Prevention Funding Allocation Model Strategic Plan

Division of Mental Health and Substance Abuse Services
Office of Prevention Services
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Table of Contents

List of Tables……4

List of Appendices……..5

List of Acronyms……6

Abstract……..8

Introduction…….……9

Assessment……..….10

A. Data Selection Process
B. Brief Profile of Selected Indicators
C. Prioritization Process

Capacity Building……..……...15

A. Areas Needing Strengthening
B. State and Community Level Activities

Planning……..…..……21

A. State Planning Model for Allocating Funds
B. Description of Community-Based Activities
C. Allocation Approach

Implementation ……..……..24

A. RFP Process for Sub-Grantees
B. Prevention Plans and Budgets
C. Technical Assistance
D. Community-level Implementation Monitoring

Evaluation……..…….28

A. Target for Change

B. The Process Evaluation
C. The Outcome Evaluation
D. Variables to Be Tracked
E. Evaluation Activities

Cross-Cutting Components and Challenges……..31

References……..…..32

List of Tables

Table 1: 310 Catchment Area Distribution by County.....12

Table 2: Alabama Identified Gaps and Solutions.....15

Table 3: Training Timeline.....18

Table 4: Funding Allocation Based on Regional Distribution.....22

Table 5: Incentive Distribution.....26

Table 6: Implementation Activity Timeline.....26

List of Appendices

Appendix 1: Office of Prevention Organizational Chart…….....33

Appendix 2: AEOW Members…….....34

Appendix 3: SPAB Members…….....36

Appendix 4: Data Sources…….....38

Appendix 5: Funding Allocation Amounts per County…….....40

Appendix 6: Z-Score Calculation Example…….50

LIST OF ACRONYMS

ADMH	Alabama Department of Mental Health
AEOW	Alabama Epidemiology Outcomes Workgroup
ALSDE	Alabama State Department of Education
ASAIS	Alabama Substance Abuse Information System
AYP	Adequate Yearly Progress
CAPT	Center for the Application of Prevention Technology
CHS	Center for Health Statistics
CSAP	Center for Substance Abuse Prevention
DMHSAS	Division of Mental Health and Substance Abuse Services Division
EBP	Evidence-Based Process
EBPP	Evidence-Based Program and Practices
MVA	Motor Vehicle Accidents
OBC	Office of Billing and Contracts
OCP	Office of Contracts and Purchasing
OIT	Office of Information Technology
OOP	Office of Prevention
PP	Prevention Plans
RFP	Request for Proposal
SAIPE	Small Area Income and Poverty Estimates
SAMHSA	Substance Abuse and Mental Health Services
SABG	Substance Abuse Prevention and Treatment block grant
SIG	State Incentive Grant

SMVF	Service Members, Veterans, and Their Families
SPAB	State Prevention Advisory Board
SPF	Strategic Prevention Framework
SSA	Single State Agency
SUPTRS	Substance Use Prevention, Treatment, and Recovery Services Block Grant
TBD	To Be Determined
T/TA	Training & Technical Assistance

Abstract

The Alabama Department of Mental Health (ADMH), Division of Mental Health and Substance Abuse Services (DMHSAS), Office of Prevention (OOP) presents this strategic plan for substance use prevention in Alabama. The strategic plan will serve as the guidance document for the implementation sustainability of funding allocation for substance use prevention programs that seek to receive Substance Use Prevention, Treatment, and Recovery Services (SUPTRS) Block Grant formerly known as Substance Abuse Prevention and Treatment Block Grant funds (SABG) to address the state's prevention needs. The purpose of the funding allocation is to sustain a model that is grounded in a data driven approach, which aligns with the original system's change (2014). A hybrid funding allocation approach utilizing county population and need as determined by multiple factors is indicated.

Utilizing the Strategic Prevention Framework (SPF), this document details how the OOP seeks to utilize a competitive bid process to disperse SUPTRS monies, expand its prevention system, positively impact workforce development, and address a diverse array of outcomes.

This document, originally guided by the efforts of the Alabama Epidemiology Outcomes Workgroup (AEOW) and the State Prevention Advisory Board (SPAB), has been updated to reflect the most up-to-date relevant information.

Introduction

At the state level, prevention services are managed through the ADMH. The ADMH was established by Alabama Acts 1965, No. 881, Section 22-50-2. 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 illness, including but not limited to, alcoholism, drug addiction, or epilepsy in combination with mental illness or intellectual disability. 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 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. However, ADMH does not operate any substance use prevention, treatment, or recovery support programs or directly provide any related services.

ADMH is also charged with the receipt and administration of the Mental Health and SUPTRS Block Grant, formerly SABG, provided by the Substance Abuse and Mental Health Services Administration (SAMHSA). The SUPTRS provided by SAMHSA is the primary funding source for Alabama's public system of substance use services. Alabama expends block grant funds to maintain a continuum of substance use services. Eighty percent of the SUPTRS funds are devoted to treatment services. Twenty percent of the SUPTRS funds are spent on primary prevention programs for individuals who do not require treatment for substance use, specifying the activities proposed for each of the six strategies to include Information Dissemination, Education, Alternatives, Problem Identification and Referral, Community-based Process and Environmental.

ADMH certifies twenty-three (23) substance use service prevention providers and provides SUPTRS funding to fifteen (15) of these providers (as of January 2023).

Assessment

During the introduction and implementation of the 2014 needs-based approach, and as needs emerged, subsequent shifts were made to maximize reach to populations of focus. The following areas of Alabama's prevention system were enhanced

- Access to prevention services was made available to all 67 counties within the State of Alabama;
- The State's prevention system was stabilized and strengthened, to include funding and other resources;
- Resources were leveraged to build the capacity of providers;
- Current high need areas and emerging issues were prioritized when making funding decisions;
- Established the need to demonstrate significant improvements in reducing the problems and consequences related to substance use;
- Provided avenues to achieve population-level outcomes;
- Increased the SSA's ability to foster the development of outcome-based performance resource allocation and expand the use of population-based strategies, environmental approaches, and strategies that reach people in the greatest need;
- Expanded prevention funds;
- Allowed the alignment of funding with needs by expanding community and environmental approaches, while maintaining school-based services; and
- Enhanced the SSA's ability to address substance use prevalence rates and corresponding problems.

Assessment provides a clearer understanding of substance use and factors related to substance use in Alabama's counties in order to best address their problems. The establishment and identification of state and national data sources will enhance substance use prevention efforts across the state. This section includes information about the data selection process for data sources and indicators, analysis of data, and usage of data for funding purposes.

Four resource allocation planning models adapted by SAMHSA/CSAP were reviewed for consideration for the funding allocation model. The selected model will guide how funding is dispensed to address the prevention needs in the state of Alabama. A description of the models is provided below.

> Equity- Dictates equitable distribution of funds across all sub-State communities. The same amount of money is awarded to each community without applying other criteria. For example, underage drinking levels being widely distributed across a State.
>
> Highest-Contributor- Concentrates funding within a subset of communities or regions that contribute the highest number of cases to a State's total. For example, a State prioritizing substance abuse-related motor vehicle accidents (MVAs) to identify regions/communities with the highest number of MVA cases.
>
> Highest-Need- Directs funding to those communities or regions that have the highest rate (e.g., 32.2 cases per 100,000) of substance-use pattern or substance-related consequence. For example, using county data from the PRIDE survey indicating the

rate of youth reporting any drinking or binge drinking in the last 30 days compared to the rate on a Statewide basis.

Hybrid- Concentrates funding on "hot-spot" problem areas as defined by both prevalence numbers and rates. For example, combining the Highest-Contributor and Highest-Need models in an urban community within a State to address non-medical prescription use.

The Office of Prevention staff met on a number of occasions to review and discuss the models and determine if any changes deemed necessary. From these meetings and review of the models, it was determined that the hybrid approach would be the continued approach to support the funding allocation model. The hybrid approach would combine equity resource allocation and need. The approach selected utilizes existing 310 Catchment Areas with considerations of population for each catchment area.

A. Data Selection Process

Information gathered from state and national sources provided preliminary data from which the needs assessment took direction. Counties were analyzed based on population and need.

The first component used in the allocation of funding was population. Population statistics are often used in determining federal and state program funding allocations. The formula, such as using total population, population for specific age groups or setting aside a portion of funding based off population, varies from program to program depending on the objectives of the program. For Alabama's funding allocation process, the total population estimates from the United States Census Bureau, 2021 Population Estimates will be used. Alabama consists of sixty-seven counties which comprise 22 310 catchment areas. The 22 catchment areas are compiled as seen below:

Table 1. 310 Catchment Areas Distribution by County

310 Catchment Area	County(ies) Currently Funded Within Catchment
M-1	Lauderdale, Colbert, Franklin
M-2	Limestone, Lawrence, Morgan
M-3	Madison
M-4	Fayette, Lamar, Marion, Walker, Winston
M-5	Jefferson, Blount, St. Clair
M-6	DeKalb, Cherokee, Etowah
M-7	Calhoun, Cleburne
M-8	Bibb, Pickens, Tuscaloosa
M-9	Clay, Coosa, Randolph, Talladega,
M-10	Choctaw, Greene, Hale, Marengo, Sumter
M-11	Chilton, Shelby
M-12	Chambers, Lee, Tallapoosa, Russell
M-13	Dallas, Perry, Wilcox
M-14	Autauga, Elmore, Lowndes, Montgomery

M-15	Bullock, Macon, Pike
M-16	Mobile, Washington
M-17	Clarke, Conecuh, Escambia, Monroe
M-18	Butler, Coffee, Covington, Crenshaw
M-19	Barbour, Dale, Geneva, Henry, Houston
M-20	Jackson, Marshall
M-21	Baldwin
M-22	Cullman

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 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

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

- Alcohol and/or Drug Related Motor Vehicle Crashes
- Substance Use Treatment Admission[1]
- Graduation Rates
- Poverty[2]
- Suicides[3]

B. Brief Profile of Selected Indicators

The following is a brief summary of the indicators selected to determine need:

Alcohol and/or Drug Related Motor Vehicle Crashes

Drunk/drugged driving is often the symptom of a larger problem of alcohol/drug use or misuse . Also, driving under the influence of alcohol and/or drugs not only puts the driver at risk, but also passengers and other people who share the road. In 2020, 3066 alcohol and/or drug related motor vehicle crashes occurred in Alabama. In 2018, there were 2829 alcohol related crashes by causal drivers age 16 to 20.

Substance Use Treatment Admissions

[1] New Jersey and Louisiana use this data element.
[2] Louisiana uses this data element.
[3] As determined by Alabama Department of Public Health's Center of Health Statistics. This indicator does not include overdose deaths.

In 2020, there were 16,535 treatment admissions that report to the Alabama Substance Abuse Information System (ASAIS) in Alabama. The primary substance for treatment admissions [4]for Alabama in 2020 was alcohol followed by marijuana then other opiates.

Graduation Rates

Poor school achievement and low school bonding is a risk factor in the early use of alcohol and/or drugs. The early onset of alcohol and/or drug use is a risk factor for developing alcohol and drug related problems later in life. In 2019, the graduation rate for Alabama was 92% (Alabama State Dept. of Education). SAMHSA states in the report, *Substance Use Among 12th Grade Aged Youths by Dropout Status*, that in the US," Dropouts had higher overall levels of current alcohol use than students (41.1 percent versus 33.7 percent) and higher rates of current binge drinking (31.8 percent versus22.1 percent)."[5]

Poverty

Financial means, whether through health insurance and/or income, is important to the access of substance use treatment. The Census Bureau uses a set of money income thresholds that vary by family size and composition to determine who is in poverty. If a family's total income is less than the family's threshold, then that family and every individual in it is considered in poverty (US Census). In 2020, the poverty rate was 14.9% for all ages in Alabama while the poverty rate was 20.9 for ages 0-17.

Suicides

Alcohol and other substance use disorders are a risk factor for suicide. In 2021, 821 people committed suicide in Alabama. The suicide rate for Whites males was 32.9per 100,000 population while black and other males was 15.1 per 100,000 population. The suicide rate for White females was 7.0 per 100,000 population while black and other females was 2.8 per 100,000 population. In Alabama, 104 youth (age 24 and younger) suicides occurred in 2018 and 2019 78% % were males of all races. In 2019, the suicide rate (16.4) is much higher than the homicide rate 12.0) in Alabama. (Alabama Dept. Of Public Health).

C. Prioritization Process

Once each indicator was selected and county-level data collected, the second step was to standardize the indicators by calculating z-scores for each indicator. Z-score is an individual test score expressed as the deviation from the mean score of the group in units of standard deviation (Merriam-Webster.com). Z-score allows for standardization of each indicator to the county average for the state. Microsoft Excel was used to calculate z-score by utilizing the formula (See Appendix 6):

$$Z = \frac{\textit{(County Value) – (Average of Counties in the Mental Health Region)}}{\textit{(Standard Deviation of Counties in the Mental Health Region)}}$$

[4] This represents treatment admissions for all ages.
[5] This is based on US data due to the limitation of ALSDE data addressing substance abuse and dropouts

Note while each indicator has a negative effect on substance use in a county, an increase in graduation rates has a positive effect. When calculated graduation rate z-score, the process was reversed by multiplying it scores by a negative one so higher score reflect a negative effect.

Finally, after the z-scores for each measure was calculated, the z-score was multiplied by its respective weight then added together to develop a composite score (need score) for each county. The overall need score is a weighted composite of five indicators: Alcohol and/or Drug Related Motor Vehicle Crashes (30%), Substance Use Treatment Admissions (30%), Suicide (20%), Graduation Rates (10%), and Poverty Rates (10%). The weights added together equal 100%. Each indicator was assigned weights based off the following criteria:

- Relation to substance use
- Relation to substance use prevention priorities

The composite scores were listed from highest to lowest scores within each mental health region.

As data is updated and becomes available, evaluation efforts will monitor increases and/or decreases in substance abuse and associated factors. The goal is to see a decrease in substance use within counties through effective prevention efforts.

Capacity Building

A. Areas Needing Strengthening

Alabama's state-level planning and implementation efforts previously focused on the management of our provider network rather than the management of our prevention service system as a whole. It is the intent of this strategic plan to serve as a guidance document in the development of capacity building in the prevention service area throughout the state.

The following are system issues that have been identified in Alabama and are clear indicators of our need to enhance our infrastructure. Below, Table 2 illustrates a summary of Alabama's identified gaps as well as solutions to address the gaps.

Table 2. Alabama Identified Gaps and Solutions

Identified Gaps	Solutions
There is a need to build capacity and buy-in for environmental strategies	Employ training opportunities to emphasize the importance of individual and environmental intervention strategies and fully understanding the necessity for broader approaches as it relates to changing conditions within communities that may lead to substance use.
There is a need for an increased understanding of appropriately defining CSAP strategies, particularly environmental.	Technical assistance will assist prevention providers in the identification, selection and implementation of the six CSAP strategies.
There is a need to expand collaboration and coordination at the state and local levels across agencies and subrecipients	Explore opportunities to increase coordination among prevention efforts at the substate level, both individually with subrecipients as well as in partnership with other state agencies and stakeholder organizations and their prevention subrecipients.
There is a need for formal, proactive efforts to build the capacity of volunteers and community and coalition members to enhance the effectiveness of community-led prevention efforts.	Technical assistance will orient prevention providers as to the essential elements of an effective organization affecting community change. Increased training in the areas of community mobilization, capacity building, environmental strategies and the integral role the components play will be incorporated.
Funding streams are not coordinated and often lead to service redundancies.	Encourage and promote coordination of prevention efforts, to include funding, in respective prevention regional areas to eliminate or reduce service duplication.
There is a need for increased evaluation and monitoring so that more reliable program participation reporting methods are developed.	Implementation of program evaluation, to include *on-site monitoring as well as quarterly reporting, to be conducted to measure program service delivery, and determine program effectiveness so that dysfunctional programs are improved or replaced, and service redundancies are eliminated. *The purpose of the on-site monitoring visit is to assess the coalition's compliance with federal and/or state regulations and to help the coalition and community improve established prevention systems. Coalition membership status, coalition meetings, capacity, accomplishments,

	barriers, will be reviewed during the visit. The results of the visit will be reviewed with Coalition designee at the conclusion of the visit, followed up by a written report within 10 business working days.
There is a need for the selection of prevention strategies or to target priority issues or populations to be data driven.	Technical assistance can assist with reviewing strategies other states have used to strengthen subrecipient use of data and evidence-based strategies.
There is a need to increase the number of programs that target economically disadvantaged populations. For example, some providers under serve rural (isolated populations), urban (inner city) populations, and economically disadvantaged youth and adults.	Biannual review of the data obtained from the prevention provider network plan highlights the disparity in populations served. The Evidence-Based Practice (EBP) Workgroup will use this review data to aid in the identification of appropriate evidence-based programs, policies, and practices to best address this target population. Training in the areas of capacity building and collaboration will be employed to broaden the scope of service areas.
Since Strategic Prevention Framework (SPF) encourages addressing prevention across life spans, and framework is incorporated into state prevention standards, we need to expand efforts to reach college and pre-school students, which traditionally are two of our larger underserved populations.	Utilization of the existing collaboration with the Alabama Department of Education and the Alabama Higher Education Partnership to assist with best approaches and ideologies in reaching pre-school and college-aged individuals.
Gender specific programs should be utilized where appropriate.	Employ training that will provide awareness, knowledge and strategies to foster a culturally relevant environment. The EBP Workgroup will partner with T/TA providers to align training that will best provide awareness, knowledge, and strategies to support gender specific programs.
There is a need to utilize community engagement strategies to build support for implementation of evidence-based strategies.	Technical assistance will assist with exploring how the base of popular local support incurred through community engagement activities (e.g., talent shows, youth ATOD prevention commercials) can be leveraged to build support for the corollary implementation of prevention strategies that have strong evidence of effectiveness in reducing local ATOD-related problems.
The continuum of services should be expanded to include children under age five and the elderly. Both populations are underserved and are at risk of developing substance use problems.	Utilization of the existing collaboration with the Alabama Department of Human Resources, Alabama Partnership for Children, and the Alabama Department of Senior Services to assist with best approaches and ideologies in reaching children under five and elderly populations.
Local planners should examine the ethnic makeup of their programs and compare them to the ethnic makeup of their target community. Programs should perform additional outreach and needs assessment among these ethnic groups to understand how they can better meet their prevention needs.	Employ training that will provide planners with general knowledge and skills on needs assessment design and methodologies in order for them to conduct their local assessment and strategic plan; interpret the results while maintaining cultural integrity.

Many of our service providers have difficulty with program data as it relates to the numbers and characteristics of persons served, thus, there is a need for ongoing training and technical assistance to ensure the necessary information for reporting purposes is captured.	Employ efforts to strengthen and revise subrecipient process evaluation protocols to ensure the ability to track and report all federal program information required to include building the capacity of providers to use ASAIS and other program data for process evaluation and management purposes.

Thus, one of the primary goals for the OOP is to build prevention capacity and infrastructure at the state and community levels. Increased capacity will allow Alabama to support effective substance use prevention services at both the state and local levels.

B. State- and Community-Level Activities

1. State Capacity Building Activities

Internally, the OOP staff will take advantage of training opportunities that expand upon the knowledge base in respect to the science and practice of prevention, the SPF model, data collection and use, underage drinking, prescription drug and illicit drug use. When possible, new staff members will have priority selection for training opportunities. When this is not available, webinars, teleconference, state information request, etc. will be utilized. DMHSAS will continue to provide training to the prevention provider network and various community entities. Extensive training and technical assistance will be provided to communities statewide to build prevention capacity at both the state and local level. Trainings will support the development and implementation of community-based prevention planning and programming. DMHSAS will provide on-going TA so that the prevention provider network and local communities collaboratively have the necessary resources and infrastructure to adequately employ effective prevention practices.

The OOP will provide T/TA to ensure that prevention providers will be capable to:

- Engage community stakeholders
- Distinguish and understand the relevancy of direct and indirect services and their impact on communities
- Train service providers and stakeholders
- Conduct sustainability planning
- Implement their strategic plan using appropriate EBPs
- Collaborate with prevention-related coalitions to prevent duplication

Training topics will include cultural relevancy, sustainability, evaluation, EBPs, environmental strategies, grant writing, needs assessment, strategic planning, and logic modeling. Additionally, we will continue to utilize national and regional TA resources and various prevention consultants. Program evaluation, to include on-site monitoring as well as bi-annual and annual reporting, will be conducted to measure the program service delivery, and to determine program effectiveness so that programs are improved or replaced, and service redundancies are eliminated.

Our needs assessment efforts will involve comprehensive and culturally relevant reviews of risk and protective factor data, service gaps, and community resources to determine how best to allocate limited prevention resources. A funding allocation approach will be utilized to ensure that prevention dollars are

not customarily disseminated, but rather distributed based on identified need.

2. Community Capacity Building Activities

    a. Collaboration & Communication

Community collaborative efforts will assist in ensuring that there is adequate representation from various interrelated entities to enhance the goals, objectives and resources of the prevention provider. Representation of an entire community such as school officials, law enforcement, clergy, parents, etc. will establish an all-encompassing decision-making forum that will enhance the existing prevention infrastructure. The forum will allow diverse community representatives to dialogue to determine who, what, and how needs are addressed in their communities. With the familiarity of the community provider network and the network's knowledge on best logistics and cultural practices, facilitation will lend to increased community involvement and buy-in regarding capacity-building efforts. Participatory stakeholder dialogue will focus on both direct and indirect services. Discussion will include items such as establishing a community outlet for youth (indirect) or teaching youth in an after-school program (direct).

    b. Training

Table 3. Training Timeline

TRAINING/TECHNICAL	DEVELOPMENT	TIMELINE	TRAINER
Welcome to Prevention – Newcomer's Orientation -This training will serve as an overview of Alabama's prevention system.	Training length: 6hrs Target delivery date: Annually or as needed Estimate development time: TBD hours of adaptation, already developed Developer: Prevention Director/Prevention Consultant	This training should be implemented annually or as needed to programs/individuals interested and/or seeking prevention certification/service delivery in the State of Alabama.	Prevention Consultant
Environmental Strategies - Interactive session which will explain structural interventions as aiming to modify social, economic, and political structures and systems in which we live. These interventions may affect legislation, media, health care, marketplace and more.	Training length: 2hrs Target delivery date: Annually or as needed Estimate Development time: 80 hours Developer: TA Provider	This training could be implemented during an existing conference as a two-day session; Or, could serve as a stand-alone session.	This training could be conducted by TA Provider, or, use a train the trainer model where the prevention consultant is trained and in turn, they implement the training with providers.
Needs Assessment-This training will provide participants with general knowledge and skills on needs assessment design and methodologies in order for them to conduct their local assessment and strategic plan. It will also include data interpretation strategies.	Training length: 2hrs Target delivery date: Annually Estimate Development time: 40 hours Developer: AEOW/Epidemiologist/Evaluator	This training could be implemented during the Prevention Provider Network quarterly meeting.	AEOW Epidemiologist Evaluator
Program Evaluation-This training will introduce participants to the basic principles of process and outcome evaluation and its	Training length: 2hrs Target delivery date: Annually Estimate Development time: TBD	This training could be implemented during the	Evaluator

TRAINING/TECHNICAL	DEVELOPMENT	TIMELINE	TRAINER
applicability to the implementation of their local strategic plan, best practice intervention and cross site evaluation.	Developer: Evaluator	Prevention Provider Network quarterly meeting for ADMH certified prevention providers. Follow-up by individualized technical assistance and training.	
Decision Making Models-This training will provide participants with skills to establish healthy leadership models.	Training length: 2 hrs Target delivery date: Annually Estimate Development time: 40 hours Developer: TA Provider	This training could be implemented during an existing conference as a two-day session; Or, could serve as a stand-alone session.	This training could be conducted by the TA Provider during a designated prevention provider meeting, or, a train-the-trainer model could be employed with Prevention Consultant and training could be conducted at Individual TA sessions.
Strategic Planning-This training will introduce the strategic planning model. It will include the SPF framework as referenced in the prevention standards.	Training length: 2hrs Target delivery date: Annually Estimate Development time: 80 hours Developer: TA Provider/AEOW/ Epidemiologist/Evaluator	This training could be implemented both individually and with all prevention providers.	This training could be conducted by TA Provider, or, the use of a train the trainer model where the Prevention Management Team and Prevention Consultant are trained and in turn, they implement the training with prevention providers.
Logic Modeling-This workshop will provide participants with skills to develop logic models that will illustrate the strategies prevention providers want to implement.	Training length: 2hrs Target delivery date: Annually Estimate Development time: 20 hours Developer: TA Provider	This training could be implemented both individually and with all prevention providers.	This training could be conducted by TA Provider if done as training with all prevention providers.
Best Practices in Evidence Based Program for Substance Use Prevention	Training length 1 hr Target delivery date: Annually Estimate Development time: 20 hours Developer: TA Provider	This training could be implemented during an existing conference or during monthly workforce development trainings.	This training could be conducted by TA Provider if done as training with all prevention providers.
TRAINING/SUSTAINABILITY	**DEVELOPMENT**	**TIMELINE**	**TRAINER**
Organizational/Partnership/Leadership Development- Help prevention providers examine their organization and partnerships and assess their organizational readiness to begin the task at hand. It will also orient them as to the essential elements of an efficient organization, as well as effective partnerships, leadership identification, and guide them towards the redesign or the strengthening of	Training length: 6 hrs Target delivery date: TBD 2 two-hour sessions Estimate Development time: 40 hours Developer: Prevention Management Team	This training could be implemented during the Prevention Provider Network quarterly meeting. Follow-up by individualized technical assistance	These trainings will be conducted by Prevention Management Team. Subsequent sessions will take place either during individual TA sessions or during other prevention provider meetings.

TRAINING/TECHNICAL	DEVELOPMENT	TIMELINE	TRAINER
their organization, partnerships, leadership and coalition through an action plan.		and training.	
Cultural Relevance-This training will provide participants with awareness, knowledge and strategies to foster a culturally relevant environment in their agency and community.	Training length: 2 hr initial training with ongoing increments of 1 hrs Target delivery date: TBD Estimate Development time: 80 hours Developer: TA Provider/Prevention Director	This training could be implemented during an existing conference as a two-day session; Or, could serve as a stand-alone session.	This training could be conducted by Prevention Director and TA Provider if done as a training with all funded programs or regionally or at individual TA sessions.
Youth Involvement- This training will provide participants with guiding principles and strategies to create meaningful partnerships between adults and young people.	Training length: 1 hour Target delivery date: Annually Estimate Development time: TBD Developer: TBD	This training could be implemented during an existing conference as a two-day session; Or, could serve as a stand-alone session.	This training could be conducted by TA Provider if done as a training with all funded programs or regionally or incorporated into the state's annual Alabama School of Alcohol and other Drug Studies.
COMMUNICATION STRATEGIES Advocacy- This workshop would introduce participants to basic advocacy principles and strategies that could be used to further the structural changes prevention providers will implement. **Media**- This workshop will provide participants with basic skills to engage the media in their efforts to implement structural change.	Training length: 1 hour Target delivery date: Annually Estimate Development time: TBD Developer: TBD	This training could be implemented during an existing conference as a two-day session; Or, could serve as a stand-alone session.	This training could be conducted by TA Provider if done as a training with all funded programs or regionally or incorporated into the state's annual Alabama School of Alcohol and other Drug Studies.
Grant Writing/Funding- This workshop will provide participants with basic information regarding strategies to secure long-term funding for the program's activities	Training length: TBD Target delivery date: TBD Estimate Development time: TBD Developer: TA Provider/Prevention Director	This training could be implemented during an existing conference as a two-day session; Or, could serve as a stand-alone session.	This training could be conducted by Prevention Director and TA Provider if done as a training with all funded programs or regionally.

Planning

A. State Planning Model for Allocating Funds

The epidemiological data provided by the epidemiologist would be used to determine the priority and the allocation model. Substance use consequences and consumption patterns are the foundation of data utilized in the epidemiological profile for Alabama.

CSAP outlined four potential planning and allocation models. The four funding models are based on highest rate/need areas, highest-contributor, and equitable distribution across Alabama, or a hybrid model where two or more of these are blended. A descriptive detail of each of these models is provided in the Assessment section of this plan. After careful consideration, Alabama selected the Hybrid Model. The Hybrid Resource-Allocation Planning Model will use a combination of the approaches mentioned above. In addition, the hybrid model was chosen to ensure a statewide effect is created while providing additional funding to areas based on the burden of substance use.

B. Description of community-based activities

Beginning fiscal year 2012 all contracted prevention providers in the state were required by prevention standard 580-9-47-.04 to utilize the SPF model. Recipients of SUPTRS funding through contract with the ADMH are subject to adherence to these standards. To ensure adherence to these standards, staff of the OOP along with the Office of Certification conduct unannounced site visits to check compliance with the standards. Similarly, this standard requires providers to embed the SPF into their prevention plans that are submitted every two years and updated on a minimum of every year. This process will include the completion of a local needs assessment designed to identify local causal factors associated with the identified priority outcomes.

Each funded community will follow a standardized procedure as set forth by the OOP for their local needs assessment and gather data to further examine the risk in their jurisdiction for the identified priority outcomes. Additional data will be gathered to determine the presence of key risk and protective factors that affect the identified priority outcomes. Communities will be made well aware of data requirements through forums, e-mail notifications, trainings, etc. and will have data access via the ADMH website. Service Members, Veterans, and Their Families (SMVF) are special populations that sub recipients will be encouraged to find data on.

A prerequisite for the success of the SPF is mobilization efforts. As a result of each sub-recipient conducting its own needs assessment, the following community level activities are suggested to assist this process. Various methods for mobilization will be used, including a SPF forum and town meeting approaches. Town hall meetings allow for education and suggest the democratic process. During these open discussions a group of citizens are gathered, sharing a common vision, willing to work, supporting community goals, and seeking plan accomplishments. This shared vision and goal perspective will allow sub recipients and non-sub recipients to identify as allies and link likeminded interests and needs. Furthermore, these meetings will provide an opportunity for networking and building relationships that could potentially encourage the growth and development of the local planning committee. Funded organizations will be required to develop a strategic plan that outlines the community-level factors identified and

appropriate evidence-based practices they will implement. The local plans will also include steps to sustain the efforts when the grant funding ends. Included in the strategic plan will be a description of local evaluation efforts.

C. Allocation Approach

According to the selected planning model, a Hybrid Resource-Allocation Planning Model will direct funding to all currently funded counties throughout the state. Through the assessment process, the OOP, AEOW and SPAB determined that the unit of analysis would be counties which are combined into their respective 310 catchment area. [6]This decision was based on the fact that the SPF program encourages community-led planning activities. The OOP determined that the following indicators would best measure the need:

- Alcohol and/or Drug Related Motor Vehicle Crashes
- Substance Abuse Treatment Admission
- Graduation Rates[7]
- Poverty
- Suicides

Five percent ($100,000.00) of the available funding is set aside for incentives and for a separate contract for evaluation services. The remaining available balance is to be utilized for the funding allocation model. Funding allocation ($4,837,291) will be based on the 22 310 catchment areas with each counties within a catchment area having an amount required to be spent in the respective county. Awardees must spend for each county at least the required county spending amount out of the total catchment allocation.

Example: If you apply for 310 catchment area 20 (Jackson, Marshall), the allocation amount you can apply for is $178,651.00. If awarded 310 catchment area you are required to spend $68,560 in Jackson and 110,091 in Marshall.

Appendix 5 displays the funding allocation for each 310 catchment area with the required spending amounts for each county in the 310 catchment area. The 310 catchment area were proportion based on the 2013 census estimates and the five need indicators found above for the funding amounts as seen below. The aforementioned funding amount is derived from FY23 SABG. Actual FY24 funding will be determined by the FY24 SABG so amounts are subject to slight change. All decisions were agreed upon by the OP, AEOW and the SPAB.

[6] Oklahoma uses a catchment type approach.
[7] South Dakota utilizes similar outcomes.

Table 4. Funding Allocation Based on 310 Catchment Area Distribution

310 Catchment Area	Total Allocation
Catchment Area 1	$226,887.00
Catchment Area 2	268,960.00
Catchment Area 3	118,764.00
Catchment Area 4	249,587.00
Catchment Area 5	322,892.00
Catchment Area 6	252,906.00
Catchment Area 7	164,565.00
Catchment Area 8	232,582.00
Catchment Area 9	225,202.00
Catchment Area 10	214,636.00
Catchment Area 11	204,128.00
Catchment Area 12	381,093.00
Catchment Area 13	151,489.00
Catchment Area 14	335,293.00
Catchment Area 15	176,965.00
Catchment Area 16	147,761.00
Catchment Area 17	203,244.00
Catchment Area 18	239,288.00
Catchment Area 19	338,270.00
Catchment Area 20	178,651.00
Catchment Area 21	118,764.00
Catchment Area 22	85,364.00

Based upon the selected funding allocation model the OP plans to utilize a Request for Proposal (RFP) process to distribute SUPTRS funds beginning FY24.

Implementation

Implementation Activities

To accomplish the hybrid (equity resource allocation and need based) funding allocation model for the state of Alabama the following are the intended implementation activities.

A. RFP Process for Sub-Grantees

Utilizing the RFP approach, the OOP will modify a previously developed Prevention Services RFP as the foundation for implementation. The modification of the RFP is slated for January 2023 and will be developed by the Director of Prevention with feedback from the OOP staff. Upon completion of the developed RFP, it will be sent for review and feedback to the Associate Commissioner of the Division of Mental Health and Substance Abuse Services. During this review period the OOP will make contact with the Office of Contracts and Purchasing (OCP) to alert them of the forthcoming RFP and the magnitude of the RFP so that the office has the capacity to field the number of RFP responses that will be received. Upon review and necessary edit consideration, the RFP will be submitted to the OCP along with a completed form C-2 from the DMHSAS Office of Billing and Contracts (OBC) for publication in February 2023. The RFP will be published on the ADMH website and all certified prevention providers and vendors will receive a notification of the RFP. Additionally, the RFP will be advertised through print media in the dominant local newspapers for the state. During this open period, RFP specific questions will be fielded by the OCP. Questions outside the scope of the OCP will be forwarded to the Director of Prevention from the OCP to respond to. Those responses will be submitted to the OCP who will in turn send the response to the individual who inquired. The RFP process is a competitive process. Allocations to each county will be based upon the funding allocation model. The RFP is anticipated to be open through May 2023.

Upon closure of the RFP, the OCP will designate the reviewers for the RFP with suggestion from the OOP. An overview to the RFP and the expectations for scoring will be provided to the OCP and/or the designated reviewers prior to the review. Proposals will be evaluated and scored in accordance with Alabama Bid Laws. Final scores will be provided by the OCP to the OOP. The OOP will review the recommendations from the score sheet for final approval.

Contract Execution Process

Upon final approval, the OOP will secure a form C-1 from the OBC as well as submit the contract language, award amount, and dates of the contract to the OBC. This information is then forwarded from the OBC to the OCP. The OCP notifies the designated applicants who will then become sub-recipients of their selection for funding. The OCP also notifies those who were not selected for funding.

B. Prevention Plans and Budgets

Subsequent to the RFP and contract execution process. Prevention plans (PP) of the sub-recipient will be submitted to the OOP with a date to be determined. The PPs will be reviewed by the OOP for any necessary edits prior to FY24 implementation of services. Sub-recipients will submit an edited budget to the OOP as a result of the PP edits. These budgets will be reviewed by OOP staff and necessary edits addressed with the sub-recipient prior to setting them up in the system by the OBC.

Upon final approval of the PP and the budget, sub-recipients will make the necessary updates in the management information system (ASAIS) prior to the start of FY24.

Funding will be distributed on a reimbursement basis up to twice a month based on data entry submissions into ASAIS as well as based on submission of contract field vouchers to the OCB.

C. Technical Assistance

As technical assistance (TA) needs are identified by the sub-recipient's those needs will be communicated to the Prevention Consultant who will deliver technical assistance via phone call, email correspondence, or face-to-face meeting. Addressing the TA needs will be ongoing. The Prevention Consultant has a well-established long standing relationship with providers and is accustom to addressing their TA needs with and through them. The Prevention Consultant work in concert with the OOP to address these needs. When needs are global, TA may take on the form of a targeted presentation at the quarterly prevention provider meetings or through Workforce Development trainings that are coordinated by the OOP throughout the state. Once the RFP is released, no TA will be provided with relation to the RFP or any of its components.

D. Community-level Implementation Monitoring

The Director of Prevention will monitor the implementation process against the timeline deliverables. Sub-recipients will submit to ASAIS at least on a monthly basis along with submissions to the OCB for reimbursement consideration. At least on a yearly basis the Epidemiologist will run data against the need measures. Equally the OOP will randomly pull data to see who is eligible based on the data to receive an incentive.

Incentive opportunities will continue to be utilized. A portion of the SABG (2.0% - $100,000) will be allocated towards incentives. The qualifiers for incentive consideration are site visit score (4 points), sustainability effort (3 points), and workforce development (3 points). A 10 point Incentive Award system will be utilized to determine prospective incentive award amount based on the qualifiers. The 10 point Incentive Award System is illustrated in the table (5) below.

Site visit scores must fall within the one and two year certification range to be eligible. Those receiving certification for two years based on the site visit score will receive 4 points. Those receiving certification for one year based on the site visit score will receive 1 point. The sustainability qualifier is tied to sub-recipient's ability to secure prevention specific funding from national and state entities outside of the SUPTRS as demonstrated by notice of award at time the data is randomly pulled by the OOP. If this qualifier is met then 3 points are awarded. The workforce development qualifier which accounts for 3 points is tied to the sub-recipient's ability to demonstrate prevention internships, award scholarships or educational incentives to staff pursuing certification, degree's, continuing education, and demonstrable relationships / partnerships with adjacent higher educational institutions that serve as catalysts of creating and sustaining prevention career paths.

Providers must have a total of 3-10 points to potentially qualify. Awards will be made based upon the number of counties the provider provides services to (as identified through their approved prevention plan and by their contract) as demonstrated in the table below. The incentive recipient's contract will be amended to add the award. The award can be utilized towards workforce development; specifically,

conference attendance and credential support,; award can be utilized for additional supplies and/or equipment for prevention staff or used toward additional monies for execution of prevention strategies. Incentives will not be available to those who have had a contract reduction due to lack of service utilization within the last year or to those who have chargebacks.

Table 5. Incentive Distribution

Accumulated Points	Counties (1-3)	Counties (4-6)	Counties (7+)
8-10	$4,204/$12,740	$4,901/$14,850	$5,953/$18,040
5-7	$2,574/$7,800	$3,376/$10,230	$4,194/$12,710
3-4	$1,802/$5,460	$2,614/$7,920	$3,383/$10,250
Total Potential	$26,000	$33,000	$41,000

Up to three (3) awards per category

Implementation Activities

Table 6. Implementation Activity Timeline

Implementation Activity	Responsible	Timeline
Strategic Plan Submission (external) – Draft plan will be submitted to the AEOW/SPAB for review and input.	Office of Prevention AEOW SPAB	February 2023
Strategic Plan & RFP Submission (internal) – Draft plan and RFP will be submitted to the Associate Commissioner for review and input.	Office of Prevention Associate Commissioner	February 2023
Edits to Strategic Plan & RFP Submission (internal) – Edits to the plan based on the internal review will be accomplished.	Office of Prevention Associate Commissioner	February 2023
RFP planning – Consult with the OCP regarding forthcoming actions i.e. mass RFP, demand for scores, ability to educate scorers prior to scoring, etc.	Office of Prevention Office of Contracts & Purchasing	Ongoing
RFP release – Submit the RFP to the OCB for generation of Form C2. OCB submit the RFP along with the C2 to OCP for release.	Office of Prevention Office of Contracts & Billing Office of Contracts & Purchasing	March 2023
RFP Scoring – OCP secures scorers for the RFP. Scorers are educated by the OOP on essentials to look for during review of proposals.	Office of Prevention Office of Contracts & Purchasing	June 2023 August 2023 (scoring complete)
Score Sheets – OCP provides the score sheets of the scored RFP's to the OOP. OOP review the submissions and ask the OCP for copy of budget and proposals of the highest scorers for each county. OOP reviews the submissions to identify TA issues to address.	Office of Prevention Office of Contracts & Purchasing	August 2023
Contract Execution – the OOP develops contract exhibit pages and sends those pages along with a list of the sub-recipient's, award amount, dates of award to the OCB. OCB develops a form C1 and submits the contract and the form to the OCP who notifies the sub-recipients.	Office of Prevention Office of Contracts & Billing Office of Contracts & Purchasing	September 2023

Implementation Activity	Responsible	Timeline
Prevention Plans – Sub-recipients submit plans and budgets to the OOP.	Sub-recipients	TBA (To be announced post scoring completion)
Prevention Plan Reviews – OOP reviews prevention plans and budgets.	OOP	TBD
ASAIS training – Office of Information Technology (OIT) provides training as necessary based on identification of need determined by the OOP.	Office of Prevention OIT	September 2023
Services – contracted services begin.	Sub-recipient's	October 2023

The OOP will support the implementation activities as it has the full responsibility for the successful implementation. Maintenance of open communication will be an integral component of support. Thus, responsible parties will be communicated with in advance of activity and timeline. As much as possible and without infringing upon other responsible parties, the OOP will ensure all required documentation is completed and submitted in a timely manner within its office and impress upon other entities the need to do the same.

Training and technical needs will be determined post RFP process for the sub-recipients. Determination will be made by review of the originally submitted prevention plans and budgets contained within the RFP proposals. Data reporting to ASAIS will be another means to identify needs. Equally, review of reimbursement vouchers will offer insight on needs. At a minimum, a bi-annual and annual progress report will be submitted by the sub-recipient's which will guide additional need identification.

Evaluation

The funding allocation model evaluation will include assessment of the implementation of the process, the outcomes, and long-terms impacts to the prevention system in the state. To establish evaluation of the process, the OOP has secured an evaluator through an RFP for evaluation services. The evaluator will design an evaluation plan for the state that is inclusive of the funding allocation process. During design and development of the evaluation plan, the OOP will provide the evaluator with continuous feedback. Additionally, the need funding factors will help guide a portion of the evaluation to assess the prevention system's ability to impact change on the indicated factors i.e. treatment admissions, poverty rates, graduation rates, and death by suicide. It is anticipated that the sub-recipient awards would be for a minimum of four years to effectively measure change across the indicated factors.

A. Target for Change

The OOP seeks to:

- sustain a funding allocation model for the state prevention system;
- develop measures (reduction in treatment admissions, decrease in poverty rates, increase in graduation rates, and reduction in death by suicide) for delivery of prevention strategies;
- establish incentives for prevention providers; and
- fund prevention services throughout all counties in the state of Alabama.

The OOP, the state Epidemiologist, the Evaluator, and the AEOW/SPAB will plan, coordinate, and manage evaluation processes. Evaluation components will include:

- Process evaluation;
- Outcome evaluation;
- Review of implementation effectiveness; and
- Development of recommendations for program improvement.

B. The Process Evaluation

The Evaluator will conduct the process evaluation to answer the major process evaluation question:

To what degree was the Funding Allocation effectively implemented?

This question will be addressed through collection and analysis of a variety of data sources to be determined and potentially developed by the Evaluator. It may include but not be limited to interviews, site visits, and training and technical assistance evaluation surveys. This array of required and appropriate data sources will provide a robust collection of data designed to collect qualitative and quantitative data relevant to these questions:

1. Did the implementation of the Funding Allocation match the plan?
2. What types of deviations from the plan occurred?
3. What led to the deviations?
4. What impact did the deviations have on implementation and desired targets for change?

Program functioning, effectiveness, and impacts will be evaluated as a part of the process evaluation. The State Evaluator will design, distribute, and evaluate project-specific evaluation instruments, conduct interviews and site visits, as well as review state-level documents to collect data to respond to the following data points:

1. The extent to which increased statewide prevention capacity is observed by the number of counties funded for and delivering prevention strategies;
2. Reduction in treatment admissions as measured by the total number of admissions per year (fiscal or calendar) by county as determined through ASAIS;
3. Decrease in poverty rates by county as measured by the
4. estimate of poverty for the total population within a county per year determined through US Census Small Area Income and Poverty Estimates;
5. Increase in graduation rates as measured by cohort graduation rate by county per year as determined through ALSDE;
6. Reduction in death by suicide as measured by the total number of completions per year (fiscal or calendar) by county as determined through ADPH data;
7. Increased units of service across all prevention strategies per year (fiscal or calendar) by state as determined through ASAIS;
8. Increased workforce development for preventionist by year (fiscal or calendar) across the state as determined by workforce development monitoring tool, prevention budgets, and prevention balance sheets;
9. Increased use of evidence-based practices, as measured by the number of EBP employed by providers throughout the state as determined by prevention plan an annual outcomes monitoring tool;
10. Increased retention of preventionist determined by dividing the total number of agency preventionist by the number of preventionist leaving the agency.

C. The Outcome Evaluation

State level outcomes will be monitored for increases in capacity building and strengthening of the substance use prevention system.

State level outcomes will be collected as deemed by the state Evaluator and may include a combination of quantitative and qualitative outcome data. At a minimum, the following outcome measures will be collected with respect to the NOMs:

- Abstinence from Drug Use/Alcohol Use
- Return to/Stay in School
- Decreased Criminal Justice Involvement
- Cost-Effectiveness of Services (Average Cost)
- Use of Evidence-Based Practices

Changes in risk factors and protective factors; community practices, norms, and attitudes are expected at the community level as a result of the expansion in the statewide prevention system. Qualitative data collected through the evaluation process will be utilized to measure these changes. Review of pre and post

test administered at the community level through sub-recipients may be a resource for reporting these findings.

The outcome evaluation seeks to answer these questions:

1. Were substance use and its related problems, prevented or reduced?
2. Did Alabama achieve the targets for change?
3. Was prevention capacity and infrastructure for the state improved?

D. Variables to be Tracked

Program variables to be tracked include:

- the National Outcome Measures (NOMs);
- the total number of evidence-based programs;
- strategies employed;
- targeted substance;
- priority(ies);
- race;
- ethnicity;
- gender;
- age;
- community type;
- community size;
- hearing status;
- domain(s);
- IOM group identifier; and
- Other (LGBTQ, homeless, students in college, military families, underserved racial & ethnic minorities, high risk youth, youth in tribal communities).

Additional variables may be identified based on updates to required data elements.

E. Evaluation Activities

The evaluator will determine the necessary evaluation activities to track the breadth of information currently collected as well as information that is yet to be collected. At a minimum frequency of yearly, the evaluator will evaluate accomplishment of prevention plan objectives.

Cross-Cutting Components and Challenges

The following are challenges that may be encountered in attempting to operationalize the funding allocation model.

- Organizational inertia and the tendency for providing agencies to be content with current trajectories could pose potential challenges.
- The allotted time frame of the award may imply a lower performance due to the restriction of data capturing and reporting in a timely manner.
- Internal infrastructure to support a timely implementation process (ADMH).
- The number of prevention providers across the state may decrease while the number of counties having prevention services increases as a result of providers addressing multiple counties which could result in a monopoly of sorts.
- The reliance on data from agencies outside of ADMH may affect ability to measure progress due to an agency making systematic changes to the data collection and analysis methodology and data availability for any indicator/variable.

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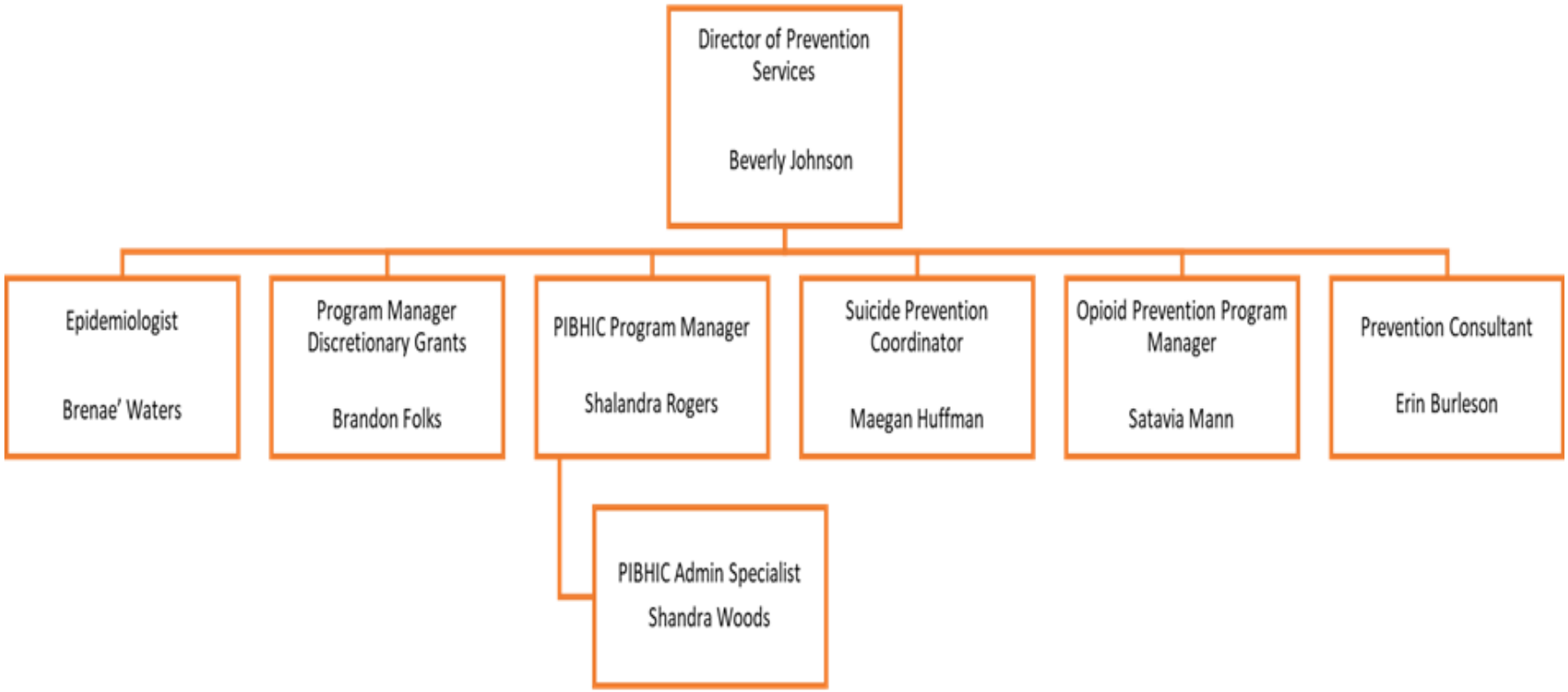
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Appendix 1 - Office of Prevention Organization Chart



Appendix 2 – Alabama Epidemiological Outcomes Workgroup Members2023

Member	Organization/Community Sector Organization Role/Title	Member Contribution/Responsibility
Waters,Brenae'	Alabama Department of Mental Health	Chairwoman – Epidemiologist Chairs the AEOW meetings, organizes the AEOW's activities and agenda, reviews identified needs and priorities as it relates to AEOW.
Johnson, Beverly	Alabama Department of Mental Health	Director, Prevention Services Provide updates on statewide initiatives as it relates to substance abuse prevention and assist with priority and need identification
Folks, Brandon	Alabama Department of Mental Health	Coordinator, Discretionary Grants Provide updates on statewide initiatives as it relates to current discretionary grants and assist with priority and need identification
Anderson, Ronada	Alabama Department of Public Health Hepatitis Coordinator	Provide updates on current trends in HIV prevalence and incidences based on ADPH research, surveillance, assessments and analysis and assist with identifying current and/or emerging SA risk factors among HIV/AIDS populations to include county and state-wide data.
Burks,Henry	Alabama Board of Pharmacy Chief Drug Inspector	Provide updates on prescription drug issues including policy changes on drug monitoring, physician obligations and assist in identifying data sources relevant to prescription drug use/misuse and/or abuse and population correlations.
Burleson, Erin	ADMH Office of Prevention Services Prevention Consultant	Ex-officio member, Provides updates related to occurring at the community level and related to working directly with providers.
		Provides updates from the perspective on the prevention providers.
Winningham, Janet	Alabama Department of Human Resources	Provides updates related to effects on children and services target to children.
Erin Burleson	ADMH Office of Prevention Services Prevention Consultant	Ex-officio member, Provides updates related to occurring at the community level and related to working directly with providers.
Means, Cesily	Governor's Office of Faith-Based and Community Initiatives Outreach Specialist	Provides updates related to community and services in the community.
Nightengale, Julie	Alabama Department of Public Health Epidemiologist	Assist with identifying correlating infectious disease such as STI's with SA risk factors, developing common themes and trends among youth in an effort to effectively select youth intervention models for prevention service delivery and activities. Also assist with identifying substance use rate data to show where rates are changing in the state.
Toney, Jim	Alabama State Department of Education	Provides updates on education on the elementary through high school level
Oakes, Robert	Alabama Department of Pardons and Paroles	Provides updates related to correction
Pendergast, Pat	Alabama Department of Youth Services Screening and Placement Coordinator	Assist with identifying relevant data on detained youth and provide recommendations on prioritizing youth prevention efforts based on risk factors associated specifically with detained youth.
Quinn, Michael	Department of Rehabilitation Program Coordinator	Provides updates on services related to children and adults with disabilities.
Reese, Sondra	Alabama Department of Public Health	Assist with updates related to Synar and chronic diseases
Shanks, Bill	ALEA Alabama Department of Public Safety	Assists with data on alcohol related motor vehicle crashes
Nelson, Loretta	AL Department of Revenue	Provides updates on others funding outside of the Dept. of Mental Health are distributed to other organization for substance

		abuse prevention.
Wilcox, Dr. Delynne	UA Office of Wellness & Promotion Assistant Director of Health Planning & Prevention	Assist with identifying, analyzing data on college-age youth and utilizing outcomes to prioritize prevention efforts on college campuses statewide. Provide recommendations on best practices for collecting and/or accessing university data.
Wright, Bennett	Sentencing Commission	Assist with identification of data sources relevant to crime and SA correlation to assist providers in prioritizing prevention efforts with law enforcement to promote effective environmental strategies.
Eden Griffin	Omni Institute's Research & Evaluation	Provides support to the Alabama Department of Mental Health

Appendix 3 – State Prevention Advisory Board Members 2023

Name	Membership Category	Sector
Selase, Seyram	Agency for Substance Abuse Prevention	Prevention Provider
Anderson, Ronada	Alabama Department of Public Health	State Partner
Finch, Shereda	Council on Substance Abuse	Prevention Provider
Hernandez, Jean	AIDS Alabama	State Partner
Stapleton, Danita	Alabama State University	State Partner
Jenkins, Liletta	Alabama Department of Children's Affairs	State Partner
Howard, Gloria	Aletheia House	Prevention Provider
Leonard, Cedric	Compact 2020	State Partner
Malone, Deegan	Healthy Sexual Solutions	State Partner
Markris, Shai	AltaPointe Health	State Partner
Moore, Michele	Mental Health of North Central Alabama	Prevention Provider
Pierre, Vandlyn	Drug Education Council	Prevention Provider
Wimberly, Carie	Addiction Prevention Coalition	Prevention Provider
Tytell, David	Alabama Department of Corrections	State Partner
Wilcox, Delynne	University of Alabama	State Partner
Dickson, Nancy	Sylacauga Alliance for Family Enhancement	Prevention Provider
Javed, Mariyam	Alabama Department of Public Health	State Partner

Appendix 4 - Data Sources

Population Estimates – US Census, QuickFacts 2021 Population Estimates

QuickFacts tables are summary profiles of the nation, states, counties, and places showing frequently requested data items from various Census Bureau programs. QuickFacts contains statistics about population, business, and geography for an area.

Alcohol and/or Drug Related Motor Vehicle Crashes – University of Alabama, Center for Advanced Public Safety; Alabama Department of Public Safety

The Center for Advanced Public Safety is a research and development center at The University of Alabama dedicated to the use of information technology to positively impact society. The research and development activities have been centered on the application of novel technology to public and transportation safety, but the work transcends these areas into health care and social services. The number of alcohol and/or drug related crashes includes where there was a positive alcohol or drug test, or the officers opinion was "yes for alcohol, drug or both.

Graduation Rate – Alabama State Department of Education**,** Accountability Reporting System

The Alabama State Department of Education (ALSDE) serves over 741,000 K-12 students in 132 public school systems. The Accountability team in the Office of Education Information and Accountability is responsible for managing and developing the state accountability program as it pertains to Adequate Yearly Progress (AYP) determinations and reporting. The Accountability Reporting System provides reports related to Cohort, AYP, Status of Systems, and Assessment Exams

Poverty Rates – US Census, Small Area Income and Poverty Estimates

The US Census Bureau, with support from other federal agencies, created the Small Area Income and Poverty Estimates (SAIPE) program to provide more current estimates of selected income and poverty statistics than those from the most recent decennial census. Estimates are created for school districts, counties, and states. These estimates combine data from administrative records, intercensal population estimates, and the decennial census with direct estimates from the American Community Survey to provide consistent and reliable single-year estimates. Poverty rate estimates for 2020 was used which was released in December 2021 .

Suicides – Alabama Department of Public Health, Center for Health Statistics, Mortality Statistical Query System

The Center for Health Statistics (CHS) collects and tabulates health-related statistical data and operates the vital records system for the State of Alabama. The Statistical Analysis Division in the Center for Health Statistics conducts studies and provides analysis of health data for public health policy and surveillance. The division prepares various statistical analyses of natality, pregnancy, general mortality, infant mortality, causes of death, marriage, divorce, and other demographic and health-related data for the state and its geographical regions. The CHS houses the Mortality Statistical Query System which provides a means to create tables showing frequencies of Alabama resident deaths for 1990 through 2021by county, race, sex, age group, and cause of death.

Substance Abuse Treatment Admissions – Alabama Department of Mental Health, Alabama Substance Abuse Information System

Alabama Substance Abuse Information System (ASAIS), is a web-based management information system that will assist the Substance Abuse Services Division in achieving the goal of providing the highest level of client care with the funds we have available. It provides substantial built-in electronic medical record components for case management, outcomes management, financial management, and provider network management resulting in streamlined processes, increased communication, and improved access to information.

Category	Measure	Impact	Data Source	Year of Data	Weight (%)
Substance Use	Alcohol and/or Drug Related Motor Vehicle Crashes	Negative	University of Alabama, Center for Advanced Public Safety	2016 -18 & 2020	30
Substance Use	Substance Abuse Treatment Admissions	Negative	Alabama Department of Mental Health, Alabama Substance Abuse Information System	2020	30
Mental Illness	Suicide Rate	Negative	Alabama Department of Public Health, Center for Health Statistics, Mortality Statistical Query System	2021	20
Social & Economic	High School Graduation	Positive	Alabama State Department of Education, Accountability Reporting System	2018 - 2019 (Graduation Cohort)	10
Social & Economic	Poverty Rate	Negative	US Census, Small Area Income and Poverty Estimates	2020	10

FY2023-2028

Appendix 5 – Funding Allocation Amounts per 310 Catchment and County

310 Catchment Area	County	Population 2021	Need	Tier	Identified Need/Population Allocation	Minimum Allocation	Required County Spending Amount	Total Catchment Allocation
1	Lauderdale	94,043	47	Need – Mid/Low Population - Highest	101,418.00			**226,887.00**
	Franklin	32,013	49	Need – Lower Bottom Population – Mid/Low	76,691.00			
	Colbert	57,474	58	Need – Lowest Population – Mid/ Low	48,778.00			
2	Morgan	123,668	22	Need – Lower Population - Highest	110,091.00			**268,960.00**
	Lawrence	33,090	63	Need – Bottom Tier Population – Mid/Low	110,091.00			
	Limestone	107,517	28	Need – Lower Tier Population - Highest	48,778.00			

Appendix 5 – Funding Allocation Amounts per 310 Catchment and County

310 Catchment Area	County	Population 2021	Need	Tier	Identified Need/Population Allocation	Minimum Allocation	Required County Spending Amount	Total Catchment Allocation
3	Madison	395,211	4	Need – Lowest Population – Highest	118,764.00			**118,764.00**
4	Fayette	16,148	65	Need – High Population –Low	28,997.00			**249,587.00**
	Lamar	13,689	64	Need – High Population – Lowest	28,997.00			
	Walker	64,818	55	Need – Mid Population - High	68,560.00			
	Marion	29,246	6	Need – Mid Population – Mid/Low	74,255.00			
	Winston	23,652	61	Need – Bottom Tier Population - Low	48,778.00			
5	Jefferson	667,820	1	Need – Lower Bottom Population – Highest	118,764.00			**322,892.00**

Appendix 5 – Funding Allocation Amounts per 310 Catchment and County

310 Catchment Area	County	Population 2021	Need	Tier	Identified Need/Population Allocation	Minimum Allocation	Required County Spending Amount	Total Catchment Allocation
	St. Clair	92,748	18	Need – Lowest Population – Highest	94,037.00			
	Blount	59,041	17	Need – Lowest Population – Mid/High	110,091.00			
6	Etowah	103,162	14	Need – Low Population - Highest	118,764.00			**252,906.00**
	Cherokee	24,996	62	Need – Lower Bottom Population - Low	48,778.00			
	DeKalb	71,813	30	Need – Lower Bottom Population – Highest	85,364.00			
7	Calhoun	115,972	10	Need – Lower Population – Highest	118,764.00			**164,565.00**

Appendix 5 – Funding Allocation Amounts per 310 Catchment and County

310 Catchment Area	County	Population 2021	Need	Tier	Identified Need/Population Allocation	Minimum Allocation	Required County Spending Amount	Total Catchment Allocation
	Cleburne	15,103	32	Need – Lower Bottom Population – Lowest	45,801.00			
8	Tuscaloosa	227,007	9	Need – Mid Population – Highest	118,764.00			**232,582.00**
	Pickens	18,801	38	Need – Mid/Low Population – Low	56,909.00			
	Bibb	22,477	43	Need – Lower Bottom Population – Low	56,909.00			
9	Coosa	10,450	41	Need – High Population – Lowest	37,128.00			**225,202.00**
	Talladega	81,524	21	Need – Low Population - Highest	85,364.00			
	Randolph	21,989	19	Need – Bottom Tier Population – Low	65,582.00			

Appendix 5 – Funding Allocation Amounts per 310 Catchment and County

310 Catchment Area	County	Population 2021	Need	Tier	Identified Need/Population Allocation	Minimum Allocation	Required County Spending Amount	Total Catchment Allocation
	Clay	14,190	45	Need – Bottom Tier Population - Lowest	37,128.00			
10	Sumter	12,164	39	Need – High Population –Low	37,128.00			**214,636.00**
	Greene	7,629	34	Need – Mid Population - Lowest	45,801.00			
	Marengo	18,996	29	Need – Low Population – Low	65,582.00			
	Hale	14,754	37	Need – Lower Population – Low	37,128.00			
	Choctaw	12,533	67	Need – Lowest Population – Lowest	28,997.00			
11	Chilton	45,274	24	Need – Mid Population – Mid	85,364.00			**204,128.00**

Appendix 5 – Funding Allocation Amounts per 310 Catchment and County

310 Catchment Area	County	Population 2021	Need	Tier	Identified Need/Population Allocation	Minimum Allocation	Required County Spending Amount	Total Catchment Allocation
	Shelby	226,902	12	Need – Bottom Tier Population – Highest	118,764.00			
12	Russell	58,722	11	Need – Mid Population – Mid/High	94,037.00			**381,093.00**
	Chambers	34,541	16	Need – Lower Population – Mid/Low	74,255.00			
	Tallapoosa	41,023	15	Need – Lower Population – Mid	94,037.00			
	Lee	177,218	5	Need – Lower Bottom Population – Highest	118,764.00			
13	Dallas	37,619	27	Need – High Population – Mid/Low	85,364.00			**151,489.00**

Appendix 5 – Funding Allocation Amounts per 310 Catchment and County

310 Catchment Area	County	Population 2021	Need	Tier	Identified Need/Population Allocation	Minimum Allocation	Required County Spending Amount	Total Catchment Allocation
	Wilcox	10,446	66	Need – Mid Population – Lowest	28,997.00			
	Perry	8,355	46	Need – Bottom Tier Population - Lowest	37,128.00			
14	Lowndes	9,965	40	Need – High Population – Lowest	37,128.00			**335,293.00**
	Montgomery	227,434	3	Need – Mid/Low Population – Highest	118,764.00			
	Elmore	89,304	8	Need – Low Population – Highest	94,037.00			
	Autauga	59,095	20	Need – Lowest Population – Mid/High	85,364.00			

Appendix 5 – Funding Allocation Amounts per 310 Catchment and County

310 Catchment Area	County	Population 2021	Need	Tier	Identified Need/Population Allocation	Minimum Allocation	Required County Spending Amount	Total Catchment Allocation
15	Pike	32,991	23	Need – High Population – Mid/Low	65,582.00			**176,965.00**
	Macon	18,895	25	Need – Mid Population – Low	65,582.00			
	Bullock	10,320	33	Need – Lower Population – Lowest	45,801.00			
16	Mobile	413,073	2	Need – Low Population - Highest	118,764.00			**147,761.00**
	Washington	15,147	56	Need – Bottom Tier Population – Low	28,997.00			
17	Escambia	36,699	35	Need – High Population – Mid/Low	76,691.00			**203,244.00**
	Conecuh	11,328	60	Need – High Population – Lowest	28,997.00			

Appendix 5 – Funding Allocation Amounts per 310 Catchment and County

310 Catchment Area	County	Population 2021	Need	Tier	Identified Need/Population Allocation	Minimum Allocation	Required County Spending Amount	Total Catchment Allocation
	Monroe	19,648	54	Need – Lowest Population – Low	48,778.00			
	Clarke	22,760	52	Need – Lowest Population – Low	48,778.00			
18	Covington	37,524	51	Need – Mid Population – Mid	76,691.00			**239,288.00**
	Butler	18,884	36	Need – Mid/Low Population – Low	56,909.00			
	Coffee	54,174	44	Need – Lower Bottom Population – Mid/High	76,691.00			
	Crenshaw	13,083	59	Need – Lowest Population – Lowest	28,997.00			
19	Geneva	26,701	48	Need – High Population – Mid/Low	56,909.00			**338,270.00**
	Houston	107,458	13	Need – Mid Population – Highest	118,764.00			

Appendix 5 – Funding Allocation Amounts per 310 Catchment and County

310 Catchment Area	County	Population 2021	Need	Tier	Identified Need/Population Allocation	Minimum Allocation	Required County Spending Amount	Total Catchment Allocation
	Henry	17,459	57	Need – Lower Population – Low	28,997.00			
	Barbour	24,964	50	Need – Lower Population – Mid/Low	56,909.00			
	Dale	49,342	42	Need – Lower Bottom Population – Mid/High	76,691.00			
20	Jackson	52,773	53	Need – Lower Population – High	68,560.00			**178,651.00**
	Marshall	98,228	31	Need – Lower Population - Highest	110,091.00			
21	Baldwin	239,294	7	Need – Lower Bottom Population – Highest	118,764.00			**118,764.00**

Appendix 5 – Funding Allocation Amounts per 310 Catchment and County

310 Catchment Area	County	Population 2021	Need	Tier	Identified Need/Population Allocation	Minimum Allocation	Required County Spending Amount	Total Catchment Allocation
22	Cullman	89,496	26	Need – Mid/Low Population – Highest	85,364.00			**85,364.00**

Appendix 6 - Z-Score Calculation Example

- This data is not factual. It is only for explanation purposes.

Step 1. Collect your data

Autauga	77
Bullock	85
Chambers	67
Choctaw	65
Dallas	74
Elmore	59
Greene	73
Hale	81
Lee	58
Lowndes	82
Macon	75

Step 2. Find the mean of the counties.
a. Add all the values together and divide the number of counties used
77+85+67+65+74+59+73+81+58+82+75 = 796
796/11= 72.36

Step 3. Calculate the standard deviation of the counties.
Represents how tightly or loosely the values are grouped around the mean. In this example, the standard deviation of the set of data is 9.091455.

Step 4. Calculate the Z score.
For this example purposes Autauga county sample was used to calculate Z-score

$$Z = \frac{\text{(County Value) – (Average of Counties in the Region)}}{\text{(Standard Deviation of Counties in the Region)}}$$

$$Z = \frac{77-72.36}{9.09} = 0.51$$

The result of that formula is the Z score of the chosen sample, indicating how many standard deviations away from the mean the chosen sample lies. For this example the Z-score indicates how many standard deviations above the mean the sample lays.

Step 5. Multiple by Weight
For this example purposes, a weight of 20% was give for the factor above.

Z-score *weight = 0.51*.20 = 0.102