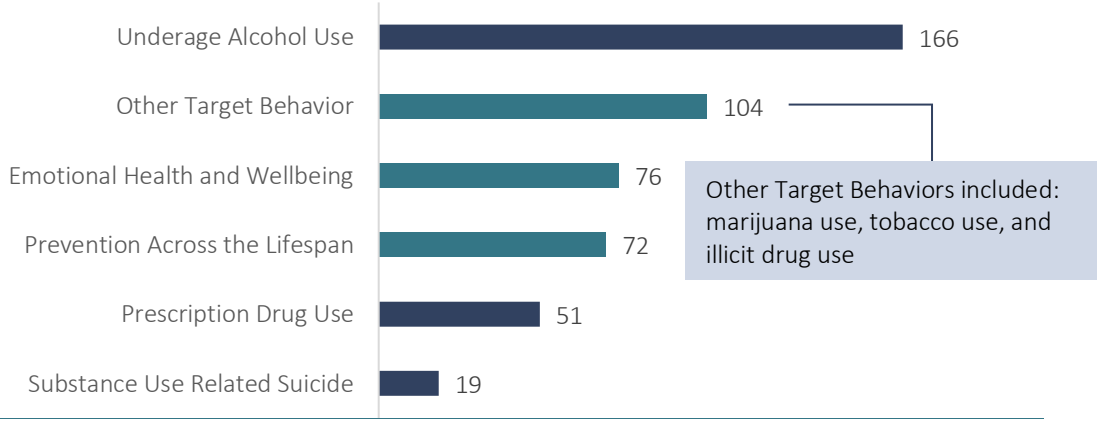
In FY22, providers completed PPTs to align their planning and implementation of prevention activities with the steps of the SPF. As a part of the PPT process, providers completed a needs assessment that included exploring risk and protective factor data as well as consequence data associated with the statewide priorities of underage drinking and prescription drug misuse. Providers could also identify additional issues or areas of concern in their communities that they intended to target with their BG funds. After completing this needs assessment process, providers decided whether to implement interventions targeting one or both of the priority areas, or an additional area of concern.

Total # of Interventions Implemented by Region



In FY22, providers implemented 236 interventions across Alabama's 67 counties. The largest number of interventions were implemented in Region 1 (*74*), followed by Region 4 (*61*), Region 2 (*53*), and Region 3 (*48*). Providers were able to choose a maximum of 10 total interventions to implement in each county. The total number of interventions in FY22 was less than in FY21, during which providers implemented 297 interventions across the state. The number of interventions implemented across counties ranged from 1 to 7 per county and the average was 4 interventions implemented per county. For a complete list of the number of interventions implemented per county, see Appendix A.

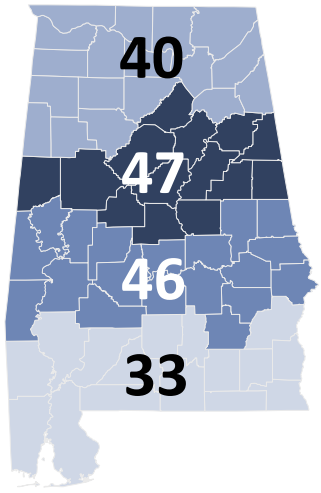
Specific behavior changes sought through implementation aligned with statewide priorities, but also highlighted additional goals of prevention interventions. Providers were able to select more than one possible behavior targeted by each intervention reported. There were 166 interventions targeting underage drinking. In addition, interventions also targeted related behaviors of prescription drug use and substance use related suicide, which align with the problem areas identified for the state.* Providers also reported 104 other target behaviors that were targeted through interventions implemented.



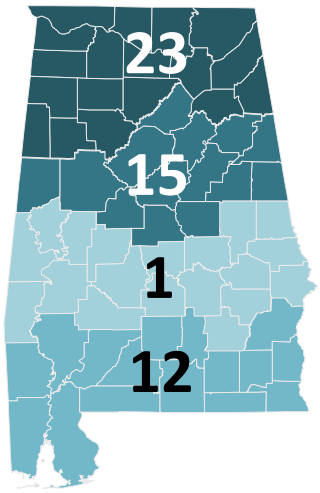
Each region implemented interventions targeting priority problem areas, but some regions focused more on one problem area than the other.

Region 2 implemented the most interventions targeting underage alcohol use, while Region 1 implemented the most interventions targeting prescription drug misuse.

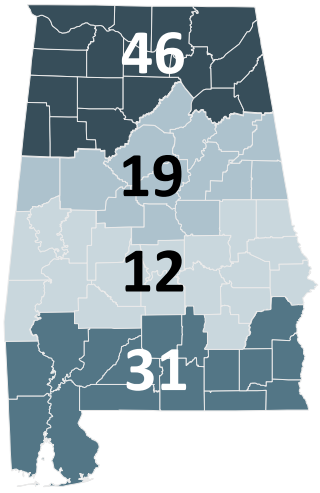
Interventions Targeting Underage Drinking Implemented by Region



Interventions Targeting Rx Drug Misuse Implemented by Region



Interventions Targeting Substance Use Related Suicide and Other Behaviors Implemented by Region



**Note: providers were able to select more than one primary and secondary target behavior. Therefore, numbers of target behaviors add up to more than the total number of interventions implemented.*

Providers served over 1.1 million people across Alabama through prevention interventions. Providers selected evidence-based prevention interventions to implement throughout their communities. These interventions fall under six CSAP strategies: Alternatives, Community-Based Processes, Education, Information Dissemination, Problem Identification and Referral, and Environmental.

BG Provider Agency*	Numbers Served
AltaPointe Health Systems	765,489
PRIDE of Tuscaloosa	246,716
Northwest Alabama MHC	93,286
South Central Alabama MHB	10,840
Drug Education Council, Inc.	7,039
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Aletheia House	1,287
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Wellstone, Inc.	606

**Note: Data on individuals served were not available for the Addiction Prevention Coalition or Mental Health Center of North Central Alabama, therefore, all totals in this report do not include individuals served by those two providers.*

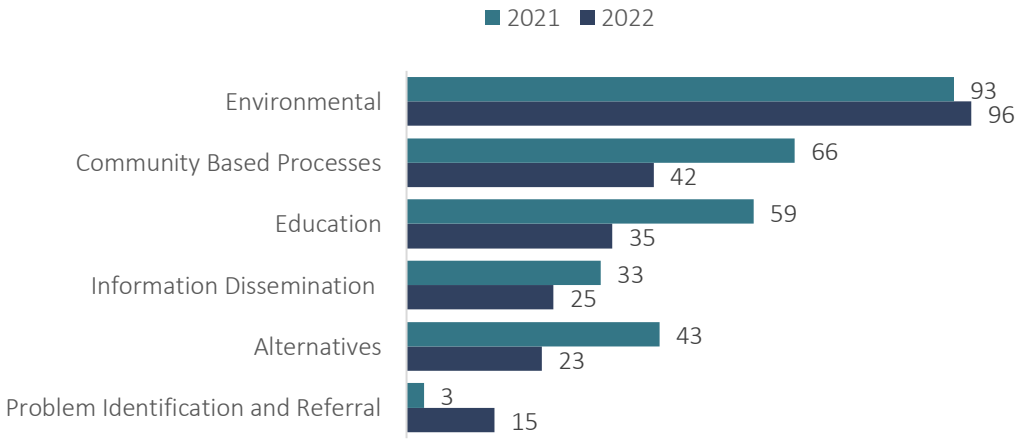
Some providers implemented more population-based interventions which accounts for their overall greater reach. Those agencies that used information dissemination or environmental CSAP strategies were able to reach higher numbers of people. Alternatively, agencies that focused on other CSAP strategies, such as education, served fewer people. See Appendix B for a breakdown of the proportion of CSAP strategies used by each individual agency.

Photo: Central Alabama Wellness providing prevention informational materials to their local community at an information booth.

Across Alabama, the most people were served by environmental and information dissemination interventions. By nature, both environmental and information dissemination interventions are designed to reach large populations with little to no contact between the source and the audience. The table below shows the number of people served by interventions for each CSAP strategy. For additional information on the subpopulations served by CSAP strategy, please see Appendix C.

CSAP Strategy	Number of People Served
Environmental	747,250
Information Dissemination	381,159
Community Based Processes	21,173
Problem Identification and Referral	933
Education	553
Alternatives	172

Like FY21, environmental strategies were the most commonly implemented of the six CSAP strategies across the state in FY22. A minimum of 50% of SABG funding must be expended for implementation of Environmental CSAP strategies, such as Take Back Events, Drug Disposal Sites, or Compliance Checks. While providers were required to expend 50% of *funds* on Environmental strategies, the overall *proportion* of environmental strategies implemented per provider did not always equal 50%, as other strategies may have lower costs to implement. For 19 of 67 counties, at least 50% of interventions were environmental strategies.



Environmental strategies were also the most commonly implemented across all four regions. Across all four regions, the proportion of Environmental CSAP strategies being implemented accounted for more than a third of the strategies being implemented and, in some regions, close to half of the strategies implemented. Community Based Processes were more prevalent in Regions 2 and 4, but on average made up about a fifth of prevention strategies. Education strategies made up a similar proportion of interventions across regions, with the exception of Region 4 which implemented a smaller percentage of education strategies compared to the other regions of the state. A greater percentage of information dissemination strategies were implemented in Region 4 compared to the rest of the state. The remaining two CSAP strategies (Alternatives, and Problem Identification and Referral) were generally less prevalent, with Problem Identification strategies the least commonly implemented.

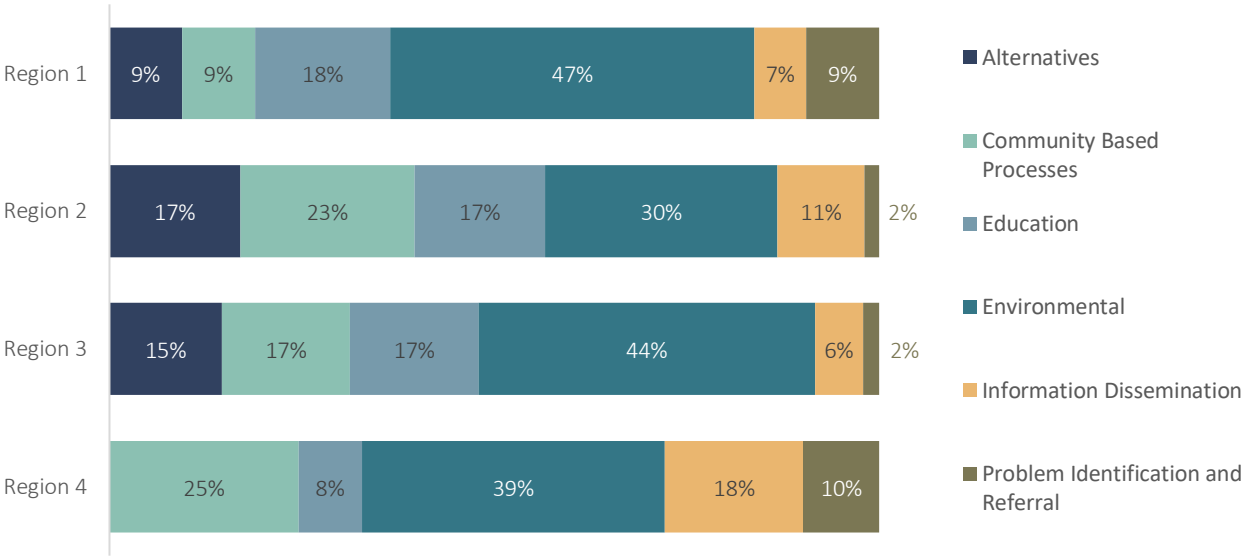
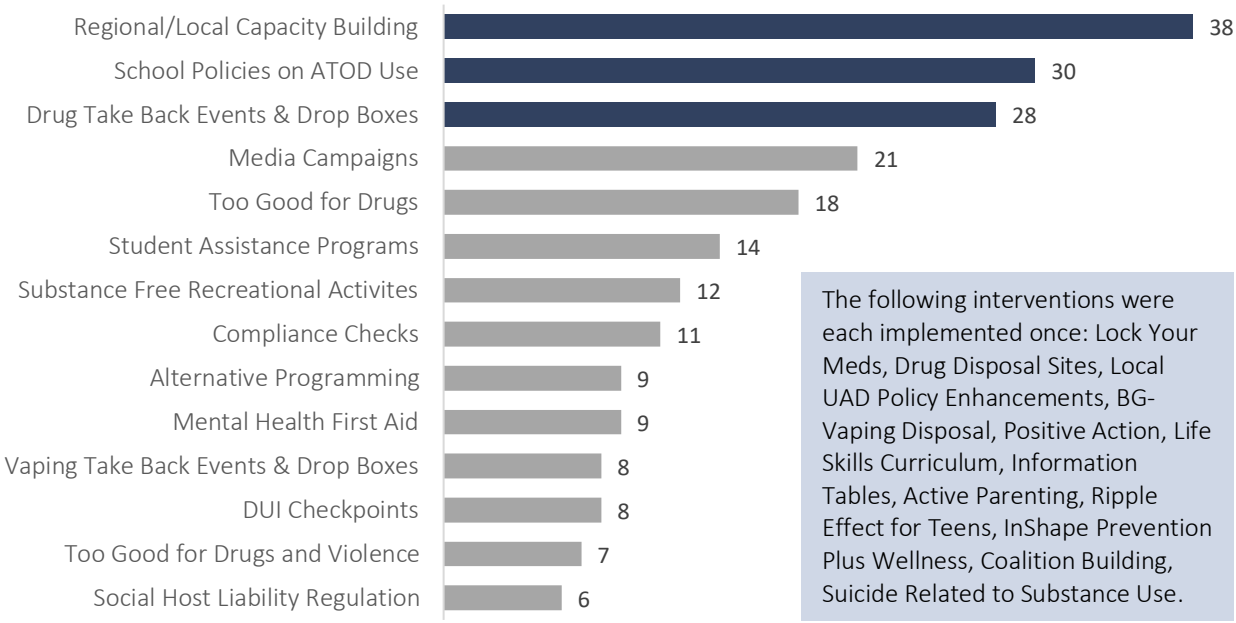


Photo: A sign from Central Alabama Wellness provides important information about the addictive nature of e-cigarettes and vaping, targeting community risk perceptions.

Capacity building programs, school policies on ATOD, and drug take back events were the most commonly implemented interventions during FY22. Providers implemented 38 capacity building interventions, including efforts such as sharing or collecting local data (e.g. the community readiness survey) or building relationships with community partners to support prevention efforts. Alternative programs included providing youth with activities such as after-school and summer programs.



The following interventions were each implemented once: Lock Your Meds, Drug Disposal Sites, Local UAD Policy Enhancements, BG-Vaping Disposal, Positive Action, Life Skills Curriculum, Information Tables, Active Parenting, Ripple Effect for Teens, InShape Prevention Plus Wellness, Coalition Building, Suicide Related to Substance Use.

Photo: Alta Pointe partnered with local law enforcement for their drug take back event.

Successes in Implementing Interventions

Providers shared the successes they experienced related to the implementation of their intervention efforts in FY22. The themes below were surfaced from the progress report responses from Quarter 4 (July to September 2022) and are listed from most to least frequently mentioned by providers.

Collaboration. This year has been about collaboration and partnerships for providers. Much of the activities centered on engaging community partners through coalition meetings, attending community events and festivals, as well as forming/strengthening relationships with schools and law enforcement. This was measured in number of meetings held, new connections or coalitions created, and memorandums of understanding being established. Providers who could not attend regular meetings worked to maintain connections with community partners regarding prevention plans and implementation.

"Community partnership have been the key to Central Alabama Wellness' Prevention Works Campaign. Building the partnership with Chilton County Children Policy Council allowed the launching of the Community Wellness Committee. The increase presence in the community through community events and policy council with Head Start connected Central Alabama Wellness with a different demographics."
-Alcohol and Drug Abuse Tx Center

Achievement in Schools. Providers indicated progress with schools regarding program implementation and substance use prevention messaging. Their interventions were successful through indicators such as number of meetings with school personnel and administration, number of presentations given, positive post-test evaluation/satisfaction scores and participant follow-ups, compliance rates, number of checkpoints or drug drop boxes installed, and trainings completed.

"Progress has been made and a drop box was ordered for both McKenzie and Georgiana Schools in Butler County. We are awaiting notification from school administrators on actual installation dates. Currently, we are working with school officials to set up vaping presentations."
-South Central Alabama Mental Health Center

Outreach. Common methods associated with success while implementing prevention interventions were outreach, public education, community discussions, information dissemination, and increased and diversified social media platform engagement.

"We reached 1,475 people on social media with the Lock Your Meds and other proper disposal and storage information."
-Mental Health Center of North Central

Challenges to Implementing Interventions

Providers also shared challenges regarding their implementation of prevention interventions. The themes below describe the most to least frequently mentioned challenges.

Staff Shortage. Many providers reported lacking the staff needed to successfully implement their interventions. Staffing shortages were felt internally amongst prevention providers due to high staff turnover, but were also felt broadly in the community, contributing to lowered capacity at partner organizations.

"Staffing shortage was our only barrier for the implementation of environmental scans."
-East Alabama Mental Health Center

Lack of Commitment from Partners. Collaboration with partners was very influential to successes in the past year, yet some providers mentioned that lack of support or commitment from community partners or agencies was a challenge. Examples include a lack of commitment from partners, issues with low partner capacity, partners not following through or following up on planned interventions, or partners being unable to engage in data sharing.

"Throughout this year it has been challenging to get community partners to commit to attending formal coalition meetings. While they support prevention efforts in the community, many of them are already serving on multiple committees and coalitions. We are working on trying to integrate prevention efforts into meetings that are already taking place in the community to reduce the burden on our community partners."
-Drug Education Council

Timing for Implementation of Statewide Survey. Providers noted challenges with implementing the Alabama Statewide Survey of Young Adults given the timing for implementation in late spring which conflicted with college students preparing for summer break. Providers noted they may have been able to recruit more students if the survey aligned with the school year. Providers also mentioned that some low engagement from target groups came from general skepticism due to privacy concerns and the sensitive nature of some of the questions. Providers were able to offset this barrier and encourage participation by emphasizing the statewide raffle that respondents would be entered into after completing the survey.

"Some of the younger adults are skeptical to take the survey even though they are anonymous. Some have even thought it might be spam. I have talked to quite a few younger adults that have completed it and asked that they get their friends to take it also. Most businesses have been willing to let me post the number for the survey."
-Etowah Dekalb Cherokee MH

Stakeholder Engagement

Engaging stakeholders in the community is crucial to the success of prevention interventions. Providers reported their involvement with different stakeholders in the counties they serve in their PPTs.

62 counties reported having active involvement in their county's Children's Policy Council, which seeks to prevent youth substance use.

A Children's Policy Council (CPC) reviews the needs of children in their county and works with local agencies to better serve the children in their area. The services provided by CPCs range from hosting monthly or quarterly meetings, providing feedback on agency services, and serving as an advisory board for prevention programs. Provider staff often serve as members on CPCs to ensure transparency across groups. One provider was working with a CPC to conduct a needs assessment for the county: "The CPC completes a yearly needs assessment for Cullman County which has identified mental health and substance abuse as the top two most important issues facing Cullman County children and families because of the far-reaching problems it creates for the health, safety, and economic security risks to the children in the county. The CPC serves as a vitally important stakeholder from whom we obtain valuable statistical information about the county population and needs assessment."

"SpectraCare Health Systems is an active member of the Barbour County CPC. A representative attends quarterly meetings and contributes to the annual needs assessment. SpectraCare also provides relevant substance abuse and mental health information to stakeholders at each meeting. Barbour County CPC has the potential to enhance organizational capacity, space for networking, identification of resources available, and information sharing."

26 counties reported having an active coalition to prevent substance use in their county.

Coalitions are effective in driving community prevention efforts, leveraging collaborative partnerships to implement strategies, and mobilizing the community. Providers collaborated with local coalitions to address key program areas, including youth substance use prevention and parent education. Activities provided through these coalitions include networking, sharing materials, offering trainings, and facilitating meetings. Providers partnered with a broad range of stakeholders, including:

- ✓ Schools and other youth serving organizations
- ✓ Faith-based communities
- ✓ Local government agencies
- ✓ Local organizations
- ✓ Law enforcement

"Compact developed a volunteer-led prevention coalition to educate, engage, and empower their local communities. The Tri-City Impact Team was developed in 2019 as one of the community coalitions. Chilton-Shelby MHC coordinates meetings, recruits new members, provides trainings, plans events, and collaborates with community and school stakeholders. The Tri-City Impact Team and Chilton-Shelby MHC will address underage drinking, low refusal skills, early initiation of use, and lack of parental monitoring."

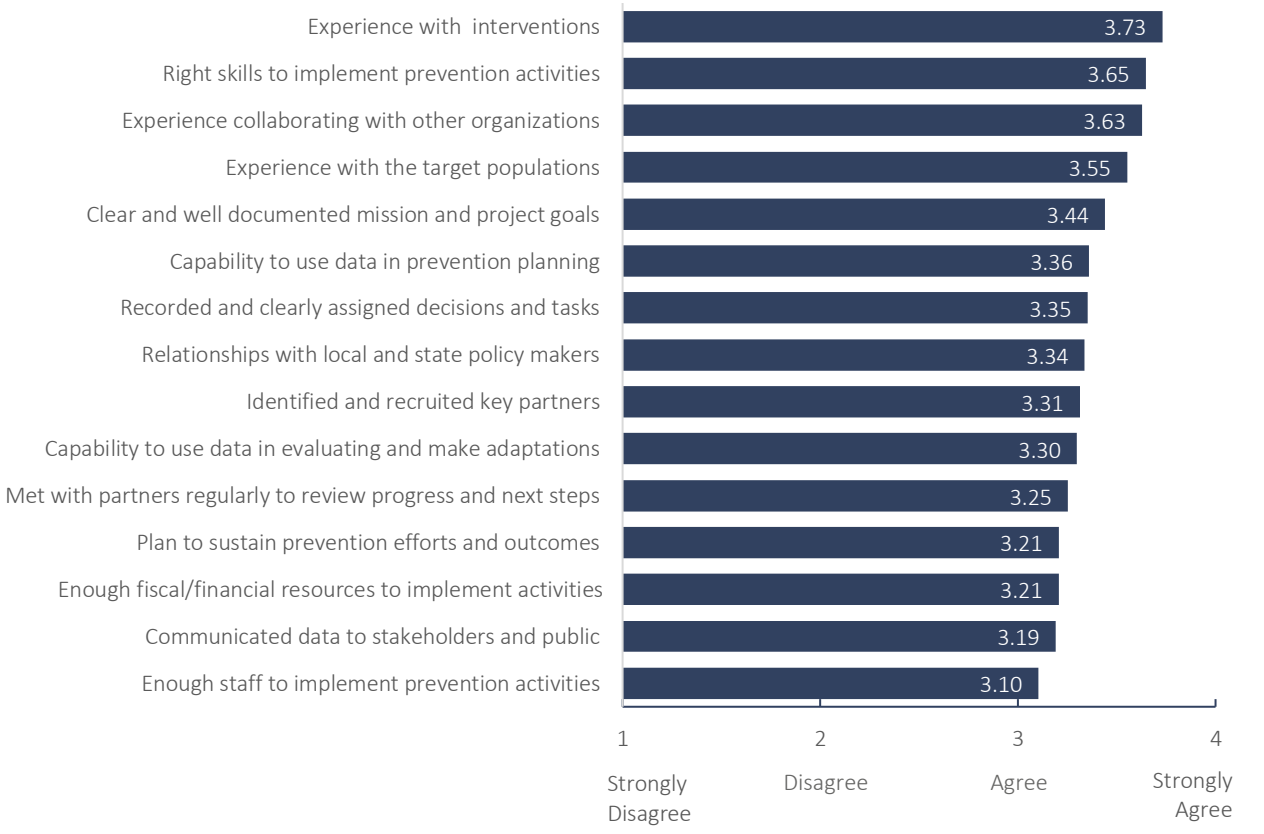
Many providers are actively involved in their local coalitions. Some providers mentioned attending meetings, implementing prevention strategies, or providing education. Other providers mentioned leadership roles in their coalitions, though serving on advisory boards or planning committees. One provider stated in their PPT that "the Tuscaloosa County coalition is called the T-town Substance Abuse Prevention Coalition (TSAPC) and is currently facilitated by PRIDE staff with 6 community members as well as 2 PRIDE employees. TSAPC meets regularly to brainstorm ideas of events and initiatives that will increase awareness of substance abuse problems in our community. TSAPC plans and facilitates parent conferences that provide up to date and specific information about substances to parents in regards to their children's schools."

"Bibb Substance Abuse Prevention Coalition (BSAPC) has been in the process of growing and incorporating different key stakeholders in the community. BSAPC has addressed the need in our community by developing a parent education course. The goal of this course will be to educate the parents more thoroughly on addiction in the modern day and some of the underlying factors that can contribute to early age substance abuse."

Provider Capacity

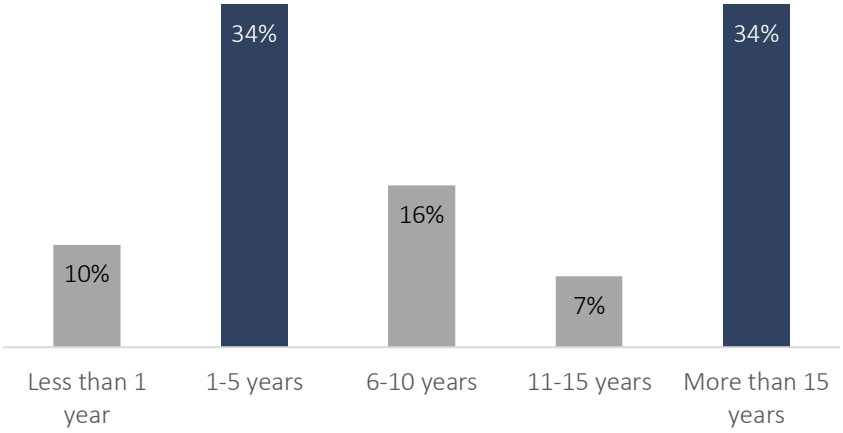
Providers were asked questions around building capacity in their counties to implement prevention interventions to address substance use.

In FY22, providers strongly agreed that their organization has the experience and skills to implement prevention interventions in their county. Providers reported less agreement with having enough staff to implement prevention activities in their county and effectively communicating data to stakeholders and the public.



Providers were also asked to report the years of experience for staff working on SABG funded prevention activities in their PPTs. 259 staff members were entered across the state, with a range of years of prevention experience. Staff also indicated various training and technical assistance (TA) needs on PPTs.

34% of staff indicated working at their organizations between 1 to 5 years or more than 15 years.* This mix of newer prevention professionals and more experienced staff may provide organizations with an ideal balance between institutional knowledge and current expertise in prevention best practices.



**Note: years of experience may total to more than 100 due to rounding.*

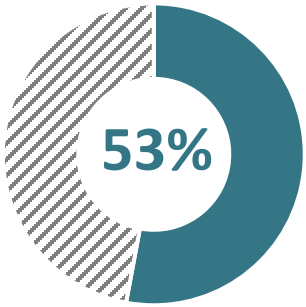
31 counties indicated TA needs around identifying and implementing environmental strategies. Providers also indicated feeling confident (and not needing TA) in selecting interventions, building partnerships, and implementing interventions.

Capacity Building to Address Health Disparities

On PPTs, providers were asked to rate their organizations' cultural competency, or their ability to interact effectively with people of different cultures. Cultural competency helps to ensure the needs of all community members are addressed.

Culture must be considered at every step of the Strategic Prevention Framework (SPF). "Culture" is a term that goes beyond just race or ethnicity. It can also refer to such characteristics as age, gender, sexual orientation, disability, religion, income level, education, geographical location, or profession.

53% of providers said they have formal, written policies in place to address cultural competency.



8 providers serving 31 counties indicated that they did not have formal written policies in place.

- 30% of providers (5) have not developed formal, written policies to address cultural competency.
- 18% of providers (3) do not have policies in place to address cultural competency, but these are being developed.

Engagement with diverse communities is important to address health disparities and provide culturally appropriate education materials. Healthy People 2030 defines a health disparity as "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion."

"We have a Human Rights Policy that is followed throughout our agency that ensures all who receive services are treated with dignity, compassion, and the needed skills to provide culturally competent treatment and prevention. We attend cultural competency trainings as a prevention program. We have people who reflect our community on our coalitions and planning committees."

Providers indicated several strategies for connecting with communities from diverse backgrounds. Cultural competency and active learning provide a foundation for growing and maintaining stakeholder relationships. Providers reported working with members of the population of focus, law enforcement, members of the justice system, educators, parents, and the faith-based community. In essence, providers worked to meet communities where they are through various community spaces and local organizations, including but not limited to:

- School systems
- Area Chambers of Commerce
- Nonprofit councils
- Local Children's Policy Council

Additionally, these organizations and community groups serve to provide a wealth of knowledge about these communities through shared lived experiences. This practice is further reflected in hiring practices where providers work to hire staff who are representative of the communities they serve. Finally, these groups operate as sounding boards for providers by giving feedback on planning/programming, offering intervention implementation guidance, and identifying community engagement strategies.

Photo: Northwest Alabama Mental Health Center at a community event distributing information from Parents Who Host Lose the Most, an information dissemination strategy targeting parents of youth to prevent underage drinking.

Leveraging coalitions and local advisory boards have proved helpful for providers as they develop their programming. PRIDE reported that they are "proud to partner with a number of local and area organizations which are culturally diverse and have a keen understanding of the needs in our community. Such organizations include the Tuscaloosa Children's Policy Council, the PRIDE-facilitated TSAPC coalition, Kid's Life Magazine, the West Alabama Chamber of Commerce, Boys & Girls Club of West Alabama, local school systems, and the West Alabama Nonprofit Council; all of which work with PRIDE and other organizations to build a culturally competent network and framework for community support. This framework guides PRIDE and other local human services organizations in the development of culturally competent, relevant, and sustainable programming and services."

"Our agency (Limestone County) works with diverse backgrounds through the school systems and community. We ensure cultural competency by working with language barriers and other barriers to provide services to as many community members as possible through Spanish materials when needed, enhanced handouts for students with sight issues and other disabilities. Our agency focuses on serving rural populations that have limited services available in their communities along with high-risk youth who have less access to prevention services. Our staff participates in cultural competency trainings on as available basis to continually improve our services in relation to diverse backgrounds."

A key component of cultural competency is addressing health disparities in providers' communities. This is achieved through practical application, including:

Addressing language barriers, including translating written materials or providing translators at in-person events or meetings.

Creating internal policies and Standards of Conduct, which can include application of CLAS Standards.

Offering trainings as professional development or part of the onboarding process, such as Cultural Competency in RELIAS.

"At ASAP we and our coalition maintain a set of attitudes, perspectives, and behaviors and ensure policies that promote positive and effective interactions with diverse cultures. It is important to regularly and honestly continue organizational cultural maintenance through workshops, trainings and other professional education experiences."

In PPTs, providers created a health disparity impact statement for high-risk populations that served as guidance for the implementation of services in FY22.

High-risk populations reported by providers included:

- Veterans and military families
- Lesbian/gay/bisexual/transgender/ queer/ questioning (LGBTQ+)
- Individuals experiencing homelessness
- Individuals involved in the criminal justice system
- Students in college
- Underserved racial and ethnic minorities
- High risk youth
- Alaska Native/American Indian
- Black/African American
- Hispanic
- Native Hawaiian/Other Pacific Islander
- Asian
- Youth in tribal communities
- Individuals living in rural areas
- Pregnant women and children
- Older population (65+)
- English second language
- Deaf or hard of hearing
- Low literacy level

Example Health Disparity Impact Statement

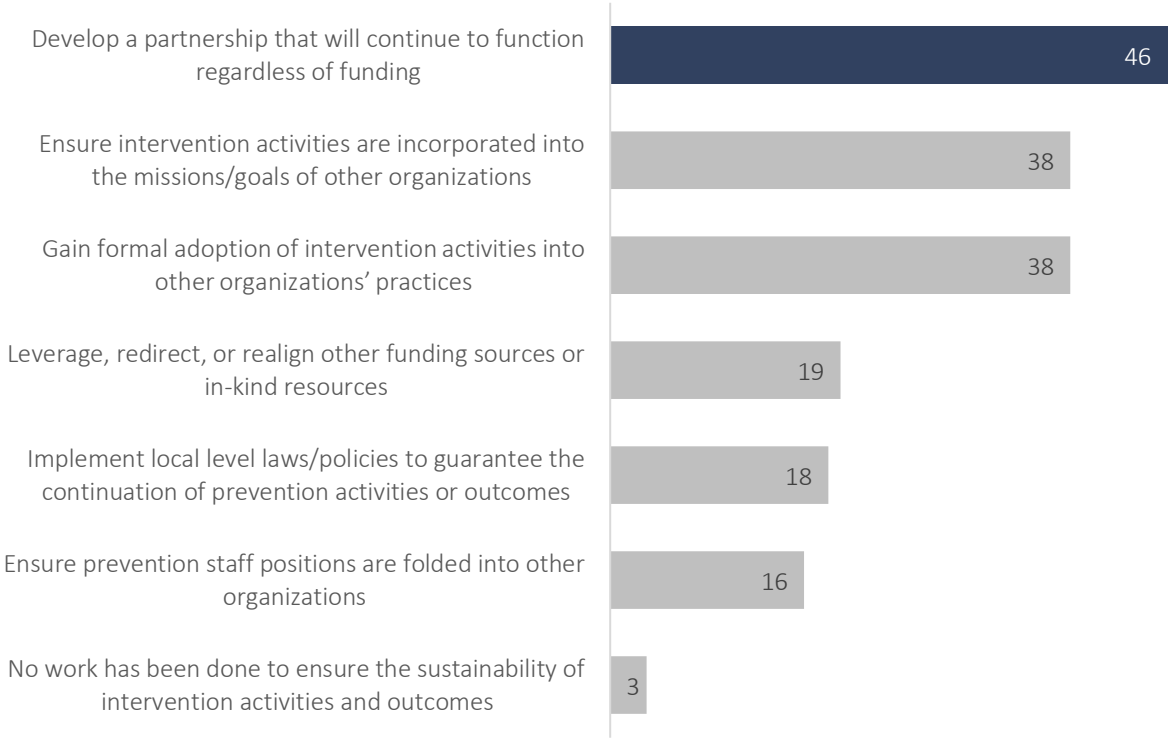
An example of a health disparity impact statement from Cullman County: *Heads Up provides services in multiple communities in Cullman County, working with various organizations to identify the highest risk population and ensure that services are provided where most needed. We provide materials in various forms-verbal and written, including written materials in multiple languages, and employing a translator as needed. Staff is consistently trained in cultural competence to ensure appropriate services to diverse populations.*

Sustainability

Providers also plan to sustain prevention outcomes and intervention activities beyond Block Grant. Most providers indicated working toward some sustainability efforts, including building stakeholder support for programs, or sharing results of prevention activities with their communities. Providers also noted that sustainability is strengthened through partnerships with coalitions to find alternative funding sources, develop follow-up policies for programs, and create data collection activities that can be conducted with established budgets. During the PPT process, providers could select all the sustainability efforts they were working on.

"The Drug Education Council and its community partners are continually seeking sources of additional funding for both new and existing substance abuse prevention programs in the community. This ongoing process includes researching and applying for grant opportunities and pursuing other local, regional, state, and federal sources of additional funding both in person and via email and web applications."

46 counties worked on developing a partnership structure that will continue to function regardless of funding.



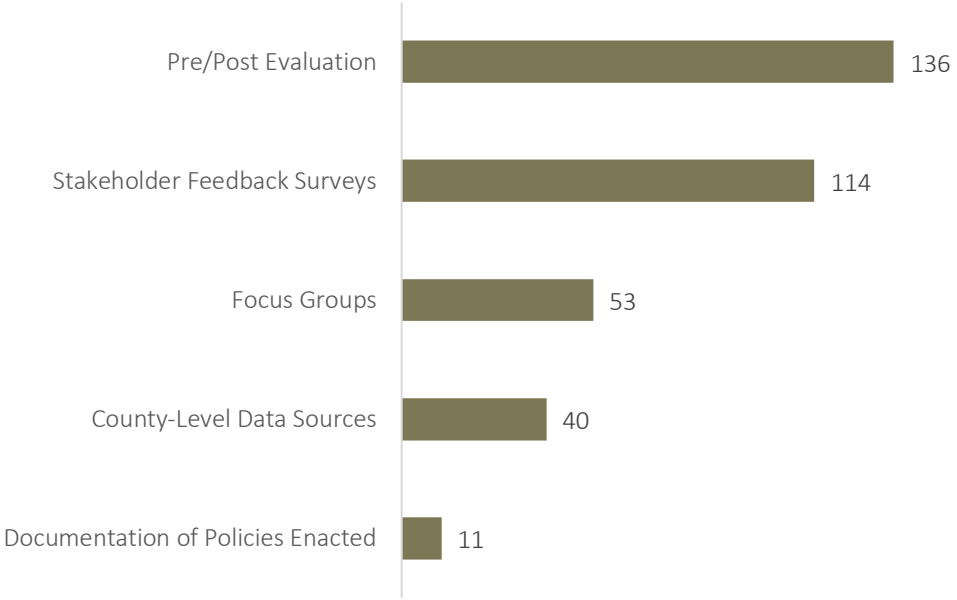
"Addiction Prevention Coalition (APC) has a sustainability plan that is being implemented and is revisited quarterly for improvements. APC continues to build stakeholder support at all stages of program development and implementation. We value and utilize input from coalition and advisory board members for all our programs. We implement evaluations, key informant interviews, and evaluations quarterly and report our findings. We are engaged with partner organizations at a high level to work towards policy changes that will prevention sustain outcomes. We continue to obtain additional funding sources and take measures to ensure prevention outcomes will sustain past the life of the programs."

FY22 Outcome Evaluation

This section of the report discusses the measurement of both short-term intervention outcomes and long-term outcomes identified through the statewide evaluation planning process. In FY22, each provider reported progress towards reaching the short-term outcomes identified in their prevention plan template.

Short-term Outcomes

Providers indicated using a variety of data sources to measure progress towards short-term outcomes. The most common data sources were pre- and post- intervention evaluations, which can measure changes in attitudes, behaviors, and other variables relevant to intervention goals. Stakeholder feedback surveys help providers understand participant satisfaction with interventions and can be a source of additional feedback on how to improve interventions in the future. Some providers also collected and monitored county-level data sources, while others conducted data collection through focus groups. Finally, providers measured short-term outcomes through documentation of policies enacted as a result of prevention efforts.



Long-term Outcomes

In addition to measuring progress towards short-term outcomes of intervention implementation in FY22, OMNI continued to monitor key indicators related to the problem areas and desired long-term outcomes identified in the Alabama Block Grant Logic Model (see Appendix D). The problem area data presented in the logic model were gathered via relevant secondary data sources at the state level and reflected the data available at the time of the creation of the logic model in 2021. Trends in these indicator data will be tracked over time to understand changes in the magnitude of the problem areas, which include problem

alcohol use, prescription drug misuse and overdoses, and substance-related suicide and death by suicide. In the following tables, data are presented along with the associated long-term outcomes desired. Below we discuss whether current indicators have been updated from the prior fiscal year and if so the direction of the change.

Recent data suggest slight decreases in the percent of drivers with a BAC of 0.1 or higher involved in fatal car crashes. The Fatality Analysis Reporting System (FARS) reported a decrease in the percent of Alabama drivers involved in fatal crashes who had a BAC of .01 or higher (31% in 2020, down from 34% in 2019). Unfortunately, data from the National Survey on Drug Use and Health (NSDUH) were not available for 2019-2020 due to methodological concerns with combining 2019 and 2020 data. OMNI will continue to track NSDUH data in the years to come in order to assess progress towards the desired outcomes related to underage alcohol use.

PROBLEM ALCOHOL USE	
Desired Outcomes	Current Indicators
↓ Decrease in underage alcohol use	15.5% of Alabama youth ages 12-20 reported using alcohol in the past month (NSDUH, 2018-2019)
↓ Decrease in underage binge drinking	9.8% of Alabama youth reported binge alcohol use in the past month (NSDUH, 2018-2019)
↓ Decrease in alcohol-related driving fatalities	31% of Alabama drivers involved in fatal crashes had a BAC of .01 or higher. (FARS, 2020)

Data from the CDC show an increased rate of drug overdose deaths in Alabama in recent years (22.3 per 100,000 in 2020, up from a rate of 16.6 per 100,000 in 2018). However, data that may speak to changing trends in prescription drug misuse were not available at the time of this report. As previously mentioned, data from the National Survey on Drug Use and Health (NSDUH) were not available for 2019-2020 due to methodological concerns with combining 2019 and 2020 data. Additionally, Youth Risk Behavior Surveillance System (YRBSS) data for 2021 were not released as of the preparation of this report, therefore it is not possible to make comparisons with that data and data from 2019. Future annual reports will include updated YRBSS and NSDUH data once they become available. Lastly, OMNI will continue to monitor trends in prescription drug misuse in the years to come. Though methodological changes may have impacted data collection for some key indicators during the pandemic, OMNI will continue to contextualize trends within the current prevention landscape to the extent possible.

PRESCRIPTION DRUG MISUSE AND OVERDOSES	
Desired Outcomes	Current Indicators
↓ Decrease in prescription drug misuse among adults	4.6% of Alabamians aged 18+ reported pain reliever misuse in the past month. (NSDUH, 2018-2019)
↓ Decrease in prescription drug misuse among youth	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. (YRBSS, 2019)
↓ Decrease in prescription drug overdose deaths	22.3 per 100,000 was the rate of drug overdose deaths in Alabama in 2020. (CDC Wonder, 2020)

With regard to substance-related suicide and deaths by suicide, slight decreases were observed in key indicators while other data were unavailable. According to CDC Wonder data, the rate of deaths by suicide decreased from 16.5 per 100,000 in 2018 to 16.0 per 100,000 in 2020. Additionally, the number of Alabamians who died by suicide due to alcohol or drug poisonings decreased from 59 individuals in 2019 to 51 individuals in 2020. Again, recent data from the YRBSS and NSDUH were not available for this report, but OMNI will include updated data in future reports.

SUBSTANCE-RELATED SUICIDE AND DEATHS BY SUICIDE	
Desired Outcomes	Current Indicators
↓ Decrease in suicide deaths and attempts in adults	16.0 per 100,000 was the rate of deaths by suicide in Alabama in 2020. (CDC Wonder, 2020)
↓ Decrease in suicide deaths and attempts in youth	11.6% of Alabama youth and 0.54% of Alabama adults reported a suicide attempt in the past year. (YRBSS, 2019 & NSDUH, 2018-2019)
↓ Decrease in substance-related deaths by suicide	51 Alabamians died by suicide due to alcohol or drug poisonings. (CDC Wonder, 2020)

FY22 Evaluation Activities

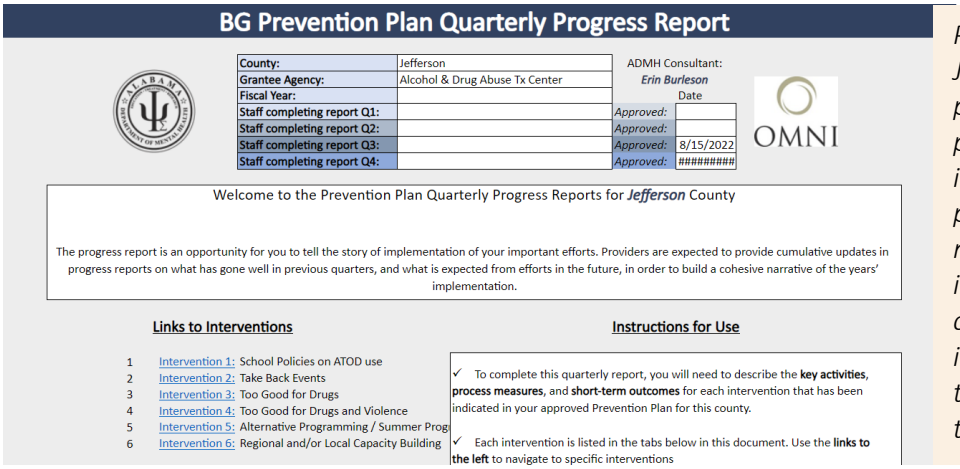
This section describes evaluation activities that OMNI supported in FY22. These activities were determined based on ADMH priorities, provider feedback, and grant evaluation requirements.

Prevention Plan Template Amendments and Progress Reports

In FY22, providers continued the implementation of strategies specified in their FY21 prevention plan templates (PPTs). The PPTs are valid for a two-year period, therefore providers only amended their plans if they needed to add a strategy (such as statewide survey implementation), remove a strategy, or otherwise modify their plans in a way that required ADMH approval. OMNI supported PPT amendment requests on an as needed basis throughout the fiscal year.

Providers were also required to complete quarterly progress reports for prevention implementation in each county they serve. In these progress reports, providers described progress toward key intervention activities, process measures, and short-term outcomes identified in their PPTs.

Starting in Quarter 2, OMNI revised the progress report format based on provider and ADMH feedback. To improve accuracy and reduce burden, the interventions, process measures, and short-term outcomes were populated in an Excel sheet. The sheets were also updated to include responses from previous quarters so providers could more clearly identify their progress on these measures and add relevant updates. Providers provided positive feedback on the updated format and reported that they wished this format was used across other grants.



BG Prevention Plan Quarterly Progress Report

County:	Jefferson
Grantee Agency:	Alcohol & Drug Abuse Tx Center
Fiscal Year:	
Staff completing report Q1:	
Staff completing report Q2:	
Staff completing report Q3:	
Staff completing report Q4:	

ADMH Consultant: *Erin Burleson*

	Date
Approved:	
Approved:	
Approved:	8/15/2022
Approved:	##########

OMNI

Welcome to the Prevention Plan Quarterly Progress Reports for ***Jefferson*** County

The progress report is an opportunity for you to tell the story of implementation of your important efforts. Providers are expected to provide cumulative updates in progress reports on what has gone well in previous quarters, and what is expected from efforts in the future, in order to build a cohesive narrative of the years' implementation.

Links to Interventions

1 Intervention 1: School Policies on ATOD use
2 Intervention 2: Take Back Events
3 Intervention 3: Too Good for Drugs
4 Intervention 4: Too Good for Drugs and Violence
5 Intervention 5: Alternative Programming / Summer Prog
6 Intervention 6: Regional and/or Local Capacity Building

Instructions for Use

✓ To complete this quarterly report, you will need to describe the **key activities**, **process measures**, and **short-term outcomes** for each intervention that has been indicated in your approved Prevention Plan for this county.

✓ Each intervention is listed in the tabs below in this document. Use the **links to the left** to navigate to specific interventions

Photo: Example of Jefferson county's prevention quarterly progress report instruction and landing page. Providers could navigate to specific interventions by clicking on the intervention links or tabs on the bottom of the spreadsheet.

Statewide Survey Implementation

Through the development of the PPTs in the prior fiscal year (FY21), OMNI and ADMH identified areas where data regarding risk and protective factors for priority areas were not readily available or did not exist for certain populations in Alabama. To bridge this gap and contribute to a greater body of data around substance use and behavioral health, OMNI began to develop a statewide survey to better understand the behaviors and attitudes of young adults (ages 18-25). The survey development process

began in FY21 and centered on adapting existing assessments of substance use risk and related health consequences across various populations to allow for a comprehensive assessment of these areas in a young adult population. OMNI also worked with ADMH and the State Prevention Advisory Board to incorporate feedback and refine survey content.

The finalized survey includes questions on:

- Alcohol, tobacco/vaping, prescription drug and other drug use, marijuana/cannabis, over the counter (OTC) medications, stimulants, and polysubstance use. In addition to frequencies and types of substances used, attitudes, opinions, and related behaviors are surveyed, such as: perceptions and knowledge of personal risk of use; beliefs about normative use among peers; age of onset of use; route of and perceptions of ease of access of substances; engagement in safe use such as storing and disposing of substances safely and attending and adhering to packet insert and health provider instructions on prescription drugs.
- Mental health behaviors and health consequences such as: stress related to the COVID-19 pandemic, and political and/or social unrest; depression; ideations and behaviors regarding self-harm and suicide; help-seeking behaviors; and an inventory of experiencing several specific adverse childhood experiences (ACEs) known to be associated with mental health and substance use outcomes in young adulthood.
- Demographic information to allow for subgroup analyses to better understand the needs of specific subpopulations.

In FY22, OMNI concluded planning for the statewide survey, which then began implementation in April of 2022. While OMNI supported the implementation of the survey through resource development, survey dissemination, and response monitoring, prevention providers were responsible for on-the-ground recruitment and administration of the survey. Providers leveraged their existing relationships with local communities, colleges, and other youth-serving organizations to administer the survey through September of 2022. OMNI has analyzed collected survey data at the state and county level and is in the process of developing a summary report.

The survey administration process:

Timeline
The survey was administered from April through September 2022 across Alabama.

One-on-One Support
The OMNI TA team conducted TA calls with providers to discuss implementation challenges and other survey administration questions.

Trainings
OMNI hosted a detailed provider training to provide resources and information to support survey implementation

Analysis & Reporting
OMNI has analyzed collected survey data at the state and county level and is in the process of developing a summary report.

Ongoing TA and Capacity Building

In addition to the statewide survey, OMNI offered capacity building services to support provider implementation and evaluation in FY22. Such capacity-building activities included:

Trainings to Build Prevention Capacity

OMNI contributed to workforce development trainings through FY22 focused on:

- Effectively reporting prevention outcomes
- Making evidence-based programs fit provides' communities
- Developing logic models
- Making data work for providers

Presentations at Quarterly Prevention Provider Meetings (QPPMs)

OMNI presented at QPPMs on the new PPT planning process, evaluation basics, and data-driven prevention planning. OMNI also provided resources to accompany these presentations.

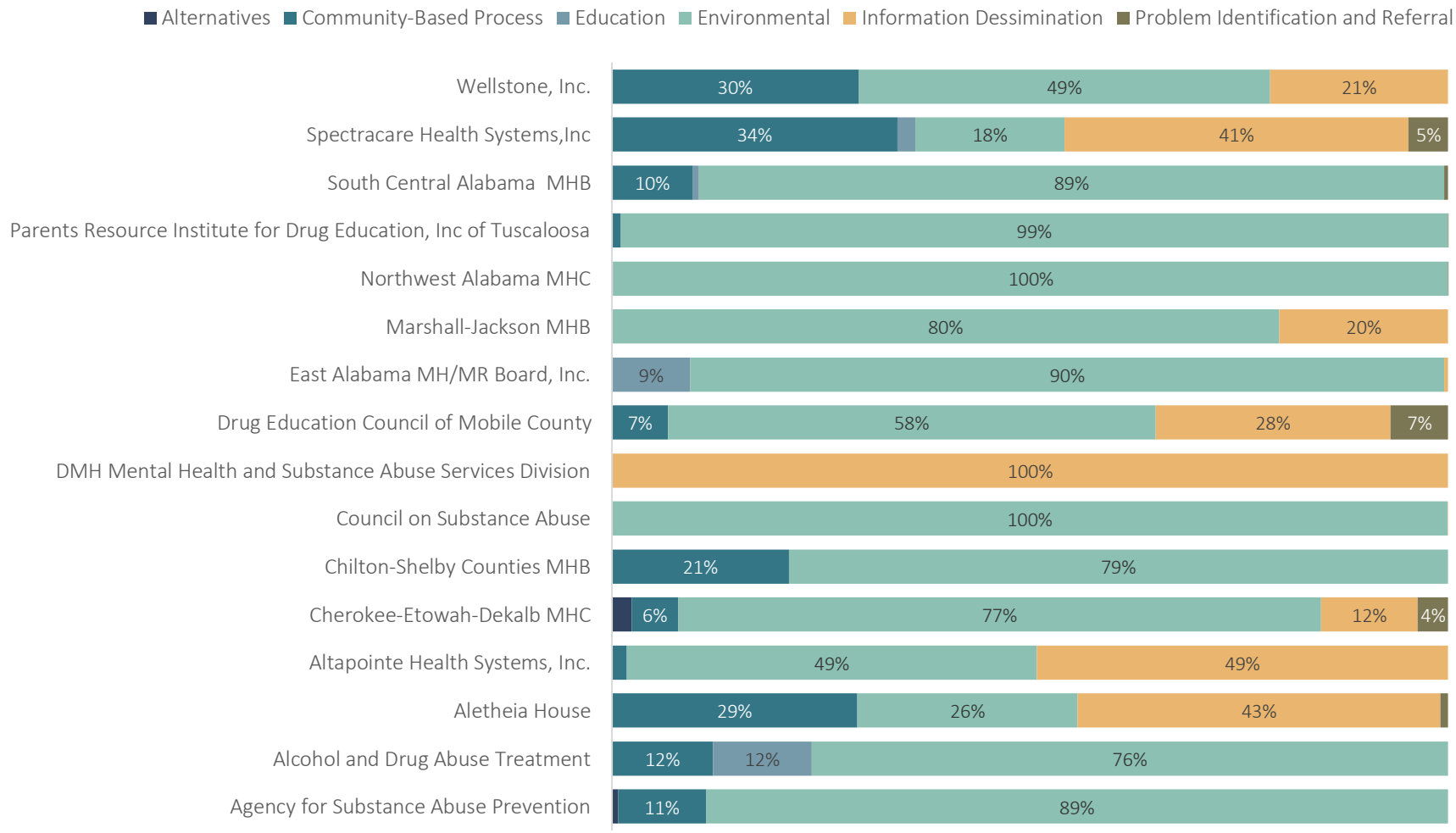
Individual Technical Assistance (TA)

OMNI participated in one-on-one meetings with providers about statewide survey administration, prevention planning interventions, or any other related questions. TA was also provided on an as needed basis, with providers able to request support at any time.

Appendix A: Total Interventions Implemented per County

County Name	Interventions Implemented	County Name	Interventions Implemented	County Name	Interventions Implemented	County Name	Interventions Implemented
Autauga	1	Conecuh	3	Houston	5	Morgan	4
Baldwin	3	Coosa	4	Jackson	4	Perry	1
Barbour	4	Covington	5	Jefferson	6	Pickens	4
Bibb	2	Crenshaw	5	Lamar	3	Pike	4
Blount	4	Cullman	7	Lauderdale	4	Randolph	4
Bullock	4	Dale	4	Lawrence	3	Russell	4
Butler	5	Dallas	1	Lee	4	Shelby	4
Calhoun	5	DeKalb	7	Limestone	4	St. Clair	4
Chambers	5	Elmore	1	Lowndes	1	Sumter	2
Cherokee	3	Escambia	3	Macon	4	Talladega	4
Chilton	4	Etowah	2	Madison	2	Tallapoosa	5
Choctaw	2	Fayette	5	Marengo	2	Tuscaloosa	3
Clarke	3	Franklin	4	Marion	5	Walker	5
Clay	4	Geneva	3	Marshall	4	Washington	3
Cleburne	1	Greene	3	Mobile	3	Wilcox	1
Coffee	5	Hale	2	Monroe	3	Winston	5
Colbert	3	Henry	4	Montgomery	1	---	---

Appendix B: Percent of Individuals Served by CSAP Strategy & Provider



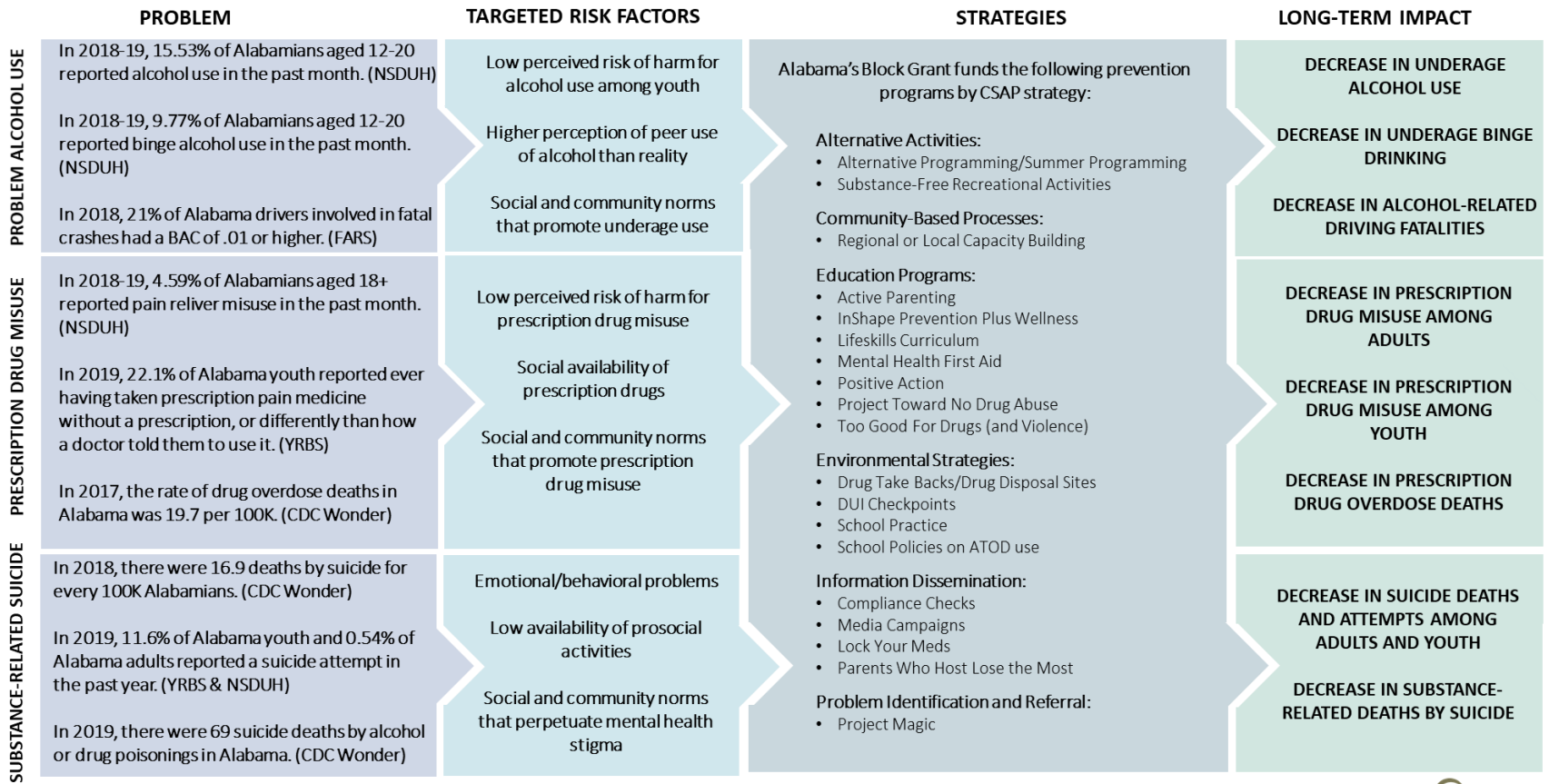
Note: Percentages of 3% or less are not labeled.

Appendix C: Subpopulations Served by CSAP Strategy

Subpopulation*	Alternatives	Community-Based Process	Education	Environmental	Information Dissemination	Problem Identification
Age 0-4	0	115	0	4704	50	0
Age 5-11	119	474	134	13057	907	15
Age 12-14	15	627	187	30727	18388	193
Age 15-17	1	414	87	28241	18485	332
Age 18-20	0	416	0	26501	16901	42
Age 21-24	0	663	1	28025	19879	4
Age 25-44	17	4717	85	128676	102475	162
Age 45-64	11	7573	40	137816	112795	136
Over 65	0	3572	3	105465	91020	10
Age Unknown	9	2602	16	244038	259	39
Male	81	7004	268	239886	183461	426
Female	83	12139	273	262413	197280	459
Gender Unknown	8	2030	12	244941	418	48
White	38	5419	190	347431	241475	477
Black/African American	20	13419	317	122759	117281	259
Hawaiian/Pacific Islander	0	28	2	85	84	2
Asian	0	19	0	3061	2231	8
Native American	1	56	11	3089	2273	26
More than one race	28	170	19	18043	10740	101
Race unknown	85	2062	14	252782	7075	60
Hispanic or Latino	95	421	26	22020	12434	130
Not Hispanic or Latino	37	18217	397	467262	361753	747
Ethnicity Unknown	40	2535	130	257968	6972	56

*Note: Sub-populations may add to different totals as they were entered into different fields during data collection. The population number used in other areas of this report is the total of the age sub-populations.

Appendix D: Alabama Block Grant Logic Model 2020-22



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