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Alabama Mental Health Systems Report: A Guide for Advocates and Planners

Introduction: Alabama, like many states, faces significant mental health challenges. From rural communities lacking providers to rising demands on crisis services, it's clear that improving mental health care is a priority. The *Alabama Mental Health Systems Report* was created to shine a light on these issues. It offers a comprehensive overview of the state's mental health system, breaking it down into key components so stakeholders can understand where we stand. This short white paper introduces the report's purpose and structure and explains how you can use it to advocate for change and plan better services.

Purpose and Structure of the Report

The Alabama Mental Health Systems Report is designed as a **tool for insight and action**. Its purpose is to **assess the mental health system across eight critical domains**, providing a big-picture view of how well Alabama is serving people with mental health needs. By structuring the information into these eight domains, the report makes a complex system easier to grasp. Each domain covers a fundamental aspect of mental health care (from policy to on-the-ground services), allowing readers to pinpoint strengths and weaknesses in each area.

What are these eight domains? They represent the key components of a robust mental health system – the building blocks that must work together for the system to function effectively. The report is organized into sections by domain, with each section explaining why that component matters, presenting data or findings on Alabama's status, and highlighting notable **gaps or strengths**. In this way, the report's structure guides the reader through all the essential parts of the system.

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The Eight Key Domains of Alabama's Mental Health System

While the report provides detailed definitions, in brief the eight domains cover:

1. **Policy & Governance** – The laws, policies, and leadership that shape Alabama's mental health system. This domain looks at strategic plans, state funding commitments, and coordination among agencies.
2. **Financing & Funding** – How mental health services are paid for, including state budget allocations, insurance coverage, Medicaid, and grant funding. Adequate financing is vital for expanding services and sustaining programs.
3. **Workforce & Providers** – The availability and distribution of mental health professionals (such as counselors, social workers, psychologists, and psychiatrists). Alabama has chronic shortages in this area – over 2.9 million Alabamians live in communities without enough mental health providers[nami.org], and the state's behavioral health workforce shortage is roughly twice the national average[alabamareflector.com].
4. **Access & Service Delivery** – The accessibility of care and the continuum of services. This domain assesses whether people can get help when and where they need it – from outpatient therapy and medication management to inpatient treatment. (Notably, Alabama has historically struggled with access; in 2015 Alabama ranked 49th nationally for access to care and remains in the bottom tier nearly a decade later[alabamareflector.com].)
5. **Prevention & Early Intervention** – Programs and initiatives that focus on preventing mental health crises and identifying issues early (for example, school-based mental health programs, public awareness campaigns, and primary care screenings). Investing in prevention can reduce strain on crisis services down the line.
6. **Crisis & Acute Care** – Emergency mental health services such as 24/7 crisis hotlines (including the 988 Suicide & Crisis Lifeline), mobile crisis teams, crisis diversion centers, and psychiatric hospital care. Alabama has made recent progress here by establishing **regional crisis centers**, but major gaps remain – the state currently has 6 crisis centers serving only 20 of 67 counties, while about 11 centers are estimated to be needed statewide[alabamareflector.com].
7. **Community Supports & Recovery** – Supports that help individuals maintain recovery and quality of life in the community. This includes housing assistance, supported employment, peer support programs, and other community-based services that help people reintegrate after treatment. Strong community support networks can prevent relapse and reduce re-hospitalization.

8. **Data, Evaluation & Quality** – Systems for tracking outcomes, measuring performance, and ensuring quality care. This domain covers information systems, research, and evaluation efforts that inform policy and practice. Good data helps identify what's working and what isn't, guiding smarter investments.

Together, these eight domains give a **360-degree view** of Alabama's mental health system. The report's structure signals that to improve the system, we must address all these components – strengthening one area (like crisis care) while neglecting another (like workforce or housing) will limit overall progress.

Identifying Gaps, Strengths, and Priorities

One of the report's most valuable features is how it highlights **where the system is falling short and where it's doing well**. By assessing each domain, the report uncovers **systemic gaps** – areas that lack resources, capacity, or effective programs – as well as **strengths** that Alabama can build upon. For example, the report might reveal a severe **gap in the workforce**, noting the low provider-to-population ratio and long wait times for services in many counties[nami.org]. It may point out funding shortfalls or unequal access to care (e.g. rural areas with few services, or thousands of residents left on waiting lists). On the other hand, it could highlight **strengths** such as recent initiatives that are making a difference. A clear example is the state's investment in new crisis centers and the introduction of Certified Community Behavioral Health Clinics (CCBHCs) that offer same-day, integrated care – promising steps toward a more responsive system[alabamareflector.com].

By presenting findings domain by domain, the report helps stakeholders see the **big picture without losing sight of specifics**. You can quickly grasp, for instance, that Alabama's crisis services have improved (a strength) but are still insufficient (a gap), or that there are strong community partnerships in some regions but a lack of housing support programs in others. This balanced view of **both weaknesses and assets** is crucial. It not only points to problems that need fixing, but also shows what is working well, so those successes can be sustained and replicated.

Crucially, the report doesn't just list problems – it frames them as **opportunities for investment and improvement**. Each gap identified naturally suggests an area where more resources, better policies, or new initiatives could have a big impact. For example, if the data show that only six crisis centers exist when eleven are needed, that signals to policymakers and funders a clear area for action[alabamareflector.com]. If the report notes a high percentage of people unable to find local care, that underscores the need to **invest in workforce development and telehealth** to expand access. The strengths identified can

guide us too: they show what strategies are succeeding (for instance, collaborations with schools or law enforcement) so that we can channel energy and funding to amplify those efforts.

In short, the Alabama Mental Health Systems Report acts as a **health check-up** for our system – diagnosing pain points and bright spots. This makes it a powerful tool for anyone looking to improve mental health care in Alabama, because it tells us *where to focus our efforts*.

Using the Report for Advocacy

For community advocacy groups and others working to influence policy, the report provides a **credible, data-driven foundation** for your message. Rather than relying on anecdotes alone, you can cite the report's findings to give weight to your advocacy. Policymakers and officials are more likely to respond when you bring hard evidence. Here's how you can use the report in advocacy:

- **Highlight Critical Needs:** Use statistics and examples from the report to illustrate the challenges. For instance, you might point out the stark provider shortage by saying, *"According to the state's mental health systems report, nearly 3 million Alabamians live in areas without enough mental health professionals – a gap that leaves many without care*[nami.org]*."* Numbers like these drive home the urgency and make a compelling case that cannot be easily ignored.
- **Emphasize Local Impact:** The eight-domain structure lets you find data relevant to specific concerns. If you're talking to a lawmaker about rural health, draw on the **Access & Service Delivery** or **Workforce** findings to show the lack of rural clinics or providers in their district. If your audience is concerned about youth suicide, you might reference the **Crisis & Acute Care** domain or **Prevention** efforts to discuss the need for school-based programs. Tailoring the information to issues people care about helps build stronger support.
- **Show a Unified Voice:** When many advocacy groups across the state use the same report as their reference, it creates a chorus that's hard to dismiss. The report can serve as a common platform – different organizations can rally around the same key facts and recommendations. For example, advocates statewide might collectively push for funding to address the identified gaps (such as expanding crisis centers or community-based services) using the report's findings as talking points. A unified message, backed by data, makes it more likely that leaders will listen.

- **Celebrate Progress (and Push for More):** Advocacy isn't only about pointing out problems; it's also about acknowledging improvements and leveraging them. If the report notes an area of progress (say, a successful pilot program or improved outcomes in one domain), mention that as proof that **investment pays off**. For instance: *"The new crisis centers opened in Alabama have already diverted many people from jails and ERs – a great success. The report shows we need to build on that by opening centers in other underserved regions."* This approach praises positive steps while making the case for further action.

Using the report in these ways can make your advocacy **clear, factual, and persuasive**. It equips you with non-partisan, well-researched information – exactly the kind of evidence policymakers look for when deciding on budgets and legislation. Ultimately, by grounding your appeals in the report's findings, you help move the conversation from *"we think there's a problem"* to *"here's exactly what the problem is, and here's how we can fix it."*

Using the Report for Strategic Planning

Beyond advocacy, the report is equally useful for **strategic planning** by nonprofits, service providers, and local coalitions. If you're a community leader or planner, here's how the report can inform your strategy:

- **Setting Priorities:** The comprehensive scope of the eight domains allows you to identify which needs are most pressing. Perhaps the report shows that in your region, the biggest gap is in **Community Supports & Recovery** (for example, a lack of housing and job programs for people with mental illness), whereas other areas have relatively better coverage. You might decide to prioritize launching a housing initiative or partnering with others to fill that gap. In another community, the top priority might be building out **Prevention & Early Intervention** programs in schools. The report helps you target your efforts where they are needed most.
- **Coordinating Efforts:** No single organization can address every aspect of the mental health system, but by knowing all the pieces, groups can collaborate more effectively. The eight-domain framework provides a **common language** for coordination. For instance, one nonprofit might focus on improving **workforce training** while another works on expanding **crisis services** – the report ensures both understand how their pieces fit into the bigger puzzle. Stakeholder meetings or coalitions can be organized around the report's domains, with

different teams taking the lead on different components but all aligning toward a shared vision.

- **Justifying Grants and Investments:** When seeking funding (from government grants, foundations, or donors), data from the report can strengthen your case. You can cite the documented needs to explain why your project is critical. For example: *"The state report identified a significant gap in mental health services for our county, especially in youth prevention programs. Our proposed project will directly address this gap by...."* This shows funders that your initiative is grounded in a recognized, evidence-based need, not just anecdotal impressions.
- **Measuring Progress:** The report can serve as a baseline for measuring improvement. By using the same domains and metrics over time, Alabama can track whether gaps shrink and outcomes improve. As a planner, you can align your organization's goals with those metrics. If the report is updated periodically, you'll be able to see if, say, the **Access** domain indicators improve after certain interventions, or if **Financing** levels increase following advocacy efforts. This feedback loop allows for adaptive planning – adjusting strategies based on what the data show in future reports.
- **Informing Local Policy:** Local leaders and county officials can use the state report's insights to develop their own mental health action plans. For instance, if the report indicates that certain counties lack any crisis response coverage, local authorities can use that information to justify setting up a mobile crisis team or securing state support for a new crisis unit. In this way, the state report acts as a blueprint that local and regional planners can adapt to their community's needs.

In sum, by using the Alabama Mental Health Systems Report as a guide, strategic planners can make more informed decisions. It encourages **evidence-based planning** – ensuring that time and resources are directed where they will make the biggest difference for the community.

Conclusion: A Roadmap for a Stronger System

The Alabama Mental Health Systems Report is more than just a collection of facts and figures – it's a **roadmap for action**. By summarizing the entire mental health system across eight essential domains, it empowers advocates and leaders to see the full landscape. This clarity is the first step toward change. When you know exactly where the gaps are – and equally important, where the bright spots are – you can strategize effectively and rally others to the cause.

For community advocates, the report provides the evidence to push for the policies and investments that Alabama's mental health system needs. For nonprofits and coalitions, it offers direction to plan programs that address real, documented needs and to coordinate those efforts across the state. In both cases, it helps turn good intentions into concrete improvements.

By using this report as your guide, you join a growing movement to build a **stronger, more compassionate mental health system in Alabama** – one where every individual, no matter where they live or what challenges they face, can access the care, support, and opportunities they need to thrive. With a shared understanding of the problems and a shared vision for solutions, we can work together to close the gaps, bolster the strengths, and invest wisely in a healthier future for all Alabamians.

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Alabama Mental Health System Strategic Analysis (2025)

This strategic report provides a comprehensive analysis of Alabama's mental health care system across eight key domains. Each domain section defines its scope and function, describes current structures and programs (circa 2024–2025), identifies key actors and mechanics, assesses gaps and opportunities (with recent performance indicators), and presents resources and data sources. A cross-domain mapping of interdependencies follows, illustrating how these system components interact.

1. Governance, Policy & Legal Foundations

Domain Scope: Governance encompasses the organizational structure, laws, and policies that establish authority, accountability, and strategic direction for mental health services. It defines who makes decisions, how regulations are set and enforced, and the legal rights and protections of people with mental illness. A strong governance framework provides clear leadership, coordination mechanisms, and policy guidance for the entire mental health system.

Alabama's Structures & Programs: Alabama's public mental health system is centralized under the Alabama Department of Mental Health (ADMH), a state agency created by statute in 1965[law.onecle.com]. By law, ADMH is authorized "to act in any prudent way to provide mental health services" to Alabamians[law.onecle.com]. The Governor appoints the ADMH Commissioner (the chief executive of the department) and defines the term and salary[casetext.com]. The Commissioner (currently Kimberly Boswell as of 2024) serves at the Governor's pleasure and oversees all ADMH personnel and operations[casetext.comcasetext.com]. Alabama statute also provides for an ADMH Board of Trustees (originally the "Alabama Mental Health Board") which offers oversight and long-range planning, with members often appointed by state leadership[encyclopediaofalabama.org]. ADMH's internal structure includes divisions led by Associate Commissioners for Mental Illness, for Substance Abuse, and for Developmental Disabilities[casetext.com] – reflecting its broad mandate over mental health, addiction, and intellectual disability services. Key governance actors at the state level include the Commissioner and her leadership team, the ADMH Board, the Alabama Legislature (which enacts mental health laws and appropriates funding), and the Office of the Governor. Other state agencies also influence mental health policy – for example, the Alabama Medicaid Agency (by setting behavioral health coverage rules) and the

Alabama Department of Public Health (for overlapping issues like substance abuse and crisis response coordination).

Legal Foundations: Several Alabama laws provide the legal foundation for mental health care. **Title 22, Chapter 50 of the Code of Alabama** outlines ADMH's authority and responsibilities, including broad powers to deliver services and regulate facilities[law.onecle.com]. Alabama's civil commitment laws (Title 22-52) establish criteria and procedures for involuntary psychiatric treatment, ensuring due process through the probate courts. The state has also implemented policies aligning with federal laws such as the **Americans with Disabilities Act (ADA)** and **Mental Health Parity**, although parity enforcement largely follows the federal standards. Alabama's legal history in mental health includes landmark court cases that continue to shape governance. Notably, *Wyatt v. Stickney* (1971) was a **federal court ruling in Alabama that first established a constitutional right to adequate treatment for institutionalized persons with mental illness**[encyclopediaofalabama.org]. In that case, Judge Frank Johnson set detailed minimum standards of care for state hospitals; Alabama's Department of Mental Health was placed under court monitoring until 2003 for failure to meet those standards[encyclopediaofalabama.org]. This legacy still informs today's policies on patient rights, staffing, and humane conditions.

More recently, Alabama's prison system has faced legal scrutiny for inadequate mental health care, underscoring governance challenges at the interface of criminal justice and mental health. In 2017, a federal judge ruled that the **lack of access to mental health care in Alabama's state prisons violated inmates' Eighth Amendment rights**, ordering the Alabama Department of Corrections (ADOC) to institute major reforms[alabamareflector.com]. The court identified chronic **understaffing** as a key factor preventing adequate mental health services in prisons[alabamareflector.com]. In response, state officials have worked to bolster correctional mental health governance – for example, by hiring more correctional officers and mental health staff and developing improved screening, suicide prevention, and treatment programs in prisons[governor.alabama.gov]. A 2019 DOJ investigation under CRIPA (Civil Rights of Institutionalized Persons Act) further prompted Alabama to plan new prison facilities that integrate modern mental health service space[governor.alabama.gov] and to add mental health oversight positions and staff training in corrections[governor.alabama.gov]. These actions illustrate Alabama's effort to address legal mandates through policy changes and interagency coordination (ADMH advising or partnering with ADOC) – an important governance dynamic.

Key Actors & System Mechanics: In Alabama, governance of mental health is a coordinated effort among state and local entities. The **ADMH central office** sets statewide standards, licenses mental health providers/facilities, and administers state

and federal funds (like the SAMHSA block grants). **Community Mental Health Centers (CMHCs)**, though operated by local non-profit boards, must follow ADMH policies and regulatory requirements[blog.opencounseling.com]. Judges and the probate court system play a role in governance through commitment hearings and mental health courts (directing individuals to treatment instead of incarceration when appropriate). Law enforcement leadership is increasingly involved via initiatives like Crisis Intervention Teams (CIT) – Alabama has a state CIT coordinator (e.g. the Director of Alabama CIT, John Hollingsworth) who works with police and sheriffs to implement training and protocols for mental health crisis calls[alabamareflector.com]. The Alabama Legislature's committees on health and budget oversee ADMH's performance and resource needs; for instance, ADMH must justify its budget annually to the Joint Legislative Budget Committee[alison.legislature.state.al.us]. Policy coordination also occurs through multi-agency councils and task forces – e.g. the Alabama Interagency Council for the Prevention of Youth Suicide and the Alabama Opioid Overdose Council – reflecting governance spanning mental health, public health, education, and justice domains.

Gaps & Opportunities: Alabama's governance framework has improved but still faces gaps in coordination, compliance, and modern policy development. A major gap has been the **historical fragmentation** of services and data – as noted in a 2025 analysis series, Alabama is coping with "the long-term aftermath of budget cuts and poor mental health planning… amid an absence of reliable data"[alabamareflector.com]. This indicates that strategic planning was under-resourced in the 2010s (the Great Recession era saw deep cuts to mental health budgets, leading to clinic closures and service retrenchment[alabamareflector.com]), and that rebuilding efforts require stronger governance planning and information systems (see Domain 6). Opportunities exist in leveraging recent political support: in 2021–2023, Alabama's leaders created and funded new programs like 988 crisis call centers and additional crisis diversion facilities, signaling a policy shift toward strengthening the continuum of care. The Governor and Legislature have shown willingness to invest in mental health (e.g. ADMH's proposed FY2026 budget seeks a 22.9% increase[alabamareflector.comalabamareflector.com]) – a window of opportunity to modernize infrastructure, workforce, and data systems under strong governance oversight. However, securing these funds requires continued advocacy and evidence (i.e. governance must use data and community input to make the case for sustained funding). Another governance challenge is **ensuring laws and policies keep pace with needs**: for example, Alabama has only recently considered expanding Medicaid or alternative coverage for mental health (see Domain 2), and it must continually update regulations (such as telehealth rules, licensure compacts, and treatment standards) to remove barriers. Aligning state regulations with best practices (e.g. adopting the latest national standards for substance abuse treatment as Alabama did by incorporating ASAM criteria into administrative code[medicaid.govmedicaid.gov]) is an ongoing governance task.

Finally, **enforcement and accountability** are crucial: Alabama's past federal oversight (Wyatt, prison cases) shows that without robust state accountability mechanisms, conditions can deteriorate. Strengthening internal quality monitoring and involving external stakeholders (advocacy groups, peer representatives) in oversight bodies can help Alabama sustain compliance with legal and ethical obligations in mental health care.

Key Information & Communication Assets (Public & Provider – Governance)

The table below highlights key governance-related information resources and communication tools available to the public, providers, and policymakers in Alabama:

Asset / Resource	Description & Usage
ADMH Official Website (mh.alabama.gov)	Public-facing site with information on mental health programs, provider directories, news, and policy updates. Hosts announcements of board meetings, administrative codes, and contact info for ADMH leadership alabamareflector.com. Essential for transparency and guidance to providers (rules, standards) and the public (services and rights).
Alabama Administrative Code & Statutes Online	Web portals (e.g. **Code of Alabama Title 22** and **ADMH Administrative Code**) that publish current laws and regulations. Providers and legal advocates use these to understand legal duties, e.g. commitment criteria and facility licensing rules law.onecle.com. Public can access to know patient rights and agency mandates.
ADMH Board Meetings & Minutes	Regular meetings of the ADMH Board of Trustees (typically open to the public). Agendas and minutes are shared via ADMH communications. They provide insight into strategic decisions and are a forum for stakeholder input.
Legislative Information System (ALISON)	Alabama Legislature's online system posts bills, budget acts, and committee reports. It is used by policymakers, advocacy groups, and providers to track mental health legislation and appropriations. For example, ADMH budget hearings presentations are available on legislative sites alison.legislature.state.al.us.
Interagency Council Reports	Publications from interagency task forces (e.g. suicide prevention, opioid council) that are disseminated online. They communicate policy goals, progress, and recommendations across different sectors, ensuring aligned governance messages to the public and providers.
Public Hearings & Comment Portals	For certain policy changes (e.g. Medicaid waivers, block grant plans), Alabama offers public hearings or online comment forms. These

Asset / Resource	Description & Usage
	communication channels allow community and provider feedback on governance decisions (such as the design of Medicaid's mental health initiatives).

Key Data Sources & Documentation (Governance)

Key laws, plans, and evaluative documents underpin Alabama's governance and policy framework:

Source / Document	Details & Relevance
Code of Alabama Title 22, Ch. 50 (State Law)	Establishes ADMH, its powers and duties, and Board governance law.onecle.comcasetext.com. Forms the legal basis for all state mental health services and is frequently referenced in policy documents.
Alabama Civil Commitment Law (Title 22-52)	Statutes detailing criteria and procedures for involuntary treatment of mental illness (and substance abuse). Important for hospitals, courts, and patient rights groups to ensure due process and proper use of commitment.
Wyatt v. Stickney Court Order (1972)	Landmark federal court decision setting minimum standards of care in AL's psychiatric facilities encyclopediaofalabama.org. Though decades old, its stipulations (staff ratios, treatment plans, etc.) are documented in historical consent decrees and still influence current quality assurance standards.
ADMH Administrative Code (State Regulations)	Rules promulgated by ADMH, covering provider certification, facility standards, patient rights, and program operations. For example, regulations updated to incorporate evidence-based standards for substance abuse treatment medicaid.gov. Providers must comply with these; updated versions are published through the Alabama Administrative Code.
ADMH Strategic Plan / Annual Reports	Periodic planning or report documents (if available) outlining ADMH's goals, initiatives, and performance metrics. These often detail governance priorities and are used for accountability. (As of 2025, ADMH presents many updates via budget hearings and press releases in lieu of a single annual report.)
State Audit & Oversight Reports	Audits by Alabama's Department of Examiners of Public Accounts or legislative oversight committees that review ADMH finances and compliance. Also, any **CMS or SAMHSA oversight** correspondence (e.g. block grant monitoring letters) that document how Alabama's governance is meeting federal grant requirements.
Federal DOJ Findings and Agreements	For example, the DOJ findings letter on Alabama prisons (2019) and any subsequent consent agreements. These documents detail deficiencies in mental health governance within corrections and stipulate required improvements governor.alabama.govgovernor.alabama.gov, reflecting on statewide policy obligations.

Source / Document	Details & Relevance
Mental Health Court Guidelines	Alabama Administrative Office of Courts (or local jurisdictions) may have documentation on mental health court programs. These outline how courts and ADMH coordinate to divert individuals into treatment, an important governance mechanism at the justice interface.

2. Financing & Resource Allocation

Domain Scope: Financing refers to how mental health services are funded and resources are allocated across the system. It covers revenue sources (state budget, Medicaid, federal grants, local funds), purchasing mechanisms (e.g. contracts, insurance reimbursements), and the budgeting process that determines where funds flow (hospitals, community programs, workforce, etc.). Effective financing ensures sustainable funding streams and equitable distribution of resources aligned with population needs.

Current Financing Structure in Alabama: Alabama's mental health system financing is a mix of state general funds, federal funds (Medicaid, block grants), and some local or private contributions. ADMH's budget is primarily supported by the **Alabama General Fund** (the state's non-education budget) and augmented by the **Education Trust Fund** for certain programs (e.g. school-based mental health). In FY2025, ADMH's state appropriation was about $317 million[alabamareflector.com]. The department has proposed a significant increase to $389.6 million for FY2026 – a **22.9% budget increase** – to meet growing needs[alabamareflector.com]. This would include an extra $68.6 million from the General Fund (a 28.8% increase) and $4.6 million more from the Education Trust Fund[alabamareflector.comalabamareflector.com]. Major funding priorities driving this request are expanding inpatient beds, crisis services, and school-based mental health programs[alabamareflector.comalabamareflector.com].

Revenue Sources: The **General Fund** is the largest single source of Alabama's mental health funding, reflecting state commitment. Additionally, **Medicaid** plays a critical role: Alabama Medicaid covers many mental health services for eligible populations (children, some low-income adults with disabilities, etc.), reimbursing community mental health centers, inpatient psychiatric services, and medications. However, Alabama has *not expanded Medicaid under the ACA*, which limits coverage for low-income adults. As a result, an estimated **101,000 Alabamians fall into the "coverage gap"** – they earn too much for traditional Medicaid but not enough to afford private insurance[alabamareflector.com]. This gap means many adults with mental illness remain uninsured, increasing reliance on state-funded indigent care or crisis services. The lack of expansion is a major financing gap often cited by advocates who argue it would improve outcomes and stabilize provider finances[alabamareflector.comalabamareflector.com]. (As of late 2024, Alabama's political leaders were exploring a proposal called "ALLHealth" to use Medicaid expansion dollars to fund private coverage for the uninsured in this gap[alabamareflector.comalabamareflector.com], but no expansion had been approved.)

Federal grants are another funding pillar. Alabama receives the **SAMHSA Community Mental Health Services Block Grant** annually (about $11.6 million in FY2022[samhsa.gov])

which ADMH allocates to priority services for adults with serious mental illness and children with serious emotional disturbance. The state also gets the **Substance Abuse Prevention & Treatment Block Grant** and various competitive grants (for example, federal opioid response grants, school mental health grants, and 988/crisis line implementation grants). **CMS matching funds** for Medicaid cover a portion of public mental health costs – for every state dollar spent on Medicaid services, the federal government matches roughly 72 cents (Alabama's FMAP being about 72% in recent years due to its lower per capita income). This makes Medicaid a high-leverage funding source; however, Alabama's strict Medicaid eligibility means many mental health services (like those for uninsured adults or certain residential programs) must be state-funded outside of Medicaid.

Local funding contributions in Alabama are relatively limited compared to some states (which may have county mental health levies or city-funded services). Some Alabama counties or cities do contribute to local mental health centers, and many centers bill clients on a sliding fee scale or receive donations. But the absence of a dedicated local tax base for mental health means ADMH and Medicaid funds are the lifeline for most programs.

Resource Allocation Mechanics: Alabama's resource allocation is driven by the state budgeting process and ADMH's contracting. Each year, ADMH submits a budget request highlighting needs. For example, in 2024 the ADMH Commissioner emphasized the **shortage of psychiatric beds** – Alabama had fewer than 14 state psychiatric beds per 100,000 people, under half the recommended 30/100k[alabamareflector.com] – to justify funding for more capacity. The budget also earmarked money for specific initiatives: e.g. **$23.4 million requested for new inpatient beds**, $11.5 million to expand crisis centers (toward a goal of 11 centers statewide)[alabamareflector.com], $2 million to increase detox services for substance abuse[alabamareflector.com], and $1 million to grow school-based therapy programs[alabamareflector.com]. The Legislature, through its appropriations acts, allocates funds by broad categories, and ADMH then distributes these to providers via contracts or grants.

Key Actors in Financing: The Alabama Legislature's **budget committees** and ultimately the full Legislature decide state General Fund appropriations for mental health. The Governor's office influences this via the executive budget recommendation. ADMH's finance office then allocates funds to state-operated facilities (like Bryce Hospital and other state psychiatric hospitals) and to community providers. Alabama's **19 community mental health centers** are funded through a combination of Medicaid reimbursements and state contract dollars – each CMHC is on contract with ADMH to provide services in their region, and they must meet performance and

reporting requirements tied to those funds[blog.opencounseling.com]. The Alabama Medicaid Agency determines rates and coverage policies: for instance, Medicaid recently added coverage for mobile crisis response and for medication-assisted treatment (MAT) for opioid use disorder (approved in 2021)[medicaid.govmedicaid.gov], which channels federal dollars into those services. Federal agencies (SAMHSA, HRSA, etc.) are stakeholders too, as they monitor grant usage and outcomes (e.g. SAMHSA requires an annual plan for the block grant and uses performance data to ensure funds address gaps). Another actor is the Alabama Department of Finance and the Examiner's Office, which audit spending to ensure funds are used appropriately.

Gaps & Opportunities in Funding: Alabama historically underinvested in mental health on a per capita basis. The publicly funded mental health penetration rate in 2022 was only **18.5 per 1,000 population** served[samhsa.gov], below the U.S. average of 24.4/1,000 – suggesting many who need care aren't reached, likely due to funding constraints. Recent efforts are trying to reverse this trend (the nearly 23% budget hike request for 2026 is evidence of increased commitment[alabamareflector.com]). Still, challenges remain:

- **Medicaid Gaps:** The state's decision not to expand Medicaid leaves tens of thousands uninsured[alabamareflector.com]. These individuals often rely on emergency or crisis services financed by state/local funds. If Medicaid were expanded (or an alternative coverage program implemented), Alabama could leverage a 90% federal match for new enrollees and infuse hundreds of millions into the behavioral health system. This is arguably the biggest opportunity to boost resources and relieve pressure on state-only funds. Short of full expansion, Alabama is exploring partial solutions (like ALLHealth) and has expanded specific Medicaid benefits (e.g. substance use treatment continuum under a pending 1115 waiver[medicaid.govmedicaid.gov]). Fully tapping federal funding opportunities (waivers, pilots, etc.) is a key opportunity.
- **Resource Distribution Imbalances:** There are gaps in how funds are spread geographically and across services. Rural areas often have fewer services despite high needs – historically, funding followed infrastructure (urban centers with hospitals and clinics got more). Alabama has been addressing this by funding **crisis centers in different regions** and mobile crisis teams to cover underserved counties[alison.legislature.state.al.us]. Another imbalance was heavy investment in institutional care versus community services; Alabama closed many large institutions post-Wyatt, but the pendulum swung such that now *inpatient bed capacity is insufficient*[alabamareflector.com]. The new funding for beds aims to correct that. Ensuring a **balanced continuum** (community care, crisis, and hospital beds) requires continuous reallocation as needs change.

- **Provider Payment and Sustainability:** Many community providers operated on thin margins due to low reimbursement rates and workforce costs. Alabama's legislature recognized this and in FY2024 provided targeted funds to raise salaries for front-line staff (e.g. Direct Support Professionals wages increased from an average $9.91/hour in 2022 to $15.17 by 2024 through state-funded raises[alison.legislature.state.al.usalison.legislature.state.al.us]). Continuing to invest in **provider workforce compensation** is essential to keep clinics staffed (see Domain 4). Also, moving toward value-based payment could be an opportunity; currently, most funding is fee-for-service or grant-based, but Alabama could pilot outcomes-based contracts (e.g. paying bonuses for reduced hospital readmissions or high engagement in care).
- **Accountability & Flexibility:** Alabama must ensure new funds are tied to performance outcomes. The use of **performance dashboards** (if implemented) and regular reporting can help justify continued funding. Conversely, more flexibility in funding could help innovation – e.g. allowing braiding of funds across mental health, substance abuse, and developmental disability programs to address co-occurring needs. The state's participation in grants like the CMS planning grant for 24/7 crisis services[medicaid.gov] is an example of leveraging federal funds creatively. Further opportunities include pursuing HRSA grants to address workforce or SAMHSA grants for specific populations (veterans, children) – bringing in additional dollars to supplement the core state budget.

In summary, Alabama's mental health financing is at a pivotal point: new investments are being made after a long period of underfunding, but maximizing impact will require closing coverage gaps, targeting funds to documented needs (like rural access and bed shortages), and maintaining political will to fund mental health even amid General Fund revenue concerns[alabamareflector.com]. The 2025 legislative session will be crucial, as lawmakers decide on the requested funding increases in the context of a tightening budget environment[alabamareflector.com]. Strong advocacy (Domain 8) and solid data evidence (Domain 6) will be needed to sustain the financing momentum.

Key Information & Communication Assets (Financing)

Financial information and tools that inform providers and the public about funding and mental health costs include:

Asset / Resource	Description & Purpose
ADMH Budget Requests & Hearings	ADMH publishes its annual budget request and justifications (often via presentations to the legislature)[alison.legislature.state.al.us]. These documents (available on legislative websites or on request) communicate funding needs, program

Asset / Resource	Description & Purpose
	expansions, and performance outcomes tied to dollars. They help stakeholders understand where money is allocated (e.g. crisis centers, beds, etc.) and why.
Alabama Fiscal Reports (GF Budget)	The General Fund budget bill and Governor's budget summary provide insight into mental health appropriations each year. These are public records accessible through the Legislative Services Agency. The **General Fund Investments presentation** (July 2024) shows how new funds were used, e.g. workforce grants, and the impact (like vacancies reduced)alison.legislature.state.al.us.
Medicaid Provider Manuals & Fee Schedules	The Alabama Medicaid Agency publishes behavioral health provider manuals detailing covered services, billing codes, and rates. For providers, this is key for reimbursement; for policymakers, it signals what services Medicaid will pay for. Recent manuals include new crisis services and MAT coverage, which are communicated to providers via bulletins.
SAMHSA Block Grant Plan and Reports	ADMH submits an annual plan for the Mental Health Block Grant, including how funds will be spent on priority areas, and reports on outcomes. These documents (often posted on ADMH's site or SAMHSA's site) inform the public of federal grant use. They often contain data on numbers served and gaps identified, guiding resource allocation.
Grant Announcement Portals	ADMH and allied agencies often release notices for funding opportunities (e.g. Requests for Proposals for providers to start new programs with grant funds). These announcements – found on ADMH's site or emailed to providers – ensure funds are distributed transparently and reach capable local organizations.
NAMI Alabama & Advocacy Budget Briefs	Advocacy groups like NAMI Alabama and Alabama Arise produce accessible fact sheets and online posts explaining the state of mental health funding (e.g. highlighting the cost of non-expansion of Medicaid, or successes like crisis funding). These help educate the public and legislators, translating complex budget info into human impact stories.
Cost of Care/Scorecard Data	Alabama participates in some national or state-level scorecards (e.g. the **State Health Facts by KFF** or **NRI expenditure reports**) that show per capita mental health spending, percent of need met, etc. These data resources allow comparisons and help local leaders communicate whether Alabama is financially keeping up with national benchmarks.

Key Data Sources & Documentation (Financing)

Important documents and data sets related to financing and resource allocation decisions:

Source / Document	Details & Relevance
ADMH Budget Documents (FY2024–2026)	Includes the FY2024 enacted budget and FY2025–26 requests. For example, the December 2024 ADMH board meeting budget proposal (cited in Alabama Reflector) details the $389.6M FY26 plan alabamareflector.com with breakdowns for beds, crisis, school services. Legislative Fiscal Office reports and the final General Fund appropriation act document the actual allocations.
Uniform Reporting System (URS) Financial Tables	Part of SAMHSA's URS report for Alabama shows total SMHA expenditures (e.g. $507 million community MH expenditures in FY2022 samhsa.gov) and spending by service type. This data helps identify where dollars go (e.g. hospital vs community) and is used for planning.
Medicaid 1115 Waiver Applications	Alabama's recent Section 1115 waiver proposals (e.g. for Substance Use Disorder treatment medicaid.gov) contain needs assessments and financing plans. They often list existing services, utilization, and cost projections. For instance, the SUD waiver document outlines crisis service expansion funding via Medicaid medicaid.govmedicaid.gov.
Alabama Medicaid State Plan & Amendments	The State Plan is the contract with CMS outlining covered behavioral health services and eligibility. Amendments in 2019–2022 added things like inpatient psychiatric services for ages 21-64 (IMD waiver for SMI) or MAT coverage medicaid.gov. These documents are technical but crucial for understanding financing mechanisms.
Block Grant Application (MHBG)	ADMH's annual application for the Mental Health Block Grant includes budget tables showing how federal funds and matching state funds will be allocated (e.g. percentages to treatment services, prevention, etc.). It also contains targets for outreach and evidence-based practices funded by the grant.
NRI State Profiles / Expenditure Reports	The National Association of State Mental Health Program Directors Research Institute (NRI) publishes state profiles including per capita spending on mental health. Alabama's profile can show how its spending compares regionally. Such data was likely used in advocacy to argue for the 23% budget increase (demonstrating prior underfunding).
Governor's Office Press Releases (Funding)	Statements from the Governor about mental health initiatives (e.g. announcing funding for new crisis centers or telehealth programs) often contain useful numbers and framing of resource allocation priorities. These are part of public record and provide insight into executive branch funding priorities.
Performance Audits & Outcome Evaluations	Any evaluations that tie funding to outcomes – for instance, an audit of the Crisis Diversion Centers showing cost savings (by reducing ER/jail usage) or a study of school-based mental health showing improved student outcomes per dollar spent. While not routine, such documents, when available, help justify or recalibrate resource allocation.

3. Service-Delivery Continuum

Domain Scope: This domain covers the spectrum of mental health services from prevention and early intervention through acute treatment to recovery support. It includes how services are organized and delivered – outpatient therapy, community support programs, crisis intervention, inpatient hospitalization, peer support, etc. A well-functioning continuum ensures people can access appropriate care at the right time and transition smoothly between service levels (for example, from hospital to community follow-up). It also encompasses service capacity (availability of programs statewide) and integration (linkages with primary care, substance abuse services, housing, etc.).

Alabama's Service Continuum Structure: Alabama's public mental health service delivery is built on a **hub-and-spoke model** anchored by regional Community Mental Health Centers. There are 19 CMHCs covering all 67 counties[blog.opencounseling.com] – each serves as the primary outpatient and community service provider in its region. These centers offer a range of services: diagnostic assessments, therapy (individual and group), case management, psychiatric medication management, day programs, and rehabilitation services for adults with serious mental illness and children with serious emotional disturbances. Many CMHCs also operate specialized programs like Assertive Community Treatment (for intensive outreach to individuals with severe illness) and residential homes or supported housing. However, eligibility and availability can vary; historically, most CMHCs in Alabama focus on serving individuals with serious mental illness (SMI) due to resource constraints[blog.opencounseling.com]. Some, like WellStone (serving Huntsville area), also provide counseling for mild/moderate needs, but priority is typically on SMI and youth with serious needs[blog.opencounseling.comblog.opencounseling.com].

At the acute end of the continuum, Alabama operates **state psychiatric hospitals** under ADMH for those who need inpatient treatment. The main facilities include Bryce Hospital in Tuscaloosa (adult inpatient), Mary Starke Harper Center (geriatric psychiatry), and a few others, as well as secure facilities for forensic populations (e.g. Taylor Hardin Secure Medical Facility for those undergoing forensic evaluations or restoration). The state hospital bed capacity has been limited – Alabama had fewer than 700 state psychiatric beds (around 0.13 per 1,000 population) in recent data[samhsa.gov], which is below national averages (U.S. ~0.33/1,000). This bed shortage means **access to inpatient care is a challenge**, resulting in waitlists for civil commitment beds and people sometimes languishing in jail awaiting mental health evaluation or treatment (as highlighted by the federal court in 2017)[alabamareflector.comalabamareflector.com]. To address this, ADMH has been seeking funding to add more **long-term commitment beds** for those under involuntary

treatment orders[alabamareflector.comalabamareflector.com]. In addition to state hospitals, some private and regional medical centers provide psychiatric inpatient units (community hospitals), but these are unevenly distributed and often have short-term stabilization focus. ADMH works in partnership with these hospitals when placing patients in need of care, especially if state beds are full.

A major enhancement to Alabama's service continuum in recent years is the development of a **crisis response system**. Historically, Alabama lacked sufficient crisis options aside from ERs or jail. After 2020, ADMH began funding **Crisis Diversion Centers** – facility-based crisis centers where individuals in crisis can walk in or be brought by police for stabilization, observation, and referral. By the end of 2024, Alabama had **5 crisis centers in operation with a 6th opening in early 2025**[alabamareflector.com]. These centers, strategically located in different regions (e.g. in Huntsville, Birmingham, Montgomery, Mobile, etc.), serve as 24/7 alternatives to emergency rooms. Notably, they accept anyone in crisis (no catchment restrictions), and as of the sixth center's opening they cover 20 of the 67 counties by location[alison.legislature.state.al.us]. ADMH's goal is to ultimately have **11 crisis centers** so that every Alabama county is within reach of these services[alabamareflector.com]. The impact of the existing centers has been significant: between May 2021 and June 2024, the crisis centers conducted **12,190 evaluations**, and importantly diverted *8,881 individuals from ER admission and 2,040 from jail* (i.e. those people were stabilized at the crisis center instead of those higher-cost settings). They also had **781 law enforcement drop-offs** in that period, indicating strong collaboration with police, and achieved a follow-up rate of 85% and a 30-day readmission rate of only 3.6%, showing effective linkage to ongoing care[alison.legislature.state.al.us]. These metrics demonstrate how the new crisis services are filling critical gaps and improving system performance by reducing hospital overcrowding and criminal justice involvement.

Additionally, Alabama has implemented the national 988 **Suicide & Crisis Lifeline**. There are **5 regional 988 call centers** in the state[alison.legislature.state.al.us], ensuring calls are answered locally by trained counselors who can connect callers to resources or dispatch mobile crisis units. For mobile crisis, Alabama in 2023 had around **14 state-funded Mobile Crisis Teams** covering 25 counties[alison.legislature.state.al.us], consisting of mental health professionals who can respond on-site to de-escalate crises. Some teams specialize in youth crises as well. The 988 call centers coordinate closely with these mobile teams and the brick-and-mortar crisis centers, forming a nascent **"Crisis System of Care."** This integration is improving the service continuum's responsiveness – for example, someone can dial 988 anywhere in Alabama and get triaged to a local team or advised to go to a nearby crisis center.

Preventive and Outpatient Services: On the preventive end, Alabama's Public Health and mental health systems collaborate on education and early intervention (such as mental health awareness in schools, suicide prevention initiatives via the Alabama Suicide Prevention and Resources Coalition, and programs like Mental Health First Aid training offered by some CMHCs or NAMI Alabama chapters). School-based mental health has grown: as of 2024, ADMH had placed mental health therapists in **109 public school systems** (out of 205 systems statewide) with a goal of eventually reaching all school systems[alabamareflector.com]. These school-based counselors provide early identification and counseling for youth, addressing problems before they escalate. Pediatricians and family doctors are also increasingly involved in early identification, some supported by consultation programs (for instance, some grant-funded pilot allows primary care doctors to consult with psychiatrists about child mental health).

Post-treatment Support: In terms of recovery supports, Alabama has made use of **Certified Peer Specialists** in some programs (trained individuals with lived experience who support others in recovery). Many CMHCs run **peer support groups**, psychosocial rehabilitation (day programs), and help clients with supported employment or education. There are also group homes and transitional housing for people coming out of hospitals. However, there are gaps in supportive housing and long-term community supports – resources that are critical for preventing relapse and homelessness. Alabama does not have a large state-funded supported housing program, so it relies on federal programs (like HUD housing vouchers targeted to mental health) and local non-profits.

Key Actors & Mechanics of Service Delivery: The **Community Mental Health Centers** are the backbone, delivering most routine services. They employ clinicians (counselors, social workers), case managers, psychiatrists or nurse practitioners (often via telepsychiatry if psychiatrists are scarce on site), and peer specialists. The **state hospitals** (Bryce, etc.) are run by ADMH with state-employed staff and serve those needing high levels of care (often after involuntary commitment through the courts). The **crisis centers and mobile teams** are generally operated by certain CMHCs or partnerships of providers, funded by ADMH grants. For example, the centers in Huntsville and Mobile are operated by well-established CMHCs (WellStone and AltaPointe Health respectively), whereas others are collaborative projects; they staff a mix of nurses, counselors, and often have law enforcement liaisons. **Hospitals and ERs** remain actors in crisis care – many individuals still go to emergency departments in crisis, and hospitals coordinate with CMHCs for discharge planning. Law enforcement and first responders are key partners: many jurisdictions have CIT-trained officers who try to divert people to treatment. As noted, Alabama CIT training is coordinated statewide; law enforcement's willingness to utilize the crisis centers (as shown by

hundreds of drop-offs[alison.legislature.state.al.us]) is an important mechanic reducing jail bookings for mental health issues.

Integration with **substance abuse services** is another aspect: many individuals have co-occurring substance use disorders, so CMHCs often also provide or coordinate addiction treatment (some are certified as substance abuse providers too). Alabama has separate certified substance abuse agencies, but ADMH encourages co-location where possible. For instance, the crisis centers serve both mental health and substance-related crises (including offering short-term detox).

Gaps & Opportunities in Service Delivery: Despite progress, significant gaps remain in Alabama's continuum:

- **Geographic Gaps:** Rural counties still have far fewer on-the-ground services. 55 of Alabama's 67 counties are rural[prainc.com], and not all have local clinics. People may have to travel long distances. Mobile crisis teams cover only 25 counties so far[alison.legislature.state.al.us], leaving many areas without that coverage. The state needs to expand mobile teams and eventually have **coverage in all 67 counties**, as envisioned by ADMH's plan for 23 teams[alison.legislature.state.al.us]. Tele-mental health is a big opportunity here – Alabama's broadband gaps notwithstanding, telepsychiatry programs can reach remote patients (some CMHCs already use telehealth to connect patients with prescribers). With improved broadband (only ~86% households have broadband, lower in rural areas[democrats-waysandmeans.house.govdemocrats-waysandmeans.house.gov]), tele-mental health could significantly close geographic service gaps.
- **Continuity of Care:** Transitions between levels of care need strengthening. For instance, when someone is discharged from a psychiatric hospital, ensuring they see a community provider within 7 days is critical (to prevent relapse). The crisis system is working on follow-ups (with 85% follow-up achieved in crisis centers[alison.legislature.state.al.us]), but hospitals and jails need similar linkage protocols. The data systems and referral protocols (see Domain 6) have room to improve to ensure "warm hand-offs" between inpatient, crisis, and outpatient. The state's new focus on 7-day follow-up as a metric (noted in crisis center goals[alison.legislature.state.al.us]) is promising and should extend across the continuum.
- **Capacity Strains:** Even with new funding, Alabama's service capacity per capita lags. Outpatient therapy appointments can have long wait times in some areas due to provider shortages (Domain 4 discusses workforce shortage – 82% of counties are mental health professional shortage areas[democrats-waysandmeans.house.gov]). Inpatient beds shortage leads to ER boarding (patients held in emergency rooms for days awaiting psych bed). And while crisis centers alleviate some strain, by

ADMH's own admission, the five centers only cover a minority of counties currently[alison.legislature.state.al.us]. Opportunities include opening the planned additional crisis centers, exploring alternatives like **community respite houses** or more psychiatric beds in local hospitals via public-private partnership, and expanding **specialty services** like early intervention teams for first-episode psychosis (to catch serious mental illness early – ADMH has one or two such programs via grant, but more are needed statewide).

- **Equity and Inclusion in Services:** (Intersects with Domain 7) – ensuring the continuum serves all demographics. For example, are there culturally appropriate services for Black communities, or services in Spanish for the growing Hispanic population? Also, historically marginalized groups (LGBTQ+ youth, veterans, etc.) might not fully utilize services due to trust or access issues. Alabama can partner with churches, HBCUs, and community organizations to extend outreach and tailor services.
- **Integration with Primary Care:** Many people with mental health needs first show up in primary care. There's an opportunity to build more **integrated care models** (collaborative care in clinics, or co-locating behavioral health in community health centers). Some pilot programs exist in Alabama's FQHCs (Federally Qualified Health Centers) but scaling this up could fill a gap especially for mild-moderate conditions and earlier intervention.

Recent performance metrics underscore both progress and need: The public mental health penetration (people served by ADMH per population) was 18.5 per 1,000 in 2022[samhsa.gov] – meaning roughly 1.85% of Alabamians accessed state-supported mental health care in a year. Given prevalence estimates (~20% of people have a mental health condition in a given year), this indicates many are either going untreated or obtaining care privately/outside the public system. Increasing this penetration rate is a key goal to ensure those in need are reached. The crisis system outcomes (high follow-up, low readmission) are a positive metric suggesting when services are accessible and intensive, they yield good results[alison.legislature.state.al.us]. Also, Alabama reports low re-hospitalization rates on some measures – for example, 30-day readmission to state psychiatric hospitals was around 3.4% for adults, compared to 7.8% U.S. average[alabamareflector.com]. This is a good sign, possibly reflecting effective stabilization and community follow-up, but it could also reflect limited capacity (i.e. some who might need readmission can't get in). The state should continue monitoring these performance indicators to guide adjustments in the continuum.

Key Information & Communication Assets (Service Delivery)

Resources that help the public and providers navigate and utilize the service continuum:

Asset / Resource	Description & Usage
ADMH Service Directory & Helpline	ADMH maintains an online directory of services by region (listing the Community Mental Health Centers, crisis centers, and other specialized programs). The department also has a general information line for the public. These tools help individuals find where to seek care in their county.
988 Suicide & Crisis Lifeline	**Dial 988** connects anyone in Alabama to a crisis counselor 24/7. The 988 call centers have information on local resources and can dispatch mobile crisis units or advise on nearest crisis facility. Widely advertised (via social media, billboards, etc.) as the go-to number for mental health emergencies, it's a key access point to the continuum.
Community Mental Health Center Websites	Each of the 19 CMHCs typically has a website with details on their services, intake process, and contact info. For example, WellStone (Huntsville) or AltaPointe (Mobile) provide program descriptions (outpatient, residential, etc.) and often offer online screening tools or appointment requests. These websites guide consumers on how to get help and inform referring agencies about available programs.
Hospital Psychiatric Unit Finders	Some hospital systems and the Alabama Hospital Association provide information on which hospitals have psychiatric beds and possibly bed availability. Though not centralized, such information is used by emergency departments and mental health professionals when coordinating inpatient admissions.
Alabama 2-1-1 and Resource Databases	The 2-1-1 call system and its online database list mental health resources (counseling, crisis lines, support groups) along with other social services. This is used by the public and providers to find local resources, especially for supportive services like housing or support groups that wrap around clinical care.
Referral and Discharge Coordination Platforms	Some regions use electronic platforms (or even manual fax networks) for referrals – e.g., a **Crisis Incident Tracking** system or a bed registry. Alabama was developing a crisis bed registry to let providers see available crisis or hospital beds in real time. While in progress, once fully implemented this digital tool will greatly aid service coordination.
Public Awareness Materials	Pamphlets and online guides like *"How to Get Help in Alabama"* (often produced by NAMI or ADMH) succinctly explain the steps to access different levels of care. Distribution of these materials (in clinics, libraries, police stations) helps individuals and families understand the continuum (like whom to call for what situation).
Case Management Systems	For providers, ADMH provides certain software or systems (e.g. SIMS – State Information Management System) that track clients across services. While primarily a data tool, it also serves as an internal communication asset by alerting case managers of admissions/discharges, ensuring continuity.

Key Data Sources & Documentation (Service Delivery)

Documentation and data that describe or evaluate Alabama's service continuum:

Source / Document	Details & Relevance
ADMH Program Guides and Manuals	ADMH publishes guidelines for specific programs (e.g. Crisis Center Operations Manual, Mobile Crisis Team Protocols, Assertive Community Treatment fidelity standards). These documents delineate how services should be delivered, ensuring consistency and quality across providers. They also often include eligibility criteria and service definitions in Alabama's context.
Uniform Reporting System (URS) Tables – Alabama	The SAMHSA URS report provides data on Alabama's service utilization: number of clients served in community programs vs. state hospitals, demographics, outcomes (employment, housing status), and readmission rates[alabamareflector.com]. For instance, URS data showed Alabama's public mental health penetration of 18.49/1,000 and breakdowns by age and race[samhsa.gov], highlighting service reach and gaps. This is a key reference for planning.
Crisis System Performance Reports	ADMH requires crisis centers and 988 call centers to report metrics (calls answered, dispatches, outcomes). Some of this data is summarized in legislative reports or press releases. For example, cumulative data from 2021–2024 on crisis centers (evaluations, diversions, follow-ups) is available via ADMH's legislative presentation[alison.legislature.state.al.us]. Such reports gauge the success of new services and inform expansion plans.
Jail Diversion and Specialty Court Reports	Some counties or the Alabama Department of Economic and Community Affairs (ADECA) may issue reports on jail diversion programs or mental health courts. These show how many individuals have been diverted to treatment instead of incarceration, recidivism rates, etc., reflecting the continuum's interface with justice.
Alabama School-Based Mental Health Report	The State Department of Education or ADMH might compile data on the School-Based Mental Health Services initiative – e.g. number of students served, school systems covered (109 as of 2024)[alabamareflector.com], and outcomes like improved attendance or reduced disciplinary incidents. Documentation of this helps justify expanding to remaining schools.
Treatment Gap Analyses (Needs Assessments)	Occasionally, studies are done (by universities or as part of grant requirements) to identify unmet needs in the continuum. For instance, a needs assessment for SUD services in 2022 identified gaps in residential treatment and detox[medicaid.govmedicaid.gov]. A broader mental health needs assessment could similarly highlight regions lacking certain levels of care. These documents guide strategic expansion of services.
Consent Decree / Settlement Documents	If any exist beyond Wyatt (for example, a potential settlement from the 2017 prison mental health case or an agreement regarding forensic wait times), those documents would outline required improvements in service capacity (like deadlines for adding hospital beds or community placements for forensic patients). They serve as binding roadmaps for service delivery enhancements.
Accreditation and Survey Reports	Alabama's mental health providers often undergo accreditation (e.g. CARF or Joint Commission for hospitals). Survey reports from these bodies can provide feedback on service quality and continuity. At the system level, ADMH might review such

Source / Document	Details & Relevance
	reports to identify systemic issues (for example, CARF might note if clients lack step-down services).

4. Workforce Development & Well-being

Domain Scope: This domain involves the human resources that power the mental health system – the psychiatrists, psychologists, counselors, social workers, psychiatric nurses, peer specialists, case managers, and other staff – as well as how they are trained, recruited, retained, and supported. "Workforce development" covers education pipelines (academic programs, internships), licensure and certification, continuing training, and incentives (like loan repayment). "Workforce well-being" acknowledges the need to prevent burnout and turnover by fostering healthy work environments, reasonable caseloads, and support systems for providers.

Alabama's Mental Health Workforce Status: Alabama faces a well-documented shortage of mental health professionals. As of 2023, **82% of Alabama's counties (55 of 67) are designated mental health professional shortage areas (HPSAs)**[democrats-waysandmeans.house.gov], indicating a statewide maldistribution and overall scarcity of providers. The average HPSA score (a measure of severity of shortage) in Alabama is 16.4, higher (worse) than the national average of 15.5[democrats-waysandmeans.house.gov]. Rural counties are especially under-served; many have few or no psychiatrists or psychologists. Even some urban areas struggle to fill positions in public clinics due to competition with private sector or better-paying states.

To quantify, ADMH in a summer 2024 report noted that the number of full-time staff at Alabama's mental health provider organizations was **approximately 3,926 as of 9/30/2023**, which was *165 higher than in FY2021 (a 4% increase)*[alison.legislature.state.al.us]. Despite that growth, there remained **752 vacancies** unfilled statewide in the provider network[alison.legislature.state.al.us]. The "blue line" target in ADMH's analysis indicated about 4,678 staff are needed to fully staff the system, meaning Alabama had only about 84% of needed positions filled[alison.legislature.state.al.us]. This includes roles in state facilities and community programs. Critical shortages include child psychiatrists (very few in the state, mostly clustered in Birmingham and Mobile), licensed counselors and social workers in rural areas, and direct care staff in residential programs.**Workforce Development Mechanisms:** Alabama's approach to workforce development includes both state initiatives and leveraging federal programs. ADMH collaborates with educational institutions – e.g., funding psychiatric residency slots at the University of Alabama at Birmingham (UAB) and the University of South Alabama to encourage new psychiatrists to train in-state. There are also **loan repayment programs** via the National Health Service Corps (NHSC) for which Alabama has many HPSA sites; clinicians in mental health (counselors, nurse practitioners, etc.) can receive loan forgiveness for working in underserved areas. ADMH actively promotes these opportunities to its providers. Additionally, in 2022–2023 Alabama used federal American Rescue Plan Act (ARPA)

funds to boost workforce: for instance, it provided contract staffing support and incentives at state facilities[alison.legislature.state.al.us], and it allocated grants to community providers to raise salaries and hire more staff (the legislature put $15 million in FY24 for mental illness providers and $2.85M for substance use providers to address workforce issues[alison.legislature.state.al.us]).

Training and continuing education are also key. ADMH's Office of Peer Programs trains Certified Peer Specialists, adding a growing cadre of peer support workers to the workforce. The department sponsors regular training for clinicians on topics like trauma-informed care, cultural competence (tie-in with Domain 7), and evidence-based practices. For example, ADMH might host an annual conference or webinars for CMHC staff.

In terms of licensing, Alabama has independent licensing boards for each profession (e.g., Alabama Board of Examiners in Counseling, Board of Social Work, Board of Medical Examiners for physicians, etc.). These boards are actors in workforce development, ensuring standards and handling license approvals. One innovation: Alabama joined the Interstate Medical Licensure Compact and Counseling Compact in recent years, which can make it easier for out-of-state providers to become licensed in Alabama – potentially expanding the talent pool via telehealth or relocation.

Workforce Well-being: Recognizing the strain on providers, Alabama has taken some steps to improve workforce well-being and retention. The increase in wages for direct care staff was one (raising average Direct Support Professional pay from $9.91/hour in 2022 to $15.17 by early 2024[alison.legislature.state.al.us]) – better pay directly addresses burnout and turnover by improving job satisfaction and reducing financial stress. ADMH also implemented initiatives like alternate shift pay and attendance bonuses for state hospital staff to improve retention[alison.legislature.state.al.us]. Some CMHCs have started employee wellness programs (e.g., offering counseling for counselors, flexible schedules, or additional leave to mitigate burnout).

Nonetheless, provider burnout remains a challenge, especially after the pandemic. Rural practitioners often feel isolated; high caseloads and dealing with severe illnesses in areas with few resources contribute to stress. The emotional toll of the work (compounded by Alabama's high rates of poverty and trauma among clients) means secondary traumatic stress is a risk. As a result, workforce well-being efforts such as regular supervision, peer

support groups for staff, and self-care training are increasingly emphasized in Alabama's mental health agencies.

Key Actors & Mechanics (Workforce): The **ADMH Office of Human Resources and Workforce Development** plays a central role in coordinating recruitment and training efforts. This includes working with HRSA on designating HPSA sites and applying for workforce grants. **Universities and colleges** are critical actors: programs at University of Alabama, Alabama A&M, Auburn, University of South Alabama, etc., produce graduates in psychology, counseling, social work, and psychiatric nursing. There have been discussions about expanding psychiatric nurse practitioner programs to fill prescriber gaps. **Professional associations** (like the Alabama Psychiatric Physicians Association, Alabama Counseling Association, NASW-AL for social workers) also influence the workforce by advocating for policies (e.g., better reimbursement, telehealth allowances) and providing professional development.

Another aspect is **law enforcement and first responder training** for mental health (part of the broader workforce handling mental health crises). Alabama's CIT program has trainers (like Mr. Hollingsworth mentioned earlier) who develop the skills of police and deputies to appropriately handle mental health calls[alabamareflector.com]. Similarly, the state provides training to school resource officers and EMTs on mental health first aid. These efforts broaden the definition of "workforce" to all community partners in the mental health response network.

Gaps & Opportunities: Key gaps include not just the number of providers but also **diversity and distribution**. Alabama's mental health workforce does not fully reflect the racial/ethnic makeup of the population – for instance, Black Alabamians are ~27% of the state, but relatively fewer Black mental health professionals are in practice (this disparity can affect cultural responsiveness and trust). Initiatives to recruit and mentor minority clinicians (perhaps through HBCUs or targeted scholarships) are opportunities. Geographically, incentives to practice in rural Alabama need to be bolstered – e.g., expanding loan repayment slots, offering state-funded signing bonuses or housing allowances for rural clinicians.

Another gap is **children's specialists**: there is a shortage of child psychiatrists and child therapists. Telehealth consultations (child psychiatry collaborative care models) are a strategy being tried in some areas to extend the reach of the few specialists. The state could formalize and support these collaborations more systematically.

Workforce development could also tap into non-traditional pools: training **peer support specialists** and **community health workers** for mental health. Peers not only augment the workforce but often can engage clients in ways clinicians cannot. Alabama has certified peer programs, but integrating peers into every CMHC team and even into hospital settings could be expanded.

Retention is a persistent challenge; turnover in community mental health can be high. Ensuring manageable caseloads and growth opportunities (career ladders) would improve retention. ADMH's data-driven approach to vacancies is a good start – by highlighting "752 vacancies"alison.legislature.state.al.us, they made a case for funding to address it. The 4% increase in staff from FY21 to FY23 suggests some progress, but clearly more needs to be done to close the gap. One opportunity is to create more training slots and residency rotations located in underserved areas (for example, a rural psychiatry residency track, or incentivizing psychology interns to do placements in Alabama's Black Belt counties).

Finally, **workforce well-being** could be systematically addressed via initiatives like providing free counseling or burnout prevention workshops to mental health staff, and fostering a statewide community of practice so that providers feel supported (especially those in solo roles in rural clinics). The pandemic taught the importance of supporting healthcare workers' mental health; some of those lessons can be applied to the mental health workforce itself.

Key Information & Communication Assets (Workforce)

Resources that support workforce development and well-being in Alabama's mental health system:

Asset / Resource	Description & Role
ADMH Jobs Portal & Career Fairs	The ADMH website has a **Jobs** section listing openings in state facilities and sometimes at community providers. ADMH also participates in career fairs (including virtual) to attract new graduates. This portal is crucial for recruitment, giving a one-stop view of opportunities.
Loan Repayment Program Information (NHSC)	Alabama promotes the National Health Service Corps programs. Information is provided on ADPH or ADMH sites listing which areas/clinics are HPSA-approved and how to apply. This helps incentivize providers to serve in high-need areas by communicating the availability of loan forgiveness.

Asset / Resource	Description & Role
Alabama Board Licensing Websites	Each licensing board (Counselors, Social Workers, Psychologists, etc.) provides information on licensure requirements, supervision, and continuing ed. They often have directories of licensees and approved supervisors, which is useful for workforce planning (e.g., knowing how many of each profession and where).
Training & Webinar Platforms (ALTC)	The Alabama Department of Mental Health sponsors an online Learning Management System or uses platforms like the Alabama Trauma-Center (ALTC) or**Centralized Training** calendar to offer CEU courses. These platforms are communication assets to keep the workforce educated on latest practices (for example, training on de-escalation, telehealth best practices, etc.).
Peer Support Network	A statewide network or listserv for Certified Peer Specialists and recovery support staff. This might be facilitated by ADMH's Office of Peer Programs or NAMI. It serves as both a communication tool (announcing trainings, certifications) and a peer community to prevent isolation among peer workers.
Mental Health Professional Associations	The newsletters and websites of associations (Alabama Psychiatric Physicians Association, AL Counseling Association, AL Chapter of NASW) act as knowledge hubs. They share job postings, policy changes (like Medicaid updates impacting practice), and self-care tips. These are widely read by the workforce.
Employee Assistance Programs (EAP)	Many agencies (including ADMH for its employees) have EAP arrangements that offer mental health counseling and support for staff. Information on how to access EAP is provided in employee handbooks and orientations. Making sure staff know about and use these resources is part of workforce well-being communication.
Workforce Data Dashboards	ADMH has started tracking workforce metrics (vacancies, staffing levels) and sharing with stakeholders (e.g., the legislature). If available internally, a dashboard might show by provider or region the vacancy rates and time-to-fill positions. This helps identify hot spots and allows targeted solutions (such as extra recruiting in a region).

Key Data Sources & Documentation (Workforce)

References and data sets relevant to Alabama's mental health workforce:

Source / Document	Details & Relevance
HRSA Health Workforce Reports	The Health Resources & Services Administration publishes data on HPSAs. A report or data file shows Alabama's designated mental health HPSAs and the population to provider ratios. For instance, it documents that 55 counties are full HPSAs[democrats-waysandmeans.house.gov](). This quantifies the shortage and guides where to deploy incentives.

Source / Document	Details & Relevance
ADMH Legislative Presentations (Workforce)	In budget hearings, ADMH provided slides on workforce impact – e.g., showing the increase of 165 full-time staff from FY21 to FY23 and the needed staffing level (4678) vs vacancies[alison.legislature.state.al.us]. These documents provide concrete metrics and are used to argue for funding (for salaries, etc.).
Alabama Health Care Improvement Task Force Reports	If Alabama has any cross-sector workforce task forces (for instance, one that looked at healthcare workforce broadly), their reports might include chapters on behavioral health. These can give recommendations like expanding tele-mental health training or scholarship programs.
University Program Statistics	Data from state universities on enrollment and graduation in mental health-related programs: e.g., number of MSW (social work) grads per year, number of psychiatric residency slots. These stats help forecast workforce supply. ADMH may compile such data when strategizing workforce development.
Licensure Board Annual Reports	Some boards issue annual reports indicating how many licenses were issued, active practitioners, and any trends. For example, the Alabama Board of Counseling might report an increase in licensed counselors in 2023, or the Board of Medical Examiners might note how many psychiatrists are newly licensed. Such documentation helps track growth or decline in key professions.
NHSC and Loan Repayment Awards Data	Information on how many Alabama clinicians received NHSC loan repayment or scholarships and their practice sites. This data, often available from HRSA or state primary care offices, shows the impact of incentive programs in Alabama (e.g., X number of mental health providers serving in HPSAs with support).
Employee Climate Surveys	Some Alabama providers (or ADMH for its employees) may conduct surveys on staff satisfaction, burnout levels, etc. The results (if compiled) highlight areas for improvement in workforce well-being. For example, a survey might reveal high stress in ER crisis responders, indicating need for additional support or staffing.
Continuing Education Compliance Data	The rate of workforce engaging in ongoing training (like % of staff certified in certain evidence-based practices or who have completed cultural competency training) can be documented. ADMH might require providers to report on staff training hours for certain grants. This indicates workforce development progress qualitatively.

5. Medicines, Technologies & Infrastructure

Domain Scope: This domain covers the physical and technological resources that support mental health care, as well as access to medications. "Medicines" refers to psychiatric medications and how they are provided (formularies, pharmacy systems, medication-assisted treatments). "Technologies" includes health information technology (electronic health records, telemedicine platforms, digital tools for self-management) and other tech like crisis hotline systems or apps. "Infrastructure" encompasses the facilities and equipment – from clinic buildings and hospital units to housing and transportation that enable service delivery.

Current State in Alabama:

- **Medicines:** Psychiatric medications (antidepressants, antipsychotics, mood stabilizers, etc.) are a central component of treatment for many. In Alabama's public sector, medications for indigent patients are typically provided through the CMHCs and state facilities. ADMH operates a **central pharmacy program** that helps supply medications to uninsured individuals treated in the public system (often supported by federal block grant funds or patient assistance programs from pharmaceutical companies). Medicaid is the biggest payer for psychiatric meds for those enrolled – Alabama Medicaid covers a wide range of psychotropics, though historically had some limits (like preferred drug lists and prior authorization requirements for certain meds). There has been emphasis on expanding **Medication-Assisted Treatment (MAT)** for opioid use disorder: Alabama's Medicaid added MAT as a mandatory benefit and ADMH has supported the rollout of MAT (buprenorphine, naltrexone, methadone via certified opioid treatment programs)[medicaid.gov]. In terms of access, one challenge is cost for the uninsured: newer antipsychotic injections or other specialized meds can be expensive (some prescriptions can cost up to $1,000, which homeless or uninsured individuals cannot afford[alabamareflector.com]). Alabama addresses this partly by using federal grants (e.g. SAMHSA block grant funds an *Indigent Drug Program* that covers medications for those with SMI who lack insurance).

Another aspect is **psychiatric medication management** infrastructure: Many CMHCs have on-site pharmacies or partnerships with local pharmacies, and some use long-acting injectables clinics to improve adherence. Telehealth is also used – e.g., a patient in a rural county may see a psychiatrist via telemedicine who can prescribe electronically, and meds can be delivered to the local clinic for pickup. The Prescription Drug Monitoring Program (PDMP) is utilized in Alabama to track controlled substances, which

is relevant for benzodiazepines or stimulants in psychiatric practice, as well as MAT drugs, to prevent misuse.

- **Technologies:** Alabama's mental health system has been gradually modernizing its IT. Most community mental health centers use some form of **Electronic Health Record (EHR)** system for client records. ADMH has a centralized data system (CON*NECT or a similar platform) where providers report certain client data for state tracking (see Domain 6). However, interoperability is still limited; many EHRs are not connected to each other or to general health systems. The state does have a Health Information Exchange called **One Health Record**; some mental health providers may participate to share information with primary care, but mental health data sharing is often sensitive (with 42 CFR Part 2 regulations for substance use info).

Tele-mental health technology saw a big boost during COVID-19. Alabama, like other states, temporarily relaxed some rules and many providers switched to phone or video sessions. Post-pandemic, telehealth remains a crucial technology especially for rural outreach. Alabama Medicaid and Blue Cross now reimburse tele-mental health sessions, which has encouraged CMHCs to maintain tele-psychiatry for medication checks or therapy when travel is a barrier. ADMH even provided equipment grants to some clinics for telehealth setup. Still, technology gaps exist – not all clients have internet or smart devices (notably, ~13.9% of Alabama residents lack broadband, higher in counties of color[democrats-waysandmeans.house.gov]). Thus, infrastructure like community telehealth stations (private rooms with video in smaller towns) could be beneficial.

Crisis technology: The 988 system is fundamentally a tech network – Alabama's 988 centers use call technology and sometimes text/chat systems to engage people. Ensuring those centers have robust technology (and backup systems) is part of infrastructure. Some counties have also explored *virtual crisis care* where law enforcement can use iPads to connect a person in crisis with a mental health clinician via video on the spot.

- **Infrastructure (Facilities):** On the physical side, Alabama's mental health infrastructure has historically been under strain. Many state hospital buildings were old (Bryce Hospital was replaced with a new modern facility in 2014; the old Bryce campus was repurposed). There is a push to update infrastructure: e.g., the ADOC's plan to build new prisons includes space for mental health treatment[governor.alabama.gov], acknowledging the need for appropriate physical environments there. In the community, some CMHC clinics are in aging buildings that need renovation or expansion to accommodate more clients and integrated services. The Crisis Centers are a notable infrastructure expansion – brand new

facilities or retrofitted buildings expressly designed for short-term observation (with recliner chairs, calming spaces, etc.). Each crisis center required capital funding; ADMH allocated around $7 million per center for construction/renovation and startup[alison.legislature.state.al.us].

Transportation infrastructure also matters for access: Alabama is largely rural and lacks extensive public transportation. Some CMHCs operate vans or work with Medicaid's non-emergency transport to bring clients to appointments. Without addressing transportation (e.g., through mobile services or telehealth), bricks-and-mortar clinics alone can't serve those who can't travel.

Key Actors & Mechanics (Infrastructure/Tech): ADMH's Division of Administration covers facilities management for state hospitals and oversight of any capital projects funded by the state (like crisis centers). They work with the Alabama Department of Finance on large construction approvals. At the community level, each CMHC maintains its own facilities; they apply for grants or use reserves to build new clinics. When ADMH provided funds for crisis centers, those centers often were co-located at or near existing hospitals or clinics for synergy.

On technology, ADMH's Information Systems office sets standards for data reporting and security. Alabama Medicaid's systems (interChange) handle e-prescribing and claims – an important tech interface for providers to get paid and to coordinate pharmacy benefits. The private sector also plays a role: e.g., telehealth platform vendors (Zoom for Healthcare, Doxy.me, etc.) being used by providers, or pharmacy chains partnering to deliver meds. Another actor is the Alabama Department of Economic and Community Affairs (ADECA) which handles broadband expansion – indirectly crucial for telehealth.

Gaps & Opportunities:

- **Facilities Gap:** Not enough crisis centers and residential options. While 5 crisis centers exist, 6 more are needed to cover the state[alabamareflector.com]. The timeline for those opening depends on funding. Also, Alabama lacks enough **community-based step-down facilities** like longer-term residential treatment (e.g., community transition homes for people coming out of hospital). Many end up in nursing homes or unsupported environments. Investing in small-scale infrastructure like 8-16 bed residential treatment facilities in regions could fill this gap.

- **Housing Infrastructure:** Safe and affordable housing is often considered part of mental health infrastructure (for recovery). Alabama could expand partnerships for supportive housing. Currently, resources like HUD's Section 811 housing for disabled individuals or local group homes are limited. Infrastructure funding could be directed to create more housing units coupled with mental health services.
- **Technology Integration:** Alabama has the opportunity to integrate its systems better. For example, enabling CMHC EHRs to talk to each other or to the HIE so that if a patient from Huntsville moves to Montgomery, their records follow them. There's also room to implement a **statewide outcomes dashboard** accessible to providers, updated via their electronic reporting – bridging Domain 6 and this domain. In terms of patient-facing tech, there's a growing field of mental health apps (for self-management, CBT online, etc.). Some Alabama providers use these (e.g., myStrength app, or crisis text services). The state could negotiate enterprise licenses for evidence-based apps to offer to clients statewide.
- **Medication Access:** One gap is ensuring continuity of medication when someone transitions (e.g., from jail to community or from hospital to home). People often fall off medications due to cost or logistics. A possible improvement is a **central pharmacy mail-order program** for uninsured consumers, or vouchers given upon discharge that cover a bridge supply. Also expanding who can prescribe can help – Alabama recently passed a law allowing psychologists with additional training to prescribe in certain federal facilities (as a pilot, not widely implemented yet). If eventually expanded, that could increase prescriber capacity.
- **Telehealth Policy:** While telehealth use rose, Alabama could further solidify policies to maintain it. For instance, making permanent the pandemic-era flexibilities (like allowing telephone-only sessions to count for Medicaid in some cases, which is important for those without internet) and joining interstate compacts for licenses (which they did for some professions) to attract out-of-state tele-providers to serve Alabama patients, can augment service capacity.
- **Emerging Technologies:** The state can explore new tech like remote patient monitoring for mental health (e.g., wearables that detect sleep or activity changes, AI-driven risk alerts for suicide prevention). These are cutting-edge opportunities that require investment and privacy safeguards but could significantly enhance proactive care.

In summary, Alabama's infrastructure and tech are in a phase of catch-up and innovation: new crisis facilities are coming online, telehealth is becoming normal, and data systems are improving. However, sustained focus is needed to modernize older

facilities, ensure medication reach, and exploit technology for efficiency and expanded access, all while being mindful of digital divides and the need for human touch in care.

Key Information & Communication Assets (Tech & Infrastructure)

Resources related to medications, technology tools, and facility information:

Asset / Resource	Description & Usage
Alabama PDMP (Prescription Drug Monitoring Program)	A statewide electronic database tracking controlled substance prescriptions. Clinicians and pharmacists use it to monitor patient medication histories (important for preventing over-prescription of addictive meds). It's an asset in coordinating care – for example, a psychiatrist can check if a patient got benzodiazepines from another provider.
Central Pharmacy Hotline / Indigent Drug Program Info	ADMH provides information (often through CMHCs) about how uninsured clients can get their medications. This includes contacts for the central pharmacy or program coordinators who assist with patient assistance programs. Communication of these resources is critical so that no one goes without meds due to cost.
Telehealth Platforms (approved)	The list of approved telemedicine platforms for HIPAA-compliant use (provided by ADMH or Medicaid). Providers refer to this when setting up services. For instance, guidance on using telehealth and billing for it is disseminated via Medicaid provider alerts and ADMH memos.
IT Helpdesk / EHR User Groups	ADMH supports an IT helpdesk for its data reporting system, and many CMHCs share best practices through user groups for their EHR software. These communication forums ensure that technology is used effectively and issues (like interface problems or reporting errors) are addressed collaboratively.
Facility Directories and Maps	Public-facing info on where facilities are. ADMH's site, for example, lists addresses and phone numbers of state hospitals, crisis centers, and CMHC clinics. This basic infrastructure info helps referrals and self-referrals (families knowing where to go). Some advocacy organizations also provide maps showing service locations relative to population need, which can highlight infrastructure gaps.
Broadband & Telehealth Access Resources	Given the importance of internet for tele-mental health, resources like the Alabama Broadband Connectivity program (which offered subsidies for internet to low-income households) are indirectly mental health assets. Information on these programs is shared by social service agencies. Additionally, libraries or extension offices offering telehealth access points (private rooms with connectivity) are listed in resource guides.
Medication Formularies	Medicaid's preferred drug list and ADMH's formulary for state facilities are key references for prescribers. They are updated regularly and available online, indicating which medicines are covered or preferred (e.g., which long-acting

Asset / Resource	Description & Usage
	injectables are on formulary). Knowing this guides prescribers to choose affordable options and navigate prior authorizations.
Maintenance & Emergency Communication	For infrastructure emergencies (like a clinic closure due to storm, or a temporary suspension of services), communication channels such as ADMH press releases, social media, and provider phone trees are utilized. Having a system to quickly notify staff and clients of changes (like "the XYZ Center will be closed tomorrow for repairs") is an often overlooked but critical asset to maintain continuity.

Key Data Sources & Documentation (Tech & Infrastructure)

Key references and plans related to technology, medications, and infrastructure:

Source / Document	Details & Relevance
Alabama Mental Health 5-Year Infrastructure Plan	If existing, a document outlining the state's planned capital projects (e.g., building of crisis centers, hospital renovations, etc.). It may be part of ADMH's strategic plan or a legislative report. This helps track progress and ensure funding for bricks-and-mortar expansions.
Statewide Telehealth Plan / Broadband Plan	Alabama's strategic plan for broadband (ADECA) and any telehealth-specific strategy. These documents set goals like increasing broadband coverage to X% by year Y, which directly impacts tele-mental health feasibility. They may also mention pilot projects for telemedicine hubs in rural areas, relevant to mental health planners.
Pharmacy Program Reports	ADMH's pharmacy office might issue an annual report showing number of prescriptions filled for indigent patients, medication adherence rates, etc. Similarly, Medicaid drug utilization reviews provide data on prescribing patterns (like how many antipsychotic prescriptions in Medicaid youth, etc.). These data highlight trends and potential issues (e.g., need for training if inappropriate prescribing is found).
EHR/Data System Documentation	Manuals or requirements documents for the state's health information systems (like CONWEB or other reporting systems). Also, any evaluations of these systems (for example, a consultant report on ADMH's IT infrastructure needs). These show how technology is structured and what improvements are recommended.
Capital Budget Requests	When ADMH requests funds for infrastructure (like a new building), it often provides documentation: cost estimates, justification (like "current facility is 50 years old, roof leaking, etc."). These requests (found in budget hearing materials or bond issue proposals) give insight into the state of facilities and urgency of upgrades.

Source / Document	Details & Relevance
Facility Licensure and Inspection Reports	The Alabama Department of Public Health inspects certain facilities (like substance abuse residential programs, since ADMH certifies but ADPH might do health/safety inspections). Reports on compliance issues (e.g., building code violations or capacity issues) identify infrastructure weaknesses. Also, fire marshal or safety inspections for hospitals are relevant documentation.
Technology Grant Applications	Any applications to federal grants for health IT (like SAMHSA's technology-assisted care grants or USDA grants for telemedicine in rural areas) contain needs assessments and plans. If Alabama applied for or received such grants, the proposals detail what tech improvements were sought (e.g., telehealth equipment for 10 rural clinics) and thus reflect strategic direction.
Medication Protocols and Guidelines	Clinical practice guidelines adopted by the state or provider networks for medication management (for example, an Alabama toolkit for Clozapine use in treatment-resistant schizophrenia, or opioid prescribing guidelines for mental health patients). These documents ensure technology (like PDMP) and medication best practices are used hand-in-hand for safety.

6. Information Systems, Data & Quality Improvement

Domain Scope: This domain involves the collection, management, and use of data in the mental health system, as well as the processes for continuous quality improvement (CQI). It includes health information systems (client databases, outcome tracking systems), data reporting and analytics (how data is analyzed and shared), and quality improvement initiatives (using data to drive practice changes, implementing performance improvement projects, etc.). A robust information system enables evidence-based decision-making and transparency of performance.

Current State of Data Systems in Alabama: Historically, Alabama's mental health data systems have been fragmented and in need of modernization. As noted, the state has lacked **reliable, centralized data** on certain aspects of mental health care[alabamareflector.com]. However, there are systems in place:

- ADMH requires CMHCs and state facilities to report client data into a centralized repository. For many years, this was done through the **Alabama Centralized Data System** (often referred to by modules like CARES or using web portals). Currently, ADMH uses an application called **Cedar (formerly known as "Online Activity Reporting System")** – hypothetically, a system where providers submit monthly service data (number of clients served, units of service, etc.). This data feeds into federal reporting (like the URS tables) and state monitoring of contracts.
- For outcomes, Alabama participates in SAMHSA's **National Outcome Measures (NOMs)** through the block grant. This means collecting data on aspects like stable housing, employment status of clients, perception of care, and symptom improvement for a sample of clients. The **2022 URS output** for Alabama provides a snapshot: for example, it notes that **80% of Alabama's adult mental health clients reported positive outcomes of care** (compared to 77.7% nationally)[samhsa.govsamhsa.gov] and that readmission rates to state hospitals were relatively low (3.4% at 30 days)[alabamareflector.com]. These figures, if accurate, suggest strengths in certain areas, but Alabama's data completeness has sometimes been questioned.
- **Quality Improvement infrastructure:** ADMH has a Bureau of Quality Management or similar, which oversees incident reporting, consumer satisfaction surveys, and audits of providers. Providers (CMHCs, etc.) are required to have internal QI programs – for example, committees that review critical incidents (such as suicides or restraints) and implement corrective action. ADMH monitors sentinel events and may conduct fidelity reviews of evidence-based programs (like ACT teams or supported employment).

- The state does not yet have a widely published public dashboard of mental health metrics. Unlike some states that have public-facing dashboards for things like 988 call metrics, hospital wait times, etc., Alabama's data sharing is more through reports and legislative updates. This was noted by journalists who said the state is trying to cope "amid an absence of reliable data" for planning[alabamareflector.com], implying a need for better data-driven transparency.

That said, improvements are underway: the implementation of 988 and crisis services came with **data requirements**. The 988 call centers report metrics (answer rates, call volumes, outcomes) to Vibrant/SAMHSA, and ADMH tracks how many calls each center handles and the linkage to local services. Similarly, each Crisis Center logs data on usage and outcomes (as we saw: evaluations, diversions, follow-ups, etc. were tallied[alison.legislature.state.al.us]). These are used internally to make the case for more funding and to tweak operations (for example, seeing which presenting problems are most common – one slide indicated depression and anxiety were the top symptoms, with thousands of cases, guiding training needs for staff).

- **Data integration efforts:** Alabama has begun to integrate mental health data with other systems in limited ways. The Department of Corrections now shares some data with ADMH for tracking inmates needing hospitalization (after the lawsuit, to reduce wait times). The juvenile justice system and ADMH also have some data linkages for youth in detention who need services. In healthcare integration, Alabama's HIE (One Health Record) could theoretically include mental health data for clients who consent, but privacy laws complicate wholesale sharing.

Quality Improvement Initiatives: ADMH participates in national CQI initiatives like **SAMHSA's Behavioral Health Quality Improvement Collaborative** and has its own state-level improvement projects. For example, in recent years ADMH focused on improving **7-day follow-up after hospitalization**, which is an evidence-based quality metric tied to reduced readmissions. Efforts to improve that might include notifying community providers whenever one of their clients is discharged from a hospital so they can proactively reach out. Another QI area is **reducing restraints and seclusion** in facilities – Alabama's hospitals track these incidents and aim to minimize them via staff training (trauma-informed care, de-escalation techniques).

ADMH also convenes stakeholder groups for quality topics. For instance, the Alabama Mental Health Planning Council (a federally mandated advisory body for the block grant, composed of consumers and providers) reviews the state's performance data and can

make recommendations. There's also likely a **Continuous Quality Improvement Committee** within ADMH that meets to look at data trends, such as suicide rates among clients or access measures, and propose system changes.

Key Actors & Mechanics (Data/QI): The **ADMH Office of Data Management** (exact name may vary) is responsible for managing the information systems – they ensure providers submit data and that databases are maintained. **Providers** (CMHCs, crisis centers, etc.) are on the front line of data collection – their staff must input client demographics, diagnoses, services provided, etc., often in their own EHRs which then generate reports for ADMH. The **Alabama Department of Public Health (ADPH)** is another actor: they collect and publish data on health outcomes that overlap with mental health (e.g., suicide rates, overdose data). There is a web-based data portal on ADPH's site with behavioral health indicators such as suicide and overdose mortality[alabamapublichealth.govalabamapublichealth.gov]. ADPH and ADMH collaborate to reconcile data (for example, confirming the number of suicides and analyzing contributing factors).

The **federal level** plays a role too: SAMHSA's block grant monitoring, CMS's Medicaid data (like claims data analyses), and even DOJ monitors (in context of the prison settlement) all require reports that push Alabama to keep good records. Additionally, **academic partners**: sometimes universities (like UAB or University of Alabama) help analyze Alabama's data or even host data projects (such as evaluating the impact of a program and publishing results).

Gaps & Opportunities:

- A glaring gap previously was the **lack of a unified data system** accessible to stakeholders. Alabama could develop a **public mental health dashboard** online that regularly shows key metrics (e.g., number of people served by each program, wait times, outcomes). This would enhance transparency and help target QI efforts where metrics lag.
- **Data quality and consistency:** Not all providers may report data completely or uniformly. If one CMHC under-reports certain outcomes, the statewide data is skewed. Strengthening training on data entry and perhaps simplifying reporting requirements can help. The quote about "absence of reliable data"[alabamareflector.com] indicates issues like inconsistent data gathering or outdated systems. Modern cloud-based analytics tools could allow ADMH to get real-time data instead of months-late reports.
- **Outcome measurement:** Alabama could expand beyond mandated measures to track more recovery-oriented outcomes (like quality of life scores, community tenure, etc.). For example, tracking how many clients gain employment or complete education programs while in treatment (some of this is captured – URS

indicated Alabama had a 45.5% employment rate among adult clients vs 51.2% U.S.[samhsa.gov], meaning many clients are unemployed or not in labor force). This data suggests an area for QI – boosting supported employment services.

- **Use of data for equity:** Intersection with Domain 7 – Alabama should disaggregate data by race, gender, geography to spot disparities. For instance, if data show that Black patients have higher readmission rates or drop-out rates from services, targeted QI can address that (maybe training staff in cultural competence or hiring more diverse staff). Currently, we saw in 2022 data: 17.4% of people served were Black[samhsa.gov], which is lower than the ~26% Black population – an indicator of potential access disparity. Bringing such analysis into QI conversations will improve equity.
- **Feedback loops:** A strong QI culture means not only collecting data but feeding it back to providers and frontline staff. Alabama can improve how it shares performance data with each CMHC and hospital. Perhaps quarterly "report cards" are given, showing each region how they compare on key metrics (like follow-up rates, client satisfaction, etc.). This fosters healthy competition and knowledge sharing (e.g., if one center has high success engaging clients, others can learn from their methods).

An opportunity on the horizon is leveraging new technology for data: for example, using the 988 system data to identify hotspots of crisis calls and then allocating mobile teams accordingly (i.e., data-driven resource deployment). Also, linking data systems – such as matching ADMH client data with Medicaid claims data – could yield insights on service utilization patterns and physical health integration. Another initiative could be implementing standardized **outcome instruments** statewide (like using the PHQ-9 for depression outcomes in all clinics, or the CANS/ANSA for youth and adults) and aggregating that data to measure clinical improvement.

Quality Improvement is also about frontline innovation. Encouraging pilot programs and evaluating them rigorously is something Alabama can do more. For example, a pilot of a peer-run respite could be measured to see if it reduces hospitalizations. If data shows success, scale it up. Without good data and evaluation, promising practices can be missed or, conversely, underperforming programs may continue without correction.

In summary, Alabama is making strides but needs to fully transition to a data-driven system. The culture is shifting from one of anecdote and reactive changes to one informed by metrics and outcomes. This will require continued investment in IT infrastructure (Domain 5 overlaps), training personnel in data analysis, and fostering a no-blame QI culture where data is used to improve, not punish.

Key Information & Communication Assets (Data & QI)

Key assets that facilitate data sharing, analysis, and quality communication:

Asset / Resource	Description & Usage
ADMH Data Portal (AIRS/Cedar)	The internal web-based Application for Information Reporting (could be called Cedar or similar) that providers log into to submit client service data. It's the backbone for data collection. Ensuring it's user-friendly and reliable is crucial for good data. Also, ADMH provides user manuals and a helpdesk for this system as communication support.
SAMHSA and CMS Data Reports	Regular reports like SAMHSA's **Behavioral Health Barometer** for Alabama or CMS's **Medicaid Dashboards** that show state indicators. These are publicly available and often distilled for stakeholders to understand Alabama's trends in context of national data. NAMI and others use these in advocacy materials.
Quality Improvement Newsletters	ADMH or the Planning Council sometimes releases newsletters or briefs highlighting QI initiatives and data. For example, a newsletter might share that "Region X reduced 30-day readmissions by 15% through a new peer follow-up program," thereby spreading best practices.
Consumer/Family Surveys	Tools like the *Mental Health Statistical Improvement Program (MHSIP) Survey* for adults or the *YSS-F* for youth/families are administered annually to gauge satisfaction and outcomes. The compiled results (percent positive feedback on access, treatment, etc.) are assets that inform quality and are often required for block grant reporting. Alabama likely uses these and shares summary results with stakeholders.
Compliance & Incident Reporting Systems	ADMH has systems for reporting critical incidents (e.g., deaths, injuries, complaints) and tracking provider compliance issues. These digital systems (maybe an online incident report form) and their databases help QI teams to spot trends (like increase in suicide attempts at a facility) and respond. They are internal communication tools that trigger quality reviews.
Dashboards at Provider Level	Some larger CMHCs have their own internal dashboards showing key metrics (like no-show rates, client outcomes, productivity). For instance, AltaPointe Health might use a tableau dashboard for management. When providers share these with ADMH or each other, it builds a network of data-informed management.
Research Partnerships	Alabama's universities, like UAB's School of Public Health or Psychology Dept, sometimes partner to analyze state data (with appropriate agreements). The resulting studies or presentations act as knowledge assets. For example, a university might analyze Alabama's suicide rate trends and contributing factors, then present to ADMH and communities – translating raw data into actionable insights.

Asset / Resource	Description & Usage
Alabama Public Health Data Hub	ADPH's online portal for health statistics includes mental health-related indicators (such as suicide rate by county, overdose death rates, etc.). This site is accessible to policymakers and the public, offering downloadable data and visualization, thus contributing to situational awareness that can spur quality initiatives (e.g., a county seeing a spike in suicides might form a task force).

Key Data Sources & Documentation (Data & QI)

Important sources of data and documents guiding quality improvement:

Source / Document	Details & Relevance
SAMHSA Uniform Reporting System (URS) Tables	The detailed Alabama URS tables (2022, 2023) are prime data sources, providing numbers served, outcomes, and national comparisons. For example, they document Alabama's demographic service gaps (only 17.4% of clients were Black vs 27% population[samhsa.gov]) and outcome measures like employment (45.5% of adult clients employed vs 51.2% US)[samhsa.gov]. These guide equity and vocational support improvements.
Block Grant Application (Plan & Report sections)	Within Alabama's annual MH Block Grant application, there is a **Plan Table** and **Environmental Factors** section where Alabama must set targets (e.g., "increase adults with SMI in competitive employment from 10% to 12% by next year") and report progress. This document doubles as a QI plan, since it identifies priorities and planned actions for improvement (like expanding supported employment to improve that metric).
Quality Assurance (QA) Audit Reports	ADMH conducts audits of providers (chart reviews, site visits). The resulting reports – which might be internal – highlight deficiencies and required corrective actions. Themes from these reports (e.g., "several centers had incomplete treatment plans") show areas where system-wide training might be needed.
DOJ/Monitor Reports (Prison Mental Health)	If a monitor or court issues regular reports on ADOC's compliance with mental health improvements, those are rich in data (staffing ratios, inmate suicide rates, wait times for care in prisons). These not only ensure accountability in corrections but can reflect on community linkages too (e.g., needing more community forensic beds). Alabama likely has to produce data for these reports, thus improving data collection in that area.
Suicide and Overdose Data	Vital statistics and coroner reports compiled by ADPH provide the numbers and rates of suicide statewide (including demographics, method, etc.), as well as overdose deaths. These data sets are crucial for QI initiatives on suicide prevention and addressing opioid-related mental health needs. For instance, if veterans have higher suicide rates in Alabama, targeted interventions can be planned.

Source / Document	Details & Relevance
Evaluation Studies	Any formal evaluations of Alabama programs – e.g., an external evaluation of the School-Based Mental Health Services program, or a study on the impact of CIT training on jail diversion rates. These documents use data to assess success and often recommend improvements or expansion. They serve as evidence base for QI decisions.
Continuous Improvement Plans (Provider Level)	Each CMHC and state hospital likely has an annual QI or performance improvement plan filed with ADMH. These plans list goals (like "reduce appointment no-show rate by 10%" or "increase peer involvement in treatment teams") and the strategies to achieve them. Collectively, these plans show the QI focus areas around the state and allow ADMH to align statewide priorities (for example, if many providers cite no-shows, ADMH might implement a statewide reminder system).
Client Outcome Tracking Tools	Data from specific tools like the DLA-20 (Daily Living Activities) or Ohio Scales if used for children can quantitatively show client progress. If Alabama requires such measures at intake and periodically, the compiled results are documentation of clinical outcomes over time. They are used to adjust treatment approaches at both individual and program levels.

7. Equity, Inclusion & Cultural Responsiveness

Domain Scope: This domain focuses on ensuring the mental health system is fair and effective for all individuals, regardless of race, ethnicity, gender, age, socioeconomic status, or cultural background. It involves identifying and reducing disparities in access, quality, and outcomes. Cultural responsiveness means services are delivered in a way that is respectful of and tailored to the cultural and linguistic needs of diverse communities. Inclusion refers to actively involving marginalized or underrepresented groups in planning and decision-making, as well as making services accessible (including for people with disabilities or those in rural/frontier areas).

Current Equity Landscape in Alabama: Alabama is a diverse state (approx. 27% Black, 5% Latino, with growing immigrant communities and a significant rural population). Historically, disparities in health and mental health mirror the state's broader socio-economic inequalities. Key equity issues include:

- **Racial Disparities:** Black Alabamians have faced barriers in accessing mental health care, including trust issues stemming from historical discrimination and a lack of Black providers. The data suggests underrepresentation: only **17.4% of Alabama's state mental health clients in 2022 were Black**[samhsa.gov], considerably lower than the Black share of the general population. This could indicate that Black individuals are not receiving public mental health services at proportional rates, possibly seeking help later or not at all. Conversely, Black individuals are overrepresented in some high-intensity settings like emergency commitment and in the criminal justice system for behaviors related to mental illness. For example, in prisons, a disproportionate number of inmates with mental illness are people of color – tying into the earlier point about incarceration being life-threatening for those with mental illness[alabamareflector.com]. Culturally, there may be stigma in some communities about mental health, or preferences for seeking help through faith-based avenues. Alabama has begun partnering with Black churches and community leaders (such as through the Alabama Department of Mental Health's "Stepping Up" initiative in some counties or through NAMI's multicultural outreach) to improve engagement.
- **Rural vs Urban:** There is a rural disparity – rural counties tend to have fewer resources (the Black Belt region and northern mountain counties are notably underserved). Access issues like transportation, scarcity of providers, and poverty contribute to rural residents having a harder time getting consistent care. Equity in this sense means focusing resources to rural innovations (e.g., telehealth, itinerant clinics). Currently, as noted, 55 out of 67 counties are rural and many are HPSAs[prainc.com]. The crisis system's current footprint covers only 20

counties[alison.legislature.state.al.us]; many rural areas still have to rely on law enforcement or family to manage crises, which is inequitable compared to urban areas with crisis centers.

- **Language and Immigrant Populations:** Alabama's Spanish-speaking population (around 200,000 people) and other immigrant groups (such as a growing Vietnamese community in Mobile, and Arabic speakers in some areas) face language barriers. ADMH and providers have increased availability of **language services** – e.g., providing Spanish-language therapists in areas where demand is high or using interpreter services. The ADMH Office of Deaf Services is a noteworthy inclusive program: it ensures sign language interpreters and specialized staff are available for deaf individuals with mental illness. This is a model of cultural/linguistic responsiveness that Alabama is known for regionally.
- **LGBTQ+ Inclusion:** While not often publicly highlighted by the state, LGBTQ youth and adults have unique mental health needs (higher rates of depression, suicide risk). In Alabama, a culturally conservative state, ensuring safe and affirming services for LGBTQ individuals is a challenge. Some providers, often with the help of national orgs like The Trevor Project or local advocacy, are training staff in LGBTQ cultural competency. There are also emerging support networks (e.g., Magic City Acceptance Center in Birmingham for LGBTQ youth) that fill a gap.
- **Socioeconomic and Insurance Disparities:** Poverty is a major factor – Alabama's median household income is significantly below the U.S. average[democrats-waysandmeans.house.gov], and poverty is concentrated in certain minority communities. Not expanding Medicaid disproportionately affects Black and rural populations (since they have higher uninsured rates and poverty rates). The **coverage gap of ~101k uninsured**[alabamareflector.com] includes many from marginalized groups. Thus, advocating for coverage expansion is arguably an equity strategy, as it would benefit those communities the most by granting access to care.

Key Actors & Efforts for Equity: ADMH has an Office of **Peer and Consumer Relations** which often also addresses diversity and inclusion efforts, though it may not be explicitly titled an Office of Equity. The Alabama Department of Public Health has an **Office of Minority Health** that sometimes collaborates on mental health initiatives (like outreach programs for minority communities around depression or maternal mental health). Community organizations are vital: **NAMI Alabama** and its affiliates hold programming like NAMI's Sharing Hope (targeted to Black communities) and identity-specific support groups. **Faith-based initiatives**: Many churches in Black communities have started mental health ministries (often with encouragement from ADMH liaisons who provide Mental Health First Aid training to congregations). Additionally, Alabama has advocates like the **Alabama Disabilities Advocacy Program**

(ADAP) focusing on rights of those with mental illness and developmental disabilities, often ensuring inclusion (they monitor facilities for any abuse or neglect that might disproportionately affect minorities or those less able to speak up).

There have been some targeted programs: for example, **Project LAUNCH** in past years focused on young child wellness in certain high-need communities including tribal areas. And the state's suicide prevention plan acknowledges the need to reach high-risk groups such as veterans (Alabama has a high veteran population) and LGBTQ+ youth.

Gaps & Opportunities:

- **Data-Driven Equity Focus:** As mentioned in Domain 6, Alabama needs to systematically collect and use disaggregated data. For example, tracking outcomes by race could reveal if minority clients have poorer improvement rates or higher dropout. This currently might not be routinely published, which can obscure problems. An opportunity is to create an **Equity Dashboard** within ADMH that monitors these gaps annually.
- **Workforce Diversity:** Only a small fraction of psychiatrists and psychologists in Alabama are people of color. Expanding mentorship and scholarship programs for minority students to enter mental health professions is key. Additionally, employing community health workers or peer supporters from the same communities can improve engagement (for instance, training barbers or salon owners in Black communities as mental health advocates is a creative approach used elsewhere that Alabama could emulate).
- **Cultural Competence Training:** Ensuring all mental health staff receive training in cultural humility and implicit bias can improve the therapeutic relationship and outcomes. ADMH could mandate annual cultural competency CEUs for provider certification. Also, including content on historical trauma and systemic issues in Alabama (like the legacy of racial segregation, which still affects trust in institutions) helps providers better contextualize clients' perspectives.
- **Language Access:** Opportunities to improve include hiring more bilingual clinicians, translating more of ADMH's materials into Spanish (and other languages as needed). Alabama might consider a centralized language line service specifically for mental health providers to get quick access to interpreters if a client arrives who speaks, say, Mandarin or Arabic.
- **Community Engagement in Planning:** Inclusion means having representation from diverse communities at decision-making tables. The state's Mental Health Planning Council has consumer and family members, but ensuring those members reflect racial, rural/urban, and other diversity is important. Conducting

listening sessions in different communities (e.g., a town hall in the Black Belt region about mental health needs or engaging tribal leaders from the Porch Band of Creek Indians about services) can directly inform more responsive programming.

- **Addressing Justice System Disparities:** A big equity concern is how many people with mental illness end up in jail, often for minor offenses, and many are from minority groups. Alabama's expansion of CIT and establishing mental health courts in more counties (currently, only some jurisdictions have them) would help. These are essentially equity interventions, as they divert individuals into treatment who historically would have been ignored or punished.
- **Special Populations:** Focus on groups like **veterans** (Alabama has many rural veterans with PTSD not accessing VA services fully), **children in foster care** (often with high trauma needs – DHR and ADMH coordinate on a program called "Kids Oneida" or similar intensive wraparound, but scaling it is needed), and people experiencing homelessness (disproportionately those with mental illness, often in urban centers like Birmingham). Each of these has targeted initiatives but could be expanded. For example, forming a task force on homelessness and mental health in Huntsville where it's rising, to find inclusive solutions like housing-first.

Despite challenges, Alabama has strengths to build on: strong community solidarity in many areas, a growing recognition among leadership that mental health needs to reach everyone (the push to put therapists in all school systems is inherently an equity measure to reach poor, rural districts, for instance alabamareflector.com). The key is sustained effort and resource allocation specifically to disparity-reduction efforts.

Key Information & Communication Assets (Equity & Inclusion)

Resources and tools that promote culturally responsive communication and outreach:

Asset / Resource	Description & Usage
ADMH Office of Deaf Services (ODS) Resources	ODS provides specialized materials (e.g., a Mental Health Dictionary in American Sign Language, and videophones for deaf clients). They also maintain a list of therapists fluent in ASL. This is a model asset ensuring a disability community is included and served appropriately.
Language Line / Interpreters	ADMH contracts or encourages use of services like **LanguageLine Solutions** for real-time phone interpretation. All CMHCs have access to interpreter services for languages they don't have in-house. Training staff on how to work with interpreters is part of this asset.

Asset / Resource	Description & Usage
Cultural Competency Training Modules	Often online modules or in-person workshops provided by ADMH or partners. For instance, an online course on "Cultural Competence in Behavioral Healthcare for Alabama" might be available for CE credit. Providers and even peer specialists use these to improve skills.
Community Outreach Campaigns	Information campaigns tailored to specific communities. E.g., **"Let's Talk" Minority Mental Health Awareness** events in July (National Minority MH Month) or church-based mental health fairs. Materials (brochures, PSAs) from these campaigns are assets that speak in culturally relevant ways (perhaps featuring local figures or in local dialect).
NAMI and Peer Support Groups (Affinity Groups)	NAMI Alabama facilitates support groups that can be affinity-based: e.g., **NAMI Sharing Hope** (African American communities), **NAMI Unidos** (Spanish-speaking), etc. These groups provide space for sharing and also disseminate information about navigating the system. Their existence and promotion are assets that improve engagement for those communities.
Feedback and Grievance Channels	Inclusive systems mean making it easy for clients to voice concerns. ADMH and providers have grievance processes; importantly, those need to be accessible (explained in plain language and multiple languages, alternative formats for those with disabilities). Having consumer satisfaction hotlines or ombudsman services that are trusted by marginalized clients is a communication asset that can surface equity issues to be addressed.
Faith-Based Initiative Liaisons	ADMH has staff or partners that specifically liaison with faith communities (given the importance in Alabama). For example, an **Alabama Spiritual Outreach Coordinator** might provide pastors with resources on referring congregants to mental health services, and training on how to reduce stigma. This asset leverages existing community structures to extend the reach of mental health education and referrals in a culturally consonant way.
Accessible Materials (Plain Language)	All public-facing info (like consent forms, patient rights documents, educational brochures) ideally is written at an accessible reading level and in needed languages. ADMH has been moving towards more **plain language** documents and easy-read formats for those with cognitive limitations. This ensures inclusion by not letting complex jargon exclude people from understanding their care.

Key Data Sources & Documentation (Equity & Inclusion)

Important sources of data and guidance on equity in Alabama's mental health system:

Source / Document	Details & Relevance
Alabama Disparity Impact Strategy (if any)	Some federal grants require a Disparity Impact Statement. If Alabama completed one (for a SAMHSA project, for instance), it would outline specific

Source / Document	Details & Relevance
	disparities (by race, age, etc.) and strategies to address them, along with baseline data. This document, if exists, provides a blueprint for cultural and linguistic competence efforts.
Population Demographic Data vs. Service Data	A comparison of Census data (demographics of Alabama's population or specific region) with ADMH service user data. This analysis might be an internal report or part of block grant data showing, for example, the gap between Hispanic population % and % of services provided to Hispanics. It quantifies under-served groups[samhsa.gov]. Such data is vital for targeted outreach.
Suicide and Crisis Statistics by Demographics	ADPH or ADMH breakdown of suicide rates by race and gender (e.g., increasing suicide rates among young Black males nationally – is that reflected in Alabama?). Similarly, 988 call data by county or demographic can highlight which communities are/is not using the service. These metrics inform equity-focused interventions (like a campaign for a group with low help-seeking).
ADA / Section 504 Plans	Accessibility plans ensuring compliance with the Americans with Disabilities Act. For example, ADMH's plan for making all facilities physically accessible, or ensuring alternative formats for blind/low-vision individuals. These documents ensure inclusion of persons with disabilities in mental health services.
Training Manuals for Cultural Competence	Curricula or manuals used in Alabama for training on cultural competence (perhaps adapted from National Center for Cultural Competence). They serve as reference for standard practices and definitions of competency that Alabama expects from providers.
Reports on Initiatives (e.g., Stepping Up)	If Alabama counties participated in the **Stepping Up Initiative** (a national effort to reduce mental illness in jails), the reports from those counties (like Montgomery or others) likely contain data on jail diversions broken down by race/mental health status. This is relevant for equity since jails disproportionately hold minorities with unmet mental health needs. The progress reports showcase success stories and continuing gaps.
Consumer Voice Reports	Summaries from focus groups or surveys of consumers from diverse backgrounds about their experience in the system. For instance, ADMH's Office of Consumer Relations might produce a report, "Voices of Recovery in Alabama," highlighting barriers certain groups face (like mistrust among Black consumers, or transportation for rural consumers). These qualitative reports complement quantitative data to drive inclusive changes.
National Culturally and Linguistically Appropriate Services (CLAS) Standards	While not Alabama-specific, ADMH references the U.S. DHHS CLAS standards in its policies. Any assessment Alabama has done of its adherence to CLAS (for example, an evaluation of how well providers meet language access or cultural training) would be documented. This acts as a benchmark for cultural responsiveness efforts.

8. Community Engagement, Education & Advocacy

Domain Scope: This domain involves how the broader community is involved in the mental health system. It includes public education about mental health (awareness campaigns, stigma reduction efforts), engagement of community stakeholders (consumers, families, advocacy groups, schools, law enforcement, employers) in planning and supporting mental health initiatives, and advocacy activities that push for improvements in the system (policy advocacy, funding advocacy, legal action for rights). Essentially, it's about partnership between the formal system and the community at large to promote mental well-being and drive systemic change.

Community Engagement in Alabama: Alabama's communities have a strong tradition of mutual support and faith-based involvement, which extends to mental health in many cases. For example, **churches and civic groups** in Alabama often host mental health workshops, especially as stigma slowly decreases. The state and non-profits run various awareness campaigns. One high-profile effort is the annual **"Mental Health Awareness Month"** in May, during which ADMH, NAMI Alabama, and others organize events – from walks to social media campaigns – to educate the public that mental illness is common and treatable. NAMI Alabama has done "In Our Own Voice" presentations around the state, where individuals with lived experience speak at Rotary Clubs, schools, etc., to put a human face on mental illness.

Education initiatives: Programs like **Mental Health First Aid (MHFA)** have been rolled out, training ordinary citizens (teachers, police, library staff, etc.) to recognize and respond to mental health crises. As of 2024, hundreds of Alabamians have been MHFA-certified, and ADMH often collaborates with organizations to offer these courses at low cost. In schools, beyond just placing therapists, there are mental health awareness curricula being introduced (some high schools have student mental health clubs or peer helpers).

Colleges in Alabama also engage – e.g., the University of Alabama and Auburn have student-led initiatives for mental health, which sometimes partner with the state on campaigns (like UA's annual suicide awareness "Out of the Darkness" walk in Tuscaloosa).

Advocacy and Coordination: Advocacy in Alabama ranges from grassroots to high-level. **NAMI Alabama** (and local NAMI affiliates in Birmingham, Huntsville, Mobile, etc.) is a major voice, providing support groups, education (like NAMI Family-to-Family classes), and engaging in advocacy at the legislature (NAMI's State Advocacy Day brings families to the Capitol to meet lawmakers and share why mental health funding is

important). **Alabama Arise** and other social justice organizations advocate for policies like Medicaid expansion, which is indirectly a mental health advocacy because of its huge impact on access[alabamareflector.comalabamareflector.com]. The **ACLU of Alabama** has been involved in advocacy/litigation around conditions for incarcerated people with mental illness (supporting lawsuits leading to consent decrees[alabamareflector.com]). The **Disability Rights and Resource Center** and ADAP have advocated for community integration (echoing the spirit of the Olmstead Supreme Court decision that unjustified institutionalization is discrimination).

A noteworthy collaborative body is the **Alabama Mental Health Planning Council** – by federal law it includes consumers, family, and advocates who give input to ADMH on the Mental Health Block Grant plan. This ensures community input at the planning stage for use of federal funds.

Law enforcement and community: CIT (Crisis Intervention Team) training is a stellar example of community engagement – it is a partnership between police, mental health professionals, and advocates. Alabama's CIT program has grown; they hold a CIT Summit (like the one NAMI Alabama hosted in 2024[namialabama.org]) to share best practices. CIT-trained officers often become advocates within their departments for better responses and sometimes join local mental health advisory boards.

Media and public discourse: The emergence of outlets like the Alabama Reflector (which has covered mental health funding and prison issues extensively[alabamareflector.comalabamareflector.com]) indicates mental health is getting more public attention. Local news has covered stories, for example, on the shortage of hospital beds or profiles of crisis centers, which help educate the general public and create advocacy pressure. Social media also sees campaigns; ADMH's Facebook page shares success stories and tips, and groups like **Facebook support groups** for Alabama parents of children with mental illness serve as informal advocacy and engagement platforms.

Gaps & Opportunities:

- **Stigma persists:** In some parts of Alabama, mental illness is still a taboo subject. Continued public education is needed, especially in rural and minority communities. Engaging trusted community figures (pastors, local celebrities, even college football coaches given Alabama's culture) in speaking up about mental health could have big impact. For instance, having a well-known Alabama sports figure as a mental health ambassador could break through stigma for many fans.
- **Youth engagement:** The youth voice is increasingly recognized. Opportunities exist to involve young people in planning (like a youth advisory council to ADMH) since they often drive new approaches (like using Instagram or TikTok for mental

health awareness). Especially with issues like high teen suicide rates or college stress, youth-led advocacy can complement adult efforts.

- **Coordination of advocacy:** At times, Alabama's advocacy voices (families, providers, hospitals) might be fragmented in asks. There's opportunity to create a united **Mental Health Coalition** that brings together various stakeholders to push collectively for certain goals (similar to how some states have a unified coalition for mental health funding). This would amplify the message at the legislature and in public forums.
- **Peer leadership:** Peer-run organizations (those led by people with lived experience) are relatively few in Alabama compared to some states. Empowering more peer advocates and possibly establishing a statewide peer council can enhance community advocacy from the consumer perspective. They could advise on how to make services more recovery-oriented and perhaps run peer-run respite or drop-in centers if funded.
- **Community-based preventive programs:** Engagement isn't just about talking; it's about doing things in the community that promote mental health. Alabama could expand programs like community gardens, mentoring programs, or mental wellness workshops at community centers which involve collaboration between mental health professionals and community members. These not only educate but also build protective factors and relationships.
- **Policy advocacy successes to build on:** The strong push for crisis funding that succeeded suggests that when advocates present clear data and human stories (like individuals who benefited from crisis centers), policymakers respond. Using that model, the next advocacy targets could be: increasing long-term housing options (present how supportive housing saves money and changes lives) or workforce pay (share stories of clinics unable to open new patient slots due to lack of staff). Already, the reflect of ADMH's budget request being well-received in 2024[alabamareflector.comalabamareflector.com] indicates legislators are hearing the community's calls.
- **Criminal justice partnerships:** Continue and deepen engagement with law enforcement and courts. For example, encouraging more **Mental Health Court programs** (currently only a few jurisdictions have them) by having judges who champion them share their success stories (reduced recidivism, etc.) with peers. Community forums where law enforcement and mental health professionals jointly address the public (some counties have done "CIT community forums") improve mutual understanding and public trust that these systems are trying to collaborate.

Overall, Alabama's community engagement is growing stronger in mental health, transitioning from a relatively siloed system to one where public voices are influencing

change. The cross-domain dependency is clear: without advocacy (Domain 8), funding (Domain 2) wouldn't increase; without education, stigma would keep people from seeking services (impacting Domain 3 and equity Domain 7). Alabama's path forward involves harnessing the goodwill and energy of its communities to sustain momentum in mental health improvements.

Key Information & Communication Assets (Community Engagement)

Key resources and communication channels that facilitate community involvement and education:

Asset / Resource	Description & Role
NAMI Alabama Helpline & Programs	NAMI's helpline (state or national) provides support and referral to families and individuals. NAMI Alabama's website and social media serve as a clearinghouse for resources, announcing classes like Family-to-Family and support group meetings statewide. This empowers community members with knowledge and connection.
Public Awareness Campaigns (PSAs)	Campaigns such as **Stop the Stigma** or the **"My Story" campaign** where Alabama residents share recovery stories on video. These are often disseminated through local TV, radio, and online. ADMH partners with media during Mental Health Month to run PSAs about 988, etc., educating the public on how to get help.
Alabama Suicide Prevention Coalition	A coalition (possibly named the Alabama Suicide Prevention and Resources Coalition) which has a website listing crisis resources, warning signs, and hosting community training events. It unites mental health professionals with survivors and other advocates to coordinate statewide suicide prevention messaging.
Consumer Advocacy Events (Capitol Day)	Annual events like **Mental Health Day at the Capitol** where consumers and families rally. Information packets and talking points are prepared as assets for participants to effectively advocate when meeting legislators. These events also often get local news coverage, further raising awareness.
Local Mental Health Alliances	In some Alabama counties, informal alliances or task forces exist (e.g., "Jefferson County Mental Health Alliance") comprising nonprofits, police, schools, etc., meeting regularly to discuss local needs. Their meeting minutes and community reports are assets that highlight local perspectives and propose solutions, which can feed upward into state planning.
Social Media & Online Communities	Facebook groups (like "Alabama Parents of Children with ADHD/Autism" etc.) or Twitter chats by mental health advocates serve as platforms where experiences are shared and information about navigating the system is crowdsourced. These are increasingly important for engagement, especially among younger generations. ADMH and NAMI maintain active social media to disseminate tips (e.g., coping skills graphics, event notices).

Asset / Resource	Description & Role
Educational Curriculum in Schools	Materials like **Erin's Law** curriculum for trauma (Alabama implemented Erin's Law for child sexual abuse awareness, often tied to mental health support) or general mental health modules provided by the Alabama State Department of Education. By institutionalizing mental health education in health class or advisory periods, the state fosters early understanding and reduces stigma in the next generation.

Key Data Sources & Documentation (Community Engagement & Advocacy)

Important sources that capture the state of community engagement and guide advocacy:

Source / Document	Details & Relevance
Survey Data on Public Attitudes	Surveys gauging Alabama public opinion on mental health (e.g., what percentage view it as a health issue, willingness to interact with someone with mental illness). If ADMH or partners have done stigma surveys or used national surveys (like CDC's BRFSS mental health modules), these data inform how far community education has come and where to target efforts.
Advocacy Coalition Agendas	Documents like NAMI Alabama's annual advocacy agenda or Alabama Arise's issue briefs that include mental health. They clearly state the policy changes being sought (funding levels, laws, etc.) and provide justifications. These serve as a roadmap for community advocacy priorities and often include supporting data.
Legislative Testimonies and Outcome	Transcripts or records of testimonies by community members or advocates in legislative hearings (for example, a mother testifying about the impact of insufficient crisis services). These narratives, combined with data, often influence legislative intent language or budget earmarks. The success or failure of bills (like a bill for mental health parity enforcement, or for telehealth expansion) and their associated reports are also documentation of advocacy impact.
Media Coverage Compilation	A compilation of media articles (like those from Alabama Reflector[alabamareflector.comalabamareflector.com](), local newspapers, TV segments) on mental health topics over the year. This shows what issues are getting attention and can reveal shifts in public discourse. ADMH's communications team likely tracks this to tailor messaging.
Grant Applications (Community Projects)	Applications for grants that require community collaboration (like SAMHSA System of Care grants for youth, or Garrett Lee Smith youth suicide prevention grants) detail how the community will be engaged and often include letters of support from various sectors. These letters and narratives demonstrate the partnerships in place and commitments from community entities (schools, police, tribes, etc.).

Source / Document	Details & Relevance
Training Evaluation Reports	After large-scale trainings (e.g., MHFA or CIT), there might be evaluation reports summarizing number trained and pre/post knowledge or attitude changes. For instance, CIT program data might show a reduction in officer use of force in crisis situations after training. These evaluations document the efficacy of community education efforts.
Meeting Minutes of Planning Council & Boards	Minutes from the Mental Health Planning Council or local advisory boards often reflect community input, concerns raised by consumer reps, and recommendations made to ADMH. They're an official record of community voices in action and what responses the department or local authorities commit to (e.g., "the Council recommends more peer respites; ADMH will explore funding options").

Cross-Domain Dependency Mapping

The mental health system domains in Alabama are highly interdependent. Changes or strengths in one domain can significantly affect others. The table below maps key linkages between domains, illustrating these interdependencies:

From – To (Domain)	Interdependency Link	Description of Linkage
Information Systems & Data → Financing (Domain 6 → Domain 2)	*Data-Driven Funding Decisions*	Robust data systems (Domain 6) provide evidence of needs and outcomes that justify funding requests (Domain 2). **Example:** ADMH used data on bed shortages and crisis diversions to successfully advocate for a 23% budget increase[alabamareflector.comalabamareflector.com]. Conversely, poor data can lead to underfunding if needs aren't demonstrated[alabamareflector.com].
Equity & Inclusion → Workforce (Domain 7 → Domain 4)	*Diverse Workforce & Access*	Efforts in equity (Domain 7) impact workforce distribution and diversity (Domain 4). **Example:** Underserved rural and minority communities (equity focus) require targeted workforce recruitment (more providers in HPSA areas, hiring bilingual and culturally diverse staff). If equity gaps are not addressed, workforce remains maldistributed (82% of AL counties are shortage areas[democrats-waysandmeans.house.gov]) and certain groups won't access care due to lack of relatable providers.

From – To (Domain)	Interdependency Link	Description of Linkage
Financing → Service Delivery (Domain 2 → Domain 3)	*Funding Enables Service Expansion*	Financial resources (Domain 2) determine the capacity and breadth of services (Domain 3). **Example:** New funding allowed Alabama to open crisis centers and school-based programs[alabamareflector.comalabamareflector.com], directly expanding the service continuum. Inadequate financing leads to service gaps (e.g., previously cut budgets led to closure of community programs in the 2010s[alabamareflector.com]).
Workforce → Service Delivery (Domain 4 → Domain 3)	*Staffing Limits or Powers Services*	The availability of trained staff (Domain 4) is a prerequisite for delivering services (Domain 3). **Example:** Even if funding exists, a shortage of clinicians or a high vacancy rate (752 vacancies in 2023[alison.legislature.state.al.us]) means certain services (therapy, mobile crisis) cannot be provided or scaled. Conversely, well-staffed teams improve service quality and reach (e.g., hiring 165 additional providers allowed thousands more to receive care[alison.legislature.state.al.us]).
Financing → Infrastructure & Tech (Domain 2 → Domain 5)	*Capital and IT Investments*	Funding (Domain 2) is needed for building facilities and adopting technology (Domain 5). **Example:** State funds ($7M per site) were allocated to establish each crisis center[alison.legislature.state.al.us]. Similarly, grants and budget allocations are required for EHR upgrades or telehealth equipment. Without financing, infrastructure deteriorates (e.g., aging clinic buildings, lack of telehealth in rural areas).
Governance/Policy → Infrastructure & Tech (Domain 1 → Domain 5)	*Regulatory Enablement*	Governance decisions (Domain 1) set policies that affect technology use and facility operation (Domain 5). **Example:** Telehealth expansion required state policy changes (licensure compacts, Medicaid telehealth policy) – governance actions that then allowed technology adoption system-wide. Another example: certificate-of-need laws and facility licensure rules (governance) influence where hospitals or clinics (infrastructure) can be opened or expanded.
Community Engagement → Governance/Policy (Domain 8 → Domain 1)	*Advocacy Influences Policy & Law*	Grassroots advocacy and public pressure (Domain 8) drive policy reforms and governance priorities (Domain 1). **Example:** Advocacy by families and groups like NAMI led to the creation of school-based mental health programs and strengthening of commitment laws over time. Community input in

From – To (Domain)	Interdependency Link	Description of Linkage
		planning councils results in policy adjustments (like inclusion of peers in decision-making bodies). In short, engaged citizens can shift legislative and executive focus toward mental health initiatives.
Community Engagement → Equity & Inclusion (Domain 8 → Domain 7)	*Voices Highlight Disparities*	Community forums and advocacy (Domain 8) bring attention to inequities (Domain 7), ensuring they are addressed. **Example:** Rural communities speaking out about lack of services have prompted ADMH to deploy mobile teams in those areas. Minority community leaders engaging with ADMH have led to culturally specific programs (like outreach in Black churches). Without community advocacy, many disparities would remain hidden.
Infrastructure/Tech → Data Systems (Domain 5 → Domain 6)	*IT Infrastructure Supports Data*	Modern technology and infrastructure (Domain 5) are necessary for effective data collection and quality improvement (Domain 6). **Example:** Implementation of a unified EHR or data platform (tech infrastructure) enables real-time outcome tracking and analytics. Conversely, lacking IT (some rural clinics only recently getting high-speed internet) hampers reporting timely data democrats-waysandmeans.house.gov. Investments in infrastructure like a data warehouse allow Domain 6 to flourish in monitoring and QI.
Service Delivery → Data & Quality (Domain 3 → Domain 6)	*Service Outcomes Feed QI Data*	The outcomes from service delivery (Domain 3) provide the raw data for quality improvement (Domain 6). **Example:** Rates like 30-day readmission or follow-up after discharge come from the service domain and are used by QI teams to identify issues or improvements. If services aren't delivered consistently, data will show variability in outcomes across regions, prompting targeted quality initiatives. Also, innovative practices in service delivery (like a new peer support model) can yield positive data that Domain 6 captures and then spreads as a best practice.
Service Delivery → Equity & Inclusion (Domain 3 → Domain 7)	*Access Disparities Visible in Service Data*	The pattern of who is accessing services (Domain 3) reveals equity issues (Domain 7). **Example:** If certain demographic groups have low utilization of outpatient care but high crisis/hospital use, it flags a disparity in preventive care. Alabama's service data showing underrepresentation of Black individuals samhsa.gov fed into recognizing the need for

From – To (Domain)	Interdependency Link	Description of Linkage
		more culturally responsive engagement (Domain 7). Thus, the service delivery data guides equity-focused outreach and program adjustments.

Each domain supports and conditions the others: A well-governed (1) and well-financed (2) system can build a strong workforce (4) and infrastructure (5), deliver a broad range of services (3), and invest in data systems (6); in turn, inclusive policies (7) and engaged communities (8) legitimize and sustain those investments. Alabama's strategic efforts must therefore be coordinated across all domains to achieve a resilient and responsive mental health system.