Alabama

UNIFORM APPLICATION
FY 2026/2027 SUPTRS BG Only ApplicationBehavioral Health Assessment and Plan

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

OMB - Approved 05/28/2025 - Expires 01/31/2028
(generated on 11/09/2025 10.26.09 AM)

Center for Substance Abuse Prevention
Division of Primary Prevention

Center for Substance Abuse Treatment
Division of State and Community Systems (DSCS)

State Information

State Information

Plan Year

Start Year	2026
End Year	2027

State Unique Entity Identification

Unique Entity ID	1630506021A1

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

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

II. Contact Person for the Grantee of the Block Grant

First Name	Nicole
Last Name	Walden
Agency Name	Alabama Department of Mental Health, Division of Mental Health and Substance Use Services
Mailing Address	100 North Union Street, Suite 420
City	Montgomery
Zip Code	36130-1410
Telephone	334-242-7287
Fax	334-242-3025
Email Address	nicole.walden@mh.alabama.gov

III. Expenditure Period

State Expenditure Period

From	
To	

IV. Date Submitted

Submission Date	10/1/2025 8:35:53 PM
Revision Date	10/1/2025 8:36:10 PM

V. Contact Person Responsible for Application Submission

First Name	Denice
Last Name	Morris
Telephone	3343286477
Fax	
Email Address	denice.morris@mh.alabama.gov

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

State Information

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

Fiscal Year 2026

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
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ASSURANCES - NON-CONSTRUCTION PROGRAMS

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As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
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10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

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

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

2. Certification Regarding Drug-Free Workplace Requirements

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

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;

b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

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

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or

attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

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

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

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

HHS Assurances of Compliance (HHS 690)

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

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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

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

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

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

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

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

State: _____

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

Signature of CEO or Designee[1]: _____

Title: _____ Date Signed: _____

mm/dd/yyyy

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

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11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

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

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

2. Certification Regarding Drug-Free Workplace Requirements

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

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;

b. Establishing an ongoing drug-free awareness program to inform employees about--

    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--

    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?

    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

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

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or

attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

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

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

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

HHS Assurances of Compliance (HHS 690)

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

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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

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

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

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

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

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

State: Alabama

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

Signature of CEO or Designee[1]: Kay Ivey

Title: GOVERNOR

Date Signed: 09/12/2025
mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

State Information

Disclosure of Lobbying Activities

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

Standard Form LLL (click here)

Name

Denice Morris

Title

Director of Substance Use Treatment

Organization

Alabama Department of Mental Health

Signature: Date:

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

ADMH does not participate in any lobbyist activities.

Planning Steps

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

Narrative Question

Provide an overview of the state's prevention system (description of the current prevention system's attention to individuals in need of substance use primary prevention), early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of mental health and SUD services. States should also include a description of regional, county, tribal, and local entities that provide mental health and SUD services or contribute resources that assist in providing these services. This narrative must include a discussion of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

1. Please describe how the public mental health and substance use services system is currently organized at the state level, differentiating between child and adult systems.

   See attachment

2. Please describe the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of mental health and substance use services.

   See attachment

3. Please describe how the public mental health and substance use services system is organized at the regional, county, tribal, and local levels. In the description, identify entities that provide mental health and substance use services, or contribute resources that assist in providing these services. This narrative must include a description of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

   See attachment

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

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

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

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

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

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

ADMH is designated as the single state agency (SSA) in Alabama authorized to receive and administer any and all funds available from any source to support the provision of services and other activities within the scope of its statutory authority. This responsibility includes receipt and administration of the Mental Illness and Substance Use Block Grants provided by the Substance Use and Mental Health Services Administration (SAMHSA). ADMH's decision to submit separate SAMHSA block grant applications for mental illness and substance use services, respectively, for FY 26 – FY 27 allows for more realistic planning based upon currently identified needs, than does submission of a combined application that plans for a behavioral health division that remains under development.

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

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

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

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

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

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

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

TABLE 1 **ADMH Mental Health Regions**

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

Marshall **Morgan** **Walker** **Winston**		**Pike** **Russell** **Sumter** **Tallapoosa** **Wilcox**	**Monroe** **Washington**

2. Service Delivery Overview

ADMH does not operate any substance use prevention, treatment, or recovery support programs or directly provide any related services. The agency has established the State's public system of services through the execution of contractual agreements with eighty-six (86) community based private and public entities located throughout Alabama. Each of these organizations receives funds from ADMH to provide one (1) or more of fifteen (15) levels of care that together, compose the state's treatment service continuum, funds to provide one or more of the six (6) primary preventions strategies, and/or funds to provide recovery support services. The number of patients served by ADMH treatment services contractors in 2024 is provided in **TABLE 2**. ADMH also certifies fifteen (15) other providers with which there is no contractual relationship.

Table 2

Region	Number of Patients
1	10,424
2	12,084
3	2,025
4	5,857
Total	30,390

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

3. Treatment Services

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

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

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

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

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

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

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

4. Use of Treatment Placement Criteria

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

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

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

5. Treatment Levels of Care

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

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

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

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

d. **Ambulatory Withdrawal Management Without On-Site Monitoring (Level 1.WM):** An organized outpatient service, which may be delivered by trained

clinicians who provide medically supervised evaluation, detoxification and referral services according to a pre-determined schedule. Such services are provided in regularly scheduled sessions under a defined medical protocol. Outpatient detoxification services shall be designed to treat the patient's level of clinical severity and to achieve safe and comfortable withdrawal from mood-altering substances and to effectively facilitate the patient's entry into ongoing treatment and recovery.

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

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

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

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

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

j. **Partial Hospitalization (Level 2.5):** A program that is delivered in an outpatient setting and generally features twenty (20) or more hours of clinically intensive programming per week. There is daily or near-daily contact, as specified in the

patient's service plan. Patients often have direct access to or close referral relationship with psychiatric, medical and lab services.

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

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

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

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

TABLE 3

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

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

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

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

TABLE 4

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

C. SUPTRS Priority Service Populations

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

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

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

2. Pregnant Women and Women with Dependent Children

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

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

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

- Shall be family centered and gender responsive addressing:

    a. Assessment of primary medical care to include prenatal care, primary pediatric care and immunization for their children.
    b. Relationships.
    c. Sexual & physical use.

d. Parenting skills and practices.
e. Childcare.

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

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

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

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

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

3. Injecting Drug Users

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

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

4. Persons with or at Risk for Tuberculosis

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

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

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

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

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

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

5. Persons at Risk for HIV

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

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

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

6. Youth in Alabama

ADMH certifies seventeen (17) adolescent substance use disorder treatment programs (See Table 5 below). Youth between the ages of 13-18 who meet DSM-V criteria are eligible for treatment services. These treatment providers offer services for youth that engage the patient and family in recovery efforts. Treatment addresses the patient's psychosocial needs along with the substance use disorder. Treatment approaches are evidenced based and modalities include residential and outpatient programs with varying intensities to meet patient needs. Services include family, group, individual counseling as well as educational sessions and other support services such as case management and peer support. Adolescent services also include in-home and school-based counseling when appropriate. Treatment providers are expected to have formal linkages with other community social service entities for referrals to ensure that individualized needs are being addressed.

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

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

The number of youths receiving services from ADMH funded substance use treatment programs for SFY 2024 was 2,739.

Table 5

Certified Adolescent Programs and LOC	
Bradford Health Services	Level 2.1, 2.5, 3.7, 3.7 WM
Bridge, Inc.	Level 0.5, 1, 2.1, 3.5
Aletheia House	Level 1, 2.1

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

7. Primary Prevention Services

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

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

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

a. Educate and counsel individuals on substance use.
b. Provide for activities to reduce the risk of such use by the individuals.
c. Give priority to populations that are at risk of developing a pattern of such use and develop community-based strategies for prevention of such use, including strategies to discourage the use of alcoholic beverages and tobacco products by individuals to whom it is unlawful to sell or distribute such beverages or products.
d. Use funds provided for the provision of comprehensive primary prevention programs that include activities and services provided in a variety of settings for both the general population, as well as targeting sub-groups who are at high risk for substance use.
e. Identify the type of target population for service provision based on the Institute of Medicine categories: Universal, Selective, or Indicated.
f. Use a variety of strategies, as appropriate for each target group, including but not

limited to the following:

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

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

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

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

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

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

- Changing economic conditions (How much things cost; how available things are);
- Changing social conditions (What people think; how people live);

- Changing media conditions (what people read, watch, hear, and see); and
- Changing political conditions (Who has power; who has influence)

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

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

Eligibility Criteria for Prevention Services:

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

Utilizing the Strategic Prevention Framework to guide the process, ADMH requires providers to submit data informed plans to ensure the needs of their diverse communities are addressed. In FY 2023, provider prevention plans focused on a comprehensive approach across the six primary strategies addressing underage drinking; prevention or reduction of illicit and prescription drug misuse, use, and use; and prevention across the lifespan with an emphasis on adolescents and young adults.

Strategic Prevention Framework

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

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

Department of Education serve on the SPAB, as well as, the AEOW (Alabama Epidemiological Outcomes Workgroup).

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

Partnerships for Success

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

Strategic Prevention Framework for Prescription Drugs

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

Opioid State Targeted Response

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

State Opioid Response

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

Strategic Prevention Framework for Prescription Drugs

In Fiscal Year 2021, ADMH began execution of an additional Cooperative Agreement with SAMHSA to sustain the Strategic Prevention Framework (SPF) initiative through the Strategic Prevention Framework for Prescription Drugs (SPF Rx) program

opportunity. The SPF project director is assigned responsibility for management of the SPF Rx Grant and will work uniformly with the SPAB and the AEOW to fulfill its objectives.

Other Prevention Services

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

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

D. Recovery Support Services

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

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

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

3. Establish protocols to demonstrate the effectiveness of the state's utilization of peer support specialists in expanding service access, facilitating care transitions, enhancing treatment retention, and thereby improving the overall health and wellness of individuals, families, and communities impacted by substance use or co-occurring disorders.

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

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

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

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

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

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

1. Alabama Medicaid Agency

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

Table 6

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

2. Other State Agencies

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

Table 7

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

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

Entities participating as providers in Alabama's public system of substance use services are legally structured as either (a) a public not-for-profit organization operating under the authority of Alabama Acts 1967, Act 310; or (b) private not-for-profit organizations or (c) private for-profit corporations or partnerships operating under the authority of Alabama Business and Nonprofits Entities Code, Title 10a of the Code of Alabama 1975. ADMH's relationship to these organizations is described below:

a. Public Not-For Profit Organizations

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

There are nineteen (19) regional 310 Boards encompassing twenty-two (22) catchment areas in the state. ADMH certifies, contracts, and funds eighteen (18) of these Boards for the operation of substance use treatment and prevention programs operated by these entities. No management, monitoring or funding responsibilities of other service providers located within respective 310 regions are passed down from ADMH to the 310 Boards.

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

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

c. Private For-Profit Organizations

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

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

Each entity contracting with ADMH must meet all certification, reporting, and data submission requirements as specified by the state. All claims for services provided, regardless of whether the payment source is SUPTRS funding, state funding, Medicaid reimbursement or other grant funding, must be submitted to ADMH

through its Substance Use Management Information System. Provider contacts incorporate all SUPTRS requirements and assurances.

F. Addressing the Needs of Underserved Communities

Approaches to address person-centered practices that demonstrate inclusive care, and the identification of individualized need are embedded within the substance use prevention, treatment, and recovery service delivery infrastructure. Individual, community, and systems barriers that can impact health outcomes as it relates to race, ethnicity, linguistics and community health influences are assessed and interwoven within the statewide substance use service delivery system through various mediums annually. In an effort to increase respectful approaches to person-centered care and enhance the awareness of prevention and treatment resources available to individuals and communities, the provision of consistent training, technical assistance and organizational collaborations are incorporated and promoted to ensure appropriate engagement and inclusive care. ADMH has two representatives on the State Cultural and Linguistic Competency Network that is managed by Georgetown University.

G. Strengths and Weaknesses of the System

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

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

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

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

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

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

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

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

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

i. A strong provider compliance monitoring process.

j. Commitment of ADMH program management to systems improvement

k. Establishment of the Recovery Support Specialist credentialing process.

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

m. Movement to the CCBHC model as an infrastructure change across divisions

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

o. Coalition Readiness

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

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

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

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

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

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

(1) Prevention is supported by community agencies.

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

(3) Agency sustainability of prevention workforce is consistent.

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

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

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

q. 2019 Funding Allocation (ADMH)

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

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

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

(4) Established incentives for prevention providers.

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

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

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

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

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

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

d. Systems Change: System change has been a very slow process in Alabama. Despite advances in knowledge about substance use disorders and its prevention and treatment, evidence-based practices in that regard, innovations in technology, and

changes health care delivery, few adaptations have been made within ADMH's provider base.

e. Lack of Medicaid expansion.

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

Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system, including state plans for addressing identified needs and gaps with MHBG/SUPTRS BG award(s)

Narrative Question

This narrative should describe your states needs assessment process to identify needs and service gaps for its population with mental or substance use disorders as well as gaps in the prevention system. A needs assessment is a systematic approach to identifying state needs and determining service capacity to address the needs of the population being served. A needs assessment can identify the strengths and the challenges faced in meeting the service needs of those served. A needs assessment should be objective and include input from people using the services, program staff, and other key community stakeholders. Needs assessment results should be integrated as a part of the state's ongoing commitment to quality services and outcomes. The findings can support the ongoing strategic planning and ensure that its program designs and services are well suited to the populations it serves. Several tools and approaches are available for gathering input and data for a needs assessment. These include use of demographic and publicly available data, interviews, and focus groups to collect stakeholder input, as well as targeted and focused data collection using surveys and other measurement tools.

Please describe how your state conducts needs assessments to identify behavioral health needs, determine adequacy of current services, and identify key gaps and challenges in the delivery of quality care and prevention services.

Grantees must describe the unmet service needs and critical gaps in the state's current systems identified during the needs assessment described above. The unmet needs and critical gaps of required populations relevant to each Block Grant within the state's behavioral health system, including for other populations identified by the state as a priority should be discussed. Grantees should take a data-driven approach in identifying and describing these unmet needs and gaps.

Data driven approaches may include utilizing data that is available through a number of different sources such as the **National Survey on Drug Use and Health (NSDUH)**, **Treatment Episode Data Set (TEDS)**, **National Substance Use and Mental Health Services Survey (N-SUMHSS)**, the **Behavioral Health Barometer**, **Behavioral Risk Factor Surveillance System (BRFSS)**, **Youth Risk Behavior Surveillance System (YRBSS)**, the CDC mortality data, and state data. Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention, treatment, and recovery support services planning. States with current Strategic Prevention Framework - Partnerships for Success discretionary grants are required to have an active SEOW.

This step must also describe how the state plans to address the unmet service needs and gaps identified in the needs assessment. These plans should reflect specific services and activities allowable under the respective Block Grants. In describing services and activities, grantees must also discuss their plan for implementation of these services and activities. Special attention should be made in ensuring each of the required priority populations listed above, and any other populations, prioritized by the state as part of their Block Grant services and activities are addressed in these implementation plans.

1. Please describe how your state conducts statewide needs assessments to identify needs for mental and substance use disorders, determine adequacy of current services, and identify key gaps and challenges in the delivery of quality care and prevention services.

   See attached narrative

2. Please describe the unmet service needs and critical gaps in the state's current mental and substance use systems identified in the needs assessment described above. The description should include the unmet needs and critical gaps for the required populations specified under the MHBG and SUPTRS BG "Populations Served" above. The state may also include the unmet needs and gaps for other populations identified by the state as a priority.

   See attached narrative

3. Please describe how the state plans to address the unmet service needs and gaps identified in the needs assessment. These plans should reflect specific services and activities allowable under the respective Block Grants. In describing services and activities, grantees must also discuss plans for the implementation of these services and activities. Special attention should be made in ensuring each of the required priority populations and any other populations prioritized by the state as part of the Block Grant services and activities are addressed in the implementation plan.

   See attached narrative

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

SECTION II: ALABAMA PLANNING STEPS

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

1. ASSESSMENT PROCESS

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

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

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

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

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

The information that follows establishes the basis for Alabama's Substance Use Block Grant (SUPTRS) priorities for FY 2026 and FY 2027. ADMH has identified unmet needs and critical gaps in the state's publicly funded substance use service delivery system through a process of review and analysis of information retrieved from data collection processes that addressed:

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

2. ALCOHOL AND OTHER DRUG USE IN ALABAMA

According to the U.S. Census Bureau, Alabama's population grew 7.9% Alabama is home to 5,108,468 individuals (U. S. Census Bureau, 2023). Alabama's population grew 7.9% since 2010. A demographic profile of the state's residents is provided in **TABLE 1** (U. S. Census Bureau, 2023).

Table 1

Age and Sex	
Persons under 18 years	22.0%
Persons 65 years and over,	18.0%
Females	52.0%
Males	48.0%
Race and Hispanic Origin	
White alone	63.0%
Black or African American alone,	25.0%
American Indian and Alaska Native alone	0.7%
Asian alone	2.0%
Native Hawaiian and Other Pacific Islander alone	0.1%
Two or More Races	4.0%
Hispanic or Latino	6.0%
Families and Living Arrangements	
Households, 2019-2023	1,969,105
Persons per household, 2015-2019	2.50

Living in same house 1 year ago, percent of persons age 1 year+, 2019-2023	87.8%
Language other than English spoken at home, percent of persons age 5 years+, 2019-2023	5.9%
Income and Poverty	
Median household income (in 2023 dollars), 2019-2023	$62,027
Per capita income in past 12 months (in 2023 dollars), 2019-2023	$34,835
Persons in poverty, percent	15.6%
Children ages under 18 in poverty (2023)	21.0%

Source: U.S. Census Bureau (2023). American Community Survey 1-year estimates. Retrieved from Census Reporter Profile page for Alabama Retrieved from <https://censusreporter.org>

In 2023, the state's overall poverty rate was 15.6% for all ages compared to 11.3% in the United States. For ages 5 to 17 in families, the poverty rate is 20.7% compared to 15.8% in the United States.

In comparison to other states, Alabama's consistent ranking at or near the bottom sector of most indicators of good health and wellbeing is a major eyesore. The United Health Foundation (American's Health Rankings) currently ranks Alabama 42th in the nation in terms of overall health outcome (2024). This ranking is based upon analysis of the following four health determinants: (a) personal health behaviors; (b) community and environmental factors that are indicative of the reality of daily living conditions; (c) public and health policies indicative of the availability of resources to encourage and maintain health, as well as, the extent that public and health programs reach into the general population; and (d) the quality, appropriateness and cost of the clinical care received at doctors' offices, clinics and hospitals (United Health, 2020). As indicated in Table 2, the state is challenged by many health related issues.

Table 2

Alabama's 2024 Health Ranking	
Health Determinant	**National Ranking**
Obesity	44
Premature Deaths	44
Drug Deaths	18
Suicide	25
Cancer	23
Diabetes	45
Low Birthweight	47
Frequent Mental Distress	30
Frequent Physical Distress	30
Smoking	36
Mental Health Providers	50
Dentists	49
Primary Care Physicians	45
Preventable Hospitalizations	49

Alabama is not a Medicaid expansion state, and its Medicaid eligibility criteria is one of the most stringent in the nation. Currently, Medicaid eligibility for non-disabled adults is limited

to parents with incomes below 18% of poverty, or about $5,787 a year for a family of four. Adults without dependent children remain ineligible regardless of their income.

Alabama has a significant alcohol and drug problem that both compounds and is compounded by the state's health and economic deficits. Alcohol and other drug use has been linked to poor health outcomes as those experienced in the Alabama. Long-term alcohol misuse is associated with liver disease, cancer, cardiovascular disease, and neurological damage as well as psychiatric problems such as depression, anxiety, and antisocial personality disorder. Excessive alcohol consumption is associated with approximately 178,000 deaths per year (NIAAA, 2024).

Alabama's Behavioral Health Barometer published by the Substance Use and Mental Health Services Administration (SAMHSA, 2024) identify the following youth and young adults drug use patterns in the state:

- Among youth aged 12-17 during 2022-2023, the annual average prevalence of past-month marijuana use was 5.5% (or 22,000).

- Among young adults aged 18-25 during 2022-2023, the annual average of 23.8% (or 128,000) had illicit drug use disorder in the past year.

- Among youth aged 12-17 during 2022-2023, the annual average prevalence of past-month cigarette use was 1.6% (or 6,000).

- Among youth aged 12-17 during 2022-2023, the annual average prevalence of past-month alcohol use was 6.1% (or 24,000).

- Among youth aged 12–17 during 2022-2023, an annual average of 6.3% (or 23,000) initiated alcohol use (i.e., used it for the first time) within the year prior to being surveyed, 4.4% (or 16,000) initiated marijuana use within the year prior to being surveyed, and 3.2% (or 12,000) initiated cigarette use.

- Among people age 12 or older during 2022-2023, 4.2% (or 181,000) misused prescription pain relievers in the past year.

Of individuals aged 18 and older in Alabama, according to the 2022-2023 National Survey on Drug Use and Health:

- About 418,000 individuals in 2022–2023 had an alcohol use disorder in the past year.
- About 662,000 individuals in 2022–2023 had used marijuana in the year prior to the survey.
- About 9,000 individuals in 2022–2023 had used heroin in the year prior to the survey.

- About 60,000 individuals in 2022–2023 had used cocaine in the year prior to the survey.
- About 1,11,200 individuals in 2022–2023 had used tobacco products in the month prior to the survey.
- About 172,000 individuals in 2022–2023 had misused pain relievers in the year prior to the survey.

Alabama's 2026 Drug Threat Assessment, prepared by the Alabama Operations Center/Gulf Coast High Intensity Drug Trafficking Area (HIDTA) identified Fentanyl and Other Opioids as the greatest drug threat by law enforcement agencies across Alabama for 2024. Methamphetamine was ranked as the second greatest drug threat. While Marijuana and Cocaine are continuing to show increases in use, Heroin and controlled prescription drugs also are continuing to show a rise in use (AL HIDTA, 2026). According to FY2024 ADMH Treatment Admissions, marijuana, heroin & other opiates, alcohol, methamphetamine, and cocaine accounted for 96% of the admissions to the AMDH-funded substance use treatment system, as presented in Table 3.

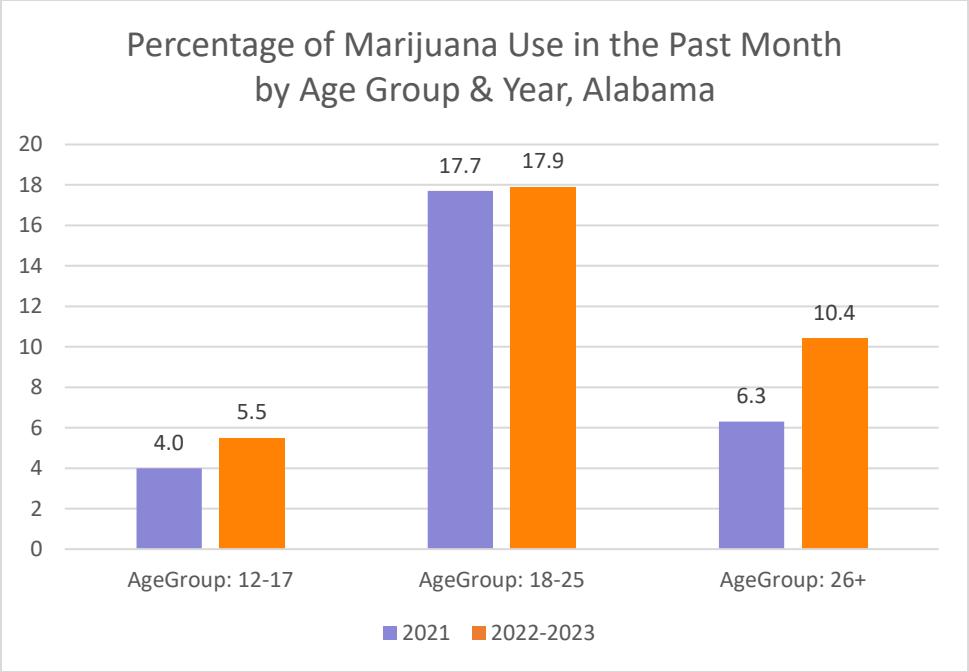
Table 3

Primary Drug Used at Admission	Total
Controlled Prescription Drugs	1,964
Cocaine (Smoked and other route)	2,290
Fentanyl	2,040
Heroin	1,970
Marijuana	5,306
Methamphetamine	4,745

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

Marijuana

According to the AL HIDTA 2026, marijuana is third most used drug in Alabama. High grade marijuana is available throughout the state. In the 2022-2023 NSDUH, 10.9% of individuals age 12 and older reported marijuana use in the past month compared to 15.2% in the US. Perceptions of great risk of smoking marijuana once a month is 20.4% for individuals age 12 and older (NSDUH 2022-23). Among individuals age 18 and older, there is a statistically significant difference in marijuana use in the past year from 2021 (19.6%) to 2022-2023 (22.9%). For Alabama in FY2024, there were 5,306 ADMH-funded treatment admissions for marijuana as the primary substance used among persons aged 12 years and older.



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2021, 2022-23.

Opioids

In the 2022-2023 NSDUH, 4.2% of individuals age 12 and older reported pain reliever misuse in Alabama in the past year compared to 3.0% in the US. Also, 0.0% of individuals age 12 and older reported heroin use in Alabama in the past year. Perceptions of great risk of trying heroin once or twice is 83.3% for individuals age 12 and older. Age group 12-17 years old (59.2%) had the lowest perception of great risk from trying heroin once or twice while 26 years old and older (86.9%) had the highest perception of great risk (NSDUH 2022-2023). For Alabama in FY2024, there were 1,970 ADMH-funded treatment admissions for heroin and other opiates as the primary substance used among persons aged 12 years and older.

According to Alabama Department of Public Health (ADPH), based on information obtained from death certificates where known or suspected drugs were specifically provided, overdose deaths involving fentanyl and methamphetamine are on the rise and prescribed opioids are on the decline. There have been increases in overdose deaths from fentanyl statewide. From fentanyl alone the death toll statewide went from 386 in 2023 to 253 in 2024 (2026 AL HIDTA). From 2019 to 2024 in Alabama, the average rate of opioid overdose deaths increased. Like all drug-related deaths, the number of opioid-related overdose deaths is considerably higher among males. Almost twice as many males died from drug overdose than females.

In 2022, the average rate of opioid-related deaths was 20.0 per 100,000 population while in 2023 the average rate of opioid-related deaths increased to 22.9 per 100,000 population and in 2024

the average rate of opioid-related deaths decreased to 19.2 per 100,000 population. In addition, naloxone administration increased from 2021 (0.3 per 100,000 population) to 2023 (0.4 per 100,000).

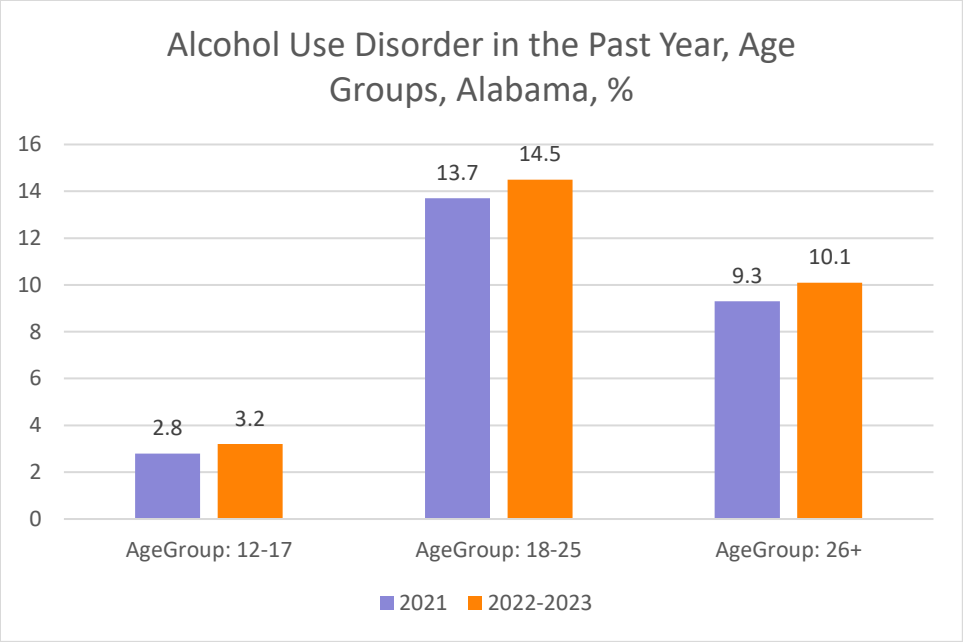
In 2023-2024, 16,157 drug overdose-related ED visits were reported; 4,846 (30%) of those involved opioids. In most age groups, more males than females have ED visits for all drug-related overdose. Similar to all drug-related overdoses, ED visits for opioid-related overdoses occur mostly among males. In the 25-44 age groups, twice as many males than females had ED visits for opioid-related overdoses. The number of opioid-related overdose ED visits dropped slightly in the 25-44 age groups but decreased slightly in the 45-64 age group from 2022-2023. The number of all drug-related overdose 911 runs was higher among males 20-49 years old.

Alcohol

According to NSDUH 2022-2023, 136,087 individuals in the state, age 12 and older, reported alcohol use during the month prior to the survey. For individuals aged 12 and older, 29,200 individuals reported an alcohol use disorder in the past year. Alcohol is the single most used substance in Alabama.

Binge alcohol use among male adults ages 18 and older in Alabama remained steady from 2014 (11.8%) to 2022 (12.8%) while female adults ages 18 and older increased from 2014 (6.8%) to 2022 (9.6%) (Source: BRFSS).

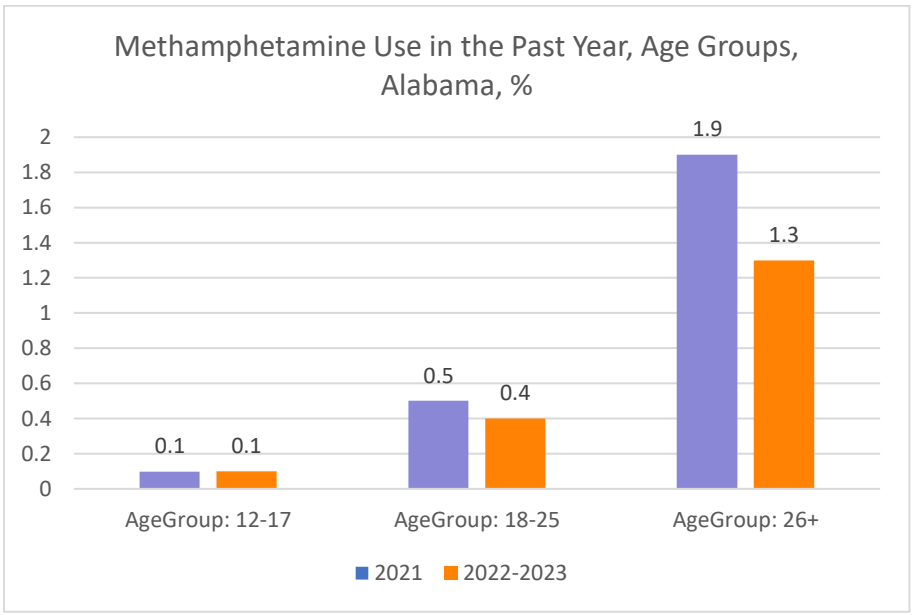
In Alabama, 29% of drivers killed in fatal crashes had a blood alcohol concentration (BAC) of .08 or higher in 2023 according to the Fatality Analysis Reporting System (FARS). In 2023, 17% of fatal crashes occurring from 3p.m. to 5:59 p.m. involved alcohol-impaired driving followed by 15% of fatal occurring from 6p.m. to 8:59 p.m. involved alcohol-impaired driving. In 2024, the rate of violent crimes in Alabama was 360.0 violent crimes per 100,000 inhabitants according to the Uniform Crime Reporting Program (UCR).



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2021 and 2022-2023.

Methamphetamine

Methamphetamine is the greatest drug threat in the state according to law enforcement according to the 2026 AL HIDTA Drug Survey. According to NSDUH 2022-2023, 47,000 individuals in the state, age 12 and older, reported methamphetamine use in the past year.

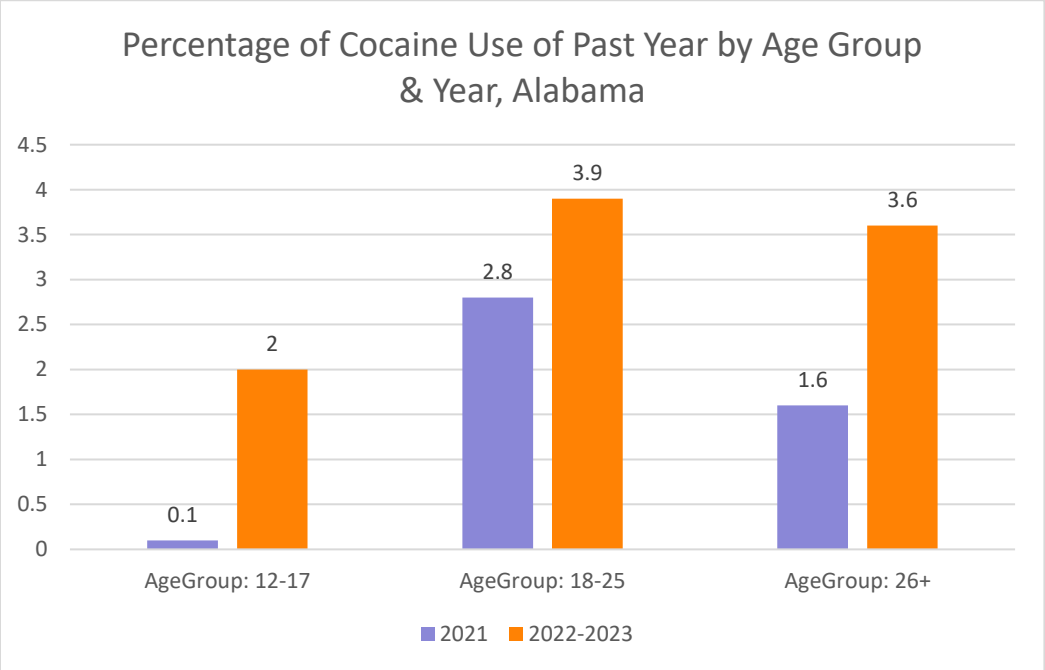


Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2021 and 2022-2023.

According to the 2026 AL HIDTA Drug Survey, methamphetamine was identified by law enforcement as the leading drug contributing to property crime, violent crime and amount of resources used. There were 300.89 kilograms of methamphetamines seized through investigations and traffic stops in Alabama for 2024.

Cocaine

In the 2022-2023 NSDUH, 1.4% of individuals in Alabama, age 12 and older, reported cocaine use in the past year compared to 1.8% in the US. Cocaine has once again fallen in rank as a drug threat according to law enforcement respondents, however, it is ranked within the top three drugs responsible for both violent and property crimes (HIDTA, 2026). For Alabama in FY2024, there were 2,290 ADMH-funded treatment admissions for marijuana as the primary substance used among persons aged 12 years and older.



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2021 and 2022-2023.

3. IDENTIFICATION OF GAPS

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

a. High Risk Youth

The potential for problematic alcohol and/or other drug use increases as the number of risk factors experienced, as illustrated in Table 4 increases. At the same time, protective factors

may reduce the risk of youth engaging in substance use that can lead to substance use, research shows. Protective factors associated with decreasing the likelihood of substance use includes parental involvement, involvement in activities, and religious beliefs influence. The more a program reduces risk factors and increases protective factors, the more it is likely to succeed in preventing substance use among children and youth.

Table 4

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

	• Low neighborhood attachment and community disorganization	• Social networks and support systems within the community
Society	• Impoverishment • Unemployment and underemployment • Discrimination • Pro-drug-use messages in the media	• Media literacy (resistance to pro-use messages) • Decreased accessibility • Increased pricing through taxation • Raised purchasing age and enforcement • Stricter driving-while-under-the-influence laws

Risk factors associated with a potential increase in substance use include poverty, child use neglect or use, academic problems, and lack of parental involvement. According to data from the Child Welfare League, children in Alabama face many risks, in 2023, 26,433 children were victims of use or neglect in Alabama at a rate of 31.6 per 1,000 children which is a decrease of 39.8% since 2013. Child deaths has remained stable from 43 deaths (2023) to 43 deaths (2018). (Child Welfare League, 2024).

As reported in the 2025 Annie E. Casey Kids Count Profile, in 2023, 21% of Alabama's children lived in poverty while 9% of Alabama's children lived in high-poverty areas. In 2023, 29% of the state's children had parents who lacked secure employment. In 2023, 7% of teenagers between age 16 and 19 who are not enrolled in school (full-or part-time) and not employed (full- or part-time).

In 2022-2023, approximately 28,000 adolescents ages 12–17 in Alabama needed but had not received treatment at a specialty facility for illicit drug use in the past year. Approximately 114,000 adolescents ages 12-17 had a major depressive episode in the past year (NSDUH). In Alabama, 19 suicides occurred in 2023 by individuals under the age of 15 years old (ADPH).

b. Underage Drinkers

In 2022-2023 NSDUH, 94,000 individuals aged 12- to 20- year-olds reported alcohol use in the past month. The years of potential life lost due to excessive alcohol use were ~4,000 years for individuals under age 21 years. In addition, the five year average (2018 to 2023) number of drivers age 20 or younger involved in fatal crashes (FARS, 2023) is 129.

In 2021, 9th –12th Graders in Alabama reported the following information in regard to underage drinking (YRBS):

- Alcohol use prior to age 13 in 2021 – 15.8%
- Male Alcohol use prior to age 13 in 2021 – 20.8%
- Female Alcohol use prior to age 13 in 2021 - 9.8%
- Binge alcohol use during the past 30 days – 0.0%

- Had at least one drink of alcohol on at least 1 day during the past 30 days – 18.8%
- Usually obtained the alcohol they drank by someone giving it to them – 0.0%
- Had at least one drink of alcohol on one day during their life –0.0%.

c. Racial/Ethnic Minorities

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

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

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

Table 5

Alabama Population Percentages	2000	2018	2024
Male	**48.3**	**48.3**	**48.5**
Female	**51.7**	**51.7**	**51.5**
White	**71.1**	**69.1**	**68.9**
Black or African American	**26.0**	**26.8**	**26.6**
American Indian/Alaska Native	**0.5**	**0.7**	**0.7**
Asian	**0.7**	**1.5**	**1.6**
Native Hawaiian and Other Pacific Islander	**0**	**0.1**	**0.1**
Two or More Races	**1.0**	**1.8**	**2.0**
Hispanic or Latino (of any race)	**1.7**	**4.6**	**5.7**

Race, ethnicity, and religion are generally perceived as the predominant elements of culture in Alabama's public substance use services delivery system. Although progress has been made in regard to the incorporation of program activities that attend to these issues,

organizational behavior, practices, and policies which are representative of a cultural and linguistic competent system of care still do not currently exist system wide.

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

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

b. Intravenous Drug Users

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

Utilizing CDC data from 2022-2023, the Robert Woods Johnson Foundation identified the following drug overdose mortality rates (number of drug poisoning deaths per 100,000 population) for Alabama (CDC Wonder, 2023). As specified in Table 7 these deaths occurred in 35 of the state's 67 counties:

TABLE 7

County	Drug Overdose Mortality Rates	County	Drug Overdose Mortality Rates
Autauga	10	Houston	18
Baldwin	77	Jackson	11
Barbour	0	Jefferson	453
Bibb	11	Lamar	0
Blount	22	Lauderdale	30
Bullock	11	Lawrence	0
Butler	0	Lee	36
Calhoun	62	Limestone	15
Chambers	11	Lowndes	0
Cherokee	10	Macon	0

Chilton	16	Madison	117
Choctaw	0	Marengo	0
Clarke	0	Marion	0
Clay	0	Marshall	31
Cleburne	0	Mobile	136
Coffee	0	Monroe	0
Colbert	25	Montgomery	37
Conecuh	0	Morgan	42
Coosa	0	Perry	0
Covington	0	Pickens	0
Crenshaw	0	Pike	0
Cullman	35	Randolph	0
Dale	10	Russell	22
Dallas	12	Shelby	51
DeKalb	21	St. Clair	43
Elmore	24	Sumter	0
Escambia	25	Talladega	23
Etowah	46	Tallapoosa	0
Fayette	0	Tuscaloosa	52
Franklin	0	Walker	63
Geneva	0	Washington	0
Greene	0	Wilcox	0
Hale	0	Winston	15
Henry	0		

Fourteen (14) of the Thirty-Five (35) Alabama counties reported in Table 7 have drug overdose mortality rates that exceed the state average of 34.1 per 100,000 persons from 2018 through 2023. Those counties are listed in Table 8.

TABLE 8

County	2023 Drug Mortality Rate
Baldwin	77
Calhoun	62
Cullman	35
Etowah	46
Jefferson	453
Lee	36
Madison	117
Mobile	136
Montgomery	37
Morgan	42
St. Clair	43
Shelby	51
Tuscaloosa	52
Walker	63

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

c. Pregnant Women and Parenting Women

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

All programs under contract with ADMH are required to give priority admission to pregnant women and to publicize the fact that priority admission is available. Strategies implemented to increase the number of treatment admissions by pregnant women has led to a significant increase in the number served in 2023 (Table 9). Yet, as the state's opioid use disorders problem continues to soar, along with the continued practice of incarcerating pregnant women who have substance use disorders in Alabama, service accessibility must continue to improve.

Table 9

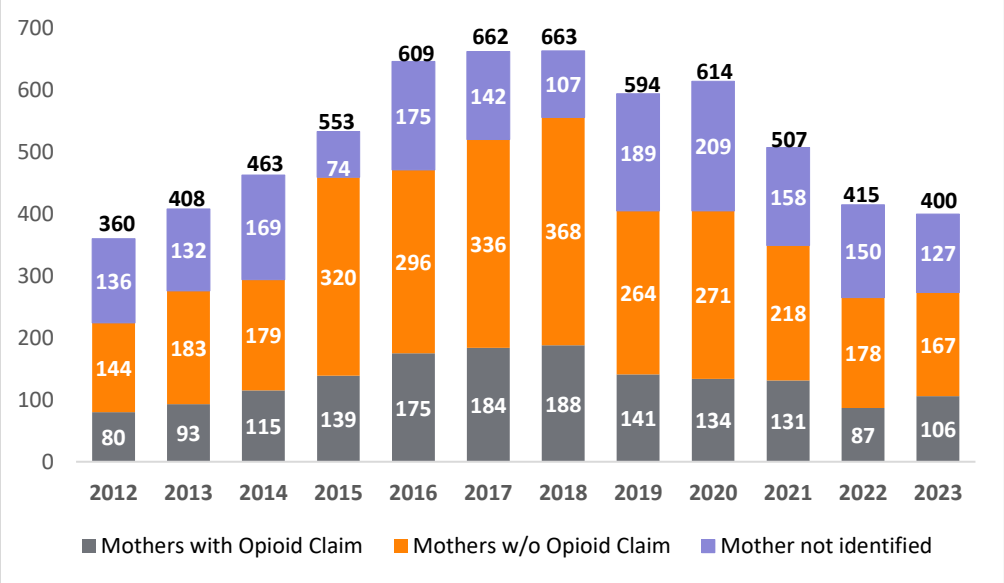
# Women Pregnant at Time of Admission	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
ADMH Funded Substance Use Treatment Programs	275	219	245	304	484	327	465	400*	447	591	340	328

According to the 2022 Pregnancy Risk Assessment Monitoring System (PRAMS) Surveillance Report conducted by the Alabama Department of Public Health, 13.2% of White mothers surveyed and 7.7% of the African American and other mothers surveyed reported they continued smoking during pregnancy. Cigarette smoking was significantly higher among mothers on Medicaid before, both during and after their pregnancies than non-Medicaid mothers.

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

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

The Alabama Medicaid Agency (AMA) pays for more births than any other entity in the state. Analysis of AMA pregnancy claims indicates the number of infants diagnosed with Neonatal Abstinence Syndrome (NAS) increased in Alabama annually between 2012 and 2023. The AMA reports that the average cost of a NAS delivery is eight times higher than a normal delivery. Ready access to treatment for women who have opioid use disorders remains an essential component of the effort to reduce NAS in Alabama (Moon, 2018).



Although admissions to treatment by pregnant women has increased, access to care continues to be identified as a barrier for women seeking substance use treatment. Services for pregnant and parenting women are not easily accessible in Alabama, primarily due to availability. Treatment programs that serve the public are not available in every Alabama County. In addition, there is only one public funded residential withdrawal management program in the state.

The adverse impact of parental substance use disorders on children is well documented in scientific literature. Alabama's child welfare agency, the Alabama Department of Human Resources, reports there were 9,082 children removed from residences in Alabama during 2021 due to parental substance use disorders compared to 1,605 in 2017. This number reflects an 82% increase in five years. (AFCARS, 2021) Drug use among parents has spiked as a reason for removing children from their care, according to the Alabama Department of Human Resources (DHR). The state's opioid crisis is viewed as a major factor in the increase of out-of-home placements.

f. Individuals With or at Risk for Tuberculosis

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

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

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

Table 10

TB Cases in Alabama						
1976	**1986**	**1996**	**2006**	**2016**	**2020**	**2023**
824	601	423	196	112	75	92

The Alabama Department of Public Health (ADPH), Division of Tuberculosis Control endeavors to eliminate TB in Alabama. The number of reported tuberculosis disease was highest in Jefferson County (11 cases) followed by Madison County (9 cases) and Montgomery County (8 cases) (ADPH, 2023).

4. UNMET SERVICE NEEDS

a. Prevention

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

Awareness & Coordination

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

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

Training and Technical Assistance

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

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

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

Data Collection

ADMH recently moved to using FEI as its Substance Use Information System, a web-based management information system which assists with the initial assessment, eligibility, determination and enrollment of substance use clients. Eventually, it will provide data on the number and demographic mix of clients receiving alcohol and other drug treatment. Implementation of the system has been slow and is still in process.

DMHSAS requires prevention providers to submit performance data on a regular basis via FEI. There is a state-level need to review the current information system as it relates to system design/organization.

b. Treatment and Recovery Support

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

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

In general, Alabama's system of care for substance use disorders is inadequately resourced to address the needs of the state's residents. The 2022-2023 National Survey on Drug Use and Health indicated 694,000 individuals, age 12 and above, in Alabama reported having a substance use disorder. The public system of substance use treatment services provided care for approximately 34,000 individuals during the same period, maintained consistent waiting lists for assessments and treatment, and reported ever-increasing service demands from the state's overcrowded criminal justice system.

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

(1) Opioid painkillers are prescribed at much higher rates in Alabama than all but one states in the nation. This continues to be true as of 2025.

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

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

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

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

(6) There are no public funded Opioid treatment Program (OTP) within the state.

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

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

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

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

At the same time, gaps exist in the public service delivery system to address all drug use disorders, in addition to those presented by the present opioid crisis. A Substance Use Planning Committee was established in 2017. The committee consists of member from

ADMH and community providers. The committee was tasked with identifying ways that the care delivery system needs to be improved. In addition, the committee continues to work on the results from a 2015 Survey which identify ways to improve access to care. The following categories were areas that were identified as needing improvement or creation:
Categorical responses were as given in **Table 11.**

Table 11

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

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

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

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

(3) Infrastructure:
- Expand Medicaid
- Allow CRNPs to practice to the full scope of their training and education
- Establish guidelines and procedures to monitor the prescribing practices of HCPs
- Minimize state intrusion in regard to the regulation of SU programs
- Make treatment services available in lieu of incarceration

(4) Education:

- More education needed for the general public, physicians, school age children
- More advertising of available resources

(5) Treatment Services: Particular concern for:

- More detox services
- Access to medication assisted treatment
- Integrated care

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

Table 12

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

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

(1) Treatment Services

- Integration of addiction and health care services
- Access to medication assisted services
- Evidence-based practices

(2) Performance Improvement

- More regulation of physicians prescribing pain meds.
- Certification of all treatment providers
- Publicly available performance outcomes
- Quality benchmarks

(3) Workforce

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

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

(5) Funding
- Increase funding for all services

Flat funding for treatment and recovery support services in Alabama, with the exception of opioid use disorders, has led to little resolution of the recommendations of the governor's task force. Thus, the identified needs remain relevant in 2026/27. A rate study is planned for FY26 to explore residential rates which have not changed in 13 years. A contractor has been identified and the kick off meeting is scheduled for October 2026.

5. ADMH FY 2026 - FY 2027 SUBSTANCE USE BLOCK GRANT PRIORITIES

Based upon review and analysis of the data put forth, herein, the FY 26 – FY 27 SUPTRS priorities have been established. These priorities are representative of some of the state's most critical gaps and needs and provide ADMH with the opportunity to enhance the lives and well-being of thousands of Alabamians impacted by the use of alcohol and other drugs.

a. Underage Drinking

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

In Alabama, epidemiological data shows that the average age of first use for Alabama youth is nine years of age. Individuals who start to drink before the age of 15 are four times more likely to also report meeting the criteria for alcohol dependence at some point in their lives. New research shows that serious drinking problems typically associated with middle age actually begin to appear much earlier, during young adulthood and even during the adolescence years. Those who start to drink at an early age are more than likely to start engaging in risky behaviors, including other drugs and negative behaviors.

Multiple risk factors exist within Alabama communities that present challenges and compelling barriers to decrease the prevalence of consequences for underage drinking. ADMH is participating in a policy academy regarding alcohol use and fetal alcohol spectrum disorder. Policies will be developed and implemented across the state as a result of this academy. This work began in 2025 and will continue through 2027.

b. Intravenous Drug Use

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

In addition, ADMH provider organizations have been slow to implement evidence-based treatment strategies appropriate for use with this population. Expansion of medication assisted treatment for opioid use disorders has expanded as a result of the federal opioid funding received within the state. In addition, ADMH will continue to utilize other federal funding to ensure that all substance use providers have the ability to offer medication assisted treatment.

The need for more rapid access to evidence-based treatment for IVDU disorders exists in the state, efforts to combat stigma, and increased outreach for minorities and individuals without the ability to pay for care. ADMH is partnering with a marketing agency to develop and implement a marketing campaign regarding opioids and opioid use. It is being designed with many audiences in mind and will continue for a minimum of two more years (started in 2025).

c. Individuals With or at Risk for Tuberculosis

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

Most of the state's substance use treatment programs accept admissions from throughout the state. This is especially true for residential treatment facilities. With individuals who have

substance use disorders representing a population at high risk for TB, an outbreak, as that in Perry County, could be transmitted to another area of the state without proper ongoing surveillance. The need exists to continue to ensure continuous screening, testing and referral of individuals receiving treatment for substance use disorders. ADMH has established billing codes for TB screening and referral using state funding only. ADMH will continue to monitor the use of these codes to ensure that individuals are receiving the service.

d. Pregnant and Parenting Women

Unmet Need / Gap: In 2023, there were 60,506 live births in Alabama. In order to combat both the potential health related consequences of drug use and pregnancy, along with the impact of actions in the state to criminalize pregnant and parenting women who have substance use disorders, the need exists to develop and implement strategies to strongly promote the efficacy and availability of treatment, and to improve service accessibility. There are 204 public funded treatment locations in Alabama. Of that number, four outpatient and two residential provide services to PWWDCs. Five additional programs provide services exclusively for adult women. For women with dependent children, accessing withdrawal management services is extremely difficult.

Efforts to mitigate the negative effects of parental substance use must be continued by ADMH. Improving access to care for pregnant women, parenting men and women, enhancing involvement of children in their parents' care, as well as implementation of strategies to address the specific needs of the children, regardless of their parents' treatment status, represent areas in need of enhancement in Alabama. ADMH is in the process of implementing CCBHCs. Pregnant and post-partum women have been identified as a priority population. Three CCBHCs have been established with plans for ten more to open by the end of 2027.

Planning Tables

Table 1: Priority Area and Annual Performance Indicators

Priority #: 1

Priority Area: Priority Area: Increasing and improving access to Special Women's Services for the treatment of PWWDC.

Priority Type: SUT

Population(s): PWWDC

Goal of the priority area:

To increase the number of substance use treatment providers in Alabama certified and contracted as Special Women's Programs (SWPs) with the state to utilize block grant funds to provide care to pregnant and parenting women.

Strategies to attain the goal:

Strategies to attain the objective:
a) Complete a specified guidebook for the application and certification process for Special Women's Programs (SWPs) in Alabama.
a. Guidebook will be completed by staff within the Office of Substance Use Treatment Services (OSUTS) of Alabama Department of Mental Health (ADMH).
b) Distribute the aforementioned guidebook to all treatment providers within the state of Alabama.
a. Distribution will be completed through email blasts from the Alabama Department of Mental Health (ADMH).
c) Provide education to existing treatment providers about Special Women's Programs (SWPs) and relevant services in Alabama.
a. Education will be provided through the monthly treatment provider huddle led by the Alabama Department of Mental Health (ADMH).
Annual Performance indicators to measure goal success:
Indicator #1: The number of certified Special Women's Programs (SWPs) in Alabama.
a) Baseline measurement (Initial data collected prior to and during SFY 2025): Prior to the current fiscal year, there are five (5) certified Special Women's Programs (SWPs) providing substance use treatment services in Alabama. Total, there are eighty (80) certified and/or contracted substance use treatment providers in Alabama. Therefore, the baseline percentage is 6.25%.
b) First-year target/outcome measurement (Progress to end of SFY 2026): By September 30, 2026, the number of certified Special Women's Programs (SWPs) in Alabama will increase by at least 1%.
c) Second year target/outcome measurement (Progress to end of SFY 2027): By September 30, 2027, the number of certified Special Women's Programs (SWPs) in Alabama will increase by at least 3%.

Data Source:
ADMH records of certification (Office of Certification within ADMH).

Data Description:
The data represents the number of providers certified as Special Women's Programs (SWPs) in Alabama. The data figure will indicate the number of providers formally recognized and certified as SWPs in Alabama.

Data issues/caveats that affect outcome measures:
No issues are currently foreseen that will affect the ability to obtain data, as it is obtained from ADMH. The department constantly evaluates the number of certified treatment providers in the state of Alabama.

Priority #: 2

Priority Area: Priority Area: Improving quality and engagement in PWWDC services.

Priority Type: SUT

Population(s): PWWDC

Goal of the priority area:

Goal of the priority area:
To enhance and expand PWWDC services to include the use of family-based interventions, doula support services, and recovery support services.

Strategies to attain the goal:

Strategies to attain the objective:
a) Expand doula support services into current roster of services for PWWDCs.
b) Expand and enhance partnerships/networks that support providers of PWWDC services to address the needs of the individuals served by providers.
c) Monitor the implementation of the expanded doula support services for PWWDC within providers.

Annual Performance indicators to measure goal success:
Indicator #1: Increase the number of dually trained Certified Recovery Support Specialists (CRSSs) to perform doula services.
a. Baseline measurement (Initial data collected prior to and during SFY 2025): Prior to the current fiscal year, there are eleven (11) Certified Recovery Support Specialists (CRSSs) dually trained to provide doula services. bi-annually at a minimum. The baseline data is eleven (11).
b. First-year target/outcome measurement (Progress to end of SFY 2026): By September 30, 2026, a minimum of fifteen (15) Certified Recovery Support Specialists (CRSS) will receive dual training as certified and trained doulas.
c. Second-year target/outcome measurement (Final to end of SFY 2027): By September 30, 2027, the number of individuals trained as Certified Recovery Support Specialists (CRSS) with dual credentialing as a certified and trained doulas will increase by 5%.
Data Source:
The number of individuals trained as Certified Recovery Support Specialists (CRSS) with dual credentialing as a certified and trained doulas will be tracked by training rosters of CRSSs attending and completing the doula certification training events.

Data Description:
Doula certification training will be offered and provided to Certified Recovery Support Specialists (CRSSs) bi-annually at a minimum. Training rosters and certifications for the doula training events will be collected and reviewed bi-annually at a minimum.

Data issues/caveats that affect outcome measures:
No issues are currently foreseen that will affect the ability to obtain data, as it is obtained from ADMH. The department constantly evaluates the number of certified treatment providers in the state of Alabama.

Priority #: 3

Priority Area: Priority Area: Children and Adolescent SUD Services

Priority Type: SUT

Population(s): Other

Goal of the priority area:

Goal of the priority area: The goal of this priority area is to raise awareness around adolescent substance use trends, the availability of substance use treatment resources and how to access quality treatment services in the State.

Strategies to attain the goal:

Strategies to attain the objective:
a) Distribute the Adolescent Treatment Services flyer (and any updates) to all ADMH certified treatment providers.
b) Disseminate adolescent treatment services resource information to adolescent systems of care providers (comprised of juvenile justice providers, public health, child welfare and family service programs). at meetings, conferences and trainings.
Annual performance indicators to measure goal success:
Indicator #1: The number of community/state meetings and trainings attended that supports the dissemination of adolescent treatment service information.
Indicator #2: The estimated number of youth service providers in attendance at meetings and trainings who will receive the adolescent resource information.
• This is a newly developed goal with accompanying performance indicators. As a result, there is no baseline data.
• First year target/outcome measurement by September 30, 2026, adolescent treatment resource information will be disseminated to 50% if adolescent system of care providers.
• Second year target/outcome measurement by September 30, 2027, adolescent treatment resource information will be disseminated to 75% if adolescent system of care providers.
Data Source:
• Community meetings and/or training agenda's
• Quantity of emails in which adolescent resource information is disseminated electronically
• Quantity of adolescent resource information disseminated manually
Data Description:
• A descriptive agenda of topics is provided for community meetings and trainings.
• The quantity of resource information disseminated can be captured electronically and manually for in person distribution.
Data issues/caveats that affect outcome measures:
• Unanticipated and last-minute travel restrictions to meetings, trainings and conferences that can impact the dissemination of adolescent substance use treatment information to newly identified systems of care service providers.

Priority #: 4

Priority Area: Priority Area: Persons Experiencing Homelessness

Priority Type: SUT, SUR

Population(s): Other

Goal of the priority area:

Goal of the priority area: The goal is to ensure that Certified Recovery Support Specialist (CRSS) are provided with a map that list all recovery community centers and crisis centers where those who have a substance use disorder and are unhoused may have a safe and supportive space to temporarily reside and be provided with resources for substance use and mental health services.

Strategies to attain the goal:

Strategies to attain the objective:
a) Distributed the map developed in digital format to CRSS for easy access of information while in the treatment field.
b) Provide training to CRSS to ensure they are confident with their knowledge of the new information, as well as who should receive the information when out in the field.
c) In the community, CRSS will provide physical map materials to individuals in contact with the CRSS so that the community members know where they can go within their county/city/area.
d) CRSS will be provided with a digital substance use treatment directory, which list substance use and mental health treatment providers certified by the ADMH. The directory is also divided by counties. The materials are made available on the ADMH website for easy sharing while in the field.
Annual Performance indicators to measure goal success:
Indicator #1: The percentage of CRSS trained and provided with the map of listed community resources.
Indicator #2: The number of people trained to distribute the tool.
7a) Prior to the current fiscal year, there were no forms of data noting the number of peers provided with the map of community and crisis centers. Therefore, the baseline will begin at zero.
7b) First year target/outcome measurement (Progress to end of SFY 2026) By September 30, 2026, among those certified within that year, 50% of all CRSS will be provided with the map of all community and crisis centers.
7c) Second year target/outcome measurement (Progress to end of SFY 2027) By September 30, 2027, 75% of all CRSS certified in the state, will be provided with the map to distribute to those persons who are unhoused and have a substance use diagnosis. The baseline is that this information hasn't been provided directly to the CRSS by the Office of Substance Use Treatment (OSUTS). OSUTS, will distribute the map created by members of the Alabama Opioid Overdose and Addiction Council Law Enforcement Committee and The Alabama Department of Mental health.
Data Source: ADMH records of training.
Data Description: All CRSS will be required to register for the training and at the successful completion of training will be logged in the system as having completed the requirements.
Data issues/caveats that affect outcome measures:
No issues are currently foreseen that will affect the ability to obtain data, as it is obtained from ADMH. The agency receives regular increases in the number of CRSS.

Priority #: 5

Priority Area: Priority Area: Individuals with co-occurring mental and substance use disorders

Priority Type: SUT

Population(s): PRSUD

Goal of the priority area:

Goal of the priority area: The goal is to ensure that contracted treatment providers who offer Level I Co-Occurring enhanced outpatient services continue to provide integrated care. The goal will be accomplished by annual compliance monitoring where clinical documentation will be reviewed to assure the use of evidenced based practices to those consumers who are identified as having Co-Occurring disorders.

Strategies to attain the goal:

Strategies to attain the objective:
a) Distribute the survey developed by the Office of Substance Use Treatment Services;
b) Ensure all treatment providers who offer co-occurring treatment services are provided with a training schedule that list opportunities to learn about co-occurring disorders with other professionals in the field;
c) Trainings in areas noted on the survey will be researched and announced via email to providers to provide opportunities to learn knowledge on the subject matter;
Annual Performance indicators to measure goal success:
Indicator #1: The percentage of contracted treatment providers that provide Level I co-occurring treatment services.

Indicator #2: Training opportunities provided on the subject matter.
7a) As of September 2025, there are six contracted treatment providers who provide Level I co-occurring treatment services. Therefore, the baseline will begin at six.
7b) First year target/outcome measurement (Progress to end of SFY 2026) By September 30, 2026, among those contracted providers within that year, 50% of all contracted Level I co-occurring treatment providers will complete a survey regarding treatment services needs and training opportunities specific to co-occurring treatment services.
7c) Second year target/outcome measurement (Progress to end of SFY 2027) By September 30, 2027, 75% of all contracted providers within the state that provide level I co-occurring treatment services will have completed the survey noting treatment needs and training opportunities specific to co-occurring treatment services.
Data Source: ADMH records of surveys and trainings.
Data Description: Employees from each agency will be required to register and attend trainings on co-occurring treatment.
Data issues/caveats that affect outcome measures:
No issues are currently foreseen that will affect the ability to obtain data, as it is obtained from ADMH. Agencies my submit applications to become a Level I co-occurring treatment provider at any time. The Office of Certification manages those applications.

Priority #: 6

Priority Area: Priority Area: Medication for Opiate Use Disorder

Priority Type: SUT

Population(s): Other

Goal of the priority area:

Goal of the priority area: Ensure Alabama Certified Treatment Programs offer Interim Treatment Services (ITS) and incorporate Shared Decision-Making (SDM) practices to assist individuals in rural areas with timely access to Medication for Opiate Use Treatment.

Strategies to attain the goal:

Strategies to attain the objective:
a) Provide specialized training for Certified Recovery Support Specialists (CRSS) so they understand both ITS and SDM, enabling them to support clients in rural and frontier areas.
b) Empower peers to reinforce patient choice and engagement throughout the interim treatment process.
c) Increase the delivery of ITS and SDM training from two (2) sessions per year to three (3) sessions annually statewide for peers and Alabama Certified Treatment Programs.
d) Use both in-person regional trainings and Zoom trainings to maximize rural providers' and peers' participation.
e) Track the number of CRSS and providers completing training, the percentage practicing SDM, and the rural counties served.
f) Integrate ITS and SDM into new staff, peer orientation, and annual refresher training for those who work in Alabama Certified Treatment Programs.
Annual Performance Indicators to measure goal success:
Indicator #1: Track the number of CRSS and Providers completing ITS and SDM training.
Indicator #2: Track the number of patients entering treatment from rural areas.
Indicator #3: Track the number of patients on the waiting list.

Targets & Outcomes
• Baseline (before SFY 2026): No prior data on CRSS trained in ITS/SDM; starting point is zero.
• Year 1 (by Sept. 30, 2026): 50% of CRSS certified peers will complete ITS and SDM training.
• Year 2 (by Sept. 30, 2027): 75% of all CRSS certified peers will complete ITS and SDM training. Training invitations will be sent by the Office of Substance Use Treatment Services (OSUTS) to all CRSS.

Data Source
• Alabama Department of Mental Health (ADMH) training records.
• ADMH Interim Service Quarterly reports records.
• ADMH Central Registry Monthly Report to track MOUD programs census.
Data Description
All CRSS and providers will be encouraged to attend the training. On successful completion, each CRSS and Provider's staff will be logged in the system as having met the training requirements.
Data Issues
No issues are currently foreseen. ADMH maintains training records and interim treatment service records for statewide participation.

Priority #: 7

Priority Area: Priority Area: Persons Experiencing Homelessness

Priority Type: SUT, SUR

Population(s): PRSUD

Goal of the priority area:

Goal of the priority area: The goal is to ensure that Certified Recovery Support Specialist (CRSS) are provided with a map that list all recovery community centers and crisis centers where those who have a substance use disorder and are unhoused may have a safe and supportive space to temporarily reside and be provided with resources for substance use and mental health services.

Strategies to attain the goal:

Strategies to attain the objective:
a) Distributed the map developed in digital format to CRSS for easy access of information while in the treatment field.
b) Provide training to CRSS to ensure they are confident with their knowledge of the new information, as well as who should receive the information when out in the field.
c) In the community, CRSS will provide physical map materials to individuals in contact with the CRSS so that the community members know where they can go within their county/city/area.
d) CRSS will be provided with a digital substance use treatment directory, which list substance use and mental health treatment providers certified by the ADMH. The directory is also divided by counties. The materials are made available on the ADMH website for easy sharing while in the field.
Annual Performance indicators to measure goal success:
Indicator #1: The percentage of CRSS trained and provided with the map of listed community resources.
Indicator #2: The number of people trained to distribute the tool.
7a) Prior to the current fiscal year, there were no forms of data noting the number of peers provided with the map of community and crisis centers. Therefore, the baseline will begin at zero.
7b) First year target/outcome measurement (Progress to end of SFY 2026) By September 30, 2026, among those certified within that year, 50% of all CRSS will be provided with the map of all community and crisis centers.
7c) Second year target/outcome measurement (Progress to end of SFY 2027) By September 30, 2027, 75% of all CRSS certified in the state, will be provided with the map to distribute to those persons who are unhoused and have a substance use diagnosis. The baseline is that this information hasn't been provided directly to the CRSS by the Office of Substance Use Treatment (OSUTS). OSUTS, will distribute the map created by members of the Alabama Opioid Overdose and Addiction Council Law Enforcement Committee and The Alabama Department of Mental health.
Data Source: ADMH records of training.
Data Description: All CRSS will be required to register for the training and at the successful completion of training will be logged in the system as having completed the requirements.
Data issues/caveats that affect outcome measures:
No issues are currently foreseen that will affect the ability to obtain data, as it is obtained from ADMH. The agency receives regular increases in the number of CRSS.

Priority #: 8

Priority Area: Underage Drinking

Priority Type: SUP

Population(s): PP

Goal of the priority area:

To promote the prevention of underage drinking throughout the state.

Strategies to attain the goal:

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

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Table 2: SUPTRS BG Planned State Agency Budget for Two State Fiscal Years (SFY)

ONLY include funds budgeted by the executive branch agency (SSA) administering the SUPTRS BG. This includes only those activities that pass through the SSA to administer substance use primary prevention, substance use disorder treatment, and recovery support services for substance use disorder.

Planning Period Start Date: 7/1/2025 Planning Period End Date: 6/30/2027

Activity	Source of Funds						
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare), etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other
1. Substance Use Disorder Prevention[a] and Treatment	$16,707,002.00		$54,109,076.00	$53,102,962.00	$50,132,462.00	$0.00	$0.00
a. Pregnant Women and Women with Dependent Children (PWWDC)[b]	$2,152,659.00						
b. All Other	$14,554,343.00		$54,109,076.00	$53,102,962.00	$50,132,462.00		
2. Recovery Support Services[c]	$1,804,000.00						
3. Primary Prevention[d]	$4,936,272.00			$7,361,024.00	$553,982.00		
4. Early Intervention Services for HIV[e]							
5. Tuberculosis					$412,718.00		
6. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)							
7. State Hospital							
8. Other Psychiatric Inpatient Care							
9. Other 24-Hour Care (Residential Care)							
10. Ambulatory/Community Non-24 Hour Care							
11. Crisis Services (5 percent set-aside) Set Aside							
12. Other Capacity Building/Systems Development[f]							
13. Administration[g]	$1,234,067.00		$1,070,220.00	$5,392,906.00	$3,082,746.00		
14. Total	**$24,681,341.00**		**$55,179,296.00**	**$65,856,892.00**	**$54,181,908.00**	**$0.00**	**$0.00**

[a] Prevention other than primary prevention.

[b] Grantees must plan expenditures for Pregnant Women and Women with Dependent Children in compliance with Women's Maintenance of Effort (MOE) over the two-year planning period.

[c] This budget category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023 and includes an aggregate of planned expenditures allowable under the 2023 guidance, "Allowable Recovery Support Services (RSS) Expenditures through the SUBG and the MHBG." Only plan RSS for those in need of RSS from substance use disorder.

[d] Row 3 should account for the 20 percent minimum primary prevention set-aside of SUPTRS BG funds to be used for universal, selective, and indicated substance use prevention activities.

[e] The most recent AtlasPlus HIV data report published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SUPTRS BG allotments to establish one or more projects to provide early intervention services regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment.

[f] Other Capacity Building/Systems development include those activities relating to substance use per **45 CFR §96.122 (f)(1)(v)**

[g] Per **45 CFR § 96.135** Restrictions on expenditure of the SUPTRS BG, the state involved will not expend more than 5 percent of the BG to pay the costs of administering the SUPTRS BG.

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Table 3: Persons in Need of/Receiving SUD Treatment – Required for SUPTRS BG Only

This table allows states to present their estimated current need and baseline reach of the priority populations laid out in the SUPTRS BG statute. This information is intended to assist the state in demonstrating the unmet need of these populations that informs their plans for FY2026 - 2027. The estimates provided should represent the unmet need at the time of the application.

To complete the Aggregate Number Estimated in Need (Column A), please refer to the most recent edition of the **National Survey on Drug Use and Health** (NSDUH) or other federal/state data that describes the populations of focus in rows 1-5.

To complete the Aggregate Number in Treatment (Column B), please refer to the most recent edition of the **Treatment Episode Data Set** (TEDS) data prepared and submitted to the Behavioral Health Services Information System (BHSIS).

States should contact their federal points of contact for assistance in drawing these estimates from national and state survey data.

Estimates should utilize the most recent data from NSDUH, TEDS, and other data sources.

	A. Aggregate Number Estimated in Need of SUD Treatment	B. Aggregate Number in SUD Treatment
Pregnant Women	1842	202
Women with Dependent Children	10021	3012
Individuals with a co-occurring M/SUD	172001	3042
Persons who inject drugs	43008	2075
Persons experiencing homelessness	4021	601

Please provide an outline of how the state made these estimates, including data sources and values used for each row. For any cell which the state is

unable to estimate the need or number in treatment, please provide an explanation for why these estimates could not be drawn.

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Planning Tables

Table 4: SUPTRS BG Planned Award Budget by Federal Fiscal Year

In addition to projecting planned budget by State Fiscal Year (Table 2b), states must project how they will use SUPTRS BG funds to provide authorized services as required by the SUPTRS BG regulations and expenditure categories. Therefore, Plan Table 4b must be completed for the SUPTRS BG awarded for Federal Fiscal Year (FFY) 2026 and FFY 2027. The totals for each FFY planning year should match the SUPTRS BG Final Allotments for the state in that award year.

Note: The FFY presented in the table is that of the award year, however states have up to two years to expend the award received. For example, the FFY 2026 award may be expended from October 1, 2025 through September 30, 2027.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Expenditure Category	FFY 2026 SUPTRS BG Award
1 . Substance Use Disorder Prevention[a] and Treatment	$15,986,002.00
2 . Recovery Support Services[b]	$1,804,000.00
3 . Substance Use Primary Prevention[c]	$4,936,272.00
4 . Early Intervention Services for HIV[d]	$0.00
5 . Tuberculosis Services	$0.00
6 . Other Capacity Building/Systems Development[e]	$821,000.00
7 . Administration[f]	$1,234,067.00
8. Total	$24,781,341.00

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[a]Prevention other than primary prevention. The amount in this row should reflect the planned budget for direct services during the planning period. Do not include budgeted funds for other capacity building/systems development, those are required to be presented in Row 6 of this table.

[b]This expenditure category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023 and includes an aggregate of budget allowable under the 2023 guidance, "Allowable Recovery Support Services (RSS) Expenditures through the SUBG and the MHBG." Only present the estimated budget for RSS for those in need of RSS from substance use disorder. Do not include budgeted funds for other capacity building/systems development, those are required to be presented in Row 6 of this table.

[c]This row should reflect the state's planned budget of direct primary prevention activities that are intended to meet the SUPTRS BG 20 percent set aside. Activities include those used for universal, selective, and indicated substance use prevention activities. The budget for direct activities in this row should match the total budget planned in Table(s) 5a and 5b. Do not include budgeted funds for other capacity building/systems development, those are required to be presented in Row 6 of this table.

[d]The most recent AtlasPlus HIV data report published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SUPTRS BG allotments to establish one or more projects to provide early intervention services regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment.

[e]Other Capacity Building/System Development include those activities relating to substance use per **45 CFR §96.122 (f)(1)(v)**. The amount presented here should reflect the total found in Planning Table 6 across treatment, recovery, and primary prevention.

[f]Per **45 CFR §96.135** Restrictions on expenditure of grant, the State involved will not expend more than 5 percent of the BG to pay the costs of administering the SUPTRS BG.

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Planning Tables

Table 5a: SUPTRS BG Primary Prevention Planned Budget by Strategy and Institutes of Medicine (IOM) Categories

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Strategy	IOM Classification	FFY 2026 SUPTRS BG Award
1. Information Dissemination	Universal	
	Selective	
	Indicated	
	Unspecified	$1,098,972
	Total	**$1,098,972**
2. Education	Universal	
	Selective	
	Indicated	
	Unspecified	$358,914
	Total	**$358,914**
3. Alternatives	Universal	
	Selective	
	Indicated	
	Unspecified	$282,747
	Total	**$282,747**
4. Problem Identification and Referral	Universal	
	Selective	
	Indicated	
	Unspecified	$162,362
	Total	**$162,362**
	Universal	
	Selective	

5. Community-Based Processes	Indicated	
	Unspecified	$787,722
	Total	**$787,722**
6. Environmental	Universal	
	Selective	
	Indicated	
	Unspecified	$2,245,555
	Total	**$2,245,555**
7. Section 1926 (Synar)-Tobacco	Universal	$0
	Selective	$0
	Indicated	$0
	Unspecified	$0
	Total	**$0**
8. Other	Universal	$0
	Selective	$0
	Indicated	$0
	Unspecified	$0
	Total	**$0**
Total Prevention Budget		**$4,936,272**
Total Award [a]		**$24,681,341**
Planned Primary Prevention Percentage		**20.00%**

[a] Total SUPTRS BG Award is populated from Plan Table 4 SUPTRS BG Planned Award Budget by Federal Fiscal Year

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Table 5b: SUPTRS BG Planned Primary Prevention Budget by Institutes of Medicine (IOM) Categories

States should identify the planned budget for primary prevention disaggregated by IOM Categories the state plans to prioritize with primary prevention set-aside dollars from the FFY 2026 and FFY 2027 SUPTRS BG allotments.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Strategy	FFY 2026 SUPTRS BG Award
1. Universal Direct	$1,146,636
2. Universal Indirect	$3,344,528
3. Selective	$282,746
4. Indicated	$162,362
5. Column Total	**$4,936,272**
6. Total SUPTRS Award[a]	**$24,681,341**
7. Primary Prevention Percentage	**20.00%**

[a] Total SUPTRS BG Award is populated from Plan Table 4 SUPTRS BG Planned Award Budget by Federal Fiscal Year

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Table 5c: SUPTRS BG Planned Primary Prevention Priorities

States should identify the categories of substances the state plans to prioritize with primary prevention set-aside dollars from the FFY 2026 SUPTRS BG award.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Priority Substances	FFY 2026 SUPTRS BG Award
Alcohol	☑
Tobacco/Nicotine-Containing Products	☑
Cannabis/Cannabinoids	☑
Prescription Medications	☑
Cocaine	☑
Heroin	☑
Inhalants	☑
Methamphetamine	☑
Fentanyl or Other Synthetic Opioids	☑
Other	☐
Priority Populations	
Students in College	☑
Military Families	☑
American Indian/Alaska Native	☑
African American	☑
Hispanic	☑
Persons Experiencing Homelessness	☑
Native Hawaiian/Pacific Islander	☑
Asian	☑
Rural	☑

Footnotes:

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Table 6: SUPTRS BG Other Capacity Building/Systems Development Activities

Please enter the total amount of the SUPTRS BG budgeted for each activity described above, by treatment, recovery support services and primary prevention. In budgeting for each activity, states should break down the row budget by funds planned for SSA activities and those planned to be contracted out under other subrecipient contracts. States should plan their budgets on a single Federal Fiscal Year (FFY), specified in the table below.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Activity	FFY 2026		
	A. SUPTRS Treatment	B. SUPTRS Recovery Support Services	C. SUPTRS Primary Prevention
1. Information Systems	$300,000.00	$0.00	$0.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$300,000.00	$0.00	$0.00
2. Infrastructure Support	$0.00	$246,000.00	$0.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$246,000.00	$0.00
3. Partnerships, community outreach, and needs assessment	$0.00	$0.00	$75,000.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$75,000.00
4. Planning Council Activities	$0.00	$0.00	$0.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00
5. Quality Assurance and Improvement	$0.00	$0.00	$0.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00
6. Research and Evaluation	$0.00	$0.00	$100,000.00

a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$100,000.00
7. Training and Education	$0.00	$100,000.00	$0.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$100,000.00	$0.00
8. Total	**$300,000.00**	**$346,000.00**	**$175,000.00**

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Environmental Factors and Plan

1. Access to Care, Integration, and Care Coordination – Required for MHBG & SUPTRS BG

Narrative Question

Across the United States, significant proportions of adults with serious mental illness, children and youth with serious emotional disturbances, and people with substance use disorders do not have access to or do not otherwise access needed behavioral healthcare. **States should focus on improving the range and quality of available services and on improving the rate at which individuals who need care access it**. States have a number of opportunities to improve access, including improving capacity to identify and address behavioral health needs in primary care, increasing outreach and screening in a variety of community settings, building behavioral health workforce and service system capacity, and efforts to improve public awareness around the importance of behavioral health. When considering access to care, states should examine whether people are connected to services, and whether they are receiving the range of needed treatment and supports.

A venue for states to advance access to care is by **ensuring that protections afforded by MHPAEA are being adhered to in private and public sector health plans, and that providers and people receiving services are aware of parity protections**. SSAs and SMHAs can partner with their state departments of insurance and Medicaid agencies to support parity enforcement efforts and to boost awareness around parity protections within the behavioral health field. The following resources may be helpful: **The Essential Aspects of Parity: A Training Tool for Policymakers**; **Approaches in Implementing the Mental Health Parity and Addiction Equity Act: Best Practices from the States**.

The integration of primary and behavioral health care remains a priority across the country to ensure that people receive care that addresses their mental health, substance use, and physical health problems. People with mental illness and/or substance use disorders are likely to die earlier than those who do not have these conditions.[1] Ensuring access to physical and behavioral health care is important to address the physical health disparities they experience and to ensure that they receive needed behavioral health care. **States should support integrated care delivery in specialty behavioral health care settings as well as primary care settings**. States have a number of options to finance the integration of primary and behavioral health care, including programs supported through Medicaid managed care, Medicaid health homes, specialized plans for individuals who are dually eligible for Medicaid and Medicare, and prioritized initiatives through the mental health and substance use block grants or general funds. States may also work to advance specific models shown to improve care in primary care settings, including Primary Care Medical Homes; the Coordinated Care Model; and Screening, Brief Intervention, and Referral to Treatment.

Navigating behavioral health, physical health, and other support systems is complicated and many individuals and families require care coordination to ensure that they receive necessary supports in and efficient and effective manner. **States should develop systems that vary the intensity of care coordination support based on the severity and complexity of individual need**. States also need to consider different models of care coordination for different groups, such as High-Fidelity Wraparound and Systems of Care when working with children, youth, and families; providing Assertive Community Treatment to people with serious mental illness who are at a high risk of institutional placement; and connecting people in recovery from substance use disorders with a range of recovery supports. States should also provide the care coordination necessary to connect people with mental and substance use disorders to needed supports in areas like education, employment, and housing.

[1]Druss, B. G., Zhao, L., Von Esenwein, S., Morrato, E. H., & Marcus, S. C. (2011). Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Medical care, 599-604.Avaiable at: **https://journals.lww.com/lww-medicalcare/Fulltext/2011/06000/Understanding_Excess_Mortality_in_Persons_With.11.aspx**

1. Describe your state's efforts to improve **access to care for mental disorders, substance use disorders, and co-occurring disorders**, including details on efforts to increase access to services for:

a) Adults with serious mental illness (SMI)

b) Adults with SMI and a co-occurring intellectual and developmental disabilities (I/DD)

c) Pregnant women with substance use disorders

d) Women with substance use disorders who have dependent children

e) Persons who inject drugs

f) Persons with substance use disorders who have, or are at risk for, HIV or TB

g) Persons with substance use disorders in the justice system

h) Persons using substances who are at risk for overdose or suicide

i) Other adults with substance use disorders

j) Children and youth with serious emotional disturbances (SED) or substance use disorders

k) Children and youth with SED and a co-occurring I/DD

l) Individuals with co-occurring mental and substance use disorders

ADMH is currently working with Alabama Medicaid to develop policy, procedures, and billing codes to advance the use of telehealth services for all certified MI, Prevention and Substance Use Treatment services. Planning committees have involved communications with drug courts, DHR, hospitals and additional mental health facilities that collaborate with ADMH certified agencies. Current strategies will allow consumers to utilize audio and audio/visual technology.
ADMH has implemented the 988 hotlines for consumers to gain access to care for suicide prevention and depression and has created the connect Alabama app for information and direct connections to access of care for. In addition, Alabama has distributed 21,797 naloxone kits and 3,800 test strips over the past fiscal year for persons using substances who are at risk for overdose or suicide. Further preventative efforts include suicide prevention trainings throughout the state that are being provided to identify the unique stressors, risk factors, and barriers to seeking help that contribute to suicide risk; define the principles of the Zero Suicide framework and how they can be applied to support prevention efforts; discuss strategies to reduce stigma and create a workplace culture that prioritizes mental health; and apply practical tools and available Alabama-specific resources, such as the Connect AL app and the 988 Lifeline to support colleagues and promote suicide prevention.
Over the past year, ADMH issued an RFP for current providers to establish outpatient and residential services in rural counties that did not have previous SU treatment services. This response has provided 62 out of 67 counties to have local treatment services. ADMH has utilized supplemental funds to aid in the treatment of pregnant and postpartum women rural counties and has implemented a plan to use transportation vouchers for women currently enrolled in treatment.

2. Describe your efforts, alone or in partnership with your state's department of insurance and/or Medicaid system, to advance **parity enforcement and increase awareness of parity protections** among the public and across the behavioral and general health care fields.

Parity Act for Alabama includes all mental health conditions listed in the mental disorders section of International Classification of Diseases. However, it explicitly states that substance use disorders are excluded. It also specifically mentions these conditions:
• Schizophrenia, schizophrenia form disorder, schizoaffective disorder.
• Bipolar disorder.
• Panic disorder.
• Obsessive-compulsive disorder.
• Major depressive disorder.
• Anxiety disorders.
• Mood disorders.
Special committees form periodically to discuss the parity act and how it can become more advance to serve those with SU disorders.

3. Describe how the state supports the provision of **integrated services and supports for individuals with co-occurring mental and substance use disorders**, including screening and assessment for co-occurring disorders and integrated treatment that addresses substance use disorders as well as mental disorders.

ADMH is currently in the planning phase of implementing CCBHC models for behavioral health care. This model is providing a comprehensive range of mental health and addiction services. The CCBHC model is a proven outpatient model that:

Ensures access to integrated services including 24/7 crisis response and medication-assisted treatment.
Meets strict criteria regarding access, quality reporting, staffing, and coordination with social services, justice, and education systems.
Receives funding to support the real costs of expanding services to fully meet the need for care in communities.

Three agencies have converted to CCBHC with an additional six planned for the next 12 months.

a. Please describe how this system differs for youth and adults.

For both children and adults, there is a strong encouragement for family involvement. The Office of Peer Programs has enlarged its office by adding family and adolescent peer recovery support to assist with both adult and adolescent services by offering age-appropriate mentoring and support services for both age groups. Also, all planning for adults and children/adolescents follows the same process outlined in administrative code that pertains to the Management Steering Committee and its sub-committees of the Substance Use Coordinating Sub-Committee and the Mental Illness Coordinating Subcommittee who meet jointly. In an effort to ensure the unique voices of children/adolescents and their families are actively involved at all levels of planning, budgeting, policymaking, and service delivery, moving into FY24, ADMH re-established the Office of Children and Family Services with the primary focus and purpose on the planning, coordination and implementation of services, to include co-occurring, that is tailored to the needs of our children and adolescents and their families.

b. Does your state provide evidence-based integrated treatment for co-occurring disorders (IT-COD), formerly known as IDDT? Please explain.

No

c. How many IT-COD teams do you have? Please explain.

n/a

d. Do you monitor fidelity for IT-COD? Please explain.

n/a

e. Do you have a statewide COD coordinator? ○ Yes ◉ No

4. Describe how the state **supports integrated behavioral health and primary health care**, including services for individuals with mental disorders, substance use disorders, co-occurring M/SUD, and co-occurring SMI/SED and I/DD. Include detail about:

a) Access to behavioral health care facilitated through primary care providers

b) Efforts to improve behavioral health care provided by primary care providers

c) Efforts to integrate primary care into behavioral health settings

d) How the state provides integrated treatment for individuals with co-occurring disorders

The current care coordination models are being utilized in Alabama primary with FQHC's who are also certified mental health and substance use providers. These centers in rural counties may also mirror components incorporated with the plan for CCBHC's. In addition, all agencies utilize screening and assessment tools with the ASAM criteria to identify and quickly address the needs of consumers with the assistance of case management and targeted case management. ADMH offers the only case management certification course that is recognize by Medicaid and this training addresses the holistic approach of case management and care coordination.

5. Describe how the state **provides care coordination**, including detail about how care coordination is funded and how care coordination models provided by the state vary based on the seriousness and complexity of individual behavioral health needs. Describe care coordination available to:

a) Adults with serious mental illness (SMI)

b) Adults with substance use disorders

c) Adults with SMI and I/DD

d) Children and youth with serious emotional disturbances (SED) or substance use disorders

e) Children and youth with SED and I/DD

Care Coordination is provided through the community mental health centers primarily through providing intensive case management that is outlined on a plan of care.
The following services must be delivered within the Care Management/Coordination Programs:
a) A systematic determination of the specific human service needs of each consumer.
b) The development of a systematic consumer coordinated written plan that is developed within 30 days of first face-to-face care management/coordination service unless services terminate earlier and that lists the actions necessary to meet the needs of each consumer.
c) Assisting the consumer through crisis situations and/or arranging for the provision of such assistance by other professional/personal caregivers.
d) The direct delivery, or the arrangement for, transportation to needed services if the consumer is unable to transport him or herself.
e) Establishing links between the consumer and service providers or other community resources.
f) Advocating for and developing access to needed services on the consumer's behalf when the consumer himself is unable to do so alone.
g) Monitoring of the consumer's access to, linkage with, and usage of necessary community supports as specified in the case plan.
h) Systematic re-evaluation (at 6 months after the original case plan was developed and intervals of 12 months thereafter for adult consumers; and at intervals of every 6 months after the original plan of care for children and adolescents as long as consumer is receiving care coordination services) of the consumer's human service needs and the consumer's progress toward planned goals so that the established plans can be continued or revised.
Care management/coordination is provided to any of the consumers with SMI or SED that is served by the contracted community mental health center, regardless of ability to pay. For consumers with Medicaid, contracted community mental health centers are able to bill for Targeted Case Management. The Targets in which they have access for consumers with SMI, SED, and SUD are as follows:
• Target 1 – SMI Adult
• Target 3 – SED Child/Adolescent – Low Intensity Care Coordination (LICC)
• Target 9 – Individuals with Substance Use Disorders (adults and child/adolescent)
• Target 10 – SED Child/Adolescent – High Intensity Care Coordination (HICC)
All are billed as fee for services. For Target 1, Target 3 and Target 9, these are billed in 5-minute increments. For Target 10, HICC is billed as a monthly payment or partial month payment.
With the transformative efforts to move the community mental health centers into a CCBHC model, access to care and care

coordination are requirements and being analyzed through the process of developing the services and supports that will be required and determining the PPS payment methodology that best fits the Alabama system.

6. Describe how the state supports the provision of **integrated services and supports for individuals with co-occurring mental and substance use disorders**, including screening and assessment for co-occurring disorders and integrated treatment that addresses substance use disorders as well as mental disorders. Please describe how this system differs for youth and adults.

   Currently ADMH bases all diagnostic impressions, screenings and placements utilizing the UNCOPE and ADMH placement assessment for adults and the CRAFFT screening tool adolescents. The assessment tool utilizes the ASAM criteria with the 6-dimensional risk ratings for placement into an appropriate level of care. For both children and adults there is a strong encouragement for family involvement. This year the office of peer certification has enlarged its division by adding family and adolescent peer recovery support to assist with both adult and adolescent services by offering age-appropriate mentoring and support services for both age groups.

7. Describe how the state supports the provision of **integrated services and supports for individuals with co-occurring mental and intellectual/developmental disorders (I/DD)**, including screening and assessment for co-occurring disorders and integrated treatment that addresses I/DD as well as mental disorders. Please describe how this system differs for youth and adults.

   With ADMH having two primary service divisions – the Division of Mental Health and Substance Use (MHSU) Services and the Division of Developmental Disabilities- we realize and embrace the need for integrated and coordinated services and supports for our individuals with co-occurring mental health and intellectual/developmental disabilities. Individuals, both adults and children/adolescents, with dual diagnoses (MI/IDD) have a more complex process to navigate our service system areas and present unique challenges not only in identification but also in comprehensive treatment planning and care coordination. Diagnosing intellectual disability and mental health issues is a delicate process. The process of determining if an individual has in intellectual/developmental disability has determined testing and tools, all required to have been established prior to the person's 18th birthday. Then, a separate mental health assessment is conducted. This process has been influenced by the rules and regulations that have been long-standing, as well as funding requirements mandated for certain programs. Individuals with a dual diagnosis often go undiagnosed or misdiagnosed due to overlapping symptoms and other complications in the diagnostic process. Like most states, we experience barriers that can hinder their access to necessary care and support. These include systemic barriers, lack of training, and access to services. To attempt to navigate this process, the MHSU Division created a position, Director of Dual Diagnoses, to serve as a bridge between, not only the two service divisions, but also to navigate the separate service providing community systems. There has been much focus on increasing meaningful trainings, analyzing access to care, exploring and implementing dually diagnosed programs, and coordination of efforts. We have made small strides by contracting with a contractor, Project Transitions, that also works as a bridge either working with a mental illness or intellectual disability service provider to promote education, training and implementation of person-centered tailored services and treatment planning or as a bridge between two separate providers on the care coordination and integration. We also implemented two unique short-term evaluation programs – one for adults and one for children/adolescents, that focus on these individuals with complex needs that end up stuck in emergency departments, inpatient psychiatric units, jails, or who are at risk of homelessness.
   Much work is still needed. We are currently analyzing how the crisis system of care fits into this continuum for this unique population, as well as the implementation of CCHBCs. Both of these programs are in their infancy stages of implementation, so it is difficult to determine their roles. The senior leadership of ADMH has this target population as a special focus and efforts continue to move toward a more coordinated system of care. The process for adults and children/adolescents and their families are the same with navigating through our processes.

8. Please indicate areas of **technical assistance needs** related to this section.

   We do not see a need for TA in this area.

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Footnotes:

Environmental Factors and Plan

3. Person Centered Planning (PCP) – Required for MHBG, Requested for SUPTRS BG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning (PCP) is a process through which individuals develop their plan of service based on their chosen, individualized goals to improve their quality of life. The PCP process may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP team may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person's strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, education, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires.

In addition to adopting PCP at the service level, for PCP to be fully implemented it is important for states to develop systems which incorporate the concepts throughout all levels of the mental health network. PCP resources may be accessed from **https://acl.gov/news-and-events/announcements/person-centered-practices-resources**

1. Does your state have policies related to person centered planning? Yes No

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

3. Describe how the state engages people with SMI and their caregivers in making health care decisions, and enhances communication.

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

5. What methods does the SMHA use to encourage people who use the public mental health system to develop Psychiatric Advance Directives (for example, through resources such as **A Practical Guide to Psychiatric Advance Directives**)?

6. Please indicate areas of technical assistance needs related to this section.

This section is not required for SUPT

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Footnotes:

Environmental Factors and Plan

4. Program Integrity – Required for MHBG & SUPTRS BG

Narrative Question

There is a strong emphasis on ensuring that Block Grant funds are expended in amanner consistent with the statutory and regulatory framework. This requires that the federal government and the states have a strong approach to assuring program integrity. Currently, the primary goals of the federal government's program integrity efforts are to promote the proper expenditure of Block Grant funds, improve Block Grant program compliance nationally, and demonstrate the effective use of Block Grant funds

While some states have indicated an interest in using Block Grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, states are reminded of restrictions on the use of Block Grant funds outlined in **42 U.S.C. § 300x–5** and **42 U.S.C § 300x-31**, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under **42 U.S.C. § 300x-55(g)**, there are periodic site visits to MHBG and SUPTRS BG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SUPTRS BG funds can only be used for individuals with or at risk for SUD. The 20% minimum primary prevention set-aside of SUPTRS BG funds should be used for universal, selective, and indicated substance use prevention. Guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: **http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf**. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SUPTRS BG resources are to be used to support, not supplant, services that will be covered through private and public insurance. In addition, the federal government and states need to work together to identify strategies for sharing data, protocols, and information to assist Block Grant program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SUPTRS BG funds are allocated to support evidence-based substance use primary prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

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

Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? (●) Yes ( ) No
2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards? (●) Yes ( ) No
3. Does the state have any activities related to this section that you would like to highlight?

   N/A
4. Please indicate areas of technical assistance needs related to this section.

   N/A

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Footnotes:

Environmental Factors and Plan

5. Primary Prevention – Required for SUPTRS BG

Narrative Question

SUPTRS BG statute requires states to spend a minimum of 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment which programs (A) educate and counsel the individuals on substance use and substance use disorders; and (B) provide for activities to reduce the risk of substance use and substance use disorders by the individual. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must serve both the general population and sub-groups that are at high risk for substance use. The program must include, but is not limited to, the following strategies:

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

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

Assessment

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

2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply):

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

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

- **a)** ☐ Children (under age 12)
- **b)** ☑ Youth (ages 12-17)
- **c)** ☑ Young adults/college age (ages 18-26)
- **d)** ☑ Adults (ages 27-54)
- **e)** ☑ Older adults (age 55 and above)
- **f)** ☑ Rural communities

i) ☐ Other (please list)

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

a) ☐ Archival indicators (Please list)

b) ☑ National survey on Drug Use and Health (NSDUH)

c) ☑ Behavioral Risk Factor Surveillance System (BRFSS)

d) ☑ Youth Risk Behavioral Surveillance System (YRBS)

e) ☐ Monitoring the Future

f) ☐ Communities that Care

g) ☑ State-developed survey instrument

h) ☐ Other (please list)

5. Does your state use needs assessment data to make decisions about the allocation of SUPTRS BG primary prevention funds? ◉ Yes ○ No

a) If yes, (please explain in the box below)

Alabama has identified an Evidence-based Practices (EBP) Workgroup, to use the SPF to identify needs and appropriate interventions for communities. The EBP Workgroup is comprised of substance use prevention experts with backgrounds in community-level prevention, academic research, and governmental administration. The EBP Workgroup, along with sub recipients have been trained in understanding the core concepts related to selecting an EBP. The key elements are to understand the two main types of prevention strategies; Reinforce the understanding of contributing factors, intervening variables, and risk and protective factors; How to apply “good fit” components to EBPs and Understand the Alabama SPF EBP Approval Process. The Evidence-Based Practice Approval Process determines the legitimacy of selected EBPs. A step-by-step guide, to include an EBP Test Fit Form, has been provided to sub recipients to determine level of appropriateness. An actual flowchart has been developed to illustrate the EBP approval process. At the State level, we require that all SPF programming and interventions be submitted and approved by the OOP, EBP Workgroup and State Evaluator. All programming and interventions are monitored and evaluated by the OOP. The State Evaluator provides continual training and technical assistance on logic modeling and/or prevention planning and ensure specific items and baselines are identified. If adjustments are needed, the State Evaluator communicates with the OOP and sub recipients. All programmatic services provided through SPF are evidence-based.

b) If no, please explain how SUPTRS BG funds are allocated:

Narratve Question

SUPTRS BG statute requires states to spend a minimum of 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment which programs (A) educate and counsel the individuals on substance use and substance use disorders; and (B) provide for activities to reduce the risk of substance use and substance use disorders by the individual. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must serve both the general population and sub-groups that are at high risk for substance use. The program must include, but is not limited to, the following strategies:

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

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

Capacity Building

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

a) If yes, please describe.

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

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

a) If yes, please describe mechanism used.

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

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

a) If yes, please describe mechanism used.

Community readiness has been assessed using the Tri- Ethnic Center model to allow communities to delve deeper into their readiness, level of knowledge, and current resources available support SPF process. The Assessment is the first step that provides guidance to get a clearer understanding of problems, needs, to address community problems.

Narratve Question

SUPTRS BG statute requires states to spend a minimum of 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment which programs (A) educate and counsel the individuals on substance use and substance use disorders; and (B) provide for activities to reduce the risk of substance use and substance use disorders by the individual. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must serve both the general population and sub-groups that are at high risk for substance use. The program must include, but is not limited to, the following strategies:

1. ***Information dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, misuse and substance use disorders on individuals families and communities.
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
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5. ***Community-based processes*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the use of alcohol, tobacco and other drugs used in the general population.

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

Planning

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

If yes, please attach the plan in WebBGAS

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SUPTRS BG?

- [x] Yes
- [ ] No
- [ ] Not applicable (no prevention strategic plan)

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

- **a)** [x] Based on needs assessment datasets the priorities that guide the allocation of SUPTRS BG primary prevention funds
- **b)** [x] Timelines
- **c)** [x] Roles and responsibilities
- **d)** [x] Process indicators
- **e)** [x] Outcome indicators
- **f)** [ ] Not applicable/no prevention strategic plan

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

- **a)** Does the composition of the Advisory Council represent the demographics of the State? (●) Yes ( ) No

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

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

Alabama has identified an Evidence-based Practices (EBP) Workgroup, to use the SPF to identify needs and appropriate interventions for the communities. The EBP Workgroup is comprised of substance use prevention experts with backgrounds in community-level prevention, academic research, and governmental administration. The EBP Workgroup, along with sub recipients have been trained in understanding the core concepts related to selecting an EBP. The key elements are to understand the two main types of prevention strategies; Reinforce the understanding of contributing factors, intervening variables, and risk and protective factors; How to apply "good fit" components to EBPs and Understand the Alabama SPF EBP Approval Process. The Evidence-Based Practice Approval Process determines the legitimacy of selected EBPs. A step-by-step guide, to include an EBP Test Fit Form, has been provided to sub recipients to determine level of appropriateness. An actual flowchart has been developed to illustrate the EBP approval process. At the State level, we require that all SPF programming and interventions be submitted and approved by the OOP, EBP Workgroup and State Evaluator. All programming and interventions are monitored and evaluated by the OOP. The State Evaluator provides continual training and technical assistance on logic modeling and/or prevention planning and ensure specific items and baselines are identified. If adjustments are needed, the State Evaluator communicates with the OOP and sub recipients. All programmatic services provided through SPF are evidence-based.

Narratve Question

SUPTRS BG statute requires states to spend a minimum of 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment which programs (A) educate and counsel the individuals on substance use and substance use disorders; and (B) provide for activities to reduce the risk of substance use and substance use disorders by the individual. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

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6. ***Environmental strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the use of alcohol, tobacco and other drugs used in the general population.

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

Implementation

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

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

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

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SUPTRS BG primary prevention dollars in at least one of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

- **a)** Information Dissemination:

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

b) Education:

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

c) Alternatives:

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

d) Problem Identification and Referral:

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

e) Community-Based Processes:

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

f) Environmental:

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

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

a) Yes (if so, please describe)

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

Narratve Question

SUPTRS BG statute requires states to spend a minimum of 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment which programs (A) educate and counsel the individuals on substance use and substance use disorders; and (B) provide for activities to reduce the risk of substance use and substance use disorders by the individual. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must serve both the general population and sub-groups that are at high risk for substance use. The program must include, but is not limited to, the following strategies:

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

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

Evaluation

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

If yes, please attach the plan in WebBGAS

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

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

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

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

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

- **a)** ☑ 30-day use of alcohol, tobacco, prescription drugs, etc
- **b)** ☑ Heavy alcohol use
- **c)** ☑ Binge alcohol use
- **d)** ☑ Perception of harm
- **e)** ☑ Disapproval of use
- **f)** ☑ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)
- **g)** ☐ Other (please describe):

Footnotes:

OMNI Institute

Alabama Substance Use Prevention Block Grant

FY25 Evaluation Plan

Submitted to:
Alabama Department of Mental Health (ADMH)
November 2025

Alabama Department of Mental Health
connecting mind and wellness

Prepared by:
OMNI Institute

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Sections

- *Acronyms*
- *Evaluation Goals*
- *Evaluation Questions*
- *Evaluation Reporting and Analysis*
- *Logic Model*

Acronyms

Here is a table of acronyms that are used throughout this document:

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

Evaluation Goals

The goal of the Substance Use Prevention and Treatment Block Grant (BG) prevention set aside is to support and advance community-driven efforts in substance use prevention. Alabama distributes BG funds to 15 prevention providers within 22 catchment areas who serve all 67 counties across the state. The State of Alabama Department of Mental Health (ADMH) has identified the following evaluation goals based on SAMHSA's Strategic Prevention Framework (SPF), the Office of Prevention (OOP) Services' mission and strategic goals, and state needs. The ADMH OOP strategic plan offers this Vision for 2023-2026:

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

Drawing on the strategic plan, the BG evaluation goals are as follows:

1. *Prevent and reduce underage drinking and young adult problem drinking.*
2. *Prevent and reduce alcohol and/or drug-related motor vehicle crashes.*
3. *Prevent and reduce prescription drug misuse, illicit opioid use, and marijuana use.*
4. *Prevent and reduce substance-related attempted suicides and deaths by suicide (emphasis on populations at high risk, especially military families, and American Indians and Alaska Natives).*
5. *Promote emotional health and wellness and prevent or delay the onset of complications from substance use and mental illness and identify and respond to emerging behavioral health issues.*

OMNI developed this state-level evaluation plan for Fiscal Year 2025 to document all the measures that will be used to track progress towards these goals. OMNI recognizes that ADMH's priorities and prevention strategies may evolve over the course of the grant period. Thus, this plan reflects evaluation activities for the second year of the funding period and will be revisited annually. Edits will be made to reflect the adjustments to the evaluation scope and ensure alignment with changing needs and priorities of ADMH, the 67 funded counties, and the SAMHSA grant requirements..

Evaluation Questions

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

Table 1. Process Evaluation Questions

Questions	Measures	Data Source and Interval
Which prevention services were delivered across the state? • What was the mix of services by CSAP strategy and IOM target? • Which counties prioritized which problem/priority areas? • How did those services differ across regions?	• Number of strategies implemented in each county (of the 33 approved strategies or "Other" strategies) • Number of people served by CSAP strategy and by IOM target • Number of counties implementing specific strategies, including aggregation of strategies implemented by region	WITS Data System (ongoing) County PPTs (bi-annually) Activity Sheets (ongoing)
To what degree were prevention services effectively implemented? • Did implementation match county-level prevention plans? • Did providers meet the goals and objectives set out in their PPTs? • When/why did deviations from the plan occur and what was the result? • What were successes and barriers related to implementation of prevention services?	• Comparisons between WITS activities, PPTs, and prevention plan quarterly and annual progress reports • Changes to PPT or intervention workplans (can be made quarterly) • Reports of goal/objective completion by providers • Successes and barriers to progress in implementation	WITS Data Systems (ongoing) County PPTs and intervention workplans (bi-annually) Prevention Plan Progress Reports (6-month and annual) Qualitative data (through SPAB/AEOW meetings, QPPM, conversations with providers, and narrative components of quarterly and annual progress reports)
To what extent were prevention services able to reach populations who traditionally experience disparities in behavioral health outcomes? • Which populations experiencing health disparities were targeted by prevention providers?	• Number of relevant demographic subpopulations identified at the county-level through PPTs • Number of people served by strategy stratified by relevant demographic subpopulations • Number and type of prevention adaptations reported by providers	WITS Data Systems (ongoing) County PPTs and intervention workplans (bi-annually) Prevention Plan Progress Reports (6-month and annual))

How was prevention capacity and infrastructure strengthened at the state and county levels? • How did stakeholder engagement at the county-level change over time? • How did provider capacity change over time? • What technical assistance activities were delivered to providers and what was the perceived helpfulness of these activities?	• Number and involvement of stakeholders at the county level • Percentage of providers that report an increase in capacity • Number of technical assistance activities and trainings • Perceived helpfulness of technical assistance • Number of supply reduction partnerships established (e.g., partnerships with law enforcement to support permanent drop box installations or hosting drug takeback events)	Stakeholder engagement items on PPTs Capacity items on PPTs Pre- and post-survey before and after trainings Requests for technical assistance from Prevention Plan Progress Reports

Table 2. Outcome Evaluation Questions

Questions	Measures	Data Source and Interval
To what extent did providers meet strategy-level goals and outcomes in the counties they serve? • Examples: changes in compliance checks, changes in knowledge or behavior as a result of prevention education, increase in supply reduction strategies, etc.	• Strategy-level outcome measures and goal statements	County PPTs and intervention workplans (annually)
How does underage (12-20) and young adult (18-25) alcohol use change over time? • How do risk and protective factors related to underage and young adult alcohol use change over time? *(Goal 1)*	• Alcohol use in the past month • Binge alcohol use in the past month • Perceived risk of harm of alcohol use among youth • Perception of peer use of alcohol • Age of first use of alcohol among youth • Perceptions and use among priority high-risk subpopulations (military family members, and American Indians and Alaska Natives)	NSDUH (annually) BRFSS (annually) Statewide survey (YAS) (bi-annually)
How do alcohol and/or drug related motor vehicle crashes change over time? • How do risk and protective factors related to alcohol and/or drug related motor vehicle crashes change over time? *(Goal 2)*	• Number of fatal crashes by alcohol-involved drivers • BAC level in crashes • Number of arrests for driving under the influence	Fatality Analysis Reporting System (annually) Uniform Crime Reports (annually)
How does prescription drug misuse and marijuana use change over time? • How do risk and protective factors related to prescription drug misuse and marijuana use change over time?	• Pain reliever misuse and marijuana use in the past month • Rate of prescription drug overdose deaths • Number of young adults reporting ever having taken prescription pain medicine without a prescription or differently than how a doctor told them to use it	CDC Wonder (annually) NSDUH (annually)

(Goal 3)	• Perceived risk of harm of prescription drug or marijuana use • Perceptions of peer use of prescription drugs or marijuana • Perceptions of social/community norms that promote (or do not discourage) use of prescription drugs or marijuana • Perceptions and use among priority high-risk subpopulations (military family members, and American Indians and Alaska Natives)	Statewide survey (YAS) (bi-annually)
How does illicit opioid use change over time? • How do risk and protective factors related to illicit opioid use change over time? *(Goal 3)*	• Illicit opioid use (i.e. heroin) in the past month • Rate of illicit opioid overdose deaths • Number of young adults reporting having ever used illicit opioids • Perceived risk of harm of illicit opioid use • Perceptions of peer use of illicit opioid use • Awareness level of fentanyl and its uses • Perceptions and use among priority high-risk subpopulations (military family members, and American Indians and Alaska Natives)	CDC Wonder (annually) NSDUH (annually) Statewide survey (YAS) (bi-annually)
How do substance-related deaths by suicide change over time? • How do risk and protective factors related to substance-related suicide change over time? *(Goal 4)*	• Number of deaths by suicide • Number of drug-induced suicides • Number of youth or adults reporting a suicide attempt • Number of emotional and behavioral problems • Perceptions of availability of prosocial activities • Number of suicides / attempted suicides among priority high-risk subpopulations (military family members, and American Indians and Alaska Natives)	CDC Wonder -National Center for Health Statistics (annually) NSDUH (annually) Statewide survey (YAS) (bi-annually)
Are prevention services promoting emotional health and well-being? • How do risk and protective factors related to mental health and wellness change over time? *(Goal 5)*	• Number of interventions targeting the promotion of emotional health and wellness • Perceptions of availability of prosocial activities • Perceptions of mental health/suicide as a key problem area in the community • Number of young adults reporting problems with mental health/wellness • Number of young adults who get the mental health care they need • Perceptions of availability of substance use prevention, treatment, recovery, and mental health resources	WITS data system Statewide survey (YAS) (bi-annually)

Evaluation Reporting and Analysis

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

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

Alabama Substance Use Block Grant Prevention Logic Model

(see next page)

ALABAMA SUBSTANCE USE BLOCK GRANT PREVENTION LOGIC MODEL - Revised for FY25

PROBLEM	TARGETED RISK FACTORS	STRATEGIES	LONG-TERM IMPACT
PROBLEM ALCOHOL USE 38.57% of Alabamians aged 12+ reported alcohol use in the past month (NSDUH, 2021). 18.82% of Alabamians aged 12+ reported binge alcohol use in the past month (NSDUH, 2021). 31% of Alabama drivers involved in fatal crashes had a BAC of .01 or higher (FARS, 2020).	Low perceived risk of harm for alcohol use among youth Higher perception of peer use of alcohol than reality Social and community norms that promote underage use	Alabama's Substance Use Block Grant funds the following prevention programs by CSAP strategy: **Alternative Activities** • Alternative or Summer Programming • Peer Leader/Helper Programs • Substance Free Recreational Activities • Youth Prevention Advisory Boards **Community-Based Processes** • Mental Health First Aid • QPR Training • Regional /Local Capacity Building • Statewide Surveys • Tri-City Impact Team • Youth Coalitions **Education Programs** • Active Parenting • Catch My Breath • InShape Prevention Plus Wellness • LifeSkills Curriculum • Positive Action • Too Good For Drugs (and Violence) **Environmental Strategies** • Alcohol Purchase Surveys • Compliance Checks • DUI Checkpoints • Local UAD, Rx Drug, Vaping Policy Enhancements • School Practice • School Policies on ATOD use • Social Host Liability Regulation/Policy Development • Social Marketing Campaigns • Supply Reduction: Drug Take Backs/Disposal Sites, Lock Boxes, Deactivation Kits, Vape disposal **Information Dissemination** • Media Campaigns (ATOD) • 988 AL Suicide & Mental Health Crisis Lifeline/Suicide Awareness • Lock Your Meds • Parents Who Host Lose the Most • School & Community Events and Presentations • Talk. They Hear You **Problem Identification and Referral** • Ripple Effects • Student Assistance Programs	**DECREASE IN UNDERAGE ALCOHOL USE** **DECREASE IN UNDERAGE BINGE DRINKING** **DECREASE IN ALCOHOL-RELATED DRIVING FATALITIES**
PRESCRIPTION DRUG MISUSE, ILLICIT DRUG & MARIJUANA USE 3.93% of Alabamians aged 18+ reported prescription pain reliver misuse in the past year (NSDUH, 2021). Of Alabama youth, 22.1% reported ever having taken prescription pain medicine without a prescription or differently than how a doctor told them to use it, and 29.7% reported ever having used marijuana (YRBS, 2019). 0.36% of Alabamians aged 18+ reported heroin use in the past year and 12.66% of those aged 12+ used marijuana in the past year (NSDUH, 2021). The rate of drug overdose deaths in Alabama was 26.4 per 100K. (CDC Wonder, 2021).	Low perceived risk of harm for prescription drug misuse, heroin use, and marijuana use Social availability of prescription drugs and marijuana High rates of prescription opioid use/misuse Social and community norms that promote prescription drug misuse and marijuana use		**DECREASE IN PRESCRIPTION DRUG MISUSE, ILLICIT DRUG USE, MARIJUANA USE AMONG ADULTS** **DECREASE IN PRESCRIPTION DRUG MISUSE, ILLICIT DRUG USE, MARIJUANA USE AMONG YOUTH** **DECREASE IN PRESCRIPTION AND ILLICIT DRUG OVERDOSE DEATH**
SUBSTANCE-RELATED SUICIDE/ EMOTIONAL HEALTH & WELLNESS There were 16.4 deaths by suicide for every 100K Alabamians (CDC Wonder, 2021). 11.6% of Alabama youth (YRBS 2019) and 3.06% of Alabamians aged 18-25 (NSDUH, 2021) reported a suicide attempt in the past year. There were 53 suicide deaths by alcohol or drug poisonings in Alabama. (CDC Wonder, 2021).	Emotional/behavioral problems Low availability of prosocial activities Social and community norms that perpetuate mental health stigma Lack of access to prevention resources		**DECREASE IN SUICIDE DEATHS AND ATTEMPTS AMONG ADULTS AND YOUTH** **DECREASE IN SUBSTANCE-RELATED DEATHS BY SUICIDE**

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

OMNI

FY23-26

STRATEGIC PLAN

OFFICE OF PREVENTION

Developed by: Beverly Johnson, Brandon Folks, Satavia Mann, Christopher Sellers, Maegan Huffman, Brenae' Waters and Erin Burleson

Revised November 2025

Table of Contents

List of Acronyms

AARP	American Association of Retired Persons
ABC	Alabama Alcoholic Beverage Control Board
ADMH	Alabama Department of Mental Health
ADPH	Alabama Department of Public Health
AEOW	Alabama Epidemiology Outcomes Workgroup
ASR	Annual Synar Report
ASU	Alabama State University
CADCA	Community Anti-Drug Coalitions of America
CCI	Community College Initiative
CSAP	Center for Substance Abuse Prevention
DMHSUS	Division of Mental Health and Substance Use Services
EBP	Evidence Based Practices
HBCU	Historically Black Colleges and Universities
JJI	Juvenile Justice Initiative
MHFA	Mental Health First Aid
OD2A	Overdose Data to Action
OOP	Office of Prevention
PFS	Partnerships For Success
QPR	Question, Persuade, Refer
RFP	Request for Proposal
SAMHSA	Substance Abuse and Mental Health Services Administration
SABG	Substance Abuse Block Grant
SIG	State Incentive Grant
SMVF	Service Members, Veterans, and Their Families
SOR	State Opioid Response
SPAB	State Prevention Advisory Board
SPF	Strategic Prevention Framework
SPF Rx	Strategic Prevention Framework for Prescription Drugs
SPF-SIG	Strategic Prevention Framework-State Incentive Grant
STR	State Targeted Response
SUPTRS	Substance Use Prevention, Treatment, and Recovery Services
UAD	Underage Drinking

Section 1: Strategic Planning

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

This statewide strategic prevention plan was initially created as a need and in response to a Center for Substance Abuse Prevention (CSAP) Core Technical Review potential enhancement recommendation (September 2011). Specifically, the state was 'encouraged to continue to develop the infrastructure plan' and to "create a comprehensive state strategic plan." The purpose of the plan is to communicate goals, action steps, distinguish responsibility, targets, and metrics to guide the prevention system. This plan seeks to assist the enhancement of the prevention system in its leadership, capacity, and processes. The plan incorporates: system organization; workforce development and capacity building; implementation; evaluation; and Synar. This strategic plan was informed by planning initiatives already underway such as: Substance Abuse and Mental Health Block Grant (SABG) application, currently known as the Substance Use Prevention, Treatment, and Recovery Services (SUPTRS) Block Grant; Substance Abuse and Mental Health Services Administration (SAMSHA) Interim Strategic Plan November 2022; Alabama Department of Mental Health Strategic Priorities; Alabama Epidemiological Profile; State Prevention Advisory Board (SPAB); Alabama Epidemiological Outcomes Workgroup (AEOW); Substance Use Prevention Workforce survey results and more. The goals of this statewide strategic prevention plan are consistent with the aforementioned documents and from input from the referenced groups and OOP staff. The plan seeks to support the mission and vision of the OOP, which are as follows:

OOP Mission

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

OOP Vision

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

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

Section 2: 2019-2022 Accomplishments

By the end of FY'22, the OOP was proud to have several accomplishments that helped move forward in supporting its mission. Accomplishments include, but are not limited to:

Promote a data driven Strategic Prevention Framework (SPF)

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

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

- Prevention provider representation is within all 67 counties with the inclusion of additional prevention funding opportunities in 16 counties via Opioid SOR; 7 counties via UAD Initiative; 7 counties via HBCU initiative; 7 counties via CCI; 4 counties via SPF Rx; 4 counties via OD2A; 7counties via SMVF initiative; 6 counties via JJI; and 2 counties via CADCA initiative.
- Increased usage of Problem Identification and Referral Strategies. In FY19 the PIDR was implemented in 7 counties. Through training and technical assistance, prevention providers expanded PIDR to 11 counties in FY20 resulting in a 57.14% increase. In FY22, PIDR was expanded to 15 counties which resulted in a 114% increase from FY19.
- Participated in and coordinated 9 statewide Prevention Observances (at the state level) that includes National Drug and Alcohol Facts Week, National Prevention Week, and Red Ribbon Week.
- Participated in and developed the statewide Suicide Prevention Plan.
- Participated in statewide Suicide Prevention efforts.
- Established the 988 Alabama Coalition with an expansion of 50 members.
- Coordinated efforts with the Alabama Department of Agriculture and provided MHFA, QPR, and suicide prevention trainings reaching more than 260 individuals in the agricultural community.

Improve organizational business management systems at the state agency level

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

Prevent or reduce consequences of underage drinking

- Collaborated with and supported the Alabama Alcoholic Beverage Control Board (ABC) in execution of compliance checks and the minor operative program.
- Successfully concluded the Strategic Prevention Framework Partnerships For Success Grant (SPF PFS) sub-recipients who implemented Underage Drinking (UD) initiatives.
- Sustained the (SPF PFS) sub-recipients who implemented Underage Drinking (UD) initiatives in 8 counties.
- Implemented the Community College Initiative (CCI) sub-recipients who implemented Underage Drinking (UD) initiatives.
- UD was a focus of effort in prevention planning in 63 counties

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

- Prevention plans took a comprehensive approach to addressing prevention across the lifespan with an emphasis on children from birth through age 25 across strategies. In addition, particular focus had been placed on the 18+ population and coordination was secured with the American Association of Retired Persons (AARP).

Prevent or reduce illicit or prescription drug use and misuse

- Prescription drug use and misuse was a focus of effort in prevention planning.
- Supported, promoted, and expanded the Prescription Drug Take Back efforts.
- Sustained the My Smart Dose initiative.
- Implemented the Opioid SOR discretionary grant in 16 counties.
- Sustained Opioid Training Institute (OTI) training opportunities.

- Implemented the Strategic Prevention Framework for Prescription Drugs (SPF Rx) discretionary grant in 9 counties.
- Implemented the HOPE statewide media campaign to promote prescription drug education and awareness.
- Implemented the Overdose Data to Action (OD2A) discretionary grant in 6 counties.
- Prescription drug and illicit opioid prevention was a focus of effort in prevention planning in 50 counties.

Prevent or reduce tobacco use

- Collaborated with ABC, Alabama Department of Public Health (ADPH), and the Youth Access to Tobacco Advisory Board.
- Supported Synar efforts to ensure submission of ASR and compliance with Synar regulations.
- Promoted tobacco-free initiatives.
- Tobacco prevention was a focus of effort in prevention planning in 28 counties.

Prevent substance-related suicides and attempted suicides

- Updated suicide prevention planning efforts to reinforce the association of primary substance use. (SAMHSA System Review Recommendations - 2016)
- Participated and collaborated with the Alabama State University (ASU) Suicide Prevention Task Force.
- Participated and collaborated with the Department of Education's Suicide Prevention Task Force.
- Participated and collaborated with the Department of Veterans Affair's Alabama Challenge for Preventing Suicide among Service Members, Veterans, and their Families (SMVF)
- Collaborated with the Department of Agriculture and Industries' A Healthy You, A Healthy Farm initiative.
- Presented at the ADPH Suicide Prevention Conference.
- Participated and facilitated Mental Health First Aid trainings.
- Educated providers on the shared risk and protective factors of substance use and suicide.
- Educated providers on National Suicide Prevention Lifeline, currently the 988 Suicide and Crisis Lifeline, and Question Persuade Refer training.
- Secured two 988 discretionary grants.
- Suicide prevention and its relationship to substance use was a focus of effort in prevention planning in 48 counties.

FY'19-22 Office of Prevention Priorities

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

Section 3: Vision for 2023-2026

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

Priority

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

Outcomes

More specifically, this plan would allow us to achieve population level outcomes in the State of Alabama in the following ways. Beginning FY2023 with and by 2026, we attempt to:

- reduce the percentage of past year use of illicit drugs such as (Marijuana and Prescription Drugs) by 3%;
- reduce the percentage of treatment admission rates by 3%;

- reduce the alcohol and/or drug related motor vehicle crashes by 3%;
- increase the graduation rates by 3%; and
- reduce the substance-related suicide completions by 3%.

Outcomes from the previous plan (FY22) demonstrate lowered percentages among all indicators captured *(See Population Level Indicators page 14)* with the exception of Alcohol use and Suicides.

The decrease in the number of treatment admissions could be attributed to the number of available resources. In addition, the number of promotion and awareness activities as it relates to accessing treatment services and associated resources could also be indicative of the decrease.
The collaborative and planning efforts of substance use prevention and suicide prevention has increased to establish comprehensive strategies to address associated risk and protective factors seeking to reduce the substance-related suicide completions statewide.

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

Section 4: Status of the OOP - Assessment

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

The prioritization process involved a discussion of what funds and resources were already being utilized to address specific issues. In addition to that discussion, the group reviewed trends, time between implementing strategies and the impact on the issue, years of potential life loss, and readiness/political climate. OOP staff members participate regularly in the SPAB meetings and will share updates. At this point in time, the SPAB has had the opportunity to review the plan.
Alabama has identified an Evidence-based Practices (EBP) Workgroup, to use the SPF to identify needs and appropriate interventions for the communities. The EBP Workgroup is comprised of substance use prevention experts with backgrounds in community-level prevention, academic research, and governmental administration. The EBP Workgroup, along with sub recipients have been trained in understanding the core concepts related to selecting an EBP. The key elements are to understand the two main types of prevention strategies; Reinforce the understanding of contributing factors, intervening variables, and risk and protective factors; How to apply “good fit” components to EBPs and Understand the Alabama SPF EBP Approval Process.

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

At the State level, we require that all SPF programming and interventions be submitted and approved by the OOP, EBP Workgroup and State Evaluator. All programming and interventions are monitored and evaluated by the OOP. T The State Evaluator provides continual training and technical assistance on logic modeling and/or prevention planning and ensure specific items and baselines are identified. If adjustments are needed, the State Evaluator communicates with the OOP and sub recipients. All programmatic services provided through SPF are evidence-based.

Funding Allocation Model

A hybrid funding allocation model combining population and highest need is utilized to support the prevention system in the state of Alabama. For Alabama's funding allocation process, the total population estimates from the United States Census Bureau, 2020 Population Estimates were used. Alabama consists of sixty-seven counties. These counties are contained in 22 catchment areas.

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

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

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

- Alcohol Use
- Illicit Drug Use
- Substance Use Treatment Admission
- Graduation Rates
- Poverty
- Suicides

To learn in-depth about this allocation model, please refer to the Prevention Funding Allocation Model Strategic Plan which is published on our website at: https://mh.alabama.gov/wp-content/uploads/2019/03/FINAL-Funding-Allocation-Strategic-Plan-January-2019.pdf **The updated link will be forthcoming**

Section 5: Capacity

The OOP has seen tremendous growth since 2011 in personnel largely due in part to additional SAMHSA funding. Currently the office has six full time staff and contractual technical assistance and evaluation services for its system. The core SUPTRS staff will have responsibility and oversight of ensuring the success of this strategic plan. Specific roles and responsibilities are outlined in personnel appraisals and within the prevention goals and deliverables. Capacity exists at the state level to engage this plan.

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

Fiscal capacity is an ongoing challenge at the state and community level. The state continues to pursue discretionary grants in an attempt to support and sustain the system beyond the SUPTRS. Since 2015, OOP has secured the following funding opportunities: Partnerships For Success (PFS) – five-year funding opportunity; Strategic Prevention Framework for Prescription Drugs (SPF Rx) – five-year funding opportunity; Opioid State Targeted Response (STR) – two-year funding opportunity; State Opioid Response (SOR) - two-year funding opportunity; SPF Rx 2.0 -five-year funding opportunity; 988 State Planning Grant Initiative – one-year funding opportunity; and 988 State Cooperative Agreement – two-year funding opportunity.

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

Section 6: Planning

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

necessary, suggestions are made toward progress. As appropriate, the progress is also aligned with SABG reporting.

Section 7: Implementation

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

Implementation Activity	Responsible	Timeline
Disseminate – Strategic Plan disseminated to OOP staff, AEOW, SPAB, and posted to OOP website.	Office of Prevention AEOW SPAB	January 2023
Goals and Deliverables – Ongoing implementation with quarterly progress updates.	OOP	Ongoing
Monitoring – Site Visit; SABG & ADMH Monitoring Visit and tools	OOP	Ongoing

Section 8: Evaluation

Evaluation of this plan will include assessment of the process, the outcomes, and the long-term impacts of implementation at both the state and community levels. The current prevention infrastructure includes a Prevention System Evaluator and an evaluation plan. To learn in-depth about this evaluation plan, please refer to the Alabama Block Grant Evaluation Plan which is published on our website at: https://mh.alabama.gov/wp-content/uploads/2023/01/Alabama-Block-Grant_Evaluation-Plan21.pdf

Section 9: Sustainability

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

Section 10: 2023-2026 Strategic Goals

To achieve the OOP's vision and mission, we will strive to achieve the following strategic goals during FY2023-2026.

OOP Goals

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

These goals are fully illustrated in the table that follows.

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

Appendices

Population Level Indicators for the State of Alabama

Indicators	Alabama
% of Illicit Drug Use in the Past Month ages 12 and older (2015-2016)	7.10
% of Alcohol Use in the Past Month ages 12 and older (2015-2016)	40.8
No. of Treatment Admissions (ADMH,2017)	25185
% of Persons Killed & Driver Blood Alcohol Concentration (.08+) in Crash 2016 (FARS, 2016)	27
Poverty (U.S. Census, 2016)	17.2
No. of Suicides (2015)	748

Indicators	Alabama
% of Illicit Drug Use in the Past Month ages 12 and older (2016-2018)	10 (2.09 % decrease)
% of Alcohol Use in the Past Month ages 12 and older (2016-2018)	45 (5.02 % decrease)
No. of Treatment Admissions (ADMH, 2020)	16535
% of Persons Killed & Driver Blood Alcohol Concentration (.08+) in Crash 2018 (FARS, 2018)	25 (2.00% decrease)
Poverty (U.S. Census, 2020)	14.9 (2.3% decrease)
No. of Suicides (2020)	793

County Level Indicators for the State of Alabama

		Populat-ion	Pop %	Illicit Drug Use	Alcohol Use	Traffic Fatal-ity	Suicid-es	Graduat-ion Rates	% in Pover-ty	ADMH Tx
	Period	**2021**		**2016-2018**	**2016-2018**	**2020**	**2020**	**2018-2019**	**2020**	**2020**
310 Board										
	United States			**11**	**52**	**11,654**	**45,979**	**86%**	**11.9**	**-**
	Alabama	**5,039,877**		**10**	**45**	**236**	**793**	**92%**	**14.9**	**16,535**
1	Colbert	57,474	1.140	9*	39*	4	8	93%	14.4	237
1	Franklin	32,013	0.635	9*	39*	4	-	93%	17.2	50
1	Lauderdale	94,043	1.866	9*	39*	2	19	94%	13.9	588
2	Lawrence	33,090	0.657	9*	39*	-	5	91%	15.4	11
2	Limestone	107,517	2.133	9*	39*	6	15	92%	10.4	209
2	Morgan	123,668	2.454	9*	39*	6	22	93%	14.4	261
3	Madison	395,211	7.842	9*	39*	15	54	95%	10.5	1,688
4	Fayette	16,148	0.320	9*	39*	-	-	93%	16.5	26
4	Lamar	13,689	0.272	9*	39*	1	-	93%	17.4	39
4	Marion	29,246	0.580	10*	44*	1	9	92%	16.8	272
4	Walker	64,818	1.286	9*	39*	2	10	94%	16.4	274
4	Winston	23,652	0.469	9*	39*	1	6	93%	17.4	146
5	Blount	59,041	1.171	9*	45*	5	13	95%	13.1	89
5	Jefferson	667,820	13.251	9*	45*	28	83	91%	14.4	3,135
5	Shelby	226,902	4.502	9*	45*	4	30	95%	7	135
6	Cherokee	24,996	0.496	9*	39*	2	-	92%	14.7	156
6	DeKalb	71,813	1.425	9*	39*	6	15	94%	15.2	543
6	Etowah	103,162	2.047	9*	45*	3	24	94%	15.6	534

7	Calhoun	115,972	2.301	9*	45*	5	28	93%	14.5	516
7	Cleburne	15,103	0.300	9*	45*	2	-	98%	14.2	-
8	Bibb	22,477	0.446	9*	45*	-	-	92%	17.8	-
8	Pickens	18,801	0.373	9*	45*	1	-	98%	22.7	21
8	Tuscaloosa	227,007	4.504	9*	45*	5	26	90%	14.4	637
9	Clay	14,190	0.282	9*	45*	-	-	88%	14.2	-
9	Coosa	10,450	0.207	9*	45*	1	0	-	17.4	12
9	Randolph	21,989	0.436	9*	45*	6	-	95%	17.5	22
9	Talladega	81,524	1.618	9*	45*	4	7	95%	16.9	216
10	Choctaw	12,533	0.249	9*	41*	1	-	93%	20.4	-
10	Greene	7,629	0.151	10*	44*	2	-	88%	27.9	-
10	Hale	14,754	0.293	10*	44*	1	-	93%	21.9	-
10	Marengo	18,996	0.377	10*	44*	2	-	91%	18.3	31
10	Sumter	12,164	0.241	10*	44*	1	-	88%	29.2	10
11	Chilton	45,274	0.898	9*	45*	2	11	88%	13.9	57
11	St. Clair	92,748	1.840	9*	45*	5	13	93%	10.5	365
12	Chambers	34,541	0.685	10*	44*	4	9	87%	16.3	177
12	Lee	177,218	3.516	10*	44*	5	21	91%	17.9	358
12	Russell	58,722	1.165	10*	44*	3	12	94%	20.3	140
12	Tallapoosa	41,023	0.814	10*	44*	4	9	92%	15.2	22
13	Dallas	37,619	0.746	10*	44*	2	-	93%	26.7	50
13	Perry	8,355	0.166	10*	44*	-	-	98%	30.7	-
13	Wilcox	10,446	0.207	9*	41*	1	0	88%	22.2	-
14	Autauga	59,095	1.173	10*	44*	2	7	89%	11.2	99
14	Elmore	89,304	1.772	10*	44*	5	16	91%	11.5	112
14	Lowndes	9,965	0.198	10*	44*	1	0	98%	21.9	20
14	Montgomery	227,434	4.513	10*	44*	11	22	87%	20.4	493

15	Bullock	10,320	0.205	10*	44*	2	0	93%	30.8	-
15	Macon	18,895	0.375	10*	44*	4	-	88%	27.9	10
15	Pike	32,991	0.655	10*	44*	2	7	93%	19.7	61
16	Mobile	413,073	8.196	9*	41*	17	55	86%	17.6	1,566
16	Washington	15,147	0.301	9*	41*	1	-	93%	17.5	-
17	Clarke	22,760	0.452	9*	41*	1	-	91%	19.5	10
17	Conecuh	11,328	0.225	9*	41*	-	-	93%	22.9	10
17	Escambia	36,699	0.728	9*	41*	4	7	90%	20.4	130
17	Monroe	19,648	0.390	9*	41*	1	-	91%	22.5	24
18	Butler	18,884	0.375	9*	41*	5	-	93%	20.6	24
18	Coffee	54,174	1.075	9*	41*	1	13	95%	13.9	29
18	Covington	37,524	0.745	9*	41*	-	10	96%	17.1	112
18	Crenshaw	13,083	0.260	9*	41*	-	-	93%	16.8	20
19	Barbour	24,964	0.495	9*	41*	1	5	85%	25.5	37
19	Dale	49,342	0.979	9*	41*	2	11	96%	15.5	302
19	Geneva	26,701	0.530	9*	41*	3	-	96%	21	124
19	Henry	17,459	0.346	9*	41*	-	5	98%	16.2	-
19	Houston	107,458	2.132	9*	41*	8	16	90%	14.8	721
20	Jackson	52,773	1.047	9*	39*	3	9	92%	15.3	272
20	Marshall	98,228	1.949	9*	39*	3	23	94%	15.4	585
21	Baldwin	239,294	4.748	9*	41*	7	51	90%	8.9	323
22	Cullman	89,496	1.776	9*	39*	6	21	95%	12.5	346

FY23-26 Prevention Goals and Deliverables[2]

Prevention System Organization and Implementation

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

Objective: Build and develop prevention prepared communities.

Action Step	Status	Primary POC	Secondary	Start Date	End Date	Total # of Days	Target Date	Metrics	Progress
1. Establish sufficient distribution of prevention strategies throughout the state.		Erin	Beverly				Ongoing	Percentage distribution should be greater emphasis on Environmental followed by CBP, Alternatives, and other strategies.	
2. Increase PIDR, community-based strategies and alternative activities.		Erin	Beverly				FY23-FY26	Increase the FY23 strategy distribution over the FY22 distribution.	
3. Issue RFP to ensure prevention services and strategies are represented throughout the state.		Beverly	Brandon				FY23	Statewide RFP issued in FY23.	

4. Promote collaborative relationships between prevention providers, coalitions, drug free communities, tribes, and multiple community sectors, including education, business, justice, housing, healthcare, military members/veterans and their families, rural and underserved populations.		Team					FY23-26	Increase the number of collaborations across entities and disciplines.	
5. Apply for and secure additional funding thorough grants such as SPF Rx, 988, Suicide		Beverly	Team				FY23-26	Make successful application for additional funding in FY24.	

Prevention and SOR.									
6. Increase services in underserved areas of the state.		Beverly	Team				Ongoing	Statewide RFP issued in FY23.	
7. Expand the reach of prevention funds.		Beverly	Team				Ongoing	Statewide RFP issued in FY23.	
8. Implement funding allocation model to assist in the distribution of SABG.		Beverly	Team				FY23	FY23 RFP scored, and providers identified.	

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

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

Action Step	Status	Primary POC	Secondary	Start Date	End Date	Total # of Days	Target Date	Metrics	Progress
1. Ensure prevention planning correlates with national efforts, SUPTRS goals, results of statewide needs assessment, and epidemiological profile.		Beverly	Team				FY23-26	Prevention goals correlate with national efforts, SUPTRS goals, results of statewide needs assessment, and epidemiological profile.	

2. Develop Continuity practical guidelines.		Team					FY23-26	Each quarter of the FY, develop at least 1 Continuity practical guideline per Office of Prevention staff member.	

Objective: Increase collaborative role of the AEOW and SPAB

Action Step	Status	Primary POC	Secondary	Start Date	End Date	Total # of Days	Target Date	Metrics	Progress
1. Promote engagement between AEOW, SPAB and their role in the prevention system.		Brenae'	Beverly				FY23	Increase engagements of AEOW & SPAB members with the prevention system efforts	

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

Action Step	Status	Primary POC	Secondary	Start Date	End Date	Total # of Days	Target Date	Metrics	Progress
1. Perform a comprehensive update of the epidemiological profile to include state and county level data. (Every two years)		Brenae'	AEOW				FY24	Comprehensive Epi profile published Oct. 2023 for state and inclusive of county data.	
2. Develop topic-specific fact sheets using Epidemiological profile.		Brenae'	AEOW				FY23	Two topic specific fact sheets each FY posted to ADMH website.	

Workforce Development and Capacity Building

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

Objective: Develop prevention workforce.

Action Step	Status	Primary POC	Secondary	Start Date	End Date	Total # of Days	Target Date	Metrics	Progress
1. Conduct workforce development opportunities.		Beverly	Erin				FY23-26	Quarterly occurrence of WFD.	
2. Promote/provide prevention theory study groups for certification prep.		Consultant					FY23-26	Eight groups conducted in a FY.	

Implementation

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

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

Action Step	Status	Primary POC	Secondary	Start Date	End Date	Total # of Days	Target Date	Metrics	Progress
1. Educate providers on emotional health and wellness integration.		Consultant					FY23-26	Deliver 2 education sessions each FY.	

2. Ensure prevention plans take a comprehensive approach to addressing emotional health and wellness across strategies.		Consultant	Beverly				FY23-26	Increase the FY23 focus of effort distribution over the FY22 distribution.	
3. Prevent or delay the onset of complications of substance use and mental illness.		Team	System				FY23-26	Reduce the percentage of persons reporting substance use in the past 30 days and reporting major depressive episodes in the year.	

Goal 2 Prevent and reduce underage drinking and young adult problem drinking.

Objective: Promote the prevention of underage drinking and young adult problem drinking.

Action Step	Status	Primary POC	Secondary	Start Date	End Date	Total # of Days	Target Date	Metrics	Progress
1. Ensure prevention plans take a comprehensive approach to addressing underage drinking across strategies to include mobilizing communities		Consultant	Beverly				FY23-26	Increase the FY23 focus of effort distribution over the FY22 distribution.	

through town hall meetings.									
2. Collaborate and support the ABC compliance checks and the minor operative program.		Beverly	Team				FY23-26	FY23-26 funding to ABC.	
3. Educate the prevention system on underage drinking and young adult problem drinking.		Consultant	ABC				FY23-26	Deliver 2 education sessions each FY.	
4. Prevent and reduce underage drinking and young adult problem drinking and its negative consequences.		Team	System				FY23-26	Decrease the percentage of youth aged 12-20 engaged in underage drinking and reporting alcohol use or binge drinking in the past 30 days.	
5. Enhance SPF sub-recipients' sustainability, implementation and evaluation.		Brandon	SPF Rx Specialist				FY23-26	Increase the number of education sessions and TA on these topics.	

Goal 3 Prevent and reduce prescription drug and illicit opioid use and misuse.
Objective: Promote the prevention or reduction of illicit and prescription drug use and misuse.

Action Step	Status	Primary POC	Secondary	Start Date	End Date	Total # of Days	Target Date	Metrics	Progress
1. Ensure prevention plans address illicit and prescription drug misuse and use, across strategies.		Brandon/Satavia	SPF Rx Specialist				FY23-26	Increase the FY23 focus of effort distribution over the FY22 distribution.	
2. Support planning and implementation of prescription drug take-back program.		Satavia	Brandon				FY23-26	Sustain the # of participating agencies and/or the # of pounds collected statewide.	
3. Expand participation in prescription drug take-back program.		Satavia	Brandon				April of each fiscal year	Increase the # of participants in FY23 over FY22.	
4. Educate the prevention system on prescription drug and illicit opioid use and misuse.		Consultant					FY23-26	Deliver 2 education sessions each FY.	
5. Prevent and reduce prescription drug and illicit opioid use and misuse.		Team	System				FY23-26	Reduce the number of opioid overdoses, overdoes-related deaths, and prevalence of opioid dependence.	

Goal 4 Prevent and reduce tobacco use.

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

Action Step	Status	Primary POC	Secondary	Start Date	End Date	Total # of Days	Target Date	Metrics	Progress
1. Collaborate with ABC, ADPH, and the Youth Access to Tobacco Advisory Board.		Beverly	Team				FY23-26	FY23-26 funding to ABC & ADPH and attendance at YATAB.	
2. Support SYNAR efforts.		Beverly	Brenae' Consultants				FY23-26	FY22 Coverage Study completion. FY23-26 ASR completion. FY Synar Workshop attendance.	
3. Promote tobacco-free initiatives in mental health, substance use treatment, and community-based prevention efforts.		Team					FY23-26		
4. Educate the prevention system on tobacco use.		Consultant					FY23-26	Deliver 2 education sessions each FY.	
5. Prevent and reduce tobacco use among youth and persons with mental and substance use disorders.		Team	System				FY23-26	Reduce the percentage of youth aged 12-17 and persons with mental and substance use disorders reporting tobacco use in the past 30 days.	

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

Objective: Promote the prevention of attempted suicides and deaths by suicide among those at high risk (white non-Hispanic males, elderly-70+, American Indian, military, etc.) for suicide.									
Action Step	**Status**	**Primary POC**	**Secondary**	**Start Date**	**End Date**	**Total # of Days**	**Target Date**	**Metrics**	**Progress**
1. Participate and collaborate with the Suicide Prevention Task Force.		Maegan	Beverly				FY23-26	Attendance at ASPARC, SPNA, SPRC, and 988 meetings.	
2. Educate the prevention system on suicide and effective practices and resources for the prevention of suicide as it relates to substance use.		Maegan	Beverly				FY23-26	Participation in 2 Information Dissemination or Education sessions each FY.	
3. Ensure prevention plans address suicide and its relationship with substance use.		Consultant	Maegan				FY23-26	Increase the FY23 focus of effort distribution over the FY22 distribution.	
4. Prevent and reduce substance-related suicides among populations at high risk.		Team	System				FY23-26	Reduce the number of suicide attempts and deaths by suicide.	

Evaluation

Goal 1 Develop a comprehensive evaluation system.

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

Action Step	Status	Primary POC	Secondary	Start Date	End Date	Total # of Days	Target Date	Metrics	Progress
1. Secure evaluation services.		Beverly					FY23	Contracted Evaluator Services	
2. Develop a plan for evaluation.		Evaluator					FY23	Evaluation plan	
3. Collaborate with Evaluator and IT staff to improve collection of prevention information to include performance indicators to measure and document success.		Evaluator	IT, Brandon				FY23-26	Evaluator secured in FY23. Ensure performance measures established in FY22 RFP are sufficient.	
4. Develop or secure a statewide survey.		Evaluator	Team				FY26	Statewide survey	

State Synar Program Compliance

Goal 1 Implement Synar in the State of Alabama.

Objective: Achieve compliance in accordance with federal standards.

Action Step	Status	Primary POC	Secondary	Start Date	End Date	Total # of Days	Target Date	Metrics	Progress
1. Collaborate with ADPH and ABC.		Beverly	ADPH, ABC				Ongoing	Contract with ABC.	
2. Support provider efforts around compliance checks.		Team					Ongoing	# of providers with compliance checks within strategy.	
3. Conduct coverage study.		Consultant	Brenae'				FY24	Completed coverage study.	
4. Develop Annual Synar Report		Brenae'	Beverly				FY23-26	Submitted ASR to SAMSHA.	

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

Environmental Factors and Plan

7. Substance Use Disorder Treatment – Required for SUPTRS BG

Narrative Question

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

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services (with medications for addiction treatment included in v-x):

i)	Screening	◉ Yes	○ No
ii)	Education	◉ Yes	○ No
iii)	Brief intervention	○ Yes	◉ No
iv)	Assessment	◉ Yes	○ No
v)	Withdrawal Management (inpatient/residential)	◉ Yes	○ No
vi)	Outpatient	◉ Yes	○ No
vii)	Intensive outpatient	◉ Yes	○ No
viii)	Inpatient/residential	◉ Yes	○ No
ix)	Aftercare/Continuing Care	◉ Yes	○ No
x)	Recovery support	◉ Yes	○ No

b) Services for special populations:

i)	Prioritized services for veterans?	◉ Yes	○ No
ii)	Adolescents?	◉ Yes	○ No
iii)	Older Adults?	○ Yes	◉ No

Criterion 2

Criterion 3

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

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

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

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

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

a) Open assessment and intake scheduling? (●) Yes ( ) No

b) Establishment of an electronic system to identify available treatment slots? (●) Yes ( ) No

c) Expanded community network for supportive services and healthcare? (●) Yes ( ) No

d) Inclusion of recovery support services? (●) Yes ( ) No

e) Health navigators to assist clients with community linkages? (●) Yes ( ) No

f) Expanded capability for family services, relationship restoration, and custody issues? (●) Yes ( ) No

g) Providing employment assistance? (●) Yes ( ) No

h) Providing transportation to and from services? (●) Yes ( ) No

i) Educational assistance? (●) Yes ( ) No

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

Currently ADMH monitors compliance for PWWDC through annual compliance monitoring of the agency and reviewing documentation of the policy and procedure manuals of each agency within the state. Facilities that are not compliant with PWWDC
policies are placed on corrective action plans and given a documented time frame to correct the activity or lack of activity. Once corrected a member of the program management team returns to the site the review updates and changes.

Criterion 4,5&6

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:

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

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

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

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

Currently ADMH monitors compliance for PWID through on-site annual compliance monitoring of the agency and reviewing documentation of the policy and procedure manuals of each agency within the state. Facilities that are not compliant with PWID policies are placed on corrective action plans and given a documented time frame to correct the activity or lack of activity. Once corrected a member of the program management team returns to the site the review updates and changes.

Tuberculosis (TB)

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

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

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

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

Currently ADMH monitors compliance for TB screenings and access to care through on-site annual compliance monitoring of the agency and reviewing documentation of the policy and procedure manuals of each agency within the state. Facilities that are not compliant with TB policies are placed on corrective action plans and given a documented time frame to correct the activity or lack of activity. Once corrected a member of the program management team returns to the site the review updates and changes.

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

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

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

- **a)** Establishment of EIS-HIV service hubs in rural areas? ( ) Yes (●) No

b) Establishment or expansion of tele-health and social media support services? (●) Yes ( ) No

c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS? (●) Yes ( ) No

Hypodermic Needle Prohibition

1. Does your state have in place an agreement to ensure that SUPTRS BG funds are NOT expended to provide individuals with hypodermic needles or syringes for the purpose of injecting illicit substances **(42 U.S.C.§ 300x-31(a)(1)(F))**? (●) Yes ( ) No

Criterion 8,9&10

Service System Needs

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

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

a) Workforce development efforts to expand service access? (●) Yes ( ) No

b) Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services? (●) Yes ( ) No

c) Establish a peer recovery support network to assist in filling the gaps? (●) Yes ( ) No

d) Incorporate input from special populations (military families, service members, veterans, tribal entities, older adults, persons experiencing homelessness)? (●) Yes ( ) No

e) Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, such as primary healthcare, public health, VA, and community organizations? (●) Yes ( ) No

Service Coordination

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

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

a) Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services (●) Yes ( ) No

b) Establish a program to provide trauma-informed care (●) Yes ( ) No

c) Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice system, adult criminal justice system, and education. (●) Yes ( ) No

Charitable Choice

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

2. Does your state provide any of the following:

a) Notice to Program Beneficiaries? ( ) Yes (●) No

b) An organized referral system to identify alternative providers? (●) Yes ( ) No

c) A system to maintain a list of referrals made by religious organizations? ( ) Yes (●) No

Referrals

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

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

a) Review and update of screening and assessment instruments? (●) Yes ( ) No

b) Review of current levels of care to determine changes or additions? (●) Yes ( ) No

c) Identify workforce needs to expand service capabilities? (●) Yes ( ) No

Patient Records

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

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

a) Training staff and community partners on confidentiality requirements? (●) Yes ( ) No

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

c) Updating written procedures which regulate and control access to records? (●) Yes ( ) No

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

Independent Peer Review

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

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

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

Currently ADMH has 5 sub-recipients who are participating in the peer reviews as a part of the Quality Assurance department which is 5% of the total sub-recipients.

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

a) Development of a quality improvement plan? (●) Yes ( ) No

b) Establishment of policies and procedures related to independent peer review? ( ) Yes (●) No

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

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

If Yes, please identify the accreditation organization(s)

i) ☐ Commission on the Accreditation of Rehabilitation Facilities

ii) ☐ The Joint Commission

iii) ☐ Other (please specify)

Criterion 7&11

Group Homes

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

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

a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service? ○ Yes ● No

b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing? ○ Yes ● No

Professional Development

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

a) Recent trends in substance use disorders in the state? ● Yes ○ No

b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services? ● Yes ○ No

c) Performance-based accountability? ● Yes ○ No

d) Data collection and reporting requirements? ● Yes ○ No

If the answer is No to any of the above, please explain the reason.

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

a) A comprehensive review of the current training schedule and identification of additional training needs? ● Yes ○ No

b) Addition of training sessions designed to increase employee understanding of recovery support services? ● Yes ○ No

c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services? ● Yes ○ No

d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort? ● Yes ○ No

3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers[1] (TTCs)?

a) Prevention TTC? ● Yes ○ No

b) SMI Adviser ○ Yes ● No

c) Addiction TTC? ○ Yes ● No

d) State Opioid Response Network? ● Yes ○ No

e) Strategic Prevention Technical Assistance Center (SPTAC) ○ Yes ● No

Waivers

*Upon the request of a state, the Secretary may waive the requirements of all or part of the sections **42 U.S.C.§ 300x-22(b)**,**300x-23**,**300x-24**, and **300x-28** (**42 U.S.C.§ 300x-32(e)**).*

1. Is your state considering requesting a waiver of any requirements related to:

a) Allocations regarding women (300x-22(b)) ○ Yes ● No

2. Is your state considering requesting a waiver of any requirements related to:

a) Intravenous substance use (300x-23) ○ Yes ◉ No

3. Is Your State Considering Requesting a Waiver of any Requirements Related to Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus (300x-24)

a) Tuberculosis ○ Yes ◉ No

b) Early Intervention Services Regarding HIV ○ Yes ◉ No

4. Is Your State Considering Requesting a Waiver of any Requirements Related to Additional Agreements (**42 U.S.C. § 300x-28**)

a) Improvement of Process for Appropriate Referrals for Treatment ○ Yes ◉ No

b) Professional Development ○ Yes ◉ No

c) Coordination of Various Activities and Services ○ Yes ◉ No

Please provide a link to the state administrative regulations that govern the Mental Health and Substance Use Disorder Programs.

http://www.alabamaadministrativecode.state.al.us/docs/mhlth/index.html

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[1] **https://www.samhsa.gov/technology-transfer-centers-ttc-program**

Footnotes:

Environmental Factors and Plan

9. Crisis Services – Required for MHBG, Requested for SUPTRS BG

Narrative Question

There is a mandatory 5 percent set-aside within MHBG allocation for each state to support evidence-based crisis systems. The statutory language outlines the following for the 5 percent set-aside:

> *…….to support evidence-based programs that address the crisis care needs of individuals with serious mental illnesses and children with serious emotional disturbances, which may include individuals (including children and adolescents) experiencing mental health crises demonstrating serious mental illness or serious emotional disturbance, as applicable.*
>
> *CORE ELEMENTS: At the discretion of the single State agency responsible for the administration of the program, the funds may be used to fund some or all of the core crisis care service components, as applicable and appropriate, including the following:*
>
> - *Crisis call centers*
> - *24/7 mobile crisis services*
> - *Crisis stabilization programs offering acute care or subacute care in a hospital or appropriately licensed facility, as determined by such State, with referrals to inpatient or outpatient care.*
>
> *STATE FLEXIBILITY: In lieu of expending 5 percent of the amount the State receives pursuant to this section for a fiscal year to support evidence-based programs as required a State may elect to expend not less than 10 percent of such amount to support such programs by the end of two consecutive fiscal years.*

A crisis response system has the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family.The expectation is that states will build on the emerging and growing body of evidence, including guidance developed by the federal government, for effective community-based crisis-intervention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination, stabilization services to support reducing distress, and the promotion of skill development and outcomes, all towards managing costs and better investment of resources.

Several resources exist to help states. These include **Crisis Services: Meeting Needs, Saving Lives**, which consists of the **National Guidelines for Behavioral Health Coordinated System of Crisis Care** as well as an **Advisory: Peer Support Services in Crisis Care** There is also the **National Guidelines for Child and Youth Behavioral Health Crisis Care** which offers best practices, implementation strategies, and practical guidance for the design and development of services that meet the needs of children, youth, and their families experiencing a behavioral health crisis. Please note that this set aside funding is dedicated for the core set of crisis services as directed by Congress. Nothing precludes states from utilizing more than 5 percent of its MHBG funds for crisis services for individuals with serious mental illness or children with serious emotional disturbances. If states have other investments for crisis services, they are encouraged to coordinate those programs with programs supported by the 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

When individuals experience a crisis related to mental health, substance use, and/or homelessness (due to mental illness or a co-occurring disorder), a no-wrong door comprehensive crisis system should be put in place. Based on the National Guidelines, there are three major components to a comprehensive crisis system, and each must be in place in order for the system to be optimally effective. These three-core structural or programmatic elements are: Crisis Call Center, Mobile Crisis Response Team, and Crisis Receiving and Stabilization Facilities.

Crisis Contact Center. In times of mental health or substance use crisis, 911 is typically called, which results in police or emergency medical services (EMS) dispatch. A crisis call center (which may provide text and chat services as well) provides an alternative. Crisis call centers should be made available statewide, provide real-time access to a live crisis counselor on a 24/7 basis, meet National Suicide Prevention Lifeline operational guidelines, and serve as "Air Traffic Control" to assess, coordinate, and determine the appropriate response to a crisis. In doing so, these centers should integrate and collaborate with existing 911 and 211 centers, as well as other applicable call centers, to ensure access to the appropriate level of crisis response. 211 centers serve as an entry point to crisis services in many states and provide information and referral to callers on where to obtain assistance from local and national social

services, government agencies, and non-profit organizations.

The public has become accustomed to calling 911 for any emergency because it is an easy number to remember, and they receive a quick response. Many of the crisis systems in the United States continue to use 911 for several reasons such as they are still building their crisis systems or because they have no mechanism to fund a call center separate from 911. However, they recognize that the sure way to minimize the involvement of law enforcement in a behavioral health crisis response is to divert calls from 911. There are basically three diversion models in operation at this time: (1) the 911-based system with dispatchers who forward calls to either law enforcement's responder team (law enforcement officer with a behavioral health professional) or to their Crisis Intervention Team (CIT) with law enforcement officers who have received Crisis Intervention Training, including awareness of mental health and substance use disorders, and related symptoms, de-escalation methods, and how to engage and connect people to supportive services; (2) the 911-based system with well-trained 911 dispatchers who triage calls to state or local crisis call centers for individuals who are not a threat to themselves or others; the call centers may then refer appropriate calls to local mobile response teams (MRTs), also called mobile crisis teams (MCTs); and (3) State or local Crisis Contact Centers with well-trained counselors who receive calls directly (without utilizing 911 at all) on their own toll-free numbers.

Mobile Crisis Response Team. Once a behavioral health crisis has been identified and a crisis line has been called, a mobile response may be required if the crisis cannot be resolved by phone alone. Historically, law enforcement has been dispatched to the location of the individual in crisis. But in an effective crisis system, mobile crisis teams, including a licensed clinician, should be dispatched to the location of the individual in crisis, accompanied by Emergency Medical Services (EMS) or police only as warranted. Ideally, peer support professionals would be integrated into this response. Assessment should take place on site, and the individual should be connected to the appropriate level of care, if needed, as deemed by the clinician and response team.

Crisis Receiving and Stabilization Facilities. In a typical response system, EMS or police would transport the individual in crisis either to an ED or to a jail. Crisis Receiving and Stabilization Facilities provide a cost-effective alternative. These facilities should be available to accept individuals by walk-in or drop-off 24/7 and should have a "no wrong door" policy that supports all individuals, including those who need involuntary services. When anyone arrives, including law enforcement or EMS who are dropping off an individual, the hand-off should be "warm" (welcoming), timely and efficient. These facilities provide assessment for, and treatment of mental health and substance use crisis issues, including initiating medications for opioid use disorder (MOUD), and also provide wrap-around services. The multi-disciplinary team, including peers, at the facility can work with the individual to coordinate next steps in care, to help prevent future mental health crises and repeat contacts with the system, including follow-up care.

Currently, the 988 Suicide and Crisis Lifeline (Lifeline) connects with local call centers throughout the United States. Call center staff is comprised of individuals who are trained to utilize best practices in handling behavioral health calls. Local call centers automatically engage in a safety assessment for every call; if an imminent risk exists and cannot be deescalated, they forward the call to either 911 or to a local mobile crisis team for a response. If there is no imminent risk, the call center will work with the individual (or the person calling on their behalf) for as long as needed or, if necessary, dispatch a local MRT.

988 – 3-Digit behavioral health crisis number. The National Suicide Hotline Designation Act (**P.L. 116-172**) provides an opportunity to support the infrastructure, service and long-term funding for community and state 988 response, a national 3-digit behavioral health crisis number that was approved by the Federal Communications Commission in July 2020. In July 2022, the National Suicide Prevention Lifeline transitioned to 988 Suicide & Crisis Lifeline, but the 1-800-273-TALK is still operational and directs calls to the Lifeline network. The 988 transition has supported and expanded the Lifeline network and will continue utilizing the life-saving behavioral health crisis services that the Lifeline and Veterans Crisis Line centers currently provide.

Building Crisis Services Systems. Most communities across the United States have limited, but growing, crisis services, although some have an organized system of services that provide on-demand behavioral health assessment and stabilization services, coordinate and collaborate to divert from jails, minimize the use of EDs, reduce hospital visits, and reduce the involvement of law enforcement. Those that have such systems did not create them overnight, but it involved dedicated individuals, collaboration, considerable planning, and creative methods of blending sources of funding.

1. Briefly describe your state's crisis system. For all regions/areas of your state, include a description of access to crisis contact centers, availability of mobile crisis and behavioral health first responder services, utilization of crisis receiving and stabilization centers.

No individual is immune from the impact of untreated behavioral health needs. Each year, there are thousands of preventable tragedies that may be addressed with proper mental health resources and access to care. To offer innovative and accessible solutions, the Alabama Crisis System of Care:

- Expands access to care and offers the right care, at the right time, at the right place
- Includes 988, Mobile Crisis Teams, and Crisis Centers
- Assists individuals before a civil commitment may occur

• Reduces the number of arrests
• Decreases frequency of admissions to hospitals
• Provides connections and referrals to agencies and organizations Assists individuals in crisis to achieve stability
• Promotes sustained recovery
• Includes someone to talk to, someone to come to you, and someplace to go
• Creates opportunities for the behavioral health workforce

Gov. Kay Ivey, the Alabama State Legislature, and the Alabama Department of Mental Health have funded six (6) Crisis Centers that offer services at staged levels. During FY 25 all six (6) state funded Crisis Stabilization Centers were opened. These centers improve access to behavioral healthcare services for individuals who are experiencing a mental health or substance abuse crisis, and they aid jails and hospitals throughout the state by alleviating the burden to house and care for individuals in need of services. They all offer "No Wrong Door" approach and can be accessed by walk-in, law enforcement, hospital or family referral. This investment helps to expand and transform the Alabama crisis system of care, dramatically lower healthcare costs, reinvest state dollars, achieve better health outcomes, and improve life for those with acute mental health needs.

988 – (Lifeline Call Centers)
The purpose of the 988 Comprehensive Behavioral Health Crisis Communication System Commission (typically called the 988 commission), created by Act 2021-359, is to study and provide recommendations for the implementation of the 988 system to enhance and expand behavioral health crisis response and suicide prevention services before it was nationally implemented on July 16, 2022, as required by Public Law No: 116-172.

988 is more than just an easy-to-remember number—it's a direct connection to compassionate, accessible care and support for anyone experiencing mental health-related distress – whether that is thoughts of suicide, mental health or substance use crisis, or any other kind of emotional distress. People can also dial 988 if they are worried about a loved one who may need crisis support. 988 calls are routed to the National Suicide Prevention Lifeline centers in each state. 988 offers rapid access to behavioral health support through connection with trained crisis specialists.

988 provides Alabama with the unique opportunity to fully integrate and intentionally align the state's crisis system design and service delivery – linking individuals directly to critical services: someone to call, someone to respond, and somewhere to go. 988 is interwoven into the Alabama Crisis System of Care, as the first step and response in a crisis. 988 offers an opportunity to decouple policing from a mental health or substance use crisis. 988 is a vital resource for people experiencing a mental health emergency.

In Alabama, calls are answered by 998 call centers right here in the state of Alabama. The four (4) 988 Lifeline Call Centers are located at AltaPointe Health in Mobile; in Birmingham at The Crisis Center Birmingham; and in Huntsville at WellStone. SpectraCare Health in Dothan will soon come online as a call center. Two (2) of these 988 Lifeline Call Centers operate 24\7\365 and also serve as backup for the other centers.

When someone calls, chats, or texts 988, they are connected to a crisis specialist who is trained and prepared to deliver support to anyone experiencing a crisis. Because a crisis is defined by the person or family experiencing it, the crisis specialist addresses the person's unique concerns and needs.

The conversation may include assessment, stabilization, referral, and follow-up for individuals at high risk for suicide and/or poor mental health outcomes. If a higher level of care is needed, the crisis specialist works with the caller to connect them to a mobile crisis response team to respond to the person in the community, inform them of the nearest Crisis Stabilization Center or relay the call to emergency responders, if needed.

ADMH and its partners are working diligently to expand capacity and improve the statewide answer rate. Challenges of stable funding and workforce must be addressed to build a sustainable system.

Mobile Crisis Teams (MCT)

In our state, 67 counties, 55 are deemed "rural" by the Alabama Department of Public Health. There are many communities, families, and individuals who reside in rural areas without the ability to travel to a Crisis Center or a community mental health center if a crisis should occur. In order to actively change the model of care and respond to this vital need, the Alabama Department of Mental Health began expanding the Alabama Crisis System of Care to include Mobile Crisis Teams (MCT).

In Fiscal Year 2021, five community mental health centers (CMHC) across the state received funding to increase their rural and mobile crisis care services:
• Cahaba Center for Mental Health
• Northwest Alabama Mental Health Center
• Southwest Alabama Behavioral Health Care Systems
• WellStone Behavioral Health (Cullman)
• West Alabama Mental Health Center

Also, two additional CMHC's were awarded funds in FY21 through federal ARPA and Block Grant awards:
• South Central Mental Health Center
• SpectraCare Health

Three Crisis Centers fund (6) Teams through state appropriation:
• AltaPointe – Mobile County
• Carastar –Montgomery, Autauga, Elmore, Lowndes Counties
• East Central –Pike, Macon, Bullock Counties
• East Alabama –Lee, Chambers, Russell, Tallapoosa Counties

3 CMHC's provide five (5) (MCT) services for Child\Adolescents through state appropriation:
• AltaPointe – Mobile 2 Child\Adolescent MCT's
• JBS – Jefferson 1 Child\Adolescent MCT
• Wellstone – Madison 2 Child\Adolescent MCT

The goals for mobile crisis services are aligned with the overarching goals of crisis care, which are to reduce the burden on EDs/Hospitals, reduce the burden on Law Enforcement/Jails, and improve access for the "right care, right time, right place." Each center will have a mobile crisis team as part of mobile crisis services. The community mental health centers may also include in their crisis services: a co-response with law enforcement and emergency medical personnel, crisis peer support, crisis case management, regional call centers, and respite options.

To transform mobile crisis care in our state, the Alabama Department of Mental Health and the Alabama Medicaid Agency received a CMS State Planning Grant for Mobile Crisis Services grant in FY22, and a year extension, allowing for further work with community mental health centers on this essential service within Alabama's Crisis System of Care. The grant and its work with providers, facilitated by VitAL, of The University of Alabama, assists in increasing the quality of care of all mobile crisis teams to ensure standardization for practices and procedures. ADMH works directly with the providers to provide technical assistance and guidance to ensure their program development is connected to the statewide crisis system of care and tailored to the specific needs of their communities, especially rural areas. ADMH is working with AMA on a submission to CMS for a new funding stream for Mobile Crisis Team services through a State Plan Amendment.

Crisis Stabilization Centers (Triage, Crisis Receiving – Temporary Observation, Stabilization – Extended Observation) All Crisis Stabilization Centers follow SAMHSA National Guidelines for Behavioral Health Crisis Care Best Practices.
Crisis Centers in Alabama are individualized to the unique needs of the communities they serve.
• AltaPointe Health: The Behavioral Health Crisis Center is located in Mobile County and serves Baldwin, Washington, Clark, Conecuh, Escambia, and Monroe Counties.
• Carastar Health (formerly MAMHA): This center is in Montgomery, but serves the entire River Region, and the counties of Chambers, Lee, Russell, and Tallapoosa, in partnership with the community mental health centers of East Alabama and East Central Alabama. Mobile Crisis Services are in operation, in conjunction with law enforcement and first responder partnerships.
• WellStone: The WellStone Emergency Services Crisis Center is located in Huntsville serving Cullman and Madison counties, and the surrounding counties of Fayette, Lamar, Marion, Walker, Winston, Lawrence, Limestone, Morgan, Jackson, Marshall, Cherokee, Dekalb, and Etowah. Mobile Crisis Services are in operation, in conjunction with law enforcement and first responder partnerships.
• Jefferson, Blount, St. Clair Behavioral Services: The Richard Craig Crisis Care Center will serve the named counties, in addition to surrounding counties.
• Indian Rivers Behavioral Health: The center will be located in Tuscaloosa County and will serve the following counties: Tuscaloosa, Bibb, Pickens, Perry, Dallas, Wilcox, Hale, Sumter, Greene, Marengo, and Choctaw. The Hope Pointe Behavioral Health Crisis Center is scheduled to begin providing services in late 2023.
• SpectraCare Health Systems: The center will be located in Dothan opened in March 2025 and is currently fully operational.

Crisis centers are designated places for individuals to walk in, and for law enforcement, first responders, and EMS personnel to take an individual that is in mental health or substance use crisis. At each Crisis Center, the individual may receive stabilization, evaluation, and psychiatric services. There are three components of the Crisis Center:
• Triage – any individual will qualify for triage, which includes linkages to appropriate services and supports.
• Temporary Observation (crisis receiving) – This is for individuals who need more treatment for their crisis that is less than 24 hours.
• Extended Observation (stabilization) – This is for individuals that need more care for stabilization but not in need of an inpatient psychiatric unit. This typical length of stay is no more than seven (7) days.

2. In accordance with the guidelines below, identify the stages where the existing/proposed system will fit in.

*a) The **Exploration** stage: is the stage when states identify their communities' needs, assess organizational capacity, identify how crisis services meet community needs, and understand program requirements and adaptation.*
*b) The **Installation** stage: occurs once the state comes up with a plan and the state begins making the changes necessary to implement the crisis services based on the published guidance. This includes coordination, training and community outreach and education activities.*
*c) **Initial Implementation** stage: occurs when the state has the three-core crisis services implemented and agencies begin to put into practice the published guidelines.*
*d) **Full Implementation** stage: occurs once staffing is complete, services are provided, and funding streams are in place.*
*e) **Program Sustainability** stage: occurs when full implementation has been achieved, and quality assurance mechanisms are in place to assess the effectiveness and quality of the crisis services.*

Check one box for each row indicating state's stage of implementation

	Exploration Planning	Installation	Early Implementation Less than 25% of counties	Partial Implementation About 50% of counties	Majority Implementation At least 75% of counties	Program Sustainment
Someone to contact	☐	☐	☐	☐	☐	☑
Someone to respond	☐	☑	☐	☐	☐	☐
Safe place to be	☐	☐	☐	☐	☐	☑

3. Briefly explain your stages of implementation selections here.

1. 988 – call centers – 988 call centers are currently implemented within four (4) community mental health centers who also operate a Crisis Center, with a 5th community mental health center working on implementation. As discussed above, there are still challenges to reach Full Implementation and Program Sustainment, such as solid funding and workforce issues.
2. Mobile Crisis Teams/Services (MCT) – Even though we have made strides with implementation of MCTs, we are still in the Early Implementation stages. MCT is available for less than 50% of the counties in Alabama. Having the CMS Planning Grant was vital to set up a foundation to determine best implementation for our state and jumpstarted the process to submit a CMS state plan amendment which will assist with the financial challenges. Workforce and capacity building, especially with the level of rural counties in Alabama remains a focus for scalability as we expand in the future.
3. Crisis Centers – There are currently six (6) funded and fully operating Crisis Stabilization Centers. However, work remains with onboarding, fully staffing and connecting all the elements of the crisis system of care and needed access to mental health, substance use, and other needed services and supports.

4. Based on the National Guidelines for Behavioral Health Crisis Care and the **National Guidelines for Child and Youth Behavioral Health Crisis Care**, explain how the state will develop the crisis system.

All planning and preparation from the onset were based on building a Crisis System of Care based on the SAMHSA's National Guideline for Behavioral Health Crisis Care. As described above, Alabama has developed the crisis system requiring all three elements of: someone to call, someone to respond, and somewhere to go. ADMH has focused on the planning stages needed to analyze and scope the system as to ensure building of the strengths of the current mental health and substance use treatment services and ensured meaningful engagement from all stakeholders, to include individuals with lived experience and their families. This has been done and continues to be addressed at the local, community, regional, and state level. ADMH hired a full-time Director of Crisis Services at ADMH who is responsible for the crisis components for planning, assessing, coordination, training, and any other identified needs as to not only monitor and provide oversight, but to help ensure the partnership and direct linkage for needed support, guidance, and technical assistance.

5. Other program implementation data that characterizes crisis services system development.

Someone to contact: Crisis Contact Capacity

a. Number of locally based crisis call Centers in state
   i. In the 988 Suicide and Crisis lifeline network: 4
   ii. Not in the suicide lifeline network: 0

b. Number of Crisis Call Centers with follow up protocols in place
   i. In the 988 Suicide and Crisis lifeline network: 4
   ii. Not in the suicide lifeline network: 0

c. Estimated percent of 911 calls that are coded out as BH related: 0

Someone to respond: Number of communities that have mobile behavioral health crisis mobile capacity (in comparison to the toal number of communities)

a. Independent of public safety first responder structures (police, paramedic, fire): 23
b. Integrated with public safety first responder structures (police, paramedic, fire): 24
c. Number that utilizes peer recovery services as a core component of the model: 24

Safe place to be

a. Number of Emergency Departments: 0
b. Number of Emergency Departments that operate a specialized behavioral health component: 0
c. Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis): 6

6. Briefly describe the proposed/planned activities utilizing the 5% set aside. If applicable, please describe how the state is leveraging the CCBHC model as a part of crisis response systems, including any role in mobile crisis response and crisis follow-up. As a part of this response, please also describe any state-led coordination between the 988 system and CCBHCs.

Through the SAMHSA Mental Health Block Grant MI Planning Council, in coordination with the Commissioner's steering committees, the decision was made to fund two additional Mobile Crisis Teams/Services which was implemented in FY21/22. One of the MCT is funded through the 5% Crisis Services with the Traditional MHBG, while the 2nd MCT is funded through the 5% Crisis Services with the COVID Supplemental and COVID ARPA funds, which are supplemental funds that ended on March 23, 2025.

Two of the CMHC's that provide all three components of the crisis services are Tier I CCBHC providers and implemented being CCBHCs in July 2024. All other CMHC's (17) are building capacity to provide the required crisis services to meet CCBHC requirements in order to become a CCBHC provider. ADMH has worked diligently to secure additional funds for the crisis system of care to include Crisis Centers, Mobile Crisis Teams, and 988, not only for sustainability but for expansion to our statewide system. ADMH is a CCBHC demonstration site, being awarded in July 2024. We are working closely with our provider system and stakeholders for implementation, expansion, and sustainability.

7. Please indicate areas of technical assistance needs related to this section.

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10. Recovery – Required for MHBG & SUPTRS BG

Narrative Question

Recovery supports and services are essential for providing and maintaining comprehensive, quality behavioral health care. The expansion in access to; and coverage for, health care drives the promotion of the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental health and substance use disorders.

Recovery is supported through the key components of health (access to quality physical health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of a recovery- guided approach to person-centered care is inclusive of shared decision-making, culturally welcoming and sensitive to social needs of the individual, their family, and communities. Because mental and substance use disorders can be chronic relapsing conditions, long term systems and services are necessary to facilitate the initiation, stabilization, and management of recovery and personal success over the lifespan.

The following working definition of recovery from mental and/or substance use disorders has stood the test of time:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, there are 10 identified guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see **Working Definition of Recovery.**

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the several federally supported national technical assistance and training centers. States are strongly encouraged to take proactive steps to implement and expand recovery support services and collaborate with existing RCOs and RCCs. Block Grant guidance is also available at the **Recovery Support Services Table**.

Because recovery is based on the involvement of peers/people in recovery, their family members and caregivers, SMHAs and SSAs should engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing organizations and direct resources for enhancing peer, family, and youth networks such as RCOs and RCCs and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing, and monitoring the state behavioral health treatment system.

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

a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care? (●) Yes ( ) No

b) Required peer accreditation or certification? (●) Yes ( ) No

c) Use Block Grant funds for recovery support services? (●) Yes ( ) No

d) Involvement of people with lived experience /peers/family members in planning, implementation, or evaluation of the impact of the state's behavioral health system? (●) Yes ( ) No

2. Does the state measure the impact of your consumer and recovery community outreach activity? (●) Yes ( ) No

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

ADMH has created the Office of Peer Support Services to provide oversight to recovery support specialist for both MI and SU populations. This office has the role of monitoring the states RCO's, certification processes, MI recovery support and family recovery support. This office also collaborates with NAMI and other local support agencies.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state. i.e., RCOs, RCCs, peer-run organizations.

DMH has created the Office of Peer Support Services to provide oversight to recovery support specialist for both MI and SU populations. This office has the role of monitoring the states RCO's, certification processes, MI recovery support and family recovery support. The services provided by the recovery organizations include outreach, peer coaching, warm hand-off to treatment, ER visits, 24/7 phone support and employment opportunities within the certified treatment facilities across the state.

5. Does the state have any activities that it would like to highlight?

Alabama currently has over 500 substance use certified peers who are active in the field. In addition, ADMH is in the process of hiring a second state certified peer to assist with the growing number of peers and the implementation of CCBHC in the state.

6. Please indicate areas of technical assistance needs related to this section.

n/a

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11. Children and Adolescents M/SUD Services – Required for MHBG, Requested for SUPTRS BG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SUPTRS BG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health disorder and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.[1] Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[2] For youth between the ages of 10 and 14 and young adults between the ages of 25 and 34, suicide is the second leading cause of death and for youth and young adults between 15 and 24, the third leading cause of death.[3]

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started using substances the age of 18. Of people who started using substances before the age of 18, one in four will develop a substance use disorder compared to one in 25 who started using substances after age 21.[4]

Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance use, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, states are encouraged to designate a point person for children to assist schools in assuring identified children relate to available prevention services and interventions, mental health and/or substance use screening, treatment, and recovery support services.

Since 1993, the federally funded Children's Mental Health Initiative (CMHI) has been used as an approach to build the system of care model in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then, states have also received planning and implementation grants for adolescent and transition age youth SUD and MH treatment and infrastructure development. This work has included a focus on formal partnership development across child serving systems and policy change related to financing, workforce development, and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the functioning of children, youth and young adults in home, school, and community settings. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult, and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.[5]

According to data from the 2017 Report to Congress on systems of care, services reach many children and youth typically underserved by the mental health system.

1. improve emotional and behavioral outcomes for children and youth.
2. enhance family outcomes, such as decreased caregiver stress.
3. decrease suicidal ideation and gestures.
4. expand the availability of effective supports and services; and
5. save money by reducing costs in high-cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

The expectation is that states will build on the well-documented, effective system of care approach. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

1. non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
2. supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education

and employment); and

3. residential services (e.g., therapeutic foster care, crisis stabilization services, and inpatient medical withdrawal management).

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[1]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children - United States, 2005-2011. MMWR 62(2).

[2]Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

[3]Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

[4]The National Center on Addiction and Substance use disorder at Columbia University. (June, 2011). Adolescent Substance use disorder: America's #1 Public Health Problem.

[5]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from **https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM**

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

a) The recovery of children and youth with SED? ○ Yes ○ No

b) The resilience of children and youth with SED? ○ Yes ○ No

c) The recovery of children and youth with SUD? ○ Yes ○ No

d) The resilience of children and youth with SUD? ○ Yes ○ No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:

a) Child welfare? ○ Yes ○ No

b) Health care? ○ Yes ○ No

c) Juvenile justice? ○ Yes ○ No

d) Education? ○ Yes ○ No

3. Does the state monitor its progress and effectiveness, around:

a) Service utilization? ○ Yes ○ No

b) Costs? ○ Yes ○ No

c) Outcomes for children and youth services? ○ Yes ○ No

4. Does the state provide training in evidence-based:

a) Substance use prevention, SUD treatment and recovery services for children/adolescents, and their families? ○ Yes ○ No

b) Mental health treatment and recovery services for children/adolescents and their families? ○ Yes ○ No

5. Does the state have plans for transitioning children and youth receiving services:

a) to the adult M/SUD system? ○ Yes ○ No

b) for youth in foster care? ○ Yes ○ No

c) Is the child serving system connected with the Early Serious Mental Illness (ESMI) services? ○ Yes ○ No

d) Is the state providing trauma informed care? ○ Yes ○ No

6. Describe how the state provides integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

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

8. Please indicate areas of technical assistance needs related to this section.

Footnotes:

Environmental Factors and Plan

12. Suicide Prevention – Required for MHBG, Requested for SUPTRS BG

Narrative Question

Suicide is a major public health concern, it is a leading cause of death nationally, with over 49,000 people dying by suicide in 2022 in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance use, painful losses, exposure to violence, economic and financial insecurity, and social isolation. Mental illness and substance use are possible factors in 90 percent of deaths by suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, M/SUD agencies are urged to lead in ways that are suitable to this growing area of concern. M/SUD agencies are encouraged to play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1. Have you updated your state's suicide prevention plan since the FY2024-2025 Plan was submitted? Yes No

2. Describe activities intended to reduce incidents of suicide in your state.

3. Have you incorporated any strategies supportive of the Zero Suicide Initiative? Yes No

4. Do you have any initiatives focused on improving care transitions for patients with suicidal ideation being discharged from inpatient units or emergency departments? Yes No

If yes, please describe how barriers are eliminated.

5. Have you begun any prioritized or statewide initiatives since the FFY 2024 - 2025 plan was submitted? Yes No

If so, please describe the population of focus?

6. Please indicate areas of technical assistance needs related to this section.

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13. Support of State Partners – Required for MHBG & SUPTRS BG

Narrative Question

The success of a state's MHBG and SUPTRS BG programs will rely heavily on the strategic partnerships that SMHAs and SSAs have or will develop with other health, social services, community-based organizations, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The State Medicaid Authority agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations.
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment.
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that prioritize risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of M/SUD, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead.
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in M/SUD needs and/or impact persons with M/SUD and their families and caregivers, providers of M/SUD services, and the state's ability to provide M/SUD services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in M/SUD.
- The state's agency on aging which provides chronic disease self-management and social services critical for supporting recovery of older adults with M/SUD.
- The state's intellectual and developmental disabilities agency to ensure critical coordination for individuals with ID/DD and co-occurring M/SUD.
- Strong partnerships between SMHAs and SSAs and their counterparts in physical health, public health, and Medicaid, Medicare, state, and area agencies on aging and educational authorities are essential for successful coordinated care initiatives. While the State Medicaid Authority (SMA) is often the lead on a variety of care coordination initiatives, SMHAs and SSAs are essential partners in designing, implementing, monitoring, and evaluating these efforts. SMHAs and SSAs are in the best position to offer state partners information regarding the most effective care coordination models, connect current providers that have effective models, and assist with training or retraining staff to provide care coordination across prevention, treatment, and recovery activities.
- SMHAs and SSAs can also assist the state partner agencies in messaging the importance of the various coordinated care initiatives and the system changes that may be needed for success with their integration efforts. The collaborations will be critical among M/SUD entities and comprehensive primary care provider organizations, such as maternal and child health clinics, community health centers, Ryan White HIV/AIDS CARE Act providers, and rural health organizations. SMHAs and SSAs can assist SMAs with identifying principles, safeguards, and enhancements that will ensure that this integration supports key recovery principles and activities such as person-centered planning and self-direction. Specialty, emergency and rehabilitative care services, and systems addressing chronic health conditions such as diabetes or heart disease, long-term or post-acute care, and hospital emergency department care will see numerous M/SUD issues among the persons served. SMHAs and SSAs should be collaborating to educate, consult, and serve patients, practitioners, and families seen in these systems. The full integration of community prevention activities is equally important. Other public health issues are impacted by M/SUD issues and vice versa. States should assure that the M/SUD system is actively engaged in these public health efforts.
- Enhancing the abilities of SMHAs and SSAs to be full partners in implementing and enforcing MHPAEA and delivery of health system improvement in their states is crucial to optimal outcomes. In many respects, successful implementation is dependent on leadership and

collaboration among multiple stakeholders. The relationships among the SMHAs, SSAs, and the state Medicaid directors, state housing authorities, insurance commissioners, prevention agencies, child-serving agencies, education authorities, justice authorities, public health authorities, and HIT authorities are integral to the effective and efficient delivery of services. These collaborations will be particularly important in the areas of Medicaid, data and information management and technology, professional licensing and credentialing, consumer protection, and workforce development.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? ○ Yes ◉ No

2. Has your state identified the need to develop new partnerships that you did not have in place? ○ Yes ◉ No

If yes, with whom?

NA

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilities Education Act.

ADMH partners with other state agencies, including but not limited to the Alabama Medicaid Agency, Department of Public Health, Juvenile and Adult Corrections, the Administrative Office of the Courts, Department of Education, Department of Corrections, and Department of Human Resources, to provide a comprehensive array of publicly funded services to adults with SMI and children/adolescents with SED through memoranda of understanding, intergovernmental service agreements or informal relationships. As in the case of most states, Alabama has experienced fiscal challenges. Strained resources, workforce issues, and the loss of a number of veteran state staff through accelerated retirement, downsizing and changes in state governmental leadership has an impact as well. Moreover, there have been several changes in leadership in most departments of state government, especially with ADMH who has experienced a change in leadership of Commissioner six times since January 2011. As such, although ADMH has a good and collaborative working relationship with partners, framing those relationships in a deliberate and collaborative fashion toward meeting the expectations of SAMHSA and aligning various departmental priorities with those objectives remain vital and important.
ADMH administers a wide range of services to adult and children/adolescent consumers in the community and at state institutions; regulates care and treatment providers; and consults with local, county, and public and non-profit agencies. The Department's responsibilities span many program areas as outlined in Section II- Planning Steps - Step 1- Assess the strengths and needs. Other state departments work closely with the State Mental Health Authority on a regular basis including the following:

Primary health and mental health services

Medicaid:
The Alabama Medicaid Agency (AMA) is a state/federal program that pays for medical and long-term care services for low-income pregnant women, children, certain people on Medicare, individuals with disabilities and nursing home residents. These individuals must meet certain income and other requirements. ADMH has had a long-standing working relationship with AMA and is already fully engaged with the Medicaid Agency on planning for health care reform.

Below are areas of focus involving AMA:

Electronic Health Record:
The One Health Record® system was created as Alabama's health information exchange (HIE) through a federal grant awarded to the state in 2009. Under the guidance of the Alabama Health Information Commission, One Health Record® has emerged as an interoperable, two-way data exchange system between providers, hospitals and others within Alabama and in other states. A Web site to encourage public involvement as Alabama develops a statewide electronic health record system is now available at www.onehealthrecord.alabama.gov as well as a link on the Alabama Medicaid Agency website. With the implementation of the CCBHC Demonstration, Once Health Record will be instrumental in sharing data, improving access to care and bridging various services systems our consumers navigate, was well as aligning with needed data point to measure qualify outcomes.

2703 Health Home State Plan Amendment (SPA):
In 2012, Medicaid partnered with the state agencies involved with Optional Medicaid services (Rehab, TCM, Waiver) to complete a 2703 Health Home State Plan Amendment (SPA). For the SPA to be approved, SAMHSA had to first approve the plan as to verify that behavioral health was written into the plan. SAMHSA conducted an interview/evaluation with ADMH in 2012 and agreed to the components of the 2703 SPA and indicated it was one of the few applications they had reviewed that demonstrated having bi-directional mental health and substance abuse care coordination/care management at a more integrated level. The SPA remained under review with CMS until May 2013 when finally approved. ADMH reached out to AMA to set up meetings to determine how the ADMH providers would participate with the implementation of the 2703 SPA as it pertains to mental health and substance abuse care. In 2013, the entire Medicaid process became a focal point of legislative focus, and the former Governor steered the state toward Medicaid Reform. It was determined that the Health Homes implemented in the four initial sites were proving to be a cost-effective process to manage both clinical care of individuals and financial cost savings. At the root of the Medicaid Reform

are the goals of the Health Homes: provide quality-driven, cost effective, culturally appropriate, and person- and family-centered health home services and coordinate Primary Medical Providers (PMPs) with Behavioral Health Providers in the Region to ensure delivery of best practices for integration and care management of chronic conditions. On April 1, 2015, the Health Home program expanded statewide to be managed by six of the eleven probationary RCOs who submitted qualifying proposals for their respective regions. On October 1, 2018, the Health Home program were incorporated into the full risk RCO's operation. This interim step was designed as a building block for probationary RCOs that are working toward full certification by facilitating network development and providing resources while offering the probationary RCOs an opportunity to demonstrate that they have the resources to manage patients in their region. However, with the ending of the RCOs, the process of statewide implementation of the Health Homes was shifted to the process to implement the Alabama Coordinated Health Networks (ACHN).

Alabama Coordinated Health Networks (ACHN);
With the closure of the RCO process, AMA initiated a Pivot Plan, which was the shift to build off the Health Homes and implement the Alabama Coordinated Health Networks (ACHN). AMA chose to continue to focus on managed care concepts but with a health home concept. The funding mechanism shifted to a 1915(b) waiver that was submitted on August 2, 2018, and approved on June 14, 2019. Guiding principles include paying for activity, not member, focusing on care management and health outcomes, and redirecting current expenditures to better achieve desired outcomes. The ACHN program was implemented on October 1, 2019. The ACHN implemented a single care coordination delivery system combining Health Homes, Maternity Program, and Plan First. It replaces silos in current care coordination efforts. Care coordination services are provided by regional Primary Care Case Management Entities (PCCM-Es), or network entities. There are seven defined regions. Also, primary care physicians practicing in district comprise at least half of board. ADMH worked closely with AMA and the implementation of the ACHN to ensure that our common consumers benefit for this care coordination opportunity. There are several quality measures are that specific to mental health and substance use.

Medicaid Quality Assurance Committee:
State law required the formation of a Quality Assurance Committee comprised of practicing healthcare professionals, 60 percent of which must be physicians. ADMH has a representative on the Medicaid Quality Assurance Committee. This group approved 42 quality measures that will be used for monitoring RCOs' performance, 10 of which will be incentivized under the new managed care system. All but one of the 42 measures are nationally recognized and validated which will allow Alabama to compare its performance to other states and national benchmarks. The measures not only include metrics related to diabetes, asthma, and well-child, but mental and substance use, care coordination and if care is provided in the most appropriate location. ADMH worked closely with the committee to provide recommendations on the mental health and substance use measures.

Integrated Care Networks (ICN):
In an effort to implement community integration for individuals who are targeted for nursing home placement, AMA worked diligently to streamline the coordinated efforts of several nursing home waivers. The Alabama's Integrated Care Network (ICN) program, based on a concept paper released by the Alabama Medicaid Agency in March 2018, was implemented. The ICN program establishes a new Medicaid long-term care program focusing on a person-centered approach to care delivery using the Primary Care Case Management (PCCM) Entity delivery model, with implementation on October 1, 2018.The ICN program, in an effort to fix the fragmentation in the LTSS delivery system and to create a more fiscally sustainable system, introduces managed care components, including a strong emphasis on care management, outreach, and an effort to increase home and community-based services (HCBS) utilization over institutional care. The PCCM model was chosen after the state deemed that a full-risk, capitated model would be more costly compared to the current Medicaid program.

Medicaid Initiatives:
EPSDT Settlement Agreement: In 2016, the State entered into a Settlement Agreement with the Alabama Disabilities Advocacy Program (ADAP) and the Center for Public Representation (CPR) to expand Intensive Home-Based Services for Medicaid-Eligible youth without need for litigation. Under the Agreement, Alabama committed to developing a suite of medically necessary, intensive home-based services for youth with Serious Emotional Disturbance (SED). The Settlement Agreement was signed in October 2017 and updated in January 2021. All parties continue to work on meeting timelines as outlined in the modified Settlement Agreement. ADMH has worked closely with AMA to include additional services implemented as part of the Settlement Agreement into the covered services. These services include High Intensity Care Coordination, Certified Peer Specialist – Youth, Certified Peer Specialist – Parent, and Therapeutic Mentoring. AMA has also implemented procedures for extending previously time-limited services such as In-Home Intervention for children and adolescents where medical necessity is met for the service. As ADMH revised the provision of care coordination services for children and adolescents, AMA allowed for additional billing opportunities to allow for better coordination and discharge planning for those returning to the community from out-of-home placements such as Psychiatric Residential Treatment Facilities (PRTFs) and Inpatient Psychiatric Hospital units. ADMH continues to work closely with Medicaid to ensure outcome measures for these services are closely monitored and to make any needed changes based on this data.
• COVID-19: During COVID-19 and the federal expansion of use of tele-health during the pandemic, ADMH collaborated with AMA to expand the use of telehealth services. ADMH developed a telehealth workgroup, in collaboration with AMA that expanded the use of telehealth as part of the treatment modalities, which led to smoother transition in March 2023 when the Public Health Emergency (PHE) was ended. ADMH worked with AMA to develop and implement the process needed to ensure telehealth could be continued as a viable treatment services and case management service through our contract providers for the consumers were serve who are SMI and/or SED. AMA now covers telepsychiatry services under the Physician's Program in addition to the Rehab Option and Targeted Case Management. The COVID-19 pandemic provided the opportunity to expand Tele-health which includes

the use of tele-connectivity for treatment services that include outpatient services, evaluations, peer services, outreach services, to name a few.
• CMS Crisis Mobile Planning Grant: To transform mobile crisis care in our state, the Alabama Department of Mental Health and the Alabama Medicaid Agency received a CMS State Planning Grant for Mobile Crisis Services grant in FY22, and a year extension, allowing for further work with community mental health centers on this essential service within Alabama's Crisis System of Care. The grant and its work with providers, facilitated by VitAL, of The University of Alabama, assists in increasing the quality of care of all mobile crisis teams to ensure standardization for practices and procedures. ADMH works directly with the providers to provide technical assistance and guidance to ensure their program development is connected to the statewide crisis system of care and tailored to the specific needs of their communities, especially rural areas. ADMH worked with AMA to submit to CMS for a new funding stream for Mobile Crisis Team services through a State Plan Amendment. This was approved by CMS in December 2024, being retroactive to October 1, 2024. ADMH continues to work with AMA on needed processes for implementation and roll-out.
• Certified Community Behavioral Health Clinic (CCBHC): Alabama is transitioning to this new, integrated business model of mental health care. CCBHCs began in the state's community mental health centers, with the awarding of a 2021 SAMHSA grant to two community mental health centers (CMHCs) to implement CCBHC model for care delivery. Over FY23, Alabama's CMHCs and the ADMH completed assessments to determine their preparedness for the development and implementation of the CCBHC integrated behavioral healthcare business model with high-quality care, practices, and reporting measures. On March 16, 2023, SAMHSA awarded ADMH a CCBHC Planning Grant in the amount of one million dollars to develop statewide certification criteria for CCBHCs. Within the year-long period of the grant, the ADMH worked closely with Alabama's CMHCs to plan a comprehensive behavioral healthcare business model to reduce health disparities; improve access to care for marginalized communities; and develop a payment system that will reward quality over volume. The CCBHC model will also improve integration, reduce silos, and support a sustainable and well-trained behavioral health workforce. A transition to the CCBHC business model will ensure statewide expansion of and access to mental and physical healthcare. Alabama was then selected as one of ten states for the Certified Community Behavioral Health Clinic (CCBHC) Medicid Demonstration Program by the US Department of Health and Human Servies (HHS) in partnership with SAMHSA in 2024, with implementation of the first two sites occurring in July 2024. This opportunity will allow ADMH, in partnership with the Alabama Medicaid Agency (AMA), to begin the process to transition our 19 Community Mental Health Centers (CMHCs) to the CCBHC business model. This demonstration will allow ADMH, AMA, and our contracted providers to shift to more sustainable funding to increase access to mental health and substance use treatment through the CCBHCs. Successful implementation of CCBHCs will provide improvements in 24/7 access to quality care, workforce capacity, and improved consumer outcomes. CBHCs integrate mental health and substance use treatment with physical health care, adhere to rigorous quality and accountability standards, and work to remove barriers to treatment. Benefits also include, but not limited to, reducing homelessness and decreasing diversion to hospitalization. The model also increases the availability of crisis intervention services and evidence-based/promising practices. This initiative builds on the ADMH Alabama Crisis System of Care, which includes crisis services throughout the state.

Alabama Department of Public Health (ADPH):
The purpose of the ADPH is to provide caring, high quality and professional services for the improvement and protection of the public's health through disease prevention and the assurance of public health services to resident and transient populations of the state regardless of social circumstances or the ability to pay. The ADPH works closely with the community to preserve and protect the public's health, to provide caring, quality services and serve the people of Alabama by assuring conditions in which they can be healthy. The ADMH works collaboratively with the following programs within ADPH.

• The Office of Primary Care and Rural Health:
The Office of Primary Care and Rural Health facilitates and participates in activities to improve access to health care services for all rural Alabamians with special concern for children, the elderly, minorities and other medically underserved vulnerable populations. They serve the following populations: Communities, Rural Health Clinics, Critical Access Hospitals, Small Rural Hospitals, Federally Qualified Health Centers, County Health Departments, Physician Practices, and Mental Health Centers. ADMH staff work closely with this Office in the designation of Health Manpower Shortage Areas and the placement of J-1 Visa physicians in mental health centers and state hospitals. ADMH partnered on a grant application that provided matching funds for placements of physicians and other mental health providers. Unfortunately, the 50% match requirement proved to be a significant barrier in times of declining funding.

• Children's Health Insurance Program (SCHIP)/ALL Kids:
ALL Kids provides low-cost healthcare coverage for Alabama's children and teens whose family incomes are above Medicaid eligibility, but below 300 percent of the Federal Poverty Level. ALL Kids comprehensive benefit package covers regular check-ups, immunizations, sick child doctor visits, prescriptions, dental and vision care, hospital and physician services and mental health and substance abuse services. Additional medical services may be available for children with special needs. Blue Cross and Blue Shield of Alabama worked with ALL Kids to become compliant with Mental Health Parity and initiated new provisions, effective October 1, 2010. Essentially, limits for mental health related services have been removed as necessary to be comparable with medical services provided through the ALL Kids Plus benefit package which had previously been limited only to those who exceeded the Basic benefit package. As required by the ACA, effective January 1, 2014, 22,939 ALL Kids enrollees were transitioned to Medicaid. This group is referred to as MCHIP. ADMH participated in the transition planning process to ensure transitioning enrollees received needed behavioral health services without interruption. This MCHIP group covers uninsured children from 6 up to age 21 with family income between 107 and 146 percent of the federal poverty level. ALL Kids is Mental Health Parity compliant as well as meets the ACA preventive services requirements. ADMH has collaborated with ALL Kids to cover additional services implemented as part

of the EPSDT Settlement Agreement. ALL Kids has been receptive to ensuring the coverage offered through the SCHIP program is comparable to coverage provided through Medicaid.

Primary Health Collaborations:

Alabama Primary Health Care Association (APHCA):
The APHCA was established in 1985 as a non-profit, professional trade association whose mission is to strengthen and expand Alabama's community health center network through service, technology, partnerships, advocacy and education so that Alabamians have access to quality primary health care. APHCA is governed by a Board of Directors comprised of one voting delegate from each organizational member and four non-voting representatives from the associate membership. As the voice for Alabama's community health centers (CHC), medically underserved and uninsured populations, APHCA is dedicated to the promotion of high-quality, family-oriented, culturally competent health care. APHCA represents the program, policy, and operational interests of approximately 166 community-based health care centers providing almost one million primary care visits to over 350,000 individuals across Alabama.

Over time, staff of the APHCA has met with ADMH staff, the Executive Directors, and Clinical Directors of the provider networks to initiate the collaborative process. Additionally, information regarding the new Health Resources and Services Administration Access Point and Capacity Expansion grants has been shared with mental health centers who are encouraged to work with the local Federally Qualified Health Center (FQHC) to develop joint applications. APHCA was a primary partner in the development and implementation of the Transformation Transfer Initiative, the foundation of which was improved collaboration between primary and mental health partners. Meetings continue to occur between FQHCs and CMHCs Executive Directors for the purposes of strengthening collaborations at a local level.

The ALAAP is the only statewide member organization of pediatricians, with 850 members across the state, representing both academic and community pediatrics in both urban and rural areas. Alabama's pediatricians serve as the first line of healthcare for children across the state and are many times the only professionals that many of the state's children come in contact with during their formative years. ALAAP Chapter members have an active voice on every state committee or collaborative effort whose mission is to serve the interests of children. The organization is a non-profit 501(c) 3 organization, operated by a volunteer board of directors and executive staff located at a central office in Montgomery.

ADMH has had a long-standing collaborative relationship with ALAAP. Throughout the past several years, ALAAP and ADMH, along with other state and community partners, have directly collaborated on several initiatives.
• In early 2015, ALAAP began a five-year partnership with ADMH and the Alabama Partnership for Children as a sub-grantee for Project LAUNCH (Linking Actions for Unmet Needs in Children's Health). The purpose of Project LAUNCH is to promote the wellness of young children from birth to eight years by addressing the physical, social, emotional, cognitive and behavioral aspects of their development. Alabama's Project LAUNCH is building on the vision of the Early Childhood Comprehensive Systems (ECCS) plan (Blueprint for Zero to Five), and other successful collaborative efforts to integrate programs that provide a complete range of developmentally supportive services to families with young children, and to expand and enhance evidence-based programs related to children's healthy development. The local implementation area for the grant was Tuscaloosa County. Upon the conclusion of the grant, ADMH continues focus on services to this population. The core strategies include:
o screening and assessment of young children – through the state Help Me Grow initiative training and support for primary providers (health care, early education, and home visiting) to use the ASQ-3/SE at regular intervals; develop a single point of referral and information and improve the roadmap for referrals; enhance 2-1-1 and Parenting Assistance Line for seamless and appropriate referrals; gather and analyze data to improve referral systems and identify service barriers
o integration of behavioral health into primary care settings – expanding the use of Social and Emotional Foundations of Early Learning materials and resources; technical assistance, training, and mentoring; training and resources to implement the ASQ-3/SE and appropriate referrals in primary care settings
o mental health consultation in early care and education, including training and mentoring for diverse early learning settings; improved access to needed interventions; and broad understanding of the social and emotional needs of young children and the negative impact of adverse childhood experiences
o enhanced home visiting with focus on social and emotional well-being by providing training and mentoring to existing and new home visitation programs; expanding evidence-based family strengthening and parent skills training – expanding and enhancing the Strengthening Families Initiative to the local implementation area including community training and resources; parent cafes; improved access to resources; parent leadership training and engagement; building family and community strengths to improve resiliency.

Alabama Hospital Association (ALAHA):
Founded in 1921, the Alabama Hospital Association (ALAHA) is a statewide trade organization that assists member hospitals in effectively serving the health care needs of Alabama, through advocacy, representation, education and service. Members of the association include primarily hospitals and health systems, as well as other companies and organizations related to health care. The Alabama Hospital Association provides advocacy and representation for its more than 100 hospital members, promoting a stable and cost-effective environment for hospitals and their patients.

Over the last several years, staff of the ALAHA has met with ADMH staff, the Executive Directors, and Clinical Directors of the provider networks to initiate the collaborative process. ADMH primarily works with the Psychiatric Section of ALAHA and has

focused on developing a care coordination system that would bridge the private and public sector, bridge outpatient and inpatient care, and improve coordination with DMH Commitments. ADMH and ALAHA have partnered through the state hospital closure process and have been direct partners with some of their members choosing to contract with ADMH's contract community mental health centers to serve committed patients. ADMH and ALAHA have worked especially close on all the areas of Medicaid reform over the years as the hospitals are the primary drivers of this system. ADMH worked with ALAHA and its members to implement a utilization process linked to committed patients and appropriate resources needed for diversion. ADMH continues to work closely with ALAHA through the Crisis system redesign and the components linked to these efforts. During FY 23, ALAHA invited representatives from each service area of ADMH (mental illness, developmental disabilities, autism services, and substance use) to meet with representatives from each of the ALAHA regions. These meetings allowed for the sharing of resources and increased collaboration for both adults and children/adolescents.

Interagency Collaboration:

ADMH works collaboratively with other local and state adult and child serving agencies to develop systems that would integrate social services, education and criminal and juvenile justice with mental health services as to develop a more comprehensive system of care in the community. A variety of avenues have been utilized in the ongoing attempts to provide a system of integrated services. For child and adolescent services, in 1986, an interagency agreement creating the Interagency Council on Youth (ICOY) was signed by all five-state child-serving agencies to cooperate on improving services to children. From that time, several noteworthy interagency collaborations have been created not only between ADMH and a singular state agency, but with multiple agencies collaborating in conjunction. The early foundation of interagency collaboration seems to have paved a path that has allowed for expansion and enhancement of mental health services in a more creative process. However, the recognition is that much more is needed in the area of interagency collaboration to move to true transformation and restructuring of a system of care for adults, children/adolescents, and their families.

Criminal Justice Services:

ADMH fosters collaborations with those in law enforcement, judiciary, and corrections at both state and local levels. ADMH was the recipient of a Bureau of Justice Assistance grant to improve coordination of services. Dr. Ron Cavanaugh, the Director of Treatment for Alabama Department of Corrections has engaged ADMH and the Council of Community Mental Health Boards to discuss the service needs and resources of prisoners who have reached end of sentence or who qualify for parole. In FY11, the Community Mental Health Clinical Directors hosted a number of Dr. Cavanaugh's treatment staff to address issues around access and care coordination for inmates being released from prison. One challenge faced by both ADOC and ADMH are inmates who are at end of sentence but for whom ADOC feels are too symptomatic to be maintained in the community. Many individuals who fall within this description often end up being admitted into the State Psychiatric System and often pose barriers to community integration due to criminal history, sex offender status, and/or limited or no financial resources.

In FY12, the ADMH and ADOC Commissioners brought together key decision makers of their staff to explore avenues to strengthen the care coordination and transition between our systems. The primary area of focus was on End of Sentence (EOS). There are two distinct paths that involves mental health inmates: 1) Re-entry 2) EOS ADMH Commitment. About EOS ADMH Commitment, through the probate commitment process, inmates may be committed to ADMH for treatment to stabilize their condition and then returned to ADOC for continued serving of the sentence. Individual who are approaching the end of their sentence, and who have mental health disorders, and are determined to need continued treatment upon release from prison can be probate committed to ADMH for inpatient treatment at the time their sentence expires. Review of the data for these type commitments over the last 11 years has shown that many of these individuals are treated and discharged to community placements after relatively brief periods of inpatient treatment. This data review has led to the development of a protocol process that can streamline this process and make better use of community resources where by mentally ill inmates can be triaged prior to the End of Sentence (EOS) date and linkages to community providers established for after-care and assistance with transition into the community. It is expected that this will reduce or eliminate the need for EOS commitments to state hospitals. In regard to Re-entry, ADMH has involved the community providers in this effort, and this remains an area that needs further assessment as to strengthen and develop a more formalized process.

With the Department of Correction lawsuit and Alabama's focus on Prison Reform, ADMH has been working with ADOC and the Alabama Board of Pardons and Parole (ABPP) on areas that pertain to mental illness and substance abuse. Key staff within ADMH from both mental illness and substance abuse worked within a workgroup that focused on several tasks. One tasks that got approved with the use of statewide screening tools. The UNCOPE was approved for substance abuse. The Correctional Mental Health Screen (CMHS) was approved for mental illness. There are two versions as to focus on gender specific – Correctional Mental Health Screen for Men (CMHS-M) and the Correctional Mental Health Screen for Women (CMHS-W). ADMH staff agreed to train all adult probation officers on the use of these approved screening tools, as well as mental health and substance use/abuse services and resources. Three trainings have been conducted in 2017.

ADMH senior leadership is currently engaged in several transformative areas of discussion as to explore and determine next best efforts for collaboration as it pertains to Crisis system redesign and other areas of focus that would allow the system to be improved as it pertains to individuals with significant mental health and substance use issues. This has been extended to also have a focus on re-entry and housing needs.

Juvenile Justice/Alabama Department of Youth Services (DYS):

In 1987, an interagency agreement was negotiated and signed with the state's juvenile justice system, Department of Youth Services (DYS). This agreement governed the referral and assessment of problematic cases, which in the past had frequently resulted in protracted legal battles.

ADMH and DYS have been collaborating for many years. Collaborations have included, but are not limited to, the following:

An Interagency task force called the Commission on Girls and Women in the Criminal Justice System. Established by a joint

legislative resolution in 2006, the commission is studying the conditions, needs, issues, and problems of the criminal justice system in Alabama as it affects girls and women. The commission issued its recommendations in October 2007. In 2008, a Phase II/New Legislative Resolution occurred to extend the work of the Taskforce so that this group could oversee the implementation of recommendations.

In 2007, an effort was made to continue to implement the strategic plan of the 2004 National Policy Academy on Improving Services for Youth with Mental Health and Co-Occurring Substance Abuse Disorders and bring together the efforts of other such initiatives currently underway in Alabama. ADMH partnered with DYS and two local counties (Jefferson and Morgan) to make application for the Models for Change Mental Health/Juvenile Justice Action Network sponsored by the MacArthur Foundation and coordinated by the National Center for Mental Health and Juvenile Justice. This grant application was not selected.

For the past decade, the Annie E. Casey Foundation and counties around the country have focused on investing in a process called the Juvenile Detention Alternatives Initiative (JDAI). They set out to show that local jurisdictions could establish more effective and efficient systems that could safely reduce reliance on secure detention. The JDAI model has proven to be cost effective, improve public safety, improve efficiency, and promote good administration. JDAI is a process, not a conventional program, whose goal is to make sure that locked detention is used only when necessary. In pursuing that goal, JDAI restructures the surrounding systems to create improvements that reach far beyond detention alone. JDAI's primary target is youth who are in detention or at-risk to be detained in the future. With the vision of key leaders in Alabama, to include the previous Governor and previous Chief Justice, as well as strong advocacy from DYS, Annie E. Casey Foundation entered a partnership to strengthen juvenile justice in the state. In April 2007, a team of experts from the Casey Strategic Consulting Group provided technical assistance in Alabama. The introduction of JDAI in Alabama started in four counties – Jefferson, Montgomery, Mobile, and Tuscaloosa. In 2008, ADMH was invited by the two of the four local JDAI sites (Jefferson and Montgomery) to participate on the Executive Committee.

In 2017, Alabama formulated the Alabama Juvenile Justice Task Force. The charge of the Task Force is to develop proposals for reform. The priorities of will be to promote public safety and hold juvenile offenders accountable; control taxpayer costs; and improve outcomes for youth, families, and communities in Alabama. The Task Force's recommendation will be used as the foundation for statutory, budgetary, and administrative changes during the 2018 legislative session. One of the Task Force members is the Commissioner of ADMH and her designee. The Pew-MacArthur Charitable Trust was invited into Alabama to assist with this process. Prior to entering Alabama, Pew had completed a similar process with Juvenile Justice focus in seven other states. June 2017 was when the first meeting of the Task Force convened and there will be a total of six meetings. DYS is the lead, and they are conducting a series of roundtable discussions around the state. One such roundtable included subject matter experts from community mental health providers and ADMH mental illness children's staff. The final report was completed in November 2017.

Administrative Office of the Courts (AOC):

AOC is charged with providing centralized, state-level administrative support necessary for the operation of the State's court system; the development of procedures and systems to enhance the operational capacity of the courts; and the collection and dissemination of information necessary for the development of policies to promote the more efficient operations of the courts. The major programs for which the Administrative Office of Courts assumes responsibility are: finance; personnel services; judicial education; legal research and assistance; automated program design and site implementation; imaging; inventory control; records and space management; judicial assignments; jury and case management; time standards and statistical data; uniform traffic ticket and complaint supply and accountability; magistrate appointment and education; trial court assistance; child support enforcement; Juvenile Court assistance; court referral programs; drug court and other problem-solving specialty courts and court planning.

ADMH and AOC have been collaborating for many years. Collaborations have included, but are not limited to, the following:

In 2006, ADMH partnered with the AOC and received a grant to establish an Adult and Adolescent Mental Health/Juvenile Task Force. The task force(s) completed a needs assessment on the state and a gap analysis that led to the development of recommendations in a strategic plan. Many of the participants of the 2004 National Policy Academy participated on the Juvenile Task Force of this initiative. This grant ended in November 2007. However, the state applied for a Phase II funding for the Justice and Mental Health Collaboration Program which was submitted by ADMH This application was not awarded.

In FY06, there was a proposed revision to the Alabama Juvenile Code of 1975. In April 2006, the Bill did not make it out of legislative committee. However, a Juvenile Code Legislative Subcommittee was appointed, with the development of specialized subcommittees to include a Mental Health Subcommittee. Primarily, the proposed revisions were to provide updates and clarify old terminology with emphasis on the delinquent statutes being in line with Federal regulations. In the 2007 Regular Legislative Session, a revised bill was introduced. That bill came out of committee but did not reach a vote in either House. During 2007, a concerted effort was made to again review the bill with all of the interested groups and entities, along with the Alabama Law Institute. During this period, the bill's provisions were again revisited and revised to meet the concerns of the different groups and interests. In 2008, the draft legislation was once again presented, and the Juvenile Justice Act of 2008 was signed into law by the Governor on May 8, 2008. While most of the changes in the law are procedural or involve only reorganization and clarification of current law, there are some changes that may impact each of the respective agencies (mental health, child welfare, education, juvenile justice). In an effort to assist partnering agencies, AOC organized meetings to discuss different state agency's training needs and ways that AOC may assist in meeting those needs. These efforts continued into FY09 with identified training needs developed and implemented to ensure agencies and communities were aware of changes as the Act became effective in two phases, January 2009 and October 2009.

Also, during the FY09 legislative session, HB 559, the amendment to the Juvenile Code, was signed by the Governor on May 21, 2009. This Act affirms the ADMH Commissioner's ability to designate a hospital/facility outside of the Department to provide services to minors and children with SMI or intellectual disabilities and to place these minors and children who have been committed to the department in said hospital/facility. It would also clarify the timeframe intended in the code as the necessary

amount of time needed in notifying the department of final commitment hearings. These changes are in line with the recommendations of the Child and Adolescent Workgroup of the Systems Reconfiguration Task Force. An internal workgroup has been charged with drafting recommended language for a Request for Proposals process by the MI Associate Commissioner and ADMH Commissioner as to work toward complying with recommendations of the System's Reconfiguration Request for Proposals (RFP) regarding Bryce Adolescent Unit was issued August 2009. University of Alabama-Birmingham (AUB) Hospital's RFP was selected. A contract transferring the operation of the Adolescent Unit from Bryce Hospital to the University of Alabama in Birmingham Department of Psychiatry and Behavioral Neurobiology was signed. The transfer was effective in October 2010.
ADMH submitted a joint application with AOC for a Department of Justice Planning and Implementation grant in 2009. The proposal focus was to establish design and outcome criteria for Juvenile Mental Health Courts. There has been increasing interests in mental health courts for juveniles and a few counties in Alabama have begun to provide diversion and alternative mental health programming through such mechanisms. The grant proposal would attempt to bring uniformity in the operation of these and any new courts so that their effectiveness can be compared and generalized across Alabama. In FY10, ADMH received this Planning and Implementation Grant from the Bureau of Justice Administration (BJA) to develop an evaluation component mechanism to evaluate mental health courts (adult and juvenile) in Alabama. The grant provided training and technical assistance opportunities to the state and various jurisdictions on public safety and treatment outcomes of individuals involved in mental health courts. The grant supported the development of a toolkit for courts and treatment providers to use and improved capacity to collect relevant data to determine outcomes within and across jurisdictions. The collaboration hosted the two-statewide mental health court conferences in 2010 and in November of 2011.
In FY23, AOC conducted a Judicial Mental Health Stakeholders meeting in an effort to pull involved partners together to determine strategies for treating individuals within shared systems. As the Judicial System attempts to tackle the backlog of court cases, Covid-19 restrictions, and issues surrounding the over-crowded jails and prisons, it was felt they had overlooked two important factors that have contributed to the court's disparity in addressing the needs of defendants: Mental Health Illnesses (MHI) and Substance Use Disorders (SUD) equal Co-occurring Disorders (COD). The Judicial Mental Health Stakeholders Committee's goal is to address the needs of citizens who are involved in the Criminal Justice System with Mental Health Illnesses and Substance Use Disorders while developing prevention and early intervention strategies. The vision is to provide services through treatment, counseling, and psychosocial programs that offer people an opportunity to live fulfilling, healthy, and productive lives. The goal is for all of us to work together to make this vision a reality. Training, education, and technical assistance was determined to be the area of initial focus. Throughout FY23, ADMH staff have partnered with AOC to provide these requested trainings, education, and technical assistance in an effort to broaden knowledge of resources available, assist in making linkages and relationships amongst the local entities, and evaluate gaps in the system and work on creative ideas to better connect the systems of care with a heightened focus on care coordination and bi-directional care. These efforts were carried into FY24/FY25, but expanded its focus to coordinated projects based on community needs with our shared target populations, such as expanding the Stepping Up case management program and establishing specialty mental health teams that bridge and coordinate treatment and care.

Education, Rehabilitation, and Employment:
Alabama Department of Rehabilitation Services (ADRS):

The mission of ADRS is "to enable Alabama's children and adults with disabilities to achieve their maximum potential." Created by the Alabama Legislature in 1994, the Alabama Department of Rehabilitation Services (ADRS) is the state agency that serves people with disabilities from birth to old age through a "continuum of services." As such, ADRS is a valued partner.
Case managers and clinicians from the mental health centers work with local educational institutions and Vocational Rehabilitation Services offices to refer consumers for education and employment services. Consumers are often provided basic educational and pre-employment services in day and residential programs. Outpatient consumers are referred to local GED classes and/or institutions of higher learning such as community colleges and universities based on the consumers' interests and abilities. Providers work with local the Rehabilitation Services office to refer people for regular rehabilitation services as well as VR supported employment.
ADMH acknowledges employment is an essential element to Recovery. Both the Mental Health & Substance Use Division and the Intellectual/Developmental Disabilities Division host employment initiatives.
In partnership with ADRS, the Office of MI Community programs has pursued the integration of employment within the mental health continuum. Preliminary work in this area was provided by an Employment Development Initiative grant which engaged provider and consumer networks about the barriers towards employment. The EDI grant sponsored Peer Support Specialist training, a statewide stakeholder strategic planning event, and a series of educational and motivational workshops: Work Works: An Essential Component to Recovery, conducted by George V. Nostrand, self-advocate and professional Employment Counselor.
In 2014, ADMH and ADRS collaboratively pursued SAMHSA Grant funding specific to supported employment. ADMH was one of seven states awarded the SAMHSA Transforming Lives through Supported Employment 5-year grant. Funds created state infrastructure for a dedicated Supported Employment Trainer/Coordinator. This position is responsible for the implementation of the evidence-based supported employment model (Individual Placement & Support). This model focuses on creating competitive employment opportunities for individuals with serious mental illness. Two pilot sites were selected (one in an urban location and one in a rural setting). A third site expanded IPS services during the grant period. Peer services are an integral component of the Alabama model of IPS. IPS teams engage in recruitment and education activities within host mental health agencies for the purposes of promoting employment as integral to the recovery process. Post grant, pilot and expansion sites achieved sustainability. In 2023, ADMH was awarded a second SAMHSA Transforming Lives through Supported Employment 5-year grant for further expansion of IPS supported employment. ADMH and ADRS work cooperatively to identify and develop practices and policies necessary for the appropriate implementation of the IPS model.

Alabama State Department of Education (ALSDE):
ADMH appreciates a long-standing collaboration with the Alabama State Department of Education (ALSDE) stemming back to 1999. ALSDE is responsible for educational services for children/adolescents in Alabama, and there are over one hundred fifty public school systems in the state. For numerous years, care coordinators/managers, in-home intervention teams, and outpatient clinicians employed by the Community Mental Health Centers (CMHCs) have had frequent contact with the educational system on behalf of children with a serious emotional disturbance and their families. Since 1999, the two agencies have collaborated to blend funds and resources on projects that began with day treatment programs and now extended into an integrated, school-based project, School-Based Mental Health (SBMH) Collaboration.
From FY 12 to date, all 19 community mental health centers (CMHCs) of Alabama and more than 120 Local Education Authorities (LEAs) have conducted initial orientation meetings with ADMH and ALSDE to discuss the SBMH collaborative process. Of these, all 19 CMHCs have partnered with at least one School System in their catchment area to implement the SBMH Collaborative program. Currently, 18 of the CMHCs have active, formalized agreements with 116 School Systems as SBMH Collaboration Partners. The SBMH model improves access to appropriate mental health services for children in need of therapeutic interventions by placing a master's level clinician in the school setting in a structured manner that ensures confidentiality while enhancing mental health service delivery. ADMH and ALSDE continue to jointly promote the School Based Mental Health Collaboration across the state and have presented workshops on SMBH at ALSDE's MEGA Conference and Transition Conference. Data from the SBMH Partner CMHCs and School Systems is gathered and analyzed by ADMH and ALSDE on a regular basis throughout the school year. Aggregate data is presented to all active SBMH partners during an annual meeting in order to inform state as well as local level decisions on mental health service needs for school age children.
ADMH feels that by implementing this promising practice, a system can be developed that ensures a more preventive effort to integrate a seamless system of mental health care in educational settings. All of this is in an effort to provide treatment that is more holistic and, in a way, to build strength and resiliency for young people personally and with their educational successes. Initially no additional funds were provided to the CMHCs or School Systems to implement this practice. Through the dedication of CMHCs and School Systems to serve students, the initial SBMH Collaboration services were developed with existing limited resources. After the school shooting in Parkland, Florida in February 2018 and with a national focus on increased services in the school setting, the Alabama Legislature appropriated $500,000 in FY 19. These funds assisted with the expansion to 9 additional School Systems that did not have the resources available to implement SBMH Collaboration services previously. The Alabama Legislature appropriated an additional $500,000 in FY20, $750,000 in FY21, $750,000 in FY22, $1,000,000 in FY23, $1,000,000 in FY24, and $1,000,000 in the upcoming FY26 to further expand the SBMH Collaboration and support existing SBMH programs. No additional funds were provided during FY 25; however, on-site visits by ADMH and ALSDE with several of the CMHCs and LEAs were implemented to help identify strengths and barriers with the goal of improving the overall program. With the continued national focus on providing proactive services in the school, ADMH continues to ask for additional funds to expand this promising practice throughout the State.
In 2020, ALSDE developed the Mental Health Service Coordinator (MHSC) position with input from ADMH. The MHSC position is employed by the LEA and is tasked with increasing mental health awareness, mental health prevention, and early intervention in the school setting. The MHSC is also instrumental in recognizing early symptoms and warning signs for mental health issues, then assisting with linking to the SBMH Collaboration therapist or other appropriate providers for therapeutic interventions. The program was implemented with approximately 2/3rds of the LEAs at the start of the 2020-2021 school year and is now available in all LEAs throughout the state. A requirement for all MHSCs is completion of a set of ADMH developed training modules and ongoing education provided by ADMH on mental health resources and supports.

Social Services/Department of Human Resources (DHR):
The Social Service agency in Alabama is the Department of Human Resources (DHR). Collaboration with DHR occurs at the local and state level to include direct care, blended services, training efforts, coordination, and planning. Social services provided for this population does include in-home and community-based care that can be provided by or linked by In-Home Intervention Teams and care coordination services.
In 1988, ADMH entered into an agreement with DHR to jointly fund three Family Integration Network Demonstration Projects (FIND). These projects consisted of in-home intervention and case management operated through a CMHC. The FIND programs served children with serious emotional disturbances and their families who are generally involved with multiple agencies. This partnership provided valuable information and outcome measures to assist ADMH in growing home-based services statewide. With the implementation of the EPSDT Settlement Agreement, the DHR funding was replaced with funds dedicated to ensuring the implementation of all EPSDT home-based services. Through the Settlement Agreement, every community mental health center catchment area has a least one designated children's care coordinator and in-home intervention team in each county served. Children and adolescents may also receive care coordination from qualified CMHC staff who has been cross trained in the delivery of care coordination to both adults and youth.
Since this first cooperative funding venture with DHR in 1988, the two agencies (ADMH and DHR) funded the University of Alabama Brewer Porch Short Term Treatment and Evaluation Program (STTEP) and Glenwood's Daniel House. STTEP was designed to provide evaluation and short-term treatment for children (ages 6 to 12) who had previously been hospitalized or were at risk of hospitalization. In FY 23, DHR ceased funding STTEP; however, ADMH was able to provide the additional funding to allow this program to continue. In June of 2024, the University of Alabama made the decision to close the Brewer Porch facility programs including the STTEP Unit. ADMH was able to retain the funds dedicated to this program and is currently in the process of finalizing the contract with another provider to operate a new STTEP Unit. Historically, Glenwood Daniel House provided residential treatment for children who would frequently have been placed in an inpatient unit or in a residential program that

would not encourage family involvement. In 2007, ADMH and DHR re-crafted this joint collaboration to allow for the contracting of beds in three of Glenwood's premier programs. Daniel House I and Daniel House II were residential treatment programs that served the most severe SED youth and their families, ranging from age six to fourteen. The contract changes allowed for contract beds in the short-term assessment program, Glenwood Drummond Center II. This 90-day assessment program alleviated the overuse of acute units for inpatient assessment needs and provided thorough recommendations as to assist family members and communities in providing more appropriate treatment. Admissions to these programs were jointly screened by the agencies involved. In FY09, due to budget issues and restructuring of their service system, Glenwood Drummond Center II was closed but the collaboration continued with the other programs. In June of 2025, Glenwood made the decision to close both Daniel House I and Daniel House II. Glenwood has re-opened the Drummond Center to provide services to co-occurring youth with both an SED and Intellectual Disability. The individuals served by this program often have involvement with both ADMH and DHR due to their complex needs.

DHR is one of the state agencies listed in the EPSDT Settlement Agreement. All parties continue to work closely together in the areas of implementation of intensive in-home services as outlined in the settlement agreement.

State Multiple Needs Childs Office:

A Joint Task Force of DHR and ADMH was established in 1991 to address problematic interagency issues. The Task Force established subcommittees to work on conflict resolution procedures, cross-agency training, promotion of coordination at the local level, and planning for future needs. In 1993, the Alabama Legislature passed the amendments to the Juvenile Justice Act, otherwise known as the Multi-need Child Legislation. Patterned after the "clusters" in Ohio, the Act required the establishment of a State Facilitation Team, and facilitation teams in each of Alabama's 67 counties. At a minimum, the agencies mandated to participate include Education, Human Resources (child welfare), Public Health, Mental Health, and Youth Services (juvenile justice). The Multiple Needs Child Act is for children who need services from two or more agencies and are at risk of out-of-home placement or movement into a more restrictive environment. These children's needs are often multifaceted and require intensive collaborative efforts and service coordination from the childcare agencies. Currently, the local teams and the state team meet monthly to discuss programmatic and funding issues in an effort to effectively serve the neediest children in the state. The local Multineeds teams utilize the provision of social services to assist the consumer and their family with maintaining community level of care in the efforts to avoid out of home placement. The Mental Illness Division continues to support maintenance of effort of $1 million each year to cover youth through the multiple needs process.

OUR Kids:

The OUR Kids Initiative which began in 2002 is a collaboration between DYS, ADMH, and DHR to serve children and families that have needs that cross each agencies area of responsibility. Our Kids has become an example of Interagency Collaboration to serve children and adolescents in their communities. The OUR Kids initiative has been noted by federal reviewing authorities from each department as a good example of interagency collaboration. (Ex. Child and Family Services Review, Mental Health Block Grant, SAMSHA, and the National Center for Mental Health and Juvenile Justice.)

The three state agencies equally contribute funds (most of it is Children First Dollars) to support specific programs selected through a joint competitive Request for Proposal (RFP) across the state. In order to respond and be eligible for funding, a provider must demonstrate the need for a specific service, the coordination and support of the partners in the county or area, and assure it is not duplicative of other services in the area.

Since 2002, specialized services, not previously available, to targeted populations have been provided through this initiative. The departments have supported community-based programs for children identified as CHINs; aftercare services for children discharged from DYS with mental health needs; intensive specialized services for children with mental health and DHR involvement; and intensive services for children with lower cognitive functioning.

In FY21, a decision was made by the three agencies to issue a RFP every three years to ensure the programs are addressing the current needs of children and adolescents of Alabama. Seven programs were awarded funding for FY22 through FY24 to meet the needs of this population. Ten programs were awarded funding for FY25 through FY27, three of these programs were previously funded during the FY22 cycle with the remaining seven programs being new. Representatives from all three agencies are actively involved in the monitoring and data analysis for these programs. At the end of FY25 Quarter 3, the three agencies jointly decided to terminate the funding for one of the ten programs due to no services being provided to youth during the previous nine months.

Children's Policy Council:

The Alabama Children's Policy Council (CPC) is a collaborative body designed to help improve the well-being of children and families statewide through policy development, community engagement, and service coordination. The CPC system originated from the Alabama Juvenile Justice Coordinating Councils and was established through legislation. The legislation created a state level Children's Policy Council co-chaired by the Secretary of the Alabama Department of Early Childhood Education (ADECE) and the Chief Justice of the Supreme Court of Alabama. All 67 counties also have a local Children's Policy Council dedicated to determining local needs. The county CPCs complete a needs survey their community on an annual basis. The state level CPC then reviews the surveys to make decisions at a statewide level. ADECE works closely with all of the child-serving agencies including ADMH to share the survey results to help inform policy and budget decisions based on the identified needs.

MI Planning Council:

Representatives from many of these organizations are members of, and actively participate on, the Alabama Mental Illness Planning Council (Please see Application Section: Environmental Factors: 14. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application and the Application Section: Behavioral Health Advisory Council Members - for Planning Council membership details). The MI Planning Council is tasked with the following responsibilities:

• Advise and assist in the development of the Mental Health Block Grant plans and reports.

• Reviewing and monitoring the Mental Health Block Grant and submitting to ADMH any recommendations for modifications.

- Prepare and submit a separate annual report of progress to the Governor.
- Promote and advocate for improved and innovative services for individuals in Alabama with serious mental illness.
- Participating in improving mental health services within the State.
- Monitoring the portion of the MHBG dollars reserved for Planning Council Special Projects.

To meet the requirements of providing a letter of support indicating agreement with the description of their role and collaboration with the SMHA, attached is letter of support from the MI Planning Council which represents the membership of collaborative partners.

4. Please indicate areas of technical assistance needs related to this section.

None at this time

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Footnotes:

Environmental Factors and Plan

14. State Planning/Advisory Council and Input on the Mental Health/Substance Use Block Grant Application – Required for MHBG, Requested for SUPTRS BG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in **42 U.S.C. §300x-3** for adults with SMI and children with SED. To assist with implementing and improving the Planning Council, states should consult the **State Behavioral Health Planning Councils: An Introductory Manual.**

Planning Councils are required by statute to review state plans and annual reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as advocates for individuals with M/SUD. States should include any recommendations for modifications to the application or comments to the annual report that were received from the Planning Council as part of their application, regardless of whether the state has accepted the recommendations. States should also submit documentation, preferably a letter signed by the Chair of the Planning Council, stating that the Planning Council reviewed the application and annual report. States should transmit these documents as application attachments.

Please respond to the following items:

1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g., meeting minutes, letters of support, letter from the Council Chair etc.)

2. Has the state received any recommendations on the State Plan or comments on the previous year's State Report?

a. State Plan ○ Yes ○ No

b. State Report ○ Yes ○ No

Attach the recommendations /comments that the state received from the Council (without regard to whether the State has made the recommended modifications).

3. What mechanism does the state use to plan and implement community mental health treatment, substance use prevention, SUD treatment, and recovery support services?

4. Has the Council successfully integrated substance use prevention and SUD treatment recovery or co-occurring disorder issues, concerns, and activities into its work? ○ Yes ○ No

5. Is the membership representative of the service area population (e.g., rural, suburban, urban, older adults, families of young children?) ○ Yes ○ No

6. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

7. Please indicate areas of technical assistance needs related to this section.

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Advisory Council Members

For the Mental Health Block Grant, **there are specific agency representation requirements** for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Mental Health Agency
State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Medicaid Agency

Start Year: 2026 End Year: 2027

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
No Data Available				

*Council members should be listed only once by type of membership and Agency/organization represented.
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Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2026 End Year: 2027

Type of Membership	Number	Percentage of Total Membership
1. Individuals in recovery (including adults with SMI who are receiving or have received mental health services)	0	
2. Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)	0	
3. Parents of children with SED	0	
4. Vacancies (individuals and family members)	0	
5. Total individuals in recovery, family members, and parents of children with SED	**0**	**0.00%**
6. State Employees	0	
7. Providers	0	
8. Vacancies (state employees and providers)	0	
9. Total State Employees & Providers	**0**	**0.00%**
10. Persons in Recovery from or providing treatment for or advocating for SUD services	0	
11. Representatives from Federally Recognized Tribes	0	
12. Youth/adolescent representative (or member from an organization serving young people)	0	
13. Advocates/representatives who are not state employees or providers	0	
14. Other vacancies (who are not individuals in recovery/family members or state employees/providers)	0	
15. Total non-required but encouraged members	**0**	**0.00%**
16. Total membership (all members of the council)	**0**	

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Environmental Factors and Plan

15. Public Comment on the State Plan – Required for MHBG & SUPTRS BG

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. §300x-51) requires, as a condition of the funding agreement for the grant, that states will provide an opportunity for the public to comment on the state Block Grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to the federal government.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

a) Public meetings or hearings? (●) Yes ( ) No

b) Posting of the plan on the web for public comment? (●) Yes ( ) No

If yes, provide URL:

mh.alabama.gov/public+comment

If yes for the previous plan year, was the final version posted for the previous year? Please provide that URL:

mh.alabama.gov/public+comment

c) Other (e.g. public service announcements, print media) ( ) Yes ( ) No

d) Please indicate areas of technical assistance needs related to this section.

None at this time

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Footnotes:

Environmental Factors and Plan

16. Syringe Services Program (SSP) – Required for SUPTRS BG if Planning for Approval of SSP

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Narrative Question:
Use of SUPTRS BG funds to support syringe service programs (SSP) is authorized through appropriation acts which provide authority for federal programs or agencies to incur obligations and make payment, and therefore are subject to annual review. The following guidance for the application to budget SUPTRS BG funds for SSPs is therefore contingent upon authorizing language during the fiscal year for which the state is applying to the SUPTRS BG.

A state experiencing, or at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, (as determined by CDC), may propose to use SUPTRS BG to fund elements of an SSP other than to purchase sterile needles or syringes for the purpose of illicit drug use. States interested in directing SUPTRS BG funds to SSPs must provide the information requested below and receive approval from the State Project Officer.

States may consider making SUPTRS BG funds available to either one or more entities to establish elements of a SSP or to establish a relationship with an existing SSP. States should keep in mind the related PWID SUPTRS BG authorizing legislation and implementing regulation requirements when developing its Plan, specifically, requirements to provide outreach to persons who inject drugs (PWID), SUD treatment and recovery services for PWID, and to routinely collaborate with other healthcare providers, which may include HIV/STD clinics, public health providers, emergency departments, and mental health centers. Federal funds cannot be supplanted, or in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

The federal government released three guidance documents regarding SSPs, These documents can be found on the **HIV.gov website.**

Please refer to guidance documents provided by the federal government on SSPs to inform the state's plan for use of SUPTRS BG funds for SSPs, if determined to be eligible. The state must follow the steps below when requesting to direct SUPTRS BG funds to SSPs during the award year for which the state is eligible and applying:

Step 1 - Request a **Determination of Need** from the CDC

Step 2 - Include request in the SUPTRS BG Application Plan to expend the funds for the award year which the state is planning support an existing SSP or establish a new SSP. Items to include in the request:

- Proposed protocols, timeline for implementation, and overall budget
- Submit planned expenditures and agency information on Table 16a listed below

Step 3 - Obtain SUPTRS BG State Project Officer Approval

Use of SUPTRS BG funds for SSPs future years are subject to authorizing language in appropriations bills, and must be re-applied for on an annual basis.

Additional Notes:

1. Section 1931(a(1)(F) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (**42 U.S.C.§ 300x-31(a)(1)(F)**) and **45 CFR § 96.135(a)(6)** explicitly prohibits the use of SUPTRS BG funds to provide PWID with hypodermic needles or syringes so that such persons may inject illegal drugs unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing injection drug use and the risk of HIV transmission to others. On February 23, 2011, the Secretary of the U.S. Department of Health and Human Services published a notice in the Federal Register (76 FR 10038) indicating that the Surgeon General of the United States had made a determination that syringe services programs, when part of a comprehensive HIV prevention strategy, play a critical role in preventing HIV among PWID, facilitate entry into SUD treatment and primary care, and do not increase the illicit use of drugs.

2. Section 1924(a) of Title XIX, Part B, Subpart II of the PHS Act (**42 U.S.C. § 300x-24(a)**) and **45 CFR § 96.127** requires entities that receives SUPTRS BG funds to routinely make available, directly or through other public or nonprofit private entities, tuberculosis services as described in section 1924(b)(2) of the PHS Act to each person receiving SUD treatment and recovery services.

3. Section 1924(b) of Title XIX, Part B, Subpart II of the PHS Act (**42 U.S.C. § 300x-24(b)**) and **45 CFR 96.128** requires "designated states" as defined in Section 1924(b)(2) of the PHS Act to set- aside SUPTRS BG funds to carry out 1 or more projects to make available early intervention services for HIV as defined in section 1924(b)(7)(B) at the sites at which persons are receiving SUD treatment and recovery services.

Section 1928(a) of Title XXI, Part B, Subpart II of the PHS Act (**42 U.S.C. 300x-28(c)**) and **45 CFR 96.132(c)** requires states to ensure that substance use prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to health services.

Syringe Services Program (SSP) Agency Name	Main Address of SSP	Planned Budget of SUPTRS BG for SSP	SUD Treatment Provider (Yes or No)	# of locations (include any mobile location)	Naloxone or other Opioid Overdose Reversal Medication Provider (Yes or No)
No Data Available					
Totals:		$0.00		0	

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Footnotes:

ADMH does not participate in any syringe service programs