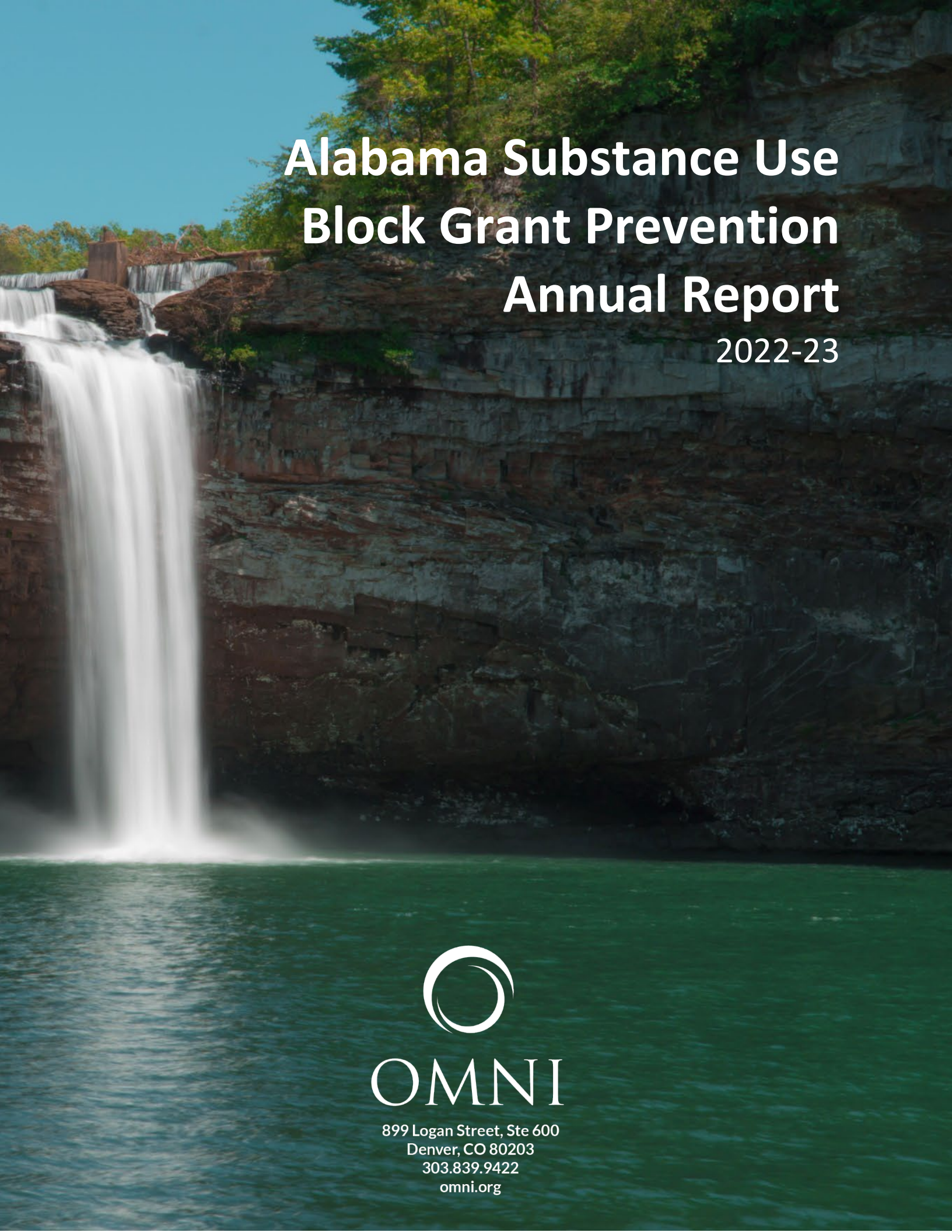

Alabama Substance Use Block Grant Prevention Annual Report

2022-23

OMNI

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Alabama Substance Use Block Grant Prevention Annual Report

2022-23

Submitted to:

Alabama Department of Mental Health, Office of Prevention
December 2023

For more information, please contact projects@omni.org

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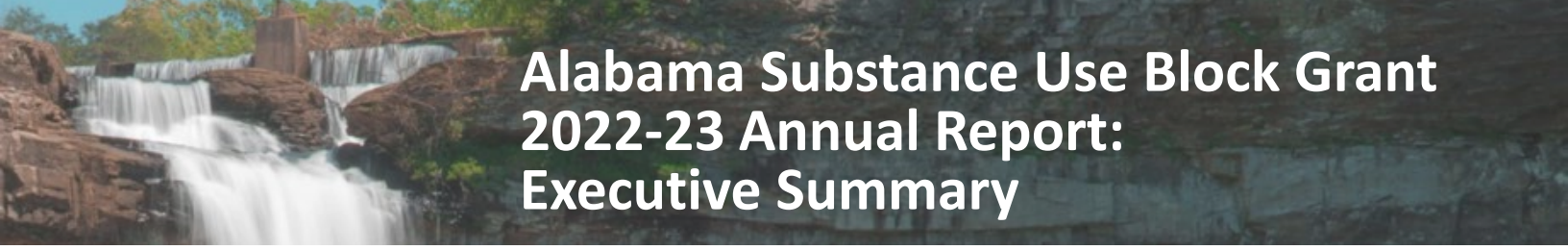


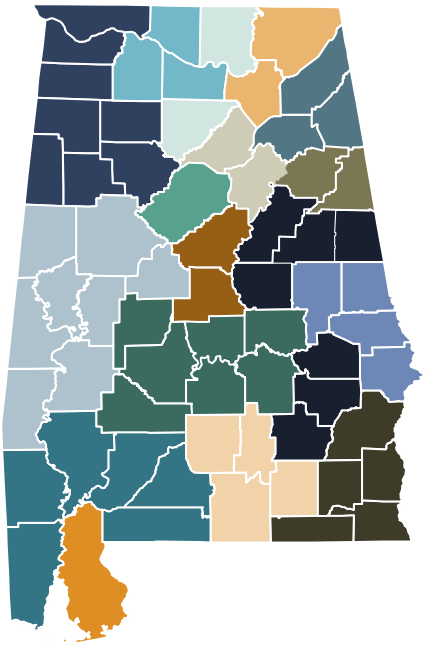
Alabama Substance Use Block Grant 2022-23 Annual Report: Executive Summary

The Substance Use Prevention, Treatment, and Recovery Services (SUPTRS) Block Grant or SUBG for short, (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 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 (BG) prevention activities during the 2023 fiscal year (October 1, 2022, through September 30, 2023). OMNI has served as the evaluator of Alabama's BG funds since January 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 2023 fiscal year (FY23) are listed to the right.



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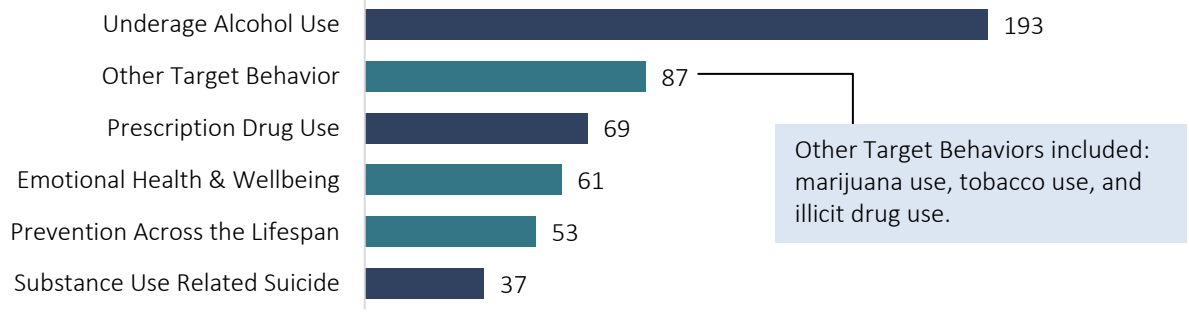
- SpectraCare Health Systems, Inc
- Wellstone, Inc.

*Central Alabama Wellness and Addiction Prevention Coalition are subcontractors of Alcohol and Drug Abuse Treatment Center

FY23 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.



OMNI

For more information on prevention efforts in Alabama, visit ADMH's Prevention website.

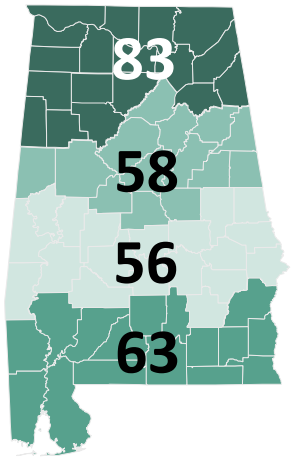
ADMH Alabama Department of Mental Health connecting mind and wellness

FY23 Process Evaluation

In fiscal year 2022-23 (FY23), providers implemented 260 interventions across Alabama's 67 counties, serving over 1.2 million people in Alabama.

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

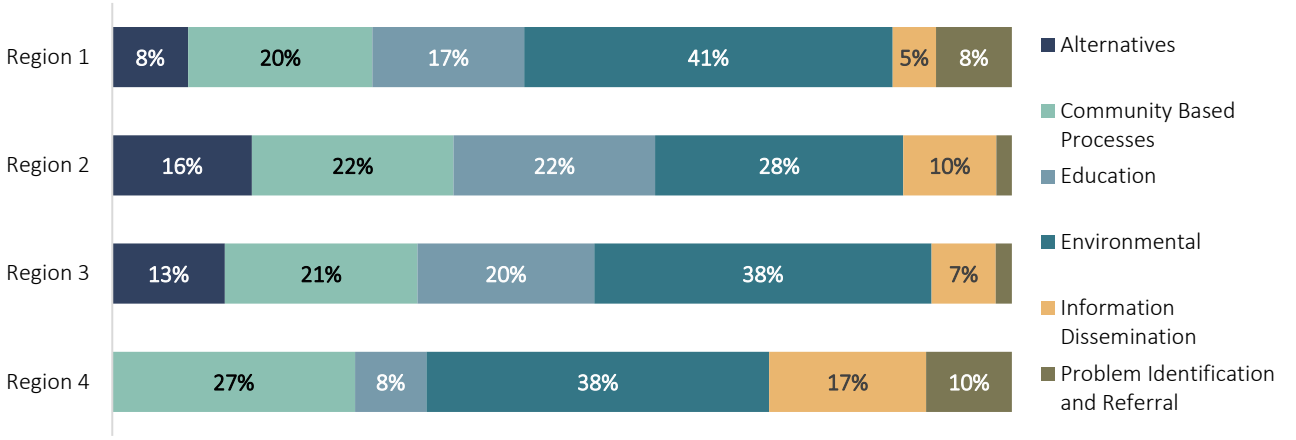
Total # of Interventions Implemented by Region



Block Grant Provider Agency	Numbers Served
AltaPointe Health Systems, Inc.	709,335
P.R.I.D.E. of Tuscaloosa	309,899
Northwest Alabama Mental Health Center	160,873
Drug Education Council (DEC)	24,483
South Central Alabama Mental Health Center	13,403
Cherokee-Etowah-Dekalb (CED) Mental Health Center	9,827
Council on Substance Abuse (COSA)-NCADD	8,572
Central Alabama Wellness (CAW)	5,794
Agency for Substance Abuse Prevention (ASAP)	4,618
SpectraCare Health Systems, Inc.	1,829
Alcohol and Drug Abuse Treatment Center (ADATC)	1,462
East Alabama Mental Health Center	790
Wellstone, Inc.	690
Mountain Lakes Behavioral Health	456
Aletheia House	258
Addiction Prevention Coalition	20

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.

877,446 served by environmental strategies

357,386 served by information dissemination strategies

12,242 served by community-based processes strategies

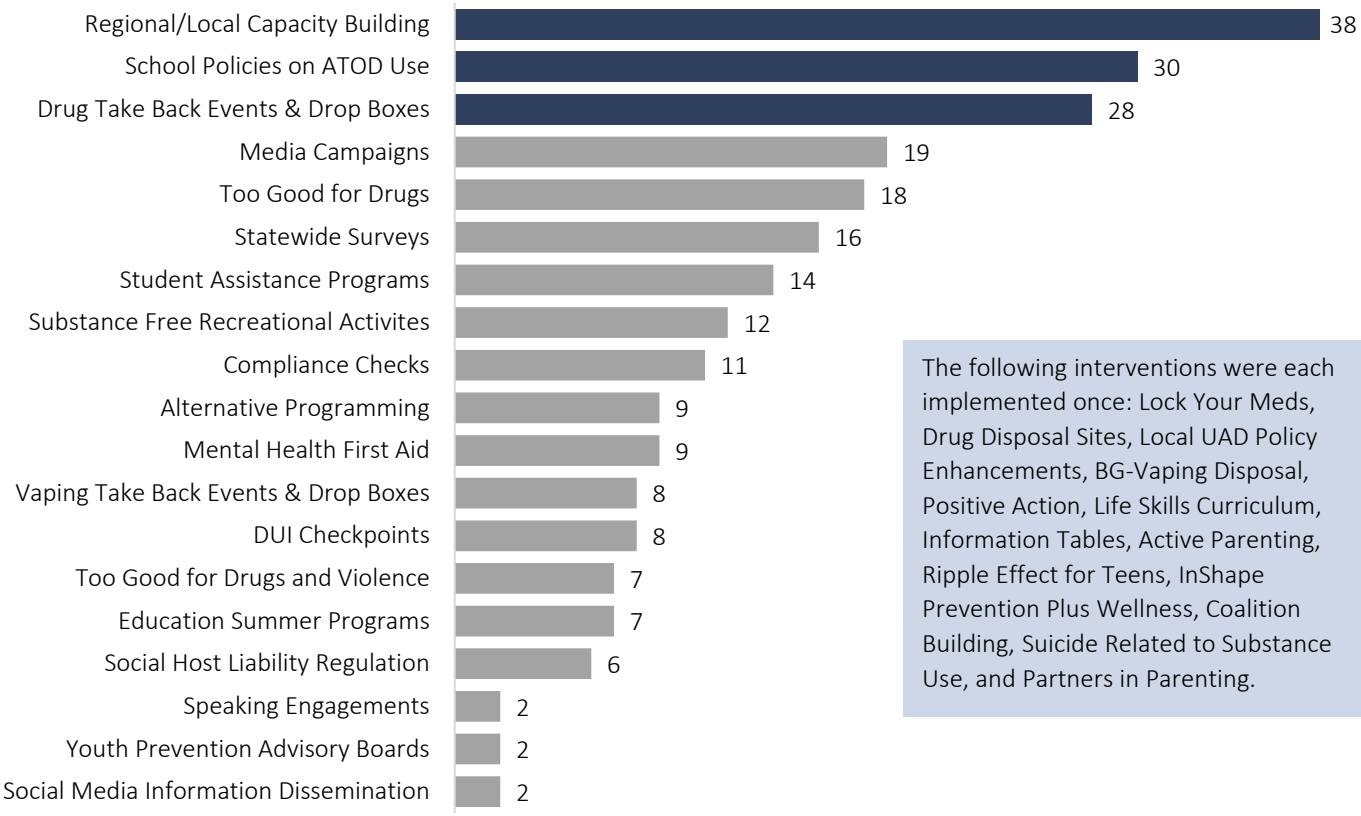
2,574 served by problem identification strategies

2,530 served by education strategies

131 served by alternative strategies

FY23 Process Evaluation

Capacity building programs, school policies on ATOD, and drug take back events and drop boxes were the most commonly implemented interventions during FY23.



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, and Partners in Parenting.

Providers shared the successes and challenges they experienced related to implementation of interventions in FY23. The themes below are listed from most to least frequently mentioned by providers.

Collaboration. Provider collaboration with key community partners led to reported success not only in implementing interventions but in establishing new partnerships. This was measured in a greater number of meetings held, new connections made, and memorandums of understanding (MOUs) being established.

Diverse prevention activities. Providers reported progress in reaching youth in schools and communities, implementing broad environmental strategies such as drug take backs and drop boxes, and reaching people with substance use prevention messaging through social media and via other materials.

Feedback and metrics. Providers reported tangible outcomes such as increases in participant knowledge and satisfaction, merchants passing compliance checks, community readiness to engage in prevention, more drugs collected via events and drop boxes, and decreases in incidences of substance use.

Staffing. Providers reported a general lack of staff needed to successfully implement their interventions. Internal challenges with hiring and capacity to train new staff were noted. A ripple effect was noted when similar issues affected partner agencies, such as school administrators or law enforcement changes.

Lack of Partner Commitment. Though collaboration with partners was influential to successes, some providers mentioned a lack of support or full commitment, hesitance to engage with providers, and challenges with school partnerships that would not allow programming. Delays in MOUs and scheduling hindered activities as well.

Systemic / Situational Impediments. Road closures, weather, busy schedules, or school vacations were just some of the systemic and unavoidable barriers providers mentioned as impacting interventions. Others noted a spread-out geography and limited communication channels in rural areas, recent tragedies in communities, and illness (including COVID-19 outbreaks) as challenges in their implementation.

FY23 Outcome Evaluation

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 (latest data year)	Change from Prior Years
↓ Decrease in underage alcohol use ↓ Decrease in underage binge drinking ↓ Decrease in alcohol-related driving fatalities	5.96% of Alabama youth ages 12-17 reported using alcohol in the past 30 days. Among those 18-25 it was 39.7%. (NSDUH, 2021) 3.4% of Alabama youth ages 12-17 reported binge alcohol use in the past month. Among those 18-25 it was 23.4%. (NSDUH, 2021). 33% of Alabama drivers involved in fatal crashes had a BAC of .01 or higher. (FARS, 2021)	↓ Decrease from 8.2% for 12-17 in 2019; Decrease from 45.8% in 2019 for 18-25. ↓ Decrease from 4.32% for 12-17 in 2019; Decrease from 27.97% in 2019 for 18-25. ↑ Increase from 31% in 2020.

PRESCRIPTION DRUG MISUSE AND OVERDOSES

Desired Outcomes	Current Indicators (latest data year)	Change from Prior Years
↓ Decrease in prescription drug misuse among adults ↓ Decrease in prescription drug misuse among youth ↓ Decrease in prescription drug overdose deaths	3.93% of Alabamians aged 18+ reported pain reliever misuse in the past month. (NSDUH, 2021) 18.8% 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, 2021) 30.1 per 100,000 was the rate of drug overdose deaths in Alabama in 2020. (CDC Wonder, 2021)	↓ Decrease from 4.6% in 2018-19 reporting rate of misuse in past month. (NSDUH, 2019)* ↓ Decrease from 22.1% in 2019 ↑ Increase from a rate of 22.3 in 2020 (CDC Wonder, 2020)

SUBSTANCE-RELATED SUICIDE AND DEATHS BY SUICIDE

Desired Outcomes	Current Indicators (latest data year)	Change from Prior Years
↓ Slight decrease in suicide deaths and attempts in adults ↓ Decrease in suicide deaths and attempts in youth ↓ Decrease in substance-related deaths by suicide	15.8 per 100,000 rate of deaths by suicide in Alabama in 2020. (CDC Wonder, 2021) and 0.53% of Alabama adults reported a suicide attempt in the past year. (NSDUH, 2021) 10.2% of Alabama youth reported a suicide attempt in the past year (YRBS, 2021) 53 Alabamians died by suicide due to alcohol or drug poisonings in Alabama. (CDC Wonder, 2021)	↓ Slight decrease from **16.0** in 2020 (CDC) and from **0.54%** in 2019 (NSDUH) ↓ Slight decrease from **11.6%** in 2019. ↑ Increase from **51** in 2020.

Introduction

The Substance Use Prevention, Treatment, and Recovery Services (SUPTRS) Block Grant or SUBG for short, (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 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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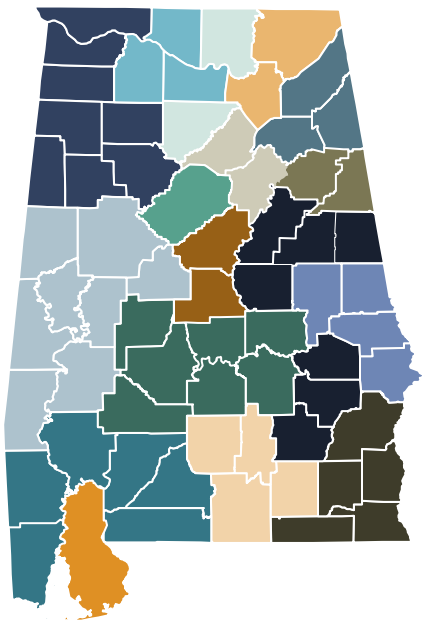
Alabama's BG activities are selected and implemented by providers through a data-driven approach based on the Strategic Prevention Framework (SPF) developed by SAMHSA.[1] The SPF is made up of a set of steps and guiding principles designed to ensure effective substance use prevention services. The steps 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 FY23



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

FY23 Process Evaluation

This section of the report will summarize interventions implemented across the state in year 2023 (FY23), 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 qualitative data from progress reports completed by providers.

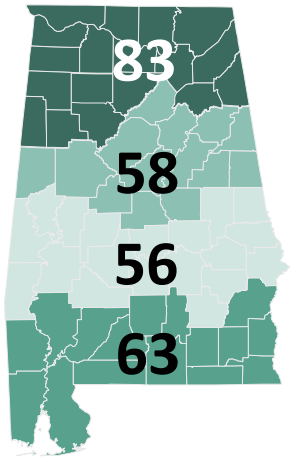
Data in this section of the report were drawn from the Alabama Substance Abuse Information System (ASAIS), Prevention Plan Templates (PPTs) for each county, and providers' progress reports. ASAIS data from FY23 were analyzed to identify the number of individuals reached or served by agencies and strategies as defined by the Center for Substance Abuse Prevention (CSAP). Data collected from each county's PPT were analyzed to identify the types of interventions that were implemented and each associated CSAP strategy. PPTs also provided qualitative data around the organizations' structures, as well as sustainability and cultural competency efforts.

Prevention planning for Alabama's public substance use service delivery system is rooted into four statewide regions which include all 67 counties. Each region consists of 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

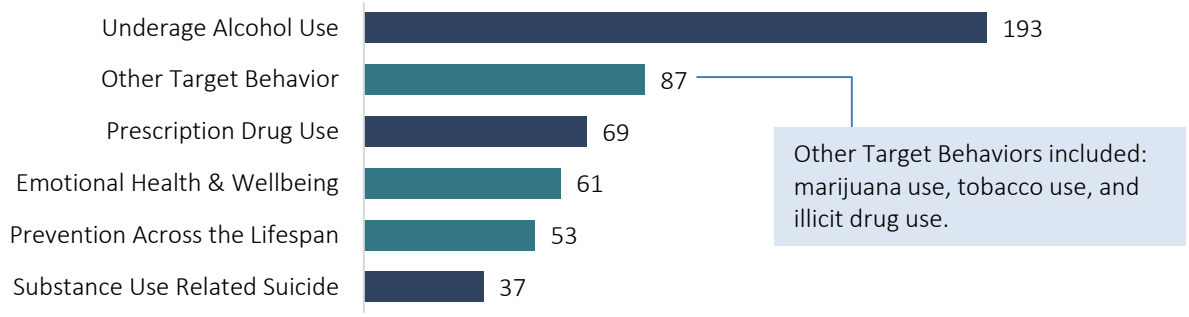
Providers completed PPTs during FY22 to align planning and implementation of prevention activities with the steps of the SPF. Each PPT reflects two years of planned prevention work. As a part of the PPT process, providers first completed a needs assessment that included exploring risk and protective 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 more priority areas, and/or an additional area of concern. In FY23, providers were able to submit amendments to their PPTs to reflect any intervention changes they made.

Total # of Interventions Implemented by Region



In FY23, providers implemented 260 interventions across Alabama's 67 counties. This is an increase from 236 in the prior fiscal year, with all four regions showing increases. The largest number of interventions were implemented in Region 1 (83, which added 9 more interventions this year), followed by Region 4 (63), Region 2 (58), and Region 3 (56). Providers could choose a maximum of 10 interventions to implement in each county. The number of interventions implemented ranged from 1 to 7 and the average was 4 per county. For a complete list of the number of interventions implemented per county, see Appendix A.

As in the prior year, targeted behaviors 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. There were 193 interventions targeting underage drinking, up from 166 last year. In addition, interventions also targeted prescription drug use and substance use-related suicide, which align with the problem areas identified for the state. This year, the greatest increases were for the priority areas of prescription drug use (up from 51) and substance use related suicide (up from 19). Providers implemented 87 interventions addressing other target behaviors such as marijuana, tobacco, and illicit drug use. This decreased from 104 the prior year.

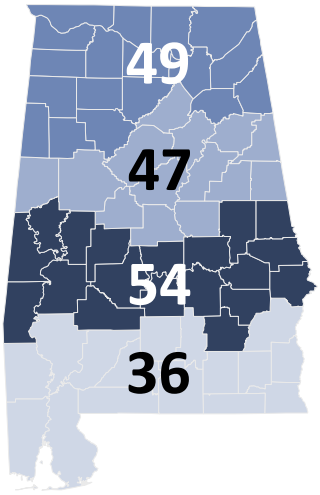


Note: Providers were able to select more than one primary and secondary target behavior. Therefore, the number of target behaviors adds to more than the total number of interventions implemented.

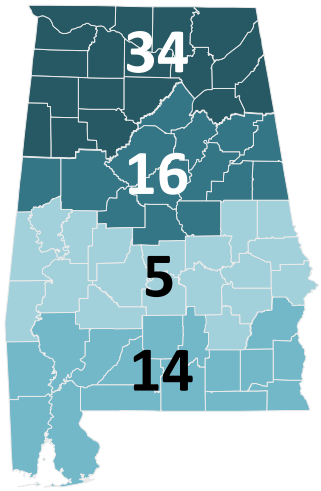
Each region implemented interventions targeting priority problem areas, but some regions focused more on one problem area than the other.

Region 3 implemented the most interventions targeting underage alcohol use (54), while Region 1 implemented the most interventions targeting prescription drug misuse (34).

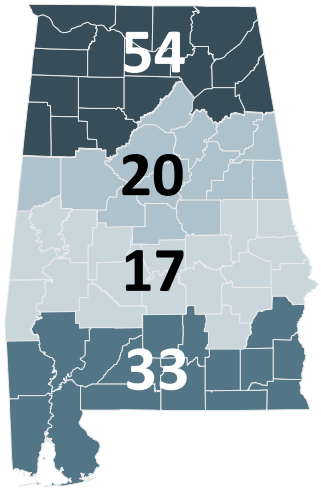
Interventions Targeting Underage Drinking Implemented by Region



Interventions Targeting Rx Drug Misuse Implemented by Region



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



Providers served over 1.2 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.

Block Grant Provider Agency	Numbers Served
AltaPointe Health Systems, Inc.	709,335
Parents Resource Institute for Drug Education, Inc of Tuscaloosa (PRIDE)	309,899
Northwest Alabama Mental Health Center	160,873
Drug Education Council (DEC)	24,483
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Mountain Lakes Behavioral Health	456
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Some providers implemented a greater number of population-based interventions, which accounts for their overall greater reach.

Agencies implementing the population-based 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.

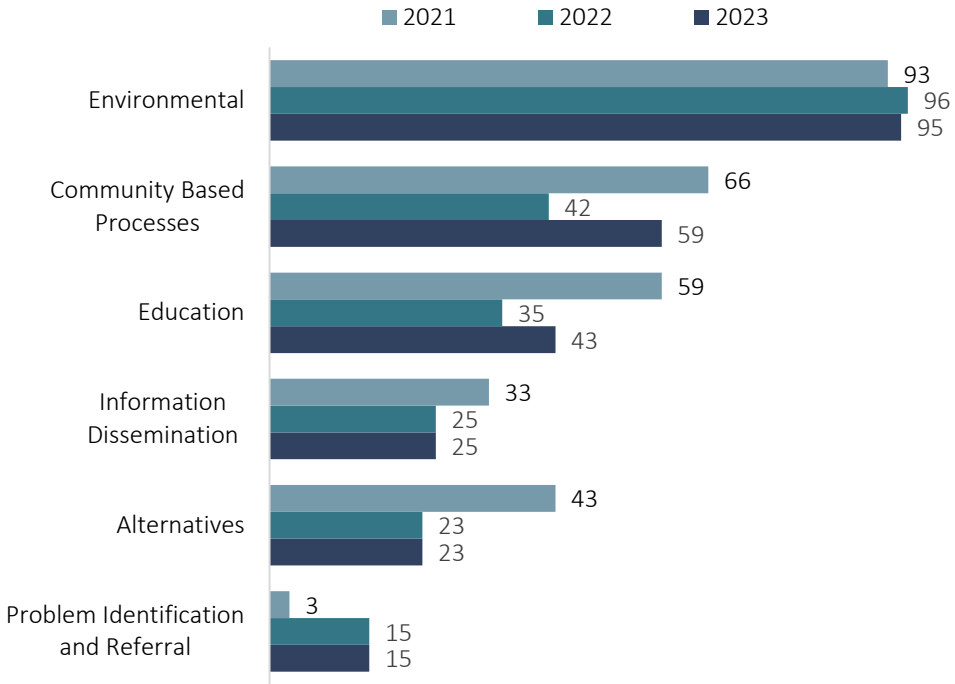
Photo: The East Alabama Mental Health Center prevention team partnered with a local law enforcement team in the spring of 2023 to hold a Prescription Drug Take Back Event in Russell County, Alabama. The photo shows some of the medication that was collected during the event. This is an example of the implementation of an environmental CSAP Strategy.

Across Alabama, the greatest number of 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	877,446
Information Dissemination	357,386
Community Based Processes	12,242
Problem Identification and Referral	2,574
Education	2,530
Alternatives	131

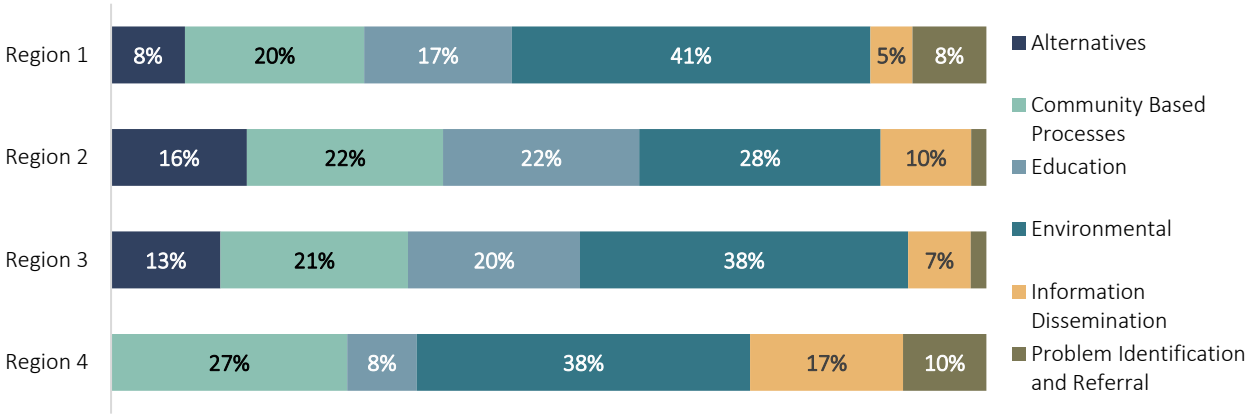
Photo: A flyer for AltaPointe Health's drug take back event in Baldwin County.

As in FY21 and FY22, in FY23, environmental strategies were the most commonly implemented of the six CSAP strategies across the state.



A minimum of 50% of BG 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 21 of 67 counties, at least 50% of their interventions were environmental strategies.

The most frequently implemented CSAP strategy across all four regions was environmental.

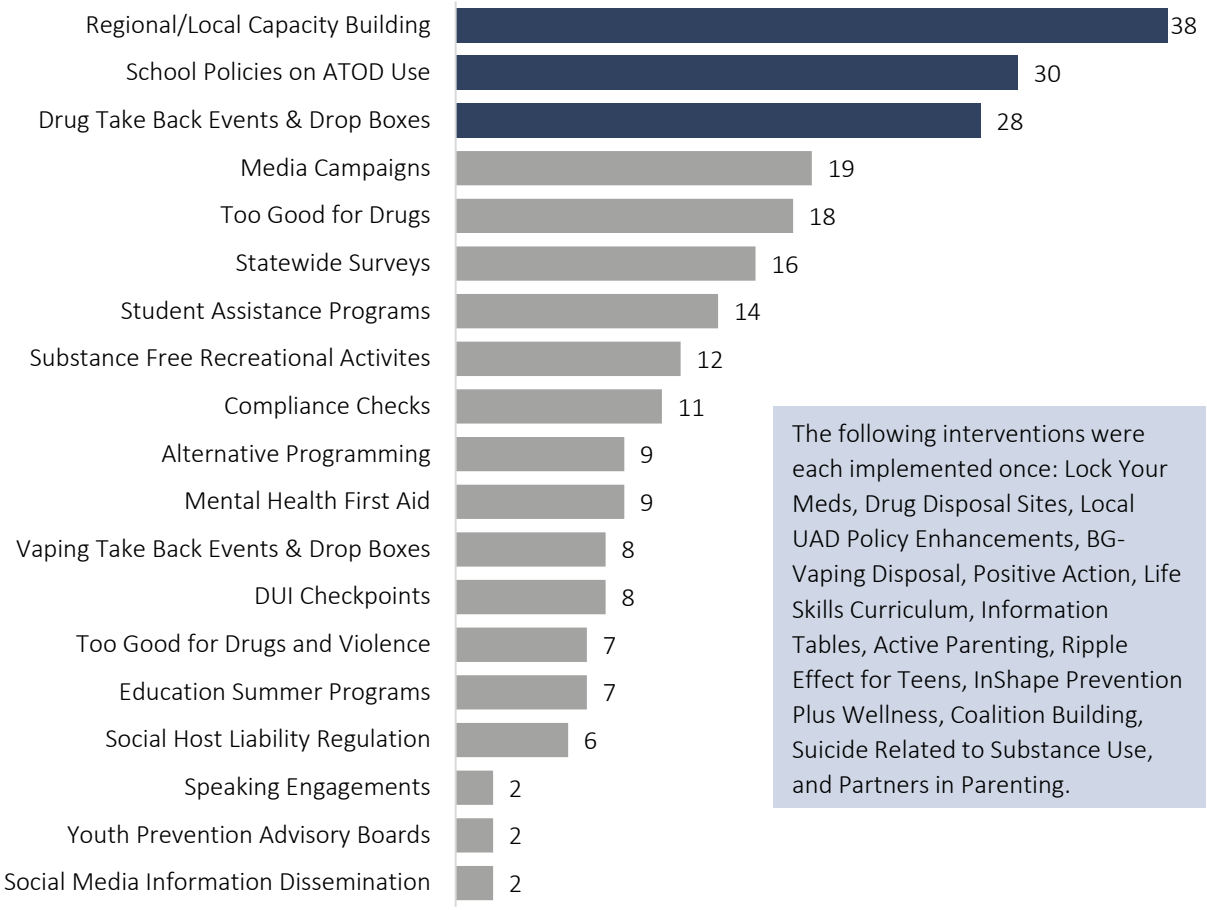


Note: Percentages of 3% or less are not labeled.

Across all four regions, the proportion of environmental CSAP strategies implemented accounted for more than 30% of the strategies being implemented and, in some regions, close to half of the strategies implemented. Community Based Processes were slightly more prevalent in Region 4 (27%), but other regions were just slightly lower than that. Education strategies made up about 20% of interventions in Regions 1, 2, and 3, while Region 4 implemented a smaller percentage of education strategies. A greater percentage of information dissemination strategies were implemented in Region 4 compared to the other regions. The remaining two CSAP strategies (Alternatives and Problem Identification and Referral) were generally less prevalent, with Problem Identification strategies being the least commonly implemented.

Photo: Team ASAP partnered with the NASCAR experience and Talladega Superspeedway to present an exhilarating experience to youth in their community – a "Gift of Speed" as an alternative recreational strategy.

As was the case in FY22, capacity building programs, school policies on Alcohol, Tobacco and Other Drugs (ATOD), and drug take back events were the most commonly implemented interventions during FY23. 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. Newly reported this year was implementation of the Alabama Statewide Survey of Young Adults by all providers. 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, and Partners in Parenting.

Photo on Left: Northwest Alabama Mental Health Center held a "We ID" art contest with area youth in Marion County.

Photo on Right: South Central Alabama Mental Health installed a vape drop box and disseminated vape awareness brochures at a local school.

Successes in Implementing Interventions

Providers shared the successes they experienced related to the implementation of their intervention efforts in FY23. The themes below were surfaced from the progress reports completed by providers at three time points during the year and are listed from most to least frequently mentioned by providers.

Success in Completing Prevention Activities. In FY23, providers moved beyond planning and began a stronger focus on implementing prevention strategies. They reported success in executing key activities tied to their prevention interventions. This included activities such as hosting community and drug take back events, completing merchant education visits, holding alternative activities for youth, reaching people on social media and through other media campaign materials, delivering classroom curricula/lessons, and installing prevention items like vaping detectors and drug drop boxes.

"COSA has been extremely successful on the Alabama State University (ASU) campus. Staff placed rack card stands at the student center and campus police department, conducted a Back to School Bash addressing underage/ binge drinking, and marijuana use…and a forum addressing domestic violence and the correlation of substance abuse. Staff attended campus events and distributed over 100 toolkits and information. Staff will continue to increase awareness of ATOD use on the campus of ASU." - COSA

Collaboration and New Relationships. This year, providers again attributed much of their success to collaborations and communications with their existing community partners. Reported efforts include maintaining relationships and planning for future implementations and working with existing partners to implement their current interventions. Providers also described their work to establish new partnerships, such as garnering community interest, asking for letters of support, confirming new commitments, and formally adopting memorandums of understanding with new agencies, organizations, or key individuals in their communities.

"We had successful community involvement at the Three Creek Festival. The community reacted very positively to us sharing prevention information. A lot of the community showed up and we got to talk to community members about our work in the community. We have also been able to communicate with our new sheriff about the drug drop boxes. He has already checked the drop box at the courthouse and emptied it for us. He agreed for us to put a drop box at the jail!" - Northwest Alabama Mental Health Center

Feedback and Metrics. Providers cited evidence of accomplishments in the form of positive feedback and anecdotes from participants, partner staff, and community members. Several stated that thank-you gifts were useful in facilitating participation and excitement with participants. Providers also reported tangible outcome metrics, such as increases in participant knowledge and satisfaction, merchants passing compliance checks, communities building readiness to engage in prevention, more drugs collected via events and drop boxes, and decreases in incidences of substance use.

"After completing the implementation of the Too Good for Drugs Curriculum, students, teachers and administration commented on the impact of the program. Students stated that they enjoyed learning material as it relates to managing difficult emotions and building healthy relationships. The teachers and administration stated that the program helped to decrease conflicts among the students." - Alcohol and Drug Abuse Treatment Centers

Capacity Building. Providers also surfaced successes around building the capacity of their organizations to implement their prevention interventions. They also reported success in building the capacity of the surrounding community. These capacity-building efforts included training new prevention staff, completing prevention start-up activities, selecting intervention curricula, holding fundraisers, offering professional development opportunities to staff, and recruiting additional coalition members from the community. Providers often reported engaging in capacity building activities when barriers would have otherwise prevented other aspects of prevention implementation.

"A period of transition occurred during the second quarter in which a previous APC staff member transitioned to a new position out of state and a new staff member was hired and is in the process of being trained at this time. The new staff member is a new resident of St. Clair County and this will allow him to more expeditiously build relationships and partnerships. Meetings have been scheduled with Ashville High School staff to begin partnerships within the area." - Addiction Prevention Coalition

Challenges to Implementing Interventions

Though most did not report any specific barriers in the narrative sections of progress reports, providers did share challenges regarding implementation of prevention interventions. The themes below describe the most to least frequently mentioned challenges.

Staff Shortages. As in last fiscal year, providers reported lacking the staff needed to successfully implement their prevention interventions. Other staff-related issues included problems with hiring, as well as issues training replacement staff. Additionally, providers mentioned a lack of available staff and staff turnover as issues occurring within partnering agencies that affected their prevention implementation, especially when those staff held key positions such as sheriffs, school principals, or other administrators.

"[A community partner] had a lot of personnel changes with people retiring and leaving for better jobs. 3-4 key personnel that we worked with in the past were gone. We had to basically start over building relationships with the new staff, explaining our agency, prevention program and the role we seek to play in the community" - Alcohol and Drug Abuse Treatment Centers

Systemic / Situational Impediments. Road closures, weather, busy end-of-year schedules, or summer vacations within school schedules were just some of the systemic barriers providers mentioned as impacting the implementation of their prevention activities. Others included navigating the spread-out geography and limited communication channels in rural areas, recent tragedies in communities, and illness (including COVID-19 outbreaks). These challenges were unexpected and caused unavoidable impacts to providers.

"Due to the majority of the county being rural, the small size of the county itself, and the limited resources of the county, it has been a challenge to get stakeholder buy-in and to increase partnership. Although APC made significant progress in this regard, the need remains strong in the county. Removal of barriers to support more prevention efforts in the county will be an ongoing and slow, incremental process." - Addiction Prevention Coalition

Community Partner Lack of Commitment / Collaboration. Often characterized as lack of referrals, hesitancy to engage with providers, lack of commitment, collaboration, or follow-through by community partners was a great barrier to providers' implementation in the last fiscal year. Providers reported that partners were too busy to execute plans or backed out of partnerships altogether. Providers also reported that school partners would not let providers "in" to conduct programs, and there was pushback from local government or administration. Lack of commitment or follow-through with law enforcement partners was noted, as they often must be present at drug take back events or when installing or emptying drug drop boxes for these prevention activities to operate within the law. Providers reported that communication with partners was often difficult, slow, or stalled. This included waiting on MOUs as well as extended back and forth scheduling attempts resulting in delayed activities.

> *"Failure to receive early approval from school officials within [local schools] serves as the current barrier to program implementation starting later within the fiscal year."* -Parents Resource Institute Drug Education (PRIDE)

Lack of Community Interest / Capacity. Providers also noted that community members, students, and other intervention participants seemed to lack interest in the available programming, training, and participation in prevention-related coalitions in the past year. This makes recruitment difficult, increases the need for creative engagement strategies, and notably reduces the number of drugs collected at take back events and drop boxes. Some providers noted a gap in understanding community members' needs, as the general lack of interest in participation made gathering data on community needs more difficult.

> *"The coalition has found that while there is some community support for prevention efforts, there are also a number of sectors of the community that don't have much knowledge about the complexity of community substance use issues and prevention. This is partly due to the lingering effects of COVID-19 and the resulting community restrictions that limited our interactions with groups of people for several years."'* - Drug Education Council

Engagement of Key Community Partners

Engaging community partners continues to be crucial to the success of prevention interventions. In their PPTs, providers reported their involvement with coalitions and Children's Policy Councils (CPCs), which are two partnership structures that can support substance use prevention goals.

The Alabama CPC system is a mechanism for collaboration throughout the state. "The work of the CPC system is to address community needs by facilitating children and family service providers collaborations to develop a comprehensive service plan that focuses on health, early care and education, parent/family engagement, safety, education (K- 12), and economic security needs of children from birth to 19."[2] A coalition is defined as a "voluntary, formal agreement and collaboration between groups or sectors of a community in which each group retains its identity, but all agree to work together toward a common goal of building a safe, healthy, and drug-free community."[3] Parents, teachers, faith-based leaders, health care

[2] Alabama Children's Policy Council (CPC) system.
[3] CADCA. What Are Community Coalitions?

providers, businesses, law enforcement, and others are common coalition members. PPT data highlights these partnerships, and others, in provider-driven prevention work.

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

Providers reported partnering with a CPC on a variety of prevention-related activities including conducting their needs assessments, contributing to prevention planning activities, participating jointly in community events and activities, providing trainings, and working together on targeted prevention areas such as underage drinking and driving, as well as risk factor mitigation such as low refusal skills, early initiation of use, and lack of parental monitoring.

"We have representatives on the CPC for all counties we serve who keep members aware of prevention activities. We also utilize members to help us with our needs assessment data gathering, planning of activities, and analysis. In addition, we use the CPC Annual Needs Assessment to help guide our program planning." – Northwest Alabama Mental Health Center

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

Coalitions are key partners in community prevention work and communities leverage these collaborative partnerships to implement strategies and mobilize the community. Providers collaborated with local coalitions to address youth and young adult substance use prevention and to provide awareness around risk factors related to substance use and violence for parents, youth, and young adults. Coalition activities included networking, sharing materials, offering trainings, and facilitating meetings.

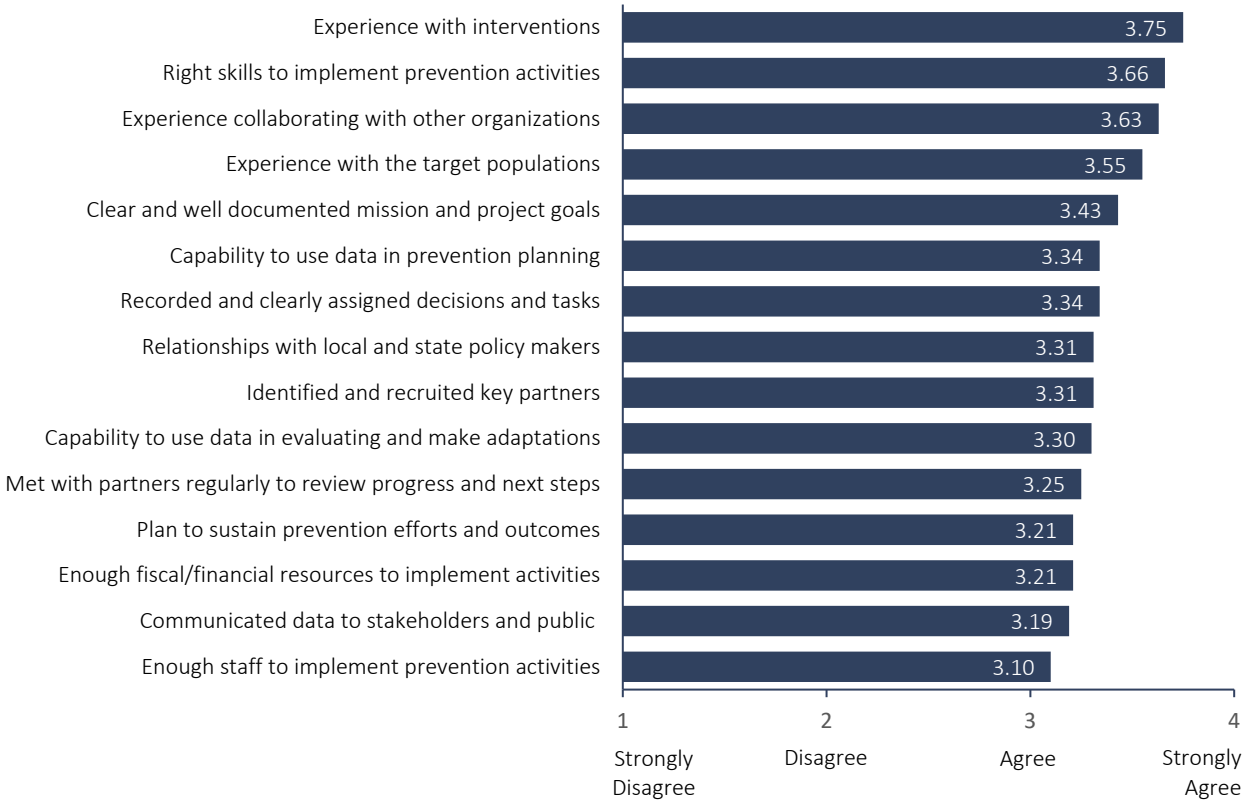
Photo: AltaPointe Health System's Sumter County Coalition Coordinator and the Sumter County Community in Action Coalition members gather to support efforts to address underage drinking in the community.

"We have both Children's Policy Council and an active coalition, the Baldwin County Community Alliance (BCCA). The BCCA is comprised of community agencies that meet regularly to discuss emerging ATOD trends and implement strategies that target underage drinking and prescription drug misuse among youth in Baldwin County. The BCCA has been in existence since 2005 and has fifty-one members representing thirty-one agencies. The current goals are to decrease access and availability of alcohol and prescription drugs among youth while positively changing community norms and attitudes. The BCCA has representation from law enforcement, school, business, media, youth serving organization, parent, religious or fraternal organization, civic or volunteer group, high school aged youth, healthcare professional, local government agencies, utilities board, college aged youth, and other organizations involved in reducing substance abuse." – AltaPointe Health System

Provider Capacity

As a part of developing their PPTs, providers were asked questions around building capacity in their counties to implement prevention interventions to address substance use.

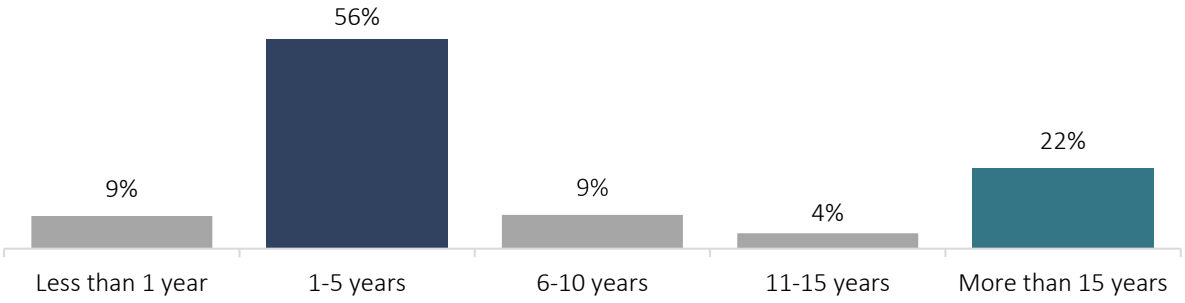
In FY23, providers strongly agreed that their organization has the experience and skills to implement prevention interventions in their county. On a scale of 1-4, providers reported less agreement with having enough staff to implement prevention activities in their county and effectively communicating data to key community partners and the public.



Providers were also asked to report the years of experience for staff working on BG funded prevention activities in their PPTs. 364 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 and progress reports. Some examples of needed TA and training topics noted include: environmental, community-based, and alternative CSAP strategies; prevention for beginners; defining and meeting short-term outcomes; finding evidence-based curriculum for middle or high school; more information on vaping, Alabama drug trends, stigma, and alcohol use disorders. OMNI was able to provide workforce development trainings in several areas, including a training on environmental CSAP strategies. More can be found in the Ongoing TA and Capacity Building section of this report, on page 23.

56% of staff indicated working at their organizations between 1 to 5 years and 22% for more than 15 years. This mix of newer prevention professionals and more experienced staff contrasts with the prior year, when the ratio of newer and experienced staff was equal. If staff are very new, there may be challenges with balancing institutional knowledge and current expertise in prevention best practices, and there may be additional training and capacity-building needs that providers experience as a result.



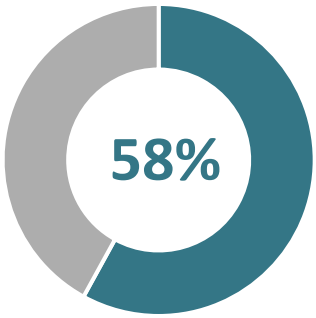
32 counties indicated TA needs around identifying and implementing environmental strategies. Providers also indicated feeling confident (and not needing TA) in selecting interventions, building partnerships, implementing interventions, and adapting interventions.

Capacity Building to Address Health Disparities

On their PPTs, providers were asked to rate the cultural competency of their organization/agency. This is defined as their ability to interact effectively with people of different cultures. Cultural competency helps to ensure the needs of all community members are adequately addressed.

At every step of the Strategic Prevention Framework (SPF), culture should be considered. "Culture" is a concept that goes beyond ethnicity or race. It can encompass such characteristics as age, gender, sexual orientation, disability, religion, income level, education, geographical location, or even profession.

58% of providers said they have formal, written policies in place to address cultural competency.



10 providers serving 37 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.

To address health disparities, engagement with diverse communities is vital. This includes the provision of culturally appropriate educational materials. Healthy People 2030[4] 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."

In reviewing the PPT data, policies related to cultural competence were either explicitly stated or were expressed as agency norms and/or longstanding practices within agencies. Some examples as expressed by providers:

"It is the policy of the Board that no individual shall, solely by reason of their disability, race, color, national or ethnic origin, religion, gender, genetics, and/or age, be excluded from the employment in, be denied the services of, or be subjected to discrimination under any program or activity." – Mountain Lakes Behavioral Health

"At ASAP our coalition and we maintain a set of attitudes, perspectives, 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." -- ASAP

[4] Healthy People 2030

Coalitions and key community partnerships are engaged with providers as they develop their interventions. These partnerships include those with law enforcement, community and human service agencies, first responders, colleges or universities, businesses, health-care professionals, faith-based entities, and youth, all in service to both educate the partners *and* to leverage the partners' valuable experience in the community to inform prevention planning.

Addressing health disparities in providers' communities is a key component of cultural competency. In their PPTs, some providers described their health disparity impact statements for high-risk populations. Several providers cited data that helped them identify these populations. Some ways providers aimed to address these disparities included[5]:

- Addressing language or accessibility barriers, including translating written materials, providing translators at events or meetings or interpreters for those with hearing impairments, offering virtual training opportunities for those with a lack of transportation, and preparing materials and enhanced handouts for students with visual impairments.
- Creating internal policies and Standards of Conduct, which can include application of National CLAS Standards.
- Offering and/or requiring trainings as professional development or part of the onboarding process, such as Cultural Competency in RELIAS.
- Engaging key community partners for input and learning regarding cultural issues connected to programs and services provided.

Photo: East Alabama Mental Health Center hosted a multi-cultural night, bringing prevention messaging to a broader audience.

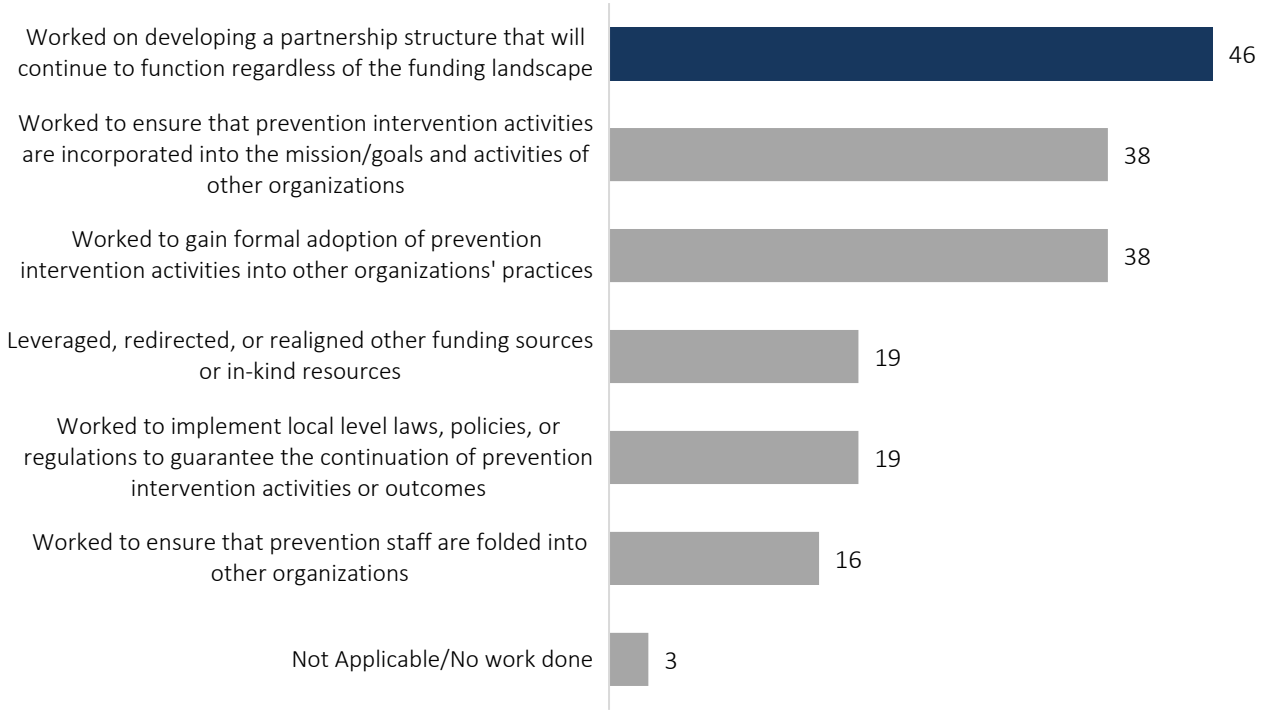
"ASAP has been meeting with the Anniston Fatherhood Initiative to target violence and substance misuse prevention in the West Anniston area and the Anniston Housing Community. The group is all men (approximately 10-20 men ages 14-and up) and meets monthly. ASAP collaborated with the Brock Foundation Inc. and the R.Y.S.E. Youth Mentoring program to create the Gift of Flight. This event gave young men a chance to learn about aviation and the dangers of substance misuse in the Aviation field. The AFI and ASAP staff also takes the young men to a Youth Male Retreat which focuses on bringing awareness to substance misuse in regards of employment and everyday life decisions. ASAP's primary goal with these young men is to address the risk factors by providing awareness to reduce violence and substance misuse activities." -- ASAP

[5] The National CLAS Standards described in this section are a set of 15 action steps intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services.

Sustainability

Providers also plan to sustain prevention outcomes and intervention activities beyond Block Grant. Most providers indicated working toward some sustainability efforts, including building key community partner support for programs, or sharing results of prevention activities with their communities. Some have formal policies related to sustainability in place and others build this capacity in other ways such as through coalitions and partnerships. Providers noted that sustainability is strengthened through partnerships with coalitions to find alternative funding sources, developing follow-up policies for programs, and creating data collection activities that can be conducted with established budgets. During the PPT process, providers could select all current efforts related to sustainability.

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



"The Drug Education Council (DEC) and its community partners are continually seeking sources of additional funding for both new and existing substance use 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." – Drug Education Council

"No formal policies are in place however the interagency council and Children's Policy Council work to ensure funding and support of programs are continuous and evolving." – Mental Health Center of North Central Alabama

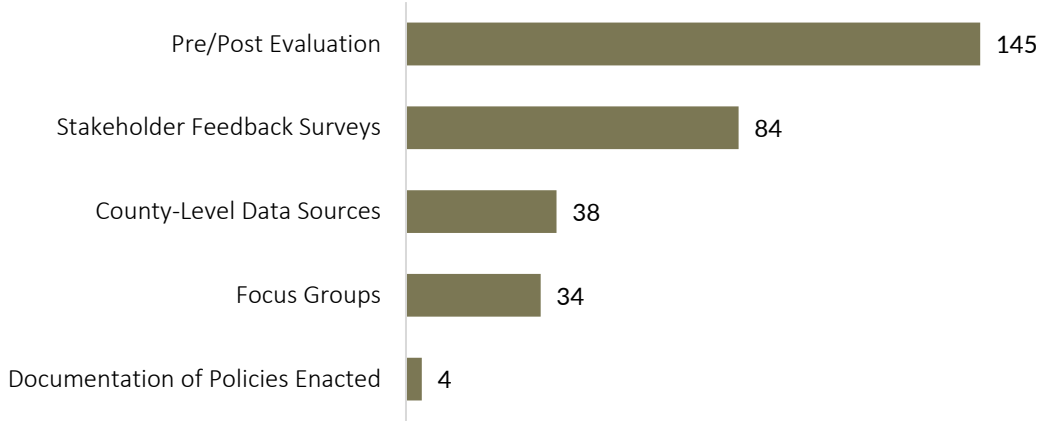
FY23 Outcome Evaluation

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 FY23, each provider reported progress towards reaching the short-term outcomes identified in their prevention plan template and in progress reports.

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. Key community partner 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.

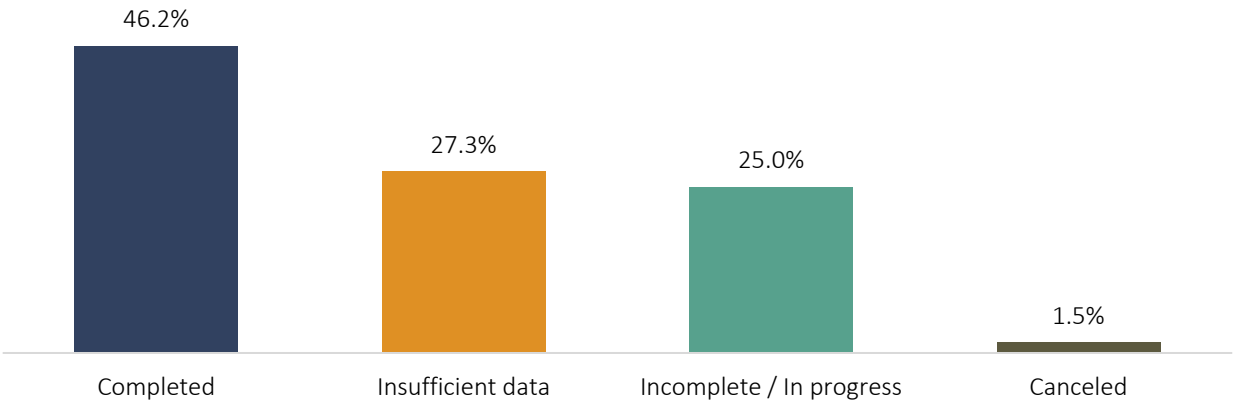


Nearly half of providers reported achieving short-term outcomes related to their intervention implementation. Gathering and reporting data on short-term outcomes was a challenge and an area for increased TA in the future.

Within FY23 progress reports, providers submitted narratives describing their progress toward their short-term outcomes across a total of 225 prevention interventions for 60 of 67 counties. At least one short-term outcome was defined and tracked for each intervention per provider, though some providers tracked up to five short-term outcomes per intervention. Common examples of short-term outcomes set by providers were:

- increases in knowledge and awareness of substance use harms by intervention participants
- high satisfaction levels with participation, such as participants' positive experience with a program, or community members' satisfaction with being involved in a coalition
- increasing the number of members in their coalition or other capacity-building groups.

As part of the FY23 review of short-term outcomes progress, OMNI coded data into four categories: completed, insufficient data, incomplete/in progress, and canceled.



- Outcomes were considered completed if they met or exceeded the original short-term outcome goal designated in the Prevention Plan Template (PPT), at any point in the fiscal year.
- Occasionally, providers did not report on the short-term outcome, or the data provided were otherwise insufficient to determine whether the outcome was achieved. Some common reasons for insufficient data were lack of survey data or lack of baseline comparisons in order to determine increases in positive outcomes (e.g., percentage of students gaining refusal skills) or decreases in negative outcomes (e.g., rates of substances used).
- Short-term outcomes were considered incomplete if the intervention they were associated with was not implemented/completed during the fiscal year, or if metrics fell short of the initial PPT outcome goal (e.g., raising participant knowledge by 3%, instead of the goal of 10%). Outcomes were considered in-progress if the short-term outcome spanned multiple years of implementation. Incomplete outcomes could be due to significant barriers to the implementation of interventions reported by providers.
- Finally, a very small portion of short-term outcomes were canceled if the intervention they were associated with was cancelled, significantly modified, or the outcome was no longer relevant or achievable.

Evaluation best practices suggest that outcomes be "SMART". This stands for specific, measurable, achievable, relevant, and time-bound.[6] The analysis of the short-term outcomes expressed by the providers suggest that some of the challenge in meeting outcomes may be because of how the outcome was originally framed at the start. Evaluation technical assistance can support the capacity of providers to better understand these best practices so that they may then apply them when setting short-term outcomes in the future.

Long-term Outcomes

In addition to measuring progress towards short-term outcomes of intervention implementation in FY23, OMNI continued to monitor key indicators related to the problem areas and desired long-term outcomes

[6] https://www.samhsa.gov/grants/how-to-apply/writing-completing-application/goals-measurable-objectives

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 are being 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. In some cases, there were changes in survey questions that resulted in slight adjustments to indicators that were reviewed; data points noted were kept as closely aligned as possible.

Recent data suggests a continuing decrease in the percentage of both 30-day alcohol use and underage binge drinking among Alabama youth and young adults. The Fatality Analysis Reporting System (FARS) reported a slight increase in the percent of Alabama drivers involved in fatal crashes who had a BAC of .01 or higher (33% in 2021, up from 31% in 2020). Note: data from the National Survey on Drug Use and Health (NSDUH) were not available for 2019-2020 due to methodological concerns. OMNI will continue to track NSDUH and FARS 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 (latest data year)	Change from Prior Years
↓ Decrease in underage alcohol use	5.96% of Alabama youth ages 12-17 reported using alcohol in the past 30 days. Among those 18-25 it was 39.7%. (NSDUH, 2021)	↓ Decrease from 8.2% for 12-17 in 2019; Decrease from 45.8% in 2019 for 18-25.
↓ Decrease in underage binge drinking	3.4% of Alabama youth ages 12-17 reported binge alcohol use in the past month. Among those 18-25 it was 23.4%. (NSDUH, 2021).	↓ Decrease from 4.32% for 12-17 in 2019; Decrease from 27.97% in 2019 for 18-25.
↓ Decrease in alcohol-related driving fatalities	33% of Alabama drivers involved in fatal crashes had a BAC of .01 or higher. (FARS, 2021)	↑ Increase from 31% in 2020.

Data from the CDC show a continually increasing rate of prescription drug overdose deaths in Alabama in recent years. However, desired decreases in prescription drug misuse among both adults and youth are noted. 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 (latest data year)	Prior Year & Change Interpretation
↓ Decrease in prescription drug misuse among adults	3.93% of Alabamians aged 18+ reported pain reliever misuse in the past year. (NSDUH, 2021)*	↓ Decrease from 4.6% in 2018-19 reporting rate of misuse in past month. (NSDUH, 2019)*
↓ Decrease in prescription drug misuse among youth	18.8% 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, 2021)	↓ Decrease from 22.1% in 2019
↓ Decrease in prescription drug overdose deaths	30.1 per 100,000 was the rate of drug overdose deaths in Alabama. (CDC Wonder, 2021)	↑ Increase from a rate of 22.3 in 2020 (CDC Wonder, 2020)

**The NSDUH data point changed in 2021, as respondents reported use in the past year, when prior they had reported use in the past month.*

With regard to substance-related suicide and deaths by suicide, slight decreases for two of three indicators were observed. According to CDC Wonder data, the rate of deaths by suicide decreased from 16.3 per 100,000 in 2019 to 15.8 per 100,000 in 2021. For youth, there was over a full percentage point decrease from 2019 to 2021. Additionally, the number of Alabamians who died by suicide due to alcohol or drug poisonings rose to 53 in 2021 after having decreased to 51 individuals in 2020.

SUBSTANCE-RELATED SUICIDE AND DEATHS BY SUICIDE		
Desired Outcomes	Current Indicators (latest data year)	Prior Year & Change Interpretation
↓ Decrease in suicide deaths and attempts in adults	15.8 per 100,000 was the rate of deaths by suicide in Alabama in 2021. (CDC Wonder, 2021) and 0.53% of Alabama adults reported a suicide attempt in the past year. (NSDUH, 2021)	↓ Slight decrease from 16.0 in 2020 (CDC) and from 0.54% in 2019 (NSDUH)
↓ Decrease in suicide deaths and attempts in youth	10.2% of Alabama high school youth reported a suicide attempt in the past year. (YRBS, 2021)	↓ Slight decrease from 11.6% in 2019.
↓ Decrease in substance-related deaths by suicide	53 Alabamians died by suicide due to alcohol or drug poisonings in Alabama. (CDC Wonder, 2021)	↑ Increase from 51 in 2020.

FY23 Evaluation Activities

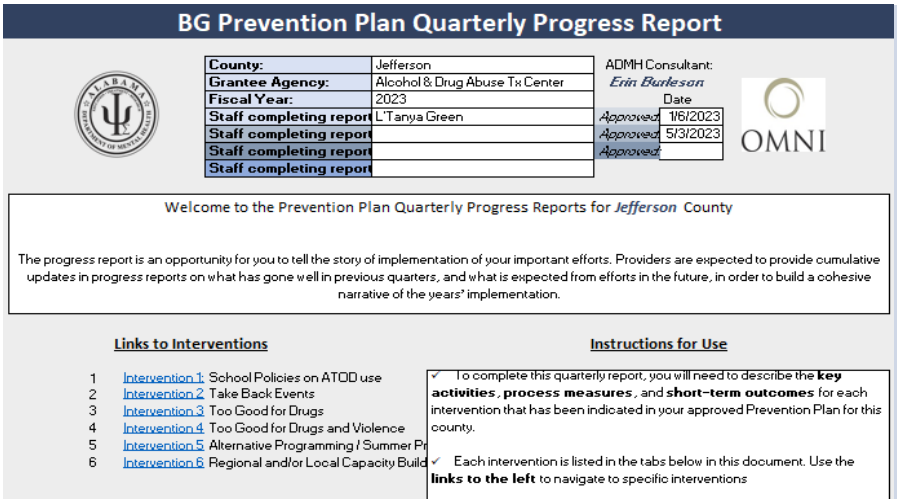
This section describes evaluation activities that OMNI supported in FY23. These activities were determined based on ADMH priorities, provider feedback, and grant evaluation requirements.

Prevention Plan Template Amendments and Progress Reports

In FY23, providers continued the implementation of strategies specified in their FY22 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 previously required to complete quarterly progress reports for prevention implementation in each county they serve. Mid-year, ADMH shifted to a twice-yearly reporting schedule. For FY23, data are available for the first two quarters and the second half of the FY. In these three reports, providers described progress toward key intervention activities, process measures, and short-term outcomes identified in their PPTs and identified successes and challenges with implementation.

Interventions, process measures, and short-term outcomes are populated by providers in an Excel sheet that is used to report progress for the entire fiscal year. The sheets include responses for all the fiscal year reporting periods so providers can more clearly identify their progress on these measures and add relevant updates.



BG Prevention Plan Quarterly Progress Report

County:	Jefferson
Grantee Agency:	Alcohol & Drug Abuse Tx Center
Fiscal Year:	2023
Staff completing report	L'Tanya Green
Staff completing report	
Staff completing report	
Staff completing report	

ADMH Consultant: *Erin Burleson*

	Date
Approved	1/6/2023
Approved	5/3/2023
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 Pr
6 Intervention 6: Regional and/or Local Capacity Build

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 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 Data Sharing

In reviewing FY21 PPTs, OMNI and ADMH identified areas where data on 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 developed and administered a statewide survey to better understand the behaviors and attitudes of

young adults (ages 18-25). Data collection ran from March through September 2022. In early FY23, OMNI analyzed the survey data at the state and county levels, released a statewide summary report, and shared statewide, provider-level, and county-level data with ADMH and providers to support their needs assessment process and data-driven prevention planning for FY24. The survey will be repeated in early 2024.

Ongoing TA and Capacity Building

OMNI offered capacity building services to support provider implementation and evaluation in FY23. Such capacity-building activities included:

Trainings to Build Prevention Capacity

At the request of ADMH, OMNI attended the Alabama School for Alcohol and Other Drug Studies (ASADS) Conference and presented a training on Engaging Community Members through Interactive Data Sharing. In addition, OMNI contributed to workforce development through FY23 trainings focused on:

- Environmental CSAP Strategies
- Overview of the Prevention Plan Process
- Conducting Local Needs Assessment Processes
- Social Media 101

Participation at State Prevention Advisory Board (SPAB) Meetings

OMNI participated in SPAB meetings by offering evaluation-related information, presenting highlights of the SABG Annual Report and Statewide Survey Results, and developing an Alabama SABG Prevention and Opioid Information Sheet.

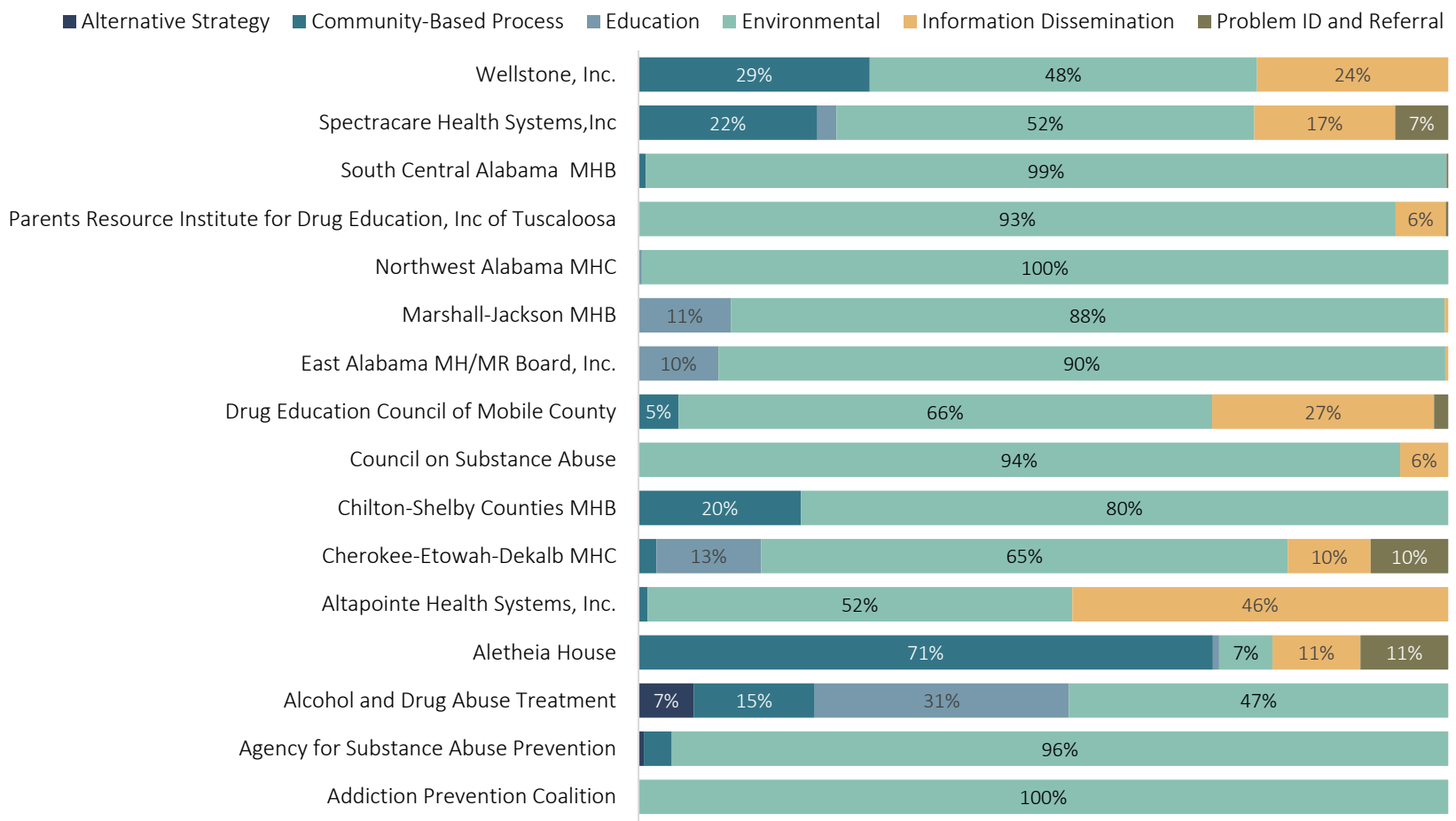
Individual Technical Assistance (TA)

OMNI participated in one-on-one meetings with providers about prevention planning interventions and amendments, statewide survey data, or any other related questions. TA was 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	4	Coosa	5	Jackson	4	Perry	1
Barbour	4	Covington	5	Jefferson	6	Pickens	5
Bibb	2	Crenshaw	5	Lamar	4	Pike	5
Blount	4	Cullman	7	Lauderdale	4	Randolph	5
Bullock	4	Dale	4	Lawrence	3	Russell	5
Butler	5	Dallas	1	Lee	5	Shelby	4
Calhoun	5	DeKalb	7	Limestone	4	St. Clair	4
Chambers	6	Elmore	1	Lowndes	1	Sumter	2
Cherokee	4	Escambia	3	Macon	5	Talladega	5
Chilton	4	Etowah	3	Madison	4	Tallapoosa	6
Choctaw	2	Fayette	6	Marengo	2	Tuscaloosa	3
Clarke	3	Franklin	4	Marion	6	Walker	6
Clay	5	Geneva	3	Marshall	4	Washington	3
Cleburne	1	Greene	3	Mobile	4	Wilcox	1
Coffee	5	Hale	2	Monroe	3	Winston	6
Colbert	3	Henry	4	Montgomery	2	---	---

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	3	5	10466	39	0
Age 5-11	22	249	1693	28576	1361	50
Age 12-14	98	212	778	49089	17039	551
Age 15-17	5	166	32	42684	16570	725
Age 18-20	0	211	2	32061	15249	45
Age 21-24	0	332	1	34161	18577	28
Age 25-44	1	3313	52	133166	90485	163
Age 45-64	5	5153	5	140937	99502	124
Over 65	0	2231	0	112181	79123	9
Age Unknown	0	372	6	294125	19441	835
Male	67	2987	1307	279147	163216	943
Female	64	8805	1158	301390	174742	770
Gender Unknown	0	450	109	296909	19428	817
White	4	2679	1710	428938	212775	1004
Black/African American	125	9007	571	113317	105770	331
Hawaiian/Pacific Islander	0	1	4	348	70	1
Asian	0	12	10	4403	2013	8
Native American	0	11	8	2965	2145	5
More than one race	2	54	154	19814	9402	304
Race unknown	0	478	117	307661	25211	877
Hispanic or Latino	4	191	201	38601	10964	483
Not Hispanic or Latino	127	11606	2272	534908	321149	1209
Ethnicity Unknown	0	445	101	303937	25273	838

**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 FY23