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Section II: Planning Steps – Step 1: Assess the strengths and needs of the service system to address specific populations

- Provide an overview of the State's behavioral health prevention, early identification, treatment, and recovery support systems. 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 SSA, the SMHA and other state agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic and sexual gender minorities.

Overview and Organization of the Public Mental Health Service Delivery System

The Alabama Department of Mental Health (DMH) was created under Act 881 of the 1965 legislature and was charged with the responsibility of establishing a public mental health system. The Department is responsible for mental illness, intellectual disability, and substance abuse services. The Department serves as both the Single State Authority (SSA) for the Substance Abuse Prevention and Treatment Block Grant, as well as the State Mental Health Authority (SMHA) for the Community Mental Health Services Block Grant (SAPT/CMHS). The Department is responsible for operating state psychiatric facilities, establishing standards for community services, and is empowered to contract for services. The Commissioner of DMH, and other Departmental staff coordinate services with other state agencies such as the Department of Human Resources (child welfare – adult and child protective agency), Department of Youth Services (juvenile justice), Department of Corrections, Department of Public Health, and Medicaid. DMH is involved in coordinating services with these agencies through multiple committees, workgroups, and daily contacts. Services are coordinated both for individuals and for systems of care.

The Commissioner of the DMH is a cabinet member appointed by the Governor. Gubernatorial elections were held for the 2011-2014 term. Upon taking office in January 2011, newly elected Governor Robert Bentley appointed Zelia Baugh as the Commissioner for the Department of Mental Health which dismissed the standing Commissioner, John Houston. Commissioner Baugh changed many of her executive staff positions, to include the Associate Commissioner of Mental Illness (Acting Dr. Beverly Bell-Shambley), Associate Commissioner of Substance Abuse (Dr. Tammy Peacock), and Associate Commissioner of Developmental Disabilities (Ann White-Spunner).

Commissioner Baugh set forth a new vision which included merging the long separated Mental Illness Division and Substance Abuse Division. Historically the DMH Division of Mental Illness, under the direction of the Associate Commissioner, has responsibility for operation of state psychiatric hospitals and the development and coordination of the system of community treatment services for mental illness. This responsibility includes contracting for services with local providers and monitoring those service contracts, evaluation, and certification of service programs in accordance with statutory standards, implementation of a joint hospital and community Performance Improvement Plan, and

planning for the development of needed services. In addition to the Offices of Community Programs, Certification, and Performance Improvement, the Division of Mental Illness includes an Office of Consumer Relations and an Office of Deaf Services.

With the merging of the Division of Mental Illness and the Division of Substance Abuse Services, DMH went from having three service divisions (MI/SA/DD) to two services divisions – the Mental Health Substance Abuse Services Division and the Developmental Disabilities Services Division. The newly appointed Associate Commissioner, Dr. Tammy Peacock, became the Associate Commissioner of the Mental Health Substance Abuse Services Division. Much work occurred to break down “service silos” that have long existed between the traditionally separate Mental Illness and Substance Abuse Divisions while at the same time providing better recovery-oriented services for those individuals with mental illnesses, substance use disorders, and co-occurring disorders.

On June 2012, Commissioner Zelia Baugh tendered her resignation with this being effective June 30, 2012, as well as the departure of two of the Associate Commissioners, Ann White-Spunner – Developmental Disabilities Service Division and Dr. Tammy Peacock – Mental Health and Substance Abuse Services Division. Governor Bentley appointed as the new Commissioner of Mental Health Jim Reddoch, effective July 2012. Commissioner Reddoch appointed three new positions – Associate Commissioner of the Developmental Disabilities Division, Courtney Tarver; Associate Commissioner of Mental Health Substance Abuse Services Division, Dr. Beverly Bell-Shambley; and General Council of DMH, Tommy Klinner.

There were six state-run mental illness inpatient treatment facilities serving adults in Alabama. Bryce Hospital in Tuscaloosa operates an acute unit and an extended care unit. In October 1, 2010, the Department of Mental Health contracted with the University of Alabama Department of Psychiatry and Behavioral Neurobiology to operate the Adolescent Unit that was formerly operated by Bryce Hospital. Two other facilities operate in Tuscaloosa: Taylor Hardin Secure Medical Facility providing services for Alabama’s male forensic psychiatric population and the Mary Starke Harper Geriatric Psychiatric Center, providing specialty geriatric services. Searcy Hospital in Mt. Vernon (near Mobile) operated an acute care unit and an extended care unit. North Alabama Regional Hospital in Decatur, AL operates acute care units. Greil Hospital in Montgomery, AL operated acute care units.

Due to severe budget reductions and a decrease in state dollars for DMH by approximately \$40 million over a four year period of time, FY12 provided unique planning opportunities for DMH and its long-standing partners (consumer and family advocate groups, providers, etc.). Through two DMH Administrations, much direct focus and planning was given to determining to most effective way to move toward a transformed system that could be provided with such funding cuts. This planning process led to a restructuring in how DMH would provide post commitment care to consumers civilly committed (Probate Court commitments) to DMH and the process would have to occur over a multiple year process to achieve true statewide restructuring. However to address the budget demands in FY12, most all of the efforts of DMH was focused on the

closure of two state-run mental illness inpatient treatment facilities serving adults in Alabama. To accomplish this meant building an infrastructure within communities of Region 3 and Region 4 (both in the southern portion of Alabama) which included an array of services to include Designated Mental Health Facilities (DMHF) to provide post-commitment care that would replace this service being provided in a state-run psychiatric hospital. By implementing this process, DMH was able to close Searcy Hospital in Mt. Vernon (near Mobile) operating an acute care unit and an extended care unit and Greil Hospital (in Montgomery) operating acute care units.

As of November 2012, there are four state-run mental illness inpatient treatment facilities serving adults in Alabama:

- Bryce Hospital in Tuscaloosa operates an acute unit and an extended care unit.
- Taylor Hardin Secure Medical Facility in Tuscaloosa operates units for Alabama's male forensic psychiatric population
- Mary Starke Harper Geriatric Psychiatric Center in Tuscaloosa operates units providing specialty geriatric services.
- North Alabama Regional Hospital in Decatur operates acute care units.

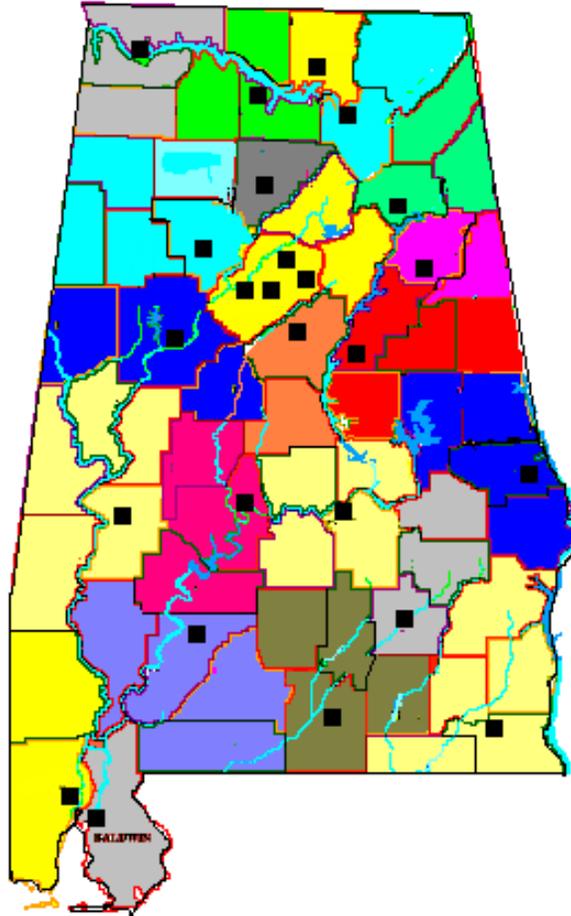
Through the Juvenile Code in Alabama, the courts have the authority to commit adolescents to DMH for psychiatric stabilization in cases where the criteria outlined in the juvenile law is met. As these are adolescents, through the Juvenile Commitment, the minor is placed in the custody of DMH for the purposes of providing psychiatric treatment. Once the committed youth consumer has met maximum benefit from commitment to DMH, the court releases DMH from commitment and re-establishes custody with an entity other than DMH. Prior to October 2010, the care for committed youth was provided in a state-run mental illness inpatient treatment facility serving adolescents at Bryce Hospital in Tuscaloosa. With appropriate amendments to the Juvenile Code, the Commissioner of DMH was provided the authority to have such committed youth consumers served in a state-run mental illness inpatient treatment facility or with a contracted inpatient treatment facility. In October 1, 2010, the Department of Mental Health contracted with the University of Alabama Department of Psychiatry and Behavioral Neurobiology to operate the DMH Adolescent Psychiatric Unit at UAB.

The public community mental health services system is based upon 22 service areas. There are 22 public, non-profit regional mental health boards (called 310 Boards based on ACT 310 of the 1967 Regular Session of the Alabama Legislature). There are 25 community mental health centers in the 22 service areas. The Birmingham area has a regional 310 Board and three mental health centers. Outside of the Birmingham area, the mental health centers are organized with a main center in the most populous county or city in their catchment area and satellite offices in outlying counties/areas. Each one of the 67 counties, with the exception of one, has a full-time office. The mental health centers provide a continuum of services to all ages with a focus on adults who have a serious mental illness and youth who have a severe emotional disturbance. In some areas, the mental health center also provides services for those who have intellectual disabilities and/or substance use disorders. In addition to the community mental health centers, the

Department contracts with two specialty child and adolescent service providers: 1) Brewer-Porch in Tuscaloosa and 2) Glenwood, Inc. in Birmingham.

Community services are funded through a mix of resources including federal MH Block Grant funds, state funds, Medicaid, Medicare, other third party (insurance), local government, donations, and client fees generated under a sliding fee scale. The level of city and county support for these providers varies significantly across the state. In addition to contracting with DMH, providers may also enter local arrangements with the Department of Human Resources, the Department of Youth Services, and local education agencies. In FY 2014, block grant funds will account for approximately 2.5% of DMH contracts for Community Mental Health services while state sources such as the General Fund, Special Mental Health Fund and other state sources accounted for 52.8% of total resources. Medicaid reimbursements and other federal funding account for an additional 45.7% of the DMH Community Mental Health budget. This does not include support that is provided by local sources, the proportion of which varies greatly from center to center.

Community Mental Health Service Areas



■ CMHC Main Centers

Hospitalization

(Downsizing effort for community integration)

Adults

In 1970 Alabama faced a lawsuit, Wyatt vs. Stickney, which brought the “right to treatment” for state psychiatric hospital patients into the foreground. This litigation significantly influenced fundamental changes in architectural features of this States’ mental health service delivery system. Upon the filing of the suit, the longest running mental health lawsuit in US history, DMH started shifting focus from providing mental

health treatment within the confines of large- scale institutional walls towards creating a new vision and thus, constructing the foundation necessary for community based mental health treatment. The 1999 Olmstead “integration mandate” decision further inspired the pursuit of building more appropriate and effective mental health service models within the community mental health landscape. As DMH continues pursuing the development and expansion of new and enhanced community supports, great effort and commitment to reflect the desires of consumer partners and to be guided by the voices of those we serve, remain at the core of its design.

DMH has moved steadily towards less reliance upon state psychiatric inpatient services by shifting funding to less costly, but more effective community services and supports. Since 1971, the census at Bryce alone dropped from over 5,000 patients to less than 400 in 2004. In order to meet the requirements of the Wyatt settlement, DMH made provisions to utilize a census reduction model in which the care of individuals housed within the States’ extended care wards would be transferred to the community provider network. Moreover, strides to better serve consumers outside of inpatient settings continued beyond those prompted by the settlement leading to a statewide reduction in hospital census as well as closures of state operated facilities. Through the dedicated efforts of state psychiatric hospitals and community partners, DMH can boast nearly a 44% statewide reduction in total state psychiatric hospital census from FY09 to present (June 2013).

In 2007, with the establishment of an appointed taskforce, transferring acute care operations from state hospital admission units to the community was the primary focus. Four regional planning groups composed of consumers, family members, mental health centers, state hospital directors, Probate Judges, and private providers, developed “acute care plans” for the establishment of new services. Increased funding in FY07 and FY08 supported the recommendations of the four regional planning groups specifically to reduce use of state psychiatric hospitals as well as to promote system transformation. Whenever possible, local providers work with hospitals to secure local psychiatric inpatient services for indigent consumers. Probate judges can also make involuntary commitments to local inpatient units or residential programs that request and receive ‘designated mental health facility’ status per the 1991 commitment law. These additions to the service array included purchase of additional local inpatient care, increased psychiatric time, and development of a psychiatric assessment center:

- Inpatient – Twelve centers proposed some type of local inpatient/psychiatric emergency service to increase/enhance local inpatient or acute care services (the Psychiatric Emergency Room proposed for Birmingham was eliminated in FY09 due to budget cuts - it had not opened)
- Residential – 325 new residential beds ranging from apartments to specialized medical homes (24 Supportive Housing units that had not opened were eliminated due to budget cuts)
- Assertive Community Treatment Teams – six new teams
- Community Support Specialists – five positions designed to assist consumers with development of daily living skills
- Adult In-home Intervention Teams – ten new two person teams

- Bridge Teams – two new teams in the Mobile area
- Psychiatric Assessment Center- Montgomery

In 2010, DMH again pursued the implementation of a census reduction model to address critical overages in state hospitals with a primary focus on Regions 2 and 4. The initial planning for the “Downsizing Project” started during FY09 at which time residents of Bryce and Searcy who were living in Extended Care units or who had a length of stay greater than 90 days were evaluated in order to determine what community services would be needed to promote discharge from the hospital. The evaluation teams were composed of hospital staff, community staff, and advocates. Based on the evaluation and the input of the consumer, community services were proposed to support discharge of these individuals. The planning process continued into FY10 and was incorporated into planning for the sale of Bryce Hospital to the University of Alabama and subsequent construction of a smaller state of the art hospital. Final plans were developed and approved by the Bryce Consumer Transitioning Work Group, the Mental Illness Coordinating Subcommittee, and the Commissioner. Nontraditional financial models were utilized such as incentive and risk barring contracts based on regional outcomes and performance. The community provider network in Regions 2 and 4 established Board of Supervisor groups for the purposes of promoting service coordination and monitoring of project goals at a regional level. New services began in June 2010 in Region 2 (Bryce) and in August 2010 in Region 4 (Searcy).

The plans included the development of the following community services in the Bryce Hospital area (Region 2):

- 84 Supportive Housing Units
- 60 Medication, Observation, and Meals (MOM) beds
- 30 Augmented existing residential beds
- 12 beds in 3 bed group homes
- Peer Bridger Team
- Clinical Support Team
- Flex Funds for Support

The plans for community services in the Searcy area (Region 4) included the following:

- 60 Supportive Housing Units
- 40 Medication, Observation, and Meals (MOM) beds
- 56 Augmented existing residential beds
- 12 beds in 3 bed group homes
- 16 Assisted Living Beds in scattered sites
- Peer Bridger Team
- Flex Funds for Support

In May 2011, the maximum capacity for Bryce’s and Searcy’s extended care units were formally reduced further underscoring DMH’s commitment to operate smaller inpatient facilities and shift budgetary funds traditionally from state hospitals, to the expansion of services and supports better constructed to promote independence and inclusion into the

community for consumers. As a result of the Downsizing Project, there was a reduction of the census at Bryce Hospital by 116 from a FY09 baseline average daily census of 318 to 202, exceeding the target goal of 222; and a reduction in the census at Searcy by 70 from a baseline average daily census of 351 to 245 exceeding the project target of 255.

In the wake of the above described initiatives, the financial atmosphere of FY11/12 and desire to advance a more responsive system of care prompted an acceleration of the Department's goals to further reduce the number of acute care psychiatric beds and to bring about the closure of some state operated facilities. The 2012 Hospital Closure Project resulted in the Department closures of Greil Memorial Psychiatric Hospital (Montgomery County) August 31, 2012 and Searcy Hospital (Mobile County) October 31, 2012. Collectively, these two hospitals served a total of 1,231 individuals in FY11. Over ninety percent of Greil and Searcy's inpatient capacity has been shifted to local communities. As a means of supporting this shift, an innovative framework for processing inpatient commitments was born from the Hospital Closure Project. The dedicated and unprecedented cooperation between state government, local provider agencies, and local probate courts resulted in a new Department of Mental Health Commitment Procedure specifically for Regions 3 and 4 and for which the success of this project hinged. A pivotal element to the newly established commitment procedure was the development of the Gateway System which permits for the tracking of probate committed individuals to be served within the community at a Designated Mental Health Facility or Willing Hospital Participant locals. This process allows for ongoing flexibility, customization, and movement within less restricted levels of care outside of state operated institutions.

The plans included the expansion and/or development of the following community services in the Region 3 area (with closure of Greil Hospital):

- Local inpatient psychiatric treatment provided in a hospital setting for either pre/post-commitment care.
- Medication cost provision for indigent population with loss of IDP.
- One ER screening system with partnership between a community mental health center and local hospital.
- Two Crisis Residential treatment facilities (31 beds) to provide psychiatric stabilization treatment in a DMHF non-hospital setting for either pre/post commitment care.
- Psychiatric access and care
- One probate liaison
- 24 Supportive Housing Units
- 22 Medication, Observation, and Meals (MOM) beds
- 2 Respite beds
- 3 crisis mobile teams

The plans included the expansion and/or development of the following community services in the Region 4 area (with closure of Searcy Hospital):

- Local inpatient psychiatric treatment provided in a hospital setting for either pre/post-commitment care.

- Four Crisis Residential treatment facilities (64 beds) to provide psychiatric stabilization treatment in a DMHF non-hospital setting for either pre/post commitment care.
- Psychiatric access and care
- 60 Supportive Housing Units
- 25 Medication, Observation, and Meals (MOM) beds
- One Centralized Service system with a community mental health center.

Presently DMH is pursuing a similar effort for Regions 1 and 2 in which the utilization of community inpatient capacity will supplement or supplant acute care functions at North Alabama Regional Hospital (NARH) and Bryce Memorial Hospital respectively. This initiative is referred to as the “Hospital Repurposing Project.” In FY12, NARH served 728 individuals with an acute inpatient bed capacity of 74. Bryce served 897 individuals with an acute and extended care inpatient bed capacity of 268.

The current plans include the expansion and/or development of the following community services in the Region 1 area:

- Local inpatient psychiatric treatment provided in a hospital setting for either pre/post-commitment care.
- Four Crisis Residential treatment facilities (64 beds) to provide psychiatric stabilization treatment in a DMHF non-hospital setting for either pre/post commitment care.
- One augmented residential care home (12 beds)

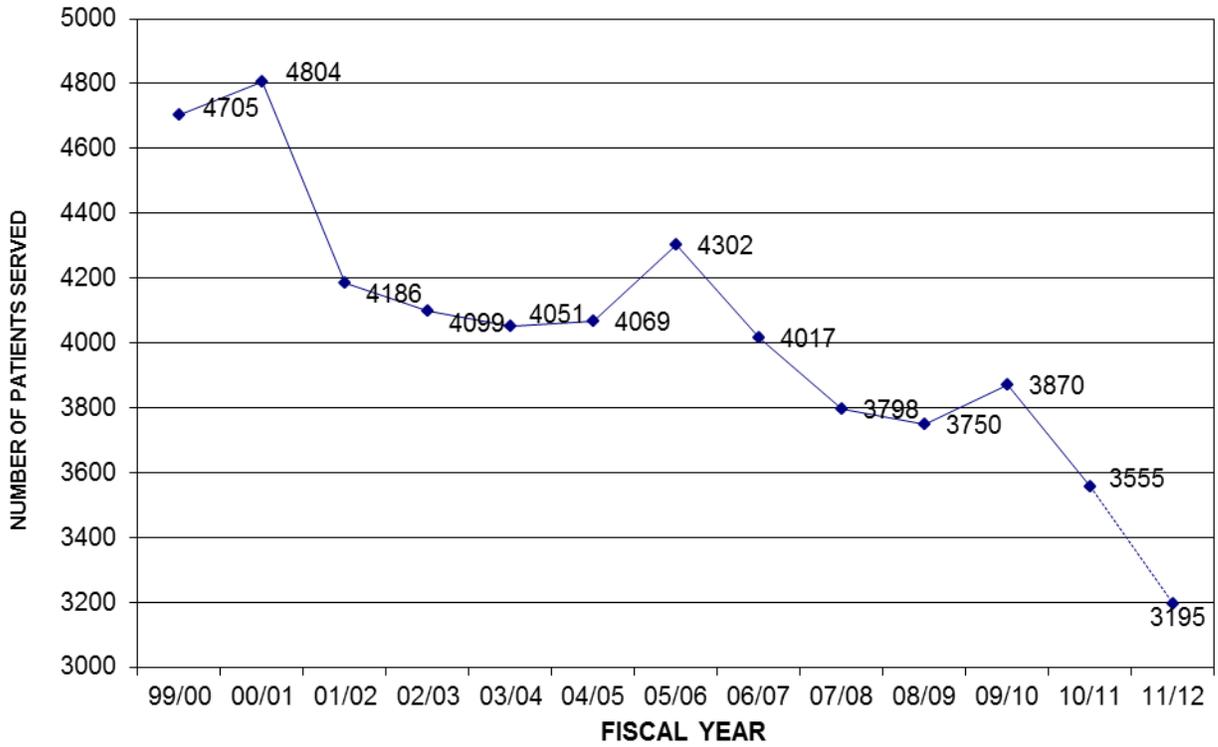
The current plans include the expansion and/or development of the following community services in the Region 2 area:

- Local inpatient psychiatric treatment provided in a hospital setting for either pre/post-commitment care.
- Medication cost provision for indigent population with loss of IDP.
- One preventive urgent behavioral health care facility
- 16 beds in a Specialized Medical group home
- 30 beds dedicated to the care of forensic consumers
- 21 beds in 3 bed group homes (15 positioned in Region 1)
- 36 Supportive Housing Units
- 5 crisis mobile teams

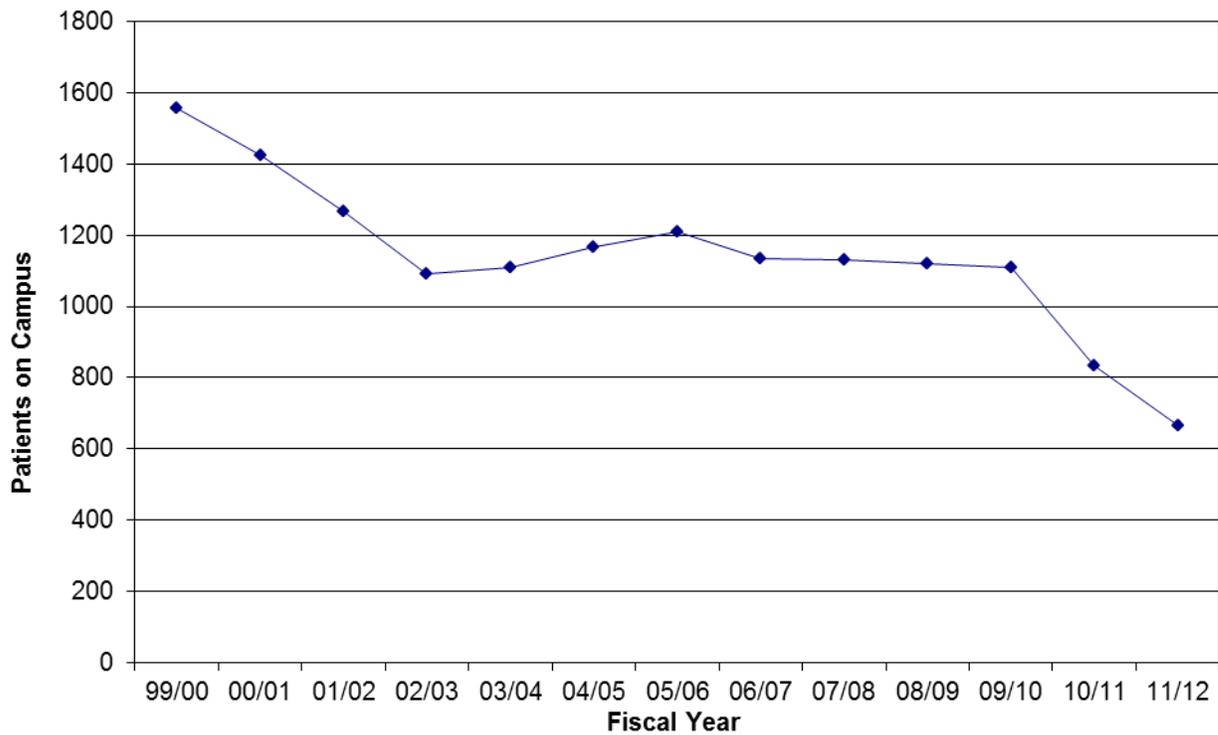
Although the overall state hospitals’ census operates above capacity in some areas, the effort over the past four years to reduce hospital census is generating significant results. The number of patients in residence at end of the year, the number of admissions/readmission, and the total served by state hospitals all show reductions. In FY09, prior to the implementation of the latest series of census reduction projects, the statewide average daily census for all state operated facilities serving adult geriatric, forensic, extended care, and acute care populations totaled 1,054. Compared to this FY09 baseline end of year average daily census, DMH reduced the total statewide

hospital census in FY12 by nearly 24%. DMH demonstrated nearly a 44% statewide reduction in total state psychiatric hospital census from FY09 to present (June 2013).

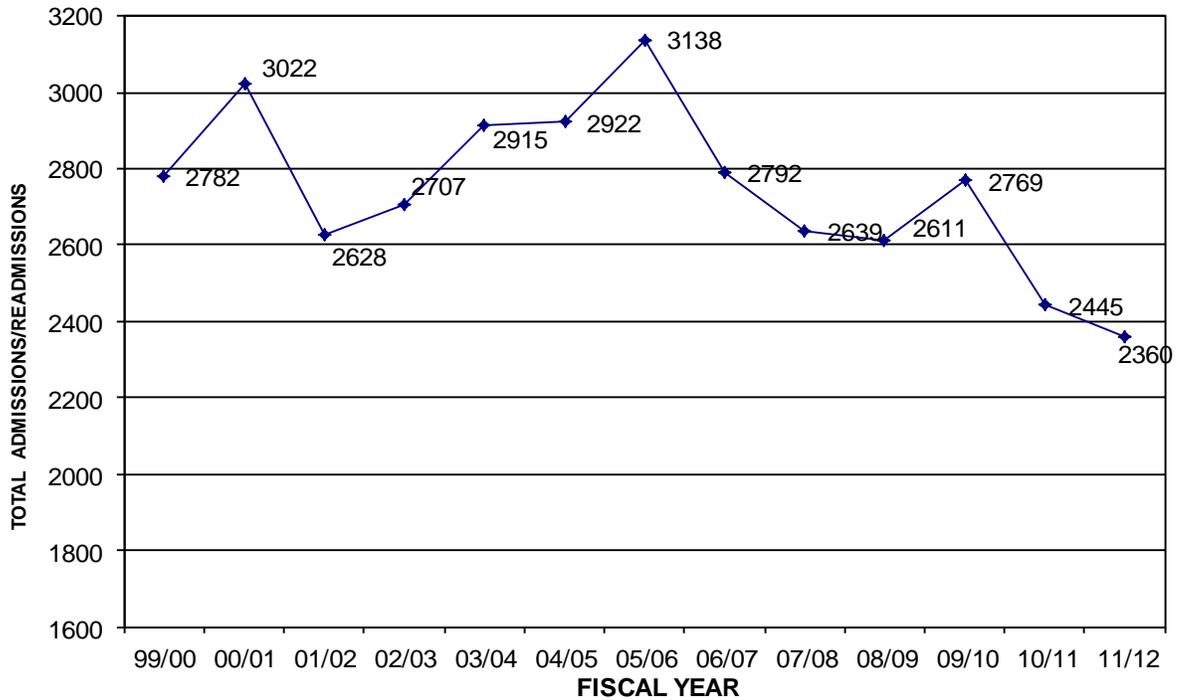
PATIENTS SERVED IN MI FACILITIES



All MI Patients at the End of Fiscal Year



ADMISSIONS & READMISSIONS TO MI FACILITIES

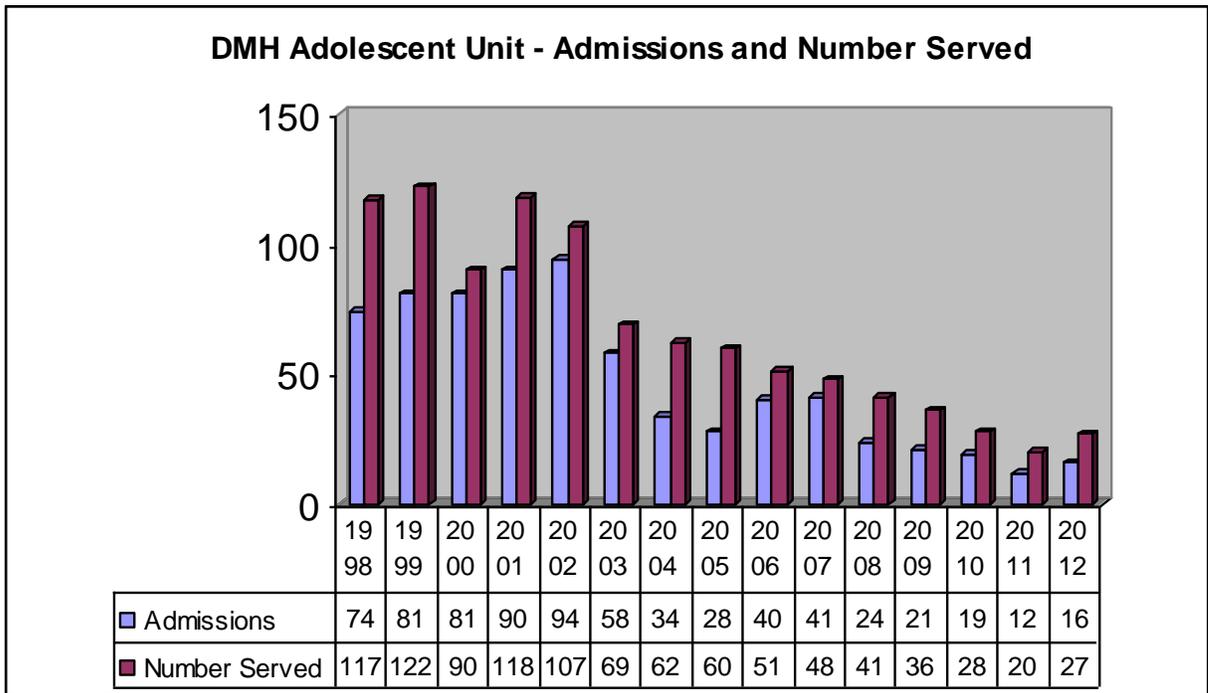


ADOLESCENTS

In regard to adolescents, the inpatient beds operated by the Mental Health system in Alabama for adolescents were located at Bryce State Hospital Adolescent Unit serving the state's child and adolescent population. In March of 2004, the original 40 bed unit for adolescents at Bryce Hospital was reduced to a 20 bed unit. While this reduction was in part a cost saving measure, it was possible because of the significant census reduction experienced by the unit. A total of 19 adolescents were admitted and 28 served at the Adolescent Unit at Bryce Hospital during FY10. This number represented a decrease in total number admitted and in total number served from the previous years. The unit remained below capacity. The ability to keep census below capacity is attributed to the expansion of community services and the development of a service referred to as a Juvenile Court Liaison. Juvenile Court Liaisons work closely with the state child and adolescent services staff, with the sole mission of appropriately diverting mental health and juvenile court commitments in lieu of more appropriate community based services. Children or adolescents are not placed in out-of-state programs by DMH, Division of Mental Illness and Substance Abuse Services.

During the FY09 legislative session, an amendment to the Juvenile Code was signed by the Governor in May 2009 that affirmed the DMH 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. These changes were in line with the recommendations of the Child and Adolescent Workgroup of the Systems Reconfiguration Task Force. A contract transferring the operation of the DMH Psychiatric Adolescent Unit from Bryce Hospital into a smaller (10 bed) unit at the University of Alabama in Birmingham Department of Psychiatry and Behavioral Neurobiology was signed. The transfer was effective in October, 2010. Since moving into the new location at UAB, the unit has continued to remain at or near capacity most of the time, even though the number of beds is half of that at the Bryce Adolescent Unit. This has been due to continued success in expanding and improving access to less-restrictive community-based treatment options for children and adolescents, and continued effective collaboration between child-serving agencies at the state and local level.



Community Based Mental Health Services

The services eligible for reimbursement for the adults who are severely mentally ill (SMI) and children and adolescents who are severely emotionally disturbed (SED) throughout the state, via contractual relationships between the Department and the 310 Boards, are shown below. Many of these service categories apply to both adult and child populations. The contract eligibility criteria specify that funds should be used to serve individuals who cannot afford to pay, are not insured, and who meet the criteria for Serious Mental Illness and Severe Emotional Disturbance as well as those individuals presenting in an emergency situation.

Mental Illness Ambulatory Services

1. *Intake/Evaluation*
2. *Diagnostic Testing*
3. *Individual Counseling or Psychotherapy*
4. *Group Counseling or Psychotherapy*
5. *Family Counseling or Psychotherapy*
6. *Crisis Intervention and Resolution*
7. *Pre-Hospitalization Screening/Court Screening*
8. *Physician/Medical Assessment and Treatment (to include telemedicine)*
9. *Medication Administration*
10. *Medication Monitoring (Non-Physician)*
11. *Partial Hospitalization Program (adults only)*
12. *Adult Intensive Day Treatment*
13. *Adult Rehabilitative Day Program*
14. *Child and Adolescent Mental Illness Day Treatment*
15. *Adult In-Home Intervention*
16. *Child and Adolescent In-Home Intervention*
17. *Assertive Community Treatment (ACT) (adults only)*
18. *Program for Assertive Community Treatment (PACT) (adults only)*
19. *Mental Illness Basic Living Skills*
20. *Family Support Education*
21. *Treatment Plan Review*
22. *Mental Health Consultation*

Case Management Services

23. *Case Management*

Residential

24. *Adult Small Capacity (3 bedroom) Residential Care Home*
25. *Adult Residential Care Home*
26. *Adult Residential Care Home with Specialized Basic Services*
27. *Adult Residential Care Home with Specialized Medical Services*
28. *Adult Residential Care Home with Specialized Behavioral Services*
29. *Adult Therapeutic Group Home*
30. *Intermediate Care Program (adults only)*
31. *Crisis Residential Program (adults only)*
32. *Psychiatric Assessment Center (adults only)*
33. *Child/ Adolescent Residential Care Program*
34. *Child/ Adolescent Residential Care Program – Intensive*
35. *Child/ Adolescent Diagnostic and Evaluation Residential Care Program*
36. *Transitional Age Residential Care Program*
37. *Medication/Observation/Meals (MOM) Program (adults only)*

Minimum Continuum of Care

Expectations for providing minimum continuum of care services for a community mental health provider or a community mental health center is outlined fully in the Alabama Department of Mental Health Mental Illness Community Programs within the Administrative Code – Chapter 580-2-9, Program Standards. A provider that meets the respective requirements will be issued one of two types of certificates depending upon the number and type of services delivered by the provider.

(a) **Mental Health Services Provider** – A provider may be certified as a Mental Health Services provider if it provides one or more (but not all) of the services as listed below in compliance with the DMH standards.

- General Outpatient
- Child and Adolescent In-Home Intervention
- Adult In-Home Intervention
- Emergency Services
- Partial Hospitalization Program
- Adult Intensive Day Treatment
- Adult Rehabilitative Day Program
- Child and Adolescent Day Treatment
- Case Management
- Residential Services
- Designated Mental Health Facility
- Consultation And Education
- Assertive Community Treatment
- Program for Assertive Community Treatment
- Child and Adolescent Seclusion and Restraint
- Adult Seclusion and Restraint
- Therapeutic Individualized Rehabilitation Services

(b) **Community Mental Health Center** – A provider will be certified as a Community Mental Health Center (CMHC) if the requirements listed below are met. The requirements are designed to assure that any provider certified as a CMHC provides the array of services defined below either directly or through specific arrangement with another agency/individual to a broad array of recipients in an identified service area without regard to age, race, language of preference, sex, and degree of psychiatric disability. The services must be coordinated in a manner that assures access to inpatient and residential care and to community supports for adults with serious mental illness and children and adolescents severe emotional disturbance.

The provider must provide the following services directly through its employees. In addition to the specific criteria listed below, the provider must also comply with the applicable sections of the program standards for each program element.

- Emergency Services.
- Outpatient Services (to include specialty services for children and elderly),

- Consultation and Education Services,
- Specialty services for persons discharged from an inpatient psychiatric setting and for persons with a serious mental illness/severe emotional disturbance and must include the following:
 - Evaluation and medication monitoring by a psychiatrist.
 - Outreach capability to provide services to consumers in their usual living situation.
 - Provision of case management services in accordance with the program standards either directly or through an arrangement approved by the Alabama Department of Mental Health.
 - Screening for admission to state psychiatric hospitals as evidenced by a written agreement with the local 310 Board (if not a 310 Board), relative to coordination of screening petitions for involuntary inpatient commitment for consumers of the CMHC.
- Partial Hospitalization/Intensive Day Treatment/ Rehabilitative Day Program, **and**
- Must provide residential services either directly through its employees or through agreement with other certified providers.

Because Community Mental Health Centers are expected to offer a broad array of services to a demographically and psychiatrically diverse population, the following additional requirements regarding the overall operation of the agency must be met:

- Staff capable of providing specialty outpatient services to children, adolescents, adults, and older adults.
- Should be able to demonstrate community outreach efforts designed to promote access from all age groups with particular emphasis on those who are seriously mentally ill or severely emotionally disturbed.
- The number of recipients both total and by service type and the services provided are acceptable for the time period that the agency has been operational and are roughly proportionate to the number of consumers and types of services provided by agencies similarly certified.
- The provider can demonstrate appropriate response to consumers for whom a petition for involuntary commitment has been issued and/or who have been hospitalized at a state psychiatric hospital.
- At the end of the first year of operation, the agency must have served at least 100 consumers and the services provided should be proportionate to the average of those agencies that are similarly certified.

Child and Adolescent Development of Continuum of Care

The Levels approach to a minimum continuum of care for mental health services delineated in 1985 by the Alabama CASSP Definition Committee and revised in 1998 and 2004 by the Strategic Plan Workgroup provides a sound framework for prioritizing service development and expansion. The structure (by delineating statewide, regional, and local levels) intends to strike a realistic balance between a minimal service set,

economy of scale, and fiscal reality. It is assumed that DMH, in conjunction with the community mental health centers, will not necessarily create and/or operate the total system, but will exhibit the leadership necessary to assure development, effective operation, and coordination. The continuum as envisioned is as follows:

Level I: (Community/County-Based)

Diagnosis and Evaluation (screening)
Outpatient (Individual, Group, Family)
Family Support (Consultation, education, training, networking to build a support system)

Level II: (Community/Catchment Area-Based)

Diagnosis and Evaluation (comprehensive)
Case Management
Day Treatment
Respite Care
In-Home Intervention
Behavioral Aide
Child and Adolescent Psychiatric Services

Level III: (Regional/Shared)

Respite Care Beds
Crisis Residential
Residential Treatment
Acute Hospitalization

Level IV: (Statewide)

Short Term Treatment and Evaluation Program (STTEP)
DMH Psychiatric Adolescent Unit at UAB

Mental Health and Rehabilitation Services

Alabama continues to develop a comprehensive system of care for children and adolescents with serious emotional disturbances that extend across the state. In addition to the main offices in the 25 community mental health centers, services are available in most of the state's 67 counties through the satellite programs of the CMHCs. The services available vary across the catchment areas (See table below).

2013 Alabama C&A MI Programs by County (8/25/2013)

PROVIDER	Out-patient	JCL	Case Mgt	In-Home	Day Tx	Respite	Tele-med	Resid	SBMH Collab	Youth Peer Spt Spec	Family Peer Spt Spec	Crisis
<u>AltaPointe</u>	---	---	---	---	---	---	---	---	---	---	---	---
Mobile	X	X	X	X	C/A/SC/SA	X	X	X	X			X
Washington	X						X					X
<u>Baldwin County MHC</u>	X	X	X	X	C/A				X			X
<u>Brewer-Porch</u>	X				C			X				X
<u>Cahaba MHC</u>	---	---	---	---	---	---	---	---	---	---	---	---
Dallas	X	X	X	X			X					X
Perry	X	X	X	X			X					X
Wilcox	X	X	X				X					X
<u>Calhoun-Cleburne</u>	---	---	---	---	---	---	---	---	---	---	---	---
Calhoun	X	X	X	X	C (X2)		X					X
Cleburne	X	X	X	X			X					X
<u>Cheaha MHC</u>	---	---	---	---	---	---	---	---	---	---	---	---
Clay	X	X	X	X			X					X
Coosa	X	X	X									X
Randolph	X	X	X				X					X
Talladega	X	X	X									X
<u>CED MHC</u>	---	---	---	---	---	---	---	---	---	---	---	---
Cherokee	X	X	X									X
Etowah	X	X	X	X	C							X
Dekalb	X	X	X									X

PROVIDER	Out-patient	JCL	Case Mgt	In-Home	Day Tx	Respite	Tele-med	Resid	SBMH Collab	Youth Peer Spt Spec	Family Peer Spt Spec	Crisis
<u>Chilton-Shelby MHC</u>	---	---	---	---	---	---	---	---	---	---	---	---
Chilton	X	X	X									X
Shelby	X	X	X	X	C (X2)							X
<u>Cullman MHC</u>	X	X	X	X					X			X
<u>East Alabama MHC</u>	---	---	---	---	---	---	---	---	---	---	---	---
Chambers	X	X	X	X	AC/SC	X						X
Lee	X	X	X	X	AC/SC	X						X
Russell	X	X	X		AC/SC	X						X
Tallapoosa	X	X	X	X	AC/SC	X						X
<u>East Central MHC</u>	---	---	---	---	---	---	---	---	---	---	---	---
Bullock	X	X	X	X		X						X
Macon	X	X	X	X		X						X
Pike	X	X	X	X		X						X
<u>Eastside MHC</u>	X				SC							
<u>Gateway</u>	X				X							
<u>Glenwood MH</u>	X				P/SC/CA			X				
<u>Indian Rivers MHC</u>	---	---	---	---	---	---	---	---	---	---	---	---
Bibb	X	X	X	X			X					X
Pickens	X	X		X			X					X
Tuscaloosa	X	X	X	X			X					X
<u>J-B-S MHA</u>	X	X	X	X		X						X
<u>MHC of Madison Co.</u>	X	X	X	X	P/SP				X			X

PROVIDER	Out-patient	JCL	Case Mgt	In-Home	Day Tx	Respite	Tele-med	Resid	SBMH Collab	Youth Peer Spt Spec	Family Peer Spt Spec	Crisis
<u>Montgomery Area</u>	---	---	---	---	---	---	---	---	---	---	---	---
Autauga	X	X	X	X								X
Elmore	X	X	X	X								X
Lowndes	X	X	X	X			X					X
Montgomery	X	X	X	X			X		X			X
<u>Mountain Lakes</u>	---	---	---	---	---	---	---	---	---	---	---	---
Jackson	X	X	X	X	AC/SC							X
Marshall	X	X	X	X								X
<u>North Central MHC</u>	---	---	---	---	---	---	---	---	---	---	---	---
Lawrence	X	X	X		P/SP/SC/ SA							X
Limestone	X	X	X	X	SC/SA							X
Morgan	X	X	X	X	SC/SA							X
<u>Northwest MHC</u>	---	---	---	---	---	---	---	---	---	---	---	---
Fayette	X	X	X		SC/SA		X					X
Lamar	X	X	X		SC/SA		X					X
Marion	X	X	X		SC/SA		X					X
Walker	X	X	X	X	SC/SA		X					X
Winston	X	X	X		P/SP		X					X
<u>Riverbend MHC</u>	---	---	---	---	---	---	---	---	---	---	---	---
Colbert	X	X	X	X	P/SC/SA							X
Franklin	X	X	X	X	P/SC/SA							X
Lauderdale	X	X	X	X	P/SC/SA							X

PROVIDER	Out-patient	JCL	Case Mgt	In-Home	Day Tx	Respite	Tele-med	Resid	SBMH Collab	Youth Peer Spt Spec	Family Peer Spt Spec	Crisis
<u>South Central MHC</u>	---	---	---	---	---	---	---	---	---	---	---	---
Butler	X	X	X	X			X					X
Coffee	X	X	X	X			X		X			X
Covington	X	X	X	X			X		X			X
Crenshaw	X	X	X	X			X					X
<u>Southwest MHC</u>	---	---	---	---	---	---	---	---	---	---	---	---
Clarke	X	X	X									X
Conecuh	X	X	X	X								X
Escambia	X	X	X	X	A		X					X
Monroe	X	X	X									X
<u>SpectraCare MHC</u>	---	---	---	---	---	---	---	---	---	---	---	---
Barbour	X	X	X				X					X
Dale	X	X	X				X					X
Geneva	X	X	X				X					X
Henry	X	X	X				X					X
Houston	X	X	X	X			X		X			X
<u>UAB MHC</u>	X				P/C/A/SP/SA							X
<u>West Alabama MHC</u>	---	---	---	---	---	---	---	---	---	---	---	---
Choctaw	X	X	X				X					X
Green	X	X	X				X					X
Hale	X	X	X				X					X
Marengo	X	X	X				X					X
Sumter	X	X	X				X					X
<u>Western MHC</u>	X											X

<u>Abbreviations</u>		
Outpatient - Individual/Family Therapy	Day Tx – Day Treatment	SP-Summer Preschool
JCL – Juvenile Court Liaison	P – Preschool	SC-Summer Child
Case Mgt – MI Case Management	C – Child	SA-Summer Adolescent
In-Home – In-Home Intervention Team	A – Adolescent	AC-After School DTx Child
Telemed. – Telemedicine	Resid – MI Residential	SBMH Collab-School-Based Mental Health Collaboration
Youth Peer Spt Spec-Youth Peer Support Specialist		Family Peer Spt Spec-Family Peer Support Specialist
--- For Informational Use Only ---		

Case Management

Through the implementation and evaluation of two federal Community Support Program (CSP) grants which provided brokerage type case management services to adults who were seriously mentally ill (1983), and adults who were homeless and seriously mentally ill (1987), and an Office of Substance Abuse Program (OSAP) local demonstration grant which focused on case management to children and adolescents with serious emotional disturbances (1987), the Alabama DMH was ready in FY88 to begin statewide implementation of case management services. The demonstration grants provided expertise and techniques to organize and deliver effective case management services, as well as staff with the training skills to disseminate the service statewide.

Two events converged to give impetus to the development of case management services in FY88. One was the funding of a CSP systems development grant which provided funding support for training 100 new case managers in the state. The other critical event was the addition of the Targeted Case Management Option to the Alabama Medicaid Plan beginning on October 1, 1988. Optional Targeted Case Management provided a new funding source specifically for services to adults who are seriously mentally ill (SMI), and children and adolescents who have serious emotional disorder (SED).

The mental health centers work with a variety of public and private resources to obtain services and supports needed by SMI and SED consumers in the community. Case Management services are essential to successful maintenance of persons who have SMI and SED in the community. Adult case managers and supervisors are trained either locally through an approved training curriculum or at training sessions provided by Jefferson-Blount-St. Clair Mental Health/Mental Retardation Authority (JBS). All Child and Adolescent case managers and their supervisors are trained through an approved training curriculum provided by JBS. In addition to mastering material specific to adults with serious mental illness and children and adolescents with serious emotional disturbances, trainees must also complete a module required by Medicaid for all case managers. These sessions held by JBS, to include C&A In-Home Intervention, occur about every two months. The certification standards require successful completion of this training prior to provision of services, with additional one day training on legal issues and

psychotropic medications necessary to be fully certified in C&A case management. In FY12, 11,501 adults and 4,072 children and adolescents had received case management services. Every community mental health center has case management services for adults and children and adolescents.

Children and adolescents with serious emotional disturbances are provided case management services in several ways in the state. First, there are Family Integration Network Development (FIND) projects, now referred to as In-Home Intervention (IHI), currently operating in twenty-one of the state's twenty-two mental health regions, which include dedicated case managers and two-person in-home intervention teams. The in-home teams also provide case management services as part of their 12-week intervention. At present, every community mental health center catchment area has a least one designated children's case manager. Children and adolescents may also receive case management from qualified CMHC staff who has been cross-trained in the delivery of case management to both adults and youth.

RESIDENTIAL CARE

Adult community residential is a key service in the community that supports discharge or diversions from state hospitals. The table below shows the current availability of residential treatment programs and housing programs listed on the Mental Illness Community Residential Placement System (MICRS) by community service area by type of program. MICRS residential slots have increased from 1,253 in FY1991 to 2,542 units to date.

Community Residential Beds July, 2013

CMHC	THOME	RCH	RCSPEC	CRISIS	SEMINT/ SHOUS	MOM	FOSTER	INTMD CARE	3 BED	EBP SHP	TOTAL
Baldwin	14	14	29		20				3	12	92
Cahaba			22		33		8		3		66
Cal-Cleb			14		16						30
CED		24					91			12	127
Cheaha	15				41		6			12	74
Chil-Shel			30							24	54
Cullman					13						13
East Al			30	11	12		2				55
East C		14	60	15			11				100
Huntsville Indian		22		10	72		33		3	12	152
Rivers		17	16	10	29	20	5			12	109
JBS	30		80		66	80	41		18	36	351
Mt. Lakes		12			8		50			12	82
Mobile			143		85		106	32	12	48	426
Montgomery	10		54	32	55	12	10		3	12	188
North C		34				20					54

Northwest			113		66						179
Riverbend			16		39	11			3		69
South C			10					16	3	24	53
Southwest			14			25				24	63
Spectracare	32	32					27	16		60	167
West AI			10		16					12	38
TOTAL	69	169	673	78	571	168	390	64	48	312	2542

THOME = Therapeutic Group Home, RCH = Residential Care Home, RCSPEC = Residential Care Home with Specialized Services, CRISIS = Crisis Residential, SEMINT= Semi-independent living with intensive supervision, SPHOUS = Supported Housing, FOSTER = Foster Care Facility, INTMD= Intermediate Care, MOM=Medication, Observation, and Meals, EBP SHP= Permanent Supportive Housing

This list represents the number of housing units for seriously mentally ill adults that are provided by community mental health centers (CMHC) or are under contract with CMHCs. There are also numerous consumers who reside in housing supported with Section 8 Rental Assistance and Alabama Housing Finance Authority units that are not tracked since they are not operated by the CMHC or under contract.

In addition to the beds listed above, annually there are 179 individuals residing in nursing homes under contract with the local community mental health center via subcontract with the DMH. Also, a small pilot program was initiated in FY07 to purchase local Assisted Living Facility (ALF) for individuals being placed out of the state geriatric psychiatric hospital. Due to the success of the pilot, the program was expanded. In FY12, 38 individuals were served in these ALF slots.

For Children and Adolescents, residential services do not exist in all catchment areas. However, there is access statewide to the following components:

Short Term Treatment and Evaluation Program

A 10 bed short-term treatment and evaluation program fills gaps in the service system for comprehensive evaluation outside of inpatient psychiatric hospitals. STTEP offers comprehensive diagnostic and evaluation services and short-term (7-90 days) residential treatment to the statewide population of children and adolescents, ages 5-12 years, with a serious emotional disturbance. This program is jointly funded by the Department of Mental Health (DMH) and the Department of Human Resources (DHR).

Children’s Residential Treatment

Two intensive residential programs, located in Birmingham, serves children with serious emotional disturbances from across the state, ages six through fourteen. Contract beds are jointly funded by the DMH and DHR. An intensive residential program located in Mobile has 8 contract DMH beds and serves children and adolescents with serious emotional disturbances from across the state. A transitional age residential program, located in Mobile, serves consumers age 17-22. The 10 contract DMH bed group home has as its priority population young adults who currently need transitional placement from the state hospitals.

SUPPORT SERVICES

As described earlier, a comprehensive system of community mental health services is being developed for adults with serious mental illness and children and adolescents with serious emotional disturbances. The primary mental health service that ties consumers to other needed services is case management. Case managers, through their assessment of consumer needs, development of comprehensive service plans, and linkage of consumers to needed services through referral, active assistance and advocacy, and monitoring of service utilization, are responsible for assuring access to the broad range of needed community services.

Consumer outcome research conducted as part of the program evaluations of demonstration case management programs for adult SMI, homeless SMI, and SED children and adolescents in the state have all found case managers to be successful in significantly increasing the use of the broad range of services needed by consumers. Research results also suggest that the level of functioning of consumers increased with the increased use of services. These outcomes suggest that increased participation in a variety of needed services not only improve the quality of life of consumers, but can also increase the adaptive functioning of consumers in areas of everyday life that are critical to their community tenure. The following are the types of housing, health, rehabilitation, employment, education, medical, dental, and support services that, in addition to mental health services described earlier, are needed in order for consumers to function in their home communities.

Housing Services

Housing is one of the State's critical gaps. It is the Department's hope that "all services will be provided from a person-centered treatment planning perspective driven by family and consumer needs and that consumers will receive not only high quality treatment services, but will receive the necessary supports to achieve the highest degree possible of independent living in safe and decent housing, to be employed, and to engage in social interaction with friends and family."

Alabama is the ninth poorest state in the nation (September 2011 24.7 Wall St. Publication), with a population of 4.8 million (2012 Census estimate), one in six individuals live below the federal poverty level. The availability of safe and affordable housing remains a challenge for consumers with mental illness and limited or no income.

Governor Robert Bentley assumed office January 2011. In February 2011, he announced the creation of Hardest Hit Alabama (HHA), a new program providing \$162 million to the Alabama Housing Finance Authority to provide targeted assistance for Alabama's unemployed homeowners for the prevention of foreclosures. This program is considered an important step in the prevention of homelessness due to widespread unemployment and risk of foreclosures in Alabama.

October 2012, ALHousingSearch, Alabama's premier housing locator service, was launched leading to multiple demonstrations of this new statewide resource created to

help people list and find safe, decent, and affordable and accessible housing, in addition to emergency housing across the state. This web based service, supported by a toll-free call center, provides information for the general public as well as for housing professionals seeking vital resources for their clients. This project was initially funded by the Alabama Council on Developmental Disabilities and is supported by Disability Rights and Resources, Collaborative Solutions, Inc., the Low Income Housing Coalition of Alabama (LIHCA) and the Montgomery Center for Independent Living.

The Department holds Board and general membership to the Low Income Housing Coalition of Alabama (LIHCA), which is a statewide coalition consisting of housing advocates, elected officials, banking institutions, nonprofit service providers, legal services groups, and low income persons and whose mission is to increase housing opportunities for individuals with the greatest financial need. LIHCA reported that the state lacks almost 90,000 affordable and available homes for residents with extremely low incomes. Alabama residents with an SSI income of \$698 per month will likely have to pay up to 81% in rent for a modest one bedroom apartment. The Low Income Housing Coalition of Alabama (LIHCA) observed that Alabama has historically relied solely on federal funding for the development of affordable housing and that public funding is critical for the future development of affordable housing. LIHCA advocated for passage of the National Housing Trust Fund and campaigned for the establishment of an Alabama Housing Trust Fund. LIHCA is currently designing a statewide Housing Needs Assessment for safe and affordable housing. This assessment will consider all low income and disability groups.

In May 2012, Governor Bentley signed into law House Bill 110 (HB 110) which established a state housing trust fund. This trust fund is meant to be a flexible source of funding for use in developing and maintaining safe and decent rental and ownership options for families, elderly, persons with disabilities, and others who cannot afford housing. Alabama is one of six states to have created housing trust funds legislatively but do not currently have public revenues committed to the funds.

Given the issues related to stigma and limited housing options available for citizens with serious mental illness, especially those with limited or no income transitioning from institutions or from homelessness, the Department has historically relied on expanding housing programs within its' own continuum of care in an attempt to meet this need. Currently, the Department contracts roughly 30 million dollars with the community mental health provider network to contribute to the provision various living arrangements such as community residential treatment settings, semi-independent living arrangements, and supportive housing models. Even with this effort, housing opportunities fall short of the projected numbers estimated to meet the needs of our consumer populations.

The Housing Advisory Council (HAC), established by the Department's Office of MI Community Programs, is made up of housing stakeholder and advocacy group representatives. This Council serves as an advisory body around the areas of housing and strategies for development. Through a NAMI-Alabama contract and in collaboration with HAC, a housing needs assessment was conducted in 2007 and a statewide supportive housing plan was developed through the efforts of two expert housing consultants. Using

gaps analysis, 8600 units of temporary and permanent housing were projected to be needed. As a result, a Supportive Housing Plan was developed and clearly laid out objectives and guiding principles. In 2011, this plan was revised with the goal to establish housing necessary to support consumers living successfully in the community and to realize the Department's plan for reducing inpatient census by closing facilities and transitioning consumers from state facilities and from community group homes to more integrated settings. This year, in continued recognition of the importance of housing as an essential part of treatment and recent hospital closures, the housing needs assessment is in the process of being updated this fiscal year 2013.

A preliminary comparison of 2007 and 2013 data listed in the Mental Illness Community Residential Placement System (MICRS), reveals significant changes in the number and type of community living alternatives for persons with mental illness. Although some types of housing programs historically used within the mental health continuum, such as foster homes and therapeutic group homes, have decreased, overall housing programs have increased by 35.6%. This represents an increase in 750 community beds of various types. Most notably evidence based permanent supportive housing were adopted post 2007 and of which there are now 312 units to date. Also realized since the initial needs assessment is the establishment and expansion of pilot programs such as the MOM (Medication, Observation, Meals) Semi-Independent model which equates to 168 units. In addition to the evidence based supportive housing units and MOM units, there has been a 47.6% increase in crisis residential beds, 150% increase in small 3 bed home beds, 25.2% increase in specialized residential treatment beds (medical and behavioral), and 116% increase in intermediate care facility beds. Again, these increases represent those beds reflected the MICRS system reported to the ADMH in 2007 compared to 2013; however, there are other supportive housing beds operated by, or available to, community mental health centers that may not be reflected in the MICRS system. Those units may include supportive housing units funded by the U.S. Department of Housing and Urban Development through the Continuum of Care Homeless Assistance Programs.

Additionally, the Department continues to maintain \$250,000 Housing Support Funds, available statewide for mental health providers to use in order to assist consumers with obtaining and maintaining more independent and stable housing.

Alabama participated as a pilot site for SAMHSA's Permanent Supportive Housing Toolkit and provided training around supportive housing principles. To date, there are 312 permanent supportive housing units in operation consistent with the evidence based model. The original 108 pilot units are directly supported by ADMH funds. The remaining numbers of units are supported by "bridge funds" obtained from the 2009 downsizing project and, most recently, the hospital closure project in which funds used to support hospitals were transferred to expand community services.

The Department continues a partnership with the Alabama Housing Finance Authority (AHFA) to focus attention on the housing needs of persons the Department serves. AHFA established HOME and Low Income Tax Credit set-aside units with reduced rental rates. These units have subsidized rents of \$180 (one-bedroom unit) and \$240

(two-bedroom unit). To date, all 498 units remain filled. Housing is also available at reduced rental rates through USDA Farmers Home developments. A Housing Advocate employed by the Department, works to ensure that priority for vacancies as they develop are given to individuals with serious mental illness, developmental disabilities, or substance abuse disorders.

HUD has remained a dedicated supporter to the Department in an effort to expand housing options for the individuals we serve. In 2011, upon hearing of the plan to close state facilities, the Alabama HUD Field Office located in Birmingham, of which Michael German is the Director, graciously extended an offer to assist the Department in efforts to transition persons from institutions. As a result, a series of meetings transpired with key leadership from HUD, Fair Housing, and Public Housing Authorities. In March 2012, the Department participated in HUD's Community Planning and Development Statewide panel discussion as a first step of many to create a framework from which to build collaborations at a local level as well as state level. Ongoing efforts include identifying cohort populations within state institutions and those living in congregate settings who, with adequate supports and access to affordable housing options, could move to more integrated settings. HUD is leading an effort to identify vacancies in set-aside units and other housing projects within their continuum available for which individuals with disabilities would qualify.

ADMH is the grantee for two HUD Shelter plus Care grants, the first of which has been longstanding within the urban area of Mobile. This grant supported a total of 54 individuals. In 2011, the Department was awarded rural based Shelter plus Care grant allowing four mental health providers to expand housing in their rural service area to approximately 52 individuals.

LICHA is sponsored by Collaborative Solutions, Inc. (CSI), an approved technical assistance consultant of the Alabama HUD Field Office. The Department has partnered with CSI to pursue Rural Housing and Economic Development (RHED) grants. CSI is the state lead for Rural Supportive Housing Initiative (RSHI) striving to establish Peer Networks linking emerging community-based organizations interested in the provision of supportive housing with experienced supportive housing developers. Through this Peer Network, CSI provides the leadership, support, and training necessary to help providers address the affordable housing challenges in their communities.

The Department acknowledges the lack of adequate affordable housing stock for Alabama residents and the need for a statewide policy and strategy to address this issue. DMH representatives will continue to work in all venues to access new housing resources for individuals we serve.

As part of the overall Housing initiative, it is anticipated that a small number of housing units may be identified and developed to assist with transition services from child and adolescent services to adult services (17-22 years of age). Due to the unique developmental, social, and educational/vocational needs of the 17-22 year old consumer population, it makes sense to offer residential services that are designed to address these needs programmatically.

DMH service delivery system recognizes adults at 18 years of age. A consumer is eligible for all adult services if they also meet the SMI criteria. At present, there is a gap in the service delivery system around residential and day treatment needs. This appears to be not one of eligibility on the part of the young consumer, but rather a perceived inappropriateness based on the developmental issues of each consumer population. This transitional population (17 – 22) presents with additional challenges in regards to legal status. Often these consumers may be under the jurisdiction of a juvenile court until they are 21, or in the legal custody of the Department of Human Resources. System wide accommodation will take some time. Until then, consumers who have needs greater than outpatient and case management are handled on an individual basis.

Transitional Age Service

An emerging issue for child and adolescent mental health services is the unique unmet needs of those adolescents transitioning from the child mental health system and entering the very different adult mental health system. In an effort to better address these needs, a work group was developed by the Child and Adolescent Task Force, which includes adult advocates and mental health professional and planners from adult services. . In FY07, recommendations were made by this workgroup, adopted by the Child and Adolescent Task Force, and approved by the Mental Illness Coordinating Sub-Committee to RFP for a Transitional Age Group Home, a Transitional Age In-Home team, and a Transitional Age Case Manager, all within a Pilot Demonstration Site. These services are to be operational by fall 2008. The workgroup continued its efforts on the development of parameters for the Transitional Age Supporting Housing Model and other outpatient/community based Transitional services. In FY09, due to budget cuts, the Transitional Age Supported Housing project lost its funding. Data is being collected on the programs. Also, based on these models, the information was utilized to develop standards around Transitional Age Residential and standards were incorporated in the revised MI Certification Standards that became effective in October 2010.

Outreach to Homeless Individuals

DMH is a recipient of the Projects for Assistance in Transition from Homelessness (PATH) Formula Grant Program for which it was most recently awarded \$547,000 in funds allocated to support five community mental health providers located in the most metropolitan areas which reflect the highest homeless point in time counts within the state. PATH funds are the only source of dedicated funding specifically targeted to serving homeless individuals who are seriously mentally ill and/or have a co-occurring disorder. The Department proposes to contact 1,110 individuals in FY13 through outreach efforts.

For FY13, Statewide mental health service data indicates approximately 74,930 adults received mental health services from community mental health providers and of that total approximately 1,272 individuals identified their living arrangements as shelter or homeless at the time of entry into mainstream mental health services. The highest concentrations of these individuals were located in the most populated areas of the state

with the Birmingham area comprising 37% of the statewide total adults receiving community mental health services. In less populous regions of the state not receiving PATH funds, regular case management is offered to those who are homeless and have a serious mental illness and/or co-occurring disorder.

The Department remains committed to supporting all plans for addressing homelessness and for increasing affordable housing opportunities and understands system wide partnerships are necessary to effectively end homelessness in Alabama. At present, the Alabama Alliance to End Homelessness (ALAEH) is steadfastly pursuing a new Executive Order for the purposes of reestablishing an organized statewide effort in the areas of homelessness and housing. Efforts are underway with representatives in the Governor's office in pursuit of this action. If signed, the Executive Order will revoke and supersede Executive Order #31 signed in 2005 under previous administration. As stated in the draft order, "the prior Governor's Statewide Interagency Council will be reestablished as the Governor's Statewide Commission on Homelessness & Housing ("the Commission") for the purpose of serving as a planning and policy development resource for the Governor, the State and its various departments and agencies and for the private sector specifically on issues related to homelessness and housing relative to issues of prevention of homelessness and rapidly re-housing in Alabama..." Upon the establishment of the Commission, the 2007 Blueprint towards a Ten-Year Plan to End Homelessness in Alabama will be revisited and strengthened for 2014.

The Department is supportive of all 8 instate Continua of Care in Alabama. Continua stationed in Montgomery, Mobile, and Birmingham have published local plans to address homelessness and are in various stages of implementation. The State PATH contact serves on the Boards for the Alabama Rural Coalition for the Homeless (ARCH) and on the Alabama Alliance to End Homelessness (ALAEH). As an ARCH board member, state level coordination of homeless services targeted for individuals in rural areas can be accomplished. ADMH representation on the ALAEH Board assures statewide planning and policies pertaining to homelessness consider the needs of those individuals with serious mental illness.

ALAEH holds membership from all Continua of Care and the Alabama HUD Field Office affiliates. This agency provides statewide training, networking opportunities, and resource information by providing conferences for which those who serve homeless populations. ALAEH, LICHA, and Collaborative Solutions, Inc. co-sponsor an annual statewide conference targeted towards service providers and individuals with lived experience. Through application, the PATH technical assistance center has partnered on numerous occasions with the Department and with ALAEH to conduct joint trainings at this conference.

Alabama has implemented SOAR training statewide. In 2007, The Department's Office of Policy & Planning partnered with the former Governor's Office of Faith Based and Community Initiatives (GFBCI) to initiate the SSI/SSDI Outreach, Access and Recovery (SOAR) Initiative in Alabama. SOAR has been instrumental in providing the skills needed for service providers to directly impact homelessness and to move forward in

accomplishing the overall arching goal of the States' Plan to End Homelessness, the States' Comprehensive Mental Health Service plan, PATH outcome targets, as well as local plans to end homelessness.

It should be noted that children and adolescents are served, when part of a homeless family, by PATH case managers and by specialized children's case managers in the mental health regions, which have dedicated children's case management. The major provider of homeless services for children and adolescents is the Department of Human Resources (DHR), the child welfare agency. Runaway youth are also identified and referred for other mental health services, including case management, by runaway shelters located across the state. The DMH staff also participates in the training of the state's law enforcement personnel. Since the police are frequently the first to encounter runaway youth, a considerable amount of time is allocated for discussion of identification and referral for mental health services.

Medical, Dental, and Health Services

For consumers who are Medicaid or Medicare eligible, almost every type of medical care is provided. Very often the only barrier to service is finding providers who serve Medicaid consumers. Other, non-Medicaid eligible clients have typically exhausted health care resources such as insurance, and must rely on health care available in their community on an indigent basis. Typically, local Public Health departments and community health clinics are the main referral resources used by case managers to meet the primary health care needs of their consumers. Local hospitals provide a very limited amount of inpatient care to indigent consumers. Because of historical practices among indigent consumers, many emergency rooms provide the only primary health care some consumers get. Individuals with mental illness have wrestled with the health care issue for years and in general this is one of the few areas where children and adolescents fare better than the adults. For example, Medicaid benefits for persons under 21 can exceed usual limits when indicated by the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. Children and adolescents in the care of DHR and DYS receive medical care from these agencies, as well as through school nurses where available. In addition to coverage by Medicaid, dental services are covered by AllKids, Alabama's SCHIP program.

The importance of improving coordination and collaboration with primary medical providers is underscored by the finding that persons with mental illness die on the average 25 years earlier than the general population, due in large part to un- or under-treated primary medical conditions. The Department received a Transformation Transfer Initiative Grant in FY08 and in FY10 to support efforts to improve integration of primary and mental health care. The following partners were convened to assist in planning grant activities: Alabama Medicaid Agency, Department of Public Health, Alabama Hospital Association, Alabama Academy of Family Physicians, Alabama Primary Health Care Association and American Academy of Pediatrics – Alabama Chapter. In FY08 ten regional meetings were conducted to obtain ideas from both primary and mental health providers relative to barriers and opportunities to improve collaboration. The findings from the regional meetings provided the foundation for the efforts funded in FY10. There

are three elements to the current grant: 1) expert panels of physicians to discuss their perspectives on collaboration; 2) provide grants to six areas to develop written plans for improving collaboration locally; and 3) support for the Child and Adolescent Psychiatric Institute focusing on primary care collaboration.

Consumers who are in state hospitals are provided medical care as part of their involuntary confinement where there is no insurance or other source of coverage for medical expenses. The state hospitals became tobacco-free on January 1, 2010. Consumers who have no health insurance and who reside in DMH community residential programs have minor medical services paid by the provider. There is a limited statewide fund for residents of foster homes to pay for incidental medical expenses when there is no other source of revenue.

Most of the adults with serious mental illness and youth with serious emotional disturbances have Medicaid coverage for medical and dental services. However, it is a challenge to find providers in some areas who will accept Medicaid. Case managers provide a vital service by linking consumers to individual practitioners who will accept Medicaid or who will agree to see consumers on a sliding scale or no fee basis. Community mental health providers routinely receive training in universal precautions. Consumers in day treatment and residential programs receive health education on general nutrition, personal hygiene, exercise, and healthy lifestyle, as well as receiving health monitoring and general health advice from staff nurses. Individuals in outpatient, day treatment, and residential services who are also receiving medication services routinely have vital signs monitored with referrals for necessary medical care. Recommendations for routine health screenings are incorporated in all services. Community resources such as health fairs, free blood pressure checks, flu vaccines, etc. are utilized when available. Additionally, people are referred to school health nurses, public health clinics and Federally Qualified Health Centers, as appropriate and when available. Administration of medications prescribed by community mental health psychiatrists is coordinated with school personnel.

Access to dental care is often cited as an unmet need for consumers. The University of Alabama in Birmingham School of Dentistry also provides free clinics around the state. The waiting list for these clinics is very long. Case managers assist consumers in getting on the waiting list for any available free clinics. In some areas of the state, local dentists volunteer time for free clinics. Again, the amount of time and the range of services are limited.

In recognition of the 25 year earlier mortality rate and health disparities suffered by individuals with serious mental illness disorders, the Department has promoted health and wellness education and activities. During the last several years, the annual Consumer Recovery Conference has provided a platform for conducting wellness screenings for a significant sample of consumers in attendance from all over the state. The 2013 Consumer Recovery Conference had approximately 123 consumers to volunteer for screenings. Screening methods included checking blood pressure for hypertension, body mass index for obesity, and blood glucose for diabetes. Due to restrictions in funding, no

lipid tests were conducted to check for high cholesterol. DMH acknowledges that research suggests smoking prevalence among U.S adults with mental illness or serious psychological distress ranges from 34.3% (phobias or fears) to 88% (schizophrenia). This was the first year in which the Fagerstrom Index was utilized to screen for nicotine dependence. Screenings were provided in partnership with Pfizer. The results of the screenings show a high degree of co-morbidity with diabetes, obesity, and hypertension. Health information and smoking cessation information was disseminated at this event. (see attachment)

RURAL ACCESS

For purposes of classifying catchment areas as rural, the criterion was that the area not include a Standard Metropolitan Statistical Area (SMSA population => 50,000) There are 10 community mental health center catchment areas that currently meet this criterion: Baldwin, Cahaba, Cheaha, Cullman, East Central, Mountain Lakes, Northwest, South Central, Southwest, and West Alabama. In the past, North Central was included. However, there is now a city that is classified as a SMSA in the North Central Catchment area. The table below lists the ten rural mental health regions and the number of adults in the region who were SMI and children and adolescents in the region who were SED and who were served by the local mental health centers during FY12. A total of 65,513 adults who were SMI were served by the local mental health centers during FY12, and 19,670 or 30.02% were served in the ten rural regions. A total of 25,321 children and adolescents who were SED were served by the local mental health centers during FY12, and 7,879 or 31.12% were served in the ten rural regions. This relationship indicates that adult with serious mental illness and children and adolescents with serious emotional disorders in rural regions continue to have the same access as in previous years. The two most frequently identified areas of need in rural areas are transportation to needed services and child and adolescent psychiatric services. Medicaid coverage of transportation services should assist in maintaining treatment access in rural areas. Services available to children and adolescents in rural areas will be maintained, and efforts will be made during the year to increase services by equal inclusion of rural areas in the implementation of legislation for the "Multi-Need Child". Each county facilitation team receives funds under the Children’s First legislation to assist with wrap-around services for children in their county. The amounts of these vary as a function of their 2000 census for children and adolescents under 18 years of age. In regard to “mini grants” awarded to county facilitation teams under the previously funded CASSP Infrastructure Grant, all counties had equal access to grant funds.

Rural Regions	# of SMI Served FY 12	# of SED Served FY 12
Baldwin County	2,224	1,441
Cahaba	1,726	559
Cheaha	2,440	530
Cullman County	1,177	732
East Central Alabama	1,618	765

Marshall – Jackson	1,684	626
North West Alabama	2,355	1,542
South Central Alabama	2,607	393
Southwest Alabama	2,192	794
West Alabama	1,647	497
Total	19,670	7,879
Total SMI/SED Served	65,513	25,321
% Rural of Total SMI/SED Served Statewide	30.02%	31.12%

Medicaid coverage of the centers as providers of Non-Emergency Transportation assists community mental health centers to maintain/expand transportation services, particularly those in rural areas. The chart below shows the number of consumers for whom transportation services have been billed to Medicaid through for FY12.

Medicaid Transportation Units (One/Consumer/Day) for FY12

Center	FY12 Consumers	FY12 Units
AltaPointe (Mobile)	688	13,745
Baldwin	47	4,836
CED	217	2,305
Cahaba	285	8,610
Calhoun-Cleburne	368	18,614
Cheaha	54	116
Chilton-Shelby	99	1,611
Cullman	134	4,171
East Alabama	383	25,844
East Central	153	5,586
Huntsville	177	1,723
Indian Rivers	90	525
JBS	480	25,772
North Central	495	29,625
Montgomery	339	11,686
Northwest	635	51,860
Riverbend	518	21,965
South Central	153	12,054
Southwest	152	6,999
Spectracare	245	28,013
West Alabama	59	6,686
Total	5,783	282,346

Bristol-Myers Squibb Foundation

Bristol- Myers Squibb partnered with the Department in providing the financial resources critical for the expansion of services within rural areas. Not only did BMS funds provide the foundation for Telemedicine within this state, funds were also used to address the specific and unique needs of hard to reach subpopulations living within rural communities. The BMS Foundation awarded Serious Mental Illness Initiative Current Partnerships and Grants. The **Alabama Coalition for a Healthier Black Belt** provided \$2,465,553 coalition partners to reduce stigma and mobilize target communities to engage in the care and support of people living with serious mental illness; to conduct pilots for telemedicine in order to increase access to psychiatric expertise in rural communities; and to build capacity for integrated mental health and primary care services. A gem of this project continues to be the mobile health unit developed through the creative and thoughtful efforts of a local mental health agency. This unit is designed to address health disparities in the black belt area by providing health and mental health screenings. The University of Alabama's Rural Medical Scholars Program remains a resource for manpower to assist in conducting surveys. Surveys are used to screen for cholesterol, diabetes, mental health services, housing needs and prescription assistance. AIDS Outreach service providers are partners conducting HIV screenings, as well. The local Women, Infants, and Children's (WIC) organization also provides educational materials. Between 2008 and 2010, a total of 3,573 contacts have been made through the mobile health clinic. An additional BMS grant in the sum of \$97,005, was awarded to a mental health provider to support a faith leadership summit and other training and outreach efforts targeting African American churches to strengthen their capacity to become mental health recovery and referral resources for their congregations and communities.

Through previous partnership with Sprint, and informal arrangements with Sorenson Communications, and ZVRS, the number of videophones in use by deaf people with mental illness through the state had grown substantially. A vast majority of our consumers now have videophones, which are much better suited to their needs than older and increasingly obsolete text-based TTY devices. These connections allow who are deaf and have mental illness more rapid response to their needs and more ready access to therapist than they had previously. The same network also allows Office of Deaf Services (ODS) staff interpreters to more efficiently serve deaf and hearing consumers through remote video interpreting. ODS has a formal contract with Birnbaum Interpreting Service based in Washington, DC for video Remote Interpreting to cover times and slots when staff or contract interpreters are not available. Another emerging benefit from this network is more ready access to peer support as consumers in recovery in one part of the state can mentor those in another – a tremendous advantage in a low-incident, widely dispersed population. ODS is working to expand its ability to tap into telecom health and psychiatry networks, some of which use equipment that is not cross-compatible.

Increased use of telecommunication technology makes services available in more locations and decreases travel time. Many of the centers are using telecommunication equipment to participate in treatment team meetings at the state hospitals, screen hospital residents for residential placement, and to provide families an opportunity to visit. Initial poor connectivity issues have been addressed with a resulting improvement in quality of interaction. The use of telecommunication equipment has been well-accepted by most clinicians and consumers. The Medicaid Agency, based in part on experience in the mental health system, now covers telepsychiatry under the Physician's Program in addition to the Rehabilitation Option.

OLDER ADULTS/ELDERLY

Community based services are provided to older adults through the existing community mental health center service structure. There were 17,027 individuals aged 55 or older who had received services from a mental health center for FY12. The following list shows the duplicated number of recipients aged 55 or older by service type:

Residential	1,504
Day Treatment	1,337
In-home Intervention	233
ACT	336
Case Management	2,629
Outpatient	16,211

Based on these numbers, older adults are receiving a variety of services through community mental health centers. Mental health centers provide both direct services to residents of nursing homes as well as case consultation to the operators.

During the second half of FY07, a small pilot project was started to purchase local Assisted Living Facility beds for individuals appropriate for this level of care who were residing in the state-operated Mary Starke Harper Geriatric Hospital. This pilot was successful enough that the pilot was expanded statewide. In FY12, 38 individuals have received services through contract Assisted Living Facilities.

In July, 2009, DMH closed its last nursing home, the 30 bed Alice Kidd facility. Most of the residents were placed in the community. Those who could not be placed in the community were transferred to the Mary Starke Harper Hospital. The Director of Mental Illness Facilities and the former director of the Kidd facility both have extensive contacts in the nursing home and assisted living industries that can be used to assist in locating proper community resources for the older residents who need to transition out of state hospital care. DMH was directly involved in planning for a Money Follows the Person grant application directed to improving discharge opportunities for residents of the Mary Starke Harper Geriatric Hospital and is working closely with the Alabama Medicaid Agency on the implementation of Money Follows the Person.

Evidence-Based Practices

Evidence-based practices are under development in Alabama through a variety of mechanisms.

Assertive Community Treatment (ACT) and the Program for Assertive Community Treatment (PACT)

ACT and PACT have served as a critical element in the diversion of adults considered to be at high risk for readmission to a state psychiatric facility. Alabama began developing ACT and PACT services in 2001. The model used is based upon the principles of PACT as outlined in the SAMHSA Toolkit. However, when the model was adopted, the DMH EBP Workgroup modified the national model to focus on mental health services using primarily a three member team in addition to a part-time psychiatrist. Mental Illness Program Standards require that the 3 full-time equivalent positions include at least 1 full-time master's level clinician, at least one half time registered nurse or licensed practical nurse, and one fulltime case manager. The remaining half time position could be filled at the agency's discretion by a master's level clinician, a nurse, or a case manager. The Substance Abuse Division (SA) funds SA treatment specialists for 5 of Assertive Community Treatment (ACT) Teams. The role of this specialist is to provide both direct services and expert guidance in how other team members can improve skills in the recognition of and treatment for substance abuse disorders. There are currently 18 certified ACT and 2 certified PACT programs in operation. For the consumer to staff ratio for the modified team is 1:12. The size of the team was based on the minimum necessary to meet the treatment and support needs of consumers while maintaining conformance to the core principles. Given the predominantly rural nature of the State, there are few areas that could support a full fidelity PACT team costing approximately \$1 Million per year. The two PACT teams are currently located in our most urban city, Birmingham.

Illness Management and Recovery (IMR)

The University of Alabama Department of Psychiatry and Behavioral Neurobiology submitted the winning proposal to be a Center of Excellence to assist DMH to implement evidence-based practices for adults with serious mental illness. The Alabama Institute for Mental Health Services (AIMHS) was created and provided training and monitoring for eight pilot sites on implementation of Illness Management and Recovery (IMR). The trainer, Patricia Scheifler, is a national expert. For a variety of reasons, the contract for the Center of Excellence was not renewed in FY10. DMH did not have the capability to continue the training and monitoring necessary to assure acceptable fidelity to the model. For that reason, the provision of IMR services is not reported.

Permanent Supportive Housing (PSH)

As stated previously, housing continues to remain a critical gap. As a means to offer housing opportunities in a manner most in keeping with the latest evidence for best housing practices and to foster community integration, DMH dedicated funding to support the development of evidence-based housing projects. In FY08, nine pilot sites were selected to implement Permanent Supportive Housing (PSH) projects creating housing capacity of this type by 108 beds. Additional projects have become operational

as a result of the community service expansion efforts of the downsizing and closure projects resulting in a total of 312 Permanent Supportive Housing beds.

Supported Employment

Employment opportunities for consumers are not well developed within the mental illness service milieu and are identified as a system weakness. In Alabama, 74,857 adults with mental illness were served by community programs in FY12. Of those served, only 10% reported being employed either part time or full time. Nearly 20% reported being unemployed but looking for work, 14% claimed unemployment without looking for work in the past 30 days, and approximately 44% identified themselves as Disabled. In comparison of data, full time employed individuals receiving services dropped from 8,049 in 2007 to 4,998 in 2012. Rates of unemployment also increased significantly from 2007 to 2012.

Outside the limited funds dedicated for the employment of certified peer specialists (CPS) within the provider network, little has been done in the way enhancing employment opportunities for individuals with serious mental illness. Traditionally community mental health programs focus on job readiness training and referrals to Vocational Rehabilitative Services. Due to the lack of a dedicated funding source, the means for offering evidence-based Supported Employment services as a vehicle to obtain competitive employment within the community at large remains undeveloped.

However, the receipt of an Employment Development Initiative (EDI) grant in FY11, has allowed DMH to initiate planning activities which will serve as a framework to foster increased employment opportunities for individuals with serious mental illness and/or substance use disorders. EDI grant funds also supported Train the Trainer technical assistance for the end purpose of creating the capacity to conduct its own in-state Certified Peer Support Specialist Training thus permitting growth of the CPS pool. Sponsored by EDI grant funds, experts on the **Individual Placement and Support (IPS) supported employment evidence-based** model served as keynote speakers at the EDI grant sponsored Alabama's Supported Employment kick-off event in 2011. These initial activities have uniquely positioned MI Community Programs to foster a relationship with Dartmouth IPS Supported Employment Center. Dartmouth continues to provide guidance and education about the IPS model and possible utility for Alabama implementation. It is the desire of MI Community Programs in strong partnership with Alabama Department of Vocational Rehabilitation (ADRS) to join the Dartmouth Learning Collaborative. ADMH and ADRS have a longstanding collaboration in serving disabled populations. Both state agencies are actively exploring the financial, program and infrastructure requirements necessary to pilot the IPS model within the mental health provider network.

Within the Department of Mental Health, the Division of Mental Health and Substance Abuse works closely with the Developmental Disabilities Division where is housed an employment specialist who works exclusively towards the development and expansion of competitive employment programs for the Intellectually Disabled population. Through cross Division collaboration, staff within MI Community Programs has invitation to participate in some of the ID supported employment planning and development activities

and initiatives. These activities include participation in the DD Supported Employment Workgroup, Alabama Association of Persons for Supporting Employment First conferences, Employment First State Leadership Mentoring Program community of practice, and Supported Employment Leadership Network (SELN) opportunities.

An Employment First Bill was introduced in this year's legislative session. Although it was well received, the legislative session ended before the Bill was adopted. Plans are underway to again introduce Employment First legislation in next year's session. The Department recently established the formation of the Alabama Interagency Planning Committee for Supported Employment. This interagency team is made up of representatives from the Alabama Department of Rehabilitation Services (VR), the Alabama Department of Economic and Community Affairs (ADECA), the Alabama Medicaid Agency, Post-Secondary Education, and Workforce Development.

Consumer Operated Services

Consumer driven recovery, such as consumer run drop-in centers and support groups are seen as essential elements of the continuum of care, but these services are not covered in the Department's contract with community mental health centers. The Block Grant is used to support the development of consumer-operated services as well as the annual consumer conference. There are five operational drop-in centers serving on average an approximate total of 102 consumers on any given day. Within the state, there are twenty-four support groups, 4 statewide consumer organizations, and six NAMI connection groups.

Certified Peer Specialists

DMH has long valued the power of peers to support fellow consumers and promote recovery. DMH first established the position of peer support specialist in 1994 at Greil Hospital and later expanded the program to all state facilities. In 2008 provisions were made to expand peer support services to the community provider network. Funding cuts restricted full expansion of peer services to every provider agency; however, due to the 2011 efforts of shifting hospital funds to community services, peer support services has once more found an opportunity to flourish. Not only has the movement towards peer services lead to the credentialing requirements for the certification of peer specialists, but it has evolved in the creation of specialty peer specialists training such as peer bridger services and peer specialists funded to assist in promoting health and wellness for consumers with chronic physical illnesses in addition to serious and persistent mental illness. Efforts continue in pursuit of Medicaid funding for this service reflective of it's true worth. Currently there are 45 certified peer specialists/peer Bridgers employed at community mental health centers, and three others serving in mental health related positions. Several previously employed specialists used their knowledge, experience, and skill gained from CPS training and employment to enhance their prospects and obtain higher paying positions outside of the mental health realm or to return to college.

Evidence Based Practice	Estimated Number Served in FY12
Assertive Community Treatment	1,083
Family Psychoeducation	0
Integrated Treatment for Co-occurring Disorders (MH/SA)*	0
Illness Management and Recovery	0
Medication Management	0
Permanent Supportive Housing	172
Supported Employment	0
Peer Support Services**	72

*There are four programs that identify themselves as specifically treating individuals with co-occurring disorders. Mental health centers address the co-occurring treatment needs of consumers through parallel and sequential mental illness and substance abuse services, but largely not in programs that would meet fidelity measures for co-occurring treatment.

**Although DMH created reportable activity codes to capture the services provided by CPS/Peer Bridger's, the number reported does not accurately reflect the actual number served and is only representative of peer activities at two mental health organizations. Fourteen community mental health centers are providing peer support services. At present, there is no incentive to report individual episodes of peer services since no reimbursement mechanism exists. The Office of Consumer and Ex-patient Relations estimates numbers served at a much higher rate.

In regard to **children and adolescents**, a number of evidence-based practices (EBP) have been under consideration in Alabama. The Core Performance Indicators include Therapeutic Foster Care as the one of the required EBP for Uniform Reporting System requirements. In Alabama, Therapeutic Foster Care is funded and licensed by child welfare, the Department of Human Resources (DHR). Because the Department of Mental Health cannot regulate or monitor these services, there are no goals listed below related to it. It is important to note that DHR has contracted with a Multi-Systemic Therapy (MST) provider in several areas in Alabama and DYS has contracted with a MST provider in one region. Funding services that have been demonstrated to be effective were considered by DMH. In FY06 and FY07, the C&A EBP Workgroup worked toward formal recommendations regarding the selection and implementation of appropriate evidence-based practices. In FY07, the EBP workgroup recommended the following: Cognitive Behavior Therapy (CBT) in the form of developed models be considered for implementation. One such CBT model recommended by the workgroup was Coping Power. The EBP workgroup also recommended securing outside assistance in any implementation of a child and adolescent focused EBP and that a Center of Excellence be considered for the request for proposal process similar to the course of action currently being incorporated by DMH with the adult SAMHSA Toolkits (this Center of Excellence no longer exists). The EBP workgroup further recommended that C&A In-Home Intervention be evaluated/assessed by a Center of Excellence as to work toward this service being recognized as a "best practice". These recommendations were submitted to the Mental Illness Coordinating Sub-Committee. In FY08 and FY09, the EBP workgroup focused on the "A Guide for Selecting and Adopting Evidence-Based Practices for

Children and Adolescents with Disruptive Behavior Disorders” Guidelines issued by SAMHSA to assist in making further recommendations on C&A EBP’s. During the same timelines, DMH was working with NASMHPD on the C&A EBP reporting issues and a National movement to have additional New Optional Table to URS for Reporting Child and Youth EBP’s. The first priority of focus for the C&A EBP workgroup and the National workgroup that DMH was involved was reviewing the EBP’s from the SAMHSA’s Guide which have a specific focus on treatment (versus prevention) and have demonstrated a good level of evidence. From those reviewed, the C&A EBP workgroup identified both prevention and intervention programs to be recommended. These were a smaller list than those being recommended by the NASMHPD workgroup. Because the EBP’s in the SAMHSA’s Guide primarily focused on disruptive behavior disorders, the C&A EBP Workgroup and the NASMHPD Workgroup researched other EBP’s for consideration. The C&A EBP Workgroup identified the other EBP’s for recommendation which mirror the recommendations of the NASMHPD Workgroup. The C&A EBP Workgroup encountered more difficulty around developing implementation strategies for recommended EBP’s. With C&A EBP’s, they are created and owned by an entity, usually a University. So, implementation is based on ability to work with the defined EBP entity. This has to be done with each EBP. For future implementation, the C&A Workgroup recommended to the MI Associate Commissioner the following, as funding permits:

1. Develop a DMH approved C&A EBP menu that would allow community providers to determine which EBP best works in their community as to best move toward transformation.
2. Contact each EBP entity approved and determine all necessary steps for implementation to include, but not limited to, training, ownership of data, certification, and all costs.
3. Consider a Center of Excellence concept similar to what has been implemented with Adult EBP’s. To properly implement C&A EBP’s, a Center of Excellence concept is what has been utilized in other states to effectively and efficiently implement EBP’s due to complex training demands, certification demands, and data/outcome demands.
4. Consider exploring avenues to have C&A In-Home Intervention evaluated/assessed as a service that could be recognized as a “promising practice” or “best practice”. To do this would only be accomplished by either working with a Center of Excellence or University.
5. As funding is the driving force for Implementation, next steps for implementation are even more complicated. Monies would have to be secured to do so either within the DMH budget, with collaborations with other State Agencies, and/or through grant opportunities.

In FY10, efforts continued to identify and develop opportunities to implement the recommended EBPs. In FY08, DMH partnered with the University of Alabama (UA) and Dr. John Lochman, creator of Coping Power to apply for a research grant. Dr. Lochman is the Director of the Center for the Prevention of Youth Behavioral Problems on the UA campus. Coping Power is an EBP recognized by SAMHSA. Dr. Lochman applied for a research grant that would partner with community mental health centers in the use of

Coping Power. This would be in partnership with UA, DMH and community mental health centers. The grant was submitted in July 2008 but was not awarded. Collaboration continues to work toward securing funding to demonstrate this EBP. DMH also participated with the UA in the application of a NIH research grant. This grant opportunity would allow for the gathering of baseline data from mental health providers over a two year period of time as to assess C&A In-Home Intervention (IHI) services. This baseline data would be utilized as a platform to move toward IHI being recognized as a “promising practice”. The UA, in collaboration with DMH, applied for this grant in June 2010 but it was not awarded. In October 2010, DMH received notification that the SAMHSA Child Mental Health Initiative Grant (SOC) application was awarded. This grant application represented a unique opportunity to develop a system of care that would serve children with serious emotional disturbance and their families in a three county rural community. DMH contracted with a community mental health center for the implementation with DMH working closely with this system of care process. After year three of the SOC grant, ECCHO met sustainability. Several EBPs were being considered for implementation within this System of Care (SOC) Grant to include: Wraparound, Coping Power, Dialectic Behavioral Therapy (DBT), Positive Behavior Support (PBIS), Bright Futures, Assuring Better Child Development (ABCD), and Cognitive Behavior Therapy and Motivational Enhancement Therapy (CBT-MET). Only Coping Power had been initiated for implementation. Funds from other streams will be utilized to continue the efforts to fully implement Coping Power in the three county area served through ECCHCO. Meetings have occurred on how to capture the data within the DMH data system once Coping Power is fully implemented through ECCHCO. In August of 2013, Dr. Lochman at UA applied for a three-year Patient-Centered Outcome Research Institute grant that would partner with DMH and community mental health centers to train up to 120 mental health clinicians to implement Coping Power and establish Coping Power programs at multiple sites across the state.

Evidence Based Practice	# Served FY12 Actual	# Served FY13 Actual	# Served FY14 Target
Multi-systemic Therapy	0	0	0
Functional Family Therapy	0	0	0
Therapeutic Foster Care	0	0	0

SAMHSA Child Mental Health Initiative/System of Care (SOC) Grant (The ECCHCO Project) was awarded to DMH in October 2010. This grant application represented a unique opportunity to develop a system of care that would serve children with serious emotional disturbance and their families in a three county rural community. DMH contracted with a community mental health center for the implementation with DMH working closely with this system of care process. This project addressed the comprehensive needs of child and adolescents with SED and their families by implementing a system based on the core values: community based with outreach services, family-driven, youth-guided, culturally and linguistically competent, and individualized treatment planning. The ECCHCO Project utilized the voices of families

and youth at all levels to include policy and decision making. There were full-time employees as the Lead Family Contact and the Youth Engagement Specialist. Both were members of the state level children's advisory committee, the MI Child and Adolescent Task Force, as well as the Youth Engagement Specialist being a member of the MI Planning Council. At the end of year three of the grant, the progress of sustainment and financial considerations allowed the ECCHCO Project to become independently sustained apart from SAMHSA funding. ECCHCO continues to sustain improvements in children's physical, social and emotional health services in Pike, Bullock and Macon Counties established during its existence as a federally funded System of Care grant program. Strong community partnerships linking parents, youth, education, local government and healthcare agencies continue to be cultivated and utilized to improve the lives of children and their families in this part of rural Alabama. There continues to be a ECCHCO Advisory Council that is utilized as the steering committee for continued efforts. There continues to be a full-time Lead Family Contact and there continues to be a voting membership for both a family and youth representative from ECCHCO on the state level children's advisory committee, the MI Child and Adolescent Task Force, as well as a voting youth membership from ECCHO on the MI Planning Council. It is the intention to utilize this SOC site as a "laboratory of learning" as to transcend traditional mental health boundaries by integrating social services, education, juvenile justice, and primary care resources with mental health services.

Child and Adolescent Needs and Strengths (CANS)

Efforts to move toward the use of a state-wide Functional Assessment Tool became a focus of attention of the Child and Adolescent Task Force for several reasons. The use of a functional assessment tool could serve as a uniformed state-wide reporting process that would be a valuable approach for consistently capturing measurable data elements that are comparable. The use of a functional assessment tool would serve as an instrument to drive treatment planning that is individualized, family-centered, and strength-based. The use of a functional assessment tool would provide an avenue to capture data needed to assist with mandatory reporting elements. The use of a functional assessment tool would provide rich data that would enhance grant applications which is highly valuable considering the current state and federal economic conditions. Recommendations were made to the Associate Commissioner to move in this direction and, on October 1, 2010, the Child and Adolescent Needs and Strength (CANS) Functional Assessment Tool was implemented state-wide. The CANS is being used statewide for children and adolescents receiving services through the public mental health system. This transformation tool, consistent with system of care values and principles, focuses on the needs of the children and families. The CANS-Comprehensive provides a common language, objective criteria to support decisions about intervention plans and intensity of services, monitors progress through outcome measures, and supports quality improvement initiatives. Information from the CANS-Comprehensive will support decisions at multiple levels – direct services, supervision, program management, and system management. For community mental health providers, the *CANS for Alabama Comprehensive Multisystem Assessment (5 to Adulthood)* or the *EC-CANS for Alabama Comprehensive Multisystem Assessment (0 to 4 Years)* tools is being utilized. The CANS was developed by John Lyons, PhD, in collaboration with several states' child serving systems and Dr. Lyons worked directly

with the Department on this venture. Dr. Lyons completed the “Super User” training/certification process in June 2010. Approximately 107 CANS Super Users were trained to support local implementation of the CANS-Comprehensive training, supervision, and integration into everyday practice. Alabama’s mental health public system providers were trained and certified as “Certified CANS Users”. A database, the Alabama Behavioral Health Assessment System (ABHAS), was developed to capture the CANS data and to provide a variety of reports to users at all levels of the child-serving system. ADMH Data Management Division created a web-based application in collaboration with Dr. Lyons to interface with this database, and the ABHAS website was initiated on October 1, 2010. All MI contracted providers have C&A staff trained and a CANS completed on all C&A consumers as of April 1, 2011. ADMH continues to collaborate with Dr. Lyons on the certification process and enhancements to the ABHAS Website.

Substance Abuse/Co-Occurring Disorders

A major gap in the current system of care for adults and children and adolescents is coordinated care for individuals with co-occurring mental illness and substance abuse problems. Often programs and services are not available due to eligibility rule-outs in their admission criteria, or complex funding requirements may hinder access to coordinated substance abuse and mental health services. As previously discussed, DMH Administration is dedicated to making positive strides in this area and first steps were taken by combining the Mental Illness and Substance Abuse Divisions. At present within the Mental Health Substance Abuse Services Division, the executive staff works directly and in coordination with each other. There are several Offices within the Division that address MI/SA/COD such as the Office of Certification, the Office of Deaf Services, and the Office of Performance Improvement. Within all other offices, coordination of care is direct and bi-directional, to include adult and children/adolescents.

One of the major responsibilities of the Office of Children Services was the planning and development of programs and services across the Department’s three divisions: Mental Illness (MI), Developmental Disabilities (DD), and Substance Abuse (SA). The funding, in FY01 and FY02, of a Juvenile Court Liaison for each community mental health center catchment area is an example of an initial effort to improve the service capacity and flexibility in addressing co-occurring disorders. Since the juvenile court is frequently where children and adolescent with co-occurring disorders first enter the system, the Juvenile Court Liaison will assist the court in assessing the individual and make appropriate treatment recommendations. They will also be responsible for linking the youth and their family members to needed services, to include substance abuse services. With changes in the previous administration, the Office of Children Services was terminated and the services within that office were distributed to the two service divisions (MHSA and DD). But the integrity of the programs that served co-occurring issues remained intact with processes being developed to maintain their integrity to include the Juvenile Court Liaisons.

Dr. Barbara Jackson, the Co-occurring Disorders Coordinator within the Mental Health Substance Abuse Services Division, has been involved in the following activities during FY12-13:

1. One of the COD Programs in South Alabama, Second Choice Inc., has shuttered its program. In addition, one of the major state mental health hospitals (Searcy Hospital) has also closed. We are fortunate however that other COD facilities in the southern region of the state have been able to absorb the patients no longer being served by these agencies. Emma's Harvest Home, Alta Pointe Health Systems, and Midland City continue to admit and treat patients from this region.
2. Adolescent COD Services continue at The Bridge, Inc at Gadsden and at UAB. The Bridge, Inc. was awarded the Federal Grant to assist with services for the juveniles involved in the criminal justice system returning/re-entering into their communities who are diagnosed with co-occurring disorders. They were allowed to carry forward monies into the current FY due to their late start with the implementation.
3. The COD Standards for adults and adolescents were published and released. They were formatted and went out for solicitation of public comment. They were later approved and ratified and are now a part of the ADMH Administrative Code. They are currently being used by all certified SA Community Programs of the MHSA division.
4. Convened two (2) quarterly meetings of ACT, REACT, and MH Specialist workgroup. Continued our collection of basic caseload data noting trends or patterns throughout the state.
5. Assisted with the development of the Client Perception of Care Survey for all ADMH SA providers in the state.
6. Represented ADMH as the department's representative for the 38th Annual Alabama School of Alcohol and Other Drugs Conference.
7. Continue to serve as a member on the Department of Mental Health's Returning Veterans, Service Members, and Families Policy Academy Workgroup.
8. Provided C & E and technical assistance for staff at provider organizations as required.
9. Developed and implemented the state wide interim case management training for the certified substance abuse providers.
10. Participated in two training opportunities for ADMH providers in the SOAR Initiative hosted by our Policy and Planning Office.

11. Continued to provide the day-to-day COD duties as the expert representative on SA Treatment Team in COD issues.
12. Provided Substance Abuse Services Division SAPT Contract Monitoring Program monitoring to all contracted providers as required.
13. Contributed to the development of information and activities for SABGT requirements as directed.

Office of Policy and Planning (OPP)

Within DMH, the Office of Policy and Planning serves as a resource for consumers, families, providers, and community stakeholders. OPP strive to educate, inform, and empower regarding issues affecting intellectual disabilities, mental illness, and substance abuse services. OPP works closely with the two service divisions. Below are efforts of collaboration worth highlighting.

ADPH Emergency Preparedness Collaboration

DMH has standing membership on the Alabama Department of Public Health's Emergency Preparedness Advisory Council and the Special Needs Task Force in which several representatives from DMH participate. Annually, the Department of Public Health (DPH) jointly sponsors a statewide emergency preparedness conference with CDC funds. This past conference was devoted to Resilience. (See attachment).

Alabama Emergency Management Agency Collaboration

In 2012, DMH participated in Alabama Emergency Management Agency (AEMA) training regarding state agency roles under the AEMA State Operations Plan. This included a review of the 2011 response to the string of tornadoes that impacted Alabama. In 2013, DMH participated in a Sheltering Workshop presented by AEMA. During 2011-2013, Policy and Planning staff participated in two (2) trainings hosted by the Alabama Emergency Management Agency (AEMA) pertaining to response at Disaster Recovery Centers and three (3) Governor's Hurricane Preparedness Workshops that were hosted by AEMA.

Governor's Mass Sheltering Task Force

DMH regularly participates in the Governor's Mass Sheltering Task Force and related training events.

BP Oil Spill Disaster Crisis Counseling Response

DMH has been active in response to the coastal oil spill since June 2010. In collaboration with SAMHSA and neighboring states, a 32 member crisis counseling team was established to serve residents of Baldwin and Mobile counties through a BP financial award. Through June 2013, 577,884 crisis counseling contacts have been made in both counties to include individual, group, educational and outreach services. SAMHSA-Disaster Technical Assistance Center (DTAC) materials were modified for coastal use and SAMHSA-DTAC resources were utilized to target Cambodian, Vietnamese and Laotian communities. Funds were also distributed to Serve Alabama to provide

economic, employment, domestic abuse and related support services through the AL VOAD (Volunteer Organizations Active in Disaster) to include Boat People SOS (BPSOS). An abbreviated crisis counseling training was provided to all participating agencies in order to expand capacity. DMH also provided funding to the Lifelines Crisis Center of Mobile for suicide prevention training. One (1) training utilized a peer-to-peer approach for community residents, and the second training was provided to pastors. The program is slated for closure effective December 31, 2013 and leadership staff are making preparations to inform the community, make final service connections and assist program staff with employment searches.

DMH was the recipient of a SAMHSA Emergency Response Grant (SERG) to conduct post-oil spill behavioral health surveillance through the University of South AL and provided its final report. The SERG allowed the states of AL, MS, and LA to routinely collaborate toward consistent reporting of outcomes across the Gulf Coast. DMH also assisted DPH and the CDC in two Community Assessments for Public Health Emergency Responses (CASPER). Additionally, DMH assisted in the development of CDC's SAMHSA funded Gulf States Population Survey (GSPS), which was modified for behavioral health surveillance.

Tornado Oil Spill Response

DMH was the recipient of a SAMHSA/FEMA Immediate Services Crisis Counseling Program to provide services to individuals impacted by the string of tornadoes affecting citizens on April 15 and April 27, 2011. Services were provided through twelve (12) community mental health centers, with a specialized program targeting students, staff, faculty and parents of the University of AL (UA). The Project Rebound Immediate Services Program (ISP) made 334,120 contacts through September 2011. The majority of these contacts was made through educational and outreach services to inform affected communities of services. ADMH partnered with the AL Chapter of the American Academy of Pediatrics, ADPH and other stakeholder groups to provide a "Supporting Children's Health Needs in the Aftermath of a Disaster" satellite conference and webinar.

The needs of individuals who are deaf were addressed through consultant, Roger Williams, to improve outreach and access to services. A modified Crisis Counseling 101 training was also provided to the ADMH Office of Deaf Services during the ISP.

Educational services included the development of Project Rebound public service announcements utilizing the head coaches of the University of AL (Nick Saban) and Auburn University (Gene Chizik). SAMHSA-DTAC and other tornado related materials were posted at the ADMH website, along with the Project Rebound toll-free number. (Calls were routed to the ISP crisis counseling phone line based upon originating area codes).

DMH was awarded a Regular Services Crisis Counseling grant to continue services for an additional nine (9) months through June 25, 2012. Services were provided through eleven (11) community mental health centers serving twenty-six (26) counties, with a specialized program targeting students, staff, faculty and parents of the University of AL

(UA). The Project Rebound Regular Services Program (RSP) made 882,513 contacts. The majority of these contacts was made through educational and outreach services to inform affected communities of services. Children and adolescents were a priority, with eighty two thousand four hundred thirty-six (82,436) individuals under the age of eighteen (18) served in group sessions in partnership with child serving organizations.

Alabama Returning Veterans Initiative

DMH is the recipient of a SAMHSA Returning Service Members, Veterans and Their Families Technical Assistance award that allowed the Alabama Returning Veterans Committee (ARVC) and other stakeholders to participate in two (2) SAMHSA sponsored In-State Policy Academies hosted by the Tuscaloosa VA Medical Center and three (3) national Policy Academies sponsored by SAMHSA. The Department enjoys a longstanding collaborative partnership with the Department of Veterans Affairs, and is the Co-lead agency for the Alabama Service Members, Veterans and Their Families (SMVF) Taskforce which is charged with improving behavioral health and support services for returning service members, veterans, and their families.

Thus far, efforts of SMVF and ADMH collaboration have resulted in the following:

1. Development of a 2008 Alabama Re-Integration Action Plan (RAP) educational publication (see attachment) which has been distributed nationally and is posted at the SAMHSA website,
2. DMH participation in three (3) SAMHSA sponsored In-State Policy Academies,
3. Through its SAMHSA technical assistance award, DMH approved a Central AL Veterans Administration staff person to become a SSI/SSDI Outreach, Access and Recovery (SOAR) Trainer to assist homeless veterans in obtaining Social Security Administration (SSA) benefits,
4. The formulation of a 2013 AL Action Plan, accessible via <http://smvftacenter.prainc.com/sites/default/files/AL%20Action%20Plan%206-17-13.pdf>, that is posted at the SAMHSA website,
5. Participation in the AL National Guard's national behavioral health site visit in 2011,
6. Ongoing DMH participation in the AL National Guard's efforts to reduce suicide and sexual assault,
7. DMH participation in the development of an interagency PTSD Conference for Service Members, Veterans and their Families in November of 2011,
8. DMH featured Veterans Service Needs at a State Justice and Mental Health Meeting held in November 2011,

9. The Tuscaloosa VA Medical Center hosted 2012 Alabama Returning Service members, Veterans and their Families Forum, addressing PTSD, TBI and Homeless Services,
10. A SAMHSA sponsored Pell City 2012 In-state Policy Academy on Peer Support Services and Outreach to include Homeless Services,
11. A 2012 Opelika forum with national and state leadership on service members and veterans' needs to include homelessness,
12. A 2012 partnership with Army One Source to pilot an online training curriculum for treatment professionals,
13. During 2013, national and state leadership meetings in Montgomery were held to continue the dialogue around veterans and service member issues,
14. Completion of a comprehensive Homelessness Veterans Report in 2013 by the AL Dept of Veterans Affairs,
15. DMH participation in a 2013 AL HUD Field Office VASH Training for Homeless Veterans
16. DMH 2013 participation in the University of AL's School's National Institute of Health (NIH) Grant Steering Committee to plan and conduct training and research on veterans issues,
17. A 2012 and 2013 Supermarket of Services that was held in Pell City and provided information on homeless services,
18. A 2013 AL Department of Veterans Affairs Supermarket of Services that was held in Opelika and provided information on community mental health and homeless services,
19. 2013 DMH participation in the newly formed AL Department of Public Health Rural Health Initiative for Veterans and their Families, and
20. DMH sponsorship of a 2013 Ministerial Conference hosted by ServeAL on the needs of Veterans and their Families with the DMH and Alabama Department of Veterans Affairs Commissioners providing opening comments.

Action is underway to obtain an Executive Order to formally establish an Interagency Council, the AlaVetNet. Alabama Department of Veterans Affairs and Alabama Department of Mental Health Commissioners have agreed to Co-Chair AlaVetNet, pending the Governor's approval. Additionally, the DMH sponsored AL School of Alcohol and Drug Studies offered training on the needs of Veterans at its 2011, 2012 and 2013 conferences.

SSI/SSDI Outreach, Access and Recovery (SOAR) Training

The Office of Policy and Planning coordinates the provision of SSI/SSDI Outreach, Access and Recovery (SOAR) Training throughout the state through a SAMHSA technical assistance award. SOAR training is designed to facilitate the acquisition of Social Security Administration (SSA) benefits to individuals with a diagnosis of serious and persistent mental illness (SMI) and/or a co-occurring disorder of SMI and substance use. Training is geared to individuals who are homeless, at-risk of homelessness or living in doubled up living arrangements.

The HUD Continuum of Care (CoC) located in south Alabama is the 2013 recipient of a SOAR award to serve Baldwin and Mobile counties. DMH collaborates with the CoC and the Veterans Administration SOAR Trainer in Tuskegee in an effort to expand and leverage services.

Alabama Department of Public Health Collaboration

DMH partners with the Alabama Department of Public Health (ADPH) through regularly scheduled meetings with its Office of Rural and Primary Health Care. The focus of this partnership is to explore and leverage resources to expand behavioral health services and to recruit and retain treatment professionals.

Alabama League of Municipalities Collaboration

The Alabama League of Municipalities affords DMH the opportunity to participate in its planning process. DMH priorities are presented in an effort to increase awareness of the needs of DMH, its stakeholders and its constituents.

Section II: Planning Steps – Step 2: Identify the unmet service needs and critical gaps within the current systems

- This step should identify the data sources used to identify the needs and gaps of the populations relevant to each Block Grant within the State's behavioral health care system, especially for those required populations described in this document and other populations identified by the State as a priority.

The State's priorities and goals must be supported by a data driven process. This could include data and information that are available through the State's unique data system (including community level data) as well as SAMHSA's data set including, but not limited to, the National Survey on Drug Use and Health, the Treatment Episode Data Set, and the National Facilities Surveys on Drug Abuse and Mental Health Services. Those States that have a State Epidemiological Outcomes Workgroup (SEOW) must describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with serious mental illness and children with serious emotional disturbances that have been historically reported. States should use the prevalence estimates, epidemiological analyses and profiles to establish substance abuse prevention, mental health promotion, and substance abuse treatment goals at the State level. In addition, States should obtain and include in their data sources information from other State agencies that provide or purchase behavioral health services. This will allow States to have a more comprehensive

approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.

In addition to in-state data, SAMHSA has identified several other data sets that are available by State through various Federal agencies such as the Center for Medicaid and Medicare Services or the Agency for Health Research and Quality. States should use these data when developing their needs assessment. If the State needs assistance with data sources or other planning information, please contact planningdata@samhsa.hhs.gov .

Historically, services have been designed and implemented through a participatory planning process that includes the Mental Illness Planning Council and the Mental Illness Coordinating Subcommittee of the Management Steering Committee. Family members, consumers, advocacy organizations, other state agencies, and providers are represented on these planning bodies. A regional planning process initiated in FY08 added participants into the planning process, primarily consumer and family advocates, to address critical overages in state hospitals and system transformation.

The regional planning structure was adopted for all departmental planning beginning in FY08 and resulted in increased numbers of family members and consumers being involved in the planning process. There have been numerous participants in the regional planning process including consumers, family members, judges, public community providers, state hospitals, and local private providers. The local and regional planning process provided the foundation for DMH's annual budget request. In FY09, the planning process was expanded to include a separate planning function for children and adolescents. This decision was based on feedback from the previous years of planning and was implemented to improve the voice of children and adolescents and their families throughout the planning process. A series of over 90 adult/children and adolescent local stakeholder planning meetings occurred in late summer and fall 2009. This provided local and regional input in determining unmet needs and critical gaps within the system at the community level. The feedback from this process was utilized within the departmental planning process as a mechanism to introduce local community input and was instrumental in the identification of needs and gaps in service. During FY 2011, DMH leadership worked jointly with the Mental Illness Coordinating Subcommittee and Management Steering Committee to make recommendations for goal and strategy improvements. This collaboration has resulted in thorough examination of planning targets that reflect the approval of stakeholder partners while balancing the realities of DMH fiscal parameters and magnifying the benefits of the integration efforts made within the division. This process has continued through FY 2013.

Planning for children and adolescent services is performed as a part of the overall Management Steering Committee process described above via a Child and Adolescent Services Task Force. The Task Force is constituted from a representative group of stakeholders, including advocates and family members whose primary focus is children and adolescents. This body assesses the needs of the state, designs the conceptual framework, and prioritizes strategic growth of child and adolescent services for the DMH Mental Illness Division.

A combination of sources was used to identify critical service gaps. For years, DMH has monitored the utilization of public mental health services through analyzing service data reported to DMH. This data, in conjunction with periodic survey of the providers, allowed DMH to identify trends in service utilization by the consumers. Please refer to “Section IV-Narrative Plan Q. Data and Information Technology” (ACSIS, CDR, CARES, MICRS, Gateway, ABHAS).

Other sources of data utilized by DMH include the U.S. Bureau of Census, the National Uniform Reporting System (URS), Mental Health Statistics Improvement Program (MHSIP) Consumer Satisfaction Surveys, DMH web-based housing inventory (MICRS), DMH certification results from provider site visits, HUD Point in Time count, Housing Needs Assessments, and hospital and community Performance Improvement data sets.

Another very valuable measure DMH has for identification of gaps in the service delivery continuum for children and adolescents is through its participation in the Case Review Committee of the Multiple Need Child Office. This staffing occurs monthly with legislatively mandated child-serving agencies charged with developing plans for children who have multiple needs and who are at risk of placement in a more restrictive setting.

DMH has exchanged service data with other state agencies, including but not limited to the Alabama Medicaid Agency, Department of Public Health, ALL Kids, Juvenile and Adult Corrections, the Administrative Office of the Courts, Department of Education, and Department of Human Resources, to provide a comprehensive array of publicly funded services to adults and children/adolescents through memoranda of understanding, intergovernmental service agreements, or informal relationships. Also, DMH worked with the Administrative Office of the Courts to match the DMH mental health database with mental health court participants.

In June, 2011, DMH released a Request for Proposals to seek a vendor to conduct a comprehensive behavioral health needs assessment in Alabama. This process was to determine the need for both mental health and substance abuse services for diverse populations. Proposals were received the contract for the needs assessment was awarded in June 2012 and Project Launch was initiated. A project work plan was developed that would be completed with a 9 month tenure. Due to the complexities of the process, the completion of the Needs Assessment to get into draft form was extended. The draft process was completed and submitted by the contractor in June 2013. DMH continues to work on final edits prior to moving to publications. Once this has occurred, DMH will utilize the data within our planning process (see attached draft Needs Assessment).

PREVALENCE
Community Programs
FY12

Overall Total Served (MI – Community and State Hospital) – 104,279

Overall Total Served (MI Community) – 102,035

SMI Adult (Contract Eligible) – 65,513

SED (Contract Eligible) – 25,321

The 2012 Uniform Reporting System (URS) Table 1 estimate of adults with serious mental illness (SMI) in Alabama is 197,841 and the estimate of children and adolescents with serious emotional disturbances (SED) is 69,555 people which is the upper limit of Level of Functioning equal to or less than 60.

The DMH definition of Serious Mental Illness is more restrictive than the federal definition in that the diagnostic categories are limited. The types of functional disability are similar between the state and federal definitions. The Alabama public sector's priority population is the SMI population that requires treatment and care outside the private sector. Many children and adolescents with serious emotional disturbance are served in the private sector, by the Department of Human Resources, by the Department of Youth Services, and by educational agencies. 27.9% of the total C&A served in Alabama compared to 28.3% nationally. 72.0% of total adults served in Alabama compared to 71.7% nationally. The FY12 Uniform Reporting System State Report shows Alabama with a penetration rate of 21.72 per 1,000 population compared to the national rate of 22.55. The community utilization rate is 21.25 per 1,000 population compared to 21.70 nationally. The penetration rate for adults with serious mental illness and children/adolescents with serious emotional disturbance exceeds the national rate in all age categories as follows:

00-17 years	Alabama 22.5 – National 17.6
18-20 years	Alabama 18.7 – National 15.0
21-64 years	Alabama 20.3 – National 15.9
65(+) years	Alabama 7.4 – National 4.1

The following is a description of those individuals who are contract eligible:

**DEFINITION OF SERIOUS MENTAL ILLNESS/
DESCRIPTION OF CONTRACT ELIGIBLE CLIENTS
(ADULTS)**

A: Persons who meet the diagnosis and disability criteria for serious mental illness listed below in Section 1 or who meet the criteria for high risk listed below in Section 2.

Section 1: Persons who are Seriously Mentally Ill:

Diagnosis: Any diagnosis listed below in combination with at least two criteria from the disability category:

Schizophrenia and Other Psychotic Disorders

295.xx	<i>Schizophrenia.</i>
.30	<i>Paranoid Type</i>
.10	<i>Disorganized Type</i>
.20	<i>Catatonic Type</i>
.90	<i>Undifferentiated Type</i>
.50	<i>Residual Type</i>
295.40	<i>Schizophreniform Disorder</i>
295.70	<i>Schizoaffective Disorder</i>
297.1	<i>Delusional Disorder</i>
298.8	<i>Brief Psychotic Disorder</i>
297.3	<i>Shared Psychotic Disorder</i>
298.9	<i>Psychotic Disorder NOS</i>

Mood Disorders (Major)

296.xx	<i>Major Depressive Disorder</i>
.2x	<i>Single Episode</i>
.3x	<i>Recurrent</i>
296.xx	<i>Bipolar I Disorder</i>
.0x	<i>Single Manic Episode</i>
.40	<i>Most Recent Episode Hypomanic</i>
.4x	<i>Most Recent Episode Manic</i>
.6x	<i>Most Recent Episode Mixed</i>
.5x	<i>Most Recent Episode Depressed</i>
.7	<i>Most Recent Episode Unspecified</i>
296.89	<i>Bipolar II Disorder</i>
296.80	<i>Bipolar Disorder NOS</i>

Anxiety Disorders (Severe)

300.01	<i>Panic Disorder Without Agoraphobia</i>
300.21	<i>Panic Disorder With Agoraphobia</i>
300.22	<i>Agoraphobia Without History of Panic Disorder</i>
300.3	<i>Obsessive-Compulsive Disorder</i>

Disability: (must meet at least two criteria listed below as a result of one of the above diagnoses)

1. Is unemployed, is employed in a sheltered setting, or has markedly limited skills and a poor work history.
2. Shows severe inability to establish or maintain personal social support systems.
3. Shows deficits in basic living skills.
4. Exhibits inappropriate social behavior.

Section 2: High Risk (must meet one of the criteria listed below):

1. A person who has a history of DMH/MR supported inpatient or public residential treatment as a result of an Axis I mental illness diagnosis (excludes mental retardation and substance abuse)
 2. A person who without outpatient intervention would become at imminent risk of needing inpatient hospitalization.
- B. An individual regardless of diagnosis shall be eligible for one intake per year and pre-hospital screening and crisis intervention as needed.

The following definition was revised and approved in August 1996, by the DMH Children and Adolescent Taskforce. The revised definition became effective October 1, 1996.

**DEFINITION OF SERIOUS EMOTIONAL DISTURBANCE/
DESCRIPTION OF CONTRACT ELIGIBLE CLIENTS
(CHILDREN AND ADOLESCENTS)**

For the purposes of this agreement/definition a child or adolescent is an individual, age 17 years or less, and a legal resident of the state of Alabama. To be eligible for contract services he/she *must* meet the following criteria for (I & II) *or* (I & III):

I. Diagnosis

Must have a DSM-IV Axis I diagnosis. A primary diagnosis of a “V” code, substance use, or mental retardation does *not* meet criteria.

However, for the purposes of Medicaid Rehabilitation and Optional Targeted Case Management match payments, individuals do not have to meet the criteria listed above, but must, of course, meet Medicaid requirements.

By policy, responsibilities for persons who are diagnosed with Autism and who have dual mental illness and mental retardation diagnoses fall under the jurisdiction of the Division of Mental Retardation within the DMH/MR.

II. Separated from Family (Out-of-Home Placement)

Separated from family due to a child or an adolescent’s admission to, residing in, or returning from an out-of-home placement in a psychiatric hospital, a residential treatment program, therapeutic foster care home, or group treatment program as the result of a serious emotional disturbance.

III. Functional Impairments/Symptoms/Risk of Separation

Functional impairment is defined as a behavior or condition that substantially interferes with or limits a child or adolescent from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills. Functional impairments of episodic, recurrent or continuous duration are included unless they are temporary and expected responses to stressful events in the environment.

Must have A *or* B *or* C as the result of a serious emotional disturbance:

A. Functional Impairment

Must be of one-year duration or substantial risk of over one year duration.

Must have substantial impairment in *two* of the following capacities to function (corresponding to expected developmental level):

1. *Autonomous Functioning*: Performance of the age appropriate activities of daily living, e.g., personal hygiene, grooming, mobility;
2. *Functioning in the Community* - e.g., relationships with neighbors, involvement in recreational activities;
3. *Functioning in the Family or Family Equivalent* - e.g., relationships with parents/parent surrogates, siblings, relatives;
4. *Functioning in School/Work* - e.g., relationships with peers/teachers/co-workers, adequate completion of school work.

B. Symptoms

Must have one of the following:

1. Features Associated with Psychotic Disorders
2. Suicidal or Homicidal Gesture or Ideation

C. Risk of Separation

Without treatment there is imminent risk of separation from the family/family equivalent or placement in a more restrictive treatment setting.

Services should be provided in a manner that is accessible to persons of both genders, all ages, and all races/ethnicities. The chart below shows that services are delivered to individuals in all categories.

<i>Measure</i>	FY09	FY10	FY11	FY12	FY13	FY14
	Actual	Actual	Actual	Actual	YTD	Goal
Age:						
0-17	23,401	27,168	26,980	27,178	24,096	23,500
18-20	5,999	5,015	5,184	4,998	4,119	4,000
21-64	61,020	62,284	64,695	64,177	54,841	55,000
65+	5,810	5,270	5,470	5,667	5,324	5,000
Unknown	138	210	038	015	014	
Gender:						
Female	51,555	53,221	55,141	55,056	47,161	48,000
Male	44,314	46,203	47,208	46,973	41,116	42,000
Unknown	415	491	026	06		
Race/Ethnicity:						
Am Ind/Al Native	322	334	394	347	269	250
Asian	116	116	140	165	155	100
Black/Afn Amn	32,692	35,322	36,703	37,410	33,102	32,000
Native Hawaiian	21	30	34	32	25	10
White	54,166	56,367	59,187	60,435	51,856	50,000
Multi-racial	816	999	1,120	1,136	1,031	900
Unknown	8,235	6,779	4,797	2,612	1,856	
Hispanic Origin:						
Hispanic/Latino	1,074	1,246	1,385	1,516	1,414	1,000
Not Hispanic	89,095	95,944	100,893	100,588	86,834	85,000
Unknown	6,199	2,757	097	033	046	

Specific to child and adolescent services, ensuring adequate staffing levels are vital. Surveys are conducted to ascertain the number of staff within community programs that provide services for the population with a Serious Emotional Disturbance. Below are the results from those surveys, which reflect a slight increase of the number of FTE positions serving children and adolescents.

Provider	Total FTE's C/A Staff	Percent Change	Percent Change			
	August 2010	August 2011	August 2012	August 2013	Aug 11-Aug 12	Aug 12-Aug 13
Baldwin County	34.3	35	36.5	38	4.29	4.11
Brewer-Porch	110	172	148	155	-13.95	4.73
Calhoun-Cleb.	18	16	18	18	12.50	0.00
Cahaba	11	10	9.25	9.25	-7.50	0.00
CED	10.73	11.1	8.5	10.73	-23.42	26.24
Cheaha	10	11	9	10	-18.18	11.11
Chilton-Shelby	10.5	10.5	10.5	10.5	0.00	0.00
Cullman	11.5	11.5	11.25	11.25	-2.17	0.00
East Alabama	29	33	29	33	-12.12	13.79
East Central	31.25	25	18	17	-28.00	-5.56
Eastside	5	5	5	5	0.00	0.00
Glenwood	28	31	34	35	9.68	2.94
H'ville-Madison	31.4	36.27	37.25	42	2.70	12.75
Indian Rivers	21.25	17	12.75	12.75	-25.00	0.00
J-B-S	74	75	65	67	-13.33	3.08
Marshall-Jackson	15	15.5	15.5	14.5	0.00	-6.45
Montgomery	23.5	23.5	17.2	19.5	-26.81	13.37
Mobile	127	132.35	141	162	6.54	14.89
North Central	23.65	26.5	31	29.5	16.98	-4.84
Northwest	60	81	81	81.5	0.00	0.62
Riverbend	44.25	47	44.25	39	-5.85	-11.86
South Central	12	12	12	17	0.00	41.67
Southwest	20.5	17	17	15.4	0.00	-9.41
UAB	10.5	10.5	10.5	10.5	0.00	0.00
West Alabama	7	6	6.5	5.5	8.33	-15.38
Western	3.68	3.25	3	3	-7.69	0.00
Wiregrass	11	11	8.46	8.48	-23.09	0.24
TOTALS	794.01	884.97	839.41	880.36	-5.15	4.88

An analysis of the unmet service needs and critical gaps within the current system

Self-Directed System of Care

Individuals with mental health issues can and do recover. Services and supports must foster the ability for self-directed recovery. Recovery benefits not only the consumer and their family, but all the community in leading to a more healthy and productive way of life. The efforts of DMH have been to develop and enhance a continuum of care for both adults and children/adolescents that lends itself to a flexible array of services that are focused on meeting as a first priority the needs of people with a serious mental illness and serious emotional disturbance. However, this process has to be consumer driven. Consumer driven means that consumers must have a voice in decisions that affect their lives and treatment. Consumers must have choices in the services they receive and where they live. Additionally, consumer driven means that the consumer voice must be present in planning, implementing, providing, and evaluating the services and care at a local, state, and national level. Consumer input and consumer-driven should not be confused. Input is providing comment or opinion. Driven is having an impact on the direction or course of actions. As we move toward a good and modern system of care, it will be vital to incorporate the core values: community-based, consumer-driven, family-guided, culturally and linguistically competent, and individualized.

As outlined in “Section IV-Narrative Plan M-Recovery”, efforts to move the system toward this have occurred at several levels. To try and develop infrastructure and build capacity, DMH has engaged in the following:

- Updated the DMH Administrative Code for MI Program Standards that incorporates person centered and recovery mandates for care, as well as addressing the specialized needs of consumers who are deaf or hard of hearing.
- Utilized a regional planning process to expand consumer and family members involvement at all levels.
- Incorporated feedback from consumers and family members in DMH planning processes which provides the foundation for DMH’s annual budget request.
- Gathered pertinent consumer feedback, to include client perception of care, through the MHSIP satisfaction survey. This data is reviewed to assist in informing the system for planning purposes.
- Continued to use Certified Peer Support Specialists within the community system.
- Initiated the use of Peer Bridgers for transitional services from state psychiatric hospitals to community settings.
- Created in-state capacity to provide Peer Support Certification training.
- Maintained funding for five existing drop-in centers.
- Submitted language related to Peer Support Services to Alabama Medicaid for consideration of a State Plan Amendment for the Rehab Option that would include Peer Support Services, Youth Peer Support Services, and Family Peer Support Services.
- Implemented the state-wide use of the Child and Adolescent Needs and Strengths (CANS) Functional Assessment Tool.

- Received a SAMHSA Children’s Mental Health Initiative System of Care (SOC) grant that covers three rural counties. This SOC met local and state level sustainability and the site will be used as a model for expansion across the state.
- Issued an RFP Needs Assessment to assist DMH with identifying the unmet needs and gaps within the State’s current mental illness and substance abuse service delivery system, as well as identifying the underserved populations. The Needs Assessment administrative process was recently completed and currently in draft.

However, DMH has a long way to go in reaching self-directed care. There continues to be much work needed with the expansions of recovery services. Even though the above efforts are to be commended, it does not meet the needs and gaps that are necessary to build capacity for an array of services to assist with self-direction. Peer Support services are not available within each of the community mental health provider. This is not even a service that exists for children and adolescents and their families. Drop-in centers have proven to provide engaging socialization and empowerment, but with scarce funding, there is no way for expansion without identifying new funding sources. Even though DMH is working with Alabama Medicaid to expand service packages, it is unclear if this service could be included as a Medicaid reimbursable service. DMH initiated the use of the CANS functional assessment tool as a means to move the system toward strength-based, individualized treatment planning process. Even though the next steps are to initiate such an instrument for adults, it has yet to occur. DMH has financially supported the efforts of the MI Planning Council in expansion of peer services and trainings through Special Project dollars. However, with scarce funds and dwindling state dollars, concerns lie with the protection of these funds not being diverted to more traditional services.

Community Integration

An array of services must be designed to incorporate the concept of community integration and social inclusion for individuals/families. Community integration ensures that people with behavioral health problems, disabilities and other chronic illnesses have the supports and services they need to live in a home/family/community setting. This includes services to help people live in housing of their choice and support them in school, work, families and other important relationships; both paid and unpaid community supports can help achieve these goals. This will require public purchasers to take a comprehensive look at how its policies impact the way urban, rural and frontier areas develop and how well those places support the people who live there, in all aspects of their lives—education, health, housing, employment, and transportation. This “place-based” approach should be taken to help communities work better for people.

The reforms mandated by Wyatt had a profound effect on mental illness services. The shift in emphasis from institutional care to community-based care was central to these reforms. The census at Bryce State Psychiatric Hospital dropped from over 5,000 patients in 1971 to less than 400 in 2004. Through the dedicated efforts of state psychiatric hospitals and community partners, DMH can boast nearly a 44% statewide reduction in total state psychiatric hospital census from FY09 to present (June 2013). Over the 33 year term of the Wyatt case, a broad network of community providers evolved, and by the termination of Wyatt in 2003, the public community mental health providers served over

100,000 Alabamians per year with offices in all 67 counties. Since then, building a continuum of care for adults and children/adolescents within the community has been the primary focus as to develop community integration. The following are continued efforts of DMH:

The evaluations conducted in February, 2009, revealed that there are significant numbers of state hospital extended care residents who can live in the community with adequate supports. There has been a prolonged and intensive planning process that began implementation in June, 2010. The plans called for a reduction in census at Bryce and Searcy Hospitals by creating additional community resources. The proposed reduction in state hospital census reduced the demand for extended care beds and permitted a shift of funds from state hospital budgets to needed community services. Efforts include the use of Peer Bridgers to ease the transitional process for long-term state hospital patients, expansion of housing resources such as MOM apartments, the augmentation of existing group homes to better address the needs of this specialty population, clinical support teams to provide intensive community supports that had not existed, the use of existing Certified Peer Support Specialists to enrich the community supports provided, and flex funds to tailor individualized care.

The financial atmosphere of FY11/12 and desire to advance a more responsive system of care prompted an acceleration of the Department's goals to further reduce the number of acute care psychiatric beds and to bring about the closure of some state operated facilities. The 2012 Hospital Closure Project resulted in the Department closures of Greil Memorial Psychiatric Hospital (Montgomery County) August 31, 2012 and Searcy Hospital (Mobile County) October 31, 2012. Collectively, these two hospitals served a total of 1,231 individuals in FY11. Over ninety percent of Greil and Searcy's inpatient capacity has been shifted to local communities. As a means of supporting this shift, an innovative framework for processing inpatient commitments was born from the Hospital Closure Project. The dedicated and unprecedented cooperation between state government, local provider agencies, and local probate courts resulted in a new Department of Mental Health Commitment Procedure specifically for Regions 3 and 4 and for which the success of this project hinged. A pivotal element to the newly established commitment procedure was the development of the Gateway System which permits for the tracking of probate committed individuals to be served within the community at a Designated Mental Health Facility or Willing Hospital Participant locals. This process allows for ongoing flexibility, customization, and movement within less restricted levels of care outside of state operated institutions.

For adolescents, much focus over the years has been on reduction of beds, going from a 40 bed unit in 2002 to currently only have a 10 bed unit. DMH also took strides to move away from the traditional stand-alone state hospital setting for these committed youth and achieved the legal ability to contract this psychiatric hospital function, allowing committed youth to be placed in a community hospital that could address not only their psychiatric needs but their primary health needs as well. Such efforts were only achievable due to continued development of community based specialty services, such as the Juvenile Court Liaison, as well as being a direct partner with the State Multi-needs

team and strong state partnerships with other child serving agencies primarily developed through the Child and Adolescent Task Force. Continued efforts will include utilizing the two sustained SAMHSA SOC initiatives to determine strategies to expand system of care values with statewide expansion opportunities.

Readmission rates are important measures of how effective discharge planning is as well as how effective reintegration is into the community. The 30 day and 180 day readmission rates are both National Outcome Measures (NOMs) and a state Performance Indicators.

DMH remains dedicated to maintaining state policy that persons with serious mental illness (SMI) and serious emotional disturbance (SED) are served as a top priority. While the number of individuals with SMI and SED are not expected to substantially increase, it is expected that the array and intensity of services will be enhanced through the development of new services. To the extent in which public funds are expended on persons most in need, contractual requirements to serve these priority populations will continue.

Even with all the efforts highlighted above, DMH continues to face critical needs and gaps in the system that negatively impacts community integration. For adults, there has not been a systematic effort to improve employment opportunities for people with serious mental illness. DMH has hired an Employment Specialist who initially focused on individuals with Intellectual Disability, but is now a resource to all divisions. Adequate funding remains a challenge for all publicly supported endeavors, including mental health services. The budget cuts made over the last several years have impaired the ability to fund Permanent Supportive Housing, Peer Support Specialists, and services designed to reduce the demand for acute state hospital beds. In fact, in FY09, 12 mental health centers lost funding for a Peer Support Specialist. The goal is to have a Peer Support Specialist at every mental health center. The availability of safe and affordable housing remains a challenge for people with mental illness and limited incomes. Finding a way to reduce hospital beds, create community resources, and save money presents a formidable challenge to an already stressed system.

For children and adolescents, DMH has continued to make strides in developing a comprehensive system of care for children and families who struggle with Serious Emotional Disturbances (SED). Beginning in the mid-eighties, with the awarding of a federal initiative CASSP grant that facilitated the development of a system of care for children and adolescents, DMH has gradually moved toward strategic growth of child and adolescent services through planning and resource development. In an effort to develop a continuum of care that offers an array of services at various levels of care, an emphasis has been placed on non-traditional service delivery that truly meets the needs of the consumer, family and community. Services for children and youth are complicated by developmental variables, legal status, educational requirements, health factors, cultural factors, and living situations. The presence of a serious emotional disturbance further complicates the need for and delivery of services. Ethnicity may make a significant difference in use of mental health services, as well.

Children with serious emotional disturbance and their families frequently require not only mental health services, but services from special education, child welfare, public health and/or juvenile justice. This need for multiple services from multiple agencies necessitates the integration and coordination of programs and services, not only in the service delivery arena, but also during the system planning process. As a result, the mental health system must approach service delivery from a systems perspective. Additionally, the mental health system needs to be a component of a tightly meshed overall system of care that incorporates all child caring agencies and programs.

EBP's/Best Practices

Adoption of Evidence-based practices (EBPs) is a National Outcome measure as well as priority with DMH. EBPs are under development in Alabama through a variety of mechanisms. There are significant gaps across the state in the availability of EBPs. For adults, there are gaps in availability of ACT and PACT teams. Less than one-half of the centers offer Permanent Supportive Housing. Fourteen centers have employed a Certified Peer Support Specialists. There has not been a systematic effort to improve employment opportunities for people with serious mental illness. DMH has hired an Employment Specialist who will be a resource to all divisions. Other adult EBPs are not being systematically implemented. Services for those experiencing co-occurring psychiatric and substance use disorders remain scarce and isolated to certain programs. EBPs for children and adolescents are not being systematically implemented at this time, primarily due to lack of funds. The MI Child and Adolescent Task Force identified and developed implementation strategies for recommended EBPs. However, the implementation is contingent on securing funding which does not currently exist. Less than 5% of what we buy conforms to national evidence-based practices (EBPs) guidelines (ACT, Supported Housing, Peer Support).

Also, the number of psychiatrists practicing in Alabama is inadequate to meet the demand in the public system. Additionally, nurse practitioners are in equally short supply. All but one of the 67 counties are designated as Psychiatric Manpower Shortage Areas. The licensing rules of the Board of Medical Examiners require that physicians moving into the state who have been out of school for more than 10 years take the general medical boards. This requirement is a disincentive for experienced psychiatrists interested in moving to Alabama. There are also restrictive parameters for nurse practitioners. DMH was able to get a waiver for psychiatrists practicing in state hospitals and community mental health centers so that they do not have to re-take the General Medical Boards if they move from another state. This waiver will permit a larger pool of candidates for employment in the public sector. While such an exemption will be helpful, more changes are needed in the licensing law to observe reciprocity with other state licensing bodies. To further address the shortage of psychiatrists, DMH implemented several initiatives. DMH has provided employment for psychiatric residents graduating from University of Alabama in Birmingham (UAB) in either a state hospital or through the community mental health centers. In the past, the Mental Illness Coordinating Subcommittee approved funding six psychiatric residency training slots – three at UAB and three at the University of South Alabama (USA). But, due to budget deficits, these funds were cut.

Use of telepsychiatry offers opportunities to more effectively use existing resources. DMH supports expansion of telemedicine capability so that existing psychiatric manpower may be more efficiently used. The Bristol-Myers-Squibb Foundation Grant provided equipment to three mental health centers which have pioneered innovative uses of the equipment, including accessing psychiatric services. Through the C&A efforts, four sites participated with a C&A Telemedicine pilot demonstration, as well. The Medicaid Agency now covers telepsychiatry services under the Physician's Program in addition to the Rehab Option.

We have sufficient information about SAMHSA-recognized EBPs. We also have interest in exploring the use of recognized Best Practices. Where we need assistance is in the large scale implementation of these practices – incorporating knowledge into practice. DMH continues to pursue other funding avenues, such as grants and collaboration with other agencies. DMH will increasingly rely upon EBPs and best practices to meet the needs of consumers and family members.

Section II: Planning Steps – Table 1 Step 3,4: -Priority Area and Annual Performance Indicators

State Priorities

States should identify specific priorities that will be included in the MHSBG and SAPTBG. The priorities must include the **target populations** (as appropriate for each Block Grant) that are the Federal goals and aims of the Block Grant programs (those that are required in legislation and regulation) and should include **other priority populations** described in this document. Please list the priorities for the plan in the State Priorities form in Section I.

#	STATE PRIORITY	STATE PRIORITY DESCRIPTION/GOAL
1	Self-Directed System of Care	Design a comprehensive system of care that promotes access, choice, and satisfaction of consumers with SMI and SED, and their families, by providing effective treatment and care that is person-centered, consumer driven, and family-guided with a focus on recovery and resiliency.
2	Community Integration	Building on Olmstead and Wyatt decisions, transition or divert consumers from state psychiatric inpatient care settings to integrated community settings by using effective treatment and recovery support services designed to promote Home, Health, Purpose, and Community.
3	EBP's/Best Practices	Develop strategies to increase capacity, implementation, and sustainability of recovery supports and evidence-based/best practices.

Section II: Planning Steps –Table 3 Step 4: Develop Objectives, Strategies and Performance Indicators

PRIORITY AREA #1: Self-Directed System of Care	
Priority Type:	MHP, MHS
Populations:	SMI, SED
GOAL:	Design a comprehensive system of care that promotes access, choice, and satisfaction of consumers with SMI and SED, and their families, by providing effective treatment and care that is person-centered, consumer driven, and family-guided with a focus on recovery and resiliency.
STRATEGIES:	<p>DMH will:</p> <ul style="list-style-type: none"> • Continue to gather access data around age, gender, and racial/ethnic groups. • Maintain 80% or better of adult consumers and youth families reporting positive general satisfaction. • Maintain the percentage of adult consumers who report positively about function 77% or higher; and for family members of youth 67% or higher. • Hold annual Consumer Recovery Conference. • Maintain five consumer operated drop-in centers. • Continue to fund the peer services/trainings recommended by the MI Planning Council funded with Special Project dollars. • Maintain percentage of adult and child/adolescent consumers served in rural communities at 25% of the statewide total served. • Continue collaboration with Alabama Medicaid to pursue funding of peer services. • Implement state-wide use of an adult strength-based functional assessment tool. • Expand access to psychiatrist via telepsychiatry.
Annual Performance Indicators to Measure Goal Success	
Indicator #1:	<ul style="list-style-type: none"> • Maintain 80% or better of adult consumers reporting positively about general satisfaction
Baseline Measurement:	<ul style="list-style-type: none"> • Initial data collected during FY12. The numerator is the number of adult consumers who report positive about general satisfaction = 3,965. The denominator is the number of survey responses = 4,567. (87%)
First-year target/outcome Measurement:	<ul style="list-style-type: none"> • Maintain 80%
Second-year target/outcome Measurement:	<ul style="list-style-type: none"> • Maintain 80%
Data Source:	<ul style="list-style-type: none"> • URS Table 11a
Description of Data:	<ul style="list-style-type: none"> • MHSIP Survey Results
Data issues/caveats that affect outcome measures:	<ul style="list-style-type: none"> • With implementation of the client level data reporting to CMHS, Alabama will be moving to the use of the adult needs and strengths assessment tool as the data source.
Indicator #2:	<ul style="list-style-type: none"> • Maintain 80% or better of youth families reporting positively about general satisfaction

Baseline Measurement:

- Initial data collected during FY12. The numerator is the number of youth families who report positive about general satisfaction = 805. The denominator is the number of survey responses = 925. (87%)

First-year target/outcome Measurement:

- Maintain 80%

Second-year target/outcome Measurement:

- Maintain 80%

Data Source:

- URS Table 11a

Description of Data:

- MHSIP Survey Results.

Data issues/caveats that affect outcome measures:

- With implementation of the client level data reporting to CMHS, Alabama will be moving to the use of the Child and Adolescent Needs and Strengths (CANS) tool as the data source.

Indicator #3:

- Maintain 77% or better of adult consumers reporting positively about functioning.

Baseline Measurement:

- Initial data collected during FY12. The numerator is the number of adult consumers who report positively about functioning = 3,504. The denominator is the number of survey responses = 4,441. (79%)

First-year target/outcome Measurement:

- Maintain 77%

Second-year target/outcome Measurement:

- Maintain 77%

Data Source:

- URS Table 11a

Description of Data:

- MHSIP Survey Results

Data issues/caveats that affect outcome measures:

- With implementation of the client level data reporting to CMHS, Alabama will be moving to the use of the adult needs and strengths assessment tool as the data source.

Indicator #4:

- Maintain 67% or better of family members of youth reporting positively about functioning.

Baseline Measurement:

- Initial data collected during FY12. The numerator is the number of youth family member who report positively about functioning = 633. The denominator is the number of survey responses = 919. (69%)

First-year target/outcome Measurement:

- Maintain 67%

Second-year target/outcome Measurement:

- Maintain 67%

Data Source:

- URS Table 11a

Description of Data:

- MHSIP Survey Results

Data issues/caveats that affect outcome measures:

With implementation of the client level data reporting to CMHS, Alabama will be moving to the use of the Child and Adolescent Needs and Strengths (CANS) tool as the data source.

Indicator #5:

- Maintain percentage of adult consumers served in the rural areas of the state at 25% of the statewide total served.

Baseline Measurement:

- Initial data collected during FY12. The numerator is total rural SMI served = 19,670. The denominator is the total SMI served statewide = 65,513. (30.02%)

First-year target/outcome Measurement:

- Maintain 25%

Second-year target/outcome Measurement:

- Maintain 25%

Data Source:

- The DMH Central Data Repository. US Bureau of Census.

Description of Data:

- Services to the CDR. Rural communities identified through the US Bureau of Census

Data issues/caveats that affect outcome measures:

Reduction in funding could also reduce access to services and decrease in service staff.

Indicator #6:

- Maintain percentage of children/adolescent consumers served in the rural areas of the state at 25% of the statewide total served.

Baseline Measurement:

- Initial data collected during FY12. The numerator is total rural SED served = 7,879. The denominator is the total SED served statewide = 25,321. (31.12%)

First-year target/outcome Measurement:

- Maintain 25%

Second-year target/outcome Measurement:

- Maintain 25%

Data Source:

- The DMH Central Data Repository. US Bureau of Census.

Description of Data:

- Services reported to the CDR. Rural communities identified through the US Bureau of Census

Data issues/caveats that affect outcome measures:

Reduction in funding could also reduce access to services and decrease in service staff.

Indicator #7:

- Increase access to psychiatry services via telepsychiatry.

Baseline Measurement:

- Initial data collected during FY12 indicates number consumers receiving telepsychiatry services is 5,805.

First-year target/outcome Measurement:

- Increase number served 3% from the baseline number.

Second-year target/outcome Measurement:

- Increase number served 6% from the baseline number.

Data Source:

- The DMH Central Data Repository.

Description of Data:

- Services reported to the CDR.

Data issues/caveats that affect outcome measures:

The ability of the providers to obtain the funding for the necessary video-conferencing equipment, as well as efficient access to bandwidth to conduct video conferencing.

PRIORITY AREA #2: Community Integration

Priority Type: MHP, MHS

Populations: SMI, SED

GOAL: Building on Olmstead and Wyatt decisions, transition or divert consumers from state psychiatric inpatient care settings to integrated community settings by using effective treatment and recovery support services designed to promote Home, Health, Purpose, and Community.

STRATEGIES:

DMH will:

- Maintain the rate of admission to state psychiatric facilities within 30 days of discharge at or below 5% for adults and adolescents; within 180 days of discharge at or below 13% (excluding forensic patients) for adults; and within 180 days of discharge at or below 10% for adolescents.
- Continue/expand services, as well as collaborate with state and local partners, in an effort to support consumers seeking and retaining competitive employment.
- Continue/expand services, as well as collaborate with state and local partners, to promote increased school attendance and positive school involvement.
- Continue/expand services, as well as collaborate with state and local partners, to promote reduction in criminal justice/juvenile justice involvement.
- Continue/expand services, as well as collaborate with state and local partners, to promote stability in housing within the community and expand access to community housing options as well as reduce homelessness.
- Maintain positive responses to social connectedness for adult and child/adolescent consumers.
- Implement approved regional community service development plans in an effort of repurposing the use of state psychiatric hospitals.
- Develop infrastructure for Peer Recovery Services to include, but not limited to, certification, training, service expansion, and funding mechanisms.
- Continue contract requirement to serve adults with SMI and children/adolescents with SED.

Annual Performance Indicators to Measure Goal Success

Indicator #1:

- Increase/Maintain Employment

Baseline Measurement:

- Initial data collected during FY12. The numerator is the number of adult consumers who were employed = 8,197. The denominator is the number of adult consumer reporting on employment = 74,857. (11%)

<p>First-year target/outcome Measurement:</p> <ul style="list-style-type: none"> • Maintain FY12 Baseline <p>Second-year target/outcome Measurement:</p> <ul style="list-style-type: none"> • Maintain FY13 Baseline <p>Data Source:</p> <ul style="list-style-type: none"> • URS Table 4 <p>Description of Data:</p> <ul style="list-style-type: none"> • Central Data Repository and URS tables <p>Data issues/caveats that affect outcome measures:</p> <ul style="list-style-type: none"> • Due to the economic climate, employment is vastly impacted and difficult to predict particularly for our target populations.
<p>Indicator #2:</p> <ul style="list-style-type: none"> • Improvement in school attendance <p>Baseline Measurement:</p> <ul style="list-style-type: none"> • Initial data collected during FY12. The numerator is the number of youth families who reported improvements in child’s school attendance = 725. The denominator is the number of survey responses = 13,761. (5.3%) <p>First-year target/outcome Measurement:</p> <ul style="list-style-type: none"> • Maintain FY12 level. <p>Second-year target/outcome Measurement:</p> <ul style="list-style-type: none"> • Maintain FY13 level. <p>Data Source:</p> <ul style="list-style-type: none"> • URS Table 19b <p>Description of Data:</p> <ul style="list-style-type: none"> • CANS data <p>Data issues/caveats that affect outcome measures:</p> <ul style="list-style-type: none"> • No issues foreseen that will affect the outcomes.
<p>Indicator #3:</p> <ul style="list-style-type: none"> • Decrease criminal justice involvement <p>Baseline Measurement:</p> <ul style="list-style-type: none"> • Initial data collected during FY12. The numerator is the number of adult consumers who reported decrease in criminal justice involvement = 551. The denominator is the number of adult consumer survey responses = 4,523. (12.18%) <p>First-year target/outcome Measurement:</p> <ul style="list-style-type: none"> • Maintain FY12 level. <p>Second-year target/outcome Measurement:</p> <ul style="list-style-type: none"> • Maintain FY13 level. <p>Data Source:</p> <ul style="list-style-type: none"> • URS Table 19a <p>Description of Data:</p> <ul style="list-style-type: none"> • MHSIP Survey Results <p>Data issues/caveats that affect outcome measures:</p> <ul style="list-style-type: none"> • With implementation of the client level data reporting to CMHS, Alabama will be moving to the use of the adult needs and strengths assessment tool as the data source.
<p>Indicator #4:</p>

- Decrease juvenile justice involvement

Baseline Measurement:

- Initial data collected during FY12. The numerator is the number of youth who reported decrease in juvenile justice involvement = 37. The denominator is the number of survey responses = 427. (8.67%)

First-year target/outcome Measurement:

- Maintain FY12 level.

Second-year target/outcome Measurement:

- Maintain FY13 level.

Data Source:

- URS Table 19a

Description of Data:

- MHSIP Survey Results

Data issues/caveats that affect outcome measures:

With implementation of the client level data reporting to CMHS, Alabama will be moving to the use of the Child and Adolescent Needs and Strengths (CANS) tool as the data source.

Indicator #5:

- Increase stability in housing

Baseline Measurement:

- Initial data collected during FY12. The percentage of adults who report being homeless in FY12 will be less than 2% of the total adults served. The numerator is number of consumers reporting homeless/shelter at end of FY12 = 1321. The denominator is 98,920. (1.34%)

First-year target/outcome Measurement:

- Less than 02% homeless/shelter

Second-year target/outcome Measurement:

- Less than 02% homeless/shelter

Data Source:

- The DMH Central Data Repository

Description of Data:

- Consumer profile demographic data collected at admission, annual review, and discharge

Data issues/caveats that affect outcome measures:

Due to the economic climate, employment is vastly impacted and difficult to predict particularly for our target populations.

Indicator #6:

- Increased Social Connectedness for adult consumers

Baseline Measurement:

- Initial data collected during FY12. The numerator is the number of adult consumers who report increased social connectedness = 3,278. The denominator is the number of survey responses = 4,389. (75%)

First-year target/outcome Measurement:

- Maintain FY12 baseline

Second-year target/outcome Measurement:

- Maintain FY13 baseline

Data Source:

- URS Table 9

<p>Description of Data:</p> <ul style="list-style-type: none"> • MHSIP Survey Results <p>Data issues/caveats that affect outcome measures: With implementation of the client level data reporting to CMHS, Alabama will be moving to the use of the adult needs and strengths assessment tool as the data source.</p>
<p>Indicator #7:</p> <ul style="list-style-type: none"> • Increased Social Connectedness for families of youth consumers <p>Baseline Measurement:</p> <ul style="list-style-type: none"> • Initial data collected during FY12. The numerator is the number of youth family members who report increased social connectedness = 763. The denominator is the number of survey responses = 915. (83%) <p>First-year target/outcome Measurement:</p> <ul style="list-style-type: none"> • Maintain FY12 baseline <p>Second-year target/outcome Measurement:</p> <ul style="list-style-type: none"> • Maintain FY13 baseline <p>Data Source:</p> <ul style="list-style-type: none"> • URS Table 9 <p>Description of Data:</p> <ul style="list-style-type: none"> • MHSIP Survey Results <p>Data issues/caveats that affect outcome measures: With implementation of the client level data reporting to CMHS, Alabama will be moving to the use of the adult needs and strengths assessment tool as the data source.</p>

PRIORITY AREA #3: EBP's/Best Practices	
Priority Type:	MHP, MHS
Populations:	SMI, SED
GOAL:	Develop strategies to increase capacity, implementation, and sustainability of recovery supports and evidence-based/best practices.
DMH will:	<ul style="list-style-type: none"> • Maintain funding for ACT/PACT, Permanent Supportive Housing, and Certified Peer Support Specialists. • Maintain the number of Permanent Supportive Housing units. • Maintain the 18 ACT and 2 PACT teams currently funded. • Maintain the number of employed Certified Peer Support Specialists. • Implement at least one identified child and adolescent (C&A) EBP. • Continue collaboration with Medicaid around restructuring, expanding, and/or transforming payment and service delivery structures to fund EBPs. • Increase telehealth capacity.
Annual Performance Indicators to Measure Goal Success	
Indicator #1:	<ul style="list-style-type: none"> • Maintain funding for Supported Housing slots <p>Baseline Measurement:</p> <ul style="list-style-type: none"> • Initial data collected during FY12. Funding for continuation of supported housing slots will be maintained at FY12 level = 312.

<p>First-year target/outcome Measurement:</p> <ul style="list-style-type: none"> • Maintain FY12 level <p>Second-year target/outcome Measurement:</p> <ul style="list-style-type: none"> • Maintain FY12 level <p>Data Source:</p> <ul style="list-style-type: none"> • MICRS. CDR <p>Description of Data:</p> <ul style="list-style-type: none"> • DMH maintains a web-based residential reporting system where the Supported Housing units are reported in addition to reporting data in the CDR. <p>Data issues/caveats that affect outcome measures:</p> <ul style="list-style-type: none"> • No issues foreseen that will affect the outcomes.
<p>Indicator #2:</p> <ul style="list-style-type: none"> • Maintain the number of employed Certified Peer Support Specialists <p>Baseline Measurement:</p> <ul style="list-style-type: none"> • Initial data collected during FY12. 45 Certified Peer Support Specialist (CPS) are employed at community mental health centers <p>First-year target/outcome Measurement:</p> <ul style="list-style-type: none"> • Maintain 45 CPS. <p>Second-year target/outcome Measurement:</p> <ul style="list-style-type: none"> • Maintain 45 CPS <p>Data Source:</p> <ul style="list-style-type: none"> • Office of Consumer Relations <p>Description of Data:</p> <ul style="list-style-type: none"> • Information collected by the Office of Consumer Relations. Provider self-report. Certification site visits. <p>Data issues/caveats that affect outcome measures:</p> <ul style="list-style-type: none"> • Reduction in funding could cause less access in services and decrease in service staff.
<p>Indicator #3:</p> <ul style="list-style-type: none"> • Implement at least one identified child/adolescent EBP/Best Practice <p>Baseline Measurement:</p> <ul style="list-style-type: none"> • Baseline measurement for this number will be 0 as there is not currently the use of an EBP/BP being reported to DMH. <p>First-year target/outcome Measurement:</p> <ul style="list-style-type: none"> • Implementation of training to staff of at least one provider to provide an EBP to efficacy of a model. <p>Second-year target/outcome Measurement:</p> <ul style="list-style-type: none"> • Provision of a C&A EBP/BP by at least one provider in the state. <p>Data Source:</p> <ul style="list-style-type: none"> • Certification site visits and CDR <p>Description of Data:</p> <ul style="list-style-type: none"> • CDR <p>Data issues/caveats that affect outcome measures:</p> <ul style="list-style-type: none"> • Reduction in funding could also reduce access to services and decrease in service staff.

Section III. Use of Block Grant Dollars for Block Grant Activities							
Table 2 State Agency Planned Expenditures							
Planning Period - From 7/01/2013 to 6/30/2015							
Activity (see instructions for using Row 1.)	A. Substance Abuse Block Grant	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACT (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other
1. Substance Abuse Prevention* and Treatment							
a. Pregnant Women and Women with Dependent Children*							
b. All Other							
2. Substance Abuse Primary Prevention							
3. Tuberculosis Services							
4. HIV Early Intervention Services							
5. State Hospital			12,231,348	7,503,142	68,684,983		
6. Other 24 Hour Care		3,605,003			41,820,366		
7. Ambulatory/Community Non-24 Hour Care		1,889,398	119,512,371	884,835	96,368,437		
8. Mental Health Primary Prevention		724,075					
9. Mental Health Evidenced-Based Prevention and treatment (5% of total award							
10. Administration (Excluding Program and Provider Level)		201,510	290,757		2,399,894		
11. TOTAL		6,419,986	132,034,476	8,387,977	209,273,680		

III: Use of Block Grant Dollars for Block Grant Activities

Table 3 State Agency Planned Block Grant Expenditures by Service

Planning Period - From **07/01/2013** to **SFY 06/30/2015**

SERVICES	Unduplicated Individuals	Units	Expenditures
Healthcare Home/Physical Health			
Specialized Outpatient Medical Services			
Acute Primary Care			
General Health Screens, Tests and Immunizations			
Comprehensive Care Management			
Care coordination and Health Promotion			
Comprehensive Transitional Care			
Individual and Family Support			
Referral to Community Services Dissemination			
Prevention (Including Promotion)			
Screening, Brief Intervention and Referral to Treatment			
Brief Motivational Interviews			
Screening and Brief Intervention for Tobacco Cessation			
Parent Training			
Facilitated Referrals			
Relapse Prevention/Wellness Recovery Support			
Warm Line			
Substance Abuse (Primary Prevention)			
Classroom and/or small group sessions (Education)			
Media campaigns (Information Dissemination)			
Systematic Planning/Coalition and Community Team Building(Community Based Process)			
Parenting and family management (Education)			
Education programs for youth groups (Education)			
Community Service Activities (Alternatives)			
Student Assistance Programs (Problem Identification and Referral)			
Employee Assistance programs (Problem Identification and Referral)			
Community Team Building (Community Based Process)			
Promoting the establishment or review of alcohol, tobacco, and drug use policies (Environmental)			

Engagement Services			\$35,000
Assessment			
Specialized Evaluations (Psychological and Neurological)			
Service Planning (including crisis planning)			
Consumer/Family Education	437	2,500	\$35,000
Outreach			
Outpatient Services			\$105,677
Evidenced-based Therapies			
Group Therapy	103	2,058	\$35,000
Family Therapy	159	795	\$35,000
Multi-family Therapy	245	1,621	\$35,677
Consultation to Caregivers			
Medication Services			
Medication Management			
Pharmacotherapy (including MAT)			
Laboratory services			
Community Support (Rehabilitative)			
Parent/Caregiver Support			
Skill Building (social, daily living, cognitive)			
Case Management			
Behavior Management			
Supported Employment			
Permanent Supported Housing			
Recovery Housing			
Therapeutic Mentoring			
Traditional Healing Services			
Recovery Supports			
Peer Support			
Recovery Support Coaching			
Recovery Support Center Services			
Supports for Self-directed Care			
Other Supports (Habilitative)			\$200,000
Personal Care			
Homemaker			
Respite	522	1,568	\$200,000

Supported Education			
Transportation			
Assisted Living Services			
Recreational Services			
Trained Behavioral Health Interpreters			
Interactive Communication Technology Devices			
Intensive Support Services			\$310,000
Substance Abuse Intensive Outpatient (IOP)			
Partial Hospital			
Assertive Community Treatment			
Intensive Home-based Services	35	3,000	\$210,000
Multi-systemic Therapy			
Intensive Case Management	240	21,739	\$100,000
Out-of-Home Residential Services			\$3,605,003
Children's Mental Health Residential Services	18	6,570	\$1,135,024
Crisis Residential/Stabilization			
Clinically Managed 24 Hour Care (SA)			
Clinically Managed Medium Intensity Care (SA)			
Adult Mental Health Residential	38	13,870	\$2,469,979
Youth Substance Abuse Residential Services			
Therapeutic Foster Care			
Acute Intensive Services			
Mobile Crisis			
Peer-based Crisis Services			
Urgent Care			
23-hour Observation Bed			
Medically Monitored Intensive Inpatient (SA)			
24/7 Crisis Hotline Services			
Other (please list)			

III: Use of Block Grant Dollars for Block Grant Activities	
Table 6b MHBG Non-Direct Service Activities Planned Expenditures	
Planning Period - From 07/01/2013 to 06/30/2014	
Service	Block Grant Dollars
MHA Technical Assistance Activities	
MHA Planning Council Activities	\$537,518
MHA Administration	\$201,510
MHA Data Collection/Reporting	
Enrollment and Provider Business Practices (3 percent of total award)	
MHA Activities Other Than Those Above	\$1,425,278
Total Non-Direct Services	\$2,164,306
Comments on Data:	

Section IV: Narrative Plan C. Coverage M/SUD Services

Beginning in 2014, Block Grant dollars should be used to pay for (1) people who are uninsured and (2) services that are not covered by insurance and Medicaid. Presumably, there will be similar concerns at the state-level that state dollars are being used for people and/or services not otherwise covered. States (or the Federal Exchange) are currently making plans to implement the benchmark plan chosen for QHPs and their expanded Medicaid programs (if they choose to do so). States should begin to develop strategies that will monitor the implementation of the Affordable Care Act in their states. States should begin to identify whether people have better access to mental and substance use disorder services. In particular, states will need to determine if QHPs and Medicaid are offering mental health and substance abuse services and whether services are offered consistent with the provisions of MHPAEA.

Please answer the following questions:

- 1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs on January 1, 2014?
- 2. Do you have a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?
- 3. Who in your state is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe their monitoring process.

- 4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations or MHPAEA?
- 5. What specific changes will the state make in what is bought given the coverage offered in the state's EHB package?

Establishing the Exchange in Alabama

Despite previously supporting Alabama's implementation of a state-based health insurance exchange, Governor Robert Bentley announced on November 13, 2012, the state will default to a federally-facilitated exchange. The federal government will assume full responsibility for running a health insurance exchange in Alabama beginning in 2014. At this time, it has not been determined what services will be covered by QHP.

At this time, Alabama will not participate with Medicaid expansion so the services currently covered by Medicaid will not change. As discussed within this application, Alabama is in the process of Medicaid Reform and the future of Medicaid and potential changes in its payment structures and/or services provided is unknown. Since the federally-facilitated exchange has yet to be implemented and the Medicaid Reform process is in the early stages, the questions above can not be answered. It is important to note that DMH has a longstanding working relationship with the Alabama Medicaid Agency and other state agencies directly involved with both processes. DMH has been and will continue to be directly involved with making recommendations on the decision making processes. Representatives from DMH participate on the multi-level committees and workgroups including the Commissioner of DMH and his designated staff.

Section IV: Narrative Plan D. Health Insurance Marketplaces

- Health Insurance Marketplaces (Marketplaces) will be responsible for performing a variety of critical functions to ensure access to desperately needed behavioral health services. Outreach and education regarding enrollment in QHPs or expanded Medicaid will be critical. SMHAs and SSAs should understand their state's new eligibility determination and enrollment system, as well as how insurers (commercial, Medicaid, and Medicare plans) will be making decisions regarding their provider networks. States should consider developing benchmarks regarding the expected number of individuals in their publicly-funded behavioral health system that should be insured by the end of FY 2015. In addition, states should set similar benchmarks for the number of providers who will be participating in insurers' networks that are currently not billing third party insurance.

QHPs must maintain a network of providers that is sufficient in the number and types of providers, including providers that specialize in mental health and substance abuse, to assure that all services will be accessible without unreasonable delay. Mental health and substance abuse providers were specifically highlighted in the rule to encourage QHP issuers to provide sufficient access to a broad range of mental health and substance abuse services, particularly in low-income and underserved communities.

Please answer the following questions:

- 1. How will the state evaluate the impact that its outreach, eligibility determination, enrollment, and re-enrollment systems will have on eligible individuals with behavioral health conditions?
- 2. How will the state work with its partners to ensure that the Navigator program is responsive to the unique needs of individuals with behavioral health conditions and the challenges to getting and keeping the individuals enrolled?
- 3. How will the state ensure that providers are screening for eligibility, assisting with enrollment, and billing Medicaid, CHIP, QHPs, or other insurance prior to drawing down Block Grant dollars for individuals and/or services?
- 4. How will the state ensure that there is adequate community behavioral health provider participation in the networks of the QHPs, and how will the state assist its providers in enrolling in the networks?
- 5. Please provide an estimate of the number of individuals served under the MHBG and SABG who are uninsured in CY 2013. Please provide the assumptions and methodology used to develop the estimate.
- 6. Please provide an estimate of the number of individuals served under the MHBG and SABG who will remain uninsured in CY 2014 and CY 2015. Please provide the assumptions and methodology used to develop the estimate.
- 7. For the providers identified in Table 8 -Statewide Entity Inventory of the FY 2013 MHBG and SABG Reporting Section, please provide an estimate of the number of these providers that are currently enrolled in your state's Medicaid program. Please provide the assumptions and methodology used to develop the estimate.
- 8. Please provide an estimate of the number of providers estimated in Question 7 that will be enrolled in Medicaid or participating in a QHP. Provide this estimate for FY 2014 and a separate estimate for FY 2015, including the assumptions and methodology used to develop the estimate.

Establishing the Exchange in Alabama

Despite previously supporting Alabama's implementation of a state-based health insurance exchange, Governor Robert Bentley announced on November 13, 2012, the state will default to a federally-facilitated exchange.

Prior to the decision, Governor Bentley issued Executive Order 17 which created the Alabama Health Insurance Exchange Study Commission to recommend how Alabama should establish a health insurance exchange. The Governor appointed an Executive Director of the Alabama Health Insurance Exchange to work with stakeholders and other state agencies on implementing the recommendations of the Commission. After meeting for three months, the 15-member Health Insurance Exchange Study Commission released final recommendations in late November 2011 to the Governor and Legislature endorsing the establishment of the "Alabama Health Insurance Marketplace." Additional recommendations included, establishing a new quasi-public authority to operate the

exchange, following a free market facilitator model, establishing one administrative entity to oversee both the individual and small business exchanges while keeping the risk-pools for both separate, and funding the exchange through fees on all products sold in the individual and small group markets inside and outside the exchange.

In May 2012, the Governor threatened to veto a bill establishing a state exchange, which passed in the House, if it cleared the Senate before the Supreme Court ruled on the constitutionality of the Affordable Care Act (ACA). The bill failed at the close of the 2012 legislative session, as did a similar bill in 2011. Governor Bentley signed into law a measure in May 2012, prohibiting health plans operating within an Alabama exchange from offering abortion services except in cases of life endangerment, rape, or incest.

Information Technology (IT): In February 2012, the Office of the Alabama Health Insurance Exchange, within the Department of Insurance, released a Request for Information on the IT systems necessary to develop the state's exchange. The state anticipated leveraging existing technology infrastructure to build components of the exchange related to screening, applications, and eligibility determinations. In June 2012, the Department released a Request for Proposals soliciting a subcontractor to build an eligibility and enrollment system capable of making determinations for the state's Exchange, Medicaid, and the Children's Health Insurance Program (CHIP); however, the award was put on hold until after the November elections. Alabama was also participating in the "Enroll UX 2014" project, which is a public-private partnership creating design standards for exchanges that all states can use.

Alabama is focusing on a significant Medicaid eligibility system upgrade. The state received CMS approval for an enhanced federal match to assist in financing IT upgrades of the state's Medicaid eligibility and enrollment system. The Alabama Medicaid Agency released a Request for Proposals earlier this year soliciting subcontractors to implement the new system which will meet future exchange interoperability standards. Work on the Medicaid eligibility system was anticipated to begin in April 2012.

Essential Health Benefits (EHB): The ACA requires that all non-grandfathered individual and small-group plans sold in a state, including those offered through the Exchange, cover certain defined health benefits. Since Alabama has not put forward a recommendation, the state's benchmark EHB plan will default to the largest small-group plan in the state, Blue Cross Blue Shield of Alabama 320 Plan PPO.

Exchange Funding

The Alabama Department of Insurance received a federal Exchange Planning grant of approximately \$1 million in 2010. In November 2011, the Department was awarded an \$8.6 million federal Level One Establishment grant to support contracts and activities around exchange implementation.

Alabama, along with nine other states, received technical assistance from the Robert Wood Johnson Foundation through the State Health Reform Assistance Network; this

assistance included help with setting up health insurance exchanges, expanding Medicaid to newly eligible populations, streamlining eligibility and enrollment systems, instituting insurance market reforms and using data to drive decisions.

Next Steps

The federal government will assume full responsibility for running a health insurance exchange in Alabama beginning in 2014.

Navigator Programs

Navigators will serve as an in-person resource for Americans who want additional assistance in shopping for and enrolling in plans in the Health Insurance Marketplace this fall. Below are the recipients of Navigator grants in Federally-facilitated program for Alabama.

Recipients marked with an asterisk (*) are operating in more than one state. The anticipated grant amount listed in each case only applies to the amount going to that organization for that state's specific operations.

Ascension Health*

Anticipated grant amount: \$202,706

Ascension Health is the nation's largest Catholic and nonprofit health system. The Ascension Health Navigator project will assist consumers (individuals and small employers) in understanding new programs, taking advantage of consumer protections, and navigating the health insurance system to find the most affordable coverage that meets their needs.

AIDS Alabama, Inc.

Anticipated grant amount: \$501,380

AIDS Alabama devotes its energy and resources statewide to helping people with HIV/AIDS live healthy, independent lives and works to prevent the spread of HIV. AIDS Alabama Navigators will conduct community-wide educational events and presentations in an effort to educate Alabamians on the Federally-facilitated Marketplace. The project will focus on those newly-eligible for health insurance, especially reaching out to lower and middle-income populations.

Samford University

Anticipated grant amount: \$326,794

Samford University, located just outside of Birmingham, Alabama will work with existing networks through its pharmacy, nursing, and education and professional studies schools to facilitate enrollment of individuals. The existing networks of schools and churches will reach a diverse community in the rural and metropolitan communities of Northern Alabama.

Catholic Social Services – Archdiocese of Mobile

Anticipated grant amount: \$20,750

The Service Center of Catholic Social Services provides essential services and skills training in Mobile County since 1953. The Service Center's Affordable Health Insurance Selection Program will provide enrollment assistance to low-income, under-insured, uninsured and vulnerable participants living in Mobile County, Alabama.

Tombigbee Healthcare Authority

Anticipated grant amount: \$392,356

Tombigbee Healthcare Authority (THA) will place Navigators in 18 counties in the Alabama Delta Region to help consumers understand the new federal Marketplace coverage options and find the most affordable coverage that meets their health care needs. To achieve this goal, THA will develop a contractual agreement with its existing Delta Rural Access Program (DRAP) partners to expand their program focus. THA and these partnering agencies have been providing the Delta Region counties access to primary and preventive health care services, education and resources for more than nine years through outreach efforts in schools, churches, community centers, homes, and other community outlets.

(see attachment for more information on Access Alabama Project)

Section IV: Narrative Plan E. Program Integrity

- The Affordable Care Act directs the Secretary of HHS to define EHBs. Non-grandfathered plans in the individual and small group markets both inside and outside of the Marketplaces, Medicaid benchmark and benchmark-equivalent plans, and basic health programs must cover these EHBs beginning in 2014. On December 16, 2011, HHS released a bulletin indicating the Secretary's intent to propose that EHBs be defined by benchmarks selected by each state. The selected benchmark plan would serve as a reference plan, reflecting both the scope of services and any limits offered by a "typical employer plan" in that state as required by the Affordable Care Act.

SMHAs and SSAs should now be focused on two main areas related to EHBs: monitoring what is covered and aligning Block Grant and state funds to compensate for what is not covered. There are various activities that will ensure that mental and substance use disorder services are covered. These include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including EHBs as per the state benchmark; (2) ensuring that individuals are aware of the covered mental health and substance abuse benefits; (3) ensuring that consumers of substance abuse and mental health services have full confidence in the confidentiality of their medical information; and (4) monitoring utilization of behavioral health benefits in light of utilization review, medical necessity, etc.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the SABG and MHBG. State systems for procurement, contract management, financial reporting, and audit vary significantly. SAMHSA expects states to implement policies and procedures that are designed to ensure that Block Grant funds are used in accordance with the four priority categories identified above. Consequently, states may have to reevaluate their current management and oversight strategies to accommodate the new priorities. They may also be required

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. States should describe their efforts to ensure that Block Grant funds are expended efficiently and effectively in accordance with program goals. In particular, states should address how they will accomplish the following:

- 1. Does the state have a program integrity plan regarding the SABG and MHBG?
- 2. Does the state have a specific staff person that is responsible for the state agency's program integrity activities?
- 3. What program integrity activities does the state specifically have for monitoring the appropriate use of Block Grant funds? Please indicate if the state utilizes any of the following monitoring and oversight practices:
 - a. Budget review;
 - b. Claims/payment adjudication;
 - c. Expenditure report analysis;
 - d. Compliance reviews;
 - e. Encounter/utilization/performance analysis; and
 - f. Audits.
- 4. How does the state ensure that the payment methodologies used to disburse funds are reasonable and appropriate for the type and quantity of services delivered?
- 5. How does the state assist providers in adopting practices that promote compliance with program requirements, including quality and safety standards?
- 6. How will the state ensure that Block Grant funds and state dollars are used to pay for individuals who are uninsured and services that are not covered by private insurance and/or Medicaid?

SAMHSA will review this information to assess the progress that states have made in addressing program integrity issues and determine if additional guidance and/or technical assistance is appropriate.

Since Alabama will not implement its own health exchange, the state may not have progressed as far as other states in planning for Affordable Care Act implementation.

The program integrity process involves a number of DMH administrative tools including the DMH MI Program Standards, DMH Administrative Division Finance Bureau Audit Guidelines Manual, DMH contracts, and DMH Mental Illness Contract Service Delivery Manual. DMH expends most of the Community Mental Health Services Block Grant (MHBG) through the community mental health centers and state-wide consumer/family

advocacy entities. DMH policy on the use of state and federal funds is expressed in the above listed tools.

The DMH MISA Services Division conducts on-site visits as indicated in DMH MI Program Standards (administrative code) for all programs certified either as a community mental health center or as a community mental health provider. The purpose of these on-site certification reviews is to evaluate program plans and services delivered to ensure consistency and conformance with services definitions, state regulations, and policies governing mental health programming. The on-site certification reviews are conducted every two years or sooner.

Under the FY14 contracts, DMH expects the centers to develop and manage a comprehensive array of mental health services with sufficient capacity as outlined in DMH MI Program Standards. In developing and managing this continuum of services, the centers are expected to include in their planning the federal mandates under the SAMHSA Mental Health Block Grant (MHBG). Within the contracts, language exists that outlines that the contractor has an affirmative responsibility to pursue any third part payment (e.g., Medicaid, Medicare, etc.) and that DMH is the payor of last resort. The contract also outlines that the contractor agrees it will comply with all applicable terms, conditions, provisions, and requirements delineated in the current DMH Audit Guidelines Manual and subsequent amendments.

MHBG budget review monitoring and oversight responsibilities on the state budget appropriation level are primarily assigned to the staff within the DMH Bureau of Finance, primarily the office of accounting. The Bureau of Finance manages the accounting, financial reporting, budgeting, purchasing, payroll, and accounts payable functions for the department. In addition, it is responsible for the financial management of the department's contracts and federal awards. The assigned staff provides quarterly projections of MHBG award balances to DMH MISA Division MI Financial Data Analysis.

A funding plan for the MHBG is reviewed annually with the MI Planning Council. In addition, the same funding plan is reviewed and approved by the Associate Commissioner of DMH MISA Services Division. Any substantial change in these plans are also reviewed and approved by the same parties. The Division has also developed a standard uniform excel budget sheet for all contracts awarded under the MHBG. These individual budgets are reviewed and approved by the MI Financial Data Analyst, Director of MI Community Programs, Associate Commissioner of the Division, and DMH Office of Accounting. The purpose of the review is to assure that all contract expenditures as described in narrative format, are consistent with the purpose of each contract, the planned expenditures Block Grant requirements and rules.

Alabama does not use insurance claims model for distributing Block Grant funding. Instead individual contracts are utilized to distribute block grant funding. Questions of payment processes under these contracts are addressed by Division managers, DMH Bureau of Finance staff, and Division's Financial Data Analyst.

On a quarterly basis, the DMH's Office of Accounting produces an excel spreadsheet summary of the financial status of all block grant-funded contracts that is distributed to the MI Financial Data Analyst and Director of MI Community Programs. The report notes if individual block grant contracts have failed to expend funding in a timely manner. On a quarterly basis, the DMH Office of Account updates obligation spreadsheets that detail the planned contract and operational expenditures for each block grant award, the contracts obligated and contracts expended. These obligation spreadsheets are reviewed by the Division's MI Financial Data Analyst, Director of MI Community Programs, and Associate Commissioner. Utilization and performance analysis reports are created to analyze block grant funded agency. These reports are reviewed by the providers, the Division MI Financial Data Analysis, and the Division Director of MI Community Programs.

Agencies receiving block grant contract awards of \$500,000 or more are required to submit single audit reports to Department staff that include a review of adherence to federal block grant requirements on an annual basis. These agencies are responsible for resolving audit findings, questioned costs, practices, etc., in accordance with applicable laws and regulations (e.g., Single Audit Act, OMB Circular A-133, Medicaid requirements,), and/or to DMH's satisfaction within six (6) months from the issue date of the respective report(s). This same responsibility and resolution period apply to the entity for any/all audit findings, questioned amounts, and/or practice of the entity's subcontractors/recipients that received funds through any DMH contract, grant, and/or agreement. DMH has oversight responsibility to coordinate and ensure that all audit findings and questions that could or do affect DMH funding are satisfactorily resolved within the required time limit. These reports are reviewed by personnel in the DMH Office of Contracts under the Bureau of Finance. Any findings of significance are passed along to Division's MI Financial Data Analyst. These findings are discussed with the Director of MI Community Programs and the Division's Associate Commissioner. Appropriate DMH staff lead an investigation of the findings and develop a corrective action or response plan. If the agency succeeds in adequately addressing the finding issues and is approved, the Commissioner has final authority only within DMH on the resolution of all audit findings. The details of the process are outlined in the DMH Administrative Division Finance Bureau Audit Guidelines Manual.

The Division has concentrated the majority of its MHBG funding on non-direct services other 24 hour care. In addition, primary focus of direct service under MHBG are serving populations that are not likely to be Medicaid or private insurance eligible and/or would not have the services DMH support paid by Medicaid or private insurance. As the Affordable Care Act is implemented, DMH will evaluate its monitoring tools and determine appropriate adjustments to the new health insurance coverage expectations.

Section IV: Narrative Plan F. Use of Evidence in Purchasing Decisions

- SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition,

SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers decisions regarding mental health and substance abuse services. SAMHSA is requesting that states respond to the following questions:

- 1) Does your state have specific staff that are responsible for tracking and disseminating information regarding evidence-based or promising practices?
- 2) Did you use information regarding evidence-based or promising practices in your purchasing or policy decisions?
 - a) What information did you use?
 - b) What information was most useful?
- 3) How have you used information regarding evidence-based practices?
 - a) Educating State Medicaid agencies and other purchasers regarding this information?
 - b) Making decisions about what you buy with funds that are under your control?

DMH has a developed process for dissemination of information within DMH between the services divisions and DMH specific offices. With the Divisions, primarily the program staff disseminates pertinent information, especially regarding evidence-based or promising practices. DMH distributes information with external sources, such as the members of the MI Planning Council, Mental Illness Coordinating Sub-Committee, and MI Child and Adolescent Task Force, as well as to the provider network and state-wide consumer and family advocacy networks. This is done through list serve/distribution emails.

Many different elements of information are used in the purchasing and policy decisions involving evidence-based or promising practices. The following EBPs are in various phases of development in Alabama.

- Assertive Community Treatment (ACT)
- Integrated Treatment for Co-Occurring Disorders (COD)
- Permanent Supportive Housing
- Supported Employment
- Peer Support Services
- Coping Power

Information used was from notifications sent out by SAMHSA, NASMHPD, and other national and state entities. From the SAMHSA website, two sources that were used were the Evidence-Based Practices Tool Kits and A Guide for Selecting and Adopting Evidence-Based Practices for Children and Adolescents with Disruptive Behavior Disorders.

The information on evidence-based and promising practices have been distributed and utilized within the previously discussed committees, councils, and task forces. In all these planning groups, there are representatives from Medicaid, S-Chip, and other purchasers. In particular to mental health children and adolescent, the Child and Adolescent Task Force developed a workgroup to assist in the guidance and recommendations of evidence-based and/or promising practices (See Section II. Step 1 for more detailed information on both adult and child/adolescent EBPs)

Evidence-Based and promising practices are part of the considerations taken into account in purchasing services. Much of the purchasing decisions are made with the Regional entities and the individual community mental health centers. Each community mental health center is expected to develop and manage a comprehensive array of mental health services with sufficient capacity for designated geographic areas.

Section IV: Narrative Plan G. Quality

- Up to 25 data elements, including those listed in the table below, will be available through the Behavioral Health Barometer which SAMHSA will prepare annually to share with states for purposes of informing the planning process. The intention of the Barometer is to provide information to states to improve their planning process, not for evaluative purposes. Using this information, states will select specific priority areas and develop milestones and plans for addressing each of their priority areas. States will receive feedback on an annual basis in terms of national, regional, and state performance and will be expected to provide information on the additional measures they have identified outside of the core measures and state barometer. Reports on progress will serve to highlight the impact of the Block Grant-funded services and thus allow SAMHSA to collaborate with the states and other HHS Operating Divisions in providing technical assistance to improve behavioral health and related outcomes.

	Prevention	Substance Abuse Treatment	Mental Health Services
Health	Youth and Adult Heavy Alcohol Use - Past 30 Day	Reduction/No Change in substance use past 30 days	Level of Functioning
Home	Parental Disapproval Of Drug Use	Stability in Housing	Stability in Housing
Community	Environmental Risks/Exposure to prevention Messages and/or Friends Disapproval	Involvement in Self-Help	Improvement/Increase in quality/number of supportive relationships among SMI population
Purpose	Pro-Social Connections Community Connections	Percent in TX employed, in school, etc - TEDS	Clients w/ SMI or SED who are employed, or in school

- 1) What additional measures will your state focus on in developing your State BG Plan (up to three)?
 - The MI Planning Council put forth much effort to develop the MHBG state priorities, strategies, and performance indicators which include the above listed areas as well as additional measures – See Table 1 Step 3,4: -Priority Area and Annual Performance Indicators.

- 2) Please provide information on any additional measures identified outside of the core measures and state barometer.
 - Expand the C&A EBPs to include other recognized EBPs/best practices, not just reporting on MST, FFT, TFC.
- 3) What are your states specific priority areas to address the issues identified by the data?
 - The MI Planning Council put forth much effort to develop the MHBG state priorities, strategies, and performance indicators which include the above listed areas as well as additional measures – See Table 1 Step 3,4: -Priority Area and Annual Performance Indicators.
- 4) What are the milestones and plans for addressing each of your priority areas?
 - The MI Planning Council put forth much effort to develop the MHBG state priorities, strategies, and performance indicators which include the above listed areas as well as additional measures – See Table 1 Step 3,4: -Priority Area and Annual Performance Indicators.

Section IV: Narrative Plan H. Trauma

- In order to better meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies, such as exposure therapy or trauma-focused cognitive behavioral approaches, should be used to ensure that treatments meet the needs of those being served. States should also consider adopting a trauma-informed care approach consistent with SAMHSA's trauma-informed care definition and principles. This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate so that these services and programs can be more supportive and avoid being traumatized again.

Please answer the following questions:

- 1. Does your state have any policies directing providers to screen clients for a personal history of trauma?
- 2. Does the state have policies designed to connect individuals with trauma histories to trauma-focused therapy?
- 3. Does your state have any policies that promote the provision of trauma-informed care?
- 4. What types of evidence-based trauma-specific interventions does your state offer across the life-span?
- 5. What types of trainings do you provide to increase capacity of providers to deliver trauma-specific interventions?

Each DMH-certified Mental Health Service Provider is required to develop Policies and Procedures that address the requirements codified in the DMH Administrative Code. The

“Consumer Records” Section of the Alabama DMH Administrative Code (updated 9/30/10) requires trauma history to be obtained from every consumer and recorded in the consumer’s clinical record so that it can be considered during treatment planning. (DMH Code 580-2-9-.06 (9)(a),17.(b.)10.). Also, in the “Child and Adolescent Restraint and Seclusion” Section of the Code (which applies only to Day and Residential Treatment programs that are certified to employ the use of seclusion or restraint techniques) clinical staff is required to perform an initial assessment at the time of admission or intake which includes information about “Preexisting medical conditions or any physical disabilities and limitations that would place the consumer at greater risk during restraint or seclusion, including developmental age and history, psychiatric condition, and trauma history.” This Section also requires that this information be recorded in the consumer record. (DMH Code 580-2-9-.23 (14)(b.) and -.23 (23)(d)3.) These requirements are codified with the belief that consideration of this information will help minimize the use of restraint and seclusion, and also to minimize the danger of re-traumatizing a consumer during the exercise of restraint or seclusion when it cannot be avoided.

Many DMH policies are rooted in the provision of person-centered and individualized treatment planning as prescribed in the DMH Administrative Code. This requirement is expressed succinctly in section 580-2-9-.08(3) entitled “General Clinical Practice,” which states, “Services must be individualized, well-planned, based on a comprehensive mental health evaluation and assessment of needed treatment and support, and should include treatment designed to enhance the consumer’s abilities to recover and function in society as normally as possible,” and also, “Each program shall provide individualized mental health care and treatment that is designed to promote Recovery and Resiliency and that represents person-centered treatment planning process.” This philosophy of care pervades all areas of service provision by DMH certified providers. Consumers who present with histories of trauma that impact their presenting mental health conditions should be provided the best interventions available to accommodate their mental health treatment needs, including trauma-focused therapeutic interventions wherever appropriate. As a true trauma-focused system of care has not yet been achieved across the state, the types of trauma-focused therapy interventions will vary by provider agency and by individual clinician. DMH does not have policies beyond what is provided for in the Administrative Code that require providers to deliver a specific trauma-focused intervention. Trauma-focused care is an important and growing field in mental health care, and a variety of training events and workshops have been conducted. Each provider is responsible to conduct or promote training opportunities for their clinicians and other treatment staff that will help them to develop professionally and to provide the best, most effective treatment possible for consumers of mental health services, including training and development in the area of trauma focused care.

Section IV: Narrative Plan I. Justice

- The SABG and MHBG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

Communities across the United States have instituted problem-solving courts, including those for defendants with mental and substance abuse disorders. These courts seek to prevent incarceration and facilitate community-based treatment for offenders, while at the same time protecting public safety. There are two types of problem-solving courts related to behavioral health: drug courts and mental health courts. In addition to these behavioral health problem-solving courts, some jurisdictions operate courts specifically for DWI/DUI, veterans, families, and reentry, as well as courts for gambling, domestic violence, truancy, and other subject-specific areas.^{42,43} Rottman described the therapeutic value of problem-solving courts: Specialized courts provide a forum in which the adversarial process can be relaxed and problem solving and treatment processes emphasized. Specialized courts can be structured to retain jurisdiction over defendants, promoting the continuity of supervision and accountability of defendants for their behavior in treatment programs. Youths in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient utilization of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; and therefore, risk factors remain unaddressed.⁴⁴

A true diversion program takes youth who would ordinarily be processed within the juvenile justice system and places them instead into an alternative program. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with mental and/or substance use disorders from correctional settings. States should also examine specific barriers such as lack of identification needed for enrollment; loss of eligibility resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention

Please answer the following questions:

- 1. Does your state have plans to enroll individuals involved in the criminal and juvenile justice systems in Medicaid as a part of coverage expansions?

Not at the present time. Governor Robert Bentley announced in November of 2012 that Alabama would not participate in Medicaid expansion because of funding and thus far this decision has not changed.

- 2. What screening and services are provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?

The establishment of a secure medical facility by the Department of Mental Health (DMH) was authorized by the Alabama Legislature in 1975. Taylor Hardin Secure Medical Facility commenced operation in November, 1981. Taylor Hardin is the state's only forensic hospital and the facility provides inpatient evaluation and treatment services throughout the judicial process. Regional evaluation programs under Taylor Hardin's supervision also provide forensic evaluation services within the community. Pre-trial evaluations and treatment services are provided for males committed by the circuit courts of all sixty-seven (67) counties within the State of Alabama and are provided from the time of arrest through trial and sentencing. Female defendants receive inpatient evaluation and treatment services at Bryce Hospital.

Rule 11. Incompetency and mental examinations, of the Alabama Rules of Criminal Procedure, provides for the evaluation of a defendant's mental competence to stand trial or to be sentenced if because of mental incompetence, he or she lacks the present ability to consult with counsel with a reasonable degree of rational comprehension or is unable to understand the nature of the proceedings. Once evidence exists to doubt the defendant's competence, the procedures for ordering a mental examination through the circuit court are implemented and the court orders are received by the Community Court Liaison at Taylor Hardin and dependent upon the order, evaluations are scheduled through the community regional examiners or defendants are admitted to Taylor Hardin or Bryce for inpatient evaluation. If a not guilty by reason of mental disease or defect defense is raised by the defendant, then the court on its own motion may order, or the defendant, the defendant's attorney, or the district attorney may move for an examination into the defendant's mental condition at the time of the offense. Orders for MSO evaluations are completed routinely on an outpatient basis by the community regional examiners or on an inpatient basis depending upon the court order. Evaluations of an individual's mental competence to waive Miranda and competence to participate in the sentencing phase are also completed as requested by the court.

- 3. Are your SMHA and SSA coordinating with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities, and the reentry process for those individuals?

The Department of Mental Health (DMH) has for years collaborated with the Department of Corrections (DOC) for the provision of treatment for individuals with mental health disorders who are serving sentences within the DOC. Through the probate commitment process, inmates may be committed to DMH for treatment to stabilize their condition and then returned to DOC 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 be in need of continued treatment upon release from prison can be probate committed to DMH for inpatient treatment at the time their sentence expires. Review of the data for these type commitments over the last 5 years has shown that many of these individuals are treated and discharged to community placements after relatively brief periods of inpatient treatment. This data has led to further discussion between the two agencies to focus on planning and developing procedures where by mentally ill inmates can be triaged prior to the 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.

A Forensic Workgroup began meeting in February 2013 to evaluate forensic services throughout the hospital and community continuum and make recommendations for improvement. Formal recommendations have not yet been finalized for submission to the Commissioner, however in the most recent meeting of the Workgroup there was discussion of the beneficial efforts of one counties Mental Health Court and the potential for these courts to have a positive impact on diverting individuals with mental

health and substance abuse disorders who have minor/misdemeanor charges, from prosecution, thus reducing the numbers of individuals who have to assert a mental state defense and be found Not Guilty by Reason of Insanity (NGI) or those who are found guilty and sentenced to the criminal justice system. Concerns with the lack of consistency in how the mental health courts operate across the state and the lack of funding for these courts was discussed and recommendations for gathering data, collaborating with the Administrative Office of Courts, and exploring funding options will be submitted to the Commissioner.

- 4. Do efforts around enrollment and care coordination address specific issues faced by individuals involved in the criminal and juvenile justice systems?
 - Per the State of Alabama DOC Administrative Regulation #700: The ADOC ensures that those in custody of ADOC have access to medical, dental, and mental health services and are housed in settings that can provide for their specific health care needs. It is the policy of the ADOC to ensure a continuity of care when an inmate is admitted into or released from the system. It is also the policy of ADOC to facilitate the coordination of efforts in the provision of mental health care between ADOC psychological services staff and contract mental health staff. Judges also have the ability to order substance use assessments and treatment. Individuals may enter the system through several avenues which may include probation, mental health courts, drug courts and other problem solving courts (e.g., juvenile, veterans, family drug courts). Individuals are assessed for appropriate care either in the detention centers at the time of entry or in the community.
 - Alabama Justice Ministries Network is a non-profit faith based organization that was founded in 2001 and works primarily with the Alabama State prison system. The goal of their mission is to provide services necessary to assist ex-offenders to best gain and retain employment opportunities. Services that are included are mentoring, educational and vocational training, life skills programming, housing and continued substance abuse treatment. They start their work with the offenders while they are still incarcerated.
 - Aid to Inmate Mothers (AIM) that was founded in 1987 and works primarily with women at Tutwiler prison, Birmingham Work Release and the Montgomery Community Based Facility. The goals of AIM are to enrich the lives of both incarcerated mothers and their families through programs that provide education and support. Care doesn't just stop once the mothers are released from prison. AIM's Project Reconnect is an aftercare program that helps them secure job and housing, and provides them with essential counseling. AIM also has transitional home for women who are leaving prison.
 - As for youth, the Alabama Department of Youth Services (ADYS), they also ensure that those in custody have access to medical, dental, educational, mental

- health, and substance abuse services, as well as housed in setting that can provide for their specific health care needs. ADYS works bi-directionally with the community courts, educational systems, and other child serving agencies (child welfare, mental health, etc.) to divert unnecessary commitments and to coordinate efforts for effective transition for return to their community. Over the years, ADYS has set up systems to fund community diversion programs as to enrich community resources in the hopes of providing rehabilitation opportunities. One such example with DMH is the partnership with OUR Kids.
- Due to the belief that too many SED youth were channeled through the juvenile justice system, DMH developed a position called the Juvenile Court Liaison (JCL) and provided funding for this position to each of the contracted community mental health centers. The JCL works directly with the court system to assist with determining appropriate treatment and care and to assist with coordination of such services and with those care agencies involved.
- 5. What cross-trainings do you provide for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?
- DMH participates in trainings with other state agencies such as AOC, DOC and DYS. There have been collaborative grants/projects that has allowed for trainings and conferences to assist in strengthening the efforts of effective care in regard to mental health and substance use/abuse issues that focus on the use of evidence-based/best practices.
 - In addition, trainings offered by DMH are open to anyone interested in attending. The DOC has been sending professionals to those trainings as a way of improving the quality of care offered to the offenders.
 - DMH also offers annual training on forensic mental health issues that is open to the public and provides forensic case manager training.
 - Law enforcement officials have been receiving training in mental health first aid as part of a grant opportunity.
 - In regard to adolescents, DMH provides annual trainings to the Juvenile Court Liaisons, as well as requested trainings by the community juvenile court systems and DHR.
 - At the local level, the DMH providers actively participate in such collaborative trainings as trainers and as participants.

42 The American Prospect: In the history of American mental hospitals and prisons, *The Rehabilitation of the Asylum*. David Rottman, 2000.

43 A report prepared by the Council of State Governments. Justice Center. Criminal Justice/Mental Health Consensus Project. New York, New York for the Bureau of Justice Assistance Office of Justice Programs U.S. Department of Justice, Renee L. Bender, 2001.

Section IV: Narrative Plan J. Parity Education

- SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action states can develop communication plans to provide and address key issues. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position.

Please answer the following questions:

- 1. How will or can states use their dollars to develop communication plans to educate and raise awareness about parity?
- 2. How will or can states coordinate across public and private sector entities to increase awareness and understanding about benefits (e.g., service benefits, cost benefits, etc.?)
- 3. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that are directly impacted by parity?

Alabama DMH recently experienced a reduction in the amount of MHBG funding due to the redistribution of funds between states as well as significant budget cuts with state dollars. Alabama is also initiating Medicaid Reform and it is currently unclear how this will impact DMH's budget. DMH can explore the most appropriate process needed to move forward with the development of a community plan to educate and raise awareness about parity. The exact approach needs to be developed with key stakeholders.

DMH has had previous success in coordinating with entities across the public and private sector to address emerging issues that affect individuals with MH/SUD. It will endeavor to do the same with parity. As it is determined how to most effectively develop a communications plan, the DMH will pursue collaboration with organizations experienced in parity education. There is an assumption that the Federally Facilitated Exchange will be doing the majority of the outreach. The applicability of this effort in Alabama is undetermined at this time.

As the development of the plan process is determined, DMH will seek to ensure that broad and strategic outreach is made to the appropriate and relevant audiences that are directly impacted by parity. The work on this effort hasn't begun. First steps will be to conduct research on how the federal and state insurance and parity laws come together. Additionally it will be important in this process to assess the impact of parity laws on various types of private health insurance plans, and Medicaid programs and benefits.

DMH will work with internal and external stakeholders to provide outreach to the appropriate and relevant audiences that are directly impacted by parity.

Section IV: Narrative Plan K. Primary and Behavioral Health Care Integration Activities

- Numerous provisions in the Affordable Care Act and other statutes improve the coordination of care for patients through the creation of health homes, where teams of health care professionals will be rewarded to coordinate care for patients with chronic conditions. States that have approved Medicaid State Plan Amendments (SPAs) will receive 90 percent Federal Medical Assistance Percentage (FMAP) for health home services for eight quarters. At this critical juncture, some states are ending their two years of enhanced FMAP and returning to their regular state FMAP for health home services. In addition, many states may be a year into the implementation of their dual eligible demonstration projects.

Please answer the following questions:

- 1. Describe your involvement in the various coordinated care initiatives that your state is pursuing?
- 2. Are there other coordinated care initiatives being developed or implemented in addition to opportunities afforded under the Affordable Care Act?
- 3. Are you working with your state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHC), other primary care practices and the publicly funded behavioral health providers?
- 4. Describe how your behavioral health facilities are moving towards addressing nicotine dependence on par with other substance use disorders.
- 5. Describe how your agency/system regularly screens, assesses, and addresses smoking amongst your clients. Include tools and supports (e.g. regular screening with a carbon monoxide (CO) monitor) that support your efforts to address smoking.
- 6. Describe how your behavioral health providers are screening and referring for:
 - a. heart disease,
 - b. hypertension,
 - c. high cholesterol, and/or
 - d. diabetes.

Currently, much focus in Alabama is on Medicaid Reform. With this process is a high focus on care coordination. DMH is currently and plans to continue to primarily participate with all levels of care coordination as it pertains to any initiatives such as Medicaid Reform, Health Homes, Money Follows the Person, and MEPD Project.

- Medicaid Reform:
- Medicaid reform legislation that would ultimately restructure the state's health care delivery system for low-income citizens (SB340) won approval in the Alabama Senate on April 25, 2013 and in the House on May 7, 2013. Governor Bentley held a ceremonial bill signing June 6, 2013 for Senate Bill 340, a measure that will help increase efficiency in Alabama Medicaid while also helping improve patient care. The approved bill is based largely on the earlier recommendations of the Alabama Medicaid Advisory Commission which was appointed by Governor Bentley to improve Medicaid's financial stability while also providing high-quality patient care. The Commission recommended in January 2013 that Alabama be divided into regions, and that a community-led network (RCO) coordinate the health care of Medicaid patients in each region, with networks ultimately bearing the risks of contracting with Alabama to provide that care. The Commissioner of DMH was one of the Commission members. The State Health Officer chaired the Medicaid Advisory Commission and is leading the Medicaid transformation effort.
- Regional Care Organizations:
- Legislation passed by the 2013 Alabama Legislature calls for the state to be divided into regions and that a community-led network coordinate the health care of Medicaid patients in each region, with networks ultimately bearing the risks of contracting with the state of Alabama to provide that care. The Alabama Medicaid Agency would have to draw regions by October 1, 2013, and regional care organizations would have to be ready to sign contracts no later than October 1, 2016. In order to implement RCOs in Alabama, the federal government must approve an exception, or waiver, to the existing program. This will be done in the form of an 1115 Waiver. This process started with the completion of an 1115 Waiver Concept Paper that had to be submitted to CMS for approval prior to completing the 1115 Medicaid State Plan Amendment (SPA). The concept paper was submitted to CMS on May 17, 2013. DMH participated with the Medicaid Workgroup and consultants on the language in the concept paper that was incorporated CMS for approval prior to completing the 1115 Medicaid State Plan Amendment (SPA). The Alabama Medicaid Agency has participated with two CMS conference calls to discuss the concept paper and another call has been scheduled. The Medicaid Agency has developed a link on their website www.medicaid.alabama.gov , Regional Care Organizations that is posting Important Notices regarding Collaboration.
- DMH is working directly with members of the Alabama Medicaid Agency, Alabama Hospital Association, the State Health Officer, and the different consultants in regard to the multi-faceted areas of the Medicaid Reform process as to ensure that the mental health and substance abuse consumers we serve are being included for their unique and specialty needs for services and care.

- DMH continues to share our willingness to partner and collaborate with the Medicaid Reform as to provide the expertise and guidance as it pertains to the consumers with severe mental illness, serious emotional disturbances, and substance abuse issues that we serve.
- After participating with the Governor's Medicaid Commission, it became evident that Medicaid Reform for the mental health and substance abuse population that DMH serves and is very complex and involved multiple layers of attention. So, DMH worked with NASMHPD and SAMHSA to secure a consultant to assist DMH with this process, including information on: benefits of commercial managed care vs. non-commercial managed care; carve in vs. carve out vs. opt out; how patient care networks directly impact this process; developing RCOs and ASOs; 1115 waiver language for behavioral health. The goal was to provide the DMH with information/guidance that will help to ensure that the needs of mental health consumers and providers are addressed under the state's evolving Medicaid system. Leslie Schwalbe, who has experience in working with states on Medicaid Reform as it pertains to the behavioral health needs of our population, was provided as the consultant.
- DMH also determined that having the voices of our consumers, family members, providers, and other stakeholders (to include Medicaid) was vital to provide instrumental feedback and guidance in these areas of Medicaid Reform. Through the DMH Associate Commissioners two coordinating sub-committees (Mental Illness and Substance Abuse) the DMH Medicaid Integrated Care Workgroup was formulated. This workgroup has conducted several meetings to initiate the workgroup process and discuss planning ideas and objectives. It was determined that for this workgroup to be most effective, it would be beneficial to set up a meeting with Dr. Williamson and/or Medicaid staff to provide assistance and guidance for this workgroup to be functional. Leslie Schwable facilitated the meeting and Dr. Moon, Medical Director for Alabama Medicaid Agency, presented. The workgroup will continue its efforts to assist DMH with guidance and recommendations and the Medicaid Reform process unfolds.
- 2703 Health Home (PCN) State Plan Amendment (SPA):
- Medicaid partnered with the state agencies involved with Optional Medicaid services (Rehab, TCM, Waiver) to complete a 2703 Health Home 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 was remained under review with CMS until May 2013 when finally approved. ADMH has made contact with Medicaid to set up meetings to determine next steps in the implementation of the 2703 SPA as it pertains to mental health and substance abuse services.
- Money Follows the Person (MFP) Initiative:
- Medicaid was awarded a MFP Rebalancing Demonstration Grant for which two populations have been targeted: Target 1: will be individuals residing in Nursing

Facilities, regardless of age or type of disability. Target 2: will be individuals residing in State Operated Psychiatric Hospitals who are currently receiving Medicaid or who are Medicaid eligible. Approximately 400 to 600 individuals are expected to benefit for this initiative. The majority of these individuals (approx. 113) reside at the Harper Geriatric Psychiatry Center. For the purposes of addressing the needs of individuals with mental illness and ID/DD who transition for nursing facilities, the State is pursuing the development of an ACTII waiver which will offer support and home based services not available in other service models. Feedback has been provided from CMS and they have decided to not allow us to address two populations with the one ACT II waiver and referenced a proposed rule written in 2010 to allow for multiple populations, but it was never finalized. The Medicaid Agency will work with DMH to determine the best avenue to address SMI as written into MFP.

- Medicaid Emergency Psychiatric Demonstration: DMH partnered with Medicaid and the Alabama Hospital Association in the Medicaid application for a CMS demonstration grant around the allowance of Medicaid payment for psychiatric care in a free standing psychiatric private hospital unit (IMD). DMH is providing the state match dollars for this demonstration. There are four inpatient psychiatric hospitals participating in the demonstration; EastPointe and BayPointe who began in July 2012 and Hillcrest and MountainView who began in October 2012. This is a three year demonstration with a data component. The first year involved getting approval of protocols and operational plans, initiating the data process, and trainings on transitional process. Year two has just been approved.
- A gain in momentum to address nicotine dependence among individuals with mental health disorder over the past decade has occurred within the state hospital settings. All state hospitals are currently smoke-free and interventions to assist consumers with this process have been implemented. For the contracted community mental health centers, there has been progress with initiation of individual endeavors to address smoking cessation, but DMH has not implemented a state-wide process to address this issue.
- For consumers who are Medicaid or Medicare eligible, almost every type of medical care is provided. Very often the only barrier to service is finding providers who serve Medicaid consumers. Other, non-Medicaid eligible clients have typically exhausted health care resources such as insurance, and must rely on health care available in their community on an indigent basis. Typically, local Public Health departments and community health clinics are the main referral resources used by case managers to meet the primary health care needs of their consumers. Local hospitals provide a very limited amount of inpatient care to indigent consumers. Because of historical practices among indigent consumers, many emergency rooms provide the only primary health care some consumers get. Individuals with mental illness have wrestled with the health care issue for years and in general this is one of the few areas where children and adolescents fare better than the adults. For example, Medicaid benefits for persons under 21 can exceed usual limits when indicated by the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. Children and adolescents in the care of DHR and DYS receive medical care from these agencies, as well as through

school nurses where available. In addition to coverage by Medicaid, dental services are covered by AllKids, Alabama's SCHIP program.

- The importance of improving coordination and collaboration with primary medical providers is underscored by the finding that persons with mental illness die on the average 25 years earlier than the general population, due in large part to un- or under-treated primary medical conditions. The Department received a Transformation Transfer Initiative Grant in FY08 and in FY10 to support efforts to improve integration of primary and mental health care. The following partners were convened to assist in planning grant activities: Alabama Medicaid Agency, Department of Public Health, Alabama Hospital Association, Alabama Academy of Family Physicians, Alabama Primary Health Care Association and American Academy of Pediatrics – Alabama Chapter. In FY08 ten regional meetings were conducted to obtain ideas from both primary and mental health providers relative to barriers and opportunities to improve collaboration. The findings from the regional meetings provided the foundation for the efforts funded in FY10. There are three elements to the current grant: 1) expert panels of physicians to discuss their perspectives on collaboration; 2) provide grants to six areas to develop written plans for improving collaboration locally; and 3) support for the Child and Adolescent Psychiatric Institute focusing on primary care collaboration.
- Consumers who are in state hospitals are provided medical care as part of their involuntary confinement where there is no insurance or other source of coverage for medical expenses. The state hospitals became tobacco-free on January 1, 2010. Consumers who have no health insurance and who reside in DMH community residential programs have minor medical services paid by the provider. There is a limited statewide fund for residents of foster homes to pay for incidental medical expenses when there is no other source of revenue.
- Most of the adults with serious mental illness and youth with serious emotional disturbances have Medicaid coverage for medical and dental services. However, it is a challenge to find providers in some areas who will accept Medicaid. Case managers provide a vital service by linking consumers to individual practitioners who will accept Medicaid or who will agree to see consumers on a sliding scale or no fee basis. Community mental health providers routinely receive training in universal precautions. Consumers in day treatment and residential programs receive health education on general nutrition, personal hygiene, exercise, and healthy lifestyle, as well as receiving health monitoring and general health advice from staff nurses. Individuals in outpatient, day treatment, and residential services who are also receiving medication services routinely have vital signs monitored with referrals for necessary medical care. Recommendations for routine health screenings are incorporated in all services. Community resources such as health fairs, free blood pressure checks, flu vaccines, etc. are utilized when available. Additionally, people are referred to school health nurses, public health clinics and Federally Qualified Health Centers, as appropriate and when available. Administration of medications prescribed by community mental health psychiatrists is coordinated with school personnel.
- Access to dental care is often cited as an unmet need for consumers. The University of Alabama in Birmingham School of Dentistry also provides free

clinics around the state. The waiting list for these clinics is very long. Case managers assist consumers in getting on the waiting list for any available free clinics. In some areas of the state, local dentists volunteer time for free clinics. Again, the amount of time and the range of services are limited.

- In recognition of the 25 year earlier mortality rate and health disparities suffered by individuals with serious mental illness disorders, the Department has promoted health and wellness education and activities. During the last several years, the annual Consumer Recovery Conference has provided a platform for conducting wellness screenings for a significant sample of consumers in attendance from all over the state. The 2013 Consumer Recovery Conference had approximately 123 consumers to volunteer for screenings. Screening methods included checking blood pressure for hypertension, body mass index for obesity, and blood glucose for diabetes. Due to restrictions in funding, no lipid tests were conducted to check for high cholesterol. DMH acknowledges that research suggests smoking prevalence among U.S adults with mental illness or serious psychological distress ranges from 34.3% (phobias or fears) to 88% (schizophrenia). This was the first year in which the Fagerstrom Index was utilized to screen for nicotine dependence. Screenings were provided in partnership with Pfizer. The results of the screenings show a high degree of co-morbidity with diabetes, obesity, and hypertension. Health information and smoking cessation information was disseminated at this event.

Section IV: Narrative Plan L. Health Disparities

- In the Block Grant application, states are routinely asked to define the population they intend to serve (e.g., adults with SMI at risk for chronic health conditions, young adults engaged in underage drinking, populations living with or at risk for contracting HIV/AIDS). Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, Latino adults with SMI may be at heightened risk for metabolic disorder due to lack of appropriate in-language primary care services, American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community, and African American women may be at greater risk for contracting HIV/AIDS due to lack of access to education on risky sexual behaviors in urban low-income communities.

While these factors might not be pervasive among the general population served by the Block Grant, they may be predominant among subpopulations or groups vulnerable to disparities. To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is being served or not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. In order for states to address the potentially disparate impact of their Block Grant funded efforts, they will be asked to address access, use, and outcomes for subpopulations, which can

be defined by the following factors: race, ethnicity, language, gender (including transgender), tribal connection, and sexual orientation (i.e., lesbian, gay, bisexual).

In the space below please answer the following questions:

- 1. How will you track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBTQ, and age?
- 2. How will you identify, address and track the language needs of disparity-vulnerable subpopulations?
- 3. How will you develop plans to address and eventually reduce disparities in access, service use, and outcomes for the above disparity-vulnerable subpopulations?
- 4. How will you use Block Grant funds to measure, track and respond to these disparities?

All community level data are collected at admission, annual update, and discharge. At or near the anniversary data of admission to the service, individual records are updated. The data currently captured with demographics are race, ethnicity, age, and gender (excluding transgender). In FY14, DMH and providers will capture data on language. It is important to note there is a requirement that providers report on hearing status of all consumers in general demographics (rather than “medical conditions” or Axis III). This readily allows DMH to track consumers who are deaf or hard of hearing and target resources in an efficient manner. This allows DMH to pinpoint and define the consumer characteristics of the 1,960 hard of hearing people and 188 deaf people that received services from DMH in FY12.

At present, we do not capture data on transgender, sexual orientation, or tribal connection but will explore including these data elements in our data collection process.

DMH has established an Office of Deaf Services (ODS) to serve deaf and hard-of-hearing Alabamians better. DMH is committed to ensuring that their peers will design programs for deaf and hard-of-hearing persons to ensure services are linguistically accessible and culturally affirmative, giving the consumer every opportunity to make progress to recovery. The ODS staff includes a director, statewide services coordinator, a statewide mental health interpreter coordinator, four regional therapists and four regional interpreters. ODS also provide significant communication and clinical support to Bryce, where deaf people needing inpatient care are served. DMH has developed specific standards of care for people with hearing loss that includes, among other things, specific requirements for measurable fluency in American Sign Language for certified community programs which work with deaf consumers. Also, through contracts with DMH, the contracted providers have access to language interpreters regardless of language and those services to assist with language needs as needed in services and care.

Also in MI Program standards, providers are to provide services that are culturally competent and linguistically competent and represents the ethnic and gender needs of the community. Annually, consumer satisfaction surveys are completed.

DMH will continue to share data information with our providers and other stakeholder entities to include National Outcome Measures (NOMS) and results from MHSIP Satisfaction Surveys and CANS results. Funding through the Data Infrastructure Grants (DIG) is utilized to assist with measuring, tracking, and responding to disparities.

Section IV: Narrative Plan M. Recovery

- SAMHSA encourages states to take proactive steps to implement recovery support services. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position. To accomplish this goal and support the wide-scale adoption of recovery supports, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Indicators/Measures

Please answer yes or no to the following questions:

- 1. Has the state developed or adopted (or is the state in the process of developing and/or adopting) a definition of recovery and set of recovery values and/or principles that have been vetted with key stakeholders including people in recovery?
 - **Yes.** (See attached 2007 White Paper)
- 2. Has the state documented evidence of hiring people in recovery in leadership roles (e.g., in the state Office of Consumer Affairs) within the state behavioral health system?
 - **Yes.**
- 3. Does the state's plan include strategies that involve the use of person-centered planning and self-direction and participant-directed care?
 - **Yes.**
- 4. Does the state's plan indicate that a variety of recovery supports and services that meets the holistic needs of those seeking or in recovery are (or will be) available and accessible? Recovery supports and services include a mix of services outlined in The Good and Modern Continuum of Care Service Definitions, including peer support, recovery support coaching, recovery support center services, supports for self-directed care, peer navigators, and other recovery supports and services (e.g., warm lines, recovery housing, consumer/family education, supported employment, supported employments, peer-based crisis services, and respite care).
 - **Yes.**
- 5. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?
 - **Under development**

- 6. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services?
 - **Yes.**
- 7. Does the state have an accreditation program, certification program, or standards for peer-run services?
 - **Yes, for certification of Adult Peer Support Specialists.**
- 8. Describe your state's exemplary activities or initiatives related to recovery support services that go beyond what is required by the Block Grant application and that advance the state-of-the-art in recovery-oriented practice, services, and systems. Examples include: efforts to conduct empirical research on recovery supports/services, identification and dissemination of best practices in recovery supports/services, other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system.

In 2008, the University of Alabama Department of Psychiatry and Behavioral Neurobiology submitted the winning proposal to be a Center of Excellence to assist DMH to implement evidence-based practices for adults with serious mental illness. The Alabama Institute for Mental Health Services (AIMHS) was created and provided training, monitoring, and expansion of selected evidence based practices. However, in 2010, the contract for the Center of Excellence was not renewed. This has severely limited the Departments ability to empirically research many of the creative and innovative practices that have emerged as a result of the Departments shift from state hospitals to community integration of the adult population.

Involvement of Individuals and Families

Recovery is based on the involvement of consumers/peers and their family members. States must work to support and help strengthen existing consumer, family, and youth networks; recovery organizations; and community peer support and advocacy organizations in expanding self-advocacy, self-help programs, support networks, and recovery support services. There are many activities that SMHAs and SSAs can undertake to engage these individuals and families. In the space below, states should describe their efforts to actively engage individuals and families in developing, implementing and monitoring the state mental health and substance abuse treatment system. In completing this response, state should consider the following questions:

- 1. How are individuals in recovery and family members utilized in the planning, delivery, and evaluation of behavioral health services?
- 2. Does the state sponsor meetings or other opportunities that specifically identify individuals' and family members' issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?
- 3. How are individuals and family members presented with opportunities to proactively engage the behavioral health service delivery system; participate in treatment and recovery planning, shared decision making; and direct their ongoing care and support?

- 4. How does the state support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

Within DMH, consumers and their families play a crucial role in policy development, system transformation, and program implementation within every level of the service delivery network. For years, DMH has valued consumer voice and promoted inclusion that was meaningful. Through strong alliances with the consumer and family advocate networks, DMH has been able to drive our system of care in the direction that not only sees our consumers and their families as recipients of services but values them as vital partners at the table who serve as experts in this process.

The DMH Office of Consumer and Ex-Patient Relations (OCER)

Over the years, the DMH Mental Illness Division has primarily focused on designing a system of care that emphasizes a rich array of community services to complement the state hospital system of care. Much of the guiding principles were based on standards outlined in the Wyatt lawsuit. This lawsuit led to sweeping reforms in mental health systems in the state and ultimately across the nation. Developing a continuum of care within the community was the priority as to increase opportunities for consumers to live in the community with appropriate services that would minimize the need for re-institutionalization. Through this process, DMH became increasingly aware of the value and need of consumer voice to guide the process. In 1990, the Alabama Office of Consumer Ex-Relations (OCER), more commonly referenced as the Office of Consumer Relations (OCR), was established. It was the FIRST office of its kind in the nation. The purpose of OCER is to infuse the consumer perspective into the decision-making process and management of the Mental Illness Division. The director is a member of the executive management team of DMH and directly reports to the Associate Commissioner. A primary strength of OCER is the ability to encourage recovery and hope among Alabama citizens with mental illness and their families. Additionally, the office promotes respect toward individuals with mental illness and works closely with consumer operated programs, advocacy and self-help organizations around the state.

OCER brings the mental illness experience, and its related treatment experiences, into the planning, policy making, and operations of the Division of Mental Illness Services.

The Office has three major functions:

- (1) To advocate and provide consumer insight to the senior management teams of the Division of Mental Illness Services and other agencies;
- (2) To promote, provide technical assistance and consultation in the establishment and funding of consumer self-help networks, peer operated services, including the Certified Peer Specialist/ Peer Bridgers, support/self-help groups, and consumer run drop-in centers;

(3) To promote recovery from mental illness.

The **Alabama Directions Council** serves as the advisory board of the Office of Consumer Relations. Its composition includes the presidents of local support groups and drop-in centers around the state, as well as the Alabama Peer Specialist Association (APSA), the Visionary Guild (for mentally ill artists), - Wings across Alabama (Wings), and the Alabama Minority Consumer Council (AMCC). The Council meets regularly to discuss important issues and to make collective decisions about the direction of the consumer movement. The Directions Council also plays a major role in planning the annual Alabama Recovery Conference and the funding of local consumer run support groups. The OCER newsletter, LISTEN, has a target audience of consumers around the state and contains information on consumer issues, activities and consumer success stories. LISTEN has a circulation of 4,000.

The Directions Council membership organizations created the first official consumer statement on recovery articulated in the 2007 statewide publication Consumer Driven Recovery Focused Mental Health System: A Consumer Perspective. This document outlines what a mental health system should look like and what the concepts, principles, key components, strategies, goals, and recommendations driving the system should be. Alabama consumers defined recovery as “an individual process in which a person with mental illness reclaims a sense of who they are in mind, body, and spirit.” This definition and the specifics of the publication are in keeping with SAMHSA’s working definition of recovery: “a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential”. This document has proven an invaluable guide, leading the planning and development of mental health services and supports to promote and sustain the stated wishes and desires of “a job, a home of their own, a social life, and to contribute to society” voiced by Alabama consumers.

The Alabama Recovery Conference

This annual conference is organized by the OCER and occurs in the largest venue available in the state. Approximately 900 participants attend each year with more than 600 attendees awarded scholarships that would not be able to attend otherwise. This year marked the 21st year this conference has been held. Activities during the conference include the presentation of the annual RESPECT awards, the annual Talent Show, a candlelight vigil, a watermelon social, and a dance. This three day conference, not only offers educational and inspirational tracks, but promotes opportunities for true peer camaraderie and empowerment. The Associate Commissioner of Mental Health Substance Abuse Services, senior executive staff, and facility directors participated in the conference to assist consumers and make their stay as pleasant as possible. Medical staff from state psychiatric facilities and community mental health centers volunteer every year to be part of the Crisis Response Team. Health Screenings were offered to consumers in attendance. These screenings were initiated in 2006 and conducted every year except for 2012.

Certified Peer Support Specialists

DMH has long valued the power of peers to support fellow consumers and promote recovery. DMH first established the position of peer support specialist in 1994 at Greil Hospital and later expanded the program to all state facilities. In 2008, the Mental Illness Coordinating Subcommittee approved allocation of \$1M in FY08 to support the equivalent of 25 full-time Peer Support positions, one to be employed at each contracted community mental health provider. Certification training based on the Georgia model was established with guidance from the National Technical Assistance Center of the National Association of State Mental Health Directors. Three trainings were initially conducted using the Depression and Bipolar Support Alliance and the Appalachian Consulting Group as trainers. When reduced budget allocations forced cuts in FY09, twelve mental health centers lost the funding for any vacant Peer Support positions. However, 2011 held more promise when grant funds allowed for the development of in-state certification training and thereby, increase the pool of certified peer specialist. With assistance from Appalachian Consulting Group, the Office Consumer Ex-Patient Relations (OCER) utilized a Train the Trainer model to create the capability to offer certification training provided by Alabama peer trainers thus reducing the dependence and cost of out of state trainers. The first two in-state training occurred in August and - October 2012.

Additionally, the need for specialty peer support services has provided opportunities to expand the use of peers in mental health settings. In light of the report that individuals with mental illness die 25 years younger than the general population, DMH and a Birmingham provider participated in a NASMHPD funded pilot project in 2009 utilizing certified peer specialist to assist consumers in improving their overall physical health. In 2010, through the hospital downsizing project, the use of Peer Bridgers was initiated. Peer Bridgers concentrate efforts in assisting consumers in making the transition from the hospital to successful living in the community.

Currently there are 45 certified peer specialists employed at community mental health centers, one located at a state facility, and two others serving in mental health related positions. There are currently three peer specialists employed by mental health centers and one employed by a mental health related agency, awaiting Certification training.

Consumer-operated services

Consumer-operated services provide alternatives for mental health consumers living in the community. Unfortunately, there is very little expansion of operations that would allow for the opportunity of choice for the consumers we serve. Consumer-driven recovery, such as consumer run drop-in centers and support groups, are seen as essential elements of the continuum of care, but these services are not covered in the Department's contract with community mental health centers. The Block Grant is used to support the development of consumer-operated services as well as the annual consumer conference. There are five operational drop-in centers serving on average an approximate total of 180 consumers on any given day.

Office of Deaf Services (ODS)

Among the one in five Alabamians who will need mental health services in their lifetime are more than 40,000 people who are deaf or hard of hearing. DMH has established an Office of Deaf Services (ODS) to serve deaf and hard-of-hearing Alabamians better. DMH is committed to ensuring that their peers will design programs for deaf and hard-of-hearing persons to ensure services are linguistically accessible and culturally affirmative, giving the consumer every opportunity to make progress to recovery. The ODS staff includes a director, statewide services coordinator, a statewide mental health interpreter coordinator, four regional therapists and four regional interpreters. ODS also provide significant communication and clinical support to Bryce, where deaf people needing inpatient care are served.

DMH has developed specific standards of care for people with hearing loss that includes, among other things, specific requirements for measurable fluency in American Sign Language for certified community programs which work with deaf consumers. There is also a requirement that providers report on hearing status of all consumers in general demographics (rather than “medical conditions” or Axis III). This readily allows DMH to track consumers who are deaf or hard of hearing and target resources in an efficient manner. This allows DMH to pinpoint and define the consumer characteristics of the 1,960 hard of hearing people and 188 deaf people that received services from DMH in FY12.

In FY12, ODS staff provided direct services to 2,131 consumers and 5,554 hours of interpreter services. Technical assistance and consultation was provided to 2,849 people and programs. Fifty-five training events were provided by ODS staff and 1,458 participants attended those events. The topics covered included screening for hearing loss, psychosocial aspects of working with deaf and hard of hearing people, working with deaf people with minimal language skills, treatment planning and person-centered program modification. Staff also provided a number of consumer oriented trainings for various groups such as state and local associations of the deaf and the annual consumer conference.

However, a shining gem of the Office of Deaf Services training is the nationally acclaimed Mental Health Interpreter Institute, which is annual 40-hour training for interpreters working with mentally ill deaf consumers. This training, which is funded by the block grant, draws participants from all over Alabama and around the country. A website, www.mhit.org, has been set up this year to help provide interested people information about the project. This training will lead to a special certification as a qualified mental health interpreter. Alabama is the first State in the nation to define specifically what skills and knowledge are needed to work effectively as an interpreter in mental health settings. These standards are part of the Code of Alabama. The Chartered Institute of Linguists, an organization based in London that serves the interests of professional linguists throughout the world and acts as a respected language assessment and accredited awarding body, has recognized the work of the Office of Deaf Services by highlighting the Mental Health Interpreter standards as the only one of its kind in the world.

The link can be found at

<http://www.iol.org.uk/qualifications/DPSI/Options/MentalHealth/Reading&PublicationsList.pdf> .

ODS has received numerous awards from professional and consumer organizations, including the National Association of the Deaf's "Golden Hands Award" and the Southeast Regional Institute on Deafness Interpreter of the Year. Several staff members have been recognized by the Council of Organizations Serving Deaf Alabamians, receiving the Leadership Award (once), Interpreter of the Year (twice) and Professional of the Year (three times). In addition, the Alabama Association of the Deaf has bestowed several awards on the staff, including the "Citizen of the Year Award" and "Outstanding Service Award." ODS Director Steve Hamerdinger was appointed by Dr. Eric Broderick, acting Director of SAMHSA, as one of the two people to represent the United States in the Mental Health and Deafness section of the International Initiative on Leadership in Mental Health. His work was nationally recognized by Gallaudet University in 2010, which presented him with their Alice Cogswell Award for Lifetime achievements in service to Deaf people. That same year, Mr. Hamerdinger was also invited to present on the work of the Office of Deaf Services at the 20th Annual Conference of the Japanese Association of Social Workers for the Deaf and Hard of Hearing in Tokyo, Japan. Statewide Mental Health Interpreter Coordinator, Charlene Crump, was named State Employee of the Year.

Consumer Advocacy Services

Rights Protection and Advocacy Services for persons in state facilities have long been a top priority for the DMH. In October 1997, the DMH greatly enhanced this effort, when the Internal Rights Protection and Advocacy Program officially expanded its role, and began providing services to persons being served in community programs that were under contract with DMH or programs which were certified by the DMH. Services provided include: information and referral services; complaint intake, investigation and resolution services; participation in certification reviews of new community programs, as well as programs with problematic rights-related issues, to ensure standard compliance; unannounced monitoring of community residential and program areas; and rights education and training.

With a staff of 26 certified advocates working out of five service area offices across the state and in the central administrative offices, the internal advocacy program provides a non-adversarial system of rights protection and advocacy that focuses on rights awareness and prevention of rights violations. A number of the advocates are family members or consumers. Community advocates conduct random or for cause unannounced visits to community residential and day program providers, now including foster care facilities. The Office of Advocacy Services has a toll-free telephone line to address rights-related issues and also is notified of all community Serious Special Incidents.

The Office of Advocacy Services meets at least quarterly with the Advocacy Advisory Board. It is represented on the Mental Illness Coordinating Subcommittee, the MI Community Standards Committee, and other MI committees as needed. Community and

facility advocacy services are integral to the quality of services and DMH's commitment to respect and enforce consumer rights.

Wings Across Alabama

In 2003, consumers across Alabama were vocalizing the need to re-establish a consumer organization. DMH and the Alabama Disabilities Advocacy Program (ADAP) coordinated grass roots meetings that became known as "Rekindling the Spirit". The mission was to unite consumers of mental health services statewide. In February 2004, DMH announced an RFP to provide state-wide consumer advocacy activities and develop a state-wide consumer organization. This RFP was awarded in April 2004 and Wings Across Alabama was established. Wings is a non-profit organization for consumers of mental health services with a dedication to making positive change in the lives of consumers through education, advocacy, training, services, and technical assistance as well as through building a strong network of consumers across Alabama with the recognition that inclusion, peer support, true community involvement and participation, self-empowerment, and quality mental health services are KEY ingredients to recovery. Wings strive to improve and reform the community mental health system so consumers of mental health services can become effective advocates for themselves and others. The organization is run by consumers of mental health services for consumers of mental health services.

National Alliance of Mental Illness – Alabama Chapter (NAMI)

NAMI Alabama is an organization comprised of local support and advocacy groups throughout the state dedicated to improving the quality of life for persons with a mental illness in Alabama. The number of such groups is growing rapidly as families become more determined to improve treatment and care for Alabamians diagnosed with a mental illness. Consumers and family members/friends affected by serious mental illness, their treatment, partners, and their supporters/allies united to advocate for a cure for severe disorders of the brain and to improve the quality of life of persons affected by serious mental illness by providing

1. Information, support, and a sense of belonging to persons with serious mental illness and their families;
2. Advocacy for nondiscriminatory and equitable federal, state, and corporate policies;
3. Research into the causes, symptoms, and treatments for severe brain disorders; and
4. Education to eliminate the pervasive stigma toward persons affected by serious mental illness.

Alabama Family Ties (AFT):

For many years, no unified statewide presence existed to represent and advocate specifically for children and adolescents with a serious emotional disturbance and their families. While many of the existing groups were active participants on mental health related statewide planning committees, a need was very evident to foster the development of a collective representation that could participate on behalf of children with a serious

emotional disturbance and their families across all agencies (e.g. juvenile justice, child welfare, education, health care). A need existed, therefore, for a coalition of families and various advocacy groups to facilitate collaboration among families, advocates, and other child-centered coalitions and organizations. Funded in October 1998, a grant from CMHS for a *Statewide Family Network* resulted in the creation of Alabama Family Ties (AFT), a coalition of parents, family members, and existing groups and organizations. In addition to the planning involvement, the grant fostered skill development of AFT in the areas of leadership and advocacy, as well as business principles and practices. The coalition has designed a Strategic Plan based upon the needs of the children and their families with the outcome of improved visibility and enhanced awareness of issues affecting children with a serious emotional disturbance and their families. A board was created as per the Articles of Incorporation and is composed primarily of family members. Alabama Family Ties fills a distinct weakness in the system development structure: the absence of an organized independent family voice that is consistently present and involved. It is critical that families have a voice when discussions are held and decisions are made that individually and collectively impact their children and their families. Alabama Family Ties has been that voice and the catalyst for a chorus of voices.

Alabama Youth M.O.V.E. (AYM):

(AYM) is a youth-led organization established in Alabama in FY11, which is devoted to improving services and systems that support positive youth growth and development through uniting the voices of individuals who have been served by various systems including mental health, education and juvenile justice. AYM works closely with Alabama Family Ties and other advocacy groups, and participates at the state level with a presence on the MI Child and Adolescent Task Force and the MI Planning Council. AYM is actively seeking to involve more youth in the advocacy process and takes an active role in events such as the annual state-wide Children's Mental Health Awareness Week.

Wings, NAMI Alabama, Alabama Family Ties and Alabama Youth MOVE are strong advocates and primary stakeholders at the local and state levels. These organizations are intimately involved in the planning for mental health services provided to adults and children/adolescents in Alabama and have representation on DMH's Management Steering Committee, the Mental Illness Coordinating Committee, and the Child and Adolescent Services Taskforce, as well as the Mental Illness Planning Council. DMH has a vibrant Planning Council that; not only reviews and monitors the Mental Health Services Block Grant, but is also active in advocating for consumers and providing leadership in program development. The bylaws spell out the purpose of the Planning Council. Consumers and family members hold majority membership on the Council. Either a consumer or a family member has chaired the Mental Illness Planning Council for the past several years.

The Governing Body of the MI facilities and the MI Facilities Directors Committee also have consumer and family member representation. Each group formed by the Department to tackle specific problems and issues has consumer and family member representation, including the Acute Care Task Force, the four regional planning groups,

the Evidence-based Practices Workgroup, the System Reconfiguration Task Force, the Financing Strategies Workgroup, and the Medicaid Managed Care Workgroup. Additionally, consumer and family involvement is guaranteed through inclusion in the *Alabama Administrative Code*, which has the force and effect of law. Consumers and family members are also involved in resource allocation and service evaluation at the local community mental health center level.

Person-centered treatment planning has been adopted as the philosophy for DMH through which consumers are assisted in articulating their vision and hope for how their lives will be changed for the better. Person-centered treatment planning training sessions have ongoing for several years in state facilities and with community mental health providers. A training manual has been developed for use by mental health professionals. Community mental health providers are expected to provide ongoing training on person-centered treatment planning and consumer directed services. In 2009, refresher training sessions were provided in four locations across the state related to the focus on improving recovery and resiliency capability of the system. Alabama's Administrative Code promotes the use of person centered treatment planning throughout.

Alabama currently has no formal policy on participant-directed services. Within DMH, the Mental Illness Division has relied on a traditional community mental health center system of care. This has provided limited choices to the community providers of what services are offered. However, within the community mental health system at a local level, individuals have choice to what services they will accept, therapist within that system to provide the service, and individualized treatment planning. The efforts of DMH have been to develop and enhance a continuum of care for both adults and children/adolescents that lends itself to a flexible array of services that are focused on meeting as a first priority the needs of people with a serious and persistent mental illness, particularly those who have been in a state psychiatric hospital. However, this is within the community mental health center itself and to develop a seamless system of care from hospital to community. All services are designed to be provided from a person-centered treatment planning perspective driven by family and consumer needs. Consumers receive not only high quality treatment services, but receive the necessary supports to achieve the highest degree possible of independent living in safe and decent housing, to be employed, to receive necessary medical care in a coordinated manner, and to engage in social interaction with friends and family. The struggle with expanding the provider network is the balancing of care coordination and collaboration necessary to maintain consumer recovery and foster resiliency.

DMH supports a model for assessment, service planning, and service delivery that is person-centered, strength based, consumer-driven, and family-focused. Efforts to move the system toward this have occurred at several levels. To try and develop infrastructure and build capacity, DMH has engaged in the following:

- Updated the DMH Administrative Code for MI Program Standards that incorporates person centered and recovery mandates for care. Person-centered treatment planning is outlined. Addressing the specialized needs of consumers who are deaf or hard of hearing was integrated in every level. So that consumers and their families can be

informed of the quality of care of the provider, DMH is moving toward having certification scores being posted on the DMH website as a “report card”.

- A regional planning structure was adopted for all departmental planning beginning in FY08 and resulted in increased numbers of family members and consumers being involved in the planning process. During FY09, there were numerous participants in the regional planning process including consumers, family members, Probate Judges, public community providers, state hospitals, and local private providers. In FY09, the planning process was expanded to separate local planning for adults from local planning for children and adolescents. This decision was based on feedback from the previous years of planning with the intent to improve the voice of children and adolescents and their families throughout the planning process. A series of local stakeholder planning meetings occurred in late summer and fall 2009. This provided an avenue to have local and regional input in determining unmet needs and critical gaps within the system at the community level. The local and regional planning process provides the foundation for the Department’s annual budget request.
- DMH implemented the state-wide use of the Child and Adolescent Needs and Strengths (CANS) Functional Assessment Tool effective October 1, 2010 in order to address the concerns about the special individualized needs of child and adolescent consumers and their family members. This strengths-based assessment instrument has cultural subscales that guide service providers in assessing cultural strengths and helping families to select services that are culturally relevant to them. The CANS is linked directly to the treatment plan as to ensure the treatment is individualized, strength based, family-driven, and youth-guided. DMH developed a statewide web-based application for the CANS as a means to gather data for NOMs and to measure performance and outcomes. It is anticipated that DMH will implement such an instrument for the adult system.
- DMH is working closely with Alabama Medicaid in efforts to expand coverage to those peer related services that would enhance a self-directed care system. DMH has submitted language for consideration of a State Plan Amendment for the Rehab Option that would include Peer Support Services, Youth Peer Support Services, and Family Peer Support Services. Work continues on these efforts as other funding stream enhancements are being explored.
- DMH received a SAMHSA Children’s Mental Health Initiative System of Care (SOC) grant that covers three rural counties. The SOC grant incorporates strategies around meeting the ethnic, cultural and linguistic needs of their children/adolescents they serve and their families. The SOC site includes cultural competency development for staff through specialized training by Troy University faculty. The ECCHCO project also has a full-time administrative parent coordinator and youth

coordinator who address the diverse needs of child and adolescent consumers and their families. Interpreters are available as needed for families who speak little or no English, as well as deaf or hard of hearing. All services are co-located with the system of care partners. There is a Family Advisory Council and a Youth Advisory Council, as well as youth and family representatives on the ECCHCO Advisory Council. The core values of system of care (community based, family-driven, youth-guided, culturally and linguistically competent) will be infused at all levels within the system of care.

Special Projects

A portion of the Block Grant is reserved for Planning Council Special Projects. Historically, these funds have been allocated to a variety of educational and service components. These projects have supported transformational activities by providing education/training for family and consumer advocates, direct service staff, administrators, and other interested parties. In addition, the largest part of the Special Projects funding supports drop-in centers and other consumer operated services that directly address Recovery for consumer. Funding for drop-in centers and education programs offered directly by NAMI Alabama, Wings Across Alabama, Alabama Family Ties, and Mental Health America was continued as was funding for the annual Consumer Recovery Conference. The funded Special Projects (see attachment) continue to offer important training and educational opportunities for families, consumers, and service providers. Administrative funds are used to pay the registration fee for Planning Council members to attend the Council of Community Mental Health Boards Annual Conference. This conference attracts several hundred mental health center and state agency staff and provides a variety of sessions of interest to Planning Council members

Housing

- 1. What are your state's plans to address housing needs of persons served so that they are not served in settings more restrictive than necessary?
- 2. What are your state's plans to address housing needs of persons served so that they are more appropriately incorporated into a supportive community?

As previously detailed in Section 2-Step 1- under Housing, the Department is committed to offering services and supports to promote individuals' receipt of mental health treatment in the least restrictive, most integrated environment possible. Spurred by the Alabama Wyatt lawsuit and following Olmstead litigation, the state has successfully increased integration efforts through hospital downsizing and community service expansion initiatives. As noted earlier, statewide hospital census has decreased from 2009 baseline numbers to date by nearly 44%. The substantial portion of this success can be traced to the 2007/2008 Acute Care Project and the subsequent 2009/2010 Downsizing Project, for which systematic evaluation and analysis process was conducted in which of individuals residing on extended hospital wards or who had lengths of stays beyond 90 days. These evaluations were conducted by teams made up of advocates, clinical staff and peer specialists in which participants were surveyed as to their living arrangement

preferences as well as service needs. This information, along with hospital treatment team assessments and recommendations, resulted in a structured plan for the development for services and housing to meet the unique needs of the target population.

Likewise, similar activities were conducted for target consumers residing in various group home and residential treatment models identified as having lengths of stays for a year or greater. Barriers to community integration were identified and served as a basis for planning housing, services, and supports necessary to address the unique requirements of this population. The specific services and program development for these projects and other integration efforts are detailed in Section 2-Step 1: Hospitalization-Downsizing Effort for Community Integration.

As an ongoing effort to monitor the appropriate utilization of residential treatment beds, the Department developed a web-based tool - Mental Illness Community Residential Placement System (MICRS). This system allows for Department level knowledge of residential utility, bed availability, specialty residential treatment programs (i.e. medical, forensic, dual-diagnosis), and lengths of stay for current occupants. DMH has funding to support to use of Utilization Review Coordinators who are available to monitor MICRS on a regional basis and provide assistance to state psychiatric hospital staff and local mental health providers in locating the most integrated settings for individuals discharging from state psychiatric facilities as well as integrated residential treatment settings.

Section IV: Narrative Plan N. Evidence Based Prevention and Treatment Approaches for the MHBG (5 percent)

- States are being asked to utilize at least five percent of their MHBG funds to award competitive grants to implement the most effective evidence-based prevention and treatment approaches focusing on promotion, prevention and early intervention. States that receive two percent or more of the total FY 2014 state allotment will be required to implement a competitive sub award process. States should describe how they intend to implement the competitive grants and/or sub award process.

It is my understanding at that this time, the request to set-aside five percent of the MHBG allocation to award competitive grants to implement the most effective evidence-based prevention and treatment approaches focusing on promotion, prevention, and early intervention is a Recommendation and not a Requirement. Therefore, for the Mental Health Block Grant, we are not planning to implement this new set-aside unless it becomes a Requirement.

Section IV: Narrative Plan O. Child and Adolescent Behavioral Health Services

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with over 160 grants awarded to states and communities, and every state has received at least one CMHI grant. In 2011, SAMHSA awarded System of Care Expansion grants to 24 states to bring this approach to scale in states.

In terms of adolescent substance abuse, in 2007, SAMHSA awarded State Substance Abuse Coordinator grants to 16 states to begin to build a state infrastructure for substance abuse treatment and recovery-oriented systems of care for youth with substance use disorders. This work has continued with a focus on financing and workforce development to support a recovery-oriented system of care that incorporates established evidence-based treatment for youth with substance use disorders.

SAMHSA expects that states will build on this well-documented, effective system of care approach to serving children and youth with behavioral health needs. Given the multi-system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs and better invest resources. The array of services and supports in the system of care approach includes non-residential services, like wraparound service planning, intensive care management, outpatient therapy, intensive home-based services, substance abuse intensive outpatient services, continuing care, and mobile crisis response; supportive services, like peer youth support, family peer support, respite services, mental health consultation, and supported education and employment; and residential services, like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification.

Please answer the following questions:

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with mental and substance use disorders?

Within DMH, the Mental Illness Division has relied upon a traditional community mental health center system of care. This has provided limited choices to the community providers of what services are offered. However, within the community mental health system at a local level, individuals have choice to what services they will accept, therapist within that system to provide the service, and contribute to individualized treatment planning. The efforts of DMH have been to develop and enhance a continuum of care that lends itself to a flexible array of services that are focused on meeting the needs of children and adolescents with a serious emotional disturbance and their families. All services are designed to be provided from a person-centered treatment planning perspective driven by youth consumer and family needs. The importance of expanding the provider network is to achieve the balance of care coordination and collaboration necessary to maintain consumer recovery and foster resiliency. Although not established state-wide, DMH does have experience in creating a modern system of care approach to delivering mental health services to children and adolescents with serious emotional disturbance and their families. In FY1997, DMH received a SAMHSA Children's Mental Health Initiative System of Care (SOC) grant that covered the largest metropolitan area in Alabama – Jefferson County. The Jefferson County Community Partnership (JCCP) project focused on developing a seamless system of care for children with a serious emotional disturbance and their families. JCCP incorporated two parent coordinators which are now the first parent support specialists in the children's mental health system in Alabama. All services were co-located with the system of care partners. The JCCP Advisory Council still exists today and is the driving force for the continued decision making process and expansion of care that holds true to the system of care values and concepts. In FY10, DMH received a second SAMHSA SOC cooperative agreement that covers three rural counties in East Central Alabama. The East Central Children's Health Collaborative (ECCHCO) Project incorporates strategies around meeting the ethnic, cultural and linguistic needs of their children/adolescents they serve and their

families. ECCHCO also has a full-time administrative parent/youth coordinator who addresses the diverse needs of child and adolescent consumers and their families. All services are co-located with the system of care partners. There is a Family Advisory Council and a Youth Advisory Council, as well as youth and family representatives on the ECCHCO Advisory Council. The core values of system of care (community based, family-driven, youth-guided, culturally and linguistically competent) are infused at all levels within this system of care. Through the DMH Child and Adolescent Task Force and within the DMH planning process, both SOC sites are used as a laboratory of learning in the continued efforts to expand SOC core values throughout the state.

DMH supports a model for assessment, service planning, and service delivery that is person-centered, strength based, consumer-driven, and family-focused. Efforts to move the system toward this have occurred at several levels. To try and develop infrastructure and build capacity, DMH has engaged in the following:

- The regional planning structure was adopted for all departmental planning beginning in FY08 and resulted in increased numbers of family members and consumers being involved in the planning process. There have been numerous participants in the regional planning process including consumers, family members, judges, public community providers, state hospitals, and local private providers. The local and regional planning process provided the foundation for DMH's annual budget request. In FY09, the planning process was expanded to include a separate planning function for children and adolescents. This decision was based on feedback from the previous years of planning and was implemented to improve the voice of children and adolescents and their families throughout the planning process. A series of over 90 adult/children and adolescent local stakeholder planning meetings occurred in late summer and fall 2009. This provided local and regional input in determining unmet needs and critical gaps within the system at the community level. The feedback from this process was utilized within the departmental planning process as a mechanism to introduce local community input and was instrumental in the identification of needs and gaps in service. During FY 2011, DMH leadership worked jointly with the Mental Illness Coordinating Subcommittee and Management Steering Committee to make recommendations for goal and strategy improvements. This collaboration has resulted in thorough examination of planning targets that reflect the approval of stakeholder partners while balancing the realities of DMH fiscal parameters and magnifying the benefits of the integration efforts made within the division. This process has continued through FY 2013.
- Planning for children and adolescent services is performed as a part of the overall Management Steering Committee process described above via a Child and Adolescent Services Task Force. The Task Force is constituted from a representative group of stakeholders, including advocates and family members whose primary focus is children and adolescents. This body assesses the needs of the state, designs the

conceptual framework, and prioritizes strategic growth of child and adolescent services for the DMH Mental Illness Division.

- The DMH Administrative Code for MI Program Standards was updated in FY10 to incorporate person centered and recovery mandates for care. Person-centered treatment planning is outlined. Addressing the specialized needs of consumers who are deaf or hard of hearing was integrated in every level. So that consumers and their families can be informed of the quality of care of the provider, DMH is moving toward having certification scores being posted on the DMH website as a “report card”.
- DMH implemented the state-wide use of the Child and Adolescent Needs and Strengths (CANS) Functional Assessment Tool effective October 1, 2010 in order to address concerns about the special individualized needs of child and adolescent consumers and their family members. This strengths-based assessment instrument has cultural subscales that guide service providers in assessing cultural strengths and helping families to select services that are culturally relevant to them. The CANS is linked directly to the treatment plan as to ensure the treatment is individualized, strength based, family-driven, and youth-guided. DMH developed a statewide web-based application for the CANS as a means to gather data for NOMs and to measure performance and outcomes. All MI contracted providers have Child Adolescent staff trained and a CANS completed on all Child/Adolescent consumers as of April 1, 2011.

2. What guidelines have and/or will the state establish for individualized care planning for children/youth with mental, substance use and co-occurring disorders?

Person-centered treatment planning has been adopted as the philosophy for DMH through which children and adolescents are assisted in articulating their vision and hope for how their lives will be changed for the better. Person-centered treatment planning training sessions have been ongoing for several years in state facilities and with community mental health providers. Community mental health providers are expected to provide ongoing training on person-centered treatment planning and consumer directed services with a focus on improving recovery and resiliency capability of the system. Alabama’s Administrative Code promotes the use of individualized, person centered treatment planning throughout and codifies meaningful contribution by the child/adolescent and responsible caregivers in all aspects of treatment planning and implementation.

3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?

DMH has for many years partnered 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, and

Department of Human Resources, to provide a comprehensive array of publicly funded services to children/adolescents through memoranda of understanding, intergovernmental service agreements or informal relationships. For specific information regarding collaborative efforts between DMH and other state child-serving agencies, please see Section IV, Narrative Plan V. Support of State Partners.

4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?

A number of different EBPs related to various aspects of mental health prevention, treatment and recovery are utilized by different Child/Adolescent service providers. Each EBP has its own training/certification process, which is managed by the agency implementing the practice. At this time, EBPs have not been established at a state-wide level. A promising current mental health provider implementation of an EBP is the establishment of the Coping Power program for children/adolescents and their families in an area of rural Alabama as part of the ECCHCO Project discussed above. A Patient Centered Outcome Research Institute grant proposal was submitted in August 2013 by Dr. John Lochman, creator of Coping Power, in collaboration with DMH, which, if awarded, will train many clinicians and conduct multiple Coping Power programs across the state. This process, if implemented, could in the future help in developing a model for training and certifying clinicians in this EBP on a statewide basis.

5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders? "

The Child and Adolescent Needs and Strengths assessment tool described above (see question 1.) is linked directly to each consumer's treatment plan to ensure that treatment is individualized, strength based, family-driven, and youth-guided. DMH developed a statewide web-based application for the CANS as a means to gather data for NOMs and to measure performance and outcomes. All MI contracted providers have Child/Adolescent staff trained to perform the CANS assessment, and a CANS is completed on all Child/Adolescent consumers during the Intake process and at least every six months afterward. Clinicians at the local level are able to access outcome information on their individual consumers over time and assess progress in a number of different functional areas. This information is explored and discussed in treatment planning sessions with the consumer and family members, and is used to help determine appropriate treatment goals and interventions during the course of treatment. At the DMH level, the CANS database is designed to provide accessible NOM information and is available to help in gauging the effectiveness of programming for children and adolescents. For example, efforts are currently underway to use CANS data to produce outcome information to help measure the effectiveness of the School-Based Mental Health project which is becoming established in many locations around the state.

Section IV: Narrative Plan P. Consultation With Tribes

- SAMHSA is required by the 2009 Memorandum on Tribal Consultation to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinions between parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues.

For the context of the Block Grants awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees. SAMHSA is requesting that states provide a description of how they consulted with tribes in their state, which should indicate how concerns of the tribes were addressed in the State Block Grant plan(s). States shall not require any tribe to waive its sovereign immunity in order to receive funds or in order for services to be provided for tribal members on tribal lands. If a state does not have any federally-recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect. For states that are currently working with tribes, a description of these activities must be provided in the area below. States seeking technical assistance for conducting tribal consultation may contact the SAMHSA project officer prior to or during the Block Grant planning cycle.

Alabama is home to only one federally recognized Indian Tribe. Operating as a sovereign nation since 1984, the Poarch Band of Creek Indians consists of descendants of a segment of the original Creek Nation which once covered almost all of the state, as well as, Georgia. The Poarch Creeks have lived together for almost 200 years in and around the reservation, which is located fifty-seven (57) miles from Mobile in Poarch, Alabama.

The Alabama Department of Mental Health (ADMH) does not currently have ties with the Poarch Band of Creek Indians, but understands the significance and value of pursuing such. Under our previous administration, DMH attempted to establish and implement an ongoing relationship with the Poarch Creek Indian Tribe as to enable regular, meaningful, government-to-government consultation and collaboration in the areas of planning, operating, and funding substance abuse and mental health services in Alabama. To date, the Poarch Creek Tribal Leaders have not responded to DMH.

DMH is dedicated to continue efforts in establishing and implementing an ongoing relationship with the Poarch Creek Indian Tribe but guidance and technical assistance will be needed to achieve this endeavor.

Section IV: Narrative Plan Q. Data and Information Technology

- In the FY 2012/2013 Block Grant application, SAMHSA asked each state to:
- Describe its plan, process, and resources needed and timeline for developing the capacity to provide unique client-level data;
- List and briefly describe all unique information technology systems maintained and/or utilized by the state agency;
- Provide information regarding its current efforts to assist providers with developing and using EHRs;
- Identify the barriers that the state would encounter when moving to an encounter/claims based approach to payment; and
- Identify the specific technical assistance needs the state may have regarding data and information technology.

Please provide an update of your progress since that time.

The Alabama Department of Mental Health (ADMH) has collected demographic and service event data at the client level for all consumers receiving community mental health services since 1995 through the Alabama Community Services Information System (ACSIS). Client level demographic and service event data is stored in a Central Data Repository (CDR) located in the ADMH Central Office and is refreshed once a month by data uploaded electronically to the ADMH secure website from each of 27 community mental health providers with whom ADMH contracts to provide services. Each provider has the capacity to report client level demographic and service event data to the CDR. The upload files conform to a standard file structure with data elements and standard codes specified by ADMH and required by contract. Monthly data files are uploaded using a secure ADMH website and are due by the 16th of the month following the month of service. Data is updated by the provider at admission, discharge, and annual review or as change occurs in the client profile status. The CARES management information system has been in use by the state operated mental health hospitals since 1991 to track admissions, discharges, transfers, client demographics, diagnoses, daily census and selected clinical information at the client level and is updated in real time. This system is being replaced by an electronic health record with implementation scheduled to begin January 2014 and completed by October 2014. The Alabama Behavioral Health Assessment System (ABHAS) is a web based system used by community mental health providers to administer, score and track the Child/Adolescent Needs and Strengths (CANS) assessment tool. The Client Level Data (CLD) Crosswalk has been submitted to NRI for approval, program specifications developed to create CLD submission files, and infrastructure programming is underway. A programmer has been hired under contract to assist with the project. However, the IT department is short a state at least one programming resource due to the catastrophic illness of a programmer/analyst and the project timeframe is very tight. The project is scheduled to be completed November 8, 2013 for reporting CLD for the fiscal year ending September 30, 2013. Once the CLD

project is completed for FY13, we will begin modifications to incorporate the electronic health record data as CARES is phased out during FY14.

IT Systems Utilized/Maintained by ADMH

Information Provided	CARES	ACSIS	ABHAS
Provider Characteristics	No	No	
Client enrollment, demographics, and characteristics	Yes	Yes	
Admission and discharge	Yes	Yes	
Assessment	No	No	Yes
Services provided, including type, amount, and Individual service provider	No	Yes	No
Prescription drug utilization*	Yes*	Yes*	No
Provider			

*Prescription drug utilization is captured for those prescriptions filled by the facility pharmacies/contract pharmacies or by community mental health pharmacies.

Twenty of the twenty seven community mental health providers already have electronic health records. Two more mental health providers plan to begin implementation of an electronic health record in 2014. The providers are responsible for procuring and implementing the EHR of their choice. They have formed user associations among themselves to obtain favorable prices on licenses and maintenance rates from several different vendors and collaborate with each other. We encourage discussion about electronic health records during meetings with IT directors and administrative managers and are encouraging their participation in the state health information exchange. We will be working with their EHR systems more closely as we approach the implementation of the ADMH EHR implementation in state hospitals and the development of an interface between their systems and the CoCentrix EHR.

Two major barriers to converting to a claims based payment system are the method of payment to providers and the existing Central Data Repository (CDR) system. Currently, the providers are paid 1/12th of their annual contract each month to provide an array of services defined in their contract. The CDR system that we have in place collects data monthly and is used as a mechanism for reporting. Client level service data is available in ACSIS for each individual service a client receives and includes the date of service, type of service, service quantity and the identity of the individual staff member. ACSIS accepts standard 837 transactions which comply with Federal data standards of CPT/HCPCS codes. The system would have to be completely replaced to incorporate fee for service payment. This would mean purchase or lease of a new system as we do not have the resources to build the system in house. Current prices for these systems would run in excess of \$1.5 million dollars plus monthly licensing and/or hosting fees. This is money that we do not have in our budget.

Technical assistance is needed to assist us in implementing SharePoint technology to bring together the data silos for mental illness, substance abuse, developmental

disabilities and Medicaid data. We are working on a data warehouse project with SharePoint as the front end and desire to use dashboards and other visual representations of data to assist our management with performance measure and outcomes.

Section IV: Narrative Plan R. Quality Improvement Plan

- In the FY 2012/2013 Block Grant application, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, that will describe the health of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, continue reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements and garner and use stakeholder input, including individuals in recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical =

In the FY 13, the MI Performance Improvement Committee met four times to review data and conduct PI business. Community Provider data that was reported and reviewed through the ADMH Performance Improvement Process includes Safety measures (critical incidents), Rights measures (complaints, grievances, and abuse/neglect allegations), Continuity of Care measures, and Outcome measures. The current active community provider PI measures are listed in Appendix B of the attached State CQI Plan. The Safety measures listed below are reported to the ADMH in accordance with the published *Alabama Department of Mental Health, Division of Mental Health and Substance Abuse Services, Procedures for Reporting Incidents and/or Critical Incidents in Certified Community Programs*. (also attached). These procedures describe the process for responding and reporting incidents and/or critical incidents. The Alabama Administrative Code also includes requirements for responding to complaints and grievances in accordance with the ADMH Internal Advocacy Program.

The following outlines the measures that were reported/reviewed each quarter/annually for the MI Community Programs:

Safety Measures

Death
Injury
Suicide attempts
Seclusion/Restraint use and any associated injuries
Medication Errors
Eloperments

Rights Measures

Abuse/Neglect Allegations
Advocacy Monitoring (complaints/grievances/rights violations)

Continuity of Care Measures

30 Day Readmissions to State Hospitals

Hospitalization

Tracking of Continuing Care Plans (Hand-off communication from state hospitals)

Outcome Measures

Certification/standards compliance

Adult/Family Consumer Perception of Care/Quality of Life (MHSIP Surveys- Annual measures)

The following outlines the key Community performance improvement initiatives for the Committee this year:

- Development of an electronic reporting system for the certified community mental health and substance abuse providers – in piloting phase currently.

MHSIP Process (Consumer Satisfaction Surveys)

The MI PI Committee provided oversight to the Community MHSIP Survey process which was conducted for the eleventh time in May of 2013. In 2010, physical health questions and substance use questions were added to the Adult MHSIP and Youth Family surveys. The addition of these questions has provided additional consumer data to be used to better address the physical and behavioral needs of consumers. A total of twenty seven (27) agencies participated in the 2013 MHSIP Survey Process. The Community MHSIP Adult, MHSIP Youth Family, MHSIP Youth Services, Life Satisfaction and Adult Family Satisfaction surveys were administered May 13, 2013 through May 24, 2013. The results for each of the following surveys will be available by September 20, 2013:

Adult MHSIP

MHSIP Family

Life Satisfaction

Youth Services Survey

Youth Services Survey – Family

The 2013 individual center survey results (as well as state and national comparison data) will be distributed to each CMHC in Sept 2013 for review and use as part of their internal performance improvement process. The State MSHIP Domain scores for the Adult MHSIP, Youth Family and Youth Services Surveys will also be presented to the MI PI Committee at the November 2013 meeting for their review and recommendations as applicable.

2012 Survey Process update:

- Results from the 2012 surveys were presented to the PI Committee and distributed to the community providers in October 2012. Each CMHC received data containing:
 - The number of positive responses to each question on all surveys
 - A breakout by question of the 7 domains (MHSIP, YSS, & YSS-F) with comparisons to the regional, state and US average.
 - A statewide regional comparison report on the Adult MHSIP
- The Statewide Regional Comparison report on the Adult MHSIP was presented at the November 2012 PI Committee.

Peer Review Child & Adolescent 2013

The Office of Performance Improvement, Division of Mental Health and Substance Abuse Services, coordinated an independent peer review for 2013. The 2013 Peer Review focus was the use of the CANS (Child and Adolescent Needs and Strength Assessment) in the development of strength based, person centered treatment planning. Jefferson – Blount - St. Clair Mental Health Authority served as host and shared their knowledge and expertise in this area with Baldwin County MHC, Huntsville Madison MHC, and East Alabama MHC. The peer review was conducted August 13, 2013. The purpose of peer review is to share ideas, best practices, and other innovative treatment strategies so that other centers may take this information back to their program and improve consumer services. Other areas covered during the Peer Review included:

- Goals of the Program
- Eligibility Criteria for the Program
- Admission Criteria for the Program
- Penetration Rate
- Assessment
- Treatment Planning
- Training
- Supervision
- Process Monitoring

- Outcomes Monitoring
- Quality Assurance
- Client Choice
- Barriers
- Things that have helped make the program a success

Peer Review Adult 2013

The Office of Performance Improvement, Division of Mental Health and Substance Abuse Services, coordinated an independent peer review for 2013. The 2013 Peer Review focus was NGI continuum of care in community services. Jefferson – Blount - St. Clair Mental Health Authority served as host and shared their knowledge and expertise in this area with CED, Indian Rivers, and South Central MHCs. The review was conducted August 7, 2013. The purpose of peer review is to share ideas, best practices, and other innovative treatment strategies so that other centers may take this information back to their program and improve consumer services. Other areas covered during the Peer Review included:

- Goals of the Program
- Eligibility Criteria for the Program
- Admission Criteria for the Program
- Penetration Rate
- Assessment
- Treatment Planning
- Training
- Supervision
- Process Monitoring
- Outcomes Monitoring
- Quality Assurance
- Client Choice
- Barriers
- Things that have helped make the program a success

The following outlines the key Inpatient performance improvement initiatives for the Committee this year:

- Joint Commission Core Measure set for Hospital-Based Inpatient Psychiatric Services (HBIPS) became mandatory in January 2011. For 2013, the inpatient core measure set will be reported to CMS through an intermediary, Quality Net, beginning August 2013. The August report will be based on October – December 2012 data.

Section IV: Narrative Plan S. Suicide Prevention

- In the FY 2012/2013 Block Grant application, SAMHSA asked states to:
- Provide the most recent copy of your state's suicide prevention plan; or
- Describe when your state will create or update your plan.

States shall include a new plan as an attachment to the Block Grant Application(s) to provide a progress update since that time. Please follow the format outlined in the new SAMHSA document Guidance for State Suicide Prevention Leadership and Plans available on the SAMHSA website at [here](#).

Alabama Suicide Prevention and Resource Coalition (ASPARC).

In 2001, the Commissioner of the Alabama Department of Mental Health and the State Health Officer of the Department of Public Health joined forces to establish the Alabama Suicide Prevention Task Force (ASPTF). In response to identified state needs, ASPTF would function to: (1) promote recognition of suicide as a problem affecting Alabama; (2) outline a strategy for the prevention of suicide in Alabama; and (3) identify federal, state, and local resources to support implementation of Alabama's Suicide Prevention Plan. Consisting of twenty seven (27) representatives of multidisciplinary public and private agencies, members of the faith community, as well as survivors, ASPTF published the State's first Suicide Prevention Plan in 2004. ADMH has maintained active representation on ASPTF since its inception.

The Alabama Suicide Prevention Task Force (ASPTF) reorganized during FY10. Evolving from task force status to a structured non-profit membership organization with a governing board, the ASPTF became the Alabama Suicide Prevention and Resource Coalition (ASPARC). ASPARC became a recipient of the Garrett Lee Smith Memorial Act grant in 2012. Thus, efforts have focused on the planning and implementation of the grant which has focused on providing QPR gatekeeping training and Lay My Burdens Down (LMBD). Ninety-nine (98) people in eleven (11) venues (colleges, high schools, churches, and social services and child focus agencies) have received QPR training. LMBD has been presented to 476 people. Through contributions of ASPARC members, a special edition on suicide were published in the peer reviewed Alabama Counseling Association Journal. This special edition is included in the attachments. At present ASPARC is planning for its annual meeting to be held on September 27, 2013. A save the date card is provided in the attached documents.

DMH continues to serve as an active participant in ASPARC activities, with a member of its staff elected to serve as its first president in 2010. The organization sought and attained 501(c)(3) Tax

Exempt Status in 2011. The 1st Annual meeting was held September 14, 2011 in honor of Suicide Prevention Week. The 2011-2012 board consists of eleven members, representing the fields of social work and counseling, multiple universities, mental health, public health, numerous crisis centers, and the military. In addition to the board, ASPARC has membership, representing survivors, family members, hospice, students, private practice, counseling / treatment facilities, and education. ASPARC board has discussed approaching the Tribal communities for inclusion but these efforts have not yet been implemented.

ASPARC began revision of Alabama's 2004 Suicide Prevention Plan (see attached) in June, 2010 and the revisions were finalized in late 2011-2012. The revision follows.

Three Year Plan for Suicide Prevention

The primary goal of ASPARC is to reduce the prevalence and incidence of suicide and suicidal behaviors in Alabama. To that end, the following activities and programs are proposed:

- Promote public awareness throughout Alabama of the magnitude of suicide and suicidal behaviors in the state and the wide-ranging, serious consequences for all segments of the population. Use available information technology and resources to inform the public about: A) the prevalence, incidence and effects of suicidal behaviors; B) risk factors, signs and symptoms of suicidal behaviors; and, C) the existence of effective, evidence-based prevention programs. Specific activities may include the following:
 - A. Develop a program to disseminate, on a continuing basis and using all available media, facts about the prevalence/incidence and effects of suicide and suicidal behaviors in all population groups and in all geographic areas of Alabama along with risk factors, signs and symptoms, and the availability of local prevention resources, including crisis centers as well as the national toll-free suicide prevention hotline.
 - B. Enlist the support of the governor and legislators to declare "Suicide Prevention Awareness Week" each September. During that week inform the public and legislators and private benefactors about the importance and benefits of suicide prevention as well as the existence of feasible, evidence-based prevention programs.
 - C. Revise and update the ASPARC/ADPH suicide prevention website with current information on suicide and suicide prevention in the state and nation and with a focus on current/future activities of ASPARC and the state health/mental health departments. Highlight on-going or planned suicide prevention activities in cities and rural areas. Invite new members to join ASPARC.

D. Create, maintain, and update every 6 months state-wide resource directories for suicide prevention and mental illness treatment. Publish directories on-line and in print. Publicize and distribute to health professionals, schools, churches, police and fire personnel, crisis centers and the public at large.

- Select a limited number of feasible, evidence-based programs and activities for funding and implementation.

A. Pilot test these programs in communities, schools, colleges and other appropriate locations. Example: The promotion of firearm safety measures that reduce quick and easy access to guns. This involves ready-made materials such as the Harvard University publication, "Means Matter: Suicide, Guns and Public Health" and "Lok-it-Up". Dissemination to parents of school children as well as health care providers would be a simple, low cost activity. (NOTE: Alabama now has the 4th highest per capita firearm death rate. Most Alabama gun deaths are suicides.)

B. Collaborate with Alabama crisis centers and hotlines in planning community-based suicide prevention activities. These might include educational, training and outreach programs, development of effective follow-up strategies for persons released from treatment, and publicizing available resources for survivors of suicide loss.

- Make gatekeeper training - on line or otherwise - for the identification and assessment of potentially suicidal persons available to health, mental health, substance abuse and human service professionals as well as to natural community helpers such as: coaches; hairdressers; bartenders; faith leaders; primary care physicians; police and fire protection first responders; clergy; teachers; correctional workers; school counselors; adult and child protective service social workers; and other social workers.

A. Establish state-wide access to an evidence-based, low-cost source for on-line gatekeeper training, such as QPR, for a nominal fee.

B. Develop a state-wide cadre of licensed trainers to conduct training coordinated by ASPARC.

C. Maintain and update gatekeeper training/education for first responders on a continuing basis.

- Make gatekeeper training - on-line or otherwise - for the identification and assessment of suicidal behavior available to family members of persons at risk.
 - A. Establish public access to an on-line gatekeeper training program, such as QPR, available for a nominal fee.
 - B. Recruit private and public sector organizations to collaborate with the ASPARC in subsidizing public access to gatekeeper training.
- Develop new suicide bereavement resources for Alabama communities. This would primarily involve the following.
 - A. Strengthen the network of Alabama support groups for survivors of suicide.
 - B. Develop at least one survivor support group per mental health area.
- Collaborate with primary care providers to help at-risk patients acknowledge and seek treatment for depression, substance abuse, and other major mental illnesses.
 - A. Identify a practical suicide screening and assessment tool for busy provider practices.
 - B. Develop a physician's information page/link for the ASPARC website.
 - C. Develop readable suicide awareness materials for primary care patients.
- Work with state and local organizations to carry out safe, effective programs in schools and colleges that address adolescent distress, provide crisis intervention, and include peer support for individuals seeking help.
 - A. Partner with the Alabama Department of Education, and local schools to incorporate suicide prevention curricula into middle and high schools. Include a local resource directory of providers and youth-serving organizations.
 - B. Provide gatekeeper training to teachers, school counselors, coaches and other personnel.
- Obtain more accurate data about the incidence of suicidal behaviors in Alabama from medical examiners, coroners, hospitals, clinics, and law enforcement.

A. Support the development of a standardized reporting system for suicides and suicide attempts through the Alabama Department of Public Health.

- Other Activities? What else should be part of the plan? Which of the above are highest priority?

For ten (10) years DMH has worked collaboratively with others to develop and implement strategies to prevent suicide in Alabama. Yet, suicide continues as a significant public health problem that impacts hundreds of families in this State each year. A recent news report indicates the suicide rate in Alabama reached an all-time high of 14.2 suicides per 100,000 people in 2009, as reported by the Alabama Department of Public Health. After five years of steady growth, the State's suicide rate is at its highest point since 1960, outpacing the national rate, and prompting health experts to call for a public discussion on how suicide can be prevented. DMH, has thus identified "Suicide Prevention" as a priority to be addressed during FY 2012-2013 as described in Section II of this Block Grant Application. Thus, in FY2012 the Office of Prevention identified as a goal to prevent suicides and attempted suicides. To address this goal the following objectives were established: 1) improve mental, emotional, and behavioral health and well-being among those at high-risk (white non-Hispanic males, elderly – 70+, American Indian, military) for suicide; and 2) increase public knowledge of the warning signs for suicide and action to take in response. The action steps that have been in progress to meet this goal and objectives are: participation and collaboration with ASPARC (DMH employee serves as ASPARC board member), ensured clearinghouses have educational materials on suicide prevention; and ensure suicide prevention is represented as a priority in prevention plans across CSAP strategies. Thus, in FY14 the prevention plan template now includes the following as a priority: Prevent suicides and attempted suicides (emphasis on populations at high risk, especially military families, LGBTQ youth, and American Indians and Alaska Natives). This updated language is currently embedded in a prevention services request for proposal (RFP) for three counties (Bibb, Pickens & Tuscaloosa) which was released on July 29, 2013 and in preparation for FY15, a similar RFP with the same language will be released in January 2014 for all 67 counties within the state. DMH increased public knowledge through a feature on suicide in its January 2013 State Prevention Advisory Board Newsletter. Lastly, DMH through the support of SAMHSA sponsored a Mental Health First Aid (MHFA) training on September 28-29, 2012 as well as featured a MHFA track at the Alabama School of Addictions and Drug Studies on April 2-5, 2013. During the February 2013 Community Anti-Drug Coalitions of America training, DMH staff attended the Building Framework to Promote the MH of Young People and Prevent Mental, Emotional and Behavioral Health Workshop.

Section IV: Narrative Plan T. Use of Technology

- In the FY 2012/2013 Block Grant application, SAMHSA asked states to describe:
- What strategies the state has deployed to support recovery in ways that leverage ICT;
- What specific application of ICTs the State BG Plans to promote over the next two years;
- What incentives the state is planning to put in place to encourage their use;

- What support system the State BG Plans to provide to encourage their use;
- Whether there are barriers to implementing these strategies and how the State BG Plans to address them;
- How the State BG Plans to work with organizations such as FQHCs, hospitals, community-based organizations, and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine;
- How the state will use ICTs for collecting data for program evaluation at both the client and provider levels; and
- What measures and data collection the state will promote to evaluate use and effectiveness of such ICTs.

States must provide an update of any progress since that time.

Interactive Communication Technologies (ICTs) are already being used in treatment settings across Alabama, and the state is taking a stronger leadership role in ensuring that these technologies are being used to their maximum effect and are available to as many of the individuals we serve as possible. Currently, the Alabama Department of Mental Health does ensure that providers are aware of technology resources through the distribution of e-mails and other invitations the state agency receives and passes along. Alabama DMH recognized the need to play a stronger leadership role in the area of information technology. Alabama DMH has been more proactive in identifying and pushing out ICTs to its community providers over the last eighteen months, but we recognize we can always do more. We continue to desire to support the use of text messaging, outreach, recovery tools, emotional support, prompts, case manager support and telemedicine by service providers across the state and by the department.

We continue to work with our providers to determine appropriate incentives that will encourage the use of these technologies on a broader scale, including ensuring that reimbursement is available for the use of such technologies in practice. Our plan to facilitate user groups on specific technologies has yet to come to fruition due to lack of staff time to accomplish the task.

We continue to be impressed with the tools being made available to help consumers with behavioral health challenges and see our role as promoting the use of those technologies throughout the provider community. The iPromises application (<http://www.ipromises.org/>) was specifically designed to help clients in residential substance abuse treatment track their progress and could have great utility for our service delivery system. We are also excited about the work being done by federal agencies in this area, particularly the Department of Defense which has continued to make a number of useful apps available through the National Center for Telehealth and Technology (<http://www.t2health.org/products/mobile-apps>). There are also a number of private firms developing useful apps as well, such as Mood Panda (<http://www.moodpanda.com>). These types of applications do not take a great amount of effort to publicize and get in the

hands of consumers and stakeholders throughout the state, and DMH continues to invest more time and resources in doing just that.

The barriers to adoption of technology are varied. We are a very rural state and many types of technology are slow to come to these areas. Broadband is still a challenge, which makes expansion of telemedicine and other interactive technologies difficult to implement on a widespread basis. Many of these initiatives will need to begin in our urban centers, where the technology is more well-known and widespread, but will be slower to come to rural areas, who will need to be more creative with selection and deployment of technology.

The state does plan to continue its outreach efforts to hospitals, FQHC's and other community-based organizations to identify ways that these technologies could help enhance integration with primary care. We plan to continue to keep these technologies as a topic of discussion in our healthcare reform workgroups and other arenas where we are at the same table with primary care providers.

Currently, the state does not have plans to collect program evaluation data at either the client or provider level utilizing these technologies, but will work with our providers to identify where that would be possible and helpful in monitoring and enhancing client care.

By not pursuing the user groups, we have lost one avenue of being able to accomplish our goals around data collection. We plan to develop surveys in the coming months to be able to understand the current use and desired use of technology throughout the service delivery system. Some baseline data was collected as part of a SAMHSA-funded needs assessment survey, but was limited to use of telemedicine and adoption of Electronic Health Records. In order to assist in growing the use of technology, we must deepen our knowledge about what is already going on.

Section IV: Narrative Plan U. Technical Assistance Needs

- States shall describe the data and technical assistance needs identified during the process of developing this plan that will facilitate the implementation of the proposed plan. The technical assistance needs identified may include the needs of the state, providers, other systems, persons receiving services, persons in recovery, or their families. Technical assistance includes, but is not limited to, assistance with assessing needs; capacity building at the state, community and provider level; planning; implementation of programs, policies, practices, services, and/or activities; evaluation of programs, policies, practices, services, and/or activities; cultural competence and sensitivity including how to consult with tribes; and sustainability, especially in the area of sustaining positive outcomes. The state should indicate what efforts have been or are being undertaken to address or find resources to address these needs, and what data or technical assistance needs will remain unaddressed without additional action steps or resources.
 - 1. What areas of technical assistance is the state currently receiving?
 - 2. What are the sources of technical assistance?

- 3. What technical assistance is most needed by state staff?
- 4. What technical assistance is most needed by behavioral health providers?

At present, as it pertains to previous Mental Health Block Grant request for technical assistance, DMH has not received any technical assistance. DMH did request technical assistance through NASMHPD to SAMHSA for assistance in regard to Medicaid Reform as it applies to behavioral health care and was assisted with having Leslie Schwalbe provided but this will be time-limited.

Alabama's mental health plan, outlined in this application, has been designed largely to conform to the resources and expertise currently available to DMH, our contractors, and direct service providers. However, there is still some areas in which technical assistance provided by SAMHSA would be greatly appreciated, specifically:

- Medicaid Reform – Alabama is a state that has NO experience in Managed Care. The process that has been initiated by the Governor, legislators, and the Alabama Medicaid Agency is monumental and will be a multiple year process. Having our current use of a national consultant has been instrumental but is time-limited. Continued consultation in this area will be vital if DMH is to assist in providing the expertise necessary to guide the decision-makers in this process as it pertains to behavioral health care.
- Medicaid Funding Opportunities – DMH mental health and substance abuse services are primarily funded through Medicaid in the Rehab Option. DMH needs technical assistance in exploring other Medicaid funding opportunities such as waivers.
- Transformation of Mental Health Block Grant dollars – DMH has operated in a climate of reductions of state dollars (\$40 million) and block grant dollars. As SAMHSA moves away from how the Block Grants was utilized from the inception, technical assistance will be needed on how to achieve this without losing vital services and recover resources within the continuum of care, especially for children and adolescents. The challenge Alabama faces is having secured funding streams that can be utilized to maintain the foundation built that are vital to continued community-based care.
- Consultation with Tribes – DMH's attempts to engage the tribal community have been unsuccessful.
- Co-Occurring Disorders – Increase the BH workforce capacity to deliver effective treatment and recover services for persons with Co-Occurring Disorders using best practices with limited resources.
- Combined Behavioral Health Planning Council – DMH supports this process and has sought technical assistance through grant opportunities but was unsuccessful. DMH realizes the importance of such a Council but is mindful in achieving this outcome in the most effective process possible.

- Implementation of Recovery Oriented Systems of Care – DMH supports moving our system to a Recovery Oriented System of Care. However, with the limitations on funds, technical assistance is needed to determine appropriate practices and funding streams.
- Expansion of Evidence-Based and promising practices – Initiate new and expand existing evidence-based and promising practices, especially with children and adolescents. Implementing these to the fidelity of the models demands staff training and data collection processes that are expensive and time consuming to establish with limited resources and funds.
- Trauma Informed Care – Initiate a Trauma Informed Care process as it pertains to all levels of care (state hospitals, residential care, and community based care) with limited resources and funds.
- Implementation of new Set-Asides – If the two new Set-asides become Required, technical assistance will be needed to assist with determining how to do so and determine what areas currently funded would be terminated.

Technical assistance for mental health providers would include:

- Medicaid Reform – how providers position themselves to provide necessary care in a managed care environment.
- Transformation of Mental Health Block Grant dollars – DMH has operated in a climate of reductions of state dollars (\$40 million) and block grant dollars. As SAMHSA moves away from the Block Grants being utilized from the inception, technical assistance will be needed on how to achieve this without losing vital services within the continuum of care, especially for children and adolescents. The challenge Alabama faces is having secured funding streams that can be utilized to maintain the foundation built that are vital to continued community-based care.
- Co-Occurring Disorders – Increase the BH workforce capacity to deliver effective treatment and recovery services for persons with Co-Occurring Disorders using best practices with limited resources.
- Implementation of Recovery Oriented Systems of Care – Providers have varied levels of such implementation. Technical assistance is needed to determine appropriate continuum of care, funding streams, and how to increase capacity of the system to use Peer Support.
- Expansion of Evidence-Based and promising practices – Initiate new and expand existing evidence-based and promising practices, especially with children and adolescents. Implementing these to the fidelity of the models demands staff training and data collection processes that are expensive and time consuming to establish with limited resources and funds.

- Trauma Informed Care – Initiate a Trauma Informed Care process as it pertains to all levels of care (state hospitals, residential care, and community based care) with limited resources and funds.
- Implementation of new Set-Asides – If the two new Set-asides become Required, technical assistance will be needed to assist with determining how to do so and determine what areas currently funded would be terminated.

Section IV: Narrative Plan V. Support of State Partners

- The success of a state's MHBG and SABG will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. States should identify these partners in the space below and describe how the partners will support them in implementing the priorities identified in the planning process. In addition, the state should provide a letter of support indicating agreement with the description of their role and collaboration with the SSA and/or SMHA, including the state education authority(ies), the State Medicaid Agency, entity(ies) responsible for health insurance and health information marketplaces (if applicable), adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency. SAMHSA will provide technical assistance and support for SMHAs and SSAs in their efforts to obtain this collaboration. These letters should provide specific activities that the partner will undertake to assist the SMHA or SSA with implanting its plan.⁴⁵ This could include, but is not limited to:
 - The State Medicaid Agency 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 the expanded Medicaid population.
 - The state justice system authorities that will work with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with mental and substance use disorders 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 target risk and protective actors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and substance use disorders, 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. Specific service issues, such as the appropriate use of psychotropic medication, can also be addressed for children and youth involved in child welfare.

- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities.

45 SAMHSA will inform the federal agencies that are responsible for other health, social services, and education

DMH 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, and Department of Human Resources, to provide a comprehensive array of publicly funded services to adults and children/adolescents through memoranda of understanding, intergovernmental service agreements or informal relationships. As in the case of most states, Alabama has experienced fiscal challenges. Strained resources and the loss of a number of veteran state staff through accelerated retirement and downsizing has increased the workload on existing staff. Moreover, with the election of a new Governor, changes in leadership in most departments of state government occurred. For DMH, the Commissioner and his executive staff have changed twice under Governor Bentley. As such, although DMH has a good 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 challenging at this time. DMH will work toward the transformation process by realigning and restructuring the process with longstanding partners and enhancing and developing the process with potentially new and less involved partners.

DMH 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 a large number of 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 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. DMH has had a long-standing working relationship with the Alabama Medicaid Agency and is already fully engaged with the Medicaid Agency on planning for health care reform.

Below are areas of focus involving the Alabama Medicaid Agency:

Health Insurance Exchange:

Despite previously supporting Alabama's implementation of a state-based health insurance exchange, Governor Robert Bentley announced on November 13, 2012, the state will default to a federally-facilitated exchange. Prior to the decision, Governor Bentley issued Executive Order 17 which created the Alabama Health Insurance Exchange Study Commission to recommend how Alabama should establish a health insurance exchange. The Governor appointed an Executive Director of the Alabama Health Insurance Exchange to work with stakeholders and other state agencies on implementing the recommendations of the Commission. After meeting for three months, the 15-member Health Insurance Exchange Study Commission released final recommendations in late November 2011 to the Governor and Legislature endorsing the establishment of the "Alabama Health Insurance Marketplace." Additional recommendations included, establishing a new quasi-public authority to operate the exchange, following a free market facilitator model, establishing one administrative entity to oversee both the individual and small business exchanges while keeping the risk-pools for both separate, and funding the exchange through fees on all products sold in the individual and small group markets inside and outside the exchange. In May 2012, the Governor threatened to veto a bill establishing a state exchange, which passed in the House, if it cleared the Senate before the Supreme Court ruled on the constitutionality of the Affordable Care Act (ACA). The bill failed at the close of the 2012 legislative session, as did a similar bill in 2011. The ACA requires that all non-grandfathered individual and small-group plans sold in a state, including those offered through the Exchange, cover certain defined health benefits. Since Alabama has not put forward a recommendation, the state's benchmark Essential Health Benefits (EHB) plan will default to the largest small-group plan in the state, Blue Cross Blue Shield of Alabama 320 Plan PPO.

Electronic Health Record:

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. The site has been established as a central point for citizens to learn about and become involved in the state's efforts to use new technology to reduce duplication, increase efficiency, improve patient health outcomes, prevent fraud and abuse, and lower health care costs. Alabama recognizes the benefits that can be achieved through a secure, interoperable exchange of electronic health information that ensures the right information will be available to the right provider at the right time which will improve the quality, safety and efficiency of health care delivered to Alabama patients. The website provides details on the state's plans for a statewide health information exchange, including the work done by the Alabama Health Information Exchange Commission and its six workgroups, links to a separate but related effort to encourage physicians and hospitals to adopt, implement or upgrade to certified information technology systems, and links to the state's federally-supported Regional Extension Center at the University of South Alabama.

Medicaid Expansion:

Governor Robert Bentley announced in November of 2012 that Alabama would not participate in Medicaid expansion because of funding and thus far this decision has not changed. Governor Bentley doesn't believe the Affordable Care Act is a "workable solution," and reaffirmed his stand against accepting a federal offer to expand Medicaid in the state. Alabama is one of about 15 states so far that is not accepting the federal waiver for Medicaid expansion. Governor Bentley has indicated that he doesn't want to expand a broken system. He is optimistic that Medicaid reform, which he signed into law in June 2013, will go a long way toward the fixes needed in Alabama. The reform employs a managed care overlay to the system, in hopes of greatly reducing costly medical encounters by Medicaid users.

Medicaid Reform:

Medicaid reform legislation that would ultimately restructure the state's health care delivery system for low-income citizens (SB340) won approval in the Alabama Senate on April 25, 2013 and in the House on May 7, 2013. Governor Bentley held a ceremonial bill signing June 6, 2013 for Senate Bill 340, a measure that will help increase efficiency in Alabama Medicaid while also helping improve patient care. The approved bill is based largely on the earlier recommendations of the Alabama Medicaid Advisory Commission which was appointed by Governor Bentley to improve Medicaid's financial stability while also providing high-quality patient care. The Commission recommended in January 2013 that Alabama be divided into regions, and that a community-led network (RCO) coordinate the health care of Medicaid patients in each region, with networks ultimately bearing the risks of contracting with Alabama to provide that care. The Commissioner of DMH was one of the Commission members. The State Health Officer chaired the Medicaid Advisory Commission and is leading the Medicaid transformation effort.

Regional Care Organizations:

Legislation passed by the 2013 Alabama Legislature calls for the state to be divided into regions and that a community-led network coordinate the health care of Medicaid patients in each region, with networks ultimately bearing the risks of contracting with the state of Alabama to provide that care. The Alabama Medicaid Agency would have to draw regions by October 1, 2013, and regional care organizations would have to be ready to sign contracts no later than October 1, 2016. In order to implement RCOs in Alabama, the federal government must approve an exception, or waiver, to the existing program. This will be done in the form of an 1115 Waiver. This process started with the completion of an 1115 Waiver Concept Paper that had to be submitted to CMS for approval prior to completing the 1115 Medicaid State Plan Amendment (SPA). The concept paper was submitted to CMS on May 17, 2013. DMH participated with the Medicaid Workgroup and consultants on the language in the concept paper that was incorporated CMS for approval prior to completing the 1115 Medicaid State Plan Amendment (SPA). The Alabama Medicaid Agency has participated with two CMS conference calls to discuss the concept paper and another call has been scheduled. The Medicaid Agency has developed a link on their website www.medicaid.alabama.gov , Regional Care Organizations that is posting Important Notices regarding Collaboration.

DMH is working directly with members of the Alabama Medicaid Agency, Alabama Hospital Association, the State Health Officer, and the different consultants in regard to the multi-faceted areas of the Medicaid Reform process as to ensure that the mental health and substance abuse consumers we serve are being included for their unique and specialty needs for services and care.

DMH continues to share our willingness to partner and collaborate with the Medicaid Reform as to provide the expertise and guidance as it pertains to the consumers with severe mental illness, serious emotional disturbances, and substance abuse issues that we serve.

After participating with the Governor's Medicaid Commission, it became evident that Medicaid Reform for the mental health and substance abuse population that DMH serves and is very complex and involved multiple layers of attention. So, DMH worked with NASMHPD and SAMHSA to secure a consultant to assist DMH with this process, including information on: benefits of commercial managed care vs. non-commercial managed care; carve in vs. carve out vs. opt out; how patient care networks directly impact this process; developing RCOs and ASOs; 1115 waiver language for behavioral health. The goal was to provide the DMH with information/guidance that will help to ensure that the needs of mental health consumers and providers are addressed under the state's evolving Medicaid system. Leslie Schwalbe, who has experience in working with states on Medicaid Reform as it pertains to the behavioral health needs of our population, was provided as the consultant.

DMH also determined that having the voices of our consumers, family members, providers, and other stakeholders (to include Medicaid) was vital to provide instrumental feedback and guidance in these areas of Medicaid Reform. Through the DMH Associate Commissioners two coordinating sub-committees (Mental Illness and Substance Abuse) the DMH Medicaid Integrated Care Workgroup was formulated. This workgroup has conducted several meetings to initiate the workgroup process and discuss planning ideas and objectives. It was determined that for this workgroup to be most effective, it would be beneficial to set up a meeting with Dr. Williamson and/or Medicaid staff to provide assistance and guidance for this workgroup to be functional. Leslie Schwable facilitated the meeting and Dr. Moon, Medical Director for Alabama Medicaid Agency, presented. The workgroup will continue its efforts to assist DMH with guidance and recommendations and the Medicaid Reform process unfolds.

2703 Health Home (PCN) State Plan Amendment (SPA):

Medicaid partnered with the state agencies involved with Optional Medicaid services (Rehab, TCM, Waiver) to complete a 2703 Health Home 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 was remained under review with CMS until May 2013 when finally approved. ADMH

has made contact with Medicaid to set up meetings to determine next steps in the implementation of the 2703 SPA as it pertains to mental health and substance abuse care.

Money Follows the Person (MFP) Initiative:

Medicaid was awarded a MFP Rebalancing Demonstration Grant for which two populations have been targeted: Target 1: will be individuals residing in Nursing Facilities, regardless of age or type of disability. Target 2: will be individuals residing in State Operated Psychiatric Hospitals who are currently receiving Medicaid or who are Medicaid eligible. Approximately 400 to 600 individuals are expected to benefit for this initiative. The majority of these individuals (approx. 113) reside at the Harper Geriatric Psychiatry Center. For the purposes of addressing the needs of individuals with mental illness and ID/DD who transition for nursing facilities, the State is pursuing the development of an ACTII waiver which will offer support and home based services not available in other service models. Feedback has been provided from CMS and they have decided to not allow us to address two populations with the one ACT II waiver and referenced a proposed rule written in 2010 to allow for multiple populations, but it was never finalized. The Medicaid Agency will work with DMH to determine the best avenue to address SMI as written into MFP.

Medicaid Emergency Psychiatric Demonstration: DMH partnered with Medicaid and the Alabama Hospital Association in the Medicaid application for a CMS demonstration grant around the allowance of Medicaid payment for psychiatric care in a free standing psychiatric private hospital unit (IMD). DMH is providing the state match dollars for this demonstration. There are four inpatient psychiatric hospitals participating in the demonstration; EastPointe and BayPointe who began in July 2012 and Hillcrest and MountainView who began in October 2012. This is a three year demonstration with a data component. The first year involved getting approval of protocols and operational plans, initiating the data process, and trainings on transitional process. Year two has just been approved.

Medicaid State Plan Amendments:

- Medicaid Rehab Option: DMH has worked with the Alabama Medicaid Agency for the last 2-3 years on making updates to the Rehab Option. This was temporarily delayed due to the Alabama Medicaid Agency needing to address some administrative claims process with CMS and needing to address the 4.19b financial process with all the state agencies involved with the Rehab Option process. DMH has submitted language for consideration of adding Peer Support Services, Youth Peer Support Services, and Family Peer Services. Other areas being explored by DMH to the SPA include child and adolescent EBP's and substance use/abuse areas of enhancements
- Targeted Case Management (TCM): DMH has worked with the Alabama Medicaid Agency for the last 2 years on making modifications to TCM Target 1 (SMI Adults) and Target 3 (SED Kids). DMH also provided proposed language to add a new target – Target 9 for Substance Abuse Adults and Kids.

Medicaid had already submitted a State Plan Update to CMS in September 2011 and had to resolve the requirements of CMS on this submission before they could make an additional request on DMH proposals. The changes that CMS needed surrounded the 4.19b financial process and this would have to be addressed with all the state agencies involved with TCM.

- 1915i: Around two years ago, DMH consulted with Medicaid around the option to complete a 1915b state plan amendment that would assist with the most complex SMI consumers we serve that linger within the state hospital system and/or have extended stays in residential care within the community. The target populations seem to be the SMI consumers that are medically fragile and behaviorally challenged. DMH formulated a workgroup to address and proceeded to the point of needing to work directly with Medicaid when the Medicaid Reform work put this on hold as to determine its role in the new Medicaid Reform process.
- Medicaid Non-Emergency Transportation: In June 2012, Medicaid decided to issue an RFP for transitioning the Non-Emergency Transportation Program from the current administrative model to a broker model. Under the broker model, Medicaid would contract with a broker to arrange a pay for NET services. Under the Medicaid arrangement with DMH, DMH pays state share (50%). The RFP process occurred in June 2012 and vendors were asked to submit proposals with two prices, one including DMH services and one excluding DMH services. Upon receiving the proposals, Medicaid made the determination to carve out the DMH mental health services and allow for the DMH providers to continue the process in place. Medicaid submitted the State Plan Amendment in January/February 2013. CMS has questions that have to be resolved which Medicaid is working on. Once approved, DMH will work with Medicaid on implementation.

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. DMH 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. DMH 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:**

Alabama was the first state to receive approval of their plan to implement the CHIP program under the new federal legislation. This plan has been implemented in phases: (1) Medicaid Expansion of the SOBRA coverage for youth ages 14-19, effective February 1, 1998, (2) Benchmark Health Insurance for children, ages 0-19, in families between 100% and 200% of poverty, effective September 1, 1998, and (3) a self insured “special needs” package of services. The third phase was implemented by a coalition of agencies – Public Health, Mental Health, Children’s Rehabilitation Services, and BC/BS. The mental health component of the Children’s Health Insurance Program, referred to as ALL Kids, was expanded in December 2002 and now mirrors the services available through the Rehab Option for those eligible for Medicaid. CHIP was reauthorized in April 2009. Through the provisions included in the Children's Health Insurance Reauthorization Act (CHIPRA), ALL Kids expanded eligibility to include children in families with income up to 300% Federal Poverty Level. Previous income eligibility was up to 200% Federal Poverty Level. This was effective Oct. 1, 2009.

As of July 31, 2011, total enrollment in ALL Kids reached 81,643, which was a result of five continuous months of record enrollment. A contributing factor to increased enrollment in ALL Kids was the implementation of a new policy allowing eligible dependent children of public agency employees to be enrolled. This new policy was approved by the Centers for Medicare and Medicaid Services (CMS) and became effective January 1, 2011. As of July 31, 2011, over 5,400 children were enrolled in ALL Kids through this new eligibility provision.

ALL Kids also received approval from CMS in June 2011 to implement temporary policy adjustments to address enrollment needs in the event of a natural disaster; such as the widespread destruction caused by tornadoes in Alabama during April 2011. This approval provides a mechanism for ALL Kids to receive expedited approval from CMS and to respond quickly to needs dictated by any future natural disaster event.

Blue Cross and Blue Shield of Alabama continued to work 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.

The ALL Kids Behavioral Health Advisory Committee, of which ADMH is a member, continues to meet on a quarterly basis. ALL Kids continues collaborative efforts with Medicaid on the Robert Wood Johnson Foundation (RWJF) Maximizing Enrollment for State Health Coverage grant which is a four year grant for which we are currently in year three. This grant addresses maximizing enrollment and retention of children in Medicaid and CHIP in our state through various avenues including 1) conducting outreach activities, 2) implementing policy and procedural changes, and 3) enhancing enrollment and eligibility systems within and between both programs. The scope of the grant has expanded to address coverage for all persons to be consistent with provisions of the Affordable Care Act (ACA).

ALL Kids continues to enroll children based on eligibility criteria up to 300% of the Federal Poverty Level. As of July 31, 2013, current total enrollment in ALL Kids was 85,316. ALL Kids recently completed the procurement process for fiscal intermediary services (required every three years) and awarded the contract to Blue Cross and Blue Shield of Alabama, effective October 1, 2013.

ALL Kids staff are also participating in various projects and committees to prepare the state to meet changes required by the Affordable Care Act (ACA). A major project associated with the ACA is the development of a new eligibility and enrollment system for Alabama Medicaid and ALL Kids. Implementation of the new system is slated for October 1, 2013. Also, as part of the ACA, effective January 1, 2014, otherwise eligible children ages 6 to 19, between 100-133 percent of the Federal Poverty Level (FPL), will be eligible for Medicaid, but covered by Title XXI funds (CHIP funds). Planning is underway to transition children currently enrolled in ALL Kids to Medicaid on January 1, 2014 for those who meet this provision of the ACA. ADMH is a part of that transition planning process to ensure children receive needed behavioral health services without interruption.

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 more than 120

community-based health care centers providing almost one million primary care visits to over 300,000 individuals across Alabama. Alabama's community health centers had an overall economic impact of \$150 million and supported 2000 jobs.

Over the last couple of years, staff of the APHCA has met with DMH staff, the Executive Directors, and Clinical Directors of the provider networks to initiate the collaborative process. The APHCA conference in 2010 had a track devoted to integration of primary and mental health care. 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.

In FY11, through a USDA grant, the University of Alabama, School of Medicine, Tuscaloosa Campus partnered with rural clinics to provide telemedicine services and distance learning. One of the sites is Capstone Rural Health Center which provides primary health care, health promotion, disease prevention and managed care to all surrounding rural areas and have partnered with a local mental health center to the benefit of 6,000 mental health consumers. In addition, the College of Community Health Sciences and the Institute for Rural Health Research at the University of Alabama was also able to access grant funds to promote the use of telemedicine and offer educational opportunities for mental health employees through distance learning on various topics and to serve as a bridge between the mental health provider and the University of Alabama Autism Spectrum Disorders clinic.

American Academy of Pediatrics – Alabama Chapter (AAP):

The AAP is the only statewide member organization of pediatricians, with 650 members across the state, representing both academic and community pediatricians 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. AAP 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 AAP. Throughout the past several years, AAP and ADMH, along with other state and community partners, have directly collaborated on several initiatives.

- Telemedicine - More than 25% of Alabama's children receiving services in the public mental health system are prescribed psychotropic medications and are in need of ongoing care and monitoring, yet there is a significant shortage of Child and Adolescent Psychiatrists. To address this shortage of appropriate psychiatric

care, the MI Child and Adolescent Task Force identified possible plans to address this issue. In 2004, a telemedicine pilot project was launched in a rural MHC catchment area where this service previously did not exist. This project was a collaborative effort by DMH, Children's Hospital, a local pediatrician, AAP, and the community mental health center and provided child and adolescent psychiatric services via the teleconferencing system set up at the local hospital. An evaluation component was added to provide necessary data to determine future goals and needs. This evaluation data led to the Alabama Medicaid Agency adding Telemedicine to the Rehab Option. Over the next several years, several C&A Telepsychiatry projects were implemented. This model was further expanded to other locations in the state for adults and children/adolescents. Funding from a Bristol-Myers-Squibb Foundation grant also supported use of telecommunication equipment in a nine county rural, poor area of the state. The equipment is being used for telemedicine, training, supervision, and connection to state hospital treatment teams. Since 2010, the Medicaid Agency, based in part on experience in the mental health system, now covers telepsychiatry under the Physician's Program in addition to the Rehabilitation Option. The use of telepsychiatry continues to expand in the state with mental health centers reporting a total of 42 sites in use for child/adolescent services as of August, 2013.

- Child and Adolescent Psychiatric Institute (CAPI) - Collaboration also occurred between ADMH, pediatricians, AAP, and community mental health psychiatrists around appropriate child and adolescent psychiatric care which led to a partnership with the Department of Public Health to allow for expansion of the Child and Adolescent Psychiatric Training Institute to include pediatricians. This partnership has occurred for the last seven Child and Adolescent Psychiatric Institutes (CAPI), allowing community mental health psychiatrists and pediatricians the opportunity to receive continuing education training around best practices information regarding the treatment of children and adolescents with severe emotional disturbances. Attendees included community mental health center psychiatrists, pediatricians, acute care psychiatrists, and DMH certified residential treatment care facility psychiatrists. The July 2010 CAPI had a primary focus of Improving Integration of Primary and Psychiatric Care. The Institute continues to provide a training forum that links physicians from the public and private sector at different levels of care as to improve clinical communication and shifts toward a more seamless system of psychiatric care for SED consumers and their families that is collaborative and integrated. Two nationally known speakers presented at this training who focused on "Medical Home" as it pertains to behavioral health care. From these training institutes, several local communities have entered into collaborative relationships and have co-located and/or

- integrated care, initiated the use or screening instruments, developed local resource guides, and explored other creative wrap services.
- A third initiative was initiated by AAP in which a planning grant was secured to address mental health needs among children/adolescents. These efforts led to a partnership with AAP who has developed a Mental Health Project, which provides a forum for addressing the shortage of appropriate psychiatric care and development of future goals and needs. At the closure of this grant, AAP chose to continue with the Mental Health Planning committee in an effort to continue collaboration and growth of blended initiatives. In January 2007, AAP partnered with DMH, Alabama Family Ties, NAMI-Alabama, and the Department of Public Health (DPH) to host an “Open Forum on Children’s Mental Health: Where do we go from here?” Presenters included the Commissioners of DMH, Medicaid, and DPH; family advocate groups, and insurance providers. The purpose of the Open Forum was to foster collaboration between state government, pediatricians and other primary care physicians, and child advocates to promote children’s mental health needs as a top-agenda item for the public, legislators, and other influential stakeholders in state government. In 2008, the Alabama Chapter-AAP received a second Healthy People 2010 grant project. This new project built on their past success by expanding into four new areas of Alabama by conducting regional roundtable dinner sessions and community service provider forums for local pediatricians so that local mental health networks could be established and community referral resources could be identified for pediatricians to access in those areas. Coordinated by a key local pediatrician, the meetings brought together pediatricians, community mental health center professionals, psychiatrists, early intervention professionals, and others serving the needs of children’s mental health. The meetings were planned by the already established Chapter Mental Health Advisory Committee in cooperation with local arms of each agency and local primary care and mental health providers. The roundtable sessions served as springboards for future collaboration at the local level. The goal of the project was to increase pediatricians’ comfort level in accessing mental health services for their patients and families in these areas.
 - In response to the devastating tornadoes that affected many locations in Alabama in April of 2011, The Alabama Chapter-American Academy of Pediatrics (AL-AAP) and the DMH partnered with DPH to secure a \$36,000 Friends of Children Fund grant from the American Academy of Pediatrics. The grant allowed the organizations to conduct a back-to-school project in fall of 2011 to support pediatricians, mental health and school professionals, and ultimately, parents and children with mental health needs in these Alabama communities. “Back to School & the 3 R’s: Recognition, Recovery and Resiliency,” provided a web-

based training on August 25, 2011 for pediatricians, family physicians and mental health professionals in Alabama on the effects of trauma and stress for children who have experienced a natural disaster. These trained professionals were equipped to take this information to parents and teachers in affected communities. They were taught how to recognize post-traumatic stress disorder symptoms in children at home or in school and what steps to take to seek appropriate treatment. The project provided \$3,000 mini-grants to community teams to conduct a back-to-school weekly educational/support group for parents/caregivers to help their children deal with emotional and/or behavioral problems. Communities applying for these mini-grants were encouraged to network with existing response efforts such as Project Rebound, an ADMH initiative that provides crisis counseling and resources. This collaboration is a good example of primary health and mental health providers working together to improve the overall health of children and families in the community.

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

DMH fosters collaborations with those in law enforcement, judiciary, and corrections at both state and local levels. DMH 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 DMH 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 DOC and DMH are inmates who are at end of sentence but for whom DOC 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 2013, the Department of Mental Health partnered with both Department of Corrections and Pardons and Paroles to develop two separate Bureau of Justice Administration grant proposals. DMH, DOC, and P&P submitted a proposal to create the Alabama Secure Sharing Utility for Recidivism Elimination (ASSURE) web-portal through which authorized personnel from DMH, ABPP and DOC will retrieve supervision information regarding clients/inmates collected by other agencies. ASSURE will also include information from the risk and needs assessments conducted by each of the partner agencies as well as supervision information where applicable. DMH also partnered with Pardons and Paroles to develop a BJA proposal that would implement a Substance Abuse and Mental health Activities supporting Recovery Team (SMART) in order to reduce individuals with mental illness from further involvement from the criminal justice system and to improve the safety of the community at large. SMART will address the lack of coordinated training and cross systems communication as it relates to individuals with mental illness or co-occurring disorders involved in the justice system.

In addition, DMH partnered with the Alabama Law Enforcement Agency to submit a BJA Justice and Mental Health Collaboration Program grant. This grant would increase the availability and quality of training for law enforcement personnel across the state who are directly involved with adult individuals with mental health or co-occurring disorders. The proposed initiative will provide education and training to approximately 1,300 law enforcement personnel, including police officers, sheriffs' deputies, and state troopers, as well as 911 dispatchers. All seven ADHS regions of the state will receive an equal amount of training opportunity. The purpose of this project is to increase the number of law enforcement and dispatcher personnel trained in a Crisis Intervention Team (CIT) model and Mental Health First Aid. An integrated training initiative will be developed that provide both regional training and a 'Train the Trainer' program for both models.

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. DMH 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 call 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, DMH was invited by the two of the four local JDAI sites (Jefferson and Montgomery) to participate on the Executive Committee.

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.

DMH and AOC have been collaborating for many years. Collaborations have included, but are not limited to, the following:

- In 2006, DMH 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 DMH. 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, like most of the bills introduced during that session, 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 DMH 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 DMH 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.

- DMH 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, DMH 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 has 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 will support 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.

Education, Rehabilitation, and Employment:

For adults, case managers and clinicians from the mental health centers work with local educational institutions and Rehabilitation Services offices to refer consumers for education and employment services. Consumers are provided basic educational services and pre-employment services in day treatment 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 the Rehabilitation Services office to refer people for regular rehabilitation services as well as supported employment. The Department acknowledges that employment is an essential element to Recovery for many consumers and therefore, hired a Consumer Employment Specialist dedicated towards the expansion of supported

employment models for all DMH target populations of which the initial focus was on those with Intellectual Disabilities. Due to the pressing need to transition from sheltered workshops towards competitive employment, the Employment Specialist was assigned to the Developmental Disabilities Division full-time. Although the Mental Health and Substance Abuse Division does not have a dedicated employee for just supported employment, the MHS Division staff enjoys a close collaborative relationship with DD benefiting from the expertise of the DMH-DD Employment Specialist. This Employment Specialist is a former career professional with the Alabama Department of Rehabilitation Services. His connections with ADRS and expertise in supported employment have well served the staff of MI Community programs. As a result, MI Community programs has forged collaboration with ADRS for piloting mental health based supported employment programs. Preliminary work in this area was provided by an Employment Development Initiative grant. Such 2011 activities supported by this grant included consumer and provider survey's as to barriers towards employment, Peer Support Specialist Train the Trainer training, a statewide stakeholder supported employment 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. DMH recently initiated the establishment of an Alabama Interagency Planning Committee for Supported Employment of which representatives from ADRS, the Alabama Department of Economic and Community Affairs (ADECA), Alabama Medicaid, Post-Secondary Education, and Workforce Development participate. This interagency

Alabama State Department of Education (ALSDE):

ALSDE is responsible for educational services for children/adolescents in Alabama, and there are over one hundred school systems in the state. For numerous years, case 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.

- In FY99, the educational system identified a portion of At-Risk funding to develop school day treatment programs in conjunction with community mental health centers. This initiative enabled 10 additional community-based child and adolescent day treatment programs to be established statewide. Further efforts for training have occurred around educational laws, with special focus on Individual with Disabilities Education Act (IDEA). All day treatment programs had to undergo necessary training, education, and adaptations. Also, case managers, Juvenile Court Liaisons, and mental health clinicians are provided in-depth training around IDEA and special education laws provided by the Alabama Disabilities Advocacy Program (ADAP).
- Through the C&A Evidence-Based Practices (EBP) Workgroup, several EBPs have been researched and recommended for consideration, to include school based EBPs. Efforts have been initiated over the last several years to secure

funding to initiate these EBPS to include budget requests and applications for grants both with ALSDE and with the University of Alabama. Also, the Department was granted a SAMHSA System of Care grant that involved three rural counties. Coping Power, a mental health/education EBP, was written into this grant as to implement this EBP in two of the three counties, as well as Positive Behavior Supports (PBS). PBS is designed to create environments of proactive approaches rather than reactive responses. Through partnership with ADMH, PBS is currently used to assist persons with intellectual disabilities in transitioning into adult life. Having an extension of PBS in the community schools would create a forte of wrap-around services that could address the needs of all students.

- Case managers and CMHC clinical staff assess their consumer's educational strengths and deficits and link consumers to training and other services necessary to enhance their educational and employment status. A variety of services are available to meet the individual educational and employment needs of adolescents transitioning into adulthood including adult education, literacy training, pre-employment services in day treatment programs, and specialized vocational and training services provided by the Department of Vocational Rehabilitation Services (VRS). For children and adolescents with a serious emotional disturbance, case managers and clinical staff have available the array of special education services provided within the educational system, as well as day-treatment programs which also contain a school component, or alternative school programs provided in other settings by mental health centers, the Department of Youth Services and some private, non-profit agencies. Case managers and clinicians work with the Rehabilitation Services office to refer people for regular rehabilitation services, as well as supported employment. Education and employment are key aspects of recovery for many consumers.
- In FY09, ADMH was invited to be a member of ALSDE's State Interagency Transition Team through the Special Education Division. The Interagency Transition Team is responsible for the development of a strategic plan that addresses issues surrounding transitional planning concerning special education students. In FY09, DMH was asked to participate as presenters in the Auburn University's Annual Transition Conference. This was a panel discussion of the service array provided by each Division within ADMH and how these potential resources could be beneficial to the transition process. In FY10, ADMH was invited to present again. A panel presentation, with representatives from ADMH, a local provider, and two youth consumers, was conducted that focused on helping young people with mental health needs face individual and institutional challenges in transition. ADMH also presented similar information at ALSDE's

- MEGA Conference (Alabama Special Education) in July 2010 on similar transition issues for youth with SED. In May 2010, ADMH presented at the Educational hosted Annual Health and Human Resources Leadership Day, presenting on mental health resources with focus on the continuum of care.
- In FY11, key administrative staff from ADMH and DOE met to discuss potential collaborative opportunities in light of health reform and budgetary issues. ADMH and DOE identified the need for a deliberate strategy aimed at improving service quality within and continuity between the two departments. The aim is to achieve greater integration of mental health services between the mental health providers and the public schools and to increase the utilization of evidence-based practices. The integration of these services fosters continuity of care and ensures sustained gains in academic and developmental domains for children, youth and their families. A School-Based Mental Health Services (SBMH) workgroup was established to facilitate this collaboration. The goal of the School-Based Mental Health Services (SBMH) collaboration between ADMH and DOE and their local entities is to ensure that children and adolescents, both general and special education, enrolled in local school systems have access to high quality mental health prevention and treatment services.
 - In FY 12 and FY 13 to date, sixteen of the 22 community mental health centers of Alabama and over thirty Local Education Authorities (LEAs) have conducted initial orientation meetings describing the SBMH collaborative process. The SBMH model improves access to appropriate mental health services by children who need them by placing a Master's level clinician in the school setting in a structured manner that ensures confidentiality while enhancing mental health service delivery. DMH and DOE 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 in FY 12 and FY 13, at Virtual Alabama's School Safety Summit in March 2013, and at the Alabama Council of Community Mental Health Boards (ACCMHB) Conference May 8, 2013. IT staff from DMH and ALSDE are currently developing processes for collection of data from both agencies to monitor efficacy in the SMBH Collaboration systems against selected outcome measures. Initial implementation of the data collection effort is targeted for the 2013-2014 School Year.
 - The ALSDE is partnering with DMH, the Alabama Office of Courts and three Local Education Authorities and their communities in the state to apply for a multi-year SAMHSA Safe Schools/Healthy Students Grant. The grant application was submitted in July, 2013 and the SS/HS awards have not yet been announced as of this writing.

- In 2013, DMH participated in an interagency workgroup of the Alabama State Department of Education (ALSDE) to promulgate proposed regulations for “State-Supported Schools.” These schools provide educational services for students who are located in facilities that provide treatment and care to children in both Special Education and General Education. Responsibility for the oversight of these programs and the student’s educational progress has historically fallen to the state and not the Local Educational Agencies (LEA). These regulations, if approved by the ALSDE Board, will vest responsibility and oversight in the Local Education Authority (LEA) where the facility is located. This was an important collaboration since DMH has certification authority for many of the treatment programs identified under “State-Supported.” Academic achievement for children with serious emotional disturbances is a significant component in their treatment and a protective factor against all risks as they transition into adulthood.

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 case management services.

- In 1988, DMH 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 serve children with serious emotional disturbances and their families who are generally involved with multiple agencies. Currently, there are forty C&A In-Home Intervention teams across the state. At present, every community mental health center catchment area has a least one designated children's case manager. Children and adolescents may also receive case management from qualified CMHC staff who has been cross-trained in the delivery of case management to both adults and youth.
- Since this first cooperative funding venture with DHR in 1988, the two agencies (DMH and DHR) have jointly funded the Brewer Porch Short Term Treatment and Evaluation Program (STTEP) and Glenwood’s Daniel House. STTEP is designed to provide evaluation and short-term treatment for children who had previously been hospitalized or were at risk of hospitalization. Glenwood Daniel House provides 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, DMH 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 II are residential treatment programs that continue to

serve the most severe SED youth and their families, ranging from age six to fourteen. The contract changes also 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 are 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 FY06, DMH entered into contract with DHR around several training opportunities to occur in FY07/FY08. The first of these collaborations was a two-day state wide conference. The “Safe and Sound II: Fostering Resiliency after the Storm” conference was held in January 2007 and provided training to professionals who interact with children and families that potentially face long-term mental health issues (trauma, PTSD, resiliency) due to traumatic events, including the hurricanes of 2005. Several nationally known speakers, to include Dr. Bruce Perry, Conni Wells, Dr. Robin Gurwitch, Dr. Russell Jones, and April Naturale, presented at this conference.
- In 2007, ADMH had a contractual collaboration with DHR to provide specialized Trauma Training that was contracted with the University of Alabama. This was specifically offered to clinicians who work for community mental health centers, providing direct clinical care to children and adolescents. The four part training sessions began in January 2007 and were completed in September 2007. It was discovered that the 60 hour course work required to be eligible for certification had been changed to 72 hours. DMH and DHR worked to develop an additional 12 hour training opportunity and DHR was able to identify funds to incorporate an additional training session which occurred in April 2008. The title of the course was *Neurosequential Model of Therapeutics* presented by Dr. Richard Gaskill, who is with The Child Trauma Academy. Once completed, the 72-hour Trauma Training provided the mental health professionals the necessary coursework to apply for national certification as a trauma counselor specialist.
- DMH had a contractual collaboration with DHR involving a partnership with a special project of the former First Lady of Alabama; Mrs. Patsy Riley, with the Parenting Assistance Line (PAL). PAL is a collaborative service of the University of Alabama Child Development Resources and the Alabama Children's Trust Fund. When callers call the toll-free number, a parenting resource specialist will answer the phone, listen to the caller, and then offer helpful information and support. Callers can also request free literature about their specific parenting concerns. Due to the high volume of calls involving PTSD linked to the

Hurricanes of 2005, DMH became a partner with this project providing funds for a state-wide media campaign through billboards, radio, and television to raise awareness of traumatic issues, especially Post Traumatic Stress Disorder. This media campaign started in May 2007. PAL remains operational. However, DMH no longer participates with funding due to lack of monies.

State Multiple Needs Childs Office:

A Joint Task Force of DHR and DMH 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 child care 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 multilineeds 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 \$544,000 each year; with ADMH providing \$1 million total to cover MI/SA/ID youth through the multiple needs process.

OUR Kids

The OUR Kids Initiative which began in 2002 is a collaboration between the departments of Youth Services, Mental Health and Mental Retardation and Human Resources 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 comprising the initiative pool funds together (most of it Children First Dollars) and issue 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 in-home and psychiatric services for children with mental health and DHR involvement; Intensive In-home services for children with lower cognitive functioning.

Today the OUR Kids Initiative supports 11 different programs across the state with a budget of 960,000 dollars. Since 2002, the initiative has averaged serving over 1300 youth per year, for a total of over 12,000 children and adolescents in their communities. These programs have become a valuable resource for County Multiple Needs Teams and other state and local agencies.

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 'O' {Tables 11 and 12} 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.

Section IV: Narrative Plan W. State Behavioral Health Advisory Council

- Each state is required to establish and maintain a state Behavioral Health Advisory Council (Council) for services for individuals with a mental disorder. While many states have established a similar Council for individuals with a substance use disorders, that is not required. SAMHSA encourages states to expand their required Council's comprehensive approach by designing and use the same Council to review issues and services for persons with, or at risk of, substance abuse and substance use disorders. In addition to the duties specified under the MHBG statute, a primary duty of this newly formed Council will be to advise, consult with, and make recommendations to SMHAs and

SSAs regarding their activities. The Council must participate in the development of the MHBG state plan and is encouraged to participate in monitoring, reviewing, and evaluating the adequacy of services for individuals with substance abuse and mental disorders within the state. SAMHSA's expectation is that the State will provide adequate guidance to the Council to perform their review consistent with the expertise of the members on the Council. States are strongly encouraged to include American Indians and/or Alaska Natives in the Council; however, their inclusion does not suffice as tribal consultation. In the space below describe how the state's Council was actively involved in the plan. Provide supporting documentation regarding this involvement (e.g., meeting minutes, letters of support, etc.)

Additionally, please complete the following forms regarding the membership of your state's Council. The first form is a list of the Council members for the state and second form is a description of each member of the Council.

There are strict state Council membership guidelines. States must demonstrate (1) that the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council and (2) that no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services. States must consider the following questions:

- What planning mechanism does the state use to plan and implement substance abuse services?
- How do these efforts coordinate with the SMHA and its advisory body for substance abuse prevention and treatment services?
- Was the Council actively involved in developing the State BG Plan? If so, please describe how it was involved.
- Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into the work of the Council?
- Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
- Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders.

The MI Planning Council has a strong, positive relationship with the Alabama DMH. DMH does not currently have an integrated MI and SA (behavioral health) Planning Council. DMH Substance Abuse representatives responsible for the SA Block Grant have actively engaged appropriate SA providers and consumer/family representatives to assist in the development of the SABG.

DMH responded to a BRSS TACS grant to assist with moving toward a single Behavioral Health Planning Council but was not awarded. Also, DMH representatives and MI Planning Council President has attended SAMHSA Block Grant TA Conferences to determine the most beneficial avenues to achieve an integrated Behavioral Health

Planning Council process and was impacted by the information that most states that have effectively achieved such an effective process has done so over a multiple year process.

The Council strives to ensure that its membership is diverse with its membership. The Council relies on the statewide advocacy organizations (WINGS, NAMI, AFT) and Office of Consumer Relations to nominate the consumer and family representatives on the Council. The Council has 50 members. Thirty two of the members are either consumers or family members. Of the thirty two members, twelve are consumer representatives, with two of these representatives being in individuals with lived youth experience of SED. In regard to family representatives, there are three parents of children with SED. Within the state employee representatives, there are both adult and youth representatives, as well as the Director of Deaf Services (who is deaf) and the Director of Consumer Relations (an individual with lived experience). The Associate Commissioner and Commissioner are also members of the Council. The other members of the Council are providers of mental health services (public and private) and a single representative from each of the following state agencies: education, child welfare, housing, corrections, youth services, vocational rehabilitation, Medicaid, S-Chip (ALL Kids), as well as two university representatives. There are also legislative representatives, a judge, and a member from the Alabama Hospital Association. Currently, the Council membership includes representation of African American members, older adults, consumer and family members of SMI and SED, and members from rural and urban areas.

Appointments to the MI Planning Council are made in several ways (depending on the membership requirements). For consumers, family members, service providers, and legislative representatives, nominations are received and the PI Planning Council's workgroup makes recommendations that are brought back to the full Council for approval. The Council submits a letter of recommendations to the Associate Commissioner who determines if the nominee will be appointed. Each Council member serves a term of two years. Any current member can be re-nominated. Council member terms are reviewed during the November/December meetings. During this time, members with expiring term will be identified and member recommendations are made. Re-appointments and new appointments will be based on participation, mandated representation, and willingness of Council members to serve on the Council. The Council meets at a minimum on a quarterly basis.

The MI Planning Council is very active and participates with other advocacy entities in the expansion of consumer and family voice with the ever changing health climate and Medicaid Reform occurring in Alabama. The planning council participates throughout the year will all phases of Block Grant work to include the review and recommendations for the Block Grant application, the details involved with the goals, priorities, strategies, and performance indicators. They have met several times to review and provide recommendations that led to the creation of the FY14-15 Block Grant application. Each year, they complete mid-year goal review and discuss the data and performance indicators. The MI Planning Council truly guides and steers the planning process. Its members are also vital representatives on the other committees/task forces/councils within DMH as to maintain a coordinated effort.

The Council develops a letter annually to accompany the MHBG application (see attachment). The letter identifies the activities and accomplishments of the council during the year, as well as challenges and issues that face Alabama's public mental health systems.

2013
ALABAMA MENTAL ILLNESS PLANNING COUNCIL

Family Members – Children and Adolescents				
			Current term	Proposed
1.	AL Family Ties	Jacquelyn Scales	12/11	12/14
2.	AL Family Ties	Gloria Hampton	12/11	12/14
3.	AL Family Ties- Alabama Youth Move	Ronnitta Ealey	12/12	12/15
4.	AL Family Ties - President	Lisa King	Designated	Designated
Family Members – Adults				
1.	Family Member	Christi Collins	12/31/11	12/14
2.	Family Member	Zina May	12/31/11	12/14
3.	Family Member	Greg Carlson	12/31/10	12/13
4.	Family Member	Jack Crosswell	12/31/10	12/13
5.	Family Member	Mary Ann Hatcher	12/31/11	12/14
6.	Family Member	Mary Elizabeth Perry	12/31/10	12/13
7.	NAMI Ex. Director	Wanda Laird	Designated	Designated
8.	NAMI President	Sue Guffey	Designated	Designated
Consumers				
1.	Wings Ex. Director	Darlene Berry	Designated	Designated
2.	Wings President	Sister Lucindia Claghorn	Designated	Designated
3.	Primary Consumer	Steve Puckett	12/31/11	12/14
4.	Primary Consumer	Mike Herring	12/31/10	12/13
5.	Primary Consumer	Jon Brock	12/31/11	12/14
6.	Primary Consumer	Sylvia Richey	12/31/10	12/13
7.	Primary Consumer	Sheila Scott	12/31/11	12/14
8.	Primary Consumer	Jerome Dorsey	12/31/11	12/14
9.	Primary Consumer	Bob Brown	12/31/11	12/14
10.	Dir. Consumer Relations	Mike Autrey	Designated	Designated
11.	AL Minority Consumer Council	Fannie Hicks	Designated	Designated
12.	Adolescent Consumer	Ericka Hall	12/31/10	12/13
State Employees/University Representatives				
1.	Commissioner	James Reddoch	Designated	Designated
2.	Associate Commissioner	Dr. Beverly Bell-Shambley	Designated	Designated
3.	Dept of Educ. Spec. Ed	Martha Holloway	Designated	Designated
4.	Dir. of Comm. Services	Kim Hammack	Designated	Designated
5.	House Fin. Authority	Gary Donegan	Designated	Designated
6.	Human Resources	Elizabeth King	Designated	Designated

7.	Public Health	Cathy Caldwell	Designated	Designated
8.	Rehabilitation Services	James Myrick	Designated	Designated
9.	Youth Services/Correctional Agency	Alesia Allen	Designated	Designated
10.	University Affiliated	Mary Grace Umlauf	12/31/10	12/13
11.	Medicaid Agency	Karen Watkins-Smith	Designated	Designated
12.	University Affiliated	James Thompson, Ph.D..	12/31/11	12/14
13.	State Coordinator of Deaf Svs.	Steve Hamerdinger	Designated	Designated
14.	Department of Corrections	Ron Cavanaugh	Designated	Designated
Providers				
1.	Council of Community of MH Boards representative	Richard Craig, Ph.D.	12/11	12/14
2.	Council Executive Director	James Dill, Ed.D.	Designated	Designated
3.	Private Provider	Emmett Poundstone	12/31/10	12/13
4.	Private Provider	Steve McCabe	12/31/11	12/31/14
Others				
1.	AL House	Pebblin Warren	12/31/2010	12/13
2.	AL House	Paul Beckman	12/31/2010	12/13
3.	AL Senate	Vivian Figures	12/31/2010	12/13
4.	AL Senate	Tom Whatley	12/31/2010	12/13
5.	Law Enforcement	Judge Tracey McCooey	12/31/08	12/31/11
6.	MHA Exec. Dir.	Brittany Wiggins	Designated	Designated
7.	MHA President	Will O'Rear	Designated	Designated
8.	Probate Judge	Judge Charles Martin	12/31/08	12/31/11

Section IV: Narrative Plan W(B). Behavioral Health Advisory Council Composition by Type of Member

IV: Narrative Plan		
Behavioral Health Advisory Council Composition by Type of Member		
Type of Membership	Number	Percentage
Total Membership	50	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	10	
Individuals in Recovery* (to include youth/young adults with SED who are receiving, or have received, mental health services)	02	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	11	
Parents of children with SED*	03	
Vacancies (Individuals and Family Members)	0	
Others (Not State employees or providers)	06	
Total Individuals in Recovery, Family Members & Others	32	64.00%
State Employees	14	
Providers	04	
Federally Recognized Tribe Representatives	0	
Vacancies	0	
Total State Employees & Providers	18	36.00%
Individuals/Family Member from Diverse Racial, Ethnic, and LGBTQ Populations	06	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	00	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	06	
Persons in recover from or providing treatment for or advocating for substance abuse services	00	

*** States are encouraged to select these representatives from state Family/Consumer organizations.**

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council may any recommendations to modify the application?

The MI Planning Council is extremely active with DMH in many avenues to include the MH Block Grant. The planning council participates throughout the year will all phases of Block Grant work to include the review and recommendations for the Block Grant application, the details involved with the goals, priorities, strategies, and performance indicators. They have met several times to review and provide recommendations that lead to the creation of the Block Grant application. Each year, they complete mid-year goal review and discuss the data and performance indicators. The MI Planning Council truly guides and steers the planning process.

Section IV: Narrative Plan X. Enrollment and Provider Business Practices, Including Billing Systems

- Each state is asked to set-aside three percent each of their SABG and MHBG allocations to support mental and substance use service providers in improving their capacity to bill public and private insurance and to support enrollment into health insurance for eligible individuals served in the public mental and substance use disorder service system. The state should indicate how it intends to utilize the three percent to impact enrollment and business practices taking into account the identified needs, including:
 - • Outreach and enrollment support for individuals in need of behavioral health services.
 - • Business plan redesign responsive to the changing market under the Affordable Care Act and MHPAEA.
 - • Development, redesign and/or implementation of practice management and accounts receivable systems that address billing, collection, risk management and compliance.
 - • Third-party contract negotiation.
 - • Coordination of benefits among multiple funding sources.
 - • Adoption of health information technology that meets meaningful use standards.

It is my understanding at that this time, the request to set-aside three percent of the MHBG allocations to support mental and substance use service providers in improving their capacity to bill public and private insurance and to support enrollment into the health insurance for eligible individuals served in the public mental and substance use disorder service system is a Recommendation and not a Requirement. Therefore, for the Mental Health Block Grant, we are not planning to implement this new set-aside unless it becomes a Requirement.

It is important to note that DMH has been working closely with our mental health providers over the recent years in their efforts to prepare for ACA and implement EHRs. The provider network has been diligently preparing for these changes as it pertains to incorporating systems that would improve their capacity to bill public and private insurance and to support enrollment into health insurance for eligible individuals. Currently, DMH does ensure that providers are aware of technology resources through the distribution of e-mails and other invitations the state agency receives and passes along. There is currently varying degrees of where our providers are in the process, with many working collaboratively to integrate the same systems, as well as securing grants and other funding to purchase necessary elements, equipment, etc. DMH and our providers have also worked directly with representatives of Medicaid and other state entities around the necessary components.

Section IV: Narrative Plan Y. Comment on the State BG Plan

- Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. 300x-51) requires that, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the State BG 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 Secretary of HHS.

The SAMHSA MHBG application public access User ID and Citizen Password have been made available as a link on the Department's website (<http://mh.alabama.gov/>). Pertinent stakeholders, including State partner agencies, members of the Mental Illness Planning Council, members of the Mental Illness Coordinating Sub-Committee, members of the Substance Abuse Coordinating Sub-Committee, members of the Mental Illness Child and Adolescent Task Force, members of the Alabama Council of Community Mental Health Boards, and peer and family run organizations were notified via email, and during in-person meetings, of the availability and were encouraged to review its contents and submit comments as necessary. Each group has been encouraged to circulate the information to others who may have interest in making public comment, as well. Citizens will be able to make comments during the application process as well as post-submission.