ADMH
Alabama Department
of Mental Health
connecting mind and wellness

South Central
Alabama
Mental Health

CCBHC Community Needs Assessment

Covington County

Prepared by:

South Central
Alabama
Mental Health

gary bess associates

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Introduction

South Central Alabama Mental Health Board Inc. (SCAMHB) is a public, non-profit, comprehensive community behavioral health center. Founded in 1968, SCAMHB provides an array of services for people who have mental illness, persons with developmental disabilities, as well as for those with substance use disorders with respect for dignity and privacy. SCAMHB has long been committed to providing comprehensive behavioral health in geographically underserved communities, and has since expanded operations in response to the rapidly evolving needs of residents. Above all, SCAMHB remains "dedicated to improving lives in a professional and caring manner."[1]

As an organization serving the communities of south-central Alabama, SCAMHB is considered quasi-governmental. It was established by local governmental entities from neighboring cities and counties, all of which make up the service area for SCAMHB's CCBHC program. These local governmental counties include: Butler, Coffee, Covington, and Crenshaw Counties; as well as the Cities of Opp, Florala, Andalusia, Red Level, Greenville, Brantley, Luverne, Elba, and Enterprise. In this way, SCAMHB's organizational history and mission aims to directly align with the needs of the surrounding communities. In an effort to "work toward a healthy future for [these] communities," SCAMHB serves approximately 4,500 clients annually.[2] The service area for SCAMHB's Certified Community Behavioral Health Clinic (CCBHC) includes four (4) counties: Butler County, Coffee County, Covington County, and Crenshaw County. Situated in south-central Alabama, this four-county service area has a total population of 123,829 people, according to the U.S. Census Bureau (2023). SCAMHB will be providing CCBHC services at all of our sites across these four (4) counties. Its headquarters is located in Covington County at: 820 South Three Notch Street, Suite B, Andalusia, AL, 36420.

[1] See "Our Mission" on the "About Us" section of the SCAMHB website: https://www.scamhc.org/about-us/.
[2] See "About Us" on the SCAMHB website: https://www.scamhc.org/about-us/.

Through the Alabama Department of Mental Health (ADMH), SCAMHB is seeking CCBHC certification in response to the rapidly evolving behavioral health needs within Butler, Coffee, Covington, and Crenshaw Counties, and the need for sustained funding to provide high quality care. ADMH and the Substance Abuse and Mental Health Services Administration (SAMHSA), the Federal agency responsible for developing and implementing the CCBHC model across the nation, requires CCBHC Needs Assessments to be conducted for all CCBHCs, with updates every three years at minimum. CCBHCs must conduct a Needs Assessment for each County within its service area. **This document serves as the CCBHC Needs Assessment for Covington County.** The image above shows Covington County, highlighted in red.

Description of Service Area – Covington County

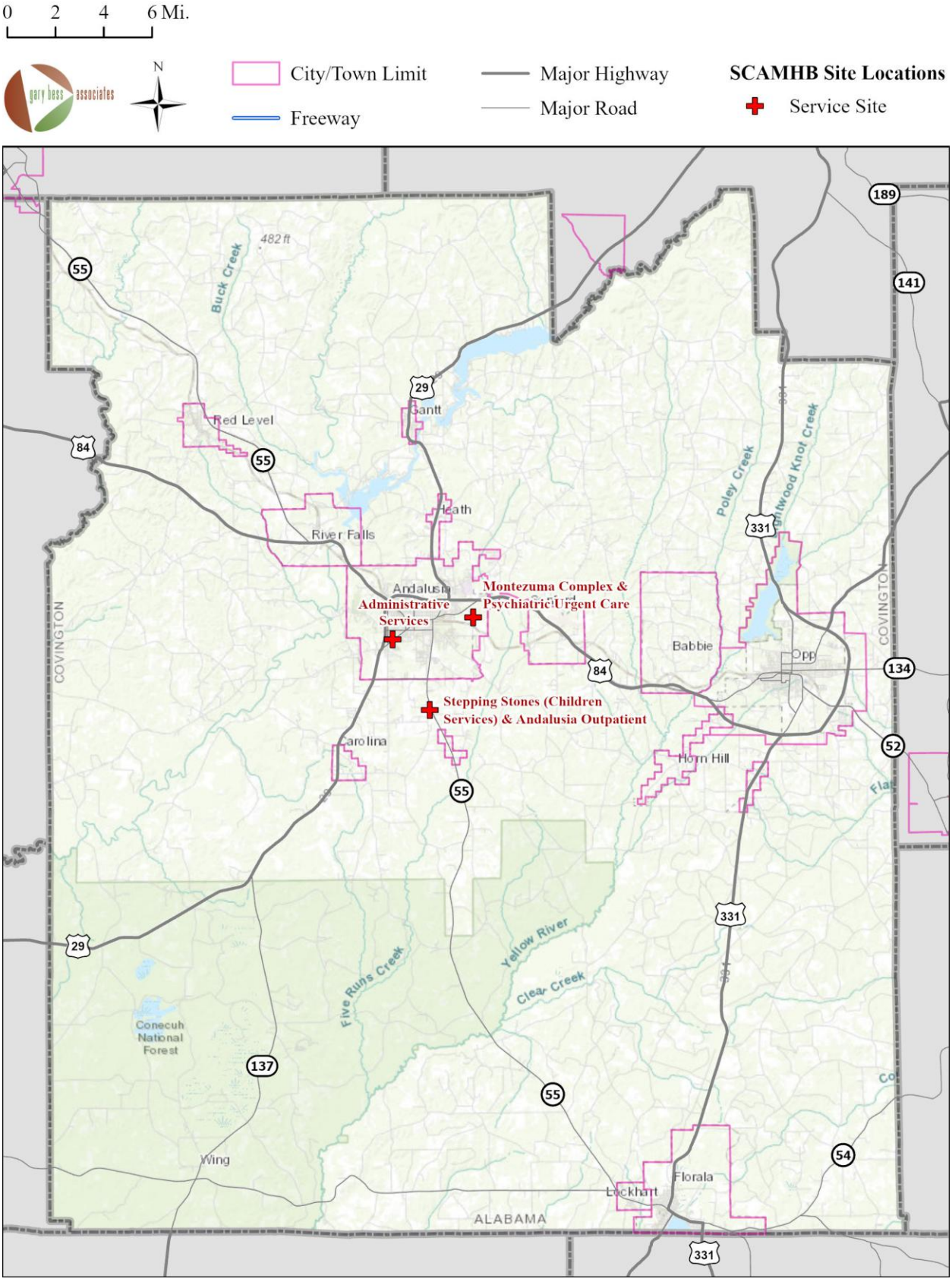
Describe the physical boundaries (i.e., what lies along the boundaries, rural, urban, etc.) and size of your service area, including identification of sites where services are delivered. How does geography impact access to care? Please describe any transportation barriers in your community.

Covington County is located in the East Gulf Coastal Plain section of the state. It includes the city of Andalusia—the county seat—and is located slightly northwest of the county's center with a population of 8,805 residents. With a total population of 37,647, according to the U.S. Census Bureau (2023), the County has a population density of 36.5 people per square mile. Covington County is bordered by Butler and Crenshaw counties to the north, Coffee and Geneva counties to the east, and Escambia and Conecuh counties to the west. To the south are counties Okaloosa and Walton, located in the state of Florida. The Conecuh National Forest extends across a portion of the county's southwestern corner. Most county residents are also located within ninety minutes of the Florida panhandle beaches. Annual events in Andalusia include the World Championship Domino Tournament in July, and Candyland in December (see image of the Covington County Court House).[3] Per classification by the Alabama Rural Health Association,[4] Covington is a "rural" county.

Within the service area of Covington County, SCAMHB has several facilities, including its Urgent Care facility and Outpatient office in Andalusia. A map detailing all of SCAMHB's service sites in Covington County is below.

[3] City of Andalusia. "Our Community." Retrieved on March 5, 2025 from: https://cityofandalusia.com/community/our-community.html.
[4] Alabama Rural Health Association, Analysis of Urban vs. Rural. Retrieved Feb. 12, 2025, from: https://arhaonline.org/analysis-of-urban-vs-rural/

SCAMHB Site Locations | Covington County, AL



Demographics of CMHC Service Area – Covington County

Population Density

	Butler County	Coffee County	**Covington County**	Crenshaw County
Total County Population[5]	18,807	54,231	37,647	13,144
County Population Density[6]	24.5	78.7	36.5	21.7

Age Groupings

	A	B	C	D	E	F	G
Age Range[7]	Count (County)	Percent (County)	Count (Agency)[8]	Percent (Agency)	Variance Percent (D-B)	Prevalence (A / Total County Population x 100)	Unmet Need
Ages 0-5	2,584	6.9 %	763	20.38 %	-1.72 %	22.1 %	1.72 %
Ages 6-17	5,735	15.2 %					
Ages 18-24	2,869	7.6 %	2,682	71.65 %	15.65 %	56.0 %	0.0 %
Ages 25-44	8,431	22.4 %					
Ages 45-64	9,780	26.0 %					
Ages 65-74	4,666	12.4 %	297	7.93 %	-13.97 %	21.9 %	13.97 %
Ages 75+	3,582	9.5 %					

Overall, children (ages 0-17) account for 22.1% of Covington County's total population. Whereas seniors (ages 65+) comprise 21.9% of the county.

Agency level data is also indicated in the table; as SCAMHB remains dedicated to serving all ages across its service area. The variance between agency data and county data demonstrates possible unmet need in Covington County, particularly for children and seniors.

Family Household Types with Children Under age 18

	A	B	C	D	E	F	G
Household Type[9]	Count (County)	Percent (County)	Count (Agency)	Percent (Agency)	Variance Percent (D-B)	Prevalence (A / Households with Children Under Age 18 x 100)	Unmet Need
Married	4,771	58.0 %	Data Not Available			58.0 %	Data Not Available
Single Moms	1,444	17.6 %	Data Not Available			17.6 %	
Single Dads	407	4.9 %	Data Not Available			4.9 %	

Fewer youth in Covington County (58.0% or 4,771 individuals) are cared for by an "independent married couple/domestic partnership" than in the state (61.3%) or U.S. (68.8%). Also in Covington County, children living with independent single mothers are more common than in the nation (15.6%), representing 17.6% of children and numbering close to 1,500 individuals. As

[5] Source for **Butler, Coffee, Covington, and Crenshaw Counties** *Total County Population*: U.S. Census Bureau, 2023 American Community Survey 5-Year Estimates, Tables B03002, B17001, and B17001B-17001I.
[6] Source for **Butler, Coffee, Covington, and Crenshaw Counties** *Population Density* (2020) Data: U.S. Census, Quick Facts. Retrieved March 25, 2025 from: https://www.census.gov/quickfacts/fact/table/crenshawcountyalabama,covingtoncountyalabama,coffeecountyalabama,butlercountyalabama/POP060220.
[7] Source for County Age Range Data: U.S. Census Bureau, 2023 American Community Survey 5-Year Estimates, Tables B01001 and B17024.
[8] Unless otherwise noted, all SCAMHB agency data is from Fiscal Year 2024 (10/1/2023-9/30/2024).
[9] Source for County *Household Type* Data: U.S. Census Bureau, 2022 American Community Survey 5-Year Estimates.

noted in the table above, 407 children are living with an independent single father—slightly more common than in the state (3.4%) and nation (3.1%). It is also much more common for children in the county to live with their grandparent(s) (7.0% or 574 individuals), in comparison to the state (6.3%) and nation (3.5%). Agency-level data were not available by household type.

Race and Ethnicity

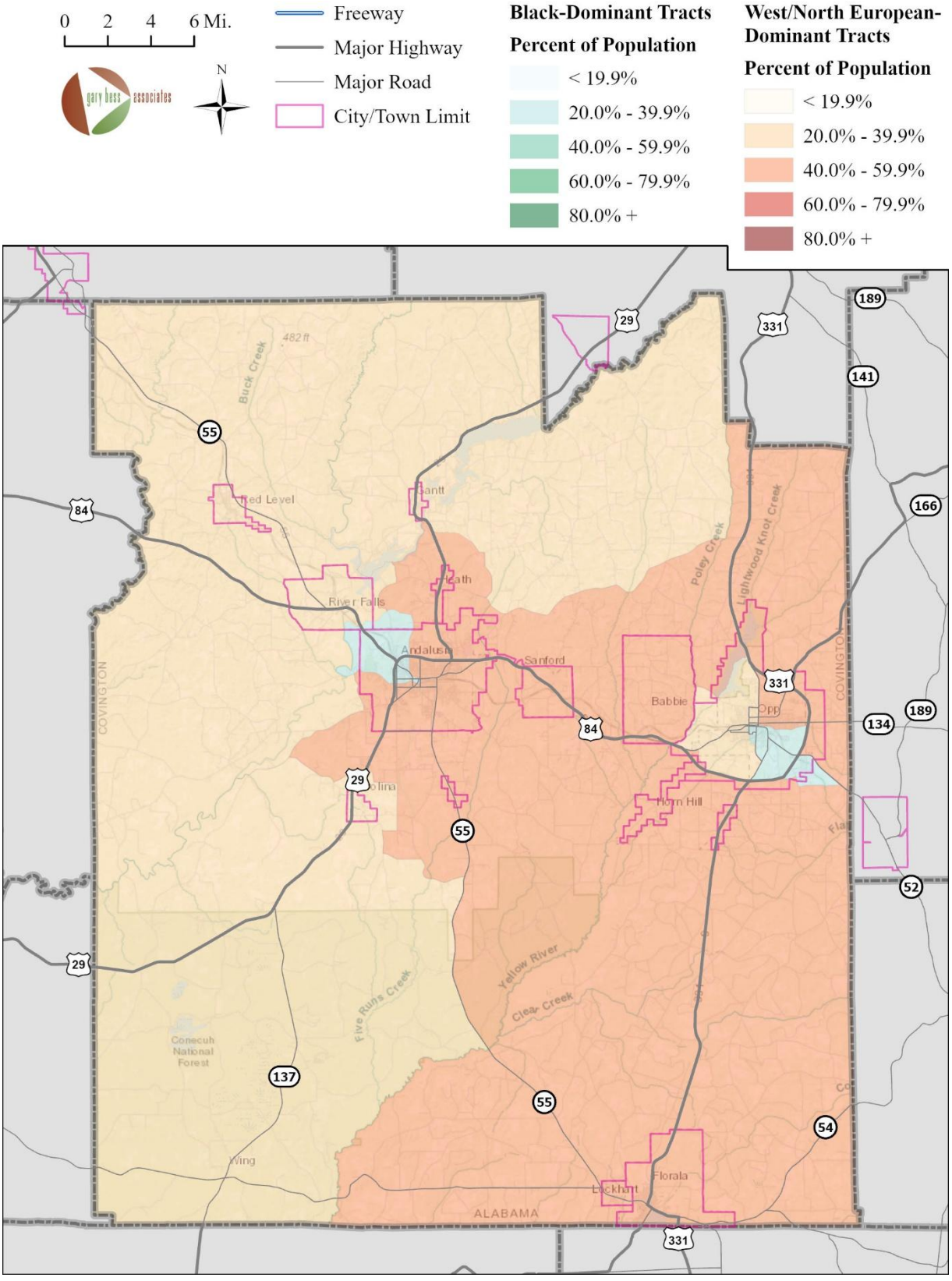
	A	B	C	D	E	F	G
Race / Ethnicity[10]	Count (County)	Percent (County)	Count (Agency)	Percent (Agency)	Variance Percent (D-B)	Prevalence (A / Total County Population x 100)	Unmet Need
Caucasian, Non-Hispanic (incl. North African and West/ Central Asian)	31,061	82.5 %	2,456	65.62 %	16.88 %	82.5 %	0.0 %
Black or African American	4,417	11.7 %	1,051	28.08 %	-16.38 %	11.7 %	16.38 %
Other/ Multiple (non-Hispanic)	1,225	3.3 %	224	5.99 %	-2.69 %	3.3 %	2.69 %
Hispanic or Latino	727	1.9 %	131	3.50 %	-1.60 %	1.9 %	1.60 %
Asian (South or East) or Asian Indian	151	0.4 %	9	0.24 %	0.16 %	0.4 %	0.0 %
American Indian, Alaska Native, Native Hawaiian, or Pacific Islander	83	0.2 %	0	0.0 %	0.20 %	0.2 %	0.0 %

Covington County is racially and ethnically diverse, with 17.5% identifying as Black or African American, Hispanic or Latino, Asian, Other/Multiple, or American Indian, Alaska Native, Native Hawaiian, or Pacific Islander. Over 80% of Covington County residents identify as Caucasian. The map below serves to demonstrate the dominant race and ethnicities present across Covington County.

Agency level data is also indicated in the table; as SCAMHB remains dedicated to serving disparate populations across its service area. The variance between agency data and county data demonstrates possible unmet need in Covington County.

[10] Source for County *Race/Ethnicity* Data: U.S. Census Bureau, 2023 American Community Survey 5-Year Estimates, Table B03002, B17001, and B17001B-17001I. Hispanic/Latino is separated only from Caucasian and Other. It is duplicated in all other race categories.

Dominant Race Map | Covington County, AL:



Country of Birth

	A	B	C	D	E	F	G
Country of Birth[11]	Count (County)	Percent (County)	Count (Agency)	Percent (Agency)	Variance Percent (D-B)	Prevalence (A / Total County Population x 100)	Unmet Need
U.S. and U.S. Territories	37,221	98.9 %	Data Not Available		Data Not Available	98.9 %	Data Not Available
All Other Nations	426	1.1 %				1.1 %	
Total foreign-born	426	1.1 %				1.1 %	

Overall, Covington County has a total population of 37,647 residents, of whom 426 or 1.1% are foreign-born. Although less so in Covington County than in Butler and Coffee counties, competencies in a diverse range of cultural backgrounds may be required to ensure service availability to the county's population.

Agency-level data were not available for County of Birth. As such, variance and unmet could not be calculated. SCAMHB plans to utilize language data as a proxy for unmet need in Covington County, and remains dedicated to ensuring services are available in primary languages across the service area.

Language Spoken Among Population Age 5 Years and Older

	A	B	C	D	E	F	G
Top Languages Spoken[12]	Count (County)	Percent (County)	Count (Agency)	Percent (Agency)	Variance Percent (D-B)	Prevalence (A / Total County Population x 100)	Unmet Need
English Only	34,414	97.2 %	3,682	98.58 %	1.38 %	97.2 %	0.0 %
Spanish	582	1.6 %	27	0.72 %	-0.88 %	1.6 %	0.88 %
All other languages	399	1.1 %	26	0.70 %	-0.40 %	1.1 %	0.40 %
Total who speak a language other than English at home	981	2.8 %	53	1.45 %	-1.35 %	2.8 %	1.35 %

Language barriers can create obstacles that interfere with quality of life and health status. The majority of county residents speak English (97.2%). Yet, 2.8% of Covington County residents speak a primary language other than English at home—the majority of which speak Spanish 1.6% or 582 individuals). Agency level data demonstrates that the majority of patients are English-speaking, although 1.45% speak a language other than English at home. The variance between agency data and county data demonstrates possible unmet need in Covington County.

[11] Source for County *Country of Birth* Data: U.S. Census Bureau, 2023 American Community Survey 5-Year Estimates, Tables B05006 and B01003.
[12] Source for County *Language Spoken* Data: Gary Bess Associates, Interpolated from U.S. Census Bureau, 2015 and 2022 American Community Survey 5-Year. Estimates for PUMA geography, Table B16001.

Social Determinants of Health Data – Covington County

Employment Status of County Population Aged 20 to 64 Years Old

	A	B	C	D	E	F	G
Civilian Employment Status[13]	Count (County)	Percent (County)	Count (Agency)	Percent (Agency)	Variance Percent (D-B)	Prevalence (A / County Population Aged 20 to 64 x 100)	Unmet Need
Armed Forces	Data Not Available		45	1.96 %	Data Not Available		
Employed	13,550	67.3 %	536	23.31 %	43.99 %	67.3 %	0.0 %
Unemployed	607	3.0 %	717	31.19 %	-28.19 %	3.0 %	28.19 %
Not in Labor Force	5,964	29.6 %	970	42.19 %	-12.59 %	29.6 %	12.59 %

Highest Level of Education Among People Aged 25 Years and Older

	A	B	C	D	E	F	G
Highest Education[14]	Count (County)	Percent (County)	Count (Agency)	Percent (Agency)	Variance Percent (D-B)	Prevalence (A / County Population Aged 25+ x 100)	Unmet Need F-C
Less than HS graduate	3,656	13.8 %	609	23.46 %	9.66 %	13.8 %	0.0 %
HS graduate	9,745	36.8 %	1,768	68.1 %	31.30 %	36.8 %	0.0 %
Some college or associate's degree	8,513	32.2 %	141	5.51 %	-43.89 %	32.2 %	43.89 %
Bachelor's degree or higher	4,545	17.2 %				17.2 %	

Income and Poverty

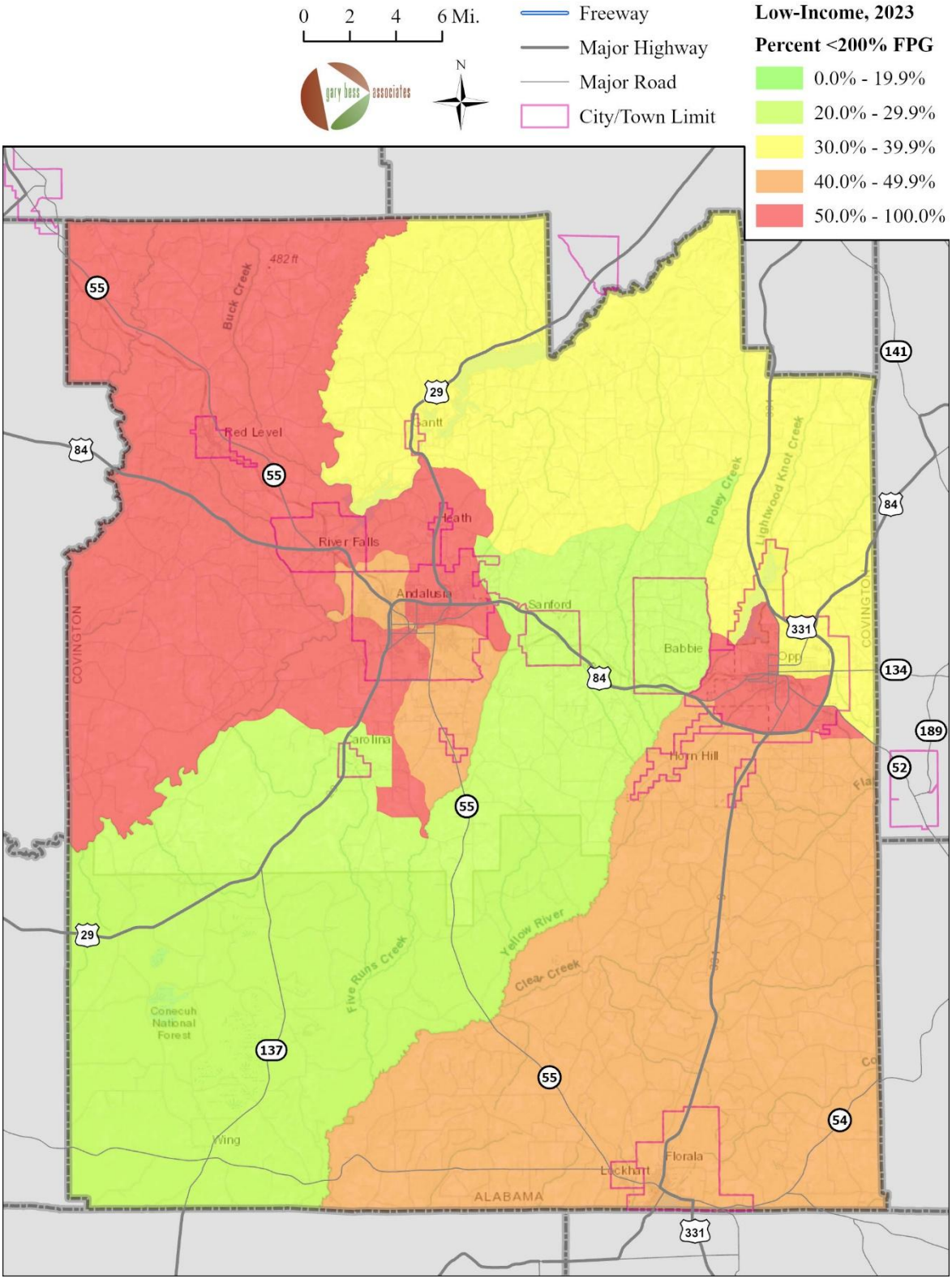
	County	State	Nation
Median Household Income[15] (50th percentile)	$ 50,886	$ 62,027	$ 78,538
Public assistance income, or SNAP (Food Stamps) [16]	14.5 %	14.1 %	12.8 %

The median household income for Covington County ($50,886) is notably lower than that of the nation ($78,538), and state ($62,027). Additionally, a slightly higher percentage of households in the county are on public assistance income or SNAP (14.5%), as compared to the state (14.1%) or nation (12.8%).

The map below shows the percent of population who are low-income by Census Tract. The map shows that there are neighborhoods, especially in close proximity to SCAMHB's service delivery sites, where the majority of the population (greater than 50%) are low-income. The map also serves to demonstrate income disparities present across the county, which may produce additional social barriers and further exacerbate economic disparities.

[13] Source for *Employment Status* Data: U.S. Census Bureau, 2023 American Community Survey (ACS) 5-Year Estimates, Tables B23001 and B23024
[14] Source for County *Education* Data: Gary Bess Associates. Estimates from U.S. Census Bureau, 2023 ACS 5-Year Estimates, Tables B15001 and B17003
[15] Source for County *Median Household Income* Data: U.S. Census Bureau, 2023 ACS 5-Year Estimates, Tables B19013, B19060 and B19080
[16] Source for County *Food Stamp* Data: U.S. Census Bureau, 2023 American Community Survey 5-Year Estimates, Tables B19052 through B19060

Low Income Map | Covington County, AL



Cost-Burdened Households

	County Occupied Housing Units	County Unaffordable Units	County Percent
Cost-Burdened Households[17] (Housing Affordability, Households paying 30% or more of Income on Housing)			
Owner-occupied housing units w/o mortgage	6,509	885	13.6 %
Owner-occupied housing units w/ mortgage	4,466	918	20.6 %
Renter occupied housing units	3,520	1,614	45.9 %
All occupied housing units	14,495	3,417	23.6 %

Housing Stability[18]	Count (County)	Percent (County)
Housing insecurity: unable to pay mortgage, rent, or utilities, past year	3,871	13.2 %
Electric, gas, oil, or water company threatened to shut off services at any time during the in the past year	2,640	9.0 %
Home was built 1979 or earlier (45+ yrs old) (number/percent of units)	9,765	52.3 %

Housing affordability and insecurity are concerns for some residents in Covington County. The standard affordability threshold used by the U.S. Census Bureau is 30% of income, meaning that if the occupant is paying more than 30% of their income on rent, mortgage, utilities, and other costs associated with habitation, the unit they are living in is unaffordable for them. As demonstrated in the tables above, close to one-quarter (23.6%) of occupied housing units in Covington County are considered "unaffordable" by this definition. Moreover, close to one-half (45.9%) of those renting are in unaffordable, and perhaps precarious housing situations. Additionally, 13.2% of residents were unable to pay their mortgage, rent, or utilities in the past year—lower than the state (14.7%), but higher than the nation (11.8%).

Health Coverage

Primary Health Insurance[19]	Count (County)	Percent (County)
Private Insurance, or VA	21,287	57.3 %
Medicare (incl. Medi-Medi)	6,093	16.4 %
Medicaid or other means-tested coverage	5,946	16.0 %
None/uninsured	3,845	10.3 %
Total noninstitutionalized persons	37,171	100.0 %
Total Uninsured or on Medicaid	9,791	26.3 %

NO Insurance, by FPG level[20]	Count (County)	Percent (County)
Below 100% FPG	1,427	37.1 %
100% to 137% FPG	349	9.1 %
138% to 199% FPG	632	16.4 %
200% to 399% FPG	923	24.0 %
400% FPG and above	503	13.1 %
Total noninstitutionalized and not medically insured	3,845	100.0 %
Total below 138% FPG	1,776	46.2 %
Total below 200% FPG	2,408	62.6 %

[17] Source for County *Cost-Burdened Renter Household* Data: U.S. Census Bureau, 2023 ACS 5-Year Estimates, Tables B2570, B25091, and B25034.
[18] Source for County *Housing Stability* Data: PLACES, Centers for Disease Control and Prevention, 2024 Release; County "Year Home was Built," U.S. Census Bureau, 2023 ACS 5-Year Estimates, B25034.
[19] Source for County *Health Coverage* Data: Gary Bess Associates (GBA). Estimates derived from U.S. Census Bureau, 2023 American Community Survey (ACS) 5-Year Estimates, Table B27010. Some values extrapolated by GBA.
[20] Source for County *Health Coverage by FPG* Data: GBA. Estimates derived from U.S. Census Bureau, 2023 ACS 5-Year Estimates, Table C27016.

A lack of health insurance can pose a barrier to accessing healthcare and can contribute to poor health. Within Covington County, 10.3% are medically uninsured, representing close to 4,000 people in the county without medical insurance, which is more than in the state of Alabama (9.4%). Additionally, 16.0% or close to 6,000 residents are insured through Medicaid or other means-tested coverage. Between the two, 26.3% of residents or 9,791 individuals are either on Medicaid or not medically insured in Covington County, higher than the state (23.3%), and nation (23.5%).

Similarly, close to two-thirds of uninsured individuals in the service area (62.6%) live below 200% FPG, and close to one-half (46.2%) live below 138% FPG. Both of these rates in Covington County are higher than in the state and nation.

Special Populations Data – Covington County

Disability Status

	A	B	C	D	E	F	G
Disability Status[21]	Count (County)	Percent (County)	Count (Agency)	Percent (Agency)	Variance Percent (D-B)	Prevalence (A / County Population under age 65 x 100)	Unmet Need
Percent w/ a Disability, Under age 65	5,195	13.8 %	868	23.19 %	9.39 %	13.8 %	0.0 %

Veterans

	A	B	C	D	E	F	G
Veteran Status[22]	Count (County)	Percent (County)	Count (Agency)	Percent (Agency)	Variance Percent (D-B)	Prevalence (A / Total County Population x 100)	Unmet Need
Number of Veterans	2,698	7.17 %	136	3.63 %	-3.54 %	7.17 %	3.54 %

Medically Underserved Area (MUA)

Service Area Name[23]	Discipline	Designation Type	Index Score[24]	Rural Status
Butler County	Primary Care	Medically Underserved Area	60.4	Rural
Coffee County	Primary Care	Medically Underserved Area	60.9	Rural
Covington County	Primary Care	Medically Underserved Area	54.8	Rural
Crenshaw County	Primary Care	Medically Underserved Area	58.7	Rural

[21] Source for County *Disability Status* Data: Retrieved from: https://www.census.gov/quickfacts/fact/table/coffeecountyalabama/DIS010223, on March 8, 2025, see "Health" section, (2019-2023). Count found using "total population" of Covington County (37,647residents) estimates from the U.S. Census (2023).
[22] Source for County *Veteran Status* Data: Retrieved from: https://www.census.gov/quickfacts/fact/table/calhouncountyalabama/PST045224, on March 8, 2025, see "Population Characteristics" section, (2019-2023). Percent found using "total population" of Covington County estimates from the U.S. Census (2023).
[23] Source for MUA Data: https://data.hrsa.gov/tools/shortage-area/mua-find.
[24] For reference, the lowest score (highest need) is 0; the highest score (lowest need) is 100.

Mental Health Prevalence Data – Covington County

Mental Health Prevalence

Mental Health Condition	Count (County Data)	Count (State Data)	Percent / Rate (County/State)
Suicide	8 [25]	817 [26]	21.3 (County rate per 100K) 15.9 (State rate per 100K)
Death by Overdose (any drug)	11 [27]	1,408 [28]	31.5 [29] (State rate per 100K)
Overdose (opioid)	Data Not Available	981	69.6% (of all State overdose deaths)

Mental Health Professional Shortage Areas (HPSA)

	YES	NO
Is there a HPSA[30] within the County?	X	

If yes, please describe the shortage areas

There are three (3) HPSAs in Covington County. The table below presents the details of each HPSA. One HPSA (M-18) covers all of SCAMHB's proposed CCBHC service area.

HPSA ID[31]	Discipline	HPSA Name	Designation Type	County Name	HPSA FTE Shortage[32]	HPSA Score[33]	Rural Status
1019886410	Primary Care	LI- Covington County	Low Income Population HPSA	Covington County, AL	2.67	17	Rural
6019165076	Dental Health	LI- Covington County	Low Income Population HPSA	Covington County, AL	1.40	14	Rural
7018940421	Mental Health	Catchment Area M-18	High Needs Geographic HPSA	Butler County, AL | Coffee County, AL | **Covington County, AL** | Crenshaw County, AL	6.28	17	Rural

[25] Source for County *Suicide* Data: Alabama Public Health Department. "113 Causes of Death by County of Residence, Race, and Sex (2022). Pages 25-27. Retrieved March 8, 2025, from: https://www.alabamapublichealth.gov/healthstats/assets/113causes_2022.pdf.
[26] Source for *State* Suicide data: National Institute on Minority Health and Health Disparities. HD Pulse. Health Outcomes. Alabama Mortality, Suicide & Self-Inflicted Injury. Alabama Counties. (2018-2022). Retrieved March 8, 2025, from: https://hdpulse.nimhd.nih.gov/data-portal/quick-profile/01/mortality.
[27] Source for County *Overdose* Data: CDC, National Center for Health Statistics. National Vital Statistics System. "Provisional County-Level Drug Overdose Death Counts." (June 2024) Retrieved March 6, 2025, from: https://www.cdc.gov/nchs/nvss/vsrr/prov-county-drug-overdose.htm.
[28] Source for State *Overdose and Opioid* Data: "Opioid Related Deaths." (2021). Retrieved March 6, 2025, from: https://druguse.alabama.gov/opioidrelateddeaths.html.
[29] Source for *State Death Rate by Overdose*: CDC, National Center for Health Statistics. Alabama. Retrieved March 6, 2025, from: https://www.cdc.gov/nchs/pressroom/states/alabama/al.htm.
[30] Source for County *HPSA* Data: https://data.hrsa.gov/tools/shortage-area/hpsa-find
[31] Source for MUA Data: https://data.hrsa.gov/tools/shortage-area/mua-find.
[32] This attribute represents the number of full-time equivalent (FTE) practitioners needed in the Health Professional Shortage Area (HPSA) so that it will achieve the population to practitioner target ratio. The target ratio is determined by the type (discipline) of the HPSA.
[33] The scores range from 0 to 26, where the higher the score indicates the greater the priority.

Frequent Mental Distress (Age 18+)

	A	B	C	D	E	F	G
Mental Distress[34]	Count (County)	Percent (County)	Count (Agency)	Percent (Agency)	Variance Percent (D-B)	Prevalence (A / County Population Aged 18+ x 100)	Unmet Need
14+ days of MH "not good," past month	5,455	18.6 %	Data Not Available		Data Not Available	18.6 %	Data Not Available

Additional Metrics from Mental Health America (MHA)

According to the Mental Health America (MHA) publication entitled, "*The State of Health in America*" (2024 Edition)[35], Alabama ranks 39th of 50 states, based on fifteen mental health prevalence and access measures for youth and adults. This means that overall, Alabama has a higher prevalence of mental illness and lower rates of access to care, when compared to 38 other states in the nation. In considering measures for adults, Alabama ranked 36th out of 50 states; and for youth measures, Alabama ranked 32 out of 50 states. For measures around Access to Care, Alabama ranked 46th of 50 states.

	A	B	C	D	E	F	G	H
MHA Metrics[36]	Per 100K Population (State)	Per 100K Population (County)	Percent (County)[37]	Count (Agency)[38]	Percent (Agency)	Variance Percent (D-B)	Prevalence (A / Total County Population x 100)	Unmet Need
Scoring Severe Depression (PHQ-9)	44.8	31.89	12.01 %	52	29.5 %	17.49 %	12.01 %	0.0 %
Scoring At-Risk for Suicide	47.8	37.03	13.94 %	35	26.0 %	12.06 %	13.94 %	0.0 %
Scoring At-Risk for PTSD	18.4	16.5	6.21 %	Data Not Available			6.21 %	Data Not Available
People Identifying as Trauma Survivors	76.9	50.4	18.97 %	Data Not Available			18.97 %	
Scoring At-Risk for Psychosis-Like Experiences	27.9	22.63	8.52 %	Data Not Available			8.52 %	

[34] Source for County *Mental Distress* Data: PLACES, Centers for Disease Control and Prevention, 2024 Release.
[35] Mental Health America (MHA) publication entitled, "The State of Health in America" (2024 Edition). Retrieved on March 5, 2025, from: https://mhanational.org/sites/default/files/2024-State-of-Mental-Health-in-America-Report.pdf.
[36] Source for County *MHA Metrics* Data: Retrieved on March 8, 2025, from: https://mhanational.org/mhamapping/mha-state-county-data (2020-2024).
[37] Percent found using "total population" of Covington County (37,647 residents) which was the total population stated on the MHA Metrics webpage.
[38] SCAMHB agency data for the MHA Metrics Table is from 04/1/24 - 03/31/25.

Hospitalizations/Hospital Discharges – Covington County

**For hospitalization metrics below, may need to find state-level or national-level metrics and extrapolate down to county/ service area level with population, if actual local-level data is not available. Local mental health/public health department may also be a resource for these metrics.*

Hospitalizations from Non-Fatal Self-Harm Injuries (Youth, 0-17)

	A	B	C	D	E	F	G
	Count (County)	Percent (County)	Count (Agency)	Percent (Agency)	Variance Percent (D-B)	Prevalence	Unmet Need F-C
Youth Hospitaliz-ations from Self-Harm, non-Fatal	Data Not Available				Data Not Available		

Hospitalizations from Non-Fatal Self-Harm Injuries (Adults, 18+)

	A	B	C	D	E	F	G
	Count (County)	Percent (County)	Count (Agency)	Percent (Agency)	Variance Percent (D-B)	Prevalence	Unmet Need F-C
Adult Hospitaliz-ations from Self-Harm, non-Fatal	Data Not Available				Data Not Available		

Hospitalizations from Mental Disorders

	A	B	C	D	E	F	G
	Count (**State**)	Percent (**State**)	Count (Agency)	Percent (Agency)	Variance Percent (D-B)	Prevalence	Unmet Need F-C
YOUTH (0-17) Hospitaliz-ations from Mental Disorders[39]	5	Data Not Available	436	11.65 %	Data Not Available		
ADULT Hospitaliz-ations from Mental Disorders	1,041	Data Not Available	Data Not Available		Data Not Available		
ALL AGES Hospitaliz-ations from Mental Disorders	1,046	Data Not Available	Data Not Available		Data Not Available		

[39] Source for County *Hospitalization, Mental Disorders* Data: State Mental Health Agencies (SMHAs) data reported for SAMHSA's Community Mental Health Block Grant. Alabama. "2022 Uniform Reporting Summary Output Tables Executive Summary" (Page 12, State and Other Psychiatric Inpatient). *Note:* Data is Limited to those in Alabama served by SAMHSA Block Grant; unknown if SUD is included. Retrieved on March 6, 2025, from: https://www.samhsa.gov/data/sites/default/files/reports/rpt42736/Alabama.pdf.

Hospitalizations from Mental Disorders (Non-drug/alcohol induced)

	A	B	C	D	E	F	G
	Count (County)	Percent (County)	Count (Agency)	Percent (Agency)	Variance Percent (D-B)	Prevalence	Unmet Need F-C
Hospitaliz-ations from Mental Disorders (Non-SUD)	Data Not Available				Data Not Available		

Hospitalizations from Mood and Depressive Disorders

	A	B	C	D	E	F	G
	Count (County)	Percent (County)	Count (Agency)	Percent (Agency)	Variance Percent (D-B)	Prevalence	Unmet Need F-C
Hospitaliz-ations from Mood and Depressive Disorders	Data Not Available				Data Not Available		

Suicide – Covington County

**For suicide metrics below, applicants may need to find state-level or national-level metrics and extrapolate down to county/service area level with population, if actual local-level data is not available. Local mental health/public health department may also be a resource for these metrics.*

Suicide Attempts (High School 9th-12th Grades)

	A	B	C	D	E	F	G
	Count (**State**)	Percent (**State**)	Count (Agency)	Percent (Agency)	Variance Percent (D-B)	Prevalence	Unmet Need F-C
Suicide Attempts, Youth[40]	Data Not Available	11.6%	Data Not Available		Data Not Available		

Suicide Attempts (Adults, 18+)

	A	B	C	D	E	F	G
	Count (County)	Percent (County)	Count (Agency)	Percent (Agency)	Variance Percent (D-B)	Prevalence	Unmet Need F-C
Suicide Attempts, Adult	Data Not Available				Data Not Available		

[40] Source for County *Suicide Attempts, High School* Data: The Jason Foundation. 2019 Youth Risk Behavioral Survey. Alabama – Youth Suicide, Statistical Impact. Retrieved March 6, 2025 from: https://jasonfoundation.com/wp-content/uploads/sites/97/2021/02/Alabama-State-Statistical-Page.pdf.

Age-adjusted Deaths from Suicide (Teen, 15-19)

	A	B	C	D	E	F	G
	Rate per 100K Pop. (**State**)	Rate per 100K Pop. (**Nation**)	Count (Agency)	Percent (Agency)	Variance Percent (D-B)	Prevalence	Unmet Need F-C
Age-Adjusted Deaths by Suicide, Teen [41]	9.0	10.5	Data Not Available		Data Not Available		

Age-adjusted Deaths from Suicide (All Ages)

	A	B	C	D	E	F	G
	Rate per 100K Pop. (**State**)	Rate per 100K Pop. (**Nation**)	Count (Agency)	Percent (Agency)	Variance Percent (D-B)	Prevalence	Unmet Need F-C
Age-Adjusted Deaths by Suicide, All Ages[42]	16.6	14.8	Data Not Available		Data Not Available		

Substance Use Data: Students – Covington County

All student data in this section is sourced from results of the High School Youth Risk Behavior Survey (YRBS), 2021, as administered by the Centers for Disease Control and Prevention (CDC)[43]. Data is provided below for the State of Alabama and the nation. County-level data is not available.

SCAMHB data is provided, wherever possible, in the tables below. As an agency, SCAMHB remains dedicated to its school-based programs. Within the most recent fiscal year (10/1/2023-9/30/2024), SCAMHB served a total of 174 students across Grades 9-12. The table below represents the number of students, by grade, who reported any use of substance.

Student Reporting Any Use of Substance

	A	B
Grade	Count (Agency)	Percent (Agency)
12th Grade	5	2.9%
11th Grade	5	2.9%
10th Grade	14	8.0%
9th Grade	20	11.5%
All Grades	44	25.3%

[41] Source for State/Nation *Age-Adjusted Death by Suicide, Teen* Data: America's Health Rankings analysis of CDC WONDER, Multiple Cause of Death Files, United Health Foundation, AmericasHealthRankings.org . "Teen Suicide by State." Retrieved March 6, 2025, from: https://www.americashealthrankings.org/explore/measures/teen_suicide/AL.

[42] Source for County *Age-Adjusted Death by Suicide, All Ages* Data: America's Health Rankings analysis of CDC WONDER, Multiple Cause of Death Files, United Health Foundation, AmericasHealthRankings.org . "Suicide by State." Retrieved March 6, 2025, from: https://www.americashealthrankings.org/explore/measures/Suicide/AL.

[43] *Source for Student Substance Use*: CDC, High School YRBS. Retrieved March 6, 2025, from: https://nccd.cdc.gov/YouthOnline/App/Results.aspx?LID=AL.

Student Reporting Any Use of Alcohol in Past 30 Days

	A	B	C	D	E	F	G
Grade	Percent (**United States**)	Percent (**Alabama**)	Count (Agency)	Percent (Agency)	Variance Percent (D-B)	Prevalence (**Alabama**)	Unmet Need
12th Grade	32.2 %	39.2 %	Data Not Available		Data Not Available	39.2 %	Data Not Available
11th Grade	26.0 %	13.9 %				13.9 %	
10th Grade	18.9 %	12.3 %				12.3 %	
9th Grade	14.7 %	8.0 %				8.0 %	
All Grades	22.7 %	18.8 %				18.8 %	
Measure: Currently Drank Alcohol (at least 1 drink of alcohol, on at least 1 day, 30 days before the survey) (2021)							

Student Reporting Having 5 or More Drinks in a Row in Past 30 Days

	A	B	C	D	E	F	G
Grade	Percent (**United States**)	Percent (**Alabama**)	Count (Agency)	Percent (Agency)	Variance Percent (D-B)	Prevalence (**Alabama**)	Unmet Need
12th Grade	22.4 %	13.6 %	Data Not Available		Data Not Available	13.6 %	Data Not Available
11th Grade	15.3 %	11.5 %				11.5 %	
10th Grade	10.6 %	8.2 %				8.2 %	
9th Grade	7.3 %	7.0 %				7.0 %	
All Grades	13.7 %	10.0 %				10.0 %	
Measure: Currently Were Binge Drinking on at least 1 day, 30 days before the survey (2019)							

Student Reporting Smoking a Cigarette in Past 30 Days

	A	B	C	D	E	F	G
Grade	Percent (**United States**)	Percent (**Alabama**)	Count (Agency)	Percent (Agency)	Variance Percent (D-B)	Prevalence (**Alabama**)	Unmet Need
12th Grade	5.2 %	12.5 %	Data Not Available		Data Not Available	12.5 %	Data Not Available
11th Grade	4.1 %	5.8 %				5.8 %	
10th Grade	3.8 %	4.3 %				4.3 %	
9th Grade	2.2 %	0.0 %				0.0 %	
All Grades	3.8 %	5.7 %				5.7 %	
Measure: Currently Smoked Cigarettes on at least 1 day, 30 days before the survey (2021)							

Student Reporting Vaping in Past 30 Days

	A	B	C	D	E	F	G
Grade	Percent (**United States**)	Percent (**Alabama**)	Count (Agency)	Percent (Agency)	Variance Percent (D-B)	Prevalence (**Alabama**)	Unmet Need
12th Grade	24.0 %	27.2 %	Data Not Available		Data Not Available	27.2 %	Data Not Available
11th Grade	19.3 %	22.5 %				22.5 %	
10th Grade	16.5 %	11.5 %				11.5 %	
9th Grade	12.9 %	8.6 %				8.6 %	
All Grades	18.0 %	17.5 %				17.5 %	
Measure: Currently Used Electronic Vapor Products on at least 1 day, 30 days before the survey (2021)							

Student Reporting Any Use of Marijuana in Past 30 Days

	A	B	C	D	E	F	G
Grade	Percent (**United States**)	Percent (**Alabama**)	Count (Agency)	Percent (Agency)	Variance Percent (D-B)	Prevalence (**Alabama**)	Unmet Need
12th Grade	22.4 %	16.2 %	3	4.48 %	-11.72 %	16.2 %	11.72 %

11th Grade	18.7 %	12.8 %	0	0.00 %	-12.80 %	12.8 %	12.80 %
10th Grade	13.3 %	8.2 %	0	0.00 %	-8.20 %	8.2 %	8.20 %
9th Grade	9.1 %	4.1 %	0	0.00 %	-4.10 %	4.1 %	4.10 %
All Grades	15.8 %	11.3 %	3	2.59 %	-8.71 %	11.3 %	8.71 %
Measure: Currently Used Marijuana on at least 1 day, 30 days before the survey (2021)							

Student Reporting Any Use of Fentanyl (No Data Available)

	A	B	C	D	E	F	G
Grade	Percent (**United States**)	Percent (**Alabama**)	Count (Agency)	Percent (Agency)	Variance Percent (D-B)	Prevalence (**Agency**)	Unmet Need
12th Grade	Data Not Available	Data Not Available	0	0.00 %	Data Not Available	0.00 %	Data Not Available
11th Grade			0	0.00 %		0.00 %	
10th Grade			0	0.00 %		0.00 %	
9th Grade			0	0.00 %		0.00 %	
All Grades			0	0.00 %		0.00 %	
There is no measure in the High School YRBS Study (2021) addressing Fentanyl Use by students							

Student Reporting Any Use of Methamphetamine, Lifetime

	A	B	C	D	E	F	G
Grade	Percent (**United States**)	Percent (**Alabama**)	Count (Agency)	Percent (Agency)	Variance Percent (D-B)	Prevalence (**Alabama**)	Unmet Need
12th Grade	1.9 %	6.1 %	0	0.00 %	-6.10 %	6.1 %	6.10 %
11th Grade	1.9 %	4.6 %	0	0.00 %	-4.60 %	4.6 %	4.60 %
10th Grade	1.5 %	0.7 %	1	11.11 %	10.41 %	0.7 %	0.0 %
9th Grade	1.4 %	2.3 %	0	0.00 %	-2.30 %	2.3 %	2.30 %
All Grades	1.8 %	3.5 %	1	0.86 %	-2.64 %	3.5 %	2.64 %
Measure: Ever Used Methamphetamines, 1 or more times in their life (2021)							

Student Reporting Any Use of MDMA/Ecstasy, Lifetime

	A	B	C	D	E	F	G
Grade	Percent (**United States**)	Percent (**Alabama**)	Count (Agency)	Percent (Agency)	Variance Percent (D-B)	Prevalence (**Alabama**)	Unmet Need
12th Grade	4.1 %	8.6 %	0	0.00 %	-8.60 %	8.6 %	8.60 %
11th Grade	3.0 %	8.5 %	0	0.00 %	-8.50 %	8.5 %	8.50 %
10th Grade	2.4 %	1.6 %	0	0.00 %	-1.60 %	1.6 %	1.60 %
9th Grade	1.7 %	2.3 %	0	0.00 %	-2.30 %	2.3 %	2.30 %
All Grades	2.9 %	5.2 %	0	0.00 %	-5.20 %	5.2 %	5.20 %
Measure: Ever Used Ecstasy, 1 or more times in their life (2021)							

Student Reporting Any Use of Crack/Cocaine, Lifetime

	A	B	C	D	E	F	G
Grade	Percent (**United States**)	Percent (**Alabama**)	Count (Agency)	Percent (Agency)	Variance Percent (D-B)	Prevalence (**Alabama**)	Unmet Need
12th Grade	3.4 %	4.5 %	0	0.00 %	-4.50 %	4.5 %	4.50 %
11th Grade	2.4 %	5.4 %	0	0.00 %	-5.40 %	5.4 %	5.40 %
10th Grade	1.9 %	2.1 %	0	0.00 %	-2.10 %	2.1 %	2.10 %
9th Grade	1.7 %	0.7 %	0	0.00 %	-0.70 %	0.7 %	0.70 %
All Grades	2.5 %	3.1 %	0	0.00 %	-3.10 %	3.1 %	3.10 %
Measure: Ever Used Cocaine, 1 or more times in their life (2021)							

Student Reporting Any Use of Hallucinogenic Drugs, Lifetime

	A	B	C	D	E	F	G
Grade	Percent (**United States**)	Percent (**Alabama**)	Count (Agency)	Percent (Agency)	Variance Percent (D-B)	Prevalence (**Agency**)	Unmet Need
12th Grade	10.5 %	Data Not Available	0	0.00 %	Data Not Available	0.00 %	Data Not Available
11th Grade	7.6 %		0	0.00 %		0.00 %	
10th Grade	4.6 %		0	0.00 %		0.00 %	
9th Grade	3.4 %		0	0.00 %		0.00 %	
All Grades	6.5 %		0	0.00 %		0.00 %	
Measure: Ever Used Hallucinogenic Drugs, 1 or more times in their life (2021)							

Student Reporting Any Use of Heroin in Past 12 Months

	A	B	C	D	E	F	G
Grade	Percent (**United States**)	Percent (**Alabama**)	Count (Agency)	Percent (Agency)	Variance Percent (D-B)	Prevalence (**Alabama**)	Unmet Need
12th Grade	1.4 %	5.0 %	0	0.00 %	-5.00 %	5.0 %	5.00 %
11th Grade	1.3 %	10.7 %	0	0.00 %	-10.70 %	10.7 %	10.70 %
10th Grade	1.4 %	2.3 %	0	0.00 %	-2.30 %	2.3 %	2.30 %
9th Grade	0.8 %	2.4 %	0	0.00 %	-2.40 %	2.4 %	2.40 %
All Grades	1.3 %	5.5 %	0	0.00 %	-5.50 %	5.5 %	5.50 %
Measure: Ever Used Heroin, 1 or more times in their life (2021)							

Student Reporting Any Use Prescription Pain Relievers Not Prescribed for Them in Past 12 Months

	A	B	C	D	E	F	G
Grade	Percent (**United States**)	Percent (**Alabama**)	Count (Agency)	Percent (Agency)	Variance Percent (D-B)	Prevalence (**Agency**)	Unmet Need
12th Grade	5.3 %	Data Not Available	0	0.00 %	Data Not Available	0.00 %	Data Not Available
11th Grade	6.3 %		0	0.00 %		0.00 %	
10th Grade	5.3 %		1	11.11 %		11.11 %	
9th Grade	6.7 %		0	0.00 %		0.00 %	
All Grades	6.0 %		1	0.86 %		0.86 %	
Measure: Currently Took Prescription Pain Medicine Without A Doctor's Prescription Or Differently Than How A Doctor Told Them To Use It, on at least 1 day, 30 days before the survey (2021)							

Substance Use Data: Adults – Covington County

Admission to Treatment Facility data is not available at the county-level. Data below is presented for the State of Alabama. Statistics were disaggregated for youth data (age 12-17).

Percent of Admissions to Treatment Facilities for SUD - Adults

Clinics are asked to refer to intake histories to obtain the agency data for this table.

	A	B	C	D	E	F	G
AGE 18 AND OLDER[44]	Count (**State**)	Percent (**State**)	Count (Agency)	Percent (Agency)	Variance Percent (D-B)	Prevalence	Unmet Need
Alcohol Only	846	6.4%	Data		Data		

[44] Source for County *Admission to Treatment for Alcohol and SUD* Data (Adult and Youth): 2023 Substance Use Treatment Services State Profile—Alabama National Substance Use and Mental Health Services Survey (N-SUMHSS). Retrieved on March 6, 2025, from: https://www.samhsa.gov/data/quick-statistics-results?parent_data_collection_id=1178&location_id=134&data_collection_ id=1283&year=2023.

Alcohol and Drug	3,281	24.8%	Not Available	Not Available
Drug Only	9,090	68.8%		
All Admissions	13,217	100.0%		

Percent of Admissions to Treatment Facilities for SUD - Youth

Clinics are asked to refer to intake histories to obtain the agency data for this table.

	A	B	C	D	E	F	G
UNDER 18 YEARS OLD	Count (**State**)	Percent (**State**)	Count (Agency)	Percent (Agency)	Variance Percent (D-B)	Prevalence	Unmet Need
Alcohol Only	33	9.1%	Data Not Available		Data Not Available		
Alcohol and Drug	240	66.6%					
Drug Only	87	24.1					
All Admissions	360	100.0%					

Percent of Admissions to Treatment Facilities for Drug Use – Adults and Youth

	A	B		C	D	E	F	G
Substance[45]	Count All Ages (**State**)	Percent All Ages (**State**)	Percent Youth (12-17) (**State**)	Count (Agency)	Percent (Agency)	Variance Percent (D-B)	Prevalence	Unmet Need
PCP	0	0.0%	0.0%	Data Not Available		Data Not Available		
Inhalants	4	0.0%	0.0%					
Sedatives	13	0.1%	0.0%					
Hallucinogens	21	0.1%	0.0%					
Other Stimulants	38	0.3%	10.5%					
Other/Unknown	59	0.4%	5.1%					
Tranquilizers	106	0.7%	3.8%					
Cocaine (Other Route)	286	1.9%	2.1%					
Cocaine (Smoked)	394	2.7%	0.3%					
Heroin	1,077	7.3%	0.0%					
Alcohol w/ Drug	1,278	8.6%	3.9%					
Alcohol Only	2,105	14.2%	1.4%					
Other Opiates	3,096	20.8%	0.9%					
Amphetamines	3,169	21.3%	0.6%					
Marijuana	3,203	21.6%	25.6%					
All Substances	14,849	100.0%	6.5%					

[45] Source for County *Admission to Treatment for Substance Use, By Substance* Data: **2023 Treatment Episode Data Set: Admissions (TEDS-A) Alabama.** Retrieved on March 6, 2025, from: https://www.samhsa.gov/data/quick-statistics-results?parent_data_collection_id=1183&location_id=134.

Clinic-Specific Data

Population Overview

Please describe how your organization will meet the needs of the population of focus and what special areas of unmet need are to be addressed.

SCAMHB's priority population for the CCBHC program includes individuals of all ages (children, adults, seniors) living in Butler, Coffee, Covington, and Crenshaw counties, Alabama, with a behavioral health diagnosis, including those with severe mental illness (SMI), severe emotional disturbance (SED), substance use disorders (SUD), and/or co-occurring disorders (COD). In addition, those served by SCAMHB's CCBHC will also be comprised mostly of individuals living at or below 200% the of Federal Poverty Guidelines (FPG). In this Needs Assessment, where possible, the data focuses on indicators related to individuals with lower incomes in Butler County, ensuring that their needs are addressed, as they are the most likely to be served by the CCBHC.

Access and Obtaining Care-Availability of Care Providers

Current Agency Vacancy and Turnover Data

Item	A	B
Year ending 2024	Count (Agency)	Percent (Agency)
Clinical Staff Vacancy Rate	30	30
30	45	23
Clinical Staff Annual Turnover	30	14
Non- Clinical Staff Annual Turnover	45	21

Access to Care Time to Service

Item	Days		% Completed	No Show Count	Cancellation Count	Cancellation %
Days to Initial Service (Evaluation)	3.5		3.6%	6	7	4.1%
Time to First Treatment Appointment	2.65		3.6%	6	7	4.1%
Time to First Medical/ Prescriber Appt.	16.99		3.6%	6	7	4.1%
Does your Center offer Same Day Access	Yes					
	No	X				
No Show/Cancelation (Total Agency)			3.6%	6	7	4.1%

Unmet Needs of Service Area

Unmet Needs Related to Outpatient Clinical Services Currently Provided by CMHC

Required Services: the CMHC will deliver directly the majority (51% or more) of encounters across the required services (excluding Crisis Services) rather than through a DCO. For each type of service, please indicate the UNMET needs, both for consumers and non-consumers, in the service area, relevant to the following:

Limits to staffing:

- *Is the staff (clinical and non-clinical) appropriate for serving the consumer population (including unserved consumers in the service area) in terms of size and composition and service providers?*
- *Does training address cultural competence; person-centered and family-centered, recovery-oriented, evidence-based, and trauma-informed care; and primary care/behavioral health integration?*
- *Does the CMHC take reasonable steps to provide meaningful access to individuals with Limited-English-Proficiency (LEP) or with language-based-disabilities?*

Limits to Access and Availability of Outpatient Clinical Services

- *Indicate where (and which) services are not available throughout the service area*
  - *Geographic limitations: services that are not offered in some parts of the service area*
  - *Transportation Barriers*
  - *Broadband Access/Computers in the home*
  - *Time limitations: services that are not offered on some nights and weekends*

Limits to Populations Served

- *Please identify specific populations that you would like to offer services to that you currently do not because of barriers and limitations*
- *Please identify any Linguistic or Cultural competency needs in your community*

1. Crisis Services

[Crisis Intervention; 24-hour mobile crisis teams; crisis receiving/stabilization; and 988 Suicide Crisis Lifeline]

Emergency mental health support needs remain partially unmet across all four counties surveyed. In Butler County, 10.8% of respondents (5.8% received services, 5.0% did not) reported needing emergency mental health support, but nearly half of those in need (46%) indicated they did not receive services. In Coffee County, 7.6% of residents reported needing emergency support, with 43% of them not receiving it. Covington County had the highest overall reported need at 12.1%, with 25% of those in need not obtaining services. In Crenshaw County, 9.8% reported needing support, and 16% did not receive it.

These findings highlight a service gap that may reflect barriers in awareness, outreach, or accessibility. Some residents may not know how or where to access support, especially during times of crisis. This underscores the need for continued community education and advertising to ensure that individuals in need are aware of how to obtain immediate help.

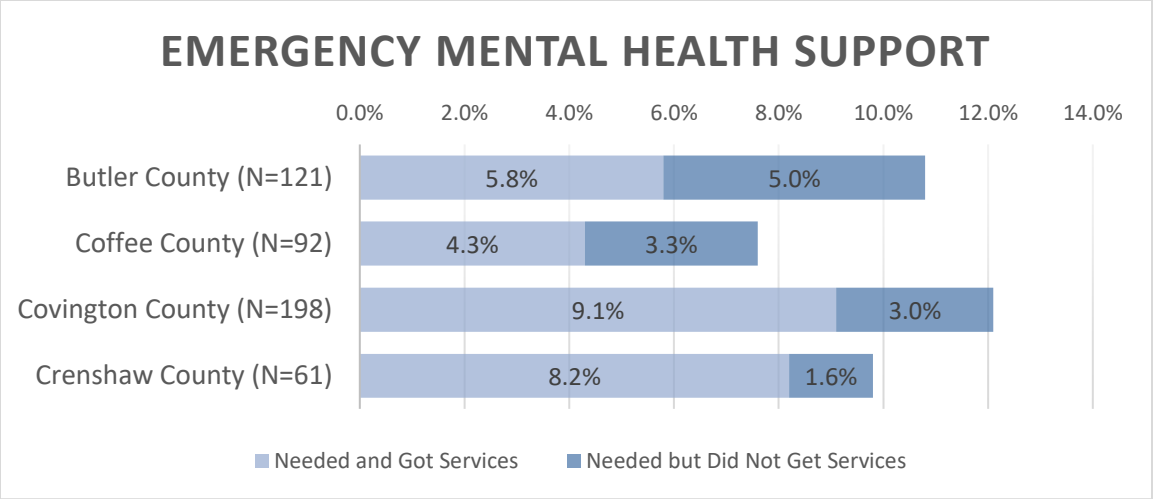


Figure 1. Household Need for Emergency Mental Health Support Services in the Past 12 Months from Community Needs Assessment Survey

To address unmet needs in our service area, we analyzed staffing, service availability, and access barriers for current and potential consumers. Based on these findings, we recommend focused solutions below to better serve our diverse community.

Limits to Staffing

- Hire additional crisis-trained clinicians or expand telehealth access during peak times to address the unmet need.
- Increase non-clinical staffing such as peer specialists to support crisis follow-up and de-escalation.
- Provide routine training in trauma-informed care, person-centered crisis planning, and integration of primary and behavioral healthcare.

Limits to Access and Availability

- Expand mobile crisis services to operate 24/7.
- Establish extended outpatient hours, including at least one evening per week and one Saturday per month.
- Expand access to MyCare crisis tablets to overcome technology and broadband barriers.
- Collaborate with local transportation services providers to improve access to crisis services.

Limits to Populations Served

- Expand crisis services for youth to include MyCare crisis tablets at schools.
- Strengthen post-crisis follow-up support through peers and community health workers to improve outcomes
- Ensure cultural competence training includes strategies to support rural Black families and growing Hispanic populations.

2. Screening & Assessment

[Screening; Assessment; Diagnosis; and Risk Assessment]

Access to screening and assessment services varied across the four counties, with notable gaps in Butler and Covington. In Butler County, a total of 10.7% of respondents reported needing these services, but over 61% of them did not receive care—indicating a significant service gap. Covington County had the highest overall need at 10.6%, with 38% of those in need going without services. In contrast, Coffee County demonstrated relatively strong access, with 6.6% of respondents needing services and only 1.1% left without them—meaning 83% of those in need received care. Crenshaw County showed moderate need at 8.2%, with 40% of those not receiving services. These findings suggest a need to expand early identification and assessment capacity, especially in Butler and Covington Counties, to reduce missed opportunities for timely intervention.

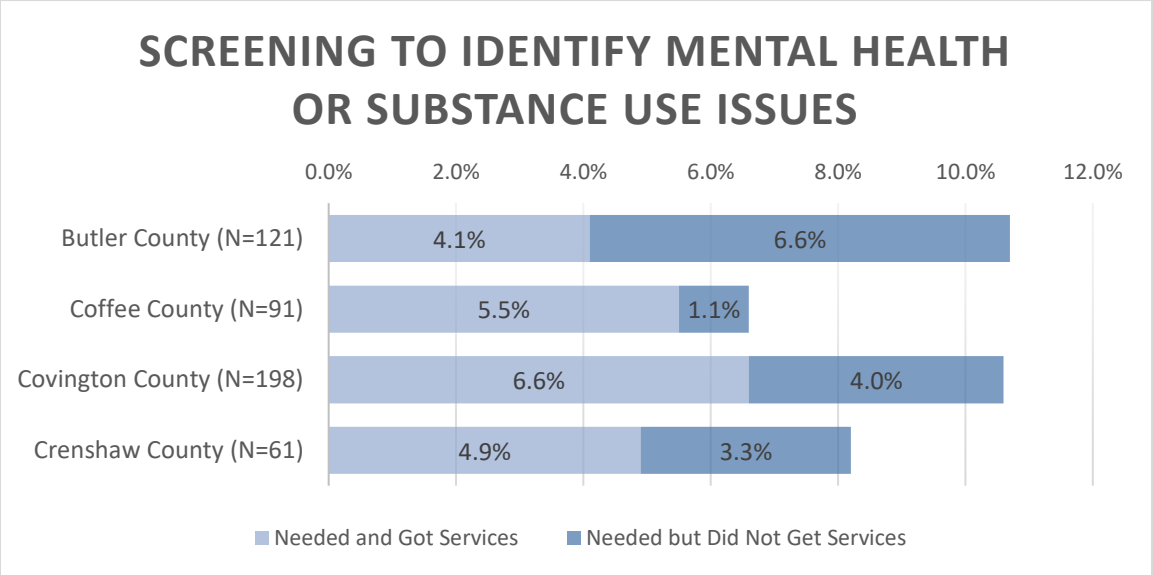


Figure 2. Household Need for Mental Health or Substance Use Screening and Assessment Services in the Past 12 Months from Community Needs Assessment Survey

To address unmet needs in our service area, we analyzed staffing, service availability, and access barriers for current and potential consumers. Based on these findings, we recommend focused solutions below to better serve our diverse community.

Limits to Staffing

- Increase the number of clinicians trained in brief screenings and diagnostic assessments to reduce wait times and expand service availability.
- Provide regular training on evidence-based, trauma-informed, person-centered screening tools and culturally competent interviewing techniques.
- Maintain and strengthen existing access to qualified interpreters and screening tools in Spanish and other languages for individuals with limited English proficiency (LEP).

Limits to Access and Availability

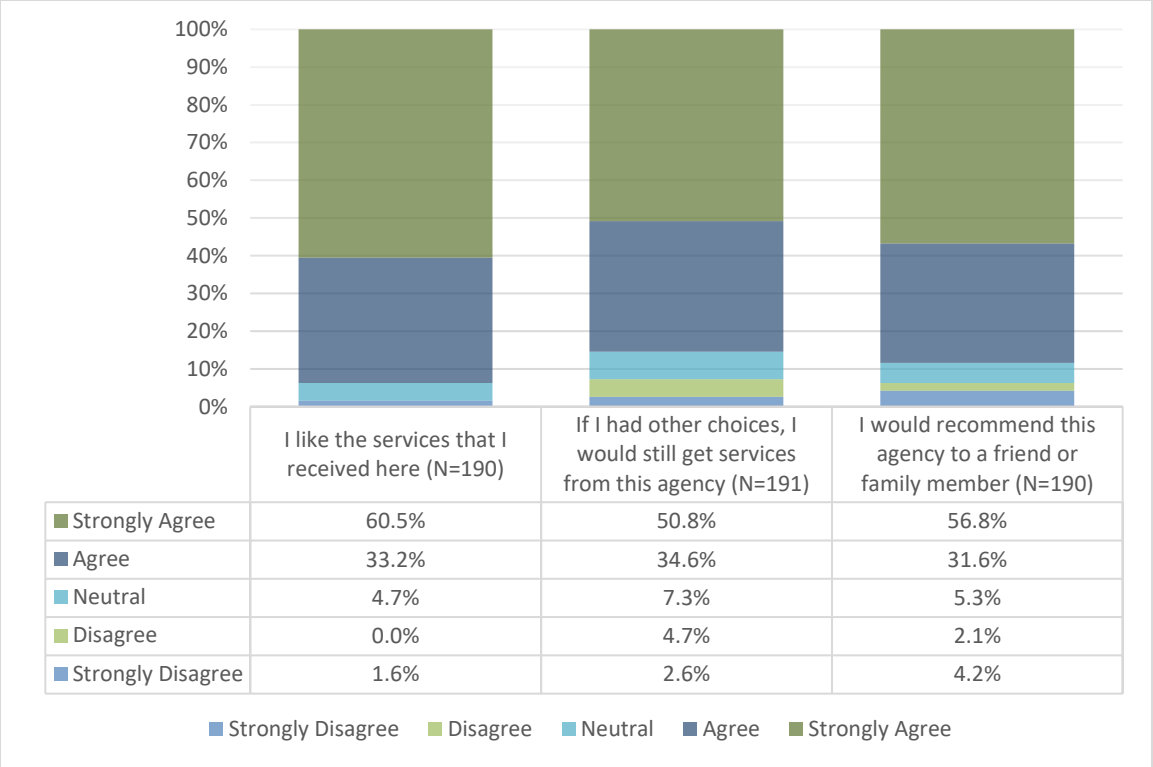
- Address geographic gaps by offering screening services at satellite offices, community-based service sites, or through mobile units.
- Work with transportation providers to ensure individuals in remote areas can access initial assessments.
- Offer tele-assessments using tablets or kiosks.
- Extend service hours for screenings to include evenings and weekends, particularly for working adults and caregivers.

Limits to Populations Served

- Prioritize outreach and screening access for school-aged youth, older adults, and individuals recently released from jail, who may be underserved.
- Invest in cultural responsiveness training and hire staff who reflect the community's racial, ethnic, and linguistic diversity.

3. Person-Centered and Family-Centered Treatment Planning

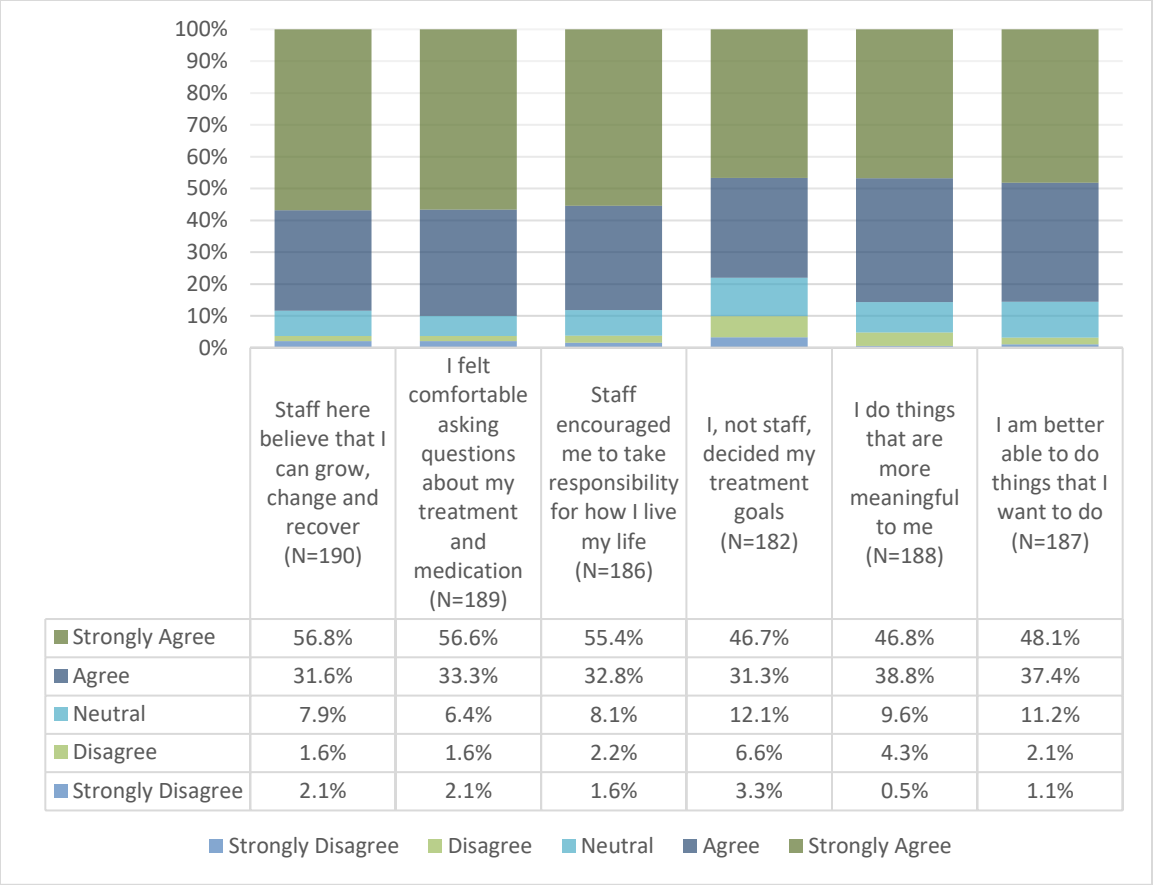
Most respondents expressed a high level of satisfaction with the services they received. When asked if they liked the services provided (N=190), 93.7% agreed or strongly agreed, with 60.5% strongly agreeing. Similarly, when asked if they would continue to use the agency's services even if they had other options (N=191), 85.4% agreed or strongly agreed, with just over half (50.8%) strongly agreeing. Additionally, 88.4% of respondents (N=190) said they would recommend the agency to a friend or family member, with 56.8% strongly endorsing the recommendation. These results indicate strong overall approval and trust in the agency's services.



	I like the services that I received here (N=190)	If I had other choices, I would still get services from this agency (N=191)	I would recommend this agency to a friend or family member (N=190)
Strongly Agree	60.5%	50.8%	56.8%
Agree	33.2%	34.6%	31.6%
Neutral	4.7%	7.3%	5.3%
Disagree	0.0%	4.7%	2.1%
Strongly Disagree	1.6%	2.6%	4.2%

Figure 3. Client Satisfaction for Services Provided from Adult MSHIP Consumer Survey

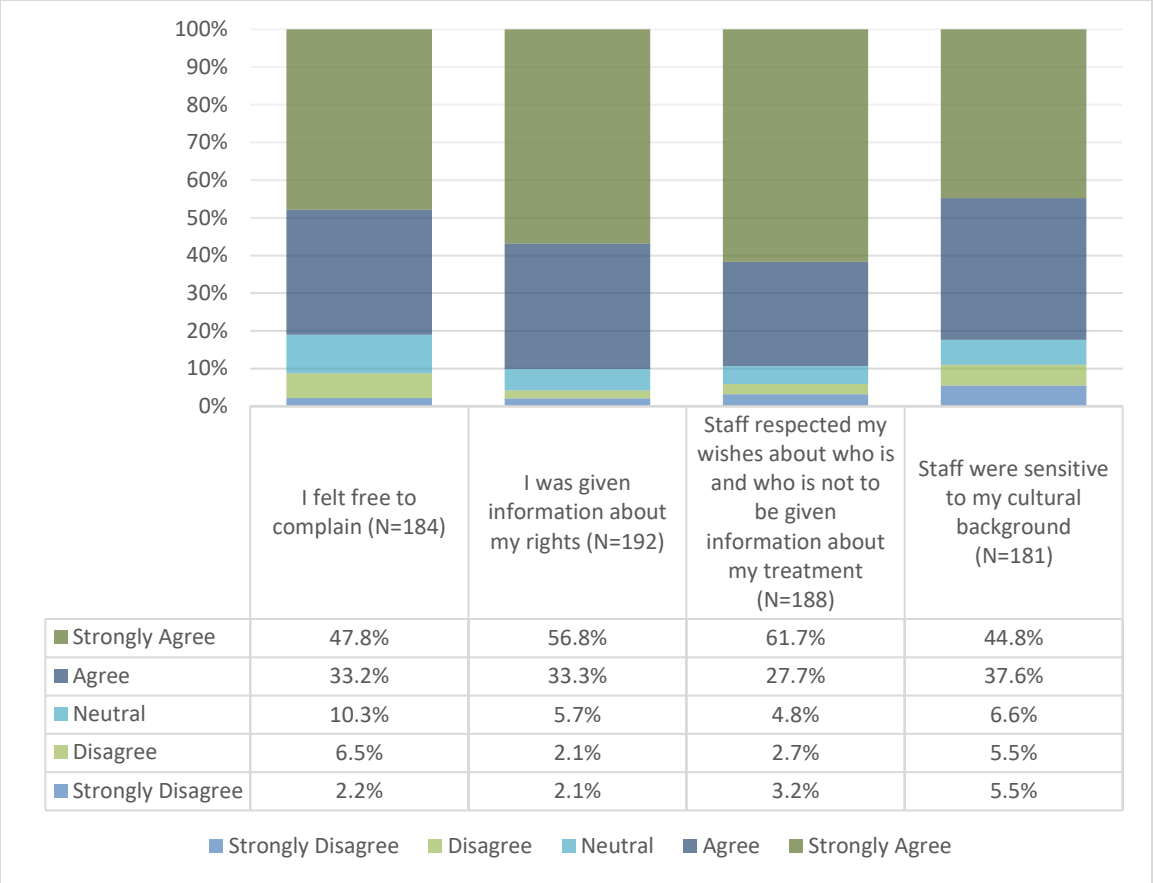
The majority of respondents expressed strong agreement that staff support their growth, recovery, and personal responsibility. Specifically, 88.4% agreed or strongly agreed that staff believe they can grow, change, and recover (with 56.8% strongly agreeing), and a similar 89.9% felt comfortable asking questions about their treatment and medication. Additionally, 88.2% agreed or strongly agreed that staff encouraged them to take responsibility for how they live their lives. While slightly lower, 78.0% of respondents said they—not staff—decided their treatment goals, indicating room for improvement in supporting client autonomy. Regarding meaningful engagement, 85.6% reported doing things that are more meaningful to them, and 85.5% felt better able to do the things they want to do. Neutral and disagreement responses were relatively low across these items, highlighting strong perceptions of empowerment and support from staff.



	Staff here believe that I can grow, change and recover (N=190)	I felt comfortable asking questions about my treatment and medication (N=189)	Staff encouraged me to take responsibility for how I live my life (N=186)	I, not staff, decided my treatment goals (N=182)	I do things that are more meaningful to me (N=188)	I am better able to do things that I want to do (N=187)
Strongly Agree	56.8%	56.6%	55.4%	46.7%	46.8%	48.1%
Agree	31.6%	33.3%	32.8%	31.3%	38.8%	37.4%
Neutral	7.9%	6.4%	8.1%	12.1%	9.6%	11.2%
Disagree	1.6%	1.6%	2.2%	6.6%	4.3%	2.1%
Strongly Disagree	2.1%	2.1%	1.6%	3.3%	0.5%	1.1%

Figure 4. Client Empowerment and Recovery Support from Adult MSHIP Consumer Survey

Most respondents felt that their rights and preferences were respected during treatment. Nearly 81% agreed or strongly agreed that they felt free to complain, with 47.8% strongly agreeing. A similar percentage (90.1%) reported being informed about their rights, and 89.4% agreed or strongly agreed that staff respected their wishes regarding who could receive information about their treatment, with a strong endorsement of 61.7% strongly agreeing. Additionally, 82.4% of respondents felt that staff were sensitive to their cultural background, though this item had slightly higher neutral and disagreement responses compared to others. Overall, these results reflect a generally positive perception of respect for rights, privacy, and cultural sensitivity within services.



	I felt free to complain (N=184)	I was given information about my rights (N=192)	Staff respected my wishes about who is and who is not to be given information about my treatment (N=188)	Staff were sensitive to my cultural background (N=181)
Strongly Agree	47.8%	56.8%	61.7%	44.8%
Agree	33.2%	33.3%	27.7%	37.6%
Neutral	10.3%	5.7%	4.8%	6.6%
Disagree	6.5%	2.1%	2.7%	5.5%
Strongly Disagree	2.2%	2.1%	3.2%	5.5%

Figure 5. Respect for Client Rights, Privacy, and Cultural Sensitivity from Adult MSHIP Consumer Survey

To address unmet needs in our service area, we analyzed staffing, service availability, and access barriers for current and potential consumers. Based on these findings, we recommend focused solutions below to better serve our diverse community.

Limits to Staffing

- Staff training should continue to emphasize cultural competence, trauma-informed care, person- and family-centered approaches, recovery orientation, and integration with primary care to improve engagement and outcomes.
- Reasonable steps should be taken to enhance meaningful access for individuals with Limited English Proficiency (LEP) or language-based disabilities, as the rural population is likely to include diverse linguistic needs. Consider expanding interpreter services and multilingual screening tools.

Limits to Access and Availability

- Geographic barriers likely affect access, particularly for residents in remote or underserved parts of Butler County. Mobile units or satellite clinics could address this gap.
- Transportation barriers remain a challenge, limiting access to in-person assessments for some individuals.

- Broadband and computer access gaps can impede telehealth or remote screening options; providing loaner tablets or in-community telehealth hubs could mitigate this.
- Extending service hours to evenings and weekends would benefit working adults and families.

Limits to Populations Served

- Cultural competency needs include enhanced sensitivity to rural, Black, and Hispanic populations; about 11% of respondents felt staff were not sensitive to their cultural background.
- Increasing staff diversity and providing ongoing cultural competence training are essential.

4. Outpatient Mental Health & Substance Use Services

Mental health service needs are significant across all four counties, with substantial portions of the population still unable to access care. In Butler County, 26.6% of respondents required mental health services, but 42% of those in need (11.3% of total) did not receive them, indicating a large service gap. Coffee County showed slightly better access, with 19.8% needing services and 28% of those (5.5% of total) unmet. Both Covington and Crenshaw Counties reported the highest overall need, with approximately one-quarter of respondents requiring mental health services (25.6% and 24.6%, respectively), yet 31% to 33% of those individuals did not receive services (8.0% and 8.2% unmet need). These findings underscore persistent barriers to timely and adequate mental health care, particularly in Covington and Crenshaw Counties, and highlight the need for expanded outreach, increased provider capacity, and enhanced service accessibility.

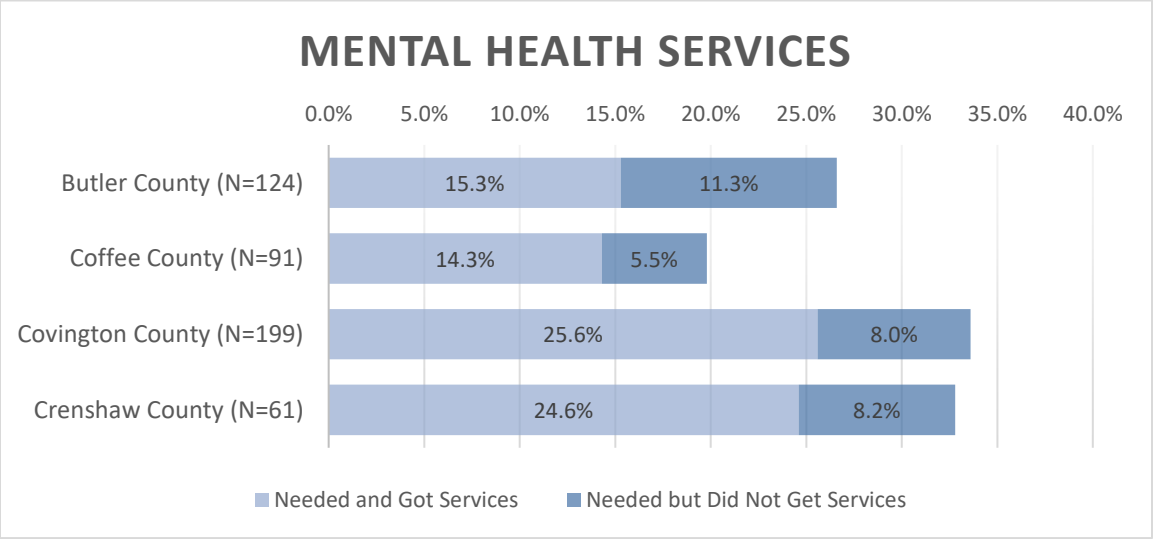


Figure 6. Household Need for Mental Health Services in the Past 12 Months from Community Needs Assessment Survey

Access to online mental health services remains limited across the four counties, with unmet need outpacing access in nearly all areas. In Butler County, 13.1% of respondents reported needing online services, yet only 25% of those in need received them, leaving 75% (9.8%)

without access—highlighting a significant digital service gap. Coffee County showed a total need of 5.5%, with 60% of those in need (3.3%) going unserved. Covington County had the highest total need at 11.2%, with 46% unmet (5.1%) and Crenshaw County followed closely with a 11.7% total need and 43% unmet (5.0%). These data reflect substantial barriers to accessing online mental health care—such as broadband limitations, technology shortages, or lack of digital literacy—particularly in Butler County, where the unmet need was three times greater than access. Addressing these disparities will require investment in digital infrastructure, device access, and outreach to ensure that online services are a viable and equitable option for care.

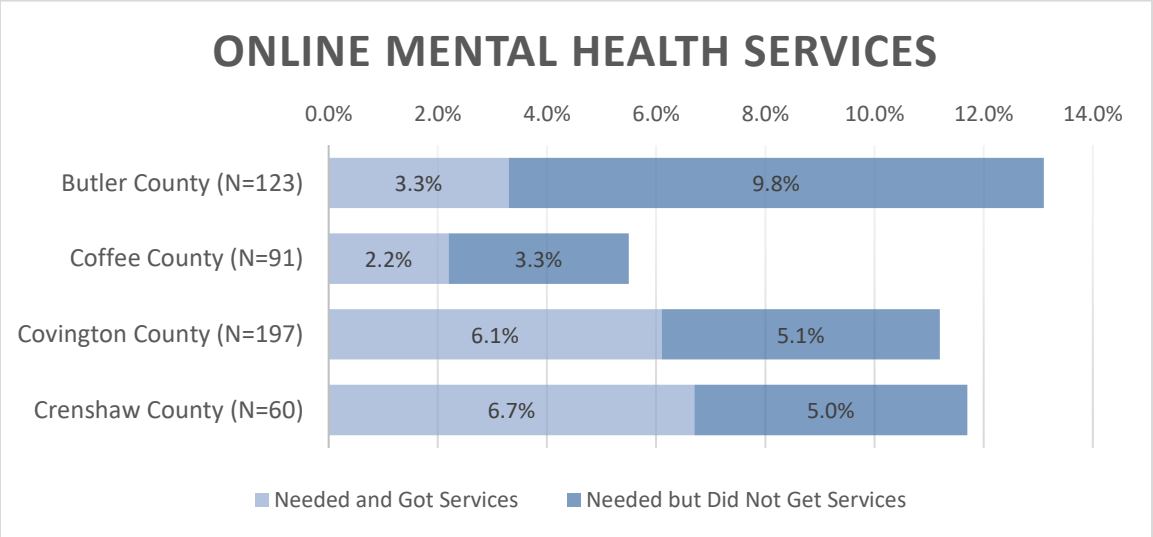


Figure 7. Household Need for Online Mental Health Services in the Past 12 Months from Community Needs Assessment Survey

Access to substance use services varies across counties, with unmet need reported in three of the four. In Butler County, 5.0% of respondents reported needing substance use services, but half of those in need (2.5%) did not receive care. Coffee County showed full access—2.2% reported needing services and 100% received them, indicating a positive example of access. In Covington County, 3.0% reported a need, but only one-third (1.0%) received services, leaving 67% (2.0%) without care. Crenshaw County had the highest overall reported need at 6.5%, with 25% of those in need (1.6%) not receiving support.

Substance use services are currently available in all four counties through South Central Alabama Mental Health Board, Inc. The unmet needs reported in the survey are likely related to limited public awareness, engagement, or understanding of how to access these services. To close these gaps, efforts could focus on expanding community education, improving early

identification, and further integrating substance use treatment into both primary and behavioral healthcare settings.

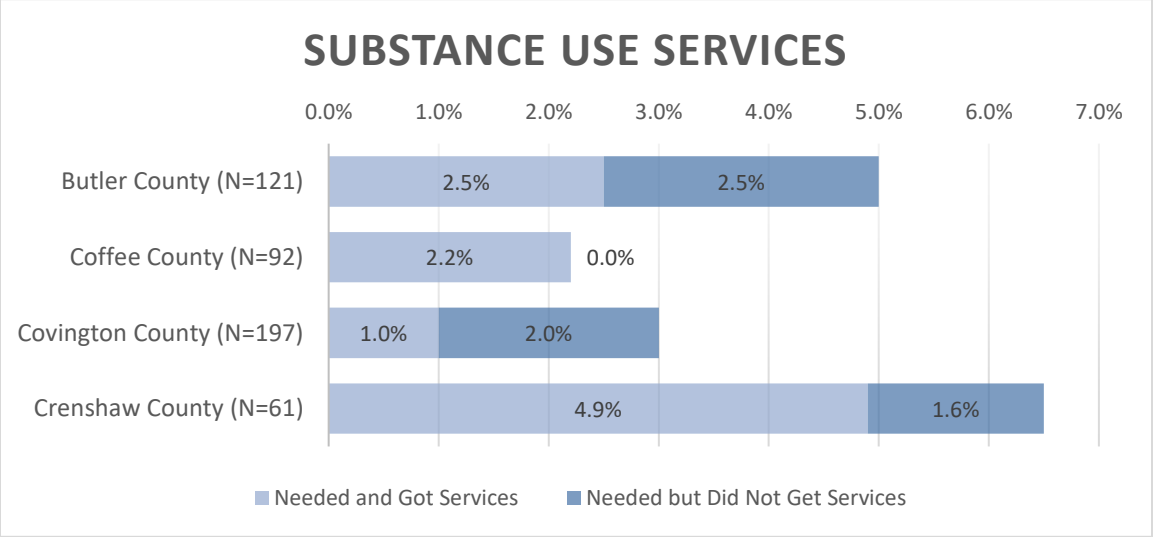


Figure 8. Household Need for Substance Use Services in the Past 12 Months from Community Needs Assessment Survey

Access to opioid use treatment services remains limited across the four counties, with unmet need present even where overall demand is low. In Butler County, 1.7% of respondents reported needing treatment, but none received services, resulting in 100% unmet need. Similarly, in Covington County, 1.5% of individuals needed opioid use treatment, but only one-third (0.5%) received it—leaving two-thirds (1.0%) without access. Crenshaw County showed a total need of 3.2%, with all individuals in need (1.6%) going unserved. Only Coffee County reported no need and no unmet need. These findings indicate a lack of available or accessible opioid treatment services in Butler, Covington, and Crenshaw Counties, where individuals who sought care were unable to receive it. Focused efforts are needed to expand medication-assisted treatment (MAT), provider training, and public awareness—especially in rural areas where opioid-related needs may be underreported but are likely to grow.

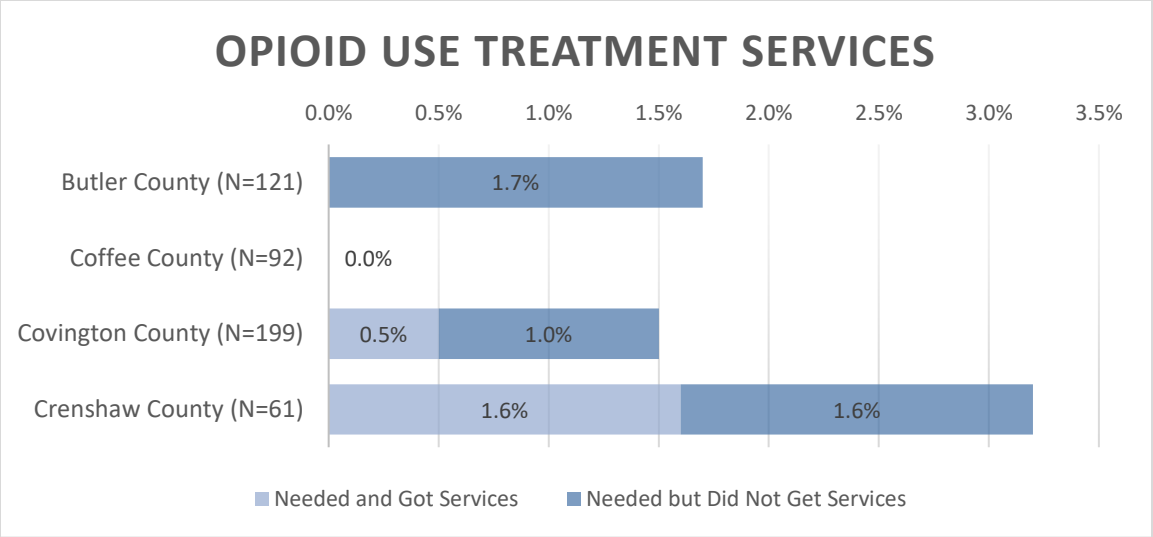


Figure 9. Household Need for Opioid Use Treatment Services in the Past 12 Months from Community Needs Assessment Survey

Access to tobacco and nicotine use services remains inconsistent across the four counties, with unmet need often exceeding access. In Butler County, 8.4% of respondents reported needing these services, but only 30% of those in need (2.5%) received care, leaving 70% (5.9%) without support. Coffee County had a total need of 2.2%, and all individuals received services, showing full access for those who sought help. Covington County reported a total need of 4.5%, with 56% of those in need (2.5%) receiving services and 44% (2.0%) going unserved. Crenshaw County presented a unique pattern: 6.6% of respondents reported needing services but none received them, resulting in 100% unmet need. These findings highlight a critical need to expand prevention, cessation, and treatment services for tobacco and nicotine use, particularly in Crenshaw and Butler Counties, and to ensure services are visible, accessible, and tailored to local community needs.

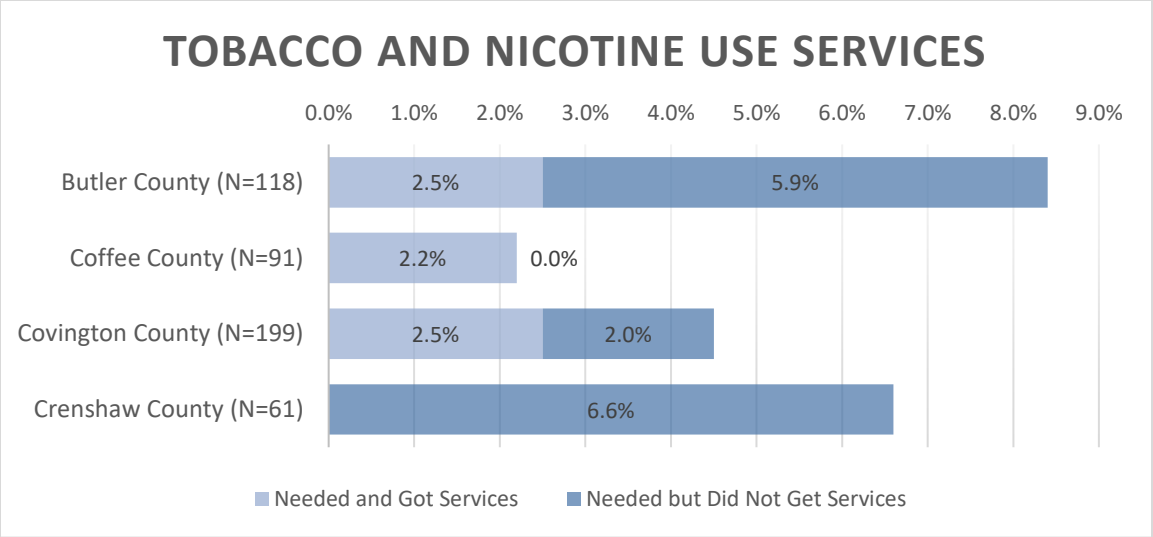


Figure 10. Household Need for Tobacco and Nicotine Use Services in the Past 12 Months from Community Needs Assessment Survey

To address unmet needs in our service area, we analyzed staffing, service availability, and access barriers for current and potential consumers. Based on these findings, we recommend focused solutions below to better serve our diverse community.

Limits to Staffing

- Staffing is not adequate to meet current needs. Butler county shows a 42% unmet need for mental health services, and 75% unmet need for online services, indicating both in-person and virtual service gaps.
- There is a need to increase staff trained in evidence-based screening and diagnostic tools, particularly for co-occurring substance use and tobacco/nicotine use, where 50–100% of identified need goes unmet.
- Ongoing training should address cultural competence, recovery-oriented, and family-centered approaches.
- The CMHC should improve LEP access by expanding interpreter availability and ensuring screening tools are accessible to individuals with language-based disabilities.

Limits to Access and Availability

- Screening and assessment services may be geographically inaccessible to rural residents. Broadband barriers contribute to a 9.8% unmet need for online services, and time constraints may limit evening and weekend access.
- Transportation remains a critical challenge, as reflected by high unmet need across nearly all behavioral health domains.
- Telehealth and mobile services should be expanded with device loans, public hotspots, and in-community service points.

Limits to Populations Served

- Youth, older adults, and individuals with opioid use or tobacco dependence may not be routinely screened or referred. All individuals who needed opioid use services went unserved, and 70% of tobacco users reported unmet need.
- Increase cultural responsiveness and hire bilingual staff to better support LEP clients and those from diverse cultural backgrounds.

5. Primary Care Screening and Monitoring

Access to medical services is generally strong across the four counties, with most individuals who needed care receiving it; however, some unmet need remains—particularly in Crenshaw County. In Butler County, 64.2% of respondents reported needing medical services, and only 3.7% of those in need (2.4% of total) did not receive care. Similarly, in Coffee County, 62.6% needed services, with 5.3% unmet (3.3% of total). Covington County had the highest overall need at 69.8%, with 6.9% unmet (4.5% of total). Crenshaw County, however, showed the highest rate of unmet need: 68.3% of individuals needed services, but 14.6% (10.0% of total) went unserved. While medical care is reaching the majority, these findings highlight the importance of reinforcing access in rural areas like Crenshaw—where staffing, transportation, or scheduling barriers may prevent timely care—despite a high level of need.

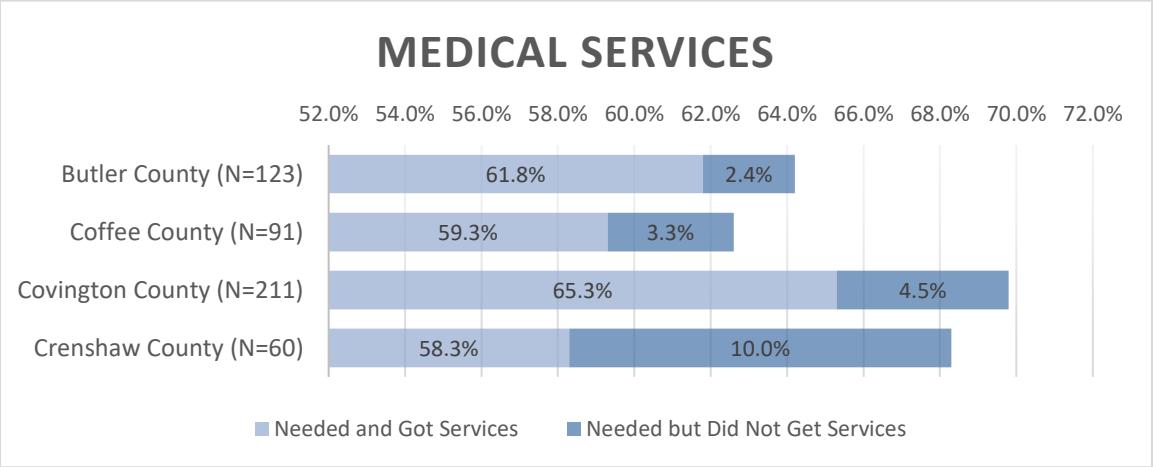


Figure 11. Household Need for Medical Services in the Past 12 Month from Community Needs Assessment Survey

Access to online medical services varies across the four counties, with some communities showing significant gaps between need and access. In Butler County, 15.1% of respondents reported needing online medical services, but only two-thirds of those in need (10.1%) received them—leaving 33% (5.0%) without access. Coffee County had a total need of 11.0%, with 80% met and 20% unmet (2.2%), indicating relatively strong access. Covington County had the highest overall need at 19.4%, with 16.3% served and 16% of those in need (3.1%) going unserved. Crenshaw County demonstrated the most significant barrier—13.4% of respondents needed online medical services, but none received them, resulting in 100% unmet need (6.7%). These findings reflect disparities in broadband availability, digital literacy, and device access,

particularly in rural areas like Crenshaw. Expanding digital infrastructure and support services is essential to close these access gaps and ensure equitable delivery of telehealth medical care.

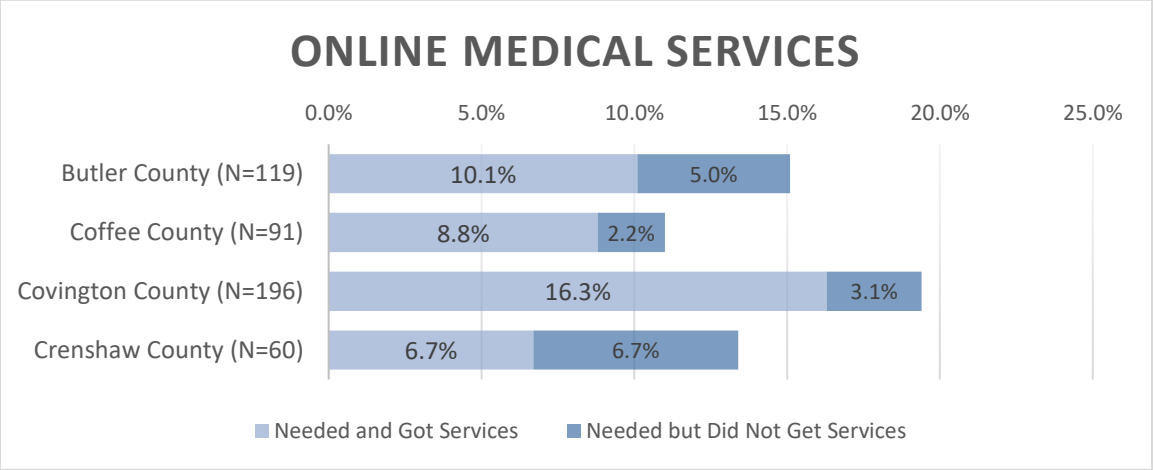


Figure 12. Household Need for Online Medical Services in the Past 12 Month from Community Needs Assessment Survey

Access to basic dental services remains a challenge across all four counties, with notable levels of unmet need among those seeking care. In Butler County, 68.3% of respondents needed dental services, but only 83% of those in need (56.9%) received them—leaving 17% (11.4%) without care. Coffee County had the highest overall need, with 71.7% of respondents requiring dental services; 91% of those (65.2%) received care, while 9% (6.5%) went unserved. In Covington County, 66.3% of respondents needed services, with 88% receiving care (58.3%) and 12% (8.0%) going without. Crenshaw County had the lowest overall need (57.4%) and 86% of those in need (49.2%) received services, while 14% (8.2%) did not. Basic dental care should be provided at least twice every 12 months to maintain a healthy mouth, meaning the actual need for services should approach 100%. These findings highlight not only gaps in access—particularly in Butler and Crenshaw Counties—but also a need for education and awareness around preventive dental hygiene. Expanding service capacity, offering transportation assistance, deploying mobile clinics, and increasing affordability supports are key strategies to reduce barriers and improve oral health outcomes.

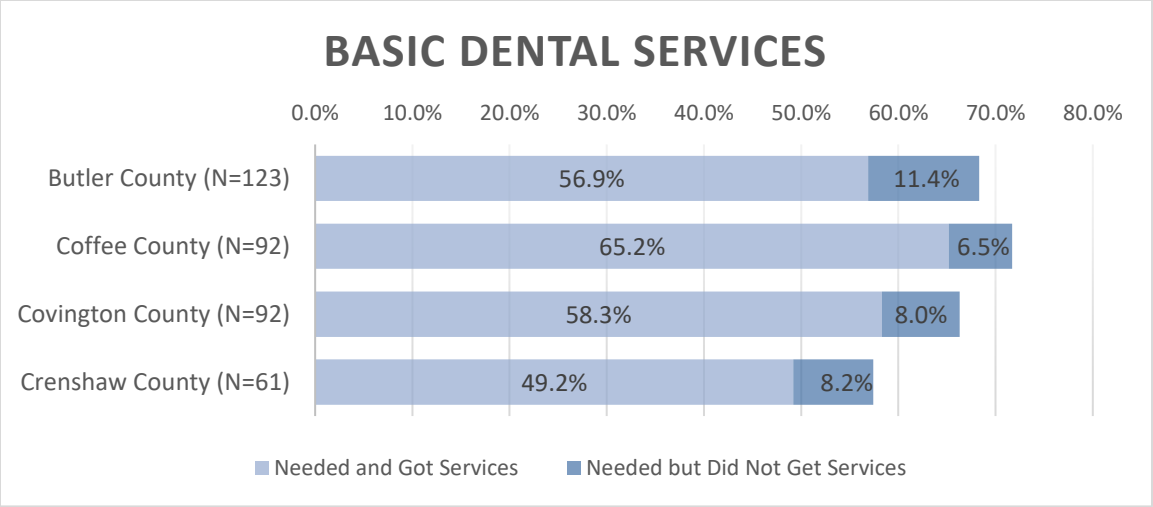


Figure 13. Household Need for Basic Dental Services in the Past 12 Month from Community Needs Assessment Survey

Access to dental repair services shows considerable unmet need across all four counties. In Butler County, 45.5% of respondents needed dental repair services, yet only 75% of those in need (34.1%) received care, leaving 25% (11.4%) without services. Coffee County had a similar pattern, with 45.1% needing dental repair and 78% receiving care (35.2%), while 22% (9.9%) went unserved. In Covington County, 48.0% reported needing dental repair, with 82% served (39.3%) and 18% unmet (8.7%). Crenshaw County had the lowest overall need (31.6%) but the highest proportion of unmet need, with only 58% (18.3%) served and 42% (13.3%) unserved. These data suggest that while a majority can access dental repair, a significant minority still faces barriers—especially in Crenshaw County—due to factors such as limited providers, cost, transportation, and appointment availability. Increasing access to routine basic dental care could help prevent more serious issues from developing, thereby reducing the overall need for dental repair services. Expanded dental repair capacity, along with targeted education and outreach, could help close existing gaps and improve long-term oral health outcomes.

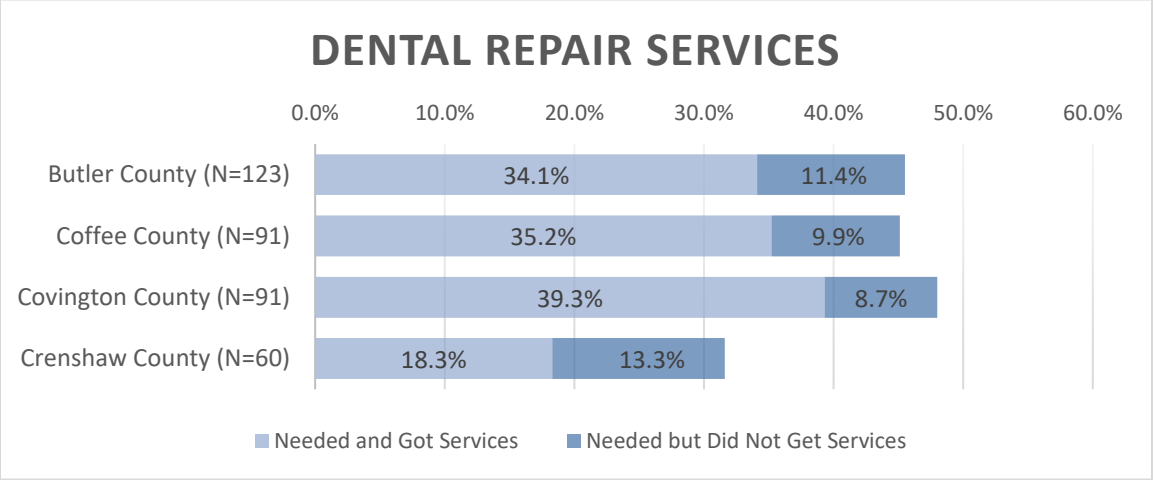


Figure 14. Household Need for Medical and Dental Services in the Past 12 Month from Community Needs Assessment Survey

To address unmet needs in our service area, we analyzed staffing, service availability, and access barriers for current and potential consumers. Based on these findings, we recommend focused solutions below to better serve our diverse community.

Limits to Staffing

- Medical and dental partners may lack sufficient staffing to meet demand, especially given notable unmet needs in dental repair and online medical services.
- Staff training at partner agencies should emphasize cultural competence, trauma-informed care, and integration with behavioral health.
- The CMHC's Community Health Workers (CHWs) play a vital role in bridging staffing gaps by coordinating care and facilitating connections to appropriate providers, including those serving LEP and disabled populations.

Limits to Access and Availability

- Geographic and transportation barriers contribute significantly to unmet medical and dental needs.
- CHWs already providing transportation should have their services expanded to reach more clients in remote or underserved areas.
- CHWs can also facilitate telehealth by assisting clients with broadband access, scheduling online medical appointments, and providing digital literacy support.
- Working with partners, CHWs can promote availability of services during evenings and weekends to accommodate client schedules.

Limits to Populations Served

- CHWs and Prevention staff can focus outreach on populations with co-occurring medical and behavioral health needs, older adults, and individuals with substance use or tobacco dependence.
- CHWs can also act as client advocates, helping ensure culturally and linguistically appropriate services.

6. Targeted Case Management Services

Assistance with scheduling and managing healthcare appointments shows varied levels of need and unmet need across the four counties. In Butler County, 10.9% of respondents required help with appointment management, but 39% of those in need (4.2%) did not receive assistance, indicating a notable gap. Coffee County had a total need of 9.8%, with 89% of those served and only 11% unmet (1.1%), reflecting better access. Covington County reported the highest overall need at 16%, yet had a low unmet need of 6% (1.0%), showing relatively good service coverage. In Crenshaw County, 11.4% needed support, with 86% served and 14% unmet (1.6%). These findings suggest that while appointment support services are generally accessible, significant gaps remain—especially in Butler County—where transportation and care coordination efforts,

such as those provided by Case Managers and Community Health Workers, could be expanded to improve appointment attendance and health outcomes.

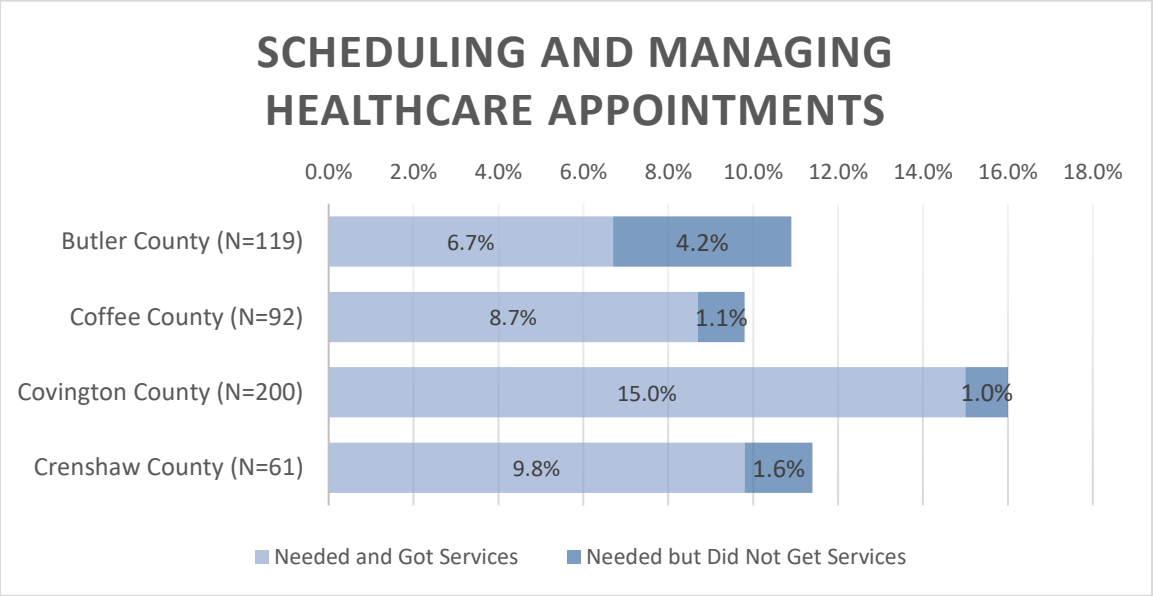


Figure 15. Household Need for Help Scheduling and Managing Healthcare Appointments in the Past 12 Months from Community Needs Assessment Survey

Need for temporary housing services varies across the four counties, with some significant unmet needs. In Butler County, 6.7% of respondents reported needing temporary housing, but only 12% of those in need (0.8%) received assistance—leaving a substantial 88% unmet (5.9%). Coffee County showed a total need of 4.4%, with most individuals served (3.3%) and a small unmet need of 25% (1.1%). In Covington County, 9.0% required temporary housing, with 72% served (6.5%) and 28% unmet (2.5%). Crenshaw County had the lowest need at 1.6%, with all individuals served and no unmet need reported. These data highlight a critical housing gap especially in Butler and Covington Counties, underscoring the need for enhanced coordination

with housing providers, increased emergency shelter options, and support services to prevent homelessness and stabilize clients in crisis.

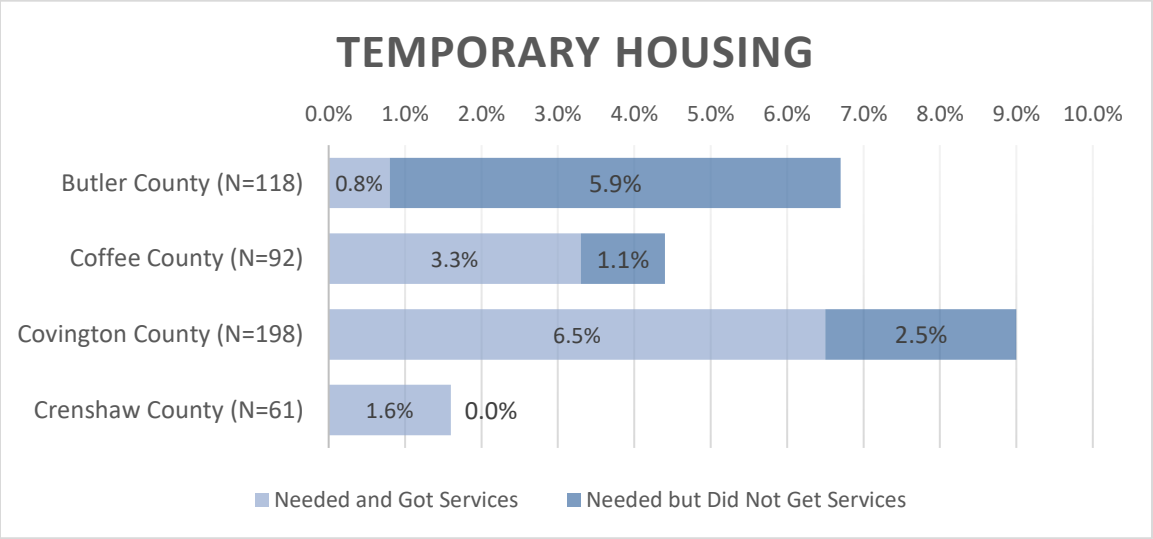


Figure 16. Household Need for Temporary Housing in the Past 12 Months from Community Needs Assessment Survey

Access to food from a food bank or pantry remains a critical need across the four counties, with varying levels of unmet demand. In Butler County, 25.7% of respondents reported needing this service, but only 17.4% received support, leaving 32% (8.3%) unserved. Coffee County had a total need of 5.4%, with 80% of those individuals (4.3%) receiving food assistance and 20% (1.1%) going without. In Covington County, 9.0% of respondents needed food support, with 72% receiving services (6.5%) and 28% (2.5%) experiencing unmet need. Crenshaw County had a higher total need at 16.4%, and 80% of those in need (13.1%) were served, while 20% (3.3%) did not receive assistance. These findings indicate that while many individuals are able to access food pantry resources, significant gaps remain—particularly in Butler and Crenshaw Counties—highlighting the importance of expanding food distribution efforts, improving community awareness of available services, and addressing transportation or access barriers for households in need.

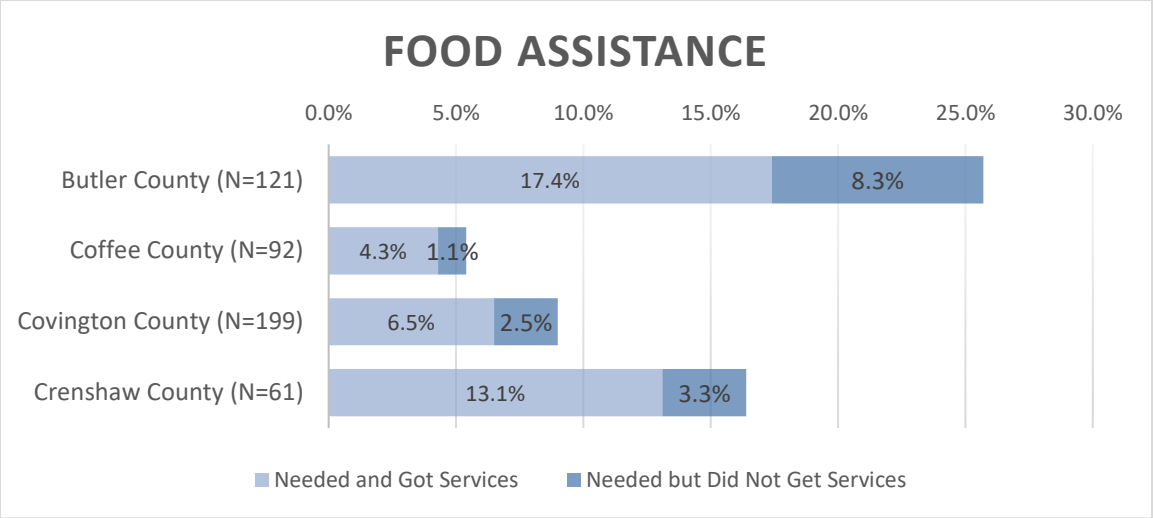


Figure 17. Household Need for Food from a Food Bank or Pantry in the Past 12 Months from Community Needs Assessment Survey

Support with applying for food stamps or health insurance is an area of clear unmet need, particularly in Butler and Crenshaw Counties. In Butler County, 15.0% of respondents needed this type of assistance, yet only one-third of those in need (5.0%) received help—leaving a significant 67% unmet (10.0%). Coffee County showed a total need of 6.5%, with two-thirds served (4.3%) and one-third unmet (2.2%). Covington County had a similar total need of 6.5%, with 77% served (5.0%) and 23% unmet (1.5%). In Crenshaw County, 11.5% needed help, but only 43% were served (6.6%), leaving 57% (4.9%) without assistance. These findings indicate a need for expanded outreach and application support services, especially in Butler and Crenshaw, where the majority of those needing help did not receive it. Community Health Workers, Case Managers, and partner agencies can play a vital role in closing these gaps by assisting with applications and navigating eligibility processes.

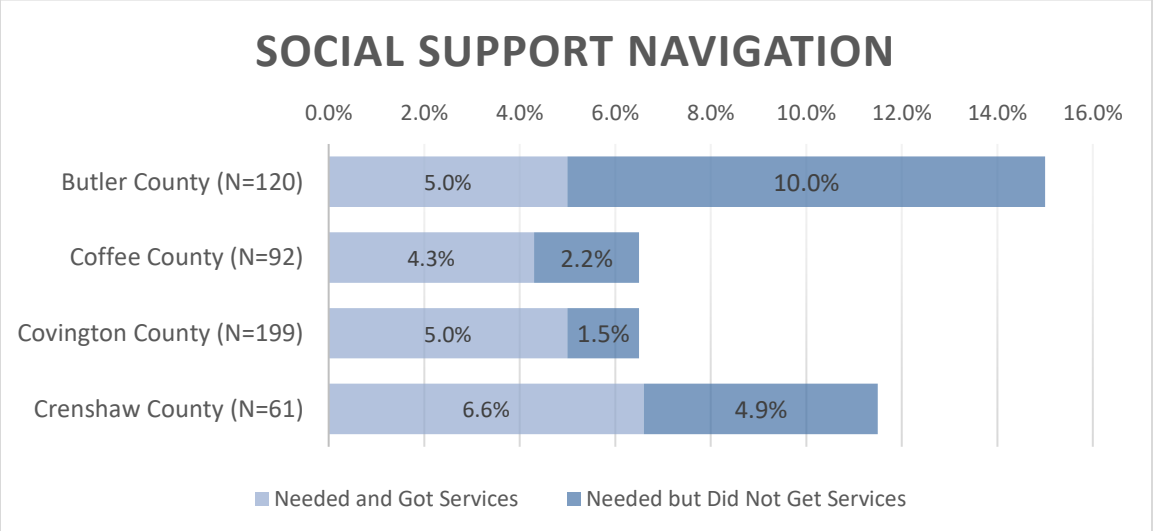


Figure 18. Household Need for Help Applying for Food Stamps or Health Insurance in the Past 12 Months from Community Needs Assessment Survey

To address unmet needs in our service area, we analyzed staffing, service availability, and access barriers for current and potential consumers. Based on these findings, we recommend focused solutions below to better serve our diverse community.

Limits to Staffing

- Staffing across partner agencies may not be adequate to meet the needs for temporary housing (6.7% needed; only 0.8% received), food application support (15% needed; only 5% received), and food bank access (25.7% needed; 17.4% received). These large gaps suggest insufficient community-facing or navigation staff capacity.
- Community Health Workers (CHWs) and Case Managers (CMs) already providing appointment help and transportation could expand their roles to assist with housing navigation, application assistance, and food access referrals.
- Ongoing training is needed across partner agencies to ensure culturally competent, trauma-informed, and person-centered service delivery, especially for CHWs, CMs, and front-line staff interacting with underserved residents.
- LEP and disability access remain a challenge; efforts should include translated materials, interpreter access, and staff training in language and communication support.

Limits to Access and Availability

- Geographic limitations and transportation barriers affect access to housing and food services, particularly for rural residents.
- Broadband gaps may limit awareness of and enrollment in online or remote scheduling or application systems.
- Evening/weekend availability is limited for support services, making it difficult for working families to engage in housing or food access programs.

Limits to Populations Served

- Populations in poverty, people experiencing homelessness, and individuals with limited literacy or digital skills are underserved.
- Spanish-speaking and other LEP residents face language and cultural barriers to accessing application help and food resources.

7. Psychiatric Rehabilitation Services

Support for job and education services remains an area of unmet need across all four counties, particularly in Butler County. In Butler County, 14% of respondents reported needing assistance, but only 29% of those in need (4.1%) received services—leaving 71% unmet (9.9%). This represents the highest gap among the counties. In Coffee County, 13.2% reported needing job or education support, with 58% served (7.7%) and 42% unmet (5.5%). Covington County had a total need of 8.5%, with 65% served (5.5%) and 35% unmet (3.0%). In Crenshaw County, 11.5% needed support, but only 57% were served (6.6%), leaving 43% unmet (4.9%). These findings indicate a consistent demand for workforce development and educational navigation

services across the region, with the most significant service gap in Butler County. Strengthening partnerships with job training programs, adult education providers, and workforce agencies—as well as integrating support through Community Health Workers or Case Managers—can help improve access and outcomes for individuals seeking employment or further education.

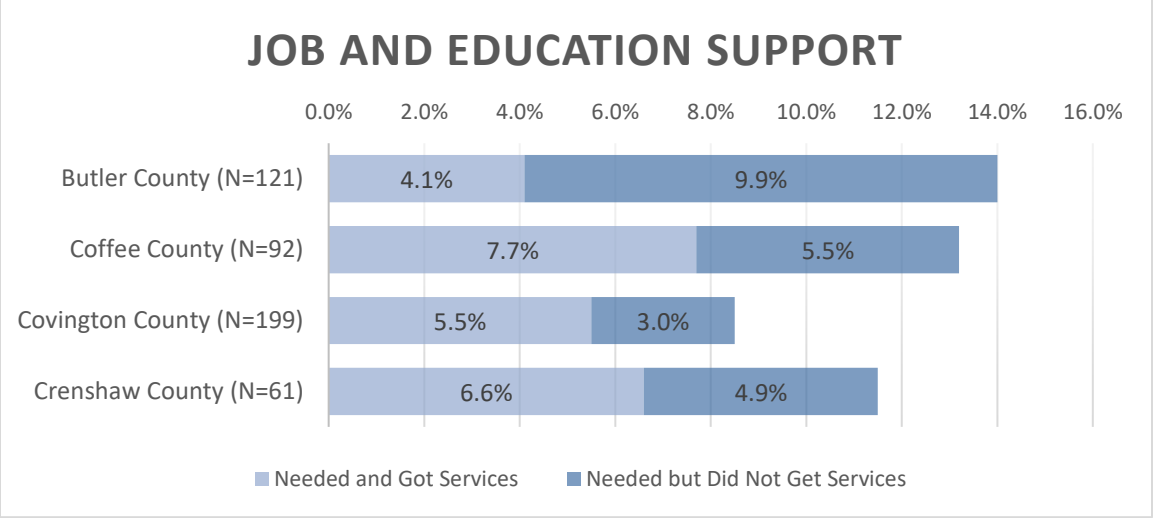


Figure 19. Household Need for Support Services to Live Independently in the Past 12 Months from Community Needs Assessment Survey

Support to live independently—such as assistance with daily living skills, housing stability, or home-based supports—remains a significant unmet need in several counties. In Butler County, 10.9% of respondents needed this type of support, but only 39% of those in need (4.2%) received services, leaving 61% unmet (6.7%). Coffee County showed a total need of 6.5%, with 66% served (4.3%) and 34% unmet (2.2%). In Covington County, 8.5% reported needing support, with 65% served (5.5%) and 35% unmet (3.0%). Crenshaw County had the highest total need at 16.7%, yet only 60% of those in need (10.0%) received help, leaving 40% unmet (6.7%). These findings highlight the importance of expanding independent living supports—particularly in Butler and Crenshaw Counties—through programs such as in-home services, skills coaching, case management, and coordination with housing partners. Community Health Workers, Case

Managers, and Peer Specialists can also play a key role in identifying needs and connecting individuals with services that promote autonomy and community integration.

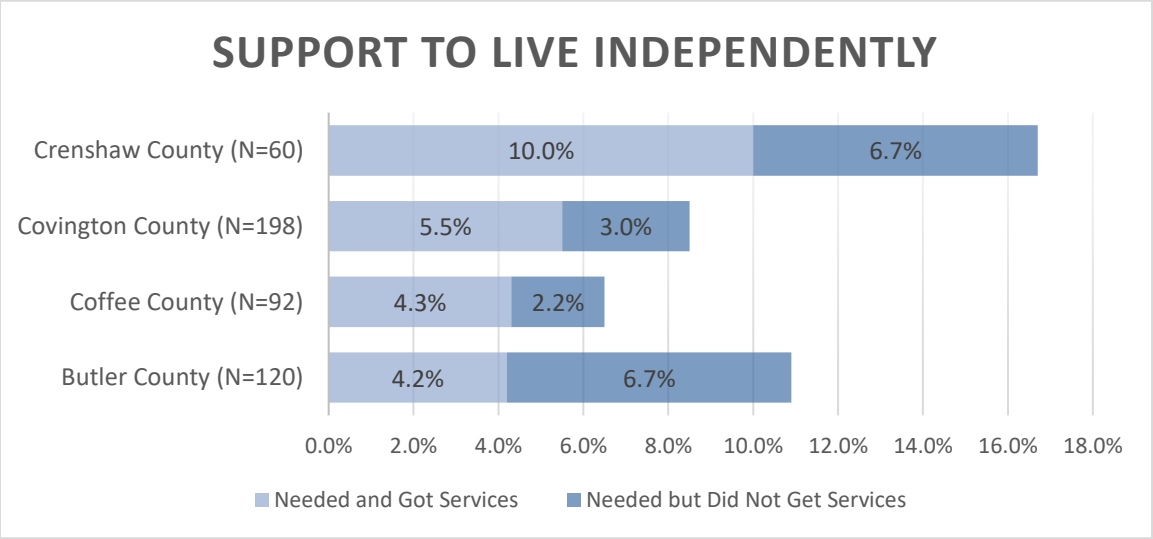


Figure 20. Household Need for Support Services to Live Independently in the Past 12 Months from Community Needs Assessment Survey

To address unmet needs in our service area, we analyzed staffing, service availability, and access barriers for current and potential consumers. Based on these findings, we recommend focused solutions below to better serve our diverse community.

Limits to Staffing

- Staffing levels and service availability are not meeting the needs for job/education (14% needed; only 4.1% received) and independent living support (10.9% needed; only 4.2% received), reflecting service gaps.
- There may be limited dedicated employment specialists or housing support coordinators. Expanding the roles of Community Health Workers (CHWs) and Case Managers (CMs) to provide support and referrals for employment, education, and life skills can help address this.
- Ongoing staff training should reinforce person-centered planning, trauma-informed care, recovery orientation, and integration with vocational and housing partners.
- Language access efforts for individuals with Limited-English-Proficiency (LEP) or communication disabilities should be expanded through translated materials and assistive communication supports.

Limits to Access and Availability

- Rural geographic barriers, transportation limitations, and low broadband access hinder service access—especially for youth, job-seekers, or those needing in-home support.
- Evening and weekend service limitations may exclude working-age adults seeking support outside of business hours.

Limits to Populations Served

- Individuals with disabilities, youth transitioning out of school systems, and older adults at risk of losing housing are under-supported.
- Services are not fully inclusive of people with LEP or cultural needs—language access, community partnerships, and culturally responsive outreach should be strengthened.

8. Peer Supports and Family/Caregiver Supports

Perceptions of peer service availability vary across the four counties, with a notable portion of respondents either unaware of or uncertain about access to peer support. In Butler County, nearly 29% disagreed or strongly disagreed that peer services were available, while 41.4% remained neutral, suggesting a lack of awareness or visibility. Coffee County showed a similar trend, with 24.4% disagreeing and 43.9% neutral. In Covington County, perceptions were somewhat more favorable—only 14.5% disagreed, and 41.3% agreed or strongly agreed, indicating relatively higher visibility or awareness. Crenshaw County reflected the greatest uncertainty and lowest confidence, with 35.1% disagreeing, 38.6% neutral, and only 26.3% agreeing that peer services were available. These findings point to an opportunity to improve outreach and communication around peer-led support, particularly in Crenshaw, Butler, and Coffee Counties. Increasing the visibility of peer specialists, integrating them into more service settings, and highlighting their roles in recovery could enhance public understanding and engagement.

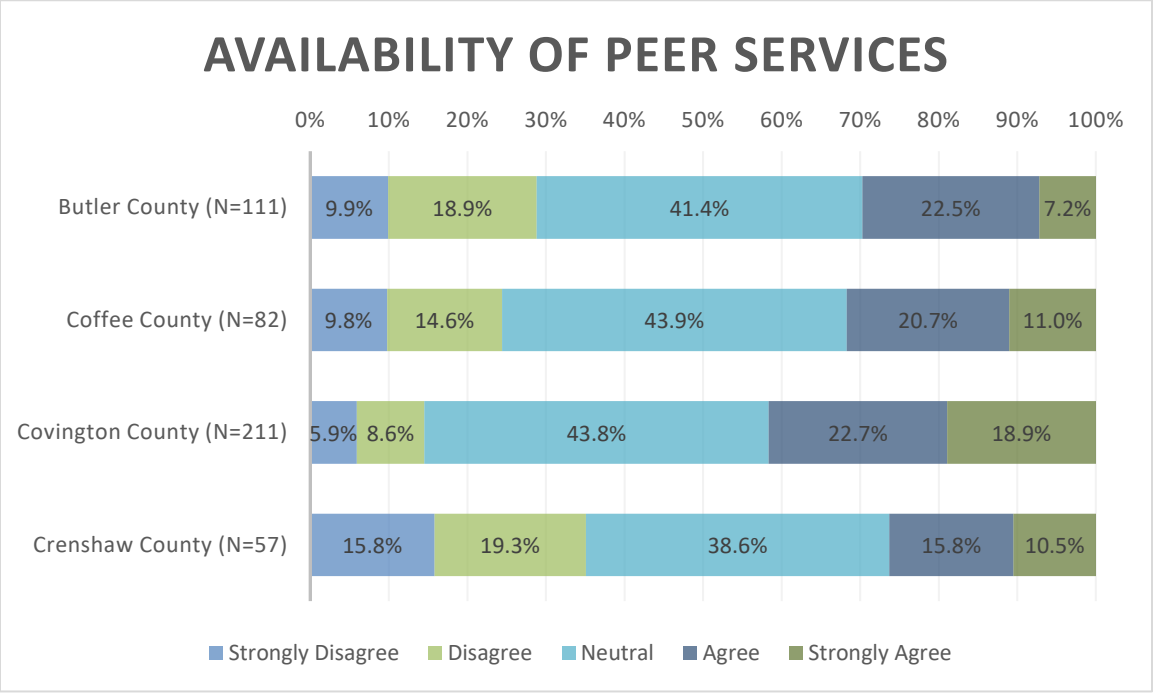
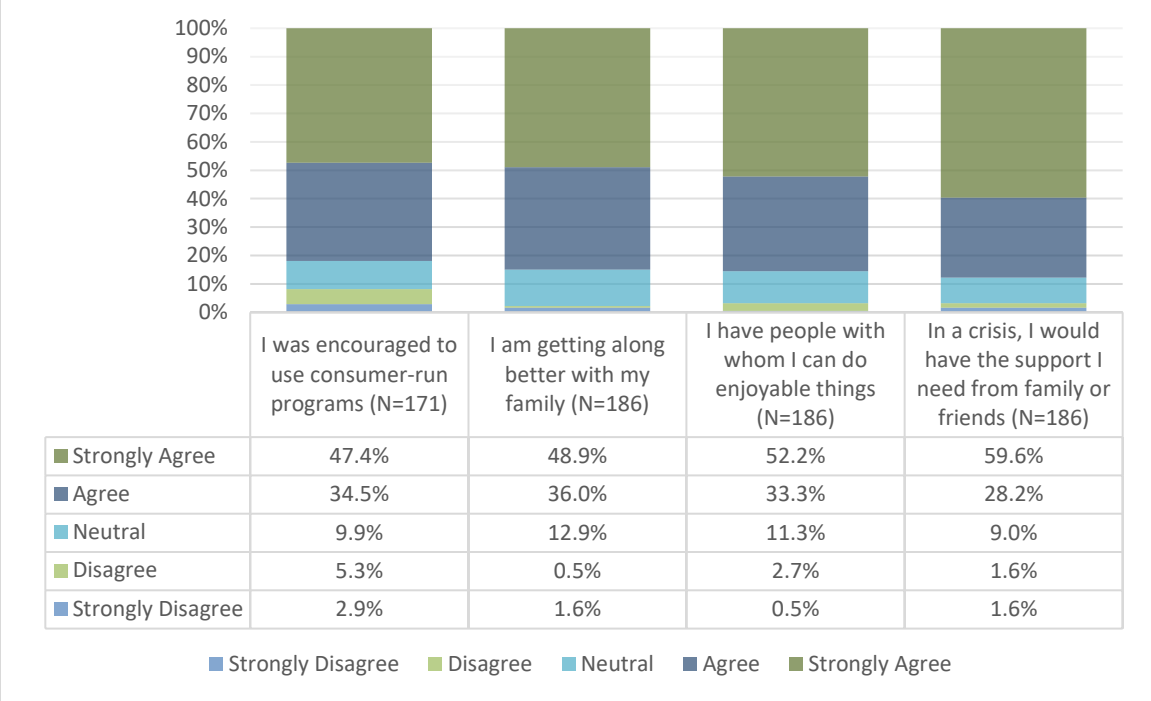


Figure 21. Perceived Availability of Peer Services from Community Needs Assessment Survey

Respondents reported strong levels of social support and connection, both within their families and through broader support networks. Nearly 82% agreed or strongly agreed that they were encouraged to use consumer-run programs, with 47.4% strongly agreeing. Most also indicated improved family relationships, with 84.9% agreeing or strongly agreeing that they are getting

along better with their family. Additionally, 85.5% reported having people with whom they can do enjoyable things, and 87.8% felt they would have support from family or friends during a crisis. These findings suggest that services are helping to strengthen social connections and increase access to peer and family support systems.



	I was encouraged to use consumer-run programs (N=171)	I am getting along better with my family (N=186)	I have people with whom I can do enjoyable things (N=186)	In a crisis, I would have the support I need from family or friends (N=186)
Strongly Agree	47.4%	48.9%	52.2%	59.6%
Agree	34.5%	36.0%	33.3%	28.2%
Neutral	9.9%	12.9%	11.3%	9.0%
Disagree	5.3%	0.5%	2.7%	1.6%
Strongly Disagree	2.9%	1.6%	0.5%	1.6%

Figure 22. Client Supportive Relationships from Adult MSHIP Consumer Survey

To address unmet needs in our service area, we analyzed staffing, service availability, and access barriers for current and potential consumers. Based on these findings, we recommend focused solutions below to better serve our diverse community.

Limits to staffing:

- Staff capacity may be insufficient to fully engage and promote peer support services, as nearly 29% of respondents disagreed or strongly disagreed that peer services were available, and 41.4% were neutral, indicating low visibility or limited integration of peer specialists.
- Training should emphasize cultural competence, person- and family-centered care, and trauma-informed approaches to better engage diverse populations and increase peer support utilization.
- The CMHC should enhance efforts to reach individuals with LEP or language-based disabilities by providing interpreters or multilingual peer specialists.

Limits to access and availability:

- Geographic barriers may limit access to peer support programs, especially in rural areas. Transportation challenges persist but could be mitigated by expanding community health worker care coordination and transportation services.

- Broadband and technology gaps may restrict access to virtual peer support options. Expanding digital literacy support and online peer groups could improve availability.
- Peer support availability may be limited during evenings and weekends, when informal supports are often most needed.

Limits to populations served:

- Populations less aware of peer support—such as older adults, culturally diverse groups, or those with limited English proficiency—could benefit from targeted outreach.
- Increasing visibility of peer services in clinics, community centers, and through family networks may enhance engagement.

9. Community Care for Uniformed Service Members and Veterans

Perceptions of the availability of veterans services vary across the four counties, with a significant portion of respondents expressing uncertainty or negative views about access. In Butler County, 30.3% of respondents disagreed or strongly disagreed that veterans services were available, while 43.1% remained neutral, reflecting a lack of clear awareness or visibility. Coffee County showed a similar pattern, with 24.4% disagreeing and 43.9% neutral, though a slightly higher proportion (31.7%) agreed or strongly agreed services were accessible. Covington County had the most favorable perceptions, with only 17.2% disagreeing and nearly 40% agreeing or strongly agreeing that veterans services were available, alongside 43.5% neutral responses. Crenshaw County reflected more skepticism, with 27.5% disagreeing and 41.4% neutral, while 31% agreed or strongly agreed services were available. These findings highlight a need to enhance outreach, education, and service integration for veterans, particularly in Butler and Crenshaw Counties, to improve awareness and utilization of veteran-specific supports.

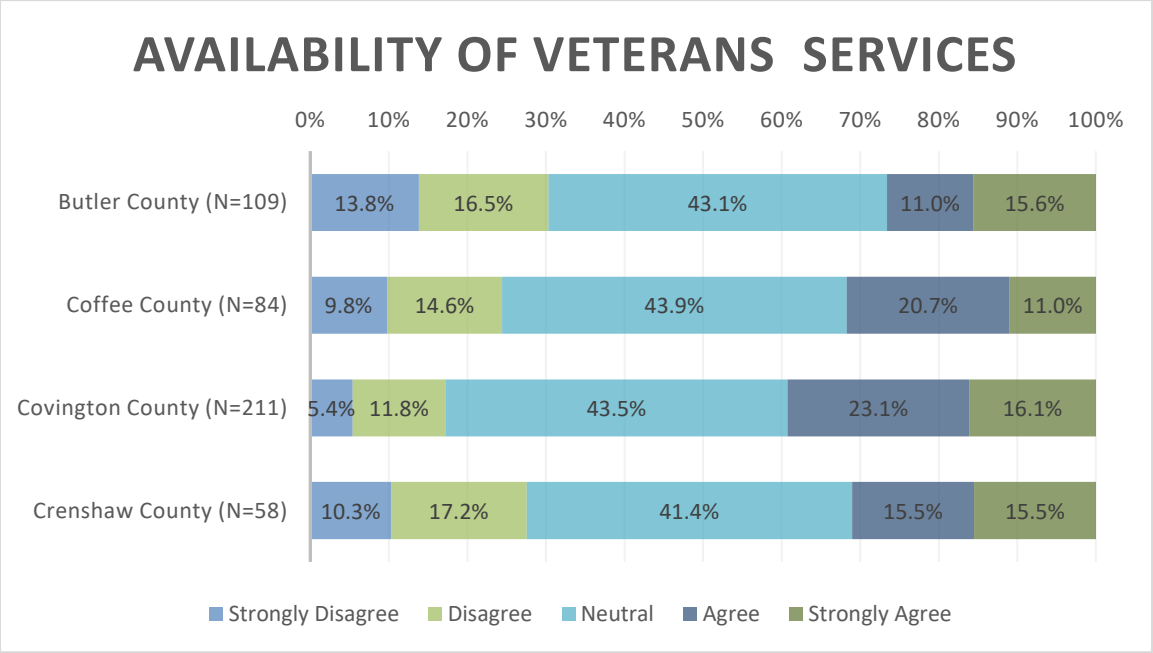


Figure 23. Perceived Availability of Veterans Services from Community Needs Assessment Survey

To address unmet needs in our service area, we analyzed staffing, service availability, and access barriers for current and potential consumers. Based on these findings, we recommend focused solutions below to better serve our diverse community.

Limits to staffing:

- Staff size and composition may be insufficient to fully address veterans' needs, as nearly 30.3% of respondents disagreed that veterans services are available, and 43.1% were neutral, indicating limited awareness or visibility of veteran-specific supports.
- Training for staff should include veteran cultural competence, trauma-informed care, recovery-oriented approaches, and integration of primary care and behavioral health to better serve veterans.
- The CMHC should enhance language access services to reach veterans with Limited English Proficiency (LEP) or language disabilities.

Limits to access and availability:

- Geographic limitations and transportation barriers may hinder veterans from accessing specialized services, especially in rural areas. Expanding community health worker and case manager care coordination and transportation could improve access.
- Broadband access challenges may limit telehealth and online peer support for veterans, requiring targeted investment.
- Service hours may not align with veterans' needs, so expanding availability during evenings and weekends should be considered.

Limits to populations served:

- Veterans with limited transportation, digital access, or language barriers are likely underserved.
- Outreach should target isolated veterans, including those not connected to VA services or community supports, to increase engagement.
- Cultural competence initiatives should be tailored to veterans' unique experiences and backgrounds.

Evidence-Based Practices

	Currently Provided – by Age				Provided by Diagnostic Group		
	Age 0-17	Age 18-21	Age 22-24	Age 65+	SED (youth)	SMI (adult)	SUD (all ages)
Motivational Interviewing	X	X	X	X	X	X	X

Please describe the Model Practices for each service category. Include the percentage of staff trained in each modality.

Motivational Interviewing (MI) is actively utilized within the Substance Use Disorder (SUD) program, including for individuals with co-occurring disorders (COD) in the adult population. All SUD staff receive comprehensive MI training through the Alabama Department of Mental Health (ADMH), the Relias online module, and our two in-house certified trainers, who provide ongoing instruction and support to ensure practical application of MI principles.

Currently, 100% of SUD staff have completed both the ADMH MI training and the Relias MI module. Additionally, all other staff members have completed the Relias MI module, with ongoing competency assessments to maintain skill proficiency. Refresher trainings and re-certifications are regularly conducted to ensure that staff remain current with best practices in MI, supporting effective engagement and treatment outcomes across programs.

	Currently Provided – by Age				Provided by Diagnostic Group		
	Age 0-17	Age 18-21	Age 22-24	Age 65+	SED (youth)	SMI (adult)	SUD (all ages)
Cognitive Behavioral Therapy (CBT)	X	X	X	X	X	X	X

Please describe the Model Practices for each service category. Include the percentage of staff trained in each modality.

Cognitive Behavioral Therapy (CBT) is utilized across all behavioral health programming. Currently, 100% of relevant staff have completed training on CBT through the Relias online module. Competency in CBT skills is regularly assessed to ensure effective application in clinical practice. Ongoing training, including refresher courses and re-certification, is provided to maintain high standards and incorporate the latest evidence-based practices.

	Currently Provided – by Age				Provided by Diagnostic Group		
	Age 0-17	Age 18-21	Age 22-24	Age 65+	SED (youth)	SMI (adult)	SUD (all ages)
Dialectical Behavior Therapy (DBT)		X	X	X		X	

Please describe the Model Practices for each service category. Include the percentage of staff trained in each modality.

DBT-informed practices and skills are offered on a case-by-case basis depending on client needs and the training level of the provider. Currently, 100% of clinical staff have received training on this modality, which is provided when clinically appropriate.

	Currently Provided – by Age				Provided by Diagnostic Group		
	Age 0-17	Age 18-21	Age 22-24	Age 65+	SED (youth)	SMI (adult)	SUD (all ages)
Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP)							

Please describe the Model Practices for each service category. Include the percentage of staff trained in each modality.

Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP) is not currently utilized within the program, as the center is not certified to provide FEP services, but will implement it as community need and Alabama Department of Mental Health (ADMH) requirements evolve.

	Currently Provided – by Age				Provided by Diagnostic Group		
	Age 0-17	Age 18-21	Age 22-24	Age 65+	SED (youth)	SMI (adult)	SUD (all ages)
Seeking Safety							

Please describe the Model Practices for each service category. Include the percentage of staff trained in each modality.

Seeking Safety is not currently utilized within the program but will implement it as community need and Alabama Department of Mental Health (ADMH) requirements evolve.

	Currently Provided – by Age				Provided by Diagnostic Group		
	Age 0-17	Age 18-21	Age 22-24	Age 65+	SED (youth)	SMI (adult)	SUD (all ages)
Assertive Community Treatment (ACT)							

Please describe the Model Practices for each service category. Include the percentage of staff trained in each modality.

Assertive Community Treatment (ACT) is not currently utilized within the program, as our center is not certified to provide ACT services. As a rural community behavioral health center, we instead implement In-Home Intervention (IHI) teams to deliver community-based support. This model allows us to meet individuals where they are and provide intensive, wraparound services in the home and community setting.

	Currently Provided – by Age				Provided by Diagnostic Group		
	Age 0-17	Age 18-21	Age 22-24	Age 65+	SED (youth)	SMI (adult)	SUD (all ages)
Forensic Assertive Community Treatment							

Please describe the Model Practices for each service category. Include the percentage of staff trained in each modality.

Forensic Assertive Community Treatment is not currently utilized within the program, as the center is not certified to provide these services, but will implement it as community need and Alabama Department of Mental Health (ADMH) requirements evolve.

	Currently Provided – by Age				Provided by Diagnostic Group		
	Age 0-17	Age 18-21	Age 22-24	Age 65+	SED (youth)	SMI (adult)	SUD (all ages)
Trauma Focused Cognitive Behavioral Therapy (TF-CBT)	X	X	X	X	X	X	X

Please describe the Model Practices for each service category. Include the percentage of staff trained in each modality.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is currently provided center-wide across all programs. Currently, 100% of clinical staff have received training on this modality, which is provided when clinically appropriate.

	Currently Provided – by Age				Provided by Diagnostic Group		
	Age 0-17	Age 18-21	Age 22-24	Age 65+	SED (youth)	SMI (adult)	SUD (all ages)
Long-acting injectable meds to treat both MH and SUD disorders		X	X	X		X	

Please describe the Model Practices for each service category. Include the percentage of staff trained in each modality.

Long-acting injectables (LAIs) are currently provided in all adult mental health programs. While the center has the capability to prescribe these medications within substance use programs, no current consumers are receiving them due to cost barriers.

Prescriptions are managed by two psychiatric providers via telemedicine. Administration is carried out by Licensed Practical Nurses (LPN). Medications are ordered through collaborative agreements with psychiatry and primary care.

High-risk individuals receive reminder calls prior to appointments and follow-up calls if appointments are missed. Dosages follow recommended clinical guidelines, and required labs are ordered before and during treatment to monitor relevant health indicators. Currently, 100% of relevant clinical staff have received training on this modality, which is provided when clinically appropriate.

	Currently Provided – by Age				Provided by Diagnostic Group		
	Age 0-17	Age 18-21	Age 22-24	Age 65+	SED (youth)	SMI (adult)	SUD (all ages)
Multi-Systemic Therapy							

Please describe the Model Practices for each service category. Include the percentage of staff trained in each modality.

Currently not included in our formal training plan. It is used on an individualized basis as needed during the needs assessment process, but will implement it as community need and Alabama Department of Mental Health (ADMH) requirements evolve.

	Currently Provided – by Age				Provided by Diagnostic Group		
	Age 0-17	Age 18-21	Age 22-24	Age 65+	SED (youth)	SMI (adult)	SUD (all ages)
Cognitive Behavioral Therapy for Psychosis		X	X	X		X	

Please describe the Model Practices for each service category. Include the percentage of staff trained in each modality.

Cognitive Behavioral Therapy for Psychosis is currently provided center-wide across all adult programs. Currently, 100% of relevant clinical staff have received training on this modality, which is provided when clinically appropriate.

	Currently Provided – by Age				Provided by Diagnostic Group		
	Age 0-17	Age 18-21	Age 22-24	Age 65+	SED (youth)	SMI (adult)	SUD (all ages)
High-Fidelity Wraparound	X				X		

Please describe the Model Practices for each service category. Include the percentage of staff trained in each modality.

We implement In-Home Intervention (IHI) teams to deliver community-based support. This model allows us to meet individuals where they are and provide intensive, wraparound services in the home and community setting. Currently, 100% of relevant clinical staff have received training on this modality, which is provided when clinically appropriate.

	Currently Provided – by Age				Provided by Diagnostic Group		
	Age 0-17	Age 18-21	Age 22-24	Age 65+	SED (youth)	SMI (adult)	SUD (all ages)
Parent Management Training		X	X	X		X	

Please describe the Model Practices for each service category. Include the percentage of staff trained in each modality.

We offer The Parent Project, a structured training designed to address defiant behaviors, school truancy, family conflict, and other challenges common in this population. Families may be referred through juvenile courts, school systems (e.g., for suspensions or expulsions), or may voluntarily enroll by requesting help from the school or contacting the program directly. Currently, 100% of

relevant clinical staff have received training on this modality, which is provided when clinically appropriate.

	Currently Provided – by Age				Provided by Diagnostic Group		
	Age 0-17	Age 18-21	Age 22-24	Age 65+	SED (youth)	SMI (adult)	SUD (all ages)
Integrated Treatment for Co-occurring Disorders		X	X	X		X	

Please describe the Model Practices for each service category. Include the percentage of staff trained in each modality.

We strive to provide integrated care for individuals with co-occurring mental health and substance use disorders. While Alabama Department of Mental Health (ADMH) billing requirements currently require separate documentation for each, we minimize fragmentation by using dually certified providers whenever possible. Clients may choose to see the same provider for both needs or separate providers, depending on their preference and clinical needs. Currently, 100% of relevant clinical staff have received training on this modality, which is provided when clinically appropriate.

	Currently Provided – by Age				Provided by Diagnostic Group		
	Age 0-17	Age 18-21	Age 22-24	Age 65+	SED (youth)	SMI (adult)	SUD (all ages)
Medications for Addiction Treatment (MAT)		X	X	X		X	

Please describe the Model Practices for each service category. Include the percentage of staff trained in each modality.

We offer Medications for Addiction Treatment (MAT) as part of a comprehensive approach to substance use recovery. MAT combines FDA-approved medications with counseling and behavioral therapies to treat opioid, alcohol, and nicotine use disorders. Currently, 100% of relevant clinical staff have received training on this modality, which is provided when clinically appropriate.

	Currently Provided – by Age				Provided by Diagnostic Group		
	Age 0-17	Age 18-21	Age 22-24	Age 65+	SED (youth)	SMI (adult)	SUD (all ages)
Individualized Placement Support, Supported Employment, and linkage to Supportive Housing		X	X	X		X	

Please describe the Model Practices for each service category. Include the percentage of staff trained in each modality.

Individualized Placement and Support (IPS) services are not currently utilized within the program. We support individuals through Adult Rehabilitative Services within our Rehabilitative Day Program (RDP). Upon completion, individuals are referred to Alabama Department of Rehabilitation Services (ADRS) for Supported Employment services.

We are certified to provide Supportive Housing and assist eligible individuals in securing stable housing that promotes recovery, independence, and community integration. Currently, 100% of relevant clinical staff have received training on this modality, which is provided when clinically appropriate.

	Currently Provided – by Age				Provided by Diagnostic Group		
	Age 0-17	Age 18-21	Age 22-24	Age 65+	SED (youth)	SMI (adult)	SUD (all ages)
Peer and Family Support	X	X	X	X	X	X	X

Please describe the Model Practices for each service category. Include the percentage of staff trained in each modality.

We offer a range of peer and family support services delivered by certified individuals with lived experience. Our team includes Certified Mental Health Peer Specialists (Adult and Youth), Parent Peer Specialists, and Certified Recovery Support Specialists. Currently, 100% of clinical staff have received training on this modality, which is provided when clinically appropriate.

CCBHC Care Coordination

Care Coordination of Behavioral Health Services by CMHC

Connections with other providers and systems that ensures seamless transitions for patients across the full spectrum of health services, including acute, chronic, and behavioral health needs.

Note: A care coordination agreement is an arrangement between the CCBHC and external entities with which care is coordinated. Such an agreement is evidenced by a contract, Memorandum of Agreement (MOA), or Memorandum of Understanding (MOU) with the other entity, or by a letter of support, letter of agreement, or letter of commitment from the other entity. The agreement describes the parties' mutual expectations and responsibilities related to care coordination.

For each service area, please describe your care coordination activities in the spaces below. Please indicate where the CMHC has agreements/partnerships with such other communities or regional services, support, and providers. Indicate where services could be offered but are currently not, due to limitations.

Schools -- Description of Care Coordination Activities

We coordinate with local schools through referral agreements to screen students for behavioral health needs and provide brief intervention services. Students identified as requiring treatment are referred to CMHC for ongoing care. Collaborative efforts support early identification and intervention within the educational environment. Our CMHC maintains contracts with the schools in our service area. If a contract is not in place with a specific school, we maintain regular contact to continue collaboration and work toward formalizing an agreement.

Emergency Departments -- Description of Care Coordination Activities

Care coordination includes the transfer of records and medications, discharge planning, and timely notifications to ensure continuity of care. Our staff supports the transition from emergency departments to community-based services and facilitates follow-up care with the CMHC. Our CMHC maintains care coordination agreements with the emergency departments in our service area. If a formal agreement is not in place with a specific emergency department, we maintain regular contact to continue collaboration and work toward formalizing an agreement.

Health Systems -- Description of Care Coordination Activities

Our partnerships with local health systems mirror those with emergency departments. We support the transfer of clinical information, discharge coordination, and follow-up planning to ensure seamless transitions for individuals moving from inpatient to outpatient care. Our CMHC maintains care coordination agreements with the health systems in our service area. If a formal agreement is

not in place with a specific health system, we maintain regular contact to continue collaboration and work toward formalizing an agreement.

FQHC -- Description of Care Coordination Activities

Coordination efforts include the exchange of medical records and medication information, discharge planning, and follow-up care. These partnerships support integrated care for shared patients and assist in transitioning individuals back into the community with appropriate behavioral health services. Our CMHC maintains care coordination agreements with the FQHC in our service area.

Child Welfare Agencies -- Description of Care Coordination Activities

We accept referrals from child welfare agencies for behavioral health assessments, crisis intervention, and treatment services. These connections ensure that children and families involved in the welfare system receive timely behavioral health support. Our CMHC maintains care coordination agreements with the child welfare agencies in our service area. If a formal agreement is not in place with a specific child welfare agency, we maintain regular contact to continue collaboration and work toward formalizing an agreement.

Juvenile and criminal justice agencies and facilities drug, mental health, veterans, and other probation parole, Jails/prisons, sheriffs, Dept.'s, specialty courts. -- Description of Care Coordination Activities

We maintain strong partnerships with jails, specialty courts, probation and parole departments, and other justice-related agencies across our service area. Bi-directional referral processes are in place to connect justice-involved individuals with behavioral health services, and our staff provide outreach, education, and enrollment assistance within these systems.

We participate in the Stepping Up Initiative and maintain a formal contract with the Covington County Sheriff's Office, through which we house a dedicated case manager to coordinate care for individuals with mental health and/or substance use challenges. In addition, we employ a Juvenile Court Liaison who supports all Juvenile Courts across Butler, Coffee, Covington, and Crenshaw counties, helping to bridge youth involved in the justice system with needed behavioral health services.

Our CMHC maintains care coordination agreements with the juvenile and criminal justice agencies and facilities drug, mental health, veterans, and other probation parole, jails/prisons, sheriffs, dept.'s, specialty courts in our service area. If a formal agreement is not in place with a specific juvenile and criminal justice agency and facility drug, mental health, veteran, and other probation parole, jail/prison, sheriffs, dept., specialty court, we maintain regular contact to continue collaboration and work toward formalizing an agreement.

Indian Health Service youth regional treatment centers -- Description of Care Coordination Activities

There is no Indian Health Service youth regional treatment center within the CMHC's catchment area.

Recognized Tribal Organizations -- Description of Care Coordination Activities

We partner with tribal organizations to ensure culturally responsive care. These collaborations include assistance with cultural competency training and integrating culturally appropriate services and alternative treatment approaches for Native American clients. Our CMHC maintains care coordination agreements with the state recognized tribal entity in our service area.

State licensed and nationally accredited child placing agencies for therapeutic foster care services -- Description of Care Coordination Activities

We accept referrals from therapeutic foster care agencies to provide behavioral health screenings, crisis intervention, and treatment planning for children and youth in care. Our CMHC maintains care coordination agreements with the state licensed and nationally accredited child placing agencies for therapeutic foster care services in our service area. If a formal agreement is not in place with a specific state licensed and nationally accredited child placing agency for therapeutic foster care services, we maintain regular contact to continue collaboration and work toward formalizing an agreement.

Other social and human services-- Description of Care Coordination Activities

Care coordination involves bi-directional referrals and collaborative efforts to support whole-person care. We work with housing agencies, food assistance programs, and other support systems to meet both behavioral and basic needs of clients. Our CMHC maintains care coordination agreements with other social and human services agencies in our service area. If a formal agreement is not in place with a specific social and human services agency, we maintain regular contact to continue collaboration and work toward formalizing an agreement.

The nearest VA medical center, clinic, drop-in center, or other facility Organizations -- Description of Care Coordination Activities

Veterans are referred to VA services as needed. Our care coordination includes support for cultural competency related to veteran and military populations, assistance with VA benefits enrollment, and linkages to specialty care. Our CMHC maintains care coordination agreements with the nearest VA medical center, clinic, drop-in center, or other facility organizations in our service area. If a formal agreement is not in place with a specific VA medical center, clinic, drop-in center, or other facility organization, we maintain regular contact to continue collaboration and work toward formalizing an agreement.

Connections with other providers and systems that ensures seamless transitions for patients across the full spectrum of health services, including acute, chronic, and behavioral health needs -- Description of Care Coordination Activities

We facilitate smooth transitions across acute, chronic, and behavioral health systems. This includes sharing records, coordinating medication transfers, planning discharges, and ensuring that follow-up care is timely and comprehensive. Our CMHC maintains care coordination agreements with other providers and systems that ensures seamless transitions for patients across the full spectrum of health services, including acute, chronic, and behavioral health needs in our service area. If a formal agreement is not in place with a specific provider and system that ensures seamless transitions for patients across the full spectrum of health services, including acute, chronic, and

behavioral health needs, we maintain regular contact to continue collaboration and work toward formalizing an agreement.

Services provided outside of the office setting (non-four walls) -- Description of Care Coordination Activities

South Central Alabama Mental Health Board, Inc. delivers mobile and community-based services, including outreach, home visits, and school- or field-based support, to reach individuals where they are.

Crisis services are received in 3 hours -- Description of Care Coordination Activities

South Central Alabama Mental Health Board, Inc. provides crisis services that meet the standard of response within three hours, ensuring timely intervention for individuals in acute behavioral health crises.

Certified Peer Specialists are available for adults; children/families; and On Crisis Teams -- Description of Care Coordination Activities

Certified Peer Specialists are available to support adults, youth, families, and crisis teams. These lived-experience professionals play an integral role in engagement, recovery, and resilience-building within our service model.

Other service model characteristics (if any) -- Description of Care Coordination Activities

None

CCBHC Core Service Delivery

Core Nine (9) Services

Connections with other providers and systems that ensures seamless transitions for patients across the full spectrum of health services, including acute, chronic, and behavioral health needs.

Of the CCBHC required services, please indicate your current capacity and readiness to provide the following services at your location. If you are not currently providing all of the services, indicate below and provide your intention to collaborate with other agencies to meet the CCBHC core services requirement.

Crisis Services -- Current Capacity and Readiness to Provide the Core Service

South Central Alabama Mental Health Board (SCAMHB) provides all required crisis services through our outpatient office, behavioral health urgent care, and mobile crisis response (MCR). Our 24/7 helpline offers telephonic crisis support aligned with most 988 Suicide & Crisis Lifeline standards, including risk assessment and intervention protocols. All calls are evaluated, and MCR are dispatched when needed. Until SCAMHB is designated as a 988 call center, the Alabama Department of Mental Health (ADMH) coordinates with the current regional 988 center to ensure continuity.

We maintain protocols to track referrals from the 988 helpline to our crisis services, documenting call and response times and ensuring timely mobile response, stabilization, and follow-up care. In urban areas, MCR responds within one hour; in rural areas, within two. If delays occur, telehealth is used to provide immediate intervention until the team arrives. The MCR is available 24/7 in

Covington and 8:00 AM – 4:00 PM in Butler, Coffee, and Crenshaw counties. We plan to expand MCR to operate 24/7 in Butler, Coffee, and Crenshaw counties by September 2025. Our MCR fully meets the CCBHC requirement for a 1–3 hour response window.

Behavioral health urgent care is available for walk-in mental health and substance use stabilization. Services are staffed by a nurse practitioner, therapist, nurse, and peer support specialist. The peer support specialist coordinates follow-up care and ensures continuity until the individual transitions to their next level of care. Walk-in hours are based on community needs and currently include: Monday 12:00 AM – 4:00 PM, Tuesday to Friday open 24 hours, and Saturday 2:00 PM – 10:00 PM, with plans to be operational 24/7 by 9/30/2025.

Crisis stabilization is also available at the outpatient office during business hours. Services are open to all, regardless of acuity or law enforcement involvement.

SCAMHB's crisis response includes suicide prevention, overdose intervention, and post-overdose support. Naloxone is available to both MCTs and urgent care staff, and may be provided to family members when appropriate. We have also installed Naloxone Emergency Wall Cabinets in all of our service locations including our group homes.

Law Enforcement Collaboration is guided by a formal protocol. Helpline staff assess for safety risks (e.g., weapons, substance use, violence) and involve law enforcement when necessary. In high-risk situations, law enforcement takes the lead in securing the scene while MCT staff provide de-escalation support. This coordinated approach ensures safety and timely care.

All staff receive annual trauma-informed care (TIC) training. SCAMHB is actively pursuing additional in-service training to strengthen crisis response through trauma-informed practices.

Screening, Diagnosis & Risk Assessment -- Current Capacity and Readiness to Provide the Core Service

SCAMHB employs trained staff to conduct comprehensive screenings and assessments, including risk assessments. Standardized tools include the PHQ-9, GAD-7, CRAFFT, UNCOPE, ACE, C-SSRS, WellRx, and a nicotine use screener. These tools are embedded in our EHR, and scores are collected to support clinical decision-making and track program outcomes, as outlined in our grant application.

Timeframes for completing assessments are guided by our Triage and Timeliness of Care protocol:

- Emergent needs: addressed within 1–3 hours
- Urgent needs: addressed within 1 business day
- Routine/non-urgent needs: completed within 10 business days

At intake, we obtain consent for treatment and releases of information. An initial screening is conducted to determine immediate clinical needs and now includes the 12 required elements. All CCBHC patients receive a comprehensive evaluation at their first routine appointment, which informs person- and family-centered treatment planning completed within 60 days. This evaluation

has been updated to include the 15 CCBHC-required elements and is trauma-informed, strength-based, culturally and linguistically responsive.

Screenings are available in English and Spanish. For patients with hearing impairments, we contract with ADMH Office of Deaf Services to provide interpreter services.

Patients are screened for substance and alcohol use using the CRAFFT and UNCOPE. If risky use is indicated, referrals are made for further SUD assessment and/or brief interventions. Staff incorporate Motivational Interviewing as part of assessment and treatment planning to ensure patient voice and preference are honored.

SCAMHB collects all required clinic- and patient-level data per Appendix B (CCBHC Performance Measures). Optional clinic-level measures will be adopted once workflow procedures are finalized.

Psychiatric Rehabilitation Services -- Current Capacity and Readiness to Provide the Core Service

Our Adult Rehab Day Program, Case Management, and Peer Support Services provide evidence-based psychiatric rehabilitation that promotes recovery, stability, and independence. Services include psychoeducation, life skills training, and coping strategies to enhance well-being and support personal goals.

Case managers and peer specialists assist individuals with vocational and educational supports by connecting them to Vocational Rehabilitation and Career One-Stop, offering help with job readiness, skill development, and sustained employment—consistent with supported employment principles.

Additionally, participants receive support for stable housing, social inclusion, and community integration. Through individualized guidance and continuous resource coordination, our programs help individuals achieve lasting stability and greater independence in their daily lives.

Outpatient Primary Care Screening & Monitoring -- Current Capacity and Readiness to Provide the Core Service

The Medical Director has developed and approved screening protocols that assess risk for diabetes, hypertension, obesity, STDs, hepatitis, HIV, and other chronic conditions. LPN nurses collect biological samples, which are analyzed through a contract with LabQuest.

During assessment and evaluation, medical service needs are identified, and referrals are made to primary care. Patients have access to care through our partner mobile FQHC, with community health workers (CHWs) coordinating appointments. CHWs currently track appointments through progress notes, and beginning January 2025, we will implement a dashboard-based appointment tracking system reviewed weekly.

CHWs and care coordinators will follow up with clients before and after appointments, ensuring documentation is collected and integrated into client records to support care coordination.

To support healthy lifestyles, care coordinators collaborate with therapists to offer client-tailored wellness activities such as walking, exercise, and wellness workshops, promoting both physical and mental well-being.

Targeted Case Management -- Current Capacity and Readiness to Provide the Core Service

We provide targeted case management directly to individuals with DD and SMI/SED. Therapists assist individuals with SUD through care coordination. High-need or at-risk patients are referred for services based on findings from the comprehensive evaluation, during care transitions, or when complex health needs are identified.

Peer, Family Support & Counselor Services -- Current Capacity and Readiness to Provide the Core Service

We deliver this core service directly through Certified Peer Support Specialists who serve adults, children, and parents.

Community-Based Mental Health Care for Veterans -- Current Capacity and Readiness to Provide the Core Service

We have established policies and protocols to serve veterans, active-duty service members, and their families. All individuals seeking services are screened for military experience and veteran status, with responses documented in the NOMs form and reported in SAMHSA Programmatic Reports.

We currently offer care to anyone identifying as a veteran or service member, regardless of documentation, and honor their preferences during enrollment and treatment. Community Health Workers provide enabling services and can contact VA partners for guidance or support as needed.

Care is provided in alignment with the VHA Uniform Mental Health Services Handbook and includes coordination across mental health, substance use, and other healthcare services. Every veteran is assigned a Principal Behavioral Health Provider, documented in the medical record, who develops a person- and family-centered treatment plan shared with the veteran.

We are actively working to establish formal care coordination agreements with local VA facilities, including Wiregrass VA Clinic and Lyster Army Health Clinic (55 miles from the CCBHC). Attempts to formalize partnerships will be made every December and June until agreements are secured.

All direct service and support staff receive military cultural competency training before service provision and annually thereafter. Our approach to care is trauma-informed and recovery-oriented for all patients, with veteran treatment plans meeting the five required elements in accordance with CCBHC standards.

Person- & Family-Centered Treatment Planning -- Current Capacity and Readiness to Provide the Core Service

Our organization follows a patient- and family-centered approach that honors patient preferences. Patients are encouraged to involve family and caregivers in their care when desired and

appropriate. We serve individuals across the lifespan—children, adults, and older adults—and track patient age through DOB data collected in the NOMS form to monitor disparities.

CCBHC staff conduct person- and family-centered planning beginning with the initial evaluation, risk assessment, screening, and crisis planning. This process leads to a fully individualized treatment plan co-created by the patient (and family/support persons if desired) and the treatment team. Plans reflect patient goals, strengths, values, and preferences—including choice of providers—and address prevention, medical, dental, and behavioral health needs.

We coordinate care with our FQHC partner and multiple external providers to ensure continuity, maintaining releases of information as needed. Treatment plans are updated at least every six months and incorporate recovery supports and measurable patient goals unique to each individual.

Patients are offered the opportunity to develop a crisis plan with clinical staff; whether a plan is made or declined is documented. Safety plans and advanced directives are available to support patient autonomy.

Outpatient Mental Health & Substance Use Services-- Current Capacity and Readiness to Provide the Core Service

We provide outpatient mental health and substance use disorder (SUD) care across the lifespan, including services for patients with co-occurring disorders. Our individualized approach serves adults, children, and families, with patient ages tracked to monitor outcomes by age group. At this time, we do not directly provide child and adolescent substance use (SU) services. Instead, referrals are made to external providers to ensure youth and families can access the appropriate level of care.

We maintain ongoing efforts to develop care coordination agreements with outside providers—including psychiatry, primary care, and behavioral health—and have both formal and informal agreements with local SUD treatment facilities offering multiple levels of care (Level 1 and 2.1). SUD counseling staff provide education and brief interventions, and smoking cessation is available upon request at intake and follow-up.

Currently, we provide Level 1 SUD care; the state has not designated us as a Level 2.1 provider. Telehealth services are offered to patients who prefer this mode of treatment. For intensive or specialized care needs, referrals and follow-ups are made, including aftercare coordination. When specialty care is unavailable, the CCBHC consults with external providers. We continue to establish written referral agreements with community-based organizations, most of which are bidirectional.

We honor traditional care practices when patients express that preference. Needs assessment findings highlighted the importance of comprehensive treatment for co-occurring SUD and mental health disorders.

Staff are trained in a range of evidence-based practices (as outlined in our grant proposal), tailored to all phases of life and development. Clinicians apply age-appropriate, evidence-based approaches and screening tools for youth, older adults, and individuals with developmental or cognitive disabilities.

Supports for children and youth are comprehensive, with bidirectional care coordination partnerships. Our care approach consistently reflects whole-person care for all patients, regardless of age.

Special Populations

Special Populations Currently Serviced by CMHC

	Currently or will be Provided – by Age				Provided by Diagnostic Group		
	Age 0-17	Age 18-21	Age 22-24	Age 65+	SED (youth)	SMI (adult)	SUD (all ages)
Members of the armed forces and veterans and their families	X	X	X	X	X	X	X

In the narrative, please specify and quantify this special population. Which treatment modalities and evidence-based practices could be used to meet the needs of this special population?

- **Trauma-Focused Therapies:**
  - **Cognitive Processing Therapy (CPT):** Targets PTSD by helping patients reframe negative thoughts related to trauma.
  - **Prolonged Exposure Therapy (PE):** Helps patients gradually confront trauma memories to reduce distress.
  - **Eye Movement Desensitization and Reprocessing (EMDR):** Uses bilateral stimulation to process traumatic memories.
- **Evidence-Based Psychotherapies:**
  - **Acceptance and Commitment Therapy (ACT):** Supports psychological flexibility, often helpful for trauma and adjustment.
  - **Dialectical Behavior Therapy (DBT):** Assists with emotion regulation, distress tolerance, and interpersonal effectiveness.
  - **Motivational Interviewing (MI):** Enhances readiness for behavior change, useful in substance use or treatment engagement.
- **Family and Couple-Based Interventions:**
  - **Cognitive-Behavioral Conjoint Therapy (CBCT) for PTSD:** Involves partners to improve relationship functioning and PTSD symptoms.
  - **Strengthening Families Program:** Supports family resilience and coping.
- **Peer Support Services:** Veteran peer specialists provide shared lived experience support, reduce stigma, and foster engagement.
- **Pharmacotherapy:** Medications approved for PTSD, depression, anxiety, and substance use disorders as part of comprehensive care.
- **Complementary and Integrative Health Approaches:** Mindfulness, yoga, and acupuncture can reduce symptoms and improve well-being.

- **Case Management and Care Coordination:** Connect veterans to VA benefits, specialized healthcare, housing, employment, and social supports.
- **Telehealth Services:** Expands access, especially in rural or underserved areas.

	Currently or will be Provided – by Age				Provided by Diagnostic Group		
	Age 0-17	Age 18-21	Age 22-24	Age 65+	SED (youth)	SMI (adult)	SUD (all ages)
Incarcerated individuals	X	X	X	X	X	X	X

In the narrative, please specify and quantify this special population. Which treatment modalities and evidence-based practices could be used to meet the needs of this special population?

- **Trauma-Informed Care:** Recognizes high rates of past trauma and adverse experiences; creates a safe, supportive environment to reduce retraumatization.
- **Cognitive-Behavioral Therapy (CBT):** Focuses on changing criminal thinking patterns, improving problem-solving skills, and managing emotions.
- **Motivational Interviewing (MI):** Enhances motivation to change behaviors, especially around substance use and recidivism
- **Dialectical Behavior Therapy (DBT):** Helps with emotion regulation, impulsivity, and interpersonal skills, which can reduce self-harm and aggression.
- **Substance Use Disorder (SUD) Treatment:** Includes medically assisted treatment (MAT) when appropriate, along with counseling and relapse prevention.
- **Anger Management Programs:** Teaches coping strategies to reduce aggression and violence.
- **Group Therapy and Peer Support:** Facilitates social connection, accountability, and shared learning among incarcerated individuals.
- **Reentry and Transition Planning:** Comprehensive discharge planning coordinates mental health, medical care, housing, employment, and social services upon release.
- **Family Engagement Programs:** Support maintaining family connections to improve reintegration outcomes.
- **Telehealth Services:** Provides access to specialists, including psychiatric care, within correctional settings.

	Currently or will be Provided – by Age				Provided by Diagnostic Group		
	Age 0-17	Age 18-21	Age 22-24	Age 65+	SED (youth)	SMI (adult)	SUD (all ages)
People in homeless shelters	X	X	X	X	X	X	X

In the narrative, please specify and quantify this special population. Which treatment modalities and evidence-based practices could be used to meet the needs of this special population?

- **Trauma-Informed Care:** Recognizes the high prevalence of trauma and adverse experiences; services create safe, respectful environments that avoid retraumatization.
- **Assertive Outreach and Engagement:** Proactively reaches individuals where they are to build rapport and encourage service use.
- **Case Management and Care Coordination:** Helps navigate healthcare, housing, social services, and benefits; supports continuity of care.
- **Integrated Mental Health and Substance Use Treatment:** Addresses co-occurring disorders simultaneously, including harm reduction approaches.

- **Cognitive-Behavioral Therapy (CBT) and Motivational Interviewing (MI):** Supports behavior change, coping skills, and motivation for treatment.
- **Peer Support Services:** Involves individuals with lived experience providing guidance, hope, and advocacy.
- **Housing First and Supported Housing Models:** Prioritize stable housing as a foundation for recovery and health improvements.
- **Crisis Intervention and Safety Planning:** Provides rapid response to crises and develops personalized plans to manage risks.
- **Basic Needs Support:** Ensures access to food, clothing, hygiene, and healthcare to reduce barriers to treatment.
- **Coordination with Community Resources:** Links shelter residents with medical, dental, vocational, and social services to support holistic care.

	Currently or will be Provided – by Age				Provided by Diagnostic Group		
	Age 0-17	Age 18-21	Age 22-24	Age 65+	SED (youth)	SMI (adult)	SUD (all ages)
People living on the streets	X	X	X	X	X	X	X

In the narrative, please specify and quantify this special population. Which treatment modalities and evidence-based practices could be used to meet the needs of this special population?

- **Outreach and Engagement:** Street-based outreach teams actively connect with individuals where they live, building trust and encouraging use of services.
- **Harm Reduction Approaches:** Focus on reducing negative consequences of substance use without requiring abstinence, including naloxone distribution and safe use education.
- **Trauma-Informed Care:** Prioritizes safety, trust, and empowerment, recognizing the prevalence of trauma and adverse experiences.
- **Mobile Crisis and Mobile Health Services:** Provide immediate response and basic health care on-site, including mental health crisis intervention.
- **Case Management and Navigation Support:** Assist with accessing healthcare, housing, legal aid, and social services to address social determinants of health.
- **Integrated Treatment for Co-occurring Disorders:** Simultaneous management of mental health and substance use disorders.
- **Motivational Interviewing and Cognitive Behavioral Therapy:** Techniques adapted for brief, flexible sessions to build motivation and coping skills.
- **Peer Support and Lived Experience Specialists:** Engage people with similar experiences to provide support and model recovery.
- **Housing First Initiatives:** Immediate access to permanent housing without preconditions, emphasizing stability as a foundation for recovery.
- **Basic Needs and Safety Planning:** Address food, clothing, hygiene, and safety to reduce barriers to care.
- **Collaborative Partnerships:** Coordination among shelters, outreach programs, health providers, and social services to ensure continuity of care.

	Currently or will be Provided – by Age				Provided by Diagnostic Group		
	Age 0-17	Age 18-21	Age 22-24	Age 65+	SED (youth)	SMI (adult)	SUD (all ages)

Aging and Older Adults	X	X	X	X	X	X	X

In the narrative, please specify and quantify this special population. Which treatment modalities and evidence-based practices could be used to meet the needs of this special population?

- **Comprehensive Geriatric Assessment:** Includes physical health, cognitive screening, mental health, social supports, and functional status.
- **Integrated Care Models:** Coordination of primary care, behavioral health, and specialty services to manage multiple chronic conditions.
- **Evidence-Based Psychotherapies:** Adapted CBT, Problem-Solving Therapy, and Reminiscence Therapy tailored for older adults.
- **Medication Management and Deprescribing:** Careful evaluation of psychotropic and other medications to reduce side effects and interactions.
- **Substance Use Screening and Brief Interventions:** Regular screening for alcohol and prescription medication misuse with motivational interviewing .
- **Caregiver Support and Education:** Resources and training to support family or professional caregivers in managing behavioral health needs.
- **Social Engagement and Community Programs:** Activities to reduce isolation, enhance social support, and promote cognitive stimulation.
- **Crisis Intervention and Safety Planning:** Plans tailored for older adults' needs, including fall risk and suicide prevention.
- **Culturally Competent and Trauma-Informed Care:** Sensitive to diverse backgrounds and life experiences, including ageism.
- **Accessible Services:** Transportation support, telehealth options, and home-based care to overcome mobility barriers.

	Currently or will be Provided – by Age				Provided by Diagnostic Group		
	Age 0-17	Age 18-21	Age 22-24	Age 65+	SED (youth)	SMI (adult)	SUD (all ages)
People in foster care	X	X	X	X	X	X	X

In the narrative, please specify and quantify this special population. Which treatment modalities and evidence-based practices could be used to meet the needs of this special population?

- **Trauma-Informed Care:** Recognizes and addresses complex trauma, focusing on safety, trust, and empowerment.
- **Attachment-Based Therapies:** Supports rebuilding healthy relationships and secure attachments with caregivers.
- **Evidence-Based Therapies:** Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Dialectical Behavior Therapy (DBT), and Parent-Child Interaction Therapy (PCIT).
- **Family and Caregiver Involvement:** Includes foster families and birth families as appropriate to support healing and stability.
- **Screening and Assessment:** Early and ongoing mental health and substance use screening tailored to developmental stages.
- **Case Management and Care Coordination:** Ensures continuity across multiple systems (child welfare, education, healthcare).
- **Life Skills and Social Support:** Training in coping, decision-making, and independent living skills.

- **Peer Support and Mentoring:** Opportunities to connect with others who have similar experiences for encouragement and guidance.
- **Crisis Intervention and Safety Planning:** Plans that address risk behaviors and promote stability.

Collaboration with Child Welfare and Juvenile Justice Systems: Coordinated services that align with legal and placement needs.

	Currently or will be Provided – by Age				Provided by Diagnostic Group		
	Age 0-17	Age 18-21	Age 22-24	Age 65+	SED (youth)	SMI (adult)	SUD (all ages)
People in other congregate living	X	X	X	X	X	X	X

In the narrative, please specify and quantify this special population. Which treatment modalities and evidence-based practices could be used to meet the needs of this special population?

- **Individualized Assessment and Care Planning:** Tailored plans addressing mental health, substance use, medical, and social needs.
- **Trauma-Informed and Person-Centered Care:** Emphasizing safety, respect, and empowerment in communal living contexts.
- **Behavioral Interventions and Psychotherapies:** Cognitive Behavioral Therapy (CBT), Motivational Interviewing, Dialectical Behavior Therapy (DBT), and other EBPs adapted to the group setting.
- **Medication Management:** Ongoing monitoring and support for psychotropic and other medications.
- **Peer Support and Social Skills Training:** Facilitating social connection, coping skills, and conflict resolution within communal living.
- **Case Management and Care Coordination:** Liaison between congregate facility, healthcare providers, and community resources.
- **Substance Use Treatment and Relapse Prevention:** Including detox support and ongoing counseling tailored for group environments.
- **Crisis Intervention and Safety Planning:** Ready access to crisis response, with plans adapted for congregate settings.
- **Life Skills and Vocational Support:** Assistance with daily living, employment, and community engagement.
- **Cultural Competency and Inclusivity:** Services responsive to diverse backgrounds and individual preferences.

	Currently or will be Provided – by Age				Provided by Diagnostic Group		
	Age 0-17	Age 18-21	Age 22-24	Age 65+	SED (youth)	SMI (adult)	SUD (all ages)
Individuals with Physical disabilities	X	X	X	X	X	X	X

In the narrative, please specify and quantify this special population. Which treatment modalities and evidence-based practices could be used to meet the needs of this special population?

- **Accessible Care Environments:** Ensuring facilities and services accommodate mobility, sensory, and communication needs.
- **Integrated Care Coordination:** Collaboration between behavioral health providers, primary care, rehabilitation, and specialty medical services.

- **Trauma-Informed and Person-Centered Approaches:** Addressing the emotional impact of disability, including grief, loss, and adjustment.
- **Cognitive Behavioral Therapy (CBT) and Other EBPs:** Adapted for physical limitations and co-occurring conditions.
- **Medication Management:** Careful coordination considering physical health and potential medication interactions.
- **Assistive Technology and Communication Supports:** Use of devices or aids to support communication and engagement in therapy.
- **Peer Support and Social Connection:** Opportunities to reduce isolation and build community with others facing similar challenges.
- **Crisis Planning and Prevention:** Tailored safety plans addressing unique risks related to physical disabilities.
- **Support for Caregivers and Family Members:** Education and resources to assist with caregiving challenges.
- **Cultural and Linguistic Competency:** Respect for diverse backgrounds and disability identities.

	Currently or will be Provided – by Age				Provided by Diagnostic Group		
	Age 0-17	Age 18-21	Age 22-24	Age 65+	SED (youth)	SMI (adult)	SUD (all ages)
Individuals with Intellectual disabilities	X	X	X	X	X	X	X

In the narrative, please specify and quantify this special population. Which treatment modalities and evidence-based practices could be used to meet the needs of this special population?

- **Developmentally Appropriate Assessment and Care Planning:** Using tools and approaches tailored to cognitive abilities.
- **Person-Centered and Family-Inclusive Planning:** Involving patients, families, and caregivers in goal setting and decision-making.
- **Behavioral Interventions and Positive Behavior Support (PBS):** Evidence-based strategies to reduce challenging behaviors and promote adaptive skills.
- **Simplified Communication and Visual Supports:** Using clear language, pictures, and other aids to improve understanding.
- **Trauma-Informed Care:** Sensitive to the increased risk of trauma and abuse in this population.
- **Medication Management:** Monitoring for side effects and interactions, considering cognitive impact.
- **Skill Building and Social Skills Training:** Supporting daily living, social interaction, and community inclusion.
- **Crisis Prevention and Intervention:** Proactive planning to manage behavioral crises safely.
- **Collaboration with Developmental Disability Services:** Coordinated care with specialized providers, schools, and community programs.
- **Cultural Competency:** Respecting diverse backgrounds and ensuring culturally appropriate supports.

	Currently or will be Provided – by Age				Provided by Diagnostic Group		
	Age 0-17	Age 18-21	Age 22-24	Age 65+	SED (youth)	SMI (adult)	SUD (all ages)
Individuals who are deaf or hard of hearing	X	X	X	X	X	X	X

In the narrative, please specify and quantify this special population. Which treatment modalities and evidence-based practices could be used to meet the needs of this special population?

- **Accessible Communication:** Provision of qualified sign language interpreters, captioning, and other assistive technologies.
- **Use of Deaf-Aware and Culturally Competent Providers:** Clinicians trained in Deaf culture and communication preferences.
- **Telehealth Adaptations:** Video remote interpreting (VRI) or direct video sessions with fluent providers.
- **Visual and Written Materials:** Using clear, accessible formats and alternative communication methods.
- **Trauma-Informed Care:** Recognizing unique stressors such as communication barriers and social isolation.
- **Peer Support from Deaf or Hard of Hearing Peers:** Facilitating connection and community.
- **Adapted Evidence-Based Practices:** CBT, motivational interviewing, and other EBPs adapted for communication needs.
- **Care Coordination:** Working with audiologists, speech therapists, and Deaf community resources.
- **Crisis Planning:** Including communication preferences and accessible emergency response.
- **Cultural and Linguistic Competency:** Affirming Deaf identity and incorporating cultural values into care.

	Currently or will be Provided – by Age				Provided by Diagnostic Group		
	Age 0-17	Age 18-21	Age 22-24	Age 65+	SED (youth)	SMI (adult)	SUD (all ages)
Individuals with Sensory disabilities	X	X	X	X	X	X	X

In the narrative, please specify and quantify this special population. Which treatment modalities and evidence-based practices could be used to meet the needs of this special population?

- **Accessible Communication Methods:** Use of braille, large print, audio materials, captioning, sign language interpreters, and assistive technologies.
- **Environmental Accommodations:** Adjusting lighting, sound levels, and physical space to support sensory needs.
- **Culturally Competent, Sensory-Aware Providers:** Training staff to understand and respect sensory disabilities and their impact on mental health.
- **Trauma-Informed Care:** Addressing vulnerabilities and potential trauma related to sensory impairments.
- **Adapted Screening and Assessment Tools:** Using sensory-appropriate instruments and alternative formats.
- **Peer Support and Community Resources:** Connecting clients with groups for sensory-disabled individuals.
- **Integrated Care Coordination:** Collaborating with vision or hearing specialists and rehabilitation services.

- **Flexible Delivery Options:** Offering telehealth with accessible features and in-person visits with accommodations.
- **Crisis Intervention Plans:** Tailored to communication preferences and sensory needs.
- **Evidence-Based Practices Adapted for Accessibility:** Modifying therapies like CBT and motivational interviewing to fit sensory accommodations.

	Currently or will be Provided – by Age				Provided by Diagnostic Group		
	Age 0-17	Age 18-21	Age 22-24	Age 65+	SED (youth)	SMI (adult)	SUD (all ages)
Individuals served by other social and human services (i.e., domestic violence centers)	X	X	X	X	X	X	X

In the narrative, please specify and quantify this special population. Which treatment modalities and evidence-based practices could be used to meet the needs of this special population?

- **Trauma-Informed Care:** Prioritizing safety, trust, and empowerment to address trauma from violence, abuse, or homelessness.
- **Integrated Service Coordination:** Close collaboration with domestic violence shelters, social services, and legal advocates to provide holistic support.
- **Flexible, Accessible Counseling:** Offering individual and group therapy tailored to survivors' experiences, including safety planning.
- **Evidence-Based Practices:** Utilizing trauma-focused CBT, motivational interviewing, and other EBPs that address co-occurring mental health and substance use issues.
- **Crisis Intervention and Safety Planning:** Developing personalized crisis plans that consider risks related to domestic violence.
- **Peer Support and Advocacy:** Connecting clients with peer mentors and advocates who understand their experiences.
- **Culturally Competent Services:** Respecting diversity and unique barriers faced by survivors from various backgrounds.
- **Resource Navigation:** Assisting clients in accessing housing, legal aid, healthcare, and financial support through partnerships.
- **Confidentiality and Privacy Protections:** Ensuring sensitive information is safeguarded to protect clients' safety.

Racial and Ethnic Populations

Racial and Ethnic Populations Currently Serviced by CMHC

	Currently or will be Provided – by Age				Provided by Diagnostic Group		
	Age 0-17	Age 18-21	Age 22-24	Age 65+	SED (youth)	SMI (adult)	SUD (all ages)
People with limited English proficiency	X	X	X	X	X	X	X

In the narrative, please specify and quantify this special population. Which treatment modalities and evidence-based practices could be used to meet the needs of this special population?

- **Language Access Services:** Providing professional interpreters (in-person or remote) and bilingual staff fluent in patients' preferred languages.

- **Translated Materials:** Offering intake forms, consent documents, educational resources, and treatment plans in patients' native languages.
- **Culturally Competent Care:** Training providers to understand cultural beliefs, stigma, and values related to mental health and substance use.
- **Use of Plain Language and Visual Aids:** Simplifying explanations and using visuals to enhance understanding.
- **Patient-Centered Communication:** Encouraging patients and families to express preferences and participate actively in treatment planning.
- **Adapted Evidence-Based Practices:** Implementing culturally tailored CBT, motivational interviewing, and other EBPs respecting linguistic and cultural contexts.
- **Community Outreach and Engagement:** Partnering with cultural organizations and community leaders to build trust and promote service awareness.
- **Flexible Service Delivery:** Offering telehealth with interpretation and community-based services that reduce barriers.
- **Ongoing Training for Staff:** Enhancing skills in cultural humility, implicit bias, and working effectively with interpreters.

	Currently or will be Provided – by Age				Provided by Diagnostic Group		
	Age 0-17	Age 18-21	Age 22-24	Age 65+	SED (youth)	SMI (adult)	SUD (all ages)
American Indians, tribal groups, and nations	X	X	X	X	X	X	X

In the narrative, please specify and quantify this special population. Which treatment modalities and evidence-based practices could be used to meet the needs of this special population?

- **Culturally Grounded Care:** Incorporating traditional healing practices, ceremonies, and spirituality alongside evidence-based treatments.
- **Community Collaboration:** Partnering with tribal leaders, health councils, and cultural advisors to design and deliver services that honor tribal values and sovereignty.
- **Trauma-Informed Approaches:** Addressing historical trauma, intergenerational loss, and ongoing discrimination through trauma-sensitive care.
- **Integrated Services:** Combining behavioral health, substance use treatment, and social supports in a holistic, person-centered model.
- **Use of Culturally Adapted EBPs:** Tailoring cognitive-behavioral therapies, motivational interviewing, and other EBPs to fit cultural beliefs and communication styles.
- **Peer and Family Support:** Engaging community members as peer specialists and involving families in recovery and treatment planning.
- **Language and Cultural Competency:** Providing services in native languages where possible and ensuring staff training on cultural humility.
- **Access to Tribal Health Resources:** Coordinating care with Indian Health Service (IHS) facilities, tribal clinics, and regional treatment centers.
- **Respect for Sovereignty and Privacy:** Upholding tribal protocols regarding confidentiality and data sharing.

	Currently or will be Provided – by Age				Provided by Diagnostic Group		
	Age 0-17	Age 18-21	Age 22-24	Age 65+	SED (youth)	SMI (adult)	SUD (all ages)
Other specific racial and ethnic groups	X	X	X	X	X	X	X

In the narrative, please specify and quantify this special population. Which treatment modalities and evidence-based practices could be used to meet the needs of this special population?

- **Culturally Adapted Care:** Modify evidence-based practices (EBPs) like CBT, motivational interviewing, and trauma-informed care to reflect cultural norms, language, and communication styles.
- **Language Access:** Provide bilingual/bicultural staff and interpreter services to ensure clear communication and comprehension.
- **Community Engagement:** Collaborate with community leaders, faith-based organizations, and cultural groups to build trust and awareness of services.
- **Addressing Social Determinants:** Recognize and address factors such as discrimination, socioeconomic challenges, and access barriers affecting mental health and substance use.
- **Family and Community Involvement:** Incorporate family, extended kinship, and community supports into treatment planning and recovery.
- **Flexible Service Delivery:** Offer services in locations and formats convenient to clients, including telehealth, community centers, and faith-based venues.
- **Staff Cultural Competency Training:** Train providers in cultural humility, implicit bias, and culturally responsive care approaches.
- **Holistic and Strength-Based Approaches:** Emphasize resilience, cultural strengths, and client empowerment in treatment.

	Currently or will be Provided – by Age				Provided by Diagnostic Group		
	Age 0-17	Age 18-21	Age 22-24	Age 65+	SED (youth)	SMI (adult)	SUD (all ages)
Other cultural needs populations	X	X	X	X	X	X	X

In the narrative, please specify and quantify this special population. Which treatment modalities and evidence-based practices could be used to meet the needs of this special population?

- **Cultural Humility and Flexibility:** Providers should approach care with openness, respect, and willingness to learn about each individual's cultural background and preferences.
- **Language and Communication Access:** Offer interpretation, translation, and materials in multiple languages; use culturally relevant metaphors and concepts.
- **Trauma-Informed Care:** Recognize cultural trauma, migration stress, discrimination, and minority stress specific to these populations.
- **Community and Faith-Based Partnerships:** Collaborate with community organizations, faith leaders, and cultural groups trusted by these populations.

- **LGBTQ+ Affirming Care:** Use inclusive, nonjudgmental approaches that recognize sexual orientation and gender identity as key factors in health.
- **Tailored Evidence-Based Practices:** Adapt EBPs to reflect cultural beliefs, healing traditions, and individual preferences.
- **Holistic and Person-Centered Models:** Integrate mental, physical, spiritual, and social wellbeing, honoring diverse cultural expressions of health.
- **Peer Support and Advocacy:** Employ peer specialists who share cultural or identity backgrounds, fostering trust and empowerment.
- **Flexible Service Delivery:** Provide services in accessible, culturally safe environments, including community centers, schools, and telehealth.

Additional Questions About your CMHC

1. Is your organization the mental health authority in the CMHC service area? Please select one option:

X	*a. Yes*
	b. No, but a designated collaborating organization is the mental health authority
	c. No, and we do not plan to partner with the mental health authority
	d. No, but we work closely with the counties who are legally designated mental health authorities
	e. Other. Please describe.

Additional Information about Subgroups Currently Being Served

2. Is there other information you would like to provide about SUD diagnostic subgroups or individuals you currently serve?

In FY 2024, South Central Alabama Mental Health Board, Inc. served a total of 3,740 unique consumers across all programs. Of these, 450 consumers (12%) received Substance Use Services.

3. Is there other information you would like to provide about SMI Adult diagnostic subgroups of individuals you currently serve?

In FY 2024, South Central Alabama Mental Health Board, Inc. served a total of 3,740 unique consumers across all programs. Of these, 2,266 consumers (61%) received services for Serious Mental Illness (SMI) in adults.

4. Is there other information you would like to provide about SED-Children/Adolescents diagnostic subgroups of individuals you currently serve?

None

Additional Information about Subgroups Not Currently Being Served

5. Is there other information you would like to provide about SUD diagnostic subgroups or individuals in your area who need services but are not currently served?

None

6. Is there other information you would like to provide about SMI Adult diagnostic subgroups of individuals in your area who need services but are not currently served?

None

7. Is there other information you would like to provide about SED-Children/ diagnostic subgroups of individuals in your area who need services but are not currently served?

At this time, we do not have a contract with Enterprise City Schools to provide school-based mental health services. However, based on regional data and community needs assessments, there is an identified gap in services for children with Serious Emotional Disturbance (SED) within the area.

Information About Inquiries to Clients and Community about Needs

8. Have you recently surveyed (survey, focus group, etc.) your clients and/or your service area regarding their stated needs?

[X] *a. Yes. If so, please send the summary information from those surveys along with this Needs Assessment document.*
[ ] *b. No*

Additional Information about Workforce

9. Does the agency experience workforce issues in recruiting and retaining qualified staff in the required CMHC service areas?
Yes, our agency experiences workforce challenges. Recruiting and retaining qualified clinical and support staff—especially in rural or underserved areas—continues to be a barrier to maintaining full staffing.

Primary workforce issues include:

- **Shortage of Licensed Professionals:** Difficulty finding licensed clinicians, prescribers, and substance use professionals.
- **High Turnover:** Staff burnout and limited local workforce pools contribute to turnover.
- **Recruitment Barriers:** Competitive hiring markets, limited salary flexibility, and geographic limitations make it challenging to attract new staff.
- **Retention Factors:** Challenges include workload demands and secondary trauma.
- **Specialty Gaps:** Recruitment for specialized roles—such as bilingual providers—remains particularly difficult.

10. What screenings are being done routinely when someone presents for services? Examples could be SUD, brain injury, history of trauma, depression/anxiety, and others. Are these screenings repeated routinely?
When an individual presents for services, our agency conducts a standardized set of evidence-based screenings to assess a broad range of behavioral health needs. These screenings are integrated into our initial evaluation and help inform person-centered treatment planning from the start.

Routinely Administered at Intake:

- **Depression:** PHQ-9
- **Anxiety:** GAD-7
- **Substance Use Disorder (SUD):** UNCOPE (adults), CRAFFT (youth)
- **Trauma History & ACEs:** ACE Questionnaire
- **Suicide Risk:** Columbia-Suicide Severity Rating Scale (C-SSRS)
- **Social Determinants of Health:** WellRx
- **Nicotine/Tobacco Use:** In-house nicotine use screening
- **Other Risk Assessments:** General risk assessment embedded in our triage process

For Youth Clients:

- In addition to the above, screenings may also include Child and Adolescent Needs and Strengths (CANS) and behavioral/emotional health tools appropriate for developmental stage.

Screening Frequency:

- **At Intake:** All individuals receive these screenings during their comprehensive assessment.
- **Ongoing/Reassessment:** Screenings may be repeated:
  - Routinely at treatment plan reviews (at least every 6 months)
  - As clinically indicated (e.g., changes in condition, reported symptoms, new concerns)

Screening results are documented in the electronic health record (EHR), used to guide diagnostic clarification, and inform referrals, treatment planning, and progress monitoring.

11. A) What primary care screening and monitoring of key health indicators and health risks is occurring currently?

Our agency provides primary care screening and monitoring of key health indicators and health risks as part of our whole-person, integrated care approach. These screenings are performed by qualified clinical staff during intake and updated as needed throughout treatment.

Current Screenings Include:

- Height, weight, and BMI calculation
- Blood pressure and pulse monitoring
- Diabetes screening (A1C or fasting blood glucose, as clinically indicated)
- Tobacco/nicotine use screening
- HIV risk assessment and referrals for testing
- Medication monitoring, including side effects of psychotropic medications (e.g., metabolic syndrome risk)

These screenings are documented in the electronic health record (EHR) and reviewed as part of the treatment planning process. Referrals to primary care providers, FQHCs, or other medical specialists are made when follow-up care is needed.

11. B) What other screenings do you feel are necessary for your consumer population?

To better serve our population—many of whom experience co-occurring mental health, substance use, and social determinants of health challenges—we believe the following additional screenings would further enhance care:

- **Traumatic Brain Injury (TBI) screening**, due to high rates of undiagnosed head trauma, especially among justice-involved and homeless populations.
- **Comprehensive trauma screening**, beyond ACEs, to identify complex trauma and guide trauma-informed care planning.

- **Nutrition and food insecurity assessments**, to address health risks tied to poor diet and unmet basic needs.
- **Fall risk screening** for older adults and individuals on medications that increase risk.
- **Cognitive screening** for early identification of memory impairment or developmental delays.
- **Housing and homelessness risk screening**, to proactively link individuals to supportive housing or case management resources.
- **Domestic violence and interpersonal violence screening**, especially for women and LGBTQ+ individuals.
- **Transportation access and digital literacy screening**, to inform care coordination, especially for telehealth services.

These screenings would support our whole-person care model and allow us to better tailor services and referrals to meet the full range of needs in our community.

12. Please list populations that you identify as needing Targeted Case Management services.

We identify the following populations as having the highest need for Targeted Case Management (TCM) services:

- **Individuals with serious mental illness (SMI)** or **serious emotional disturbance (SED)**, especially those with functional impairments in daily living.
- **People with co-occurring mental health and substance use disorders**, who require coordination across multiple systems of care.
- **Children and adolescents involved in the child welfare or juvenile justice system**, who often experience high rates of trauma and require cross-system coordination.
- **Individuals recently discharged from psychiatric inpatient facilities or crisis stabilization units**, to ensure safe transitions and continuity of care.
- **People experiencing chronic homelessness or housing instability**, who often face barriers accessing consistent treatment and supports.
- **Justice-involved individuals**, including those transitioning from jails, prisons, or specialty courts, who need support reintegrating into the community.
- **Veterans and service members**, especially those with service-related trauma, behavioral health needs, or navigating VA and community-based systems.
- **Older adults with behavioral health concerns**, particularly those experiencing isolation, physical decline, or cognitive impairment.
- **People with complex medical conditions and behavioral health needs**, who benefit from integrated coordination of physical and mental healthcare.

Targeted case management helps these individuals overcome barriers, link to needed services, and remain engaged in treatment—supporting recovery, stability, and community integration.

13. Have you recently surveyed (survey, focus group, etc.) your service area regarding their needs?

Please see #8 above.

14. Does the agency have a psychiatrist who functions as the medical director?

X	*Yes. If so, please describe their role.*
	b. No

Yes, the agency employs a psychiatrist who serves as the medical director. This individual oversees the clinical and medical components of service delivery, ensures compliance with evidence-based psychiatric care standards, and provides leadership in areas such as medication management, integrated care planning, and clinical quality assurance. The medical director also participates in interdisciplinary team meetings, supports clinical staff development, and plays a key role in shaping policies that support whole-person care across the agency.

15. What accountability measures are in place to ensure staff provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs?

Our agency has implemented multiple accountability measures to ensure that care is effective, equitable, understandable, and respectful—meeting the diverse cultural, linguistic, and health literacy needs of the populations we serve:

- **Staff Training and Competency**
  All staff receive ongoing training in cultural humility, health equity, trauma-informed care, and communication best practices. Training includes topics such as implicit bias, person-centered language, working with interpreters, and respecting cultural health beliefs and practices. Attendance and understanding are tracked through learning management systems or HR files.
- **Use of Qualified Interpreters and Language Access Services**
  We provide interpreter services (including American Sign Language) at no cost to individuals with limited English proficiency or hearing impairments. Preferred language is documented at intake and used throughout service delivery. Materials are available in English and Spanish, with additional translations available upon request.
- **Culturally Responsive Policies**
  Organizational policies reflect a commitment to equity and nondiscrimination. We incorporate cultural preferences and family involvement into treatment planning and offer culturally appropriate peer and community supports when available.
- **Data Monitoring and Quality Improvement**
  We collect and analyze data related to client demographics, service outcomes, satisfaction, and access to identify and address disparities. This includes review by the Quality Improvement Committee and integration into our annual Disparity Impact Statement.
- **Client Feedback and Grievance Processes**
  We routinely solicit client feedback through surveys and have a clearly posted grievance process. Complaints related to cultural insensitivity or communication issues are tracked, investigated, and addressed through corrective action and staff coaching as needed.
- **Inclusive Intake and Treatment Planning**
  Intake assessments gather information on health literacy and language preferences. Treatment planning is person- and family-centered, incorporating client-defined goals and respecting cultural values.

16. Please identify any Tribal affiliations and/or collaborations for your organization or for providers within your organization.

Our organization has an active care coordination agreement with the Ma-Chis Lower Creek Indian Tribe of Alabama, a state-recognized Tribal Nation. Through this partnership, we collaborate to ensure access to culturally respectful behavioral health services for Tribal members. Our collaboration includes:

- **Bidirectional referral processes** to ensure timely access to care for Tribal members.
- **Cultural consultation and input** from Ma-Chis representatives, particularly for individuals identifying as Native American or with Tribal affiliation.
- **Support for alternative or culturally significant practices** as part of the treatment planning process, when desired by the individual.
- **Engagement in ongoing relationship-building** to enhance trust, coordination, and culturally responsive care delivery.

17. A) Please identify the relationships with community providers.

Our organization maintains a broad network of collaborative relationships with community providers to ensure coordinated, whole-person care. These relationships are formalized through Memorandums of Understanding (MOUs), referral agreements, and informal partnerships, and span across healthcare, education, criminal justice, and social service systems. Key provider relationships include:

- **Federally Qualified Health Centers (FQHCs):** For integrated care coordination, medical screenings, referrals for primary care, and co-management of individuals with behavioral and physical health conditions.
- **Hospitals and Emergency Departments:** To support transitions of care, including sharing of discharge summaries, medication reconciliation, and ensuring timely follow-up with behavioral health services.
- **Local Schools and School Systems:** For referral to behavioral health services, school-based prevention programs, student screenings, and brief interventions.
- **Law Enforcement and Correctional Facilities:** Including local jails, sheriff departments, and probation/parole officers to support crisis response, diversion, re-entry planning, and treatment continuity for justice-involved individuals.
- **Child Welfare Agencies:** To support the mental health needs of children and families involved in the child welfare system through crisis intervention, outpatient services, and family-based care planning.
- **Substance Use Treatment Providers:** Including detox facilities and medication-assisted treatment providers for warm handoffs, SUD assessment, and treatment coordination.
- **Local Housing Authorities and Shelters:** For individuals experiencing homelessness or housing instability, including crisis stabilization, case management, and supportive housing referrals.
- **Vocational Rehabilitation and Workforce Development Partners:** Including Career One-Stop centers for coordinated support related to employment, education, and training goals.
- **Peer Support and Recovery Organizations:** For ongoing peer-led services and recovery supports, including group facilitation and navigation assistance.
- **Tribal Organizations:** Specifically with the Ma-Chis Lower Creek Indian Tribe of Alabama, to ensure culturally responsive care and bidirectional referrals for Tribal members.

17. B) What is the level of engagement with these providers?

Our organization maintains active and ongoing engagement with community providers across all sectors to ensure seamless care coordination and comprehensive service delivery. Engagement occurs through multiple channels and is characterized by:

- **Regular communication and case coordination:** Frequent exchange of information via secure messaging, phone calls, and meetings to coordinate care plans, referrals, and follow-up services.
- **Formal agreements and protocols:** MOUs and referral agreements clarify roles and responsibilities, streamline processes, and support timely access to services.
- **Multidisciplinary meetings and collaborative teams:** Participation in community coalitions, care coordination teams, and specialty task forces fosters shared problem-solving and service integration.
- **Joint training and capacity-building:** Collaborative staff trainings, workshops, and cross-sector education promote consistent standards of care and cultural competency.
- **Crisis response collaboration:** Close partnerships with law enforcement, emergency departments, and mobile crisis teams facilitate coordinated crisis interventions and warm handoffs.
- **Data sharing and quality improvement:** Where feasible, partners share data and participate in joint quality improvement initiatives to monitor outcomes and enhance service delivery.
- **Community outreach and engagement:** Providers collaborate on outreach efforts, education, and prevention programming to reach underserved populations.

18. What are your organizational strengths as a provider?

Our organization's strengths include a combination of dedicated staff, innovative practices, and strong community partnerships that enable us to deliver high-quality, client-centered care. Key strengths are:

- **Innovative Work Culture:** We foster creativity and continuous improvement across all levels of the organization.
- **In-House Training:** Ongoing professional development ensures staff remain skilled and up-to-date on best practices.
- **Specialized Medical Staff:** Our team includes highly qualified professionals with expertise in behavioral health and primary care.
- **Diverse, Cross-Trained Staff:** A diverse workforce trained across multiple disciplines enhances service delivery flexibility and cultural competency.
- **Strong Partnerships:** Collaborative relationships with other agencies strengthen care coordination and resource sharing.
- **Supportive Governance:** A cooperative and engaged board supports organizational stability and strategic growth.
- **High-Quality Services and Facilities:** We provide comprehensive, evidence-based care in well-equipped, accessible settings.
- **Fair Staff Treatment and Benefits:** Competitive benefits and a supportive work environment promote staff retention and morale.
- **Financial Stability:** Sound fiscal management ensures sustainability and capacity for innovation.

- **Flexible Leadership and Staffing Models:** Adaptive leadership and flexible scheduling allow responsiveness to client and community needs.
- **Vehicle Leasing Program:** Partnership with Enterprise supports transportation needs critical for outreach and service delivery.
- **Client-Centered Care Philosophy:** We prioritize individualized treatment plans that respect client preferences and needs.
- **Flexible Service Delivery:** Multiple modalities of care (in-person, telehealth, mobile) increase access and engagement.
- **Community Engagement:** Strong ties with local stakeholders promote trust and alignment with community needs.
- **Long-Standing Community Presence:** Established reputation builds credibility and enhances outreach effectiveness.
- **Multidisciplinary Team Approach:** Collaborative care across specialties ensures holistic treatment.
- **Internal Grant Management:** Capacity to secure and manage grants supports program development and innovation.

19. What steps are you taking to ensure Plain Language (to remove/explain acronyms, simplify requests for information, etc.) in documents for clients?

To ensure plain language in documents for clients, we take several deliberate steps:

- **Acronym Management:** We avoid using acronyms whenever possible. If an acronym is necessary, we spell it out fully on first use and provide a clear, simple explanation.
- **Clear, Simple Language:** Documents are written using everyday language, short sentences, and familiar words to improve comprehension.
- **Client Review:** We involve clients and community members in reviewing materials to ensure clarity and relevance.
- **Use of Visuals:** When appropriate, we include charts, icons, or infographics to support understanding.
- **Readability Checks:** We use readability tools and guidelines (such as aiming for a 6th-8th grade reading level) to assess and improve text clarity.
- **Training Staff:** Staff who create or distribute materials receive training on plain language principles and cultural competence.
- **Multilingual Support:** Materials are translated and culturally adapted for clients with limited English proficiency, including glossaries for specialized terms.

20. What are your technological needs or concerns related to becoming a CCBHC?

As we transition to becoming a Certified Community Behavioral Health Clinic (CCBHC), several technological needs and concerns have been identified:

- **Electronic Health Record (EHR) Integration:** We need to ensure our EHR system fully supports all CCBHC-required data collection, reporting, and billing functions, including integration of clinical quality measures and performance metrics.
- **Data Management and Reporting:** Enhanced tools are necessary for efficient collection, analysis, and secure transmission of patient-level and clinic-level data to meet CCBHC reporting requirements.

- **Telehealth Capacity:** Expanding and upgrading telehealth platforms is critical to provide flexible, accessible behavioral health services, especially for rural or transportation-challenged populations.
- **Interoperability:** Systems must be capable of seamless information sharing with other providers, hospitals, and care partners to support coordinated care and reduce duplication.
- **Staff Training:** Ongoing technology training is needed to ensure all staff are proficient with new systems and workflows associated with CCBHC certification.
- **Security and Compliance:** Maintaining robust cybersecurity measures is essential to protect sensitive patient information and comply with HIPAA and CCBHC regulations.
- **Resource Allocation:** Sufficient funding and IT support are required to implement necessary hardware and software upgrades and sustain technology infrastructure.

Barriers for Special Populations and Access to Care

21. What barriers exist in the community and in the clinic that prevent the people in special populations from receiving services?

Several barriers exist both in the community and within the clinic that hinder special populations from receiving needed services:

Community Barriers:

- **Transportation Challenges:** Limited access to reliable transportation, especially in rural areas, makes it difficult for clients to attend appointments.
- **Financial Constraints:** High costs of medications, services, and lack of insurance coverage prevent many from seeking care.
- **Stigma and Cultural Factors:** Fear of judgment, distrust of healthcare systems, and cultural misunderstandings discourage engagement in services.
- **Limited Awareness:** Many individuals do not know where or how to access available behavioral health or support services.
- **Housing Instability:** Homelessness or unstable housing complicates consistent treatment adherence and follow-up.
- **Language and Communication:** Lack of linguistically and culturally appropriate services creates barriers for non-English speakers or those with limited literacy.

Clinic Barriers:

- **Workforce Shortages:** Difficulty recruiting and retaining qualified staff limits service availability and timely access.
- **Appointment Availability:** Long wait times and limited appointment slots reduce timely access to care.
- **Technological Limitations:** Insufficient telehealth capacity or slow internet access impacts service delivery, especially for remote clients.
- **Coordination Gaps:** Challenges in connecting patients to specialty care or wraparound services limit comprehensive care.
- **Physical Accessibility:** Facilities may not be fully accessible to individuals with disabilities.

22. What barriers exist to culturally and linguistically competent care such as: systems of care not designed for diverse populations, poor communication, fear and mistrust, stigma, or lack of diversity in the clinic's work force?

Several barriers hinder the delivery of culturally and linguistically competent care:

- **Systems Not Designed for Diversity:** Many care systems are structured around a "one-size-fits-all" model that does not adequately address the unique cultural, linguistic, or social needs of diverse populations.
- **Poor Communication:** Language differences, lack of interpreter services, and limited health literacy contribute to misunderstandings and ineffective care.
- **Fear and Mistrust:** Historical injustices and negative experiences with healthcare or social services create distrust, leading some individuals to avoid or delay seeking care.
- **Stigma:** Cultural stigma around mental health and substance use can prevent open discussion and willingness to engage in services.
- **Lack of Workforce Diversity:** Insufficient representation of diverse racial, ethnic, and cultural backgrounds among staff limits culturally relevant care and the ability to build trust with patients.
- **Inadequate Training:** Staff may lack ongoing training in cultural humility, trauma-informed care, and language access, reducing their ability to meet patients' needs fully.
- **Limited Community Engagement:** Insufficient partnerships with community leaders and organizations from diverse groups restrict outreach and understanding of population-specific barriers.

23. What languages and cultures are represented in the local community and not present in the clinic in terms of staff representing those populations, printed materials interpreters and interior that also address limited English proficiency and or other communication needs?

The local community includes diverse languages and cultures that are currently underrepresented in clinic staffing and resources:

Languages:

- Spanish is the most common non-English language spoken in the community.
- Other languages include Vietnamese, Arabic, and various Indigenous languages, though in smaller numbers.
- Limited availability of bilingual or multilingual staff and professional interpreters for these languages impacts communication and care quality.
- Printed materials and signage are predominantly in English, with only some resources translated into Spanish. Other languages lack accessible printed or digital materials.

Cultures:

- The community includes Hispanic/Latino, Southeast Asian, Middle Eastern, and Indigenous cultural groups.
- Cultural representation among clinical and support staff is limited, reducing culturally relevant care and rapport.
- Traditional cultural practices and health beliefs of these groups are not always integrated into care planning or outreach efforts.

Communication Needs:

- Limited English proficiency clients face barriers due to insufficient interpreter services and translated materials.

- The clinic has minimal use of assistive communication devices or services for people with hearing, vision, or cognitive impairments.
- There is a need for enhanced training and infrastructure to accommodate diverse communication preferences and needs.

24. What barriers exist in the community and in the clinic that prevent behavioral health services for members of the U.S. Armed Forces and Veterans?

Barriers to behavioral health services for members of the U.S. Armed Forces and Veterans, both in the community and within the clinic, include:

Community Barriers:

- **Stigma and Cultural Norms:** Military culture often emphasizes self-reliance and toughness, leading many veterans to avoid seeking mental health support due to stigma or fear of appearing "weak."
- **Lack of Awareness:** Veterans may not know about available behavioral health resources or how to access them outside the VA system.
- **Geographic and Transportation Challenges:** Rural or underserved areas may lack nearby veteran-specific behavioral health services or have limited transportation options.
- **Complex Eligibility and Benefits Navigation:** Difficulty understanding and navigating VA benefits and eligibility can delay or prevent timely access to care.
- **Fragmented Services:** Limited coordination between VA and community providers can lead to gaps in care or duplication of services.

Clinic Barriers:

- **Limited Veteran-Specific Training:** Clinic staff may lack specialized training in military culture and the unique behavioral health needs of veterans, such as PTSD and traumatic brain injury.
- **Insufficient Coordination with VA:** Lack of formal partnerships or data-sharing agreements with VA facilities can hinder continuity of care.
- **Resource Constraints:** Clinics may have limited capacity or funding to offer veteran-tailored programs or outreach.
- **Cultural Competency Gaps:** The clinic workforce may lack diversity and cultural competency to effectively engage veterans from diverse backgrounds.
- **Trust Issues:** Veterans may mistrust civilian healthcare systems due to previous negative experiences or concerns about confidentiality.

25. What barriers exist in the community and in the clinic that prevent behavioral health services for deaf and hard of hearing individuals?

Barriers that prevent behavioral health services for deaf and hard of hearing individuals, both in the community and clinic settings, include:

Community Barriers:

- **Limited Access to Qualified Interpreters:** There is often a shortage of skilled American Sign Language (ASL) interpreters or communication specialists familiar with behavioral health

terminology. We contract with ADMH's Office of Deaf Services to provide interpreter services, but they do not provide 24/7 access to their interpreters.

- **Lack of Awareness:** Deaf and hard of hearing individuals may not be aware of available behavioral health resources or how to access services that accommodate their communication needs.
- **Social Isolation:** Communication barriers contribute to isolation, which can exacerbate behavioral health challenges and reduce help-seeking behavior.
- **Stigma:** Cultural stigma around mental health within the deaf community may discourage individuals from seeking services.

Clinic Barriers:

- **Insufficient Staff Training:** Behavioral health providers may lack training in deaf culture, communication preferences, and the unique needs of deaf and hard of hearing clients.
- **Inadequate Communication Accommodations:** Clinics may not consistently provide or arrange for ASL interpreters, captioning, or assistive technologies during sessions.
- **Lack of Deaf-Competent Providers:** Few clinicians are fluent in ASL or specifically trained to work with deaf clients, limiting access to culturally competent care.
- **Physical Accessibility Issues:** Clinics may lack visual alert systems or accessible communication devices in waiting rooms and treatment areas.
- **Trust and Comfort:** Communication barriers and unfamiliarity with deaf culture can cause discomfort or mistrust, leading to underutilization of services.

26. What governance structures at the prospective CCBHC prevent the communities identified as special populations from receiving services in the clinic?

As an Alabama 310 mental health center operating under the Certified Community Behavioral Health Clinic (CCBHC) model, our governance structures are designed to promote equitable access and prevent barriers to care. There are no formal governance policies or practices in place that prevent the communities identified as special populations from receiving services at our clinic.

Our board and leadership team prioritize inclusivity and compliance with all federal, state, and local regulations, including nondiscrimination policies and provisions for culturally and linguistically appropriate services. We actively work to remove systemic barriers through community outreach, staff training, and service adaptations to meet the diverse needs of our service area.

Any challenges in access typically relate to external factors such as transportation, insurance coverage, or social determinants of health, rather than governance limitations. We remain committed to continuous evaluation and improvement to ensure that all special populations have meaningful access to our services.

27. What is the transportation needs of the communities identified as special populations?

- **Reliable and Affordable Options:** Many individuals in special populations—such as low-income households, elderly, people with disabilities, veterans, and those experiencing

homelessness—require dependable, low-cost transportation to access healthcare, employment, education, and social services.

- **Accessible Vehicles and Services:** People with physical disabilities need wheelchair-accessible vans, paratransit services, or other specialized transport options.
- **Flexible Scheduling and Routes:** Populations such as those with irregular work hours, medical appointments, or caregiving responsibilities benefit from flexible transit schedules and on-demand or door-to-door services.
- **Transportation to Behavioral Health and Crisis Services:** Access to urgent care, outpatient clinics, crisis centers, and pharmacies is critical, especially for individuals managing mental health or substance use disorders.
- **Long-Distance Travel Support:** Some special populations, particularly those in rural or remote areas, face challenges traveling longer distances to regional specialty care or VA facilities.
- **Assistance with Coordination:** Support navigating public transit, ride-share programs, or obtaining transportation vouchers helps reduce missed appointments.

28. What does transportation look like? What are the transportation resources (vouchers, etc.)?

Our center recognizes transportation as a critical barrier. To address this, we offer the following:

- **Transportation Assistance:** We provide or coordinate rides for patients to and from appointments, especially for those lacking personal vehicles or access to public transit.
- **Partnerships:** We collaborate with local transportation providers, such as Covington Area Transit System (CATS), to help connect patients with transportation resources.
- **Flexible Scheduling:** Appointment times are arranged to accommodate available transportation options whenever possible, reducing missed visits.
- **Outreach for Hard-to-Reach Populations:** For individuals in shelters, rural areas, or without reliable transportation, we offer mobile crisis and outreach services to ensure access to care.

29. What are the educational needs of students, specifically as it relates to special education?

At our center, we recognize that students with special education needs require comprehensive support to thrive academically and socially. We provide:

- **Behavioral Health Screenings and Assessments:** Early identification of mental health, developmental, and behavioral challenges that affect learning.
- **Brief Interventions and Referrals:** Timely, school-coordinated support and connections to specialized services as needed.
- **Collaboration with Schools and Families:** We work closely with educators, families, and caregivers to develop coordinated care plans that support students' educational and behavioral health goals.
- **Support for Transition Planning:** Assistance with planning for successful transitions from school to employment, higher education, or independent living.
- **Training and Resources:** Offering training to school staff and caregivers on strategies to support students with special needs, promoting a trauma-informed and inclusive approach.

30.A) What are the demographics of the LBGTQ+ individuals in your community?

Our community includes a diverse LGBTQ+ population across all age groups, ethnicities, and socioeconomic backgrounds. While exact numbers are difficult to determine due to underreporting and privacy concerns, national estimates suggest that approximately 4.5% of adults in the U.S. and 3.1% of adults in Alabama identify as LGBTQ+.[46]

Locally, we recognize the presence of LGBTQ+ youth, adults, and older adults who may face unique behavioral health challenges related to stigma, discrimination, and access to culturally competent care. We strive to collect voluntary self-identification data to better understand and serve this population, ensuring that services are inclusive, affirming, and tailored to meet their needs.

30. B) What are the community supports for LBGTQ+ individuals in your community?

Our community offers a growing network of supports aimed at meeting the unique needs of LGBTQ+ individuals. These include:

- **Mental Health and Behavioral Health Providers:** Some with specific training and cultural competency in LGBTQ+ issues.
- **School and Youth Programs:** Initiatives promoting acceptance and anti-bullying programs.
- **Online Resources:** Virtual support groups and educational platforms accessible to those who may lack local in-person options.

31. What are your technological needs or concerns related to becoming a CCBHC?

Please see #20 above.

32. Are Interpreter (i.e., translation, American Sign Language) services offered at your agency? If so, please describe.

[X] *Yes. If so, please describe.*
[ ] *b. No*

Our agency offers interpreter services to ensure effective communication and culturally competent care for all clients. These services include:

- **Language Translation:** Access to professional interpreters for a wide range of languages, available in-person, by phone, or via video remote interpreting.
- **American Sign Language (ASL) Interpretation:** Qualified ASL interpreters are provided for deaf and hard-of-hearing clients to facilitate full participation in assessments, treatment, and other services.
- **Accessibility Accommodations:** For clients with hearing impairments or limited English proficiency, we use assistive technologies and collaborate with certified interpreting agencies to meet individual needs.
- **Staff Training:** Our staff are trained to recognize when interpreter services are needed and how to effectively utilize these resources to support client communication.

33. A) What are the current times/days that services are available through the organization?

Our organization offers services on the following schedule to best meet community needs:

[46] UCLA Williams Institute. January 2019. "LGBT Demographics Data Interactive: Alabama" and "LGBT Demographics Data Interactive: USA." Retrieved on March 5, 2024 from https://williamsinstitute.law.ucla.edu/visualization/lgbt-stats/?topic=LGBT&area=1#about-the-data and https://williamsinstitute.law.ucla.edu/visualization/lgbt-stats/?topic=LGBT#density

- **Monday:** 12:00 AM – 4:00 PM
- **Tuesday – Friday:** 24 Hours
- **Saturday:** 2:00 PM – 10:00 PM
- **Sunday:** Closed

Additionally, our crisis services, including the helpline, operate around the clock, every day of the week. Mobile Crisis Response is available 24/7 in Covington County and 8:00 AM – 12:00 PM in Butler, Coffee, and Crenshaw counties.

Appointment scheduling is flexible, and walk-in appointments are available four days a week to accommodate urgent, emergent, and routine care needs, with telehealth options offered during regular business hours and crisis support available 24/7.

33. B) What additional times and days are needed to meet the needs of the communities identified as special populations?

To better serve our special populations, expanding service availability during evenings, weekends, and holidays would be beneficial.

34. What is the care coordination needs of the communities identified as special populations?

The communities identified as special populations require comprehensive, culturally responsive care coordination to navigate complex health and social service systems. Key needs include:

- **Enhanced communication and collaboration** between behavioral health, primary care, social services, schools, and justice systems to provide seamless, integrated care.
- **Assistance with referrals, appointment scheduling, and transportation** to reduce barriers to accessing services.
- **Support for social determinants of health**, such as housing, food security, and employment, which impact health outcomes.
- **Family and caregiver involvement** in treatment planning, especially for youth and older adults.
- **Targeted outreach and engagement** to build trust with underserved populations, including veterans, individuals experiencing homelessness, and people involved in the justice system.
- **Use of peer support specialists and community health workers** to enhance engagement and provide culturally relevant support.

35. Which external organizations currently exist in the community that are meeting the needs of the communities identified as special populations?

- **South Central Alabama Mental Health Board (SCAMHB):** Provides comprehensive behavioral health and substance use services for adults, children, and youth. Specialized services include peer support, mobile crisis, and urgent care.
- **Department of Human Resources (DHR)**: Leads child protective services and coordinates care for families in crisis.
- **Local School Districts & School-Based Counselors:** Provide behavioral health referrals and crisis intervention for students with emotional and behavioral needs.
- **Southeast Alabama Rural Health Associates (SARHA):** SARHA operates several Federally Qualified Health Centers (FQHCs) across the region, including in Coffee and Crenshaw counties. These centers deliver comprehensive primary care, pediatric care, and preventive

services with integrated behavioral health in select locations. SARHA serves all patients regardless of ability to pay and is a trusted partner in care coordination for individuals with complex medical and social needs.

- **Mizell Memorial Hospital (Opp, AL):** Mizell provides essential medical care, including emergency services, primary care, senior care, and specialty referrals for underserved and rural residents in Covington County. The hospital also operates a Rural Health Clinic (RHC) that offers family medicine services on a sliding fee scale, making care more accessible for lower-income and uninsured populations.
- **Regional Medical Center of Central Alabama (RMCCA) (Greenville, AL):** RMCCA is a community healthcare provider with a 72-bed facility offering comprehensive inpatient, outpatient, medical, and surgical care. As a Regional Medical Hospital, RMCCA includes specialized services such as a detoxification unit and a senior care unit.

36. In what ways do you partner with the community to design, implement and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness?

Our organization actively partners with the community to design, implement, and evaluate policies and services that reflect the cultural and linguistic needs of the populations we serve. Key strategies include:

- **Advisory Committees & Surveys:** We engage diverse voices through advisory councils and consumer feedback sessions, and we use client satisfaction and community needs surveys—disaggregated by age, race/ethnicity, language, and veteran status—to shape policy and practice.
- **Language Access:** We maintain contracts with professional translation and interpretation services, including ASL and Spanish, and use bilingual staff where possible. Written materials are translated, and screening tools can be administered in multiple formats to meet literacy, language, and sensory needs.
- **Staff Training:** We provide ongoing cultural competency training for staff, including modules on trauma-informed care, health equity, and working with special populations (e.g., veterans, LGBTQ+ individuals, and non-English speakers).
- **Feedback and Continuous Improvement:** Input from clients, families, and partners is incorporated into program planning and review. We use this data to revise internal policies and staff protocols to improve accessibility and responsiveness.

37. A) How could the prospective CCBHC develop care coordination agreements or partnerships with existing external providers?

- **Memorandums of Understanding (MOUs):** Establish MOUs with hospitals, FQHCs, schools, child welfare agencies, law enforcement, and other social service providers to define roles, responsibilities, and referral processes.
- **Integrated Referral Pathways:** Create shared workflows for warm hand-offs, release-of-information protocols, and feedback loops to ensure timely coordination of care and service continuity.
- **Joint Case Staffing & Multidisciplinary Teams:** Facilitate regular case conferences and joint planning meetings with external partners to support complex cases and whole-person care.
- **Cross-Training Opportunities:** Offer joint training sessions on trauma-informed care, cultural responsiveness, and system navigation to align service philosophies and build mutual understanding.

- **Centralized Points of Contact:** Assign dedicated care coordinators or liaisons for partner agencies to streamline communication and support coordinated service delivery.
- **Shared Outcomes and Data Sharing (as appropriate):** With appropriate releases, collaborate on outcome tracking and reporting for shared clients to enhance accountability and care quality.

37. B) How could those organizations provide referrals to the prospective CCBHC?

- **Dedicated Referral Forms & Portals:** Partner agencies will be provided with standardized referral forms and access to a secure electronic referral system (via fax, email, or shared platform).
- **Warm Handoff Protocols:** Referrals may occur in real time through warm handoffs—either by phone or in person—ensuring a seamless connection between the referring provider and CCBHC intake staff.
- **Designated Points of Contact:** Each partner agency will have a designated CCBHC contact person to streamline communication, answer questions, and follow up on referrals.
- **24/7 Crisis Line Access:** Agencies can refer individuals in urgent need directly to our 24/7 helpline or mobile crisis team for immediate evaluation and intervention.
- **Onsite Presence & Outreach:** For schools, courts, shelters, and other key settings, CCBHC staff may be available for onsite support, consultation, or direct service delivery, facilitating immediate referral when appropriate.
- **Community Education and Training:** We will provide ongoing training to partner agencies on identifying behavioral health needs and understanding the referral process, including eligibility criteria, documentation, and follow-up procedures.

38. What are the identified gaps in service to meet the needs of the community within the communities identified as special populations?

Several service gaps have been identified that impact the ability to fully meet the needs of communities identified as special populations—including individuals experiencing homelessness, veterans, people with disabilities, children with special education needs, individuals involved in the justice system, and rural, lower-income populations. These gaps include:

- **Limited Transportation Access:** Many individuals in rural or economically disadvantaged areas lack reliable transportation to access behavioral health services, especially outside of standard hours.
- **Lack of After-Hours and Weekend Availability:** Extended hours are needed to accommodate working families, youth in school, and individuals with non-traditional schedules.
- **Insufficient Crisis Stabilization Options:** While mobile crisis services exist, there is limited availability of local 24/7 walk-in or short-term residential crisis care, especially for youth and individuals with co-occurring disorders.
- **Low Availability of Specialized Services:**
    - Veterans may have to travel significant distances to access VA-specific behavioral health care.
    - There is a lack of culturally competent services for minority groups, including tribal or linguistically diverse populations.

    - Limited local providers offer specialized care for individuals with co-occurring intellectual/developmental disabilities (IDD) and mental health needs.
- **Insufficient Housing Support Services:** For individuals in homeless shelters or at risk of homelessness, there are too few transitional or supportive housing programs with integrated behavioral health support.
- **Underdeveloped Data Sharing and Coordination:** Many agencies and sectors lack formalized systems to share referral information or co-manage care, creating fragmented service delivery.

39. What are the critical gaps preventing individuals from gaining access to services? What is your possible plan to address this? Which are essential to change? (This is different from listing the gaps in service in the previous question.)

Critical gaps preventing individuals from gaining access to service include:

- **Transportation Barriers:** Many individuals—especially in rural areas—lack access to reliable transportation, preventing them from attending appointments or receiving care consistently.
- **Workforce Shortages:** Difficulty recruiting and retaining qualified behavioral health staff limits service availability and increases wait times, particularly for specialized services (e.g., child psychiatry, substance use treatment, bilingual providers).
- **Lack of Awareness and Misinformation:** Community members often don't know what services are available or how to access them. Some individuals distrust providers or don't believe services will help.
- **Technology and Broadband Gaps:** Limited internet access in some parts of the service area makes telehealth inaccessible, particularly for lower-income or elderly populations.
- **Stigma and Cultural Mistrust:** Fear, stigma, and mistrust of behavioral health systems—especially among veterans, minority groups, and justice-involved individuals—reduce help-seeking behavior.
- **Inadequate Crisis and 24/7 Service Coverage:** While crisis services are expanding, not all areas have access to same-day care or after-hours support, leading to unnecessary ER visits or law enforcement involvement.

Planned strategies to address these gaps include:

- **Expand Mobile and Telehealth Services** to reach people where they are, including via MyCare tablets and improved access to crisis response in the home and community.
- **Strengthen Transportation Support** by pursuing grant funding (e.g., 5310) to add vehicles and partnering with local transit agencies.
- **Enhance Workforce Recruitment and Retention** through career development programs, student internships, flexible scheduling, and retention incentives.
- **Launch Outreach and Public Awareness Campaigns** to reduce stigma, increase visibility of services, and improve understanding of how and when to seek care.
- **Invest in Peer Support Expansion** to provide culturally responsive care and increase trust through lived-experience navigation.
- **Formalize Cross-System Partnerships** to strengthen referral pathways, streamline care transitions, and better serve high-need populations (e.g., schools, courts, shelters, VA).

Essential changes include improving transportation, expanding workforce capacity, and reducing stigma through community engagement. These efforts are essential to ensuring consistent and timely access to care for all individuals in our service area.

40. A) What services need to be added to the clinic? Or how does the intensity, frequency or duration of existing services need to change to meet the needs of the communities identified as special populations?

To better meet the needs of communities identified as special populations—such as veterans, justice-involved individuals, people experiencing homelessness, and children with special education needs, several key service additions and modifications are needed.

Services that need to be added include:

- **Expansion of Community Health Worker Services:** To ensure a seamless connection between the referring provider and CMHC intake staff.
- **Peer Support Services:** Expanding Certified Peer Specialists would improve engagement and outcomes for individuals and families with children receiving services.
- **Expanded School-Based Services:** Additional staff are needed to provide on-site counseling, early intervention, and case coordination in local schools, especially for students with behavioral or developmental concerns.
- **Short-Term Crisis Residential Beds:** A local crisis stabilization bed option would reduce ER visits and law enforcement holds for individuals experiencing behavioral health crises.
- **Specialty Services for Veterans and Military Families:** Veterans need increased access to culturally competent care that recognizes military-specific trauma. Adding staff with military backgrounds, implementing culturally appropriate training, and/or establishing a veteran-specific clinic day would help meet this need.
- **Dedicated Homeless Outreach and Housing Navigation:** A formal housing-focused outreach team would help connect individuals in shelters or unstable housing to behavioral health care and community-based supports.

Needed changes to intensity, frequency, or duration of existing services include:

- **Increase After-Hours and Weekend Availability:** Services should be available during evenings and weekends to accommodate families, students, and individuals working traditional hours.
- **More Frequent Contact for High-Risk Individuals:** Clients with co-occurring disorders, recent incarceration, or housing instability would benefit from increased care coordination and more frequent check-ins.
- **Longer Duration of Support for Complex Cases:** Clients with chronic mental illness or multiple social needs (e.g., housing, food insecurity) often require longer engagement periods to ensure stabilization and follow-through.

41. Which treatment modalities and evidence-based practices will the clinic commit to offering (including Motivational Interviewing, Cognitive Behavior Therapy and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)?

Our clinic is committed to providing a comprehensive range of evidence-based practices (EBPs) tailored to meet the diverse needs of the populations we serve. The following treatment modalities are currently offered or planned for implementation:

- Motivational Interviewing (MI)

- Cognitive Behavioral Therapy (CBT)
- Integrated Treatment for Co-Occurring Disorders
- Medications for Addiction Treatment (MAT)
- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
- Peer and Family Support
- Evidence Based Supportive Housing

We provide in-house and external training to ensure staff are equipped to deliver EBPs with fidelity. Regular supervision, consultation, and outcome monitoring are used to maintain quality and effectiveness across all modalities.

42. How will your staffing plan address your community needs findings?

Our staffing plan is designed to directly respond to the specific needs identified in our community assessment, ensuring we have the right mix of qualified professionals to deliver comprehensive, culturally competent, and accessible care. Key elements include:

- **Expand Behavioral Health Workforce:** Increase hiring of licensed clinicians skilled in evidence-based practices for mental health and substance use disorders, including specialists in trauma-informed care and co-occurring conditions.
- **Enhance Peer Support Services:** Recruit and train additional Certified Peer Specialists, including those with lived experience in youth services, justice involvement, and veteran care, to improve engagement and recovery support.
- **Targeted Roles for Special Populations:** Add staff with expertise in veteran services, homeless outreach, and school-based behavioral health to provide tailored, population-specific care coordination and clinical support.
- **Multidisciplinary Team Model:** Employ case managers, social workers, nurses, and community health workers to address social determinants such as housing, employment, and transportation, improving whole-person care.
- **Cultural and Linguistic Competency:** Prioritize recruitment of bilingual staff and those with cultural knowledge relevant to our community demographics.
- **Flexible Scheduling:** Staff coverage will include evenings and weekends to meet the needs of working families, youth, and others requiring non-traditional hours.
- **Ongoing Training and Retention:** Invest in continuous professional development, supervision, and staff wellness initiatives to reduce turnover and maintain high-quality care delivery.

43. What training needs surfaced in the Needs Assessment will be in the training plan?

The community needs assessment highlighted several key training priorities to ensure staff are equipped to meet client needs effectively and provide high-quality, culturally competent care. Our training plan will address the following areas:

- Trauma-Informed Care (TIC)
- Cultural and Linguistic Competency
- Evidence-Based Practices (EBPs)
- Crisis Intervention and De-escalation
- Care Coordination and Collaborative Practices
- Use of Screening Tools and Outcome Measurement

- Special Population Needs
- Telehealth Delivery

44. What is needed in order to provide culturally and linguistically competent care, including for those with sight, hearing, or cognitive impairments?

To provide culturally and linguistically competent care—including for individuals with sight, hearing, or cognitive impairments—an organization needs the following:

- **Diverse and Trained Workforce:** Hire and retain staff who reflect the cultural and linguistic makeup of the community. Provide ongoing training on cultural humility, implicit bias, and effective communication strategies.
- **Language Access Services:** Offer professional interpretation and translation services in multiple languages, including American Sign Language (ASL) for deaf or hard-of-hearing individuals. Ensure written materials are available in languages spoken by the population served.
- **Accessible Communication Methods:** Provide alternative formats for individuals with vision impairments, such as large print, braille, or audio recordings. Use assistive technologies and communication aids tailored to cognitive or sensory disabilities.
- **Tailored Assessment and Treatment:** Adapt screening tools, evaluations, and interventions to be culturally sensitive and accessible to persons with disabilities, ensuring informed consent and comprehension.
- **Physical Accessibility:** Ensure facilities comply with ADA standards—ramps, signage, lighting, and quiet spaces—to accommodate individuals with mobility or sensory challenges.
- **Patient-Centered Approach:** Involve patients and families in care planning, respecting cultural values, preferences, and needs related to communication and decision-making.
- **Collaboration with Community Resources:** Partner with organizations specializing in disability services, cultural groups, and language access to strengthen support networks.
- **Ongoing Quality Improvement:** Regularly assess and address barriers to culturally and linguistically competent care, incorporating feedback from patients with diverse needs.

45. How will these unmet needs and barriers to service influence location choices, hours of operation, and the overall look and feel of the public areas of the clinic?

The identified unmet needs and barriers will significantly shape our clinic's location, hours, and environment to improve access and patient experience:

- **Location Choices:** We will prioritize sites that are centrally located or easily reachable by public transportation to reduce travel barriers, especially for those without vehicles. Proximity to community hubs such as schools, social service agencies, and public transit stops will be key. Consideration will also be given to areas with higher populations of underserved or special populations to enhance accessibility.
- **Hours of Operation:** To accommodate individuals facing scheduling conflicts, inconvenient appointment times, or transportation challenges, we will offer extended hours, including evenings and weekends. This flexibility helps serve working adults, students, and caregivers who might otherwise forgo care.
- **Clinic Design and Public Areas:** The clinic environment will be welcoming, culturally sensitive, and trauma-informed to reduce fear, stigma, and mistrust. Clear signage in multiple languages and accessible formats, when available and applicable, will assist

navigation. Comfortable, private waiting areas will respect confidentiality and reduce anxiety. The design will incorporate accessibility features for mobility, vision, and hearing impairments. Warm colors, natural light, and art reflecting community diversity will create a sense of belonging and safety.

46. What needs must be met to advance and sustain organizational governance and leadership that promotes health equity through policy, practices, and allocated resources?

To advance and sustain organizational governance and leadership that promote health equity, the following needs must be met:

- **Diverse and Inclusive Leadership:** Boards and leadership teams should reflect the diversity of the communities served, including race, ethnicity, gender, socioeconomic status, and lived experience, to bring varied perspectives and cultural insights.
- **Equity-Focused Training and Education:** Ongoing training for leadership and staff on systemic inequities, implicit bias, cultural humility, and anti-racism is critical to inform equitable policies and practices.
- **Transparent and Accountable Governance Structures:** Establish mechanisms for regular equity assessments, including data review and community feedback, to monitor progress and hold leadership accountable for health equity goals.
- **Community Engagement and Partnerships:** Governance should actively involve community members—especially those from underserved or marginalized groups—in advisory roles and decision-making processes to ensure policies meet real needs.
- **Data-Driven Decision Making:** Implement robust data collection and analysis systems to identify inequities, evaluate interventions, and inform continuous improvement with an equity lens.
- **Supportive Organizational Culture:** Foster a culture that values diversity, equity, and inclusion through recognition, communication, and policies that promote staff well-being and equitable opportunities.

47. Describe your plans to update the community needs assessment at minimum every three years?

We plan to update the community needs assessment (CNA) at least every three years to ensure our services remain responsive to evolving community needs. This process will include:

- **Data Collection:** Gathering updated demographic, health, and social determinants data from multiple sources such as public health databases, local agencies, and community surveys.
- **Stakeholder Engagement:** Conducting focus groups, interviews, and/or surveys with community members, clients, providers, and partner organizations to capture diverse perspectives and emerging issues.
- **Analysis:** Reviewing trends, gaps, and new challenges to identify priority areas for service planning and resource allocation.
- **Reporting and Dissemination:** Sharing findings with stakeholders, advisory boards, and the community to maintain transparency and foster collaboration.
- **Integration into Planning:** Using the updated CNA to inform strategic planning, grant applications, and program development to improve health outcomes.

Prospective Payment Questions

48. What service offerings are currently operating at a loss through the FFS payment model?

- Developmental Disabilities (DD) Services
- First Step Adult High Intensity Residential Treatment for Adult Males
- Urgent Care Services, including:
    - Mobile Crisis Teams (MCT)
    - Psychiatric Urgent Care
- Adult Mental Illness (MI) Outpatient Services
- Forensic Services (losses vary depending on the level of medical care required)

49. Which positions within your agency are primarily grant funded?

- Grant Program Coordinators/Managers
- Community Health Workers
- Nurses
- Prevention Specialists
- Outreach and Education Staff
- Data Analysts/Evaluation Specialists
- Peer Support Specialists
- Project-specific Clinicians or Case Managers
- Administrative Support for Grant Programs
- Psychiatrist
- CR-NP
- Data Evaluators

50. Please list positions that could benefit from PPS structure (i.e., school liaison, criminal justice liaison, suicide coordinator)?

Positions that could benefit from a Prospective Payment System (PPS) structure include:

- School Liaison
- Criminal Justice Liaison
- Suicide Prevention Coordinator
- Child and Adolescent Services Assistant Director
- Community Health Workers
- Case Managers
- Peer Support Specialists
- Mobile Crisis Team Coordinator/Responders
- Outreach and Engagement Specialists
- Veterans Services Coordinators
- Data and Quality Improvement Specialists
- Psychiatrists
- Psychiatric Nurses
- Child Psychiatrists
- Licensed Marriage and Family Therapists

51. In regard to school-aged justice involving youth, please provide confirmation that you have spoken with the appropriate stakeholders (i.e., schools, DHR, jails, courts, etc.) in your communities about services for these individuals.

We have engaged with key stakeholders in our communities regarding services for school-aged youth involved in the justice system. This includes regular communication and collaboration with local schools, the Department of Human Resources (DHR), law enforcement agencies, juvenile detention centers, courts, and probation/parole offices. These partnerships ensure coordinated referrals, shared care planning, and tailored behavioral health support for youth at risk or involved with the justice system. We will continue to maintain and strengthen these relationships to improve service access and outcomes for this population.

52. Are there any programs/services (i.e., Substance Use Prevention Programs, Stepping Up, Juvenile Justice, School-based Mental Health, Women's Specialty Services, Infant & Early Childhood Mental Health Consultation programs, etc.) that your CMHC currently offer that is not Medicaid reimbursable?

[X] *Yes. If so, please list below.*
[ ] *b. No*

- Substance Use Prevention Programs
- Stepping Up Initiatives

53. Identify other services currently not reimbursed by Medicaid that your consumer population could benefit from.

- Housing Support Services
- Early Childhood Mental Health Services
- Educational and Vocational Support
- Family Support and Caregiver Training
- Telehealth Access Support

54. Identify any ancillary service (i.e., housing support, welfare services) that would be necessary to providing the service(s) identified above.

- Housing Support Services
- Transportation Services
- Welfare and Social Services
- Employment and Education Services
- Childcare Services
- Legal and Advocacy Services
- Cultural and Linguistic Support
- Technology Access
- Dental Services
- Integrated Care