

Nebraska Division of Behavioral Health  
**State Advisory Committee on Mental Health Services**

August 7, 2012 / 9:00 am – 4:00 pm  
Lincoln, NE – Country Inn & Suites

Meeting Minutes

**I. Call to order and roll call** *Jim Harvey*

Jim Harvey, Division of Behavioral Health Committee Facilitator, welcomed committee members, and others present, to the meeting. Chairperson Bev Ferguson, State Advisory Committee on Mental Health Services, called the meeting to order at 9:03 am, on Tuesday, August 7, 2012. Roll call was conducted and a quorum was determined. Jim Harvey asked new committee members to introduce themselves.

**II. Housekeeping and summary of agenda** *Jim Harvey*

Jim Harvey confirmed the order of the agenda and described housekeeping logistics.

**III. Approval of minutes** *Bev Ferguson*

Chairperson Bev Ferguson requested a motion to approve the minutes. Motion was made by Cameron White and seconded by Sheri Dawson to approve the May 3, 2012 minutes of the Joint Meeting of the State Advisory Committee on Mental Health Services, the State Advisory Committee on Substance Abuse Services, and the State Committee on Problem Gambling. The motion was carried by general consent.

**IV. Public comment**

- a) Alan Green, Executive Director of the Mental Health Association of Nebraska, stated that peer support is serious business and he recommends the committee work with the Office of Consumer Affairs to ensure the work of peers is on par with other service provision. Peers should not be forced to donate their time in supporting other peers. An individual receives stringent training to work in peer support. Peers support peers in many aspects of their lives. Peer support is proven to be cost effective and efficient.
- b) Jonah Deppe, representing the National Alliance on Mental Illness (NAMI), made the committee aware of the Grassroots Advocacy Training sponsored by NAMI. Jonah handed out a brochure with information about the training content and how to schedule training. (Attachment A)

**V. DBH Committees – Feedback Survey Results** *Cody R. Meyer*

(Attachment B)

Cody R. Meyer is a Statistical Analyst with the Data Section of the DHHS-Division of Behavioral Health. Cody thanked the committee for participating in the 2012 Advisory Committee Survey. The results of the survey were reviewed. Overall, positive responses were received. The Division of Behavioral Health values the committee comments, and will continue to review them and take appropriate action. The committee suggested the survey be conducted annually.

Committee comments included: An exit interview with similar questions be conducted when members leave the committee.

**VI. Update on EBP Workgroup** *Blaine Shaffer*

(Attachment C)

Blaine Shaffer is the Chief Clinical Officer with the DHHS-Division of Behavioral Health. He provided a brief update on the work of the Evidence Based Practices (EBP) Workgroup. The federal Community Mental Health Services Block Grant requires recipients to report on the services offered, actual services

paid, and the fidelity of those services. The purpose of the workgroup is primarily to develop and clarify a process by which fidelity of behavioral health services is monitored. The information received from fidelity monitoring is reported to the federal government as part of Block Grant fund monitoring. Fidelity monitoring is necessary to ensure the State is getting the necessary services outcomes for the funding received. Quality Improvement practices are implemented to ensure providers are utilizing EBP effectively and efficiently.

#### **VII. DBH Strategic Plan and Issues from NASMHPD**

*Scot Adams*

Scot Adams is the Director of the DHHS-Division of Behavioral Health. The Division of Behavioral Health Strategic Plan was purposely timed to end in 2015 so it would overlap with national health care reform. We are one-third of the way through the Strategic Plan period. A questionnaire will be sent to stakeholders for comment; comments will be compiled and posted on the DHHS-DBH website. One of the goals relating to Sex Offenders is currently being addressed as training for providers who treat sex offenders has started. Scot reports that the DHHS-Division of Medicaid and Long-Term Care has issued a Request for Information for an At Risk Managed Care program, and DBH staff will have an opportunity for input. Scot invites comments and feedback on any of these issues as well as on the Strategic Plan as a whole.

Scot reported attending the annual meeting of the National Association of State Mental Health Program Directors (NASMHPD). He reported the primary concern discussed involves the interface of behavioral health with primary care. He reported the idea that “there is no health without behavioral health” is not fully understood by all providers.

Scot discussed the relationship between DBH and the Criminal Justice system stating that the State Criminal Justice system and behavioral health are very inter-twined. A subset of criminal justice and behavioral health is the forensic population. Scot reported that some States are utilizing their State Hospitals solely for the forensic population. The topic of children’s mental health was also discussed at the NASMHPD meeting. No State reported feeling they are doing everything right related to children and families’ mental health needs.

Nebraska is making changes under the leadership of Thomas Pristow, Director of the Division of Children and Family Services (CFS). Oversight committees have been established to monitor the work of CFS. Some Behavioral Health Regions are working closely with the school systems. DBH is working closely with the CFS Service Area staff. Additional legislation will be introduced next year to address children and families.

#### **VIII. Behavioral Health Inmates in the State Correctional System**

*Cameron White*

(Attachment D)

Cameron White is the Behavioral Health Administrator with the Nebraska Department of Correctional Services (DCS). The statistics Cameron reported are taken from information the Mental Health and Substance Use Disorder Intake staff collect during the inmate intake process. The rate of diagnosed mental illness at intake has remained stable over the past five years. DCS utilizes a consistent intake process of evaluating inmates for suicide ideation, medical screening, and a diagnostic interview to determine diagnosis. History reports and self-report are also included in the intake information. The number of inmates with prescribed psychiatric medications is a Point in Time count conducted on June 30 each year. The use of psychiatric medications is in line with national data, however the number of women in the prison system with prescribed psychiatric medications has increased 50% during the data collection period. The number of inmates diagnosed with substance abuse at intake is relatively stable. In 2006, LB1199 created the statutory definition of sexual offenses. A large number of inmates incarcerated for sexual offenses are discharged from DCS each year. There has not been a specific drill down of data to determine if more people have entered the prison system due to discharging from the State Hospital system.

## **IX. Peer Support roles, paid versus not paid - Discussion**

*Carol Coussons de Reyes*

(Attachment E and Attachment F and Attachment G)

Jim Harvey noted this topic will also be discussed at the State Advisory Committee on Substance Abuse Services at their September 6, 2012 meeting. Both committees will have a follow-up discussion together at the Joint Committee meeting in November.

Carol Coussons de Reyes is the Administrator of the Office of Consumer Affairs (OCA). Carol stated that she has concern with “versus”, and suggests there are opportunities for both paid and volunteer peer support work in all behavioral health settings. Carol reported currently, across Nebraska, there are 40 paid Peer Support workers, 92 Certified Peer Support and Wellness Specialists (CPSWS), and at least 105 other paid peer staff.

The peer support staff helps with a variety of issues because there is no one way to recovery for everyone, and varies for each individual according to their need. Paid and not paid should be considered Both/And rather than Either/Or (“black and white” thinking). Volunteers have a role, but they can come and go as they please, whereas paid individuals are held to a standard. Individuals have reported peer support workers have been more helpful than professional therapists, primarily due to lived experience and unconditional regard. Documents are available that compare the similarities and differences between paid and not paid workers. One is a Substance Abuse and Mental Health Services Administration (SAMHSA) document available on their website at:

<http://store.samhsa.gov/product/What-Are-Peer-Recovery-Support-Services-/SMA09-4454>. Living Well (<http://www.livingwellne.org/>) is another resource for achieving a variety of specific health goals. The definitions for Peer-Run and Peer Recovery/Resilience Supports are being developed for Block Grant measures. The definitions have been reviewed and modified by the OCA People’s Council. The difference between Peer-Run and Peer Recovery is that Peer-Run does not have clinical supervision and Peer Recovery may or may not include clinical supervision. Peer support could be billable under Medicaid, State funds could be allocated, and Block Grant funds could be available due to health care reform reallocations.

Committee comments included: Peers have built the recovery model. Peers often have time to sit with an individual where they are at the time in their reality, which decreases cost for higher levels of care and need for unnecessary resources. Concerns about hiring and firing policies have been addressed in some settings with peer support workers being considered as all other employees. Training is available for providers to work with peer support workers to help the peer support workforce to be most effective. Utilizing the Transition to Independence Process (TIP) Model in developing the measures for youth. The criteria “Emphasize Self-Help, Growth, Well-Being, Personal Choice, and Responsibility” should not be optional, but be one of the required criteria. Family organizations across the State utilize clinical consultation, which is not the same as clinical supervision. Counting both services and number of people, and counting both funded staff and community volunteers for Block Grant measures.

DBH will develop a tool to count paid and not paid services, for discussion at the Joint Committee meeting on November 8, 2012.

## **X. Children’s Behavioral Health**

*Vicki Maca*

(Attachment H and Attachment I and Attachment J and Attachment K and Attachment L)

Vicki Maca is the Deputy Director of Protection and Safety with the DHHS-Division of Children and Family Services (CFS). The CFS Service Area staff are County employees and the CFS Division staff are State employees. CFS currently has one contract with Nebraska Families Collaborative (NFC) in Omaha to provide case management for children and families in the foster care system. Several positive changes have been/are being implemented in CFS, including monthly review of data, a process to

monitor performance, putting children and families first, implementing Quality Improvement practices and Trauma Informed practices, which has allowed CFS to move forward in a positive direction. There is still much work to be done, but changes are occurring.

It is imperative that CFS and DBH work closely together so it is clear to families what services are available and how to access them.

Trauma Informed is being implemented because additional trauma is added when children are placed with strangers.

It is a myth that foster care means safe care. The number of State Wards has been reduced, but nationally Nebraska is one of five states with the highest rate of out-of-home placements. CFS is focusing on why children are coming into the system, where are they coming from, and who is bringing them in. It is a myth that DHHS has authority to remove children from their home when in reality Law Enforcement is the only entity with this authority. Families are more involved in decision-making concerning their children. CFS has implemented an assessment tool—Structured Decision Making—to determine if children are safe and UNCOPE—to screen and assess and connect with services. Implementing peer support services in CFS is a resource to teach parenting skills.

#### **XI. SAMHSA Block Grant – review of the Priority Indicators**

*Jim Harvey and DBH staff*

(Attachment M and Attachment N and Attachment O and Attachment P)

--Renee Faber is the DBH Prevention Coordinator. There are three Block Grant measures for Substance Abuse Prevention. The Prevention Strategic Plan is nearing finalization. Nebraska has decreased the sale of tobacco products to minors, reduced the number of Drinking Under the Influence offenses, reduced the number of youth reporting getting into a car with an impaired driver, and decreased marijuana use among youth, but the rate of binge drinking by young adults has increased over the past two years. On the mental health side of behavioral health, prevention is referred to as Mental Health Promotion. Renee noted the following Prevention resources: *Preventing Mental, Emotional, & Behavioral Disorders among People*; National Research Council and the Institute of Medicine, August, 2009. *Clinical Manual of Prevention in Mental Health*; Michael T. Compton, M.D., M.P.H., 2010.

--Sue Adams is the DBH Network Services Administrator. Sue reported on the Block Grant measures related to Transition Age Youth and Young Adult and the Professional Partners Program. Dr. Hewitt B. "Rusty" Clark, Director of the National Network on Youth Transition for Behavioral Health (NNYT) is coming to Nebraska to train on the Transition to Independence (TIP) Model. This information will assist providers to discover new ways to keep young adults engaged in services after they age out of children's behavioral health services. The Professional Partners Program utilizes a wrap-around model to keep children at home and in school. DBH is developing a Fidelity Monitoring tool to measure wrap-around outcomes.

--Sheri Dawson is the DBH Deputy Director of Community Based Services. The DBH Strategic Plan, along with the roadmap of Evidence Based Practices (EBP) developed by the EBP Workgroup, is guiding the development of co-occurring disorders services. Implementation of the COMPASS-EZ tool will determine the level of the dual capability of providers. Dual enhanced providers ensure individuals receive both mental health and substance abuse treatment. Dual capable providers provide mental health or substance abuse as primary service, but assure both needs are addressed. Trauma Informed Care is the expectation, not the exception. Trauma Informed assessments indicate how trauma informed a service is and providers develop quality improvement plans to align with standards.

--Jim Harvey is the DBH Federal Resources Manager. The Block Grant performance indicator and goal is to define what Permanent Supported Housing (PSH) in Nebraska is and to improve services related to PSH. Currently, the Housing Related Assistance (HRA) program is the PSH service. Other options include counting rental subsidy or other Community Support housing services. DBH is focusing only on HRA for Fidelity Monitoring and is utilizing the SAMHSA PSH toolkit. To truly support an individual with housing, the individual should be able to choose where they would like to live.

A summary of the Supported Employment (SE) service definition is included in the DBH draft Rules and Regulations. The challenge is which Fidelity Monitoring tool to use to monitor SE outcomes.

**XII. Community Mental Health Services Block Grant Application for 2013 funds *Jim Harvey/Karen Harker***

(Attachment Q)

Karen Harker is the DBH Fiscal and Federal Resources Administrator. DBH goal is to use Block Grant funds the most cost effectively as possible. Last year, a two-year budget plan was submitted with the combined Substance Abuse Prevention and Treatment and Community Mental Health Services Block Grant Application. Today the Fiscal Year 2013 budget was presented to the committee. The mental health and substance abuse service funds continue to be awarded separately and tracked separately. There is confusion on how Block Grant funds are tracked after funds contracted to Regions. DBH tracks the funds, but reporting to the federal government is more difficult due to specific service definitions. Committee comments included: Request for clarification on block grant funds versus other funding sources.

(DBH Response: The funding information presented today is part of the Fiscal Year 2013 Budget Plan. DBH purchases services with Block Grant funds through contracts with the Regions who sub-contract with service providers. DBH monitors the expenditure of these funds, which are reported in a separate report at a later date.)

**XIII. Public comment**

- a) Jonah Deppe, with the National Alliance on Mental Illness (NAMI), commented that Peer Specialists are very important to the recovery process. Part of the recovery process for peers is having a paid job as the first step back to the workforce. Both paid peer support and volunteer work should be recognized as important.
- b) Alan Green, Executive Director of the Mental Health Association of Nebraska, thanked the committee members for commenting on the survey that the public comment component of the meetings is beneficial. The Behavioral Health conference held in May was successful with 450 people in attendance and revenues increased by 30%. A consumer from British Columbia is running around the world to raise awareness of behavioral health and will be in Lincoln on August 30. Be aware that people are emerging who have been traumatized during treatment which creates a unique circumstance for Trauma Informed Care (TIC). TIC is more than completing an eight-hour class. There is ambiguity and confusion related to Recovery Support Workers and Certified Peer Specialists. The Supported Employment definition needs to include more employee supports rather than supported employment—support on the job versus distinct services.
- c) Carol Coussons de Reyes, Office of Consumer Affairs Administrator, asked what Nebraska Permanent Supported Housing looks like.

[DBH Response: The integration piece has never been defined. The U.S. Department of Housing and Urban Development (HUD) 811 grants now require less than 25% of residents in a housing complex have a behavioral health disorder.]

**XIV. Committee recommendations and comments**

*Committee Members*

Committee comments included:

- a) Add Criminal Justice to Block Grant goals in future applications.
- b) Note on the Service Expectations for Supported Employment that Vocational Rehabilitation does benefit orientation, not benefit analysis.
- c) Address how Peer Support fits into the Parole-Probation-Corrections services; how can the Advisory Committee help Parole and Probation understand the concept of Peer Support and how it may be used in these services.

- d) Like the Supported Employment Individual Placement and Support (IPS) Model, but concern on meeting integration on treatment team standards.
- e) How was the Certified Peer Support and Wellness Specialist process decided on? How was the formal process to follow this peer support model determined?
- f) Encouraged to hear Children and Family Services and the foster care system are improving. There are other vulnerable populations, such as adults in assisted living facilities, who need monitoring. (Response-Individuals may notify the facility licensure section in DHHS-Public Health Division, or advocacy groups for disability rights, or Adult Protective Services.)
- g) Consider creating peer support for individuals living in assisted living facilities.
- h) Suggest peer support be pursued in places where individuals are transitioning out of hospitals to home or prison to home
- i) Peer support discussion helpful in implementing peer support at the Veterans' Administration.
- j) Is there peer support available at the Lincoln Regional Center (and other State operated facilities)? (DBH response: Recovery Specialists are employed at the Lincoln Regional Center.)

There were no committee recommendations.

#### **XV. Items for next agenda**

*Committee Members*

- a) Election of Committee Officers
- b) Schedule 2013 meetings
- c) Review Block Grant Implementation Report for mental health and substance abuse services
- d) Lay the foundation for the FY2014-15 Block Grant Application (includes the last two years of the Strategic Plan), including the Needs Assessment.
- e) Peer Support (how Peer Support was developed in Nebraska; and DBH proposal on how to measure Peer Support)

#### **XVI. Adjournment and next meeting**

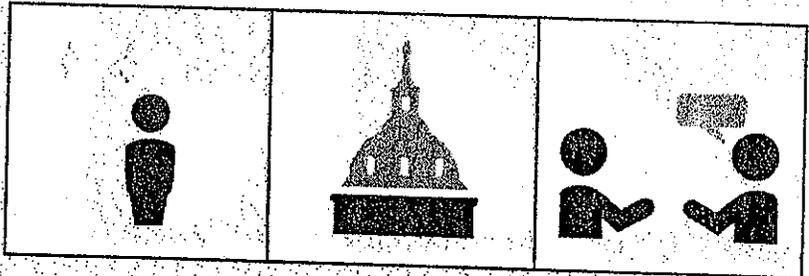
- Motion to adjourn approved at 4:03 pm
- The next meeting of the Joint Committee of the State Advisory Committee on Mental Health Services and the State Advisory Committee on Substance Abuse Services is scheduled for Thursday, November 8, 2012 from 9:00 am – 4:00 pm
- The meeting was well organized with good facilitation
- The font size on handouts needs to be easier to read
- Need new membership list; send website link to membership list

(NOTE: *Comment* means one or more committee members made a statement on a topic. *Recommend* means a topic was discussed, a motion was made and seconded, and a formal roll call vote was recorded.)

Attachment A

To schedule training  
 Contact  
 Jonah Deppa  
 Advocacy Director  
 NAMI Nebraska  
 415 S 25th Avenue  
 Omaha, NE 68131  
 402-345-8101  
 877-463-6264

# NAMI SMARTS for ADVOCACY



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Attachment B

## State Advisory Committee on Mental Health Services – 2012 Survey Results

Cody Meyer – Statistical Analyst II, Division of Behavioral Health  
August 7, 2012

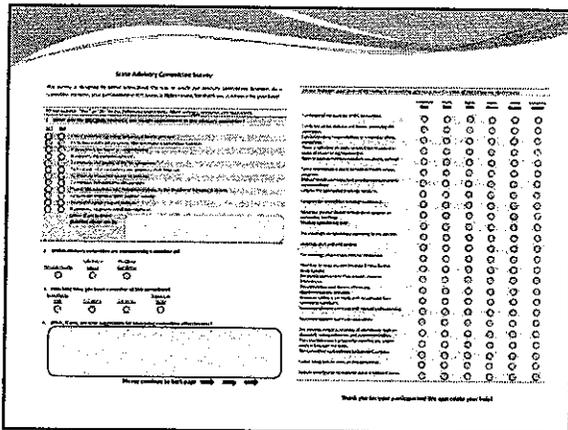


### About the Survey...

- The Advisory Committee survey was developed to assess the current attitudes and opinions of committee members regarding their experiences in participating on their respective committee.
- The survey is anonymous and serves as a baseline to compare results against future surveys.
- Members who were not present had the survey e-mailed to them. Those members then returned the completed survey.
- Total of 31 surveys received.

Which advisory committee are you currently a member of?		How long have you been a member of the MHT advisory committee?	
Advisory Committee	Count	Duration	Count
Mental Health	17	Less than a year	2
Substance Abuse	10	1-2 years	5
Problem Gambling	4	3+ years	5
		3 years or more	5
			20 (64.5%)

Note: For the purpose of today's meeting we will focus on the results of the 17 returned surveys from the Mental Health Advisory Committee.



### Q1. What was the original reason(s) you sought appointment to this advisory committee? (Indicate all that apply)

Reason	Yes	No	Missing / Not marked
To improve the quality of life for consumers	16 (94.1%)	0	1 (5.9%)
To improve behavioral health services	16 (94.1%)	0	1 (5.9%)
To provide assistance and recommendations to the Division of Behavioral Health	16 (94.1%)	0	1 (5.9%)
To improve consumer access to services	15 (88.2%)	0	2 (11.8%)

Note: All respondents who answered the highlighted items answered "Yes" (< 100% due to items missing / not marked).

### Q1. What was the original reason(s) you sought appointment to this advisory committee? (Indicate all that apply)

Reason	Yes	No	Missing / Not marked
I was specifically asked to consider becoming a committee member	14 (82.4%)	3 (17.6%)	0
I have expertise regarding behavioral health services	13 (76.5%)	3 (17.6%)	1 (5.9%)
To be a voice for consumers and promote their interests	13 (76.5%)	2 (11.8%)	2 (11.8%)
It supports my personal interests	12 (70.6%)	2 (11.8%)	3 (17.6%)

### Q1. What was the original reason(s) you sought appointment to this advisory committee? (Indicate all that apply)

Reason	Yes	No	Missing / Not marked
To promote peer support services	10 (58.8%)	5 (29.4%)	2 (11.8%)
It gives me a feeling of accomplishment	9 (52.9%)	4 (23.5%)	4 (23.5%)
It supports my professional development	9 (52.9%)	5 (29.4%)	3 (17.6%)
To evaluate organized peer support services	8 (47.1%)	7 (41.2%)	2 (11.8%)

### Descriptive Statistics

	N	Min.	Max.	Mean
Meetings start and end on time	17	5	6	5.88
The meetings are conducted according to the agenda	17	5	6	5.82
The minutes reflect a summary of attendance, matters discussed, voting outcomes, and recommendations	17	5	6	5.76
Recommendations are made respectfully	17	5	6	5.59
The public comment periods provide valuable information	17	5	6	5.53
I attend this committee meetings regularly	17	4	6	5.47

- These 6 items show a very positive evaluation of many of logistic and administrative details
- Tremendous level of agreement on these items. All of these items were answered by all of the respondents. All 17 indicated agreement with each of these statements.

Note: These items are coded so that greater values indicate greater agreement

### Descriptive Statistics

	N	Min.	Max.	Mean
I value being able to serve on this committee	16	2	6	5.38
I feel free to voice my opinion, even if I may be the minority vote	16	2	6	5.38
Meeting agendas are clear	16	3	6	5.31
I would be willing to do more for my committee if asked	17	3	6	5.24
I am knowledgeable about behavioral service programs	17	5	6	5.24
I follow trends and important developments related to my committee	17	4	6	5.24
Materials are distributed sufficiently in advance of committee meetings	17	3	6	5.24
The committee accomplishes its intended purpose	16	4	6	5.19
I understand the purpose of this committee	17	2	6	5.18
I understand my responsibilities as a member of this committee	17	2	6	5.18
The meetings allow ample time for discussion	17	2	6	5.12
The committee uses data to inform any recommendations provided	17	3	6	5.06
Recommendations are made with equal input from committee members	17	2	6	5.06

While these means are in the middle range, they are still very positive results. All of these averages are around 5 on a 6 point scale. Also there are a few items where all respondents agree with the statement, but there is variation within how much they agree.

### Descriptive Statistics

	N	Min.	Max.	Mean
Recommendations are made with mutual understanding	17	3	6	4.94
Roles of each committee members are clearly defined	16	3	6	4.94
I understand the statutes and bylaws governing this committee	17	1	6	4.88
I prepare for committee meetings in advance	17	3	6	4.88
There is sufficient diversity amongst the members in terms of voices being represented	17	3	6	4.82
The committee has a process for handling any agenda matters between meetings	14	2	6	4.64

- These 6 items represent have the lowest mean scores, but there are some important conclusions to make from these items. Average scores are still suggesting general agreement with all of these statements (All items > 4)
- All of these items have room for improvement, however it seems that they all have realistic solutions as well!

Note: These items are coded so that greater values indicate greater agreement

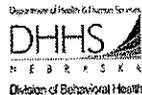
- ### Suggestions from Committee to Improve Effectiveness – General Themes
- There were concerns raised about the relationship between the MH Advisory Committee and the Division of Behavioral Health. That is, committee members expressed concern if Advisory Committee discussions and recommendations are given serious consideration by DBH & DHHS.
  - Also concerns about DBH staff presenting information as “matter of fact” with lack of input from MH Advisory Committee.
  - It was suggested that the Advisory Committee / DBH consider shortening the meetings, and focusing each meeting on fewer topics, but giving each topic greater opportunity for discussion.
  - It was suggested to make the Committee meetings available by teleconference / webinar / other “distance-related” methods.

- ### DBH Questions for Discussion
- Does the information presented here generate additional questions? Items that should be addressed.
  - How can we use this information and make it meaningful for Advisory Committee members?
  - Suggestions for frequency of survey administration... (annually? every 2 years?)
  - Questions about the survey design or data analysis.

## Thank you!

Questions?  
Comments?  
Feedback?

Please contact Cody Meyer:  
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402-471-7746  
Or Heather Wood  
Heather.Wood@nebraska.gov  
402-471-1423



Department of Health & Human Services  
**DHHS**  
NEBRASKA  
Division of Behavioral Health

**Evidence Based Practices Workgroup**  
**Statewide Quality Improvement Team**  
**(EBP Workgroup)**

Report to State Advisory Committee on Mental Health Services  
 From: Blaine Shaffer, M. D., Chief Clinical Officer  
 Division of Behavioral Health (DBH) – Nebraska Department of Health & Human Services  
 August 7, 2012

**EBP Workgroup Charge**

The Charge of the Evidence Based Practices Workgroup is to provide recommendations to DBH leadership by September 29, 2012 on a consistent and sustainable way of doing fidelity monitoring linked to outcomes on Evidence Based Practices (EBPs). Using EBPs is an investment in what works. The goal is to improve the use of EBPs in order to achieve more effective use of limited community resources.

**SAMHSA Evidence Based Practices (EBP) Kits**

<http://store.samhsa.gov/facet/Professional-Research-Topics/term/Evidence-Based-Practices?filterToAdd=Kit>

Title	Publication Date
1. Assertive Community Treatment (ACT)	10/2008
2. MedTEAM (Medication Treatment, Evaluation, and Management)	2/2011
3. Permanent Supportive Housing	7/2010
4. Supported Employment	2/2010
5. Integrated Treatment for Co-Occurring Disorders	1/2010

**Meeting Schedule**

2:00 to 4:00 p.m. CDT using Conference Call and Live Meeting hosted at DBH Conference Room

March 1, 2012	orientation to the task assigned to the EBP Workgroup
April 5, 2012	reviewed and discussed the EBP Workgroup assigned questions.
May 10, 2012	focus on Supported Employment (SE)*
June 21, 2012	focus on Permanent Supportive Housing (PSH)*
August 9, 2012	focus on Assertive Community Treatment (ACT)*
Sept. TBD, 2012	focus on MedTEAM (Medication Treatment, Evaluation, and Management)*

\* Providers of the EBP service funded by the Division are invited to the relevant meeting to contribute to the discussion.

The Co-Occurring Disorder Services Quality Initiative Workgroup II will address the issues connected to the EBP Integrated Treatment for Co-Occurring Disorders.

**DBH Advisory Committees – Consumer Representation**

- State Advisory Committee on Mental Health Services (§71-814) – Kathleen Hanson, Bev Ferguson, Cody Manthei, Kasey Moyer, Sharon Dalrymple, and Jette Hogenmiller.
- State Advisory Committee on Substance Abuse Services (§71-815) – Corey Brockway and Dr. Jorge Rodriguez-Sierra.



**DRAFT****Behavioral Health Inmates in the State Correctional System FY 2012**

**Source:** Cameron S. White, Ph.D.; Behavioral Health Administrator, Nebraska Department of Correctional Services - Central Office, Lincoln, NE (8-1-2012).

One challenge in the State Behavioral Health System is offenders discharging from prison who need access to community based behavioral health services including psychiatric, mental health, substance abuse, and dual diagnosis treatment to address their needs.

The literature indicates that a significant percentage of inmates in state prison are mentally ill. A commonly cited estimate is that about 16 percent of inmates in state prisons have a mental illness. Other studies have found the rate of mental health problems of prison and jail inmates to be even higher.

**Source:** Bureau of Justice Statistics Special Report, Mental Health Problems of Prison and Jail Inmates by Doris J. James and Lauren E. Glaze, September 2006.

Table 1 shows the rates of mental illness diagnosed at Nebraska state correctional intake facilities for the last eight fiscal years. The rate of mental illness in the Nebraska state prison system is slightly lower than the prior year but fairly consistent for the last four years.

Please note that the state prison system is different from the county jail system. Many people are arrested and are sent to county jail facilities during the course of any given year, however only a very small percentage of this group go on to state prison. The general criteria for state prison is commission of a felony and having a sentence of a year or longer.

**Table 1: Rate of Diagnosed Mental Illness at Intake Made By NE Dept of Correctional Services**

	FY2005		FY2006		FY2007		FY2008	
Number of inmates with mental illness	341	16%	645	25%	768	31%	949	40%
Total Intakes	2,121		2583		2,447		2,379	
	FY2009		FY2010		FY 2011		FY 2012	
Number of inmates with mental illness	656	29%	843	35%	824	32%	851	30%
Total Intakes	2,289		2,418		2573		2794	

**Note:** Total is for all Axis I diagnoses exclusive of sole substance-related diagnoses. Includes data for adult males, adult females, and youthful offenders. Total number of intakes includes county safe keepers and ninety day evaluators.

Another indicator of the high rate of persons with mental illness in the state prison system is the number of inmates who are prescribed psychiatric medication. On June 30, 2012, 1295 inmates were on psychiatric medication which is about 28 percent of the inmate population. This rate represents a slight increase compared to the last fiscal.

**Table 2: Nebraska Department of Correctional Services Inmate Population With Prescribed Psychiatric Medications on One Day (Point in Time)**

On June 30, 2005		Of June 30, 2006		on June 30, 2007		On June 30, 2008	
854	20.2%	871	19.4%	858	19.7%	817	18.7%
On June 30, 2009		On June 30, 2010		On June 30, 2011		On June 30, 2012	
1,080	24.1%	907	20%	1191	26.5%	1295	28%

The rate of individuals diagnosed with substance-related disorders at intake in the state prison system is significant and has remained fairly stable, but is slightly lower for the most recent fiscal year (see Table 3 below).

Table 3: Substance Related Diagnosis Made By Nebraska  
Department of Correctional Services Substance Abuse Staff at Intake

	FY2005		FY2006		FY2007		FY2008	
Inmate population with a substance abuse or dependence diagnosis	1,743	82%	1,372	89%	1,782	86%	1,741	89%
Number of inmates screened	2,121		1,538		2,081		1,967	

	FY2009		FY2010		FY2011		FY2012	
Inmate population with a substance abuse or dependence diagnosis	1,496	78.6%	1,477	76%	1,666	77%	1,430	76.0%
Number of inmates screened	1,903		1,955		2,175		1,874	

A large number of inmates who were incarcerated for committing sexual offenses are discharged from NDCS each year. For example, during fiscal year 2012, 206 inmates who had committed a sexual offense discharged. Of that number, 17, or about 8.%, were recommended by DCS staff for post incarceration mental health board hearings for possible civil commitment. The chart below summarizes the number of offenders who came from each of the State Behavioral Health Regions (i.e., they were sentenced in a county in that region) and the number who were recommended for possible civil commitment.

Table 4: Number of Sex Offenders Released and Recommended for Civil Commitment FY2012

Region	I	II	III	IV	V	VI	Totals
# Released	7	17	24	20	55	83	206
#Recommended	0	2	2	2	7	4	17

NDCS has focused on providing re-entry services for mentally ill inmates prior to release. Social workers help offenders plan to discharge and assist with identifying treatment resources, benefits, and housing. NDCS also works closely with the DHHS Regions regarding discharge planning for high needs cases.

Finally, it is worth noting that the Nebraska Department of Correctional Services Behavioral Health consists of about 130 professionals including psychiatrists, mid-level psychiatric providers, psychologists, mental health practitioners, social workers, nurses, and drug and alcohol abuse counselors. The focus is to provide clinical treatment services to the priority populations including those with severe mental illness, violent offenders, substance dependent offenders, and sex offenders.

# Peer-Run & Peer Recovery/Resiliency Supports

Definitions for Block Grant Measurement (this does not refer directly to our Recovery Support service definition)-

## Adult

*Peer-Run Recovery Support for an Adult will meet the following criteria:*

- 1) Non-traditional Behavioral Health Service led by and staffed with persons with lived experience with a Behavioral Health Condition

*Peer-Run Recovery Support for an Adult will meet 4 out of the 5 criteria:*

- 2) Consumer-Run Board with a 51% or higher Consumer Majority, and has an organizational structure that is owned, operated, and controlled by people with lived experience with a behavioral health condition
- 3) Has no Clinical Service Delivery Components
- 4) Has no Clinical Supervision
- 5) Emphasize Self-Help, Growth, Well-Being, Personal Choice, and Responsibility
- 6) Utilizes Staff with State Certification as Nebraska Peer Support and Wellness Specialists

*Examples of Peer Run Recovery Supports in Nebraska for Adults:*

- Keya House
- Hope Program
- Safe Harbor

*Peer Recovery Support for an Adult will meet the following criteria:*

- 1) Behavioral Health Service staffed with persons with lived experience with a Behavioral Health Condition

*Peer Recovery Support for an Adult will meet 3 out of the 4 criteria:*

- 2) Has No Clinical Service Delivery Components, but may collaborate with a clinical team
- 3) May or may not have Clinical Supervision
- 4) Emphasize Self-Help, Growth, Well-Being, Personal Choice, and Responsibility
- 5) Utilizes Staff with State Certification as Nebraska Peer Support and Wellness Specialists

*Examples of Peer Recovery Supports in Nebraska for Adults:*

- Peer Support Service Providers
- Recovery Support Service workers that hire a peer to offer service

## Transition Age Youth (Age 17-26)

Peer-Run Recovery Supports and Peer Recovery Supports for Transition Age Youth would be the same definition as the adult service model.

## Child

*Family-Peer Run Resiliency Supports for a Child will meet the following criteria:*

- 1) Non-traditional Behavioral Health Service lead by and staffed by a family members of a child with lived experience with a Behavioral Health Condition

*Family-Peer Run Resiliency Supports for a Child will meet 5 out of the 6 criteria:*

- 2) Family Member ( of Child Consumer)-Run Board with a 51% or higher Family Member (of Child Consumer) Majority; and has an organizational structure that is owned, operated, and controlled by family members with children living with a behavioral health condition
- 3) Has no Clinical Service Delivery Components
- 4) Has no Clinical Supervision
- 5) Emphasize Self-Help, Growth, Well-Being, Personal Choice, and Responsibility
- 6) Utilizes Staff Trained in a Nebraska Family Peer Support Model that is non-clinical in nature

*Examples of Family-Peer Run Recovery Supports in Nebraska for Children*

- SPEAKOUT
- Voices 4 Families
- Families Care
- Parent to Parent Network
- Families Inspiring Families
- Nebraska Family Support Network
- Nebraska Federation of Families for Children's Mental Health

*Family-Peer Resiliency Supports for a Child will meet the following criteria:*

- 1) Service staffed by family members of a child with lived experience with a Behavioral Health Condition

*Family-Peer Resiliency Supports for a Child will meet 3 out of the 4 criteria:*

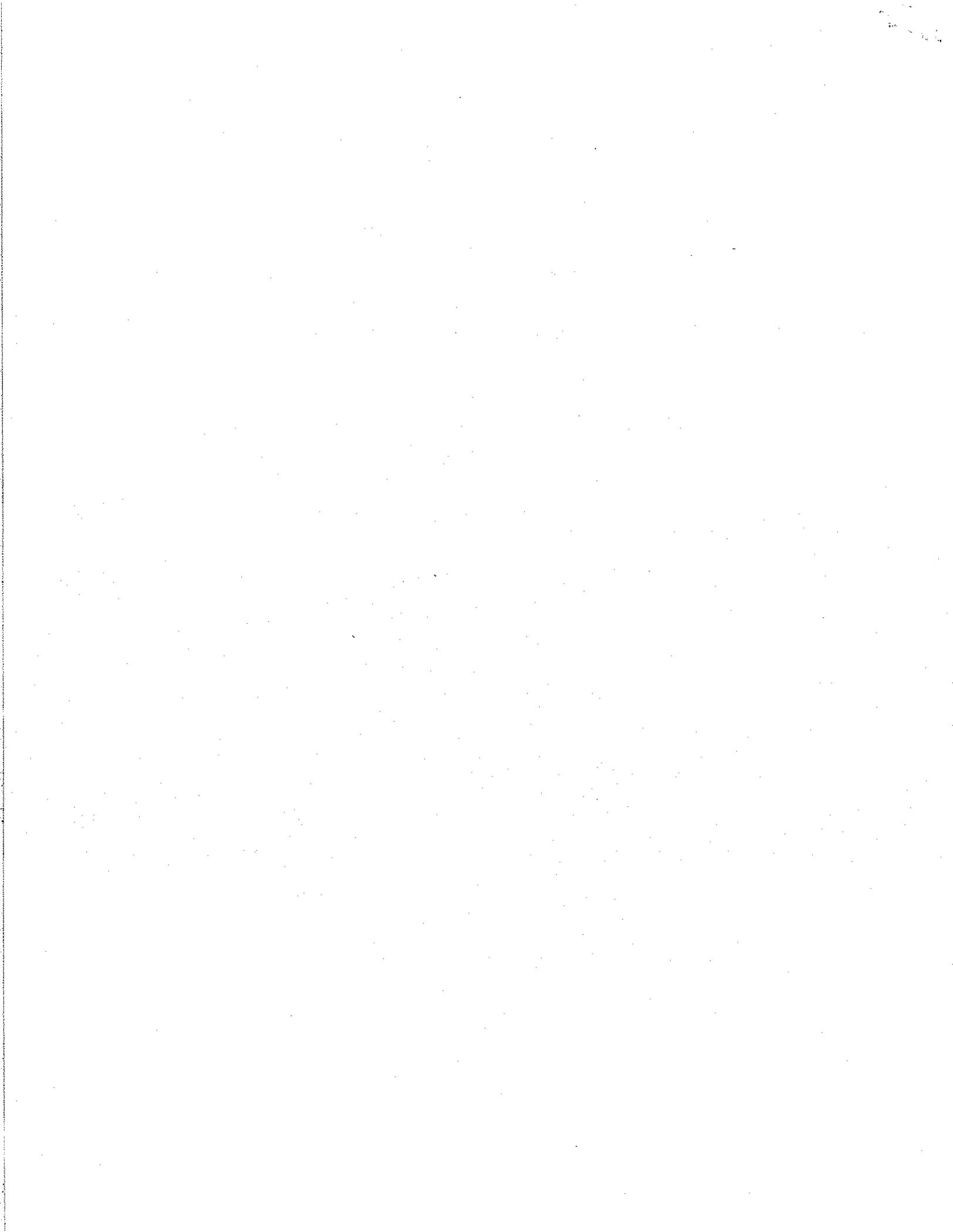
- 2) Has no Clinical Service Delivery Components, but may collaborate with a clinical team
- 3) May or may not have Clinical Supervision
- 4) Emphasize Self-Help, Growth, Well-Being, Personal Choice, and Responsibility
- 5) Utilizes Staff Trained in a Nebraska Family Peer Support Model that is non-clinical in nature

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## ***Questions on the Peer-Run & Peer Recovery/Resiliency Supports***

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- 1) Should we be counting by service or by person or both?**
  
- 2) Should we be counting funded staff or community volunteers related?**
  
- 3) How should we count? Magellan? Regional Consumer Specialists?  
Other?**



## DEFINITION

Working definition of recovery from mental disorders and/or substance use disorders

A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

Through the Recovery Support Strategic Initiative, SAMHSA has delineated four major dimensions that support a life in recovery:

### Health

Overcoming or managing one's disease(s) or symptoms—for example, abstaining from use of alcohol, illicit drugs, and non-prescribed medications if one has an addiction problem—and for everyone in recovery, making informed, healthy choices that support physical and emotional wellbeing.

### Home

A stable and safe place to live

### Purpose

Meaningful daily activities, such as a job, school, volunteering, family caretaking, or creative endeavors, and the independence, income and resources to participate in society

### Community

Relationships and social networks that provide support, friendship, love, and hope

Drawing on research, practice, and personal experience of recovering individuals, within the context of health reform, SAMHSA will lead efforts to advance the understanding of recovery and ensure that vital recovery supports and services are available and accessible to all who need and want them.

Please see SAMHSA's Recovery Support Initiative (<http://www.samhsa.gov/recovery>) for more information on recovery.

## SAMHSA'S WORKING DEFINITION OF RECOVERY

## 10 GUIDING PRINCIPLES OF RECOVERY



## BACKGROUND

Recovery has been identified as a primary goal for behavioral health care. In August 2010, leaders in the behavioral health field, consisting of people in recovery from mental health and substance use problems and SAMHSA, met to explore the development of a common, unified working definition of recovery. Prior to this, SAMHSA had separate definitions for recovery from mental disorders and substance use disorders. These different definitions, along with other government agency definitions, complicated the discussion as we work to expand health insurance coverage for treatment and recovery support services.

Building on these efforts and in consultation with many stakeholders, SAMHSA has developed a working definition and set of principles for recovery. A standard, unified working definition will help advance recovery opportunities for all Americans, and help to clarify these concepts for peers, families, funders, providers, and others.

# 10 GUIDING PRINCIPLES OF RECOVERY

---

Hope	Relational
Person-Driven	Culture
Many Pathways	Addresses Trauma
Holistic	Strengths/Responsibility
Peer Support	Respect

---

## Recovery emerges from hope

The belief that recovery is real provides the essential and motivating message of a better future—that people can and do overcome the internal and external challenges, barriers, and obstacles that confront them. Hope is internalized and can be fostered by peers, families, providers, allies, and others. Hope is the catalyst of the recovery process.

## Recovery is person-driven

Self-determination and self-direction are the foundations for recovery as individuals define their own life goals and design their unique path(s) towards those goals. Individuals optimize their autonomy and independence to the greatest extent possible by leading, controlling, and exercising choice over the services and supports that assist their recovery and resilience. In so doing, they are empowered and provided the resources to make informed decisions, initiate recovery, build on their strengths, and gain or regain control over their lives.

## Recovery occurs via many pathways

Individuals are unique with distinct needs, strengths, preferences, goals, culture, and backgrounds—including trauma experiences—that affect and determine their pathway(s) to recovery. Recovery is built on the multiple capacities, strengths, talents, coping abilities, resources, and inherent value of each individual. Recovery pathways are highly personalized. They may include professional clinical treatment; use of medications; support from families and in schools; faith-based approaches; peer support; and other approaches. Recovery is non-linear, characterized by continual growth and improved functioning that may involve setbacks. Because setbacks are a natural, though not inevitable, part of the recovery process, it is essential to foster resilience for all individuals and families. Abstinence from the use of alcohol, illicit drugs, and non-prescribed medications is the goal for those with addictions. Use of tobacco and non-prescribed or illicit drugs is not safe for anyone. In some cases, recovery pathways can be enabled by creating a supportive environment. This is especially true for children, who may not have the legal or developmental capacity to set their own course.

## Recovery is holistic

Recovery encompasses an individual's whole life, including mind, body, spirit, and community. This includes addressing: self-care practices, family, housing, employment, transportation, education, clinical treatment for mental disorders and substance use disorders, services and supports, primary healthcare, dental care, complementary and alternative services, faith, spirituality, creativity, social networks, and community participation. The array of services and supports available should be integrated and coordinated.

## Recovery is supported by peers and allies

Mutual support and mutual aid groups, including the sharing of experiential knowledge and skills, as well as social learning, play an invaluable role in recovery. Peers encourage and engage other peers and provide each other with a vital sense of belonging, supportive relationships, valued roles, and community. Through helping others and giving back to the community, one helps one's self. Peer-operated supports and services provide important resources to assist people along their journeys of recovery and wellness. Professionals can also play an important role in the recovery process by providing clinical treatment and other services that support individuals in their chosen recovery paths. While peers and allies play an important role for many in recovery, their role for children and youth may be slightly different. Peer supports for families are very important for children with behavioral health problems and can also play a supportive role for youth in recovery.

## Recovery is supported through relationship and social networks

An important factor in the recovery process is the presence and involvement of people who believe in the person's ability to recover; who offer hope, support, and encouragement; and who also suggest strategies and resources for change. Family members, peers, providers, faith groups, community members, and other allies form vital support networks. Through these relationships, people leave unhealthy and/or unfulfilling life roles behind and engage in new roles (e.g., partner, caregiver, friend, student, employee) that lead to a greater sense of belonging, personhood, empowerment, autonomy, social inclusion, and community participation.

## Recovery is culturally-based and influenced

Culture and cultural background in all of its diverse representations—including values, traditions, and beliefs—are keys in determining a person's journey and unique pathway to recovery. Services should be culturally grounded, attuned, sensitive, congruent, and competent, as well as personalized to meet each individual's unique needs.

## Recovery is supported by addressing trauma

The experience of trauma (such as physical or sexual abuse, domestic violence, war, disaster, and others) is often a precursor to or associated with alcohol and drug use, mental health problems, and related issues. Services and supports should be trauma-informed to foster safety (physical and emotional) and trust, as well as promote choice, empowerment, and collaboration.

## Recovery involves individual, family, and community strengths and responsibility

Individuals, families, and communities have strengths and resources that serve as a foundation for recovery. In addition, individuals have a personal responsibility for their own self-care and journeys of recovery. Individuals should be supported in speaking for themselves. Families and significant others have responsibilities to support their loved ones, especially for children and youth in recovery. Communities have responsibilities to provide opportunities and resources to address discrimination and to foster social inclusion and recovery. Individuals in recovery also have a social responsibility and should have the ability to join with peers to speak collectively about their strengths, needs, wants, desires, and aspirations.

## Recovery is based on respect

Community, systems, and societal acceptance and appreciation for people affected by mental health and substance use problems—including protecting their rights and eliminating discrimination—are crucial in achieving recovery. There is a need to acknowledge that taking steps towards recovery may require great courage. Self-acceptance, developing a positive and meaningful sense of identity, and regaining belief in one's self are particularly important.

## What are

### Consumer-Operated Services?

A consumer-operated service is an independent organization that is owned, administratively controlled, and operated by mental health consumers. It may offer a range of services, but all emphasizes self-help and recovery.

Consumer-Operated Services is an evidence-based practice (EBP) that has consistently demonstrated effectiveness in helping people with mental illness achieve their desired goals.

## How do Consumer-Operated Services Help People?

Consumer-operated services support participants in many ways. They provide opportunities for people to learn about recovery, take on new responsibilities or new roles, make discoveries about themselves, and make new friends. When people feel accepted for who they are, they begin to think about themselves differently, learn new ways to handle problems, and make positive changes. Consumer-operated services generate hope, open new doors, and increase members' sense of well-being.

## What Makes Consumer-Operated Services Unique?

Consumer-operated services are run by people who have personal experience living with a psychiatric diagnosis. They understand how it can affect every aspect of living, including one's hopes for the future. Consumer-operated leaders and members are living proof that people can and do recover.

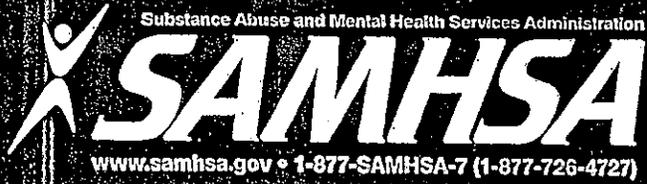
Consumer-operated services have a different approach to "helping" than traditional mental health services. They emphasize growth and well-being, self-help, and personal choice and responsibility. Members discover that helping others is often a way of helping oneself.

## What services are offered?

Different programs offer different kinds of services. These may include the following:

- Drop-in centers
- Peer counseling
- Self-help and peer support groups
- Crisis response and respite
- Assistance with basic needs
- Help with housing, employment, and education
- Links to human services or resources
- Social and recreational opportunities
- Advocacy services
- Arts and expression
- Information and resources

**Recovery is real. Claim it for yourself. Support or join a local consumer-operated service.**

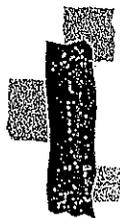


## Consumer-Operated Services

CONTACT INFO HERE



Consumer-Operated Services Works!



EVIDENCE-BASED PRACTICES

**KIT**

Knowledge Informing Transformation

*Recovery is real.  
Claim it for yourself.*

This document was prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA) by Abt Associates, Inc., and Advocates for Human Potential, Inc., under contract number 260-2003-00029 and Westat under contract number 270-03-6005, with SAMHSA, U.S. Department of Health and Human Services (HHS). Pamela Fisher, Ph.D., served as the Government Project Officer.

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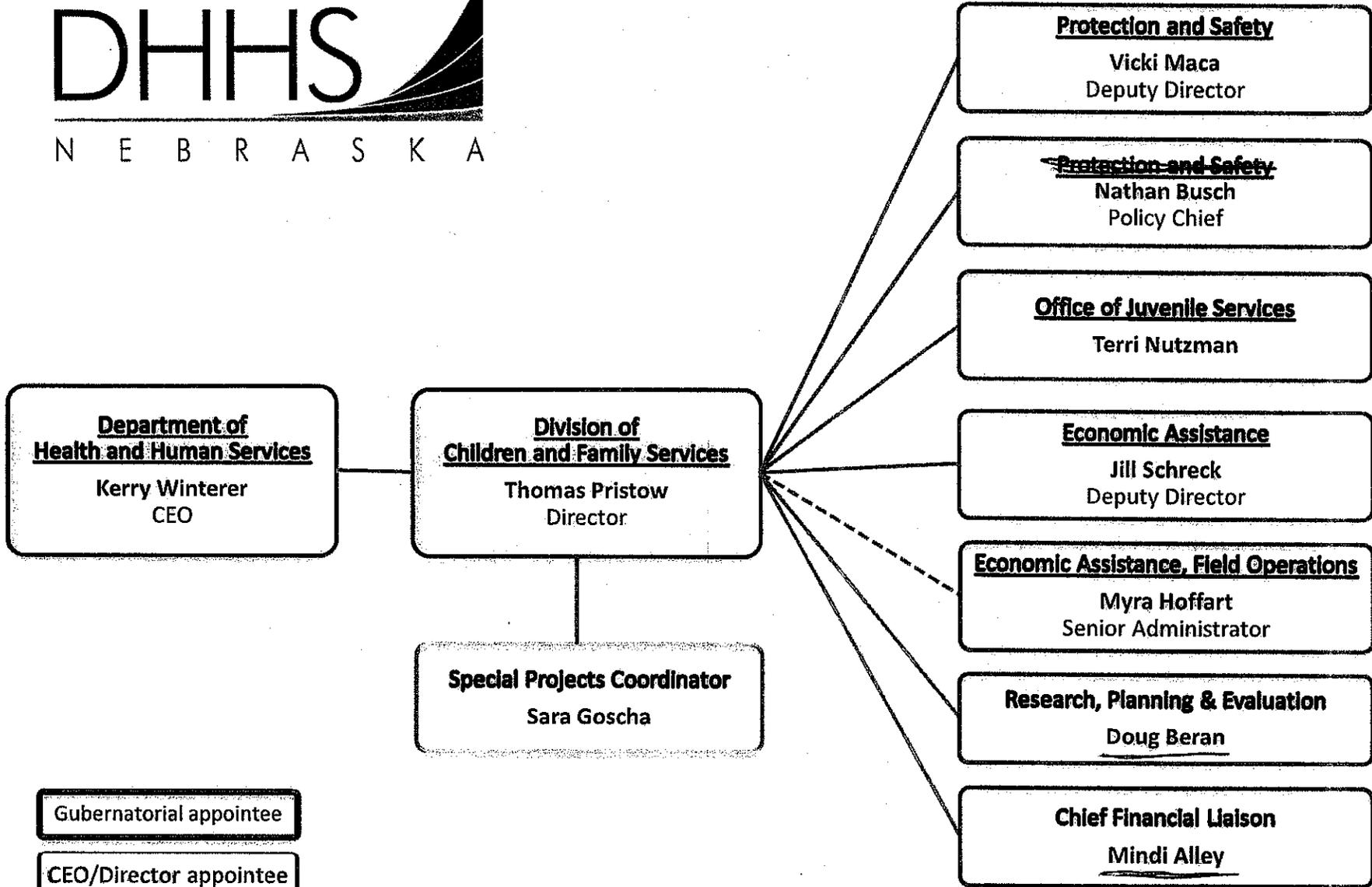
Substance Abuse and Mental Health Services Administration  
www.samhsa.gov

Guide to Discussion on Peer Support

1. Paid Peer Support and Unpaid Peer Support
  
2. Peer Recovery Supports- Peer Run and Peer Recovery/Resiliency Supports
  - Adult- Peer Run Recovery Support
  - Adult- Peer Recovery Support
  - Transition Age Youth-Run Recovery Support
  - Transition Age Youth Recovery Support
  - Family Peer Run Resiliency Supports for a Child
  - Family Peer Resiliency Supports for a Child

Attachment #

Department of Health & Human Services



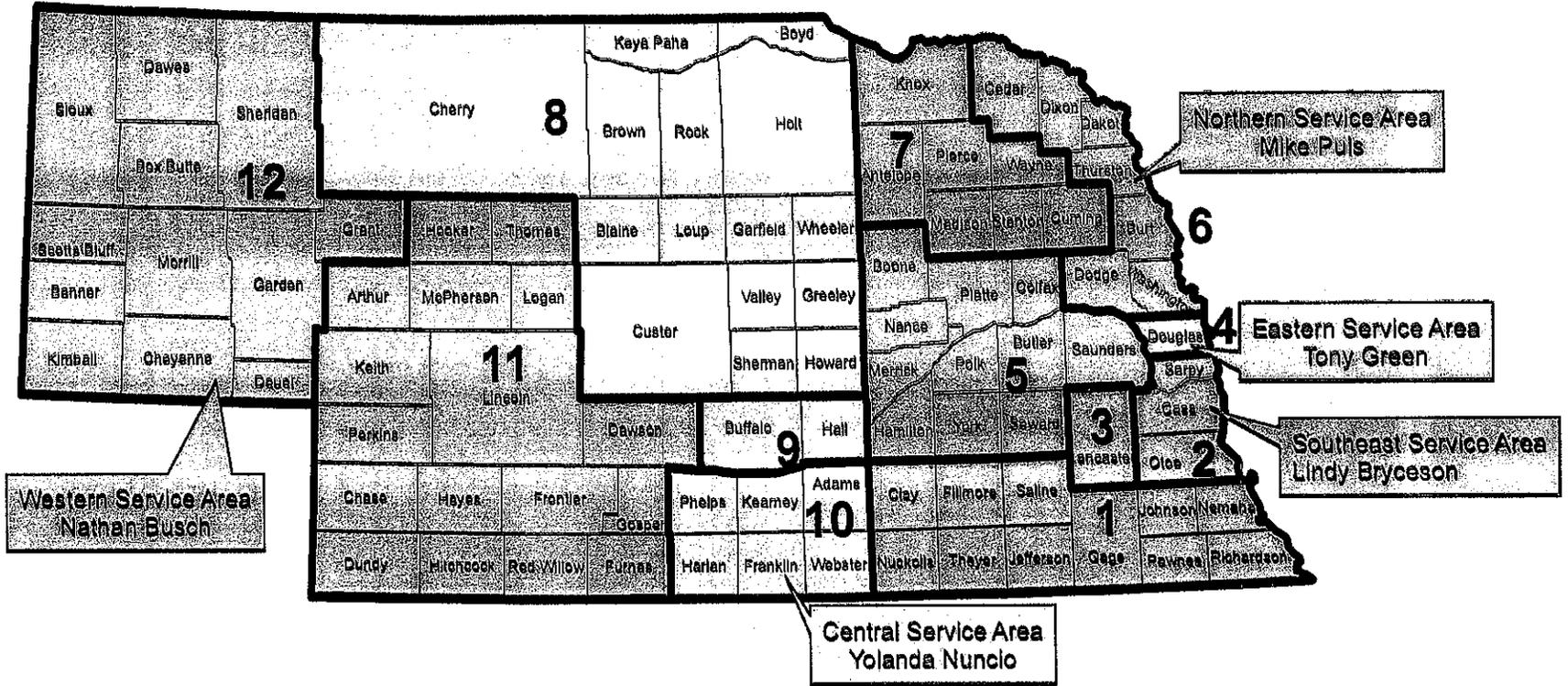
Gubernatorial appointee

CEO/Director appointee

07/11/2012

# Judicial Districts aligned with CFS Service Areas

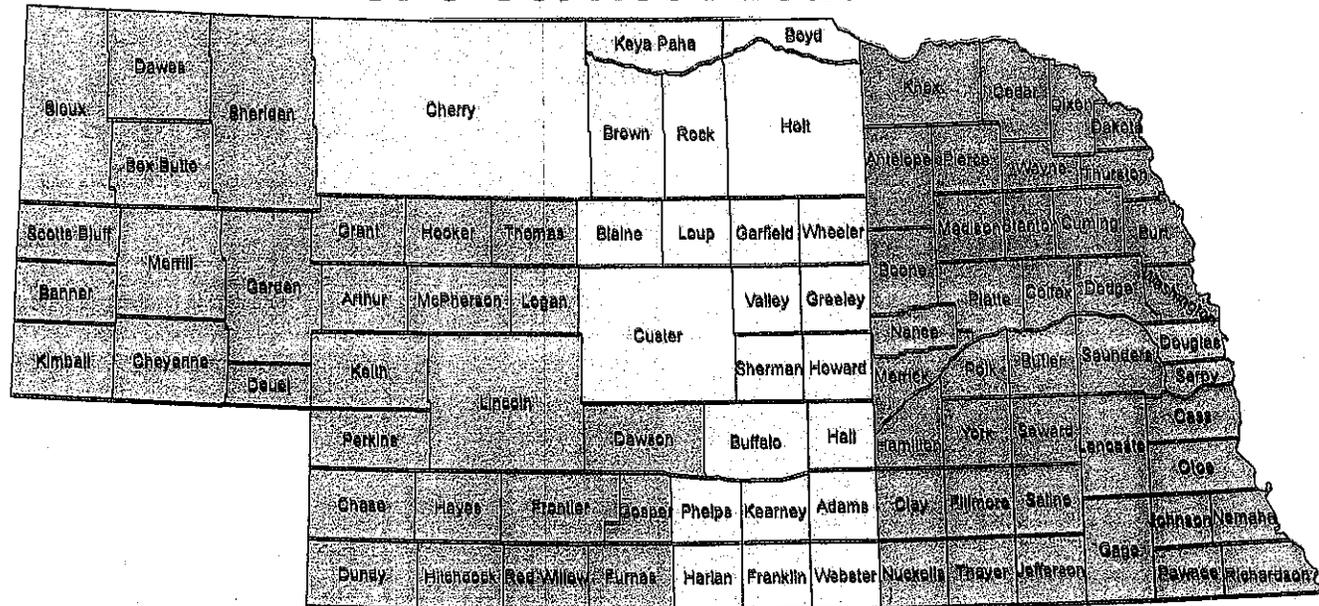
Attachment I



Department of Health & Human Services



## CFS Service Areas



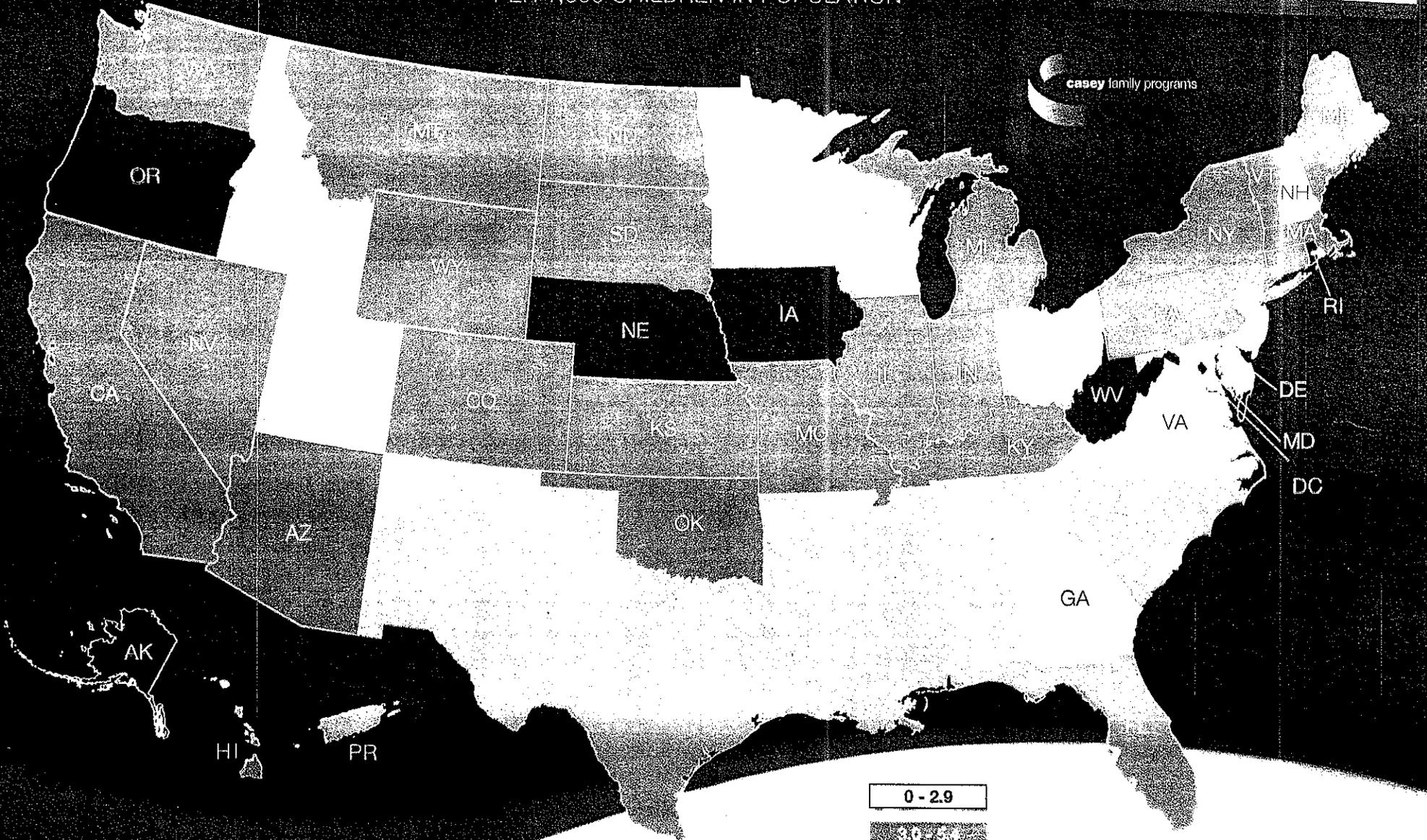
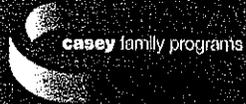
### Legend

- Judicial Districts
- Western
- Central
- Southeast
- Eastern
- Northern

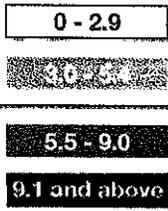
# Rate of children in out-of-home care 2010

Attachment J

PER 1,000 CHILDREN IN POPULATION



National Average: 5.4



www.casey.org

Source: AFCARS, Claritas Population projections/estimates.

As of 9/12/2011

## The Effects of Removing Children and Placing in Foster Care

The bulleted points below come from several research articles that have explored the practice of removing children from their homes as a result of abuse/neglect. For ease of reading, I have selected what I thought to be the most informative quotes and included them here.

### The Impact of Foster Care on Development (Lawrence, Carlson, & Egeland, 2006)

- Longitudinal study investigating the effects of foster care on the development of child behavior and functioning.
- “A broad review of foster care research suggests that foster children deviate from typical development in all domains and are at significant risk for unusually high rates (30-80%) of psychological and behavioral problems and special needs.” (Arad, 2001; Hochstadt, Jaudes, Zimo, & Schachter, 1987; McIntyre & Keesler, 1986; Rutter, 2000; Zima et al., 2000)
- “Rates of behavior problems and clinically significant symptoms measured by the Child Behavior Checklist are reported as up to 2.5 times higher for children in foster care than for those of samples thought to share demographic characteristics but not entering protective custody (Hulsey and White, 1989; McIntyre and Keesler, 1986; Zima et al, 2000).
- “Studies of children in foster care suggest that this population is at significantly heightened risk for behavior problems. The severity and frequency of behavior problems far exceed the norm for children reared at home with similarly adverse backgrounds.” (Fanshel & Shin, 1978; Simms & Halfon, 1994)
- The participants in this study included “. . . 189 children and families from the Minnesota Longitudinal Study of Parents and Children.”
- “From the total sample of 189 children, three subgroups were identified:
  - 46 children who entered the foster care system;
  - 46 children who were maltreated but remained at home with the maltreating caregiver; and

- 97 children who did not experience foster placement or maltreatment.” (Lawrence, Carlson, & Egeland, 2006)
- Children’s behavioral and emotional functioning was evaluated during four points:
  - Early childhood (ages 12 months to Kindergarten), and before placement in foster care;
  - At around 6<sup>th</sup> grade (or at time of release from foster care);
  - At age 16;
  - At age 17.
- This study also tracked whether children were placed with strangers or were placed with familiar caregivers. (Lawrence, Carlson, & Egeland, 2006)
- “The findings suggest that the. . .behavior problems of children in foster care increased significantly between baseline assessment and subsequent measurement immediately following release from care.” (Lawrence, Carlson, & Egeland, 2006)
- The study also concluded that children who were placed in foster care with caregivers who were unfamiliar to them (not family or a family friend), had significantly worse emotional adjustment when leaving foster care compared to those who were placed with familiar caregivers, those remaining with caregivers who maltreated them, and other at-risk children.
- “.. [T]he results support a general view that foster care may lead to an increase in behavior problems that continues after exiting the system.” (Lawrence, Carlson, & Egeland, 2006)
- “The increase in problematic behavior following departure from foster care significantly exceeded change in behavior problems among those reared by maltreating parental figures (in the parental home), suggesting an exacerbation of problem behavior in the context of out of home care.” (Lawrence, Carlson, & Egeland, 2006)

**Children in Foster Care: A Vulnerable Population at Risk (Bruskas, 2008)**

- “Some studies show that over half of children in foster care may experience at least one or more mental disorder. . .” (Bruskas, 2008)
- “In the final report of the Washington State’s Office of Children’s Administration Research (2004), results also revealed poor educational outcomes for alumni of foster care. The report found that

only 50% of foster children in the study graduated from high school or earned a general educational development (GED) credential. (Bruskas, 2008)

- “Results showed that 89% of foster children in this study obtained a GED rather than completing high school.” (Bruskas, 2008)
- “For those seeking bachelor’s degree or higher, only 1.8% of alumni would continue to postsecondary education compared to 24% of the general population.” (Case Family Programs, 2005; Children’s Administration Research; U.S. Census Bureau).

### **Child Protection and Child Outcomes: Measuring the Effects of Foster Care (Doyle, 2007)**

- Studied the outcomes of children in foster care, but also examined the removal tendency of investigators and its effect on the likelihood of children being removed.
- “The results [of the study] suggest that children assigned to investigators with higher removal rates are more likely to be placed in foster care themselves, and they have higher delinquency rates, teen birth rates, and lower earnings.” (Doyle, 2007)
- The study focused on marginal cases – those cases where investigators may disagree about the need for removal.
- Regardless of administrative rules regarding removal, case managers are thought to rely more heavily on “practice wisdom” when making recommendations for removal. It appears that the threshold for placement is not constant across time or investigators. (Doyle, 2007)
- Male case managers are slightly less likely to be associated with foster care placement.
- “The results . . . point to better outcomes when children on the margin of placement remain at home.” (Doyle, 2007)

### **Developmental Issues for Young Children in Foster Care (Committee on Early Childhood, Adoption and Dependent Care, 2000)**

- Emotional and cognitive disruptions in the early lives of children have the potential to impair brain development.
- “Any time spent by a child in temporary care may be harmful to the child’s growth, development, and well-being. Interruptions in the

continuity of a child's caregiver are often detrimental." (Committee on Early Childhood, Adoption and Dependent Care, 2000)

- "Any intervention that separates a child from primary caregiver who provides psychological support should be cautiously considered and treated as a matter of urgency and profound importance." (Committee on Early Childhood, Adoption and Dependent Care, 2000)
- Older children who have been traumatized often suffer from posttraumatic stress disorder and automatically freeze when they feel anxious, and therefore are considered oppositional or defiant by those who interact with them. (Committee on Early Childhood, Adoption and Dependent Care, 2000)

### **Foster Care and Early Child Development: Implications for Child Welfare Policy and Practice (Dupree & Stephens, 2002)**

- "Specific factors critical to a secure attachment between a child and caregiver include: quantity of time spent together, face-to-face interactions, eye contact, physical proximity, touch and other primary sensory experiences such as smell, sound and taste" (Perry, 2001)
- "As strategies for intervention are developed for children in foster care, analysis of current practice should be carried out with an understanding of the ways in which the foster care experience can support or hinder positive child development." (Dupree & Stephens, 2002)
- ". [T]he development of attachment relationships is changed in dramatic ways as a result of out-of-home placement. (Dupree & Stephens, 2002)
- "If a child is in foster care, his or her ability to develop secure attachment relationships with primary caregivers has already been compromised." (Dupree & Stephens, 2002)
- Delays in brain development as a result of trauma are often not identified correctly, resulting in the development being further delayed. An example would be ongoing conflicts with peers that might be evidence of underdeveloped social cognitive skills. "However, the presenting behavior may be treated solely as a disciplinary problem when it really required cognitive intervention based on an understanding of the child's perceptions of threat or motives of others." (Dupree & Stephens, 2002)

## **Trauma-Aware Foster Care (Stirling, 2010)**

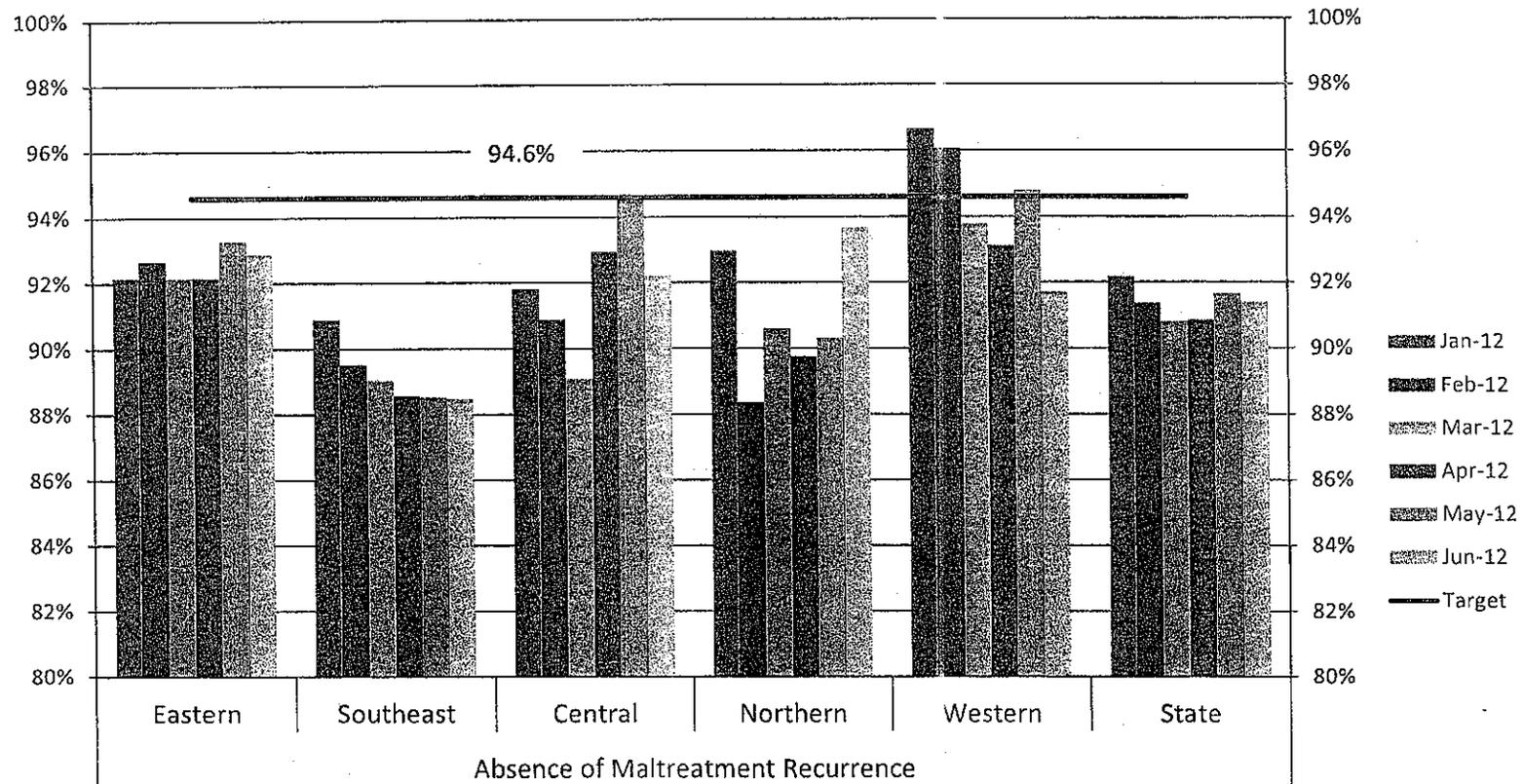
- “Adverse childhood experiences determine the likelihood of the ten most common causes of death in the United States:
  - Smoking
  - Severe obesity
  - Physical inactivity
  - Depression, suicide attempt
  - Alcoholism, illicit drug use
  - 50+ sexual partners, Sexually transmitted disease (Stirling, 2010)
- A national study of adult “foster care alumni” found higher rates of PTSD (21%) compared with the general population (4.5%). This was higher than rates of PTSD in American war veterans. (Stirling, 2010)
- Foster children are a unique group of kids. They have a “trauma-altered physiology” and lack resilience as a whole. (Stirling, 2010)

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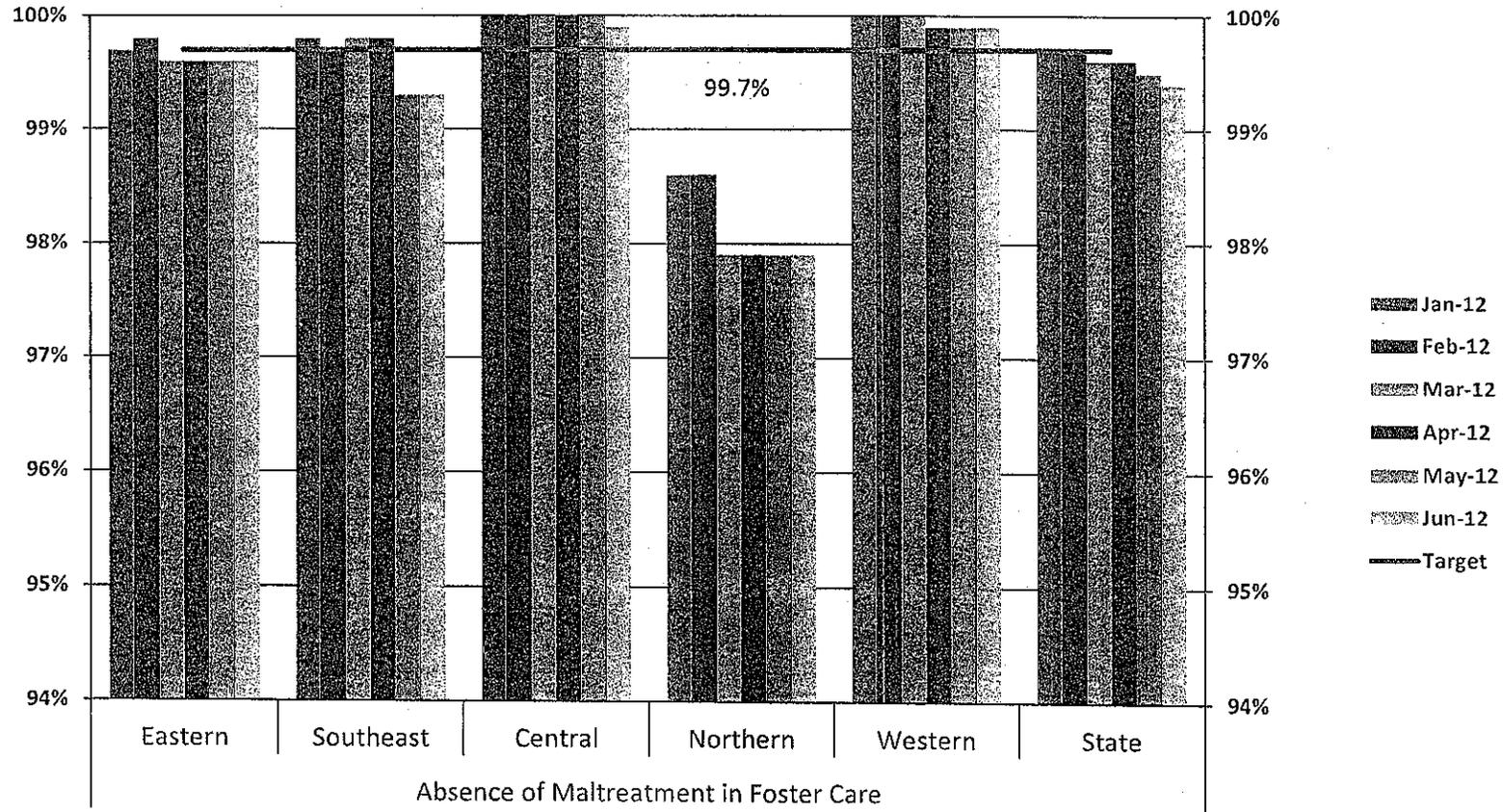
# Attachment L

## 2012 Compass Scores



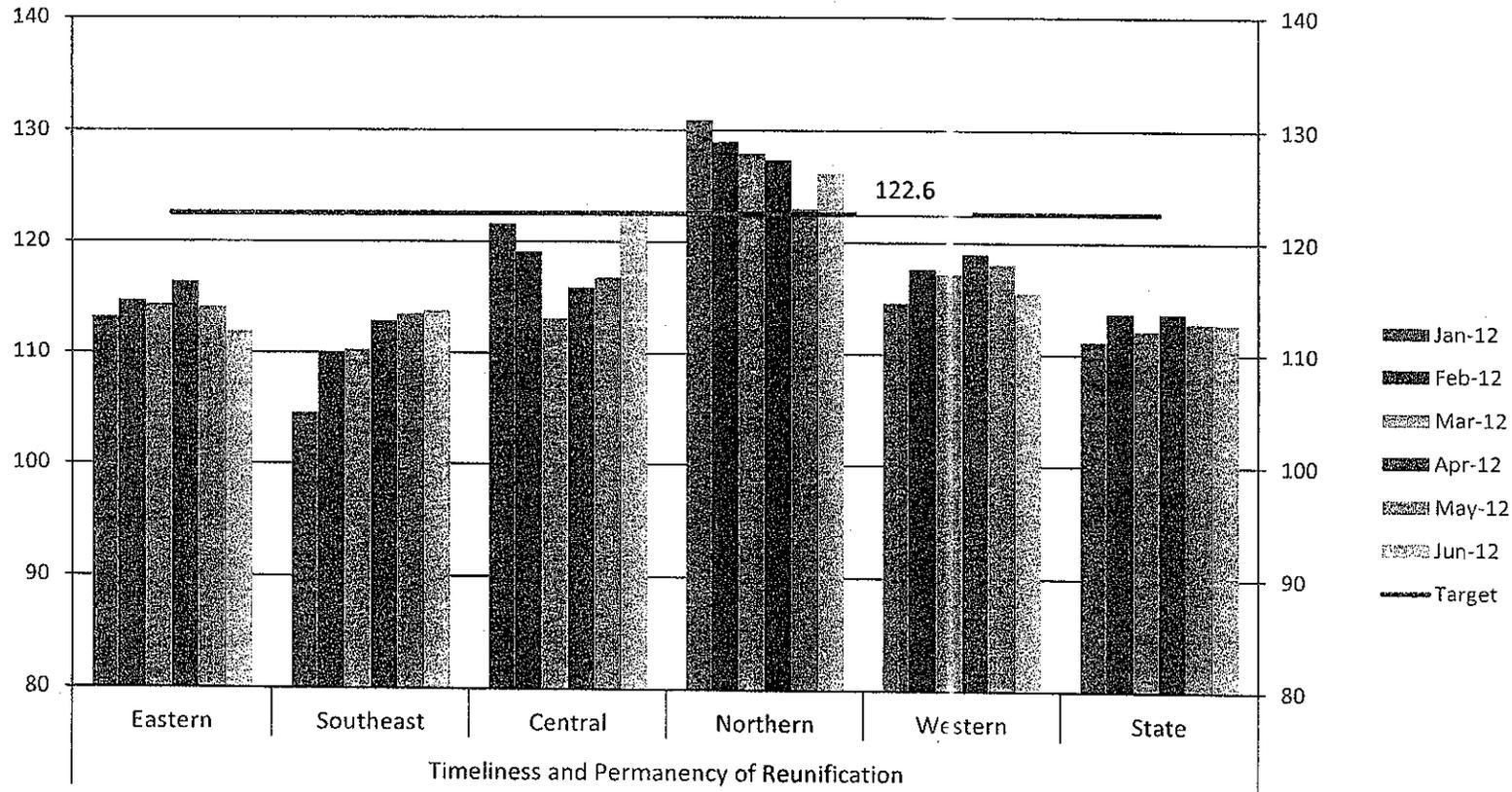
This is Federal Measure that reports on a rolling 12 month period. Data Source: N-FOCUS COMPASS-State wards. The children included in this report were victims of abuse or neglect during the first six months of the 12 month period. If the child was a victim of a subsequent abuse or neglect incident within 6 months of the first incident of abuse or neglect they appear on this report. Victims are defined as children where the court or DHHS has substantiated the allegations of abuse or neglect.

## 2012 Compass Scores



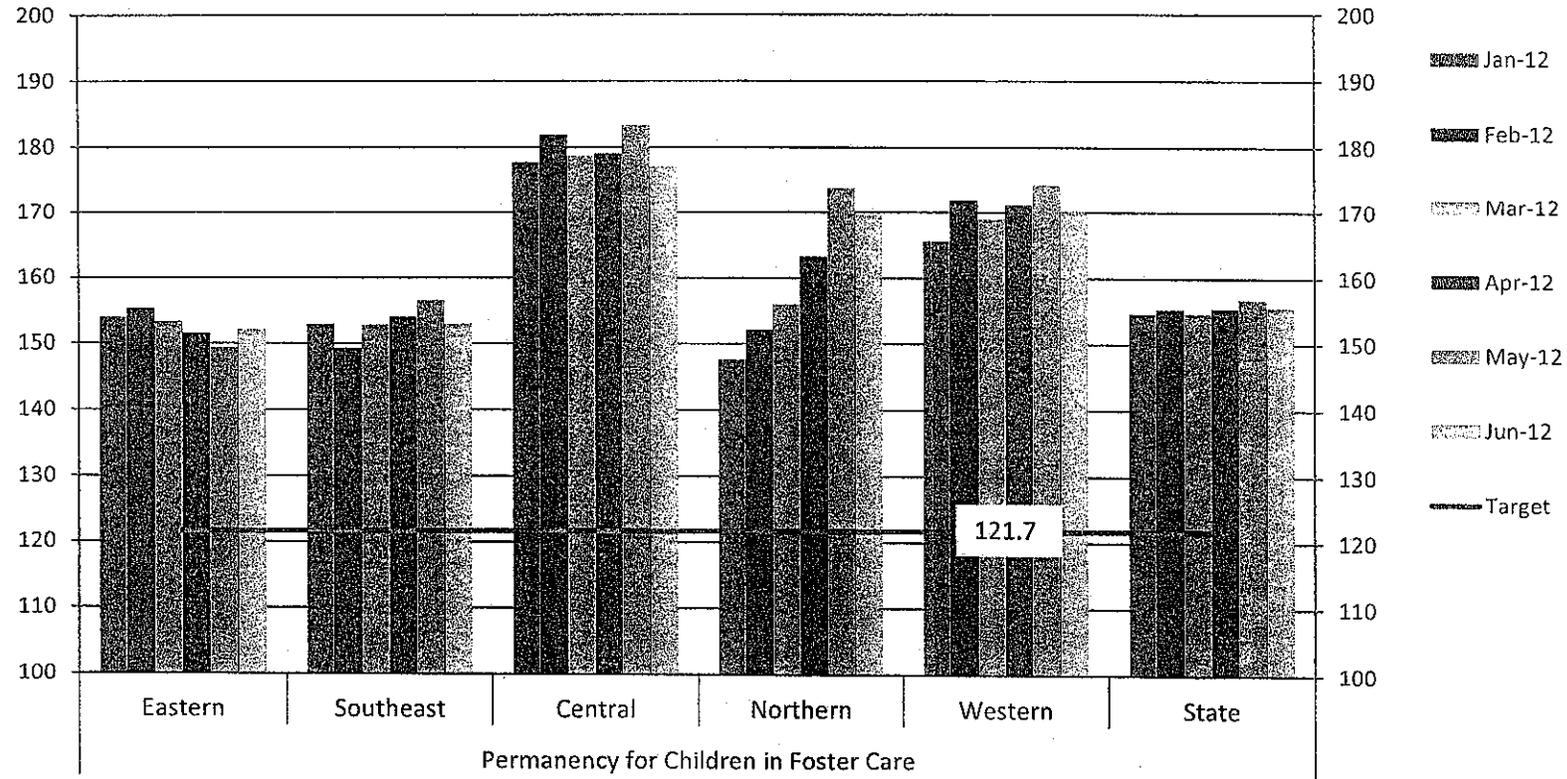
This is a Federal Measure that reports on a rolling 12 month period. Data Source: N-FOCUS COMPASS-Statewards. This measure is of all children who are placed outside of their parental home either in a foster home or group care, the percent that were not abused or neglected by either a foster parent or a facility staff member.

## 2012 Compass Composite Scores



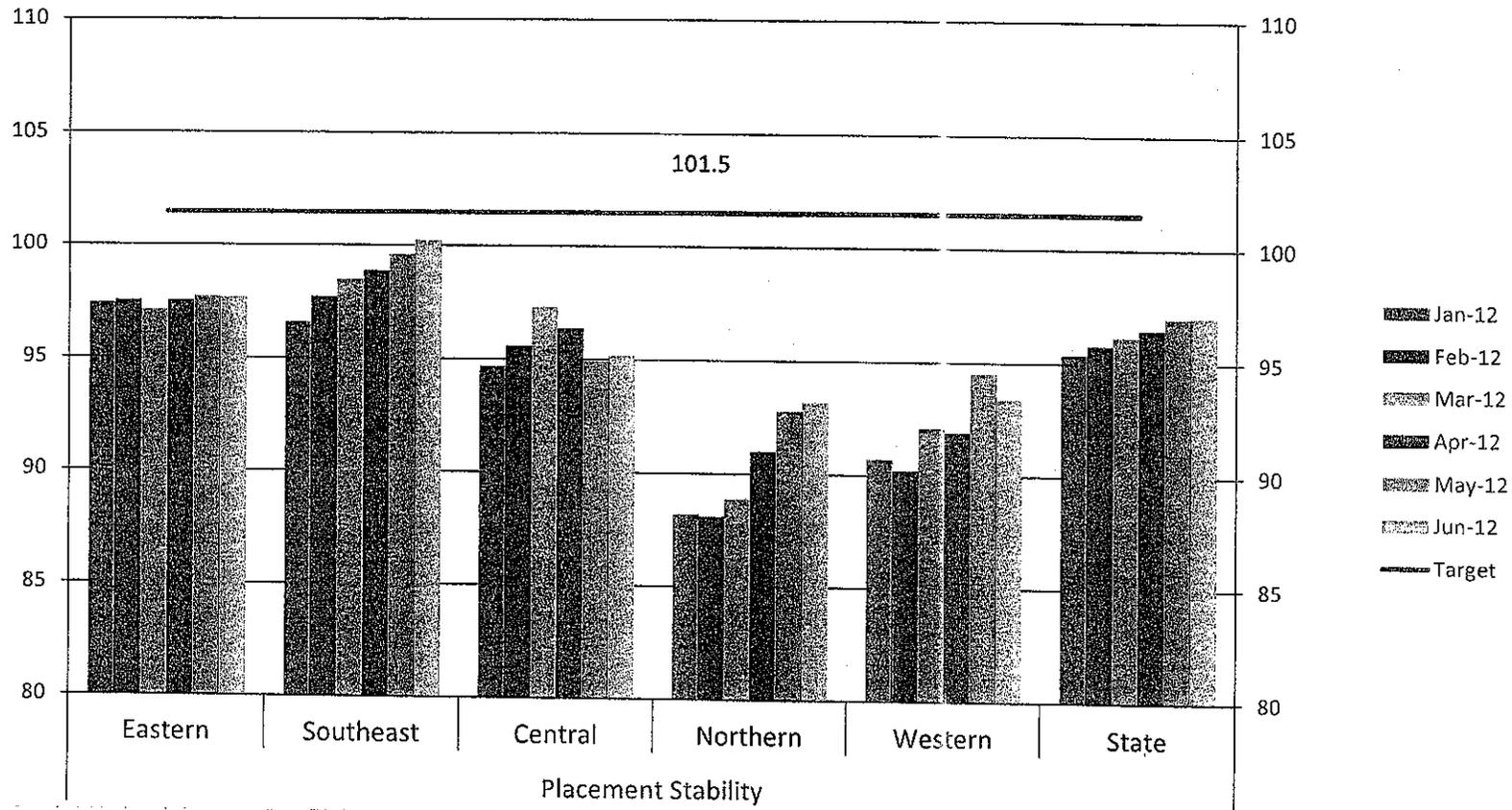
This is a Federal Composite Measure. Data Source: N-FOCUS COMPASS- State Wards. This is a Federal Measure that reports on a rolling 12 month period. The Reunification Composite measures the timeliness of reunification and whether the reunification was permanent over a specific period of time. The Reunification Composite includes four measures: Reunification in Less Than 12 Months, Median Time to Reunification, Entry Cohort Reunification in Less Than 12 Months, and Permanence of Reunification.

## 2012 Compass Composite Scores



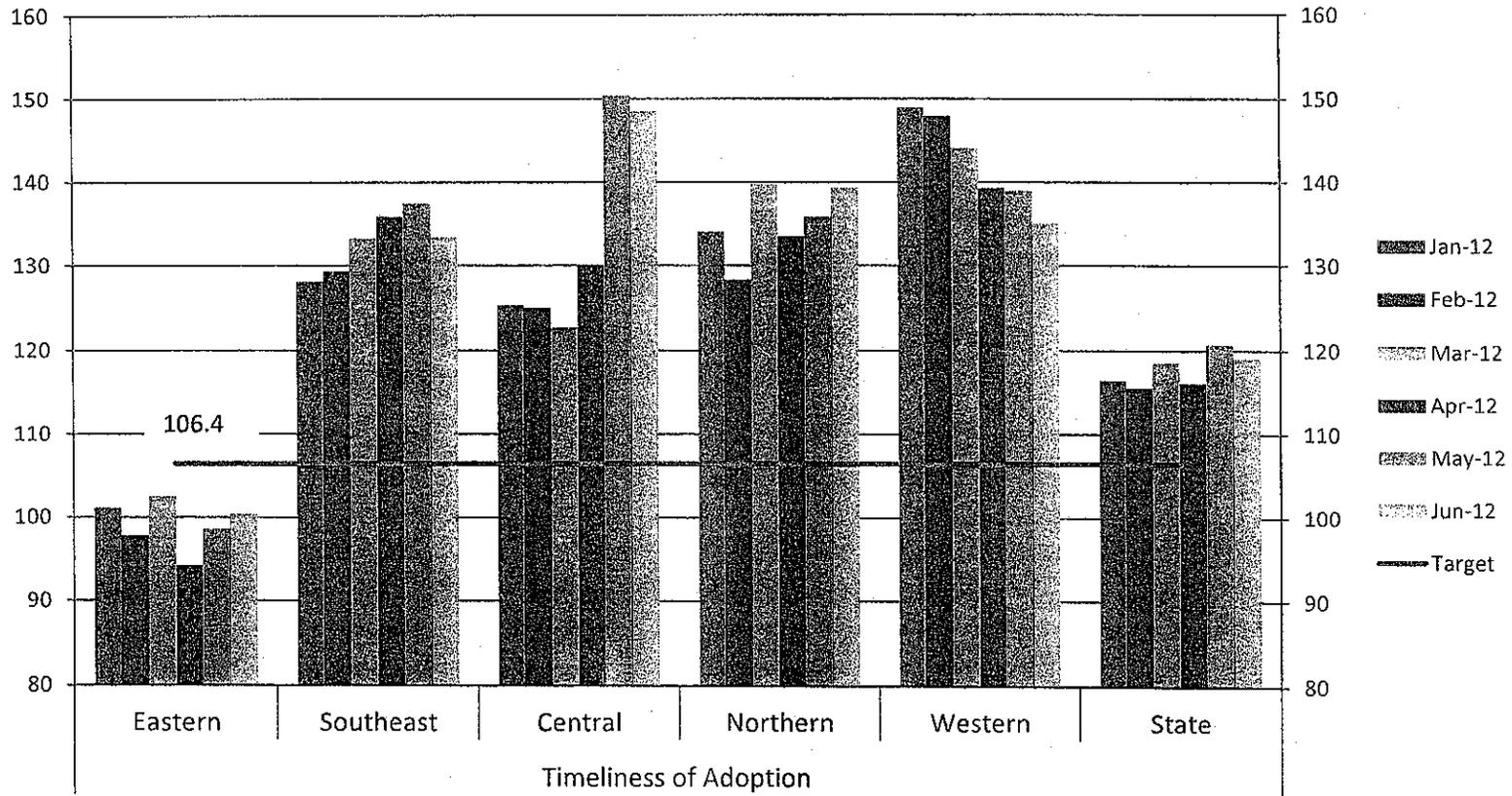
This is a Federal Composite Measure that reports on a rolling 12 month period. Data Source: N-FOCUS COMPASS-State Wards The Permanency Composite measures the frequency that permanency is achieved for children and youth who have been in care for longer periods of time. Permanency is defined as exiting care to reunification, adoption or guardianship. The Composite includes three measures: 1. Exits to Permanency Prior to the Child's 18th Birthday for Children in Care for 24 More Months or More; 2. Exits to Permanency for Children Who are Free for Adoption; and 3. Children Emancipated Who Were in Foster Care for 3 Years or More.

## 2012 Compass Composite Scores



This is the Federal Composite Measure on Placement Stability. This is a Federal Measure that reports on a rolling 12 month period. Data Source: N-FOCUS COMPASS-Statewards. The national standard is 2 or fewer placements over specific periods of time. Placements are not counted for children who experience a brief hospitalization or for children who are on runaway status.

## 2012 Compass Composite Scores



This is a Federal Composite Measure: Data Source: N-FOCUS COMPASS-State wards. This is a Federal measure that reports on a rolling 12 month period. The Adoption Composite measures the timeliness of adoptions and includes the following five measures: Adoption in less than 24 Months, Median Time to Adoption, Children in care for 17 Months or Longer Who Are Adopted by the End of the Year, Children in Care for 17 Months or Longer Who Are Legally Free for Adoption within 6 Months, and Children Who Are Legally Free for Adoption Who Are Adopted within 12 Months.

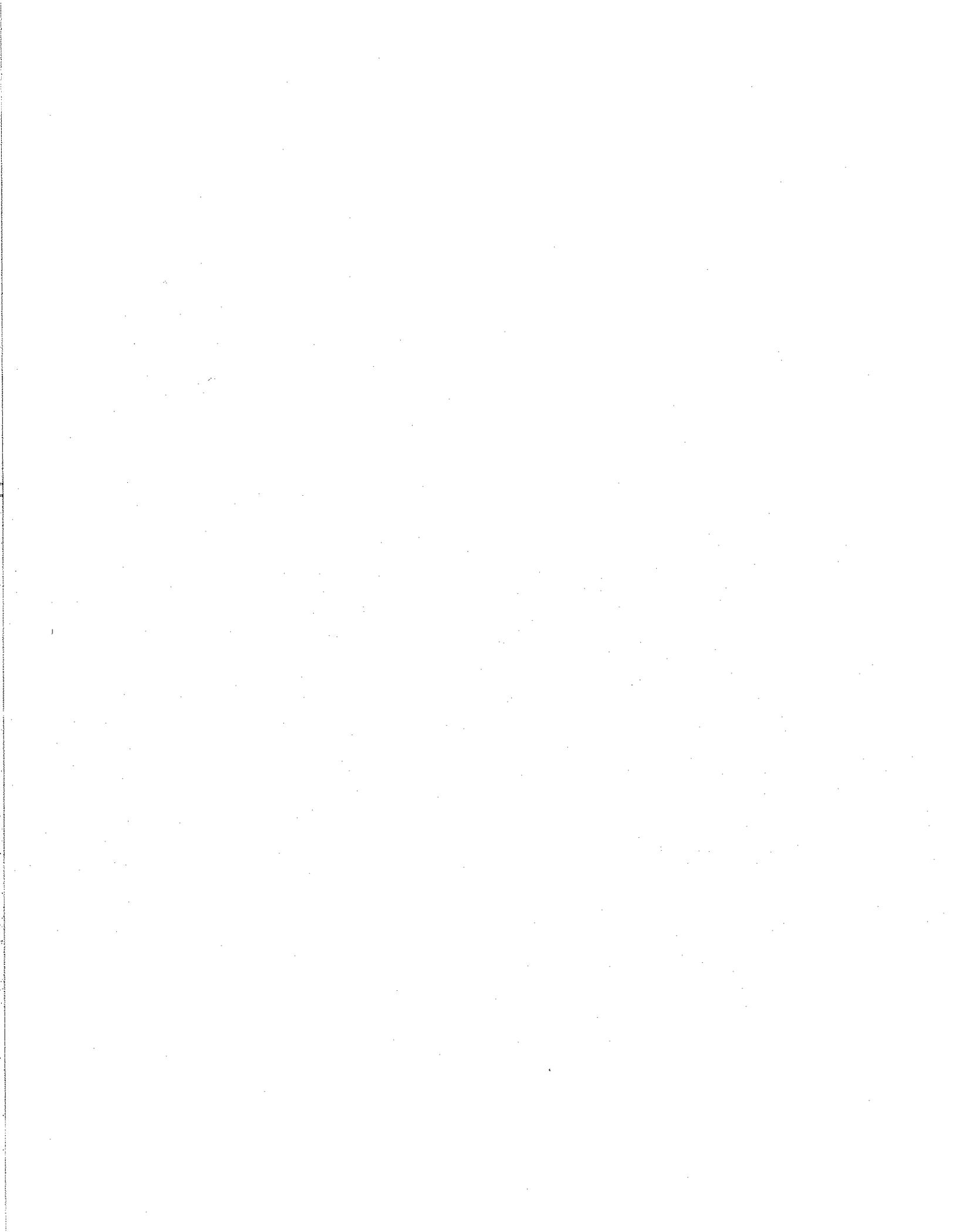
# Attachment M

Nebraska Division of Behavioral Health - Implementation Report  
 FY 2012 SAMHSA Block Grant Reporting Section  
 CFDA 93.958 (Mental Health)  
 CFDA 93.959 (Substance Abuse Prevention and Treatment)

Prioritize State Planning	Goal & Performance Indicator	Implementation Progress as of June 30, 2012
1 Substance Abuse Prevention	<p>Goal: To complete a Strategic Plan for Prevention.</p> <p>Performance Indicator: Contingent upon when Technical Assistance is received, the Strategic Plan for Prevention will be completed by the target date of 9-30-12.</p>	DBH has been working with a CSAP consultant and key partners to produce a draft strategic plan. This draft is currently being reviewed by stakeholders and various advisory bodies. DBH is on target for having an approved plan by 9-30-12.
1 Substance Abuse Prevention	<p>Goal: To reduce the sale of tobacco to youth.</p> <p>Performance Indicator: The total number of sales to minors (Retailer Violation Rate – RVR). Nebraska’s RVR was 10.6% in FY11 and will maintain this percentage in FY12 and FY13.</p>	Via contract with the Nebraska State Patrol and Region 6/Omaha Police Department, Synar Tobacco Compliance Checks are currently being conducted across the state. Upon completion of the required sample and receipt of the data, DBH staff will aggregate the Retailer Violation Rate for Calendar Year 2012 and develop the Annual Synar Report by December 1, 2012.
1 Substance Abuse Prevention	<p>Goal: To reduce underage drinking and excessive drinking by adults through the use of environmental strategies.</p> <p>Performance Indicator: A total of 28 of environmental activities related to the reduction of underage and excessive drinking by adults were performed and funded by DBH in FY11. In the FY12, the number will be increased to 40 and 55 in FY13.</p>	In FY12, the number of environmental activities performed that relate to reduction of underage and excessive drinking by adults was 87.

Prioritize State Planning		Goal & Performance Indicator	Implementation Progress as of June 30, 2012
5	Transition Age Youth and Young Adult	Goal: To increase access to services for young adults/youth transitioning to adulthood.	Total number of persons age 16-24 served between July 2011 and June 2012 was 6,668.
		Performance Indicator: Total number of persons age 16-24 served. Baseline for total number of persons age 16-24 served on June 30, 2011 was 6,110. This will increase to 6,500 by June 30, 2013.	
6	Professional Partners Program	Goal: To implement Wrap Around in the Professional Partners Program with integrity.	Wraparound Fidelity Instrument (WFI) version 4. WFI Data will be received on July 31. 5 Regions will submit their WFI-4.0 data for FY12. One Region will start using WFI-4.0 on 7/1/2012 and be able to report on WFI-4.0 in FY13. WFI measures for FY12 will be shared with the Regions first before bring to the public.
		Performance Indicator: WFI measures as compared to WFI national benchmarks. Establish the baseline across 11 WFI measures by September 30, 2012. Increase the number of measures at which we are meeting or exceeding the national benchmarks.	
7	Co-Occurring Disorder Services	Goal: To increase the capacity of the public behavioral health workforce to be able to deliver effective prevention and treatment in recovery-oriented systems of care for people with co-	Trainings were held with COMPASS-EZ developers June 5th, June 11th and June 12th to provide DBH, Regions and providers with information on the COMPASS-EZ tool and how to complete the assessment process. The Division has asked that the Regions submit to the Division, no later than December 15, 2012, results of the COMPASS-EZ for each of the Regionally contracted providers (except Prevention providers). Results should be based on findings from the COMPASS-EZ assessment. Results to be shared with the Division of Behavioral Health for each program should include 3 to 5 "action Items" for improvement and a statement on what was learned about the program throughout the assessment process.
		Performance Indicator: Total number of behavioral health providers that are dual capable and dual enhanced. Baseline is zero as of January 1, 2012. One hundred percent (100%) of the providers under contract with the six RBHAs will complete the COMPASS-EZ by January 1, 2013.	

Prioritize State Planning	Goal & Performance Indicator	Implementation Progress as of June 30, 2012
11 Intravenous Drug Abusers	<p>Goal: To Serve Intravenous Drug Abusers</p> <p>Performance Indicator: Count of persons served who are Intravenous Drug Abusers. In FY2011, the unduplicated count persons served who were Pregnant Injecting Drug Users was 34 and the Injecting Drug Users was 1,559. DBH will maintain this service level through June 30, 2013.</p>	Count of persons served who are Intravenous Drug Abusers in FY2012: The unduplicated count persons served who were Pregnant Injecting Drug Users was 36 and the Injecting Drug Users was 1599.
12 Tuberculosis (TB)	<p>Goal: To Screen for TB</p> <p>Performance Indicator: Maintain the contractual requirements of the six Regional Behavioral Health Authorities to conduct the TB screenings.</p>	Done! The contractual requirements of the six Regional Behavioral Health Authorities to conduct the TB screenings was maintained.



**DBH Prevention System  
FY12 Update  
Goals and Indicators**

Combined Block Grant Application 2011-2013  
August 7, 2012  
Presented by Renee Faber, Prevention Coordinator

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**Priority #1 Prevention**

- To Complete a Strategic Plan for Prevention
- Indicator: Finalize by 9-30-12.
  - Draft is out for review.

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**Priority #1 Prevention**

- To Reduce the Sale of Tobacco to Youth.
- Indicator: Total Number of Sales to Minors.
  - Maintain the current RVR of 10% or less.

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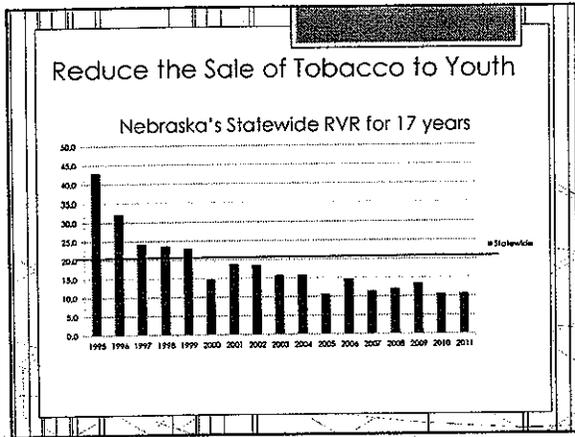
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### Priority #1 Prevention

- Reduce Underage Drinking and Excessive Drinking by Adults through the use of Environmental Strategies.
- Indicator: A total of 28 Environmental Activities were performed in FY11.
- This number was 87 for FY12!

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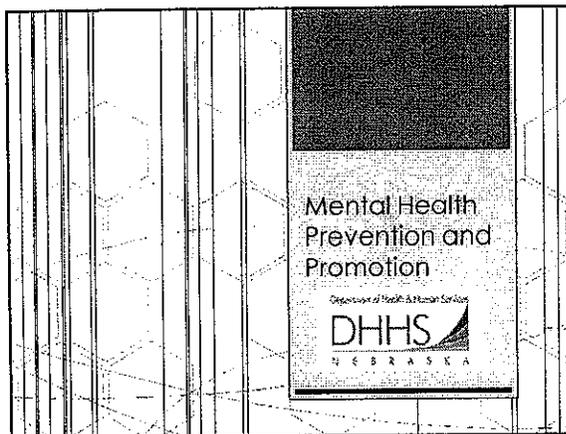
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<ul style="list-style-type: none"> <li>Health promotion is the process of enabling people to increase control over, and to improve, their health.</li> <li>It moves beyond a focus on individual behavior towards a wide range of social and environmental interventions.</li> </ul>	<p>What is Health Promotion?</p>
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PUBLIC HEALTH MODEL

PUTTING INTO

<p>"A state of complete physical, mental and social well-being, and not merely the absence of disease".</p> <ul style="list-style-type: none"> <li>It is related to the promotion of well-being, the prevention of mental disorders, and the treatment and rehabilitation of people affected by mental disorders.</li> </ul>	<p>What is Mental Health Promotion?</p>
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<ul style="list-style-type: none"> <li>By 2020, mental and substance use disorders will surpass physical diseases as a major cause of disability worldwide.</li> <li>The annual total estimated societal cost of substance abuse in the U.S. is \$510.8 billion, with an estimated 23.5 million Americans aged 12 and older needing treatment for substance use.</li> <li>More than 34,000 Americans die every year as a result of suicide, approximately one every 15 minutes.</li> <li>Half of all lifetime cases of mental and substance use disorders begin by age 14 and three-fourths by age 24. In 2008, 9.8 million adults in the U.S. had a serious mental illness.</li> </ul>	<p>What is Behavioral Health?</p> <p>It is the state of mental/emotional being and/or choices and actions that affect wellness.</p> <p>(Substance abuse and misuse are one set of behavioral health problems)</p>
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- o In prevention it is our responsibility to be mindful of the connection between mental, physical health.
- o Our goal should be to improve overall health.
- o By collaboratively working across disciplines, pooling resources, and reaching people in those various settings we can have the most impact.

**Mental and Physical Health: A Collaboration**

Good mental health often contributes to good physical health.

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**Continuum of Care**

- o **Prevention:** Delivered prior to the onset of a disorder, these interventions are intended to prevent or reduce the risk of developing a behavioral health problem.
- o **Promotion:** These strategies are designed to create environments and conditions that support behavioral health and the ability of individuals to withstand challenges.

UNIVERSAL - ALL PEOPLE

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INDICATED -

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- o **Risk factors** are characteristics at the biological, psychological, family, community, or cultural level that precedes and is associated with a higher likelihood of problem outcomes.
- o **Protective factors** are characteristics associated with a lower likelihood of problem outcomes or that reduce the negative impact of a risk factor on problem outcomes.

**Levels of Risk, Levels of Intervention**

Risk and protective factors.

INCREASE

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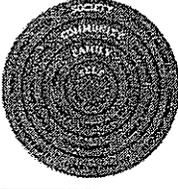
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- o Risk and protective factors occur in multiple contexts.
- o The effects of risk and protective factors can be correlated and cumulative.

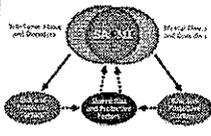


**Prevention Approaches with Risk and Protective Factors**

Utilizing universal, selective and indicated prevention interventions.

INCREASING  
LIFE SKILLS  
& CONFIDENCE

- o Some risk and protective factors have specific effects, but others are associated with multiple behavioral health problems.
- o They influence each other and behavioral health problems over time.

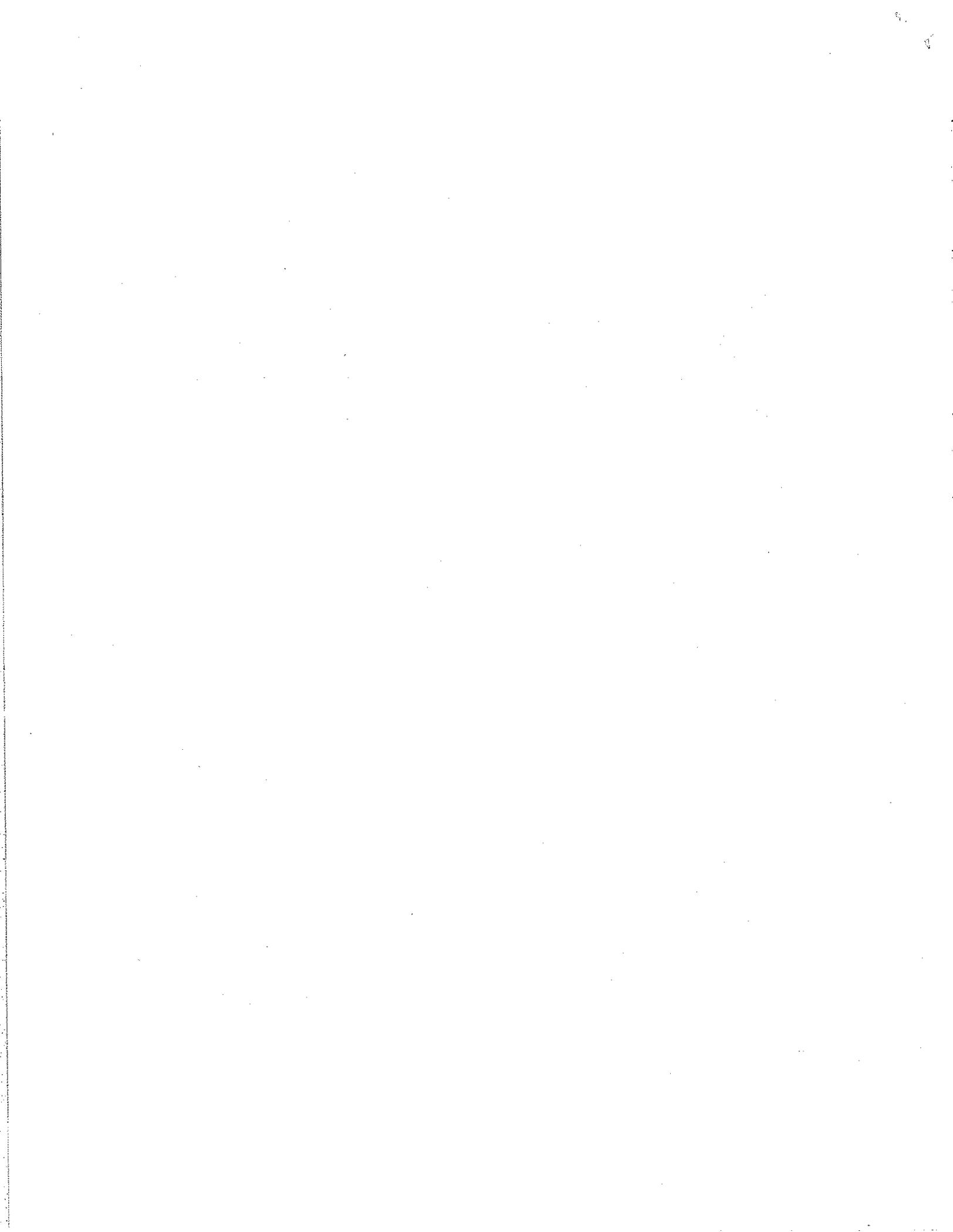


**Risk and Protective Factors**

- o **Infancy and Early Childhood:** this is the beginning of understanding their own and others' emotions, to regulate their attention and to acquire functional language.
- o **Middle Childhood:** children learn how to make friends, get along with peers, and understand appropriate behavior in social settings.
- o **Adolescence:** focus on developing good health habits, practice critical and rational thinking, and seek supportive relationships.
- o **Early Adulthood:** individuals learn to balance autonomy with relationships to family, make independent decisions and become financially independent.

**The Developmental Framework**

This approach to prevention helps ensure that interventions have the broadest and most significant impact.



9	Permanent Supportive Housing	Goal: To improve the Permanent Supportive Housing services.
		Performance Indicator: Define what Permanent Supportive Housing services means in Nebraska by January 2013. Create process for fidelity monitoring by June 30, 2013. Total number persons served in Permanent Supportive Housing baseline as of June 30, 2011 was 817. This will increase.

## Define What Permanent Supportive Housing Services Means in Nebraska

Draft – August 7, 2012

In Nebraska, Permanent Supportive Housing services are the Housing-Related Assistance program [Neb. Rev. Stat. 71-812(3)]. This program is administered by the Department of Health and Human Services – Division of Behavioral Health (DBH).

The SAMHSA Permanent Supportive Housing Evidence-Based Practices (EBP) calls for:

- (1) Flexible, voluntary supports, (2) Quality housing, (3) Rental assistance, (4) Standard lease, (5) Functional separation of housing and supports, as well as (6) Integration.

Affordable housing programs are extremely complex, highly competitive, and difficult to access. In defining what Permanent Supportive Housing (PSH) services means in Nebraska, Division of Behavioral Health (DBH) can count a program if there is any combination of rental subsidy (includes monitoring for housing quality, standard lease, separation of housing and supports, and integration) as well as appropriate behavioral health supports. This could include all of Section 8 rental assistance received by people with a behavioral health disorder as well as other related forms of subsidized housing in Nebraska in combination with the behavioral health supports.

This was discussed as part of the Evidence Based Practices (EBP) Workgroup meeting on June 21, 2012. Based on that meeting discussion, for the purposes of PSH fidelity monitoring, DBH will only focus upon Housing Related Assistance (HRA). DBH supplies funding for and reports under the SAMHSA Block Grant on Supported Housing using HRA.

In contrast, the U.S. Department of Housing and Urban Development (HUD) manages the Section 8 tenant-based and project-based rental assistance programs as well as other public housing units through the local public housing agencies (PHAs). The behavioral health supports for people living on HUD Section 8 are provided by various behavioral health organizations. Some receive DBH funds, other are funded by Medicaid, still others from other sources. There is no central administrative structure for these organizations to be monitored as PSH providers.

The only place DBH has authority to go to monitor PSH is with those they have a contract to fund and manage for Housing Related Assistance. HRA does meet the PSH standards:

- Housing cost burden is addressed by a rental subsidy.
- Housing must meet the HUD Housing Quality Standards (HQS) criteria.
- People receive BH Support Services via NE DHHS.
- DBH contracts with the six Regions to provide this Housing Related Assistance consistent with a Supportive Housing approach.

Permanent Supportive Housing Fidelity monitoring was completed at all six Regions between December 2008 and March 2009. The focus was on the Nebraska Housing Related Assistance program as authorized in State Statute. At that time DBH used a survey instrument based on the draft SAMHSA Toolkit.

- NE fidelity monitoring method based on SAMHSA Permanent Supportive Housing tool kit

Housing Related Assistance Program Fidelity Monitoring Site Visits

Region	Reviewers	Date Reviewed
1	Denise Anderson and Dan Powers	February 26, 2009
2	Denise Anderson and Dan Powers	February 25, 2009
3	John Turner and Dan Powers	January 29, 2009
4	John Turner and Dan Powers	February 19, 2009
5	Denise Anderson and Dan Powers	December 11, 2008
6	John Turner and Dan Powers	March 13, 2009

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SAMHSA Permanent Supportive Housing Evidence-Based Practices (EBP) KIT

<http://store.samhsa.gov/product/Permanent-Supportive-Housing-Evidence-Based-Practices-EBP-KIT/SMA10-4510>

Flexible, voluntary supports	Permanent Supportive Housing staff offers flexible, voluntary services designed to help people choose housing that meets their needs, obtain and pay for that housing, and keep the housing for as long as they choose.
Quality housing	Housing meets standards for safety and quality established by local, state, and federal laws and regulations. Housing is similar to what is available to others at similar income levels in the community.
Rental assistance	Tenants typically pay 30 percent of their income toward rent plus basic utilities. The remainder is paid either by tenant based rental assistance, which tenants can use in housing of their choice, or project-based rental assistance, which is linked to a specific location.
Standard lease	Tenants typically pay 30 percent of their income toward rent plus basic utilities. The remainder is paid either by tenant based rental assistance, which tenants can use in housing of their choice, or project-based rental assistance, which is linked to a specific location.
Functional separation of housing and supports	Tenants sign a standard lease, just like any other member of the community, giving tenants the same legal rights. Continued tenancy is not subject to any special rules or participation in any particular services.
Integration	Tenants' homes are located throughout the community or in buildings in which a majority of units are not reserved for people with disabilities. Tenants have opportunities for interactions with the community.

H:\Block Grant SAMHSA 2012 2013 2014\Unified Block Grant for webBGAS 2011\Define what Permanent Supportive Housing services means july 2012.docx

**SUPPORTED EMPLOYMENT**

Attachment P

<b>Basic Definition</b>	Supported Employment is designed to provide recovery and rehabilitation services and supports to consumers engaged in community-based competitive employment-related activities in normalized settings. A Supported Employment team provides assistance with all aspects of employment development as requested and needed by the consumer. The intent of the service is to support the consumer in the recovery process so the consumer's employment goals can be successfully obtained.
<b>Service Expectations</b>	<ul style="list-style-type: none"> <li>• Initial employment assessment completed within one week of program entry.</li> <li>• Individualized Employment Plan developed with consumer within two weeks of program entry.</li> <li>• Assistance with benefits counseling through Vocational Rehabilitation for consumers who are eligible for or potentially eligible but not receiving benefits from Supplemental Security Income (SSI) and/or Social Security Disability Insurance (SSDI).</li> <li>• Individualized and customized job search with consumer.</li> <li>• Employer contacts based on consumer's job preferences and needs and typically provided within one month of program entry.</li> <li>• On-site job support and job skill development as needed and requested by consumer.</li> <li>• Provide diversity in job options based on consumer preference including self-employment options.</li> <li>• Follow-along supports provided to employer and consumer.</li> <li>• Participation on consumer's treatment/rehabilitation/recovery team as needed and requested by consumer including crisis relapse prevention planning.</li> <li>• Employment Plan reviewed and updated with consumer as needed but not less than every six months.</li> <li>• Services reflect consumer preferences with competitive employment as the goal and are integrated with other services and supports as requested by consumer.</li> <li>• Frequency of face-to-face contacts based upon need of the consumer and the employer.</li> <li>• Job Development activities.</li> <li>• All services must be culturally sensitive.</li> </ul>
<b>Staffing Ratio</b>	One full-time Employment Specialist to 25 consumers.
<b>Desired Consumer Outcome</b>	<ul style="list-style-type: none"> <li>• Consumer has made progress on his/her self-developed service plan goals and objectives.</li> <li>• Consumer is competitively employed and maintaining a job of his/her choice.</li> </ul>

**UTILIZATION GUIDELINES - ADMISSION GUIDELINES**

*Consumer must meet all of the following admission guidelines to be admitted to this service.*

1. DSM diagnosis of a behavioral health disorders i.e. mental illness, alcoholism, drug abuse, or related addictive disorder.
2. Consumer desires to return to work and requires supports to secure and maintain competitive employment.
3. Zero exclusion-This means every consumer who wants employment and meets other admission guidelines is eligible regardless of job readiness or past history.

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**Title 206 Nebraska Administrative Code - Behavioral Health Services**

Division of Behavioral Health Draft Regulations; For Public Hearing April 7, 2011

DBH Service Definitions: an attachment to the 206 Regulations

24 final) SD (Service Definition) Supported Employment 5-17-10 revised 11-10-10

<http://www.sos.ne.gov/rules-and-regs/regtrack/proposals/000000000000965.pdf>

## Supported Employment (SE) Fidelity Scale

SAMHSA Evidence-Based Practices KIT Draft 2003 / Publication Date: 2/2010		Dartmouth Individual Placement and Support (IPS) The most recent fidelity scale is dated 1/7/08	
<b>Staffing Criterion</b>			
1	Caseload (up to 25 consumers)	1	Caseload size (20 or fewer clients)
2	Vocational services staff	2	Employment services staff
3	Vocational generalists	3	Vocational generalists
<b>Organization Criterion</b>			
1	Integration of rehabilitation with mental health treatment	1	<b>Integration of rehabilitation with mental health thru team assignment</b> [Employment Specialists (ES) are attached to one or two MH treatment teams, from which 90% of the ES's caseload is comprised]
		2	<b>Integration of rehabilitation with mental health thru frequent team member contact</b> [ES actively participate in weekly MH treatment team meetings (not replaced by administrative meetings) that discuss individual clients & their employment goals with shared decision-making. ES's office is in close proximity to (or shared with) their MH treatment team members. Documentation of MH treatment & employment services are integrated in a single client chart. ES help the team think about employment for people who haven't yet been referred to Supported Employment services.]
		3	<b>Collaboration between ES and Vocational Rehabilitation counselors</b> (ES & VR counselors have frequent contact for the purpose of discussing shared clients & identifying potential referrals.)
2	<b>Vocational unit</b> (Employment specialists function as a unit rather than a group of practitioners. They have group supervision, share information, and help each other with cases).	4	<b>Vocational unit</b> (At least 2 full-time ES & a team leader form an employment unit)
3	<b>Zero-exclusion criteria</b> (No eligibility requirements such as job readiness, lack of substance abuse, no history of violent behavior, minimal intellectual functioning, and mild symptoms).	5	<b>Role of employment supervisor</b>
		6	<b>Zero exclusion criteria</b>
		7	<b>Agency focus on competitive employment</b>
		8	<b>Executive team support for SE</b>
<b>Services Criterion</b>			
		1	<b>Work incentives planning</b>
		2	<b>Disclosure</b> (Employment specialists provide clients with accurate information and assist with evaluating their choices to make an informed decision regarding what is revealed to the employer about having a disability.)
1	<b>Ongoing work-based assessment</b>	3	<b>Ongoing, work-based vocational assessment</b>
2	<b>Rapid search for competitive jobs</b>	4	<b>Rapid search for competitive job</b>
3	<b>Individualized job search</b>	5	<b>Individualized job search</b>
		6	<b>Job development—Frequent employer contact</b>
		7	<b>Job development—Quality of employer contact</b>
4	<b>Diversity of jobs developed</b> (ES provide job options that are in different settings).	8	<b>Diversity of job types</b>
		9	<b>Diversity of employers</b>
5	<b>Permanence of jobs developed</b>	10	<b>Competitive jobs</b>
		11	<b>Individualized follow-along supports</b>
6	<b>Jobs as transitions</b> (All jobs are viewed as positive experiences on the path of vocational growth & development. ES help consumers end jobs when appropriate & then find new jobs).	12	<b>Time-unlimited follow-along supports</b> (ES has face-to-face contact w/in 1 week before starting a job, w/in 3 days after starting a job, weekly for the first month, & at least monthly for a year or more, on average, after working steadily & desired by clients. Clients are transitioned to step down job supports, from a MH worker following steady employment clients. Clients are transitioned to step down job supports from a MH worker following steady employment. ES contacts clients within 3 days of hearing about job loss.)
7	<b>Follow-along supports</b>		
8	<b>Community-based services</b>	13	<b>Community-based services</b>
9	<b>Assertive engagement and outreach</b>	14	<b>Assertive engagement and outreach by integrated treatment team</b>

Attachment Q

## Projected State Agency Expenditure Report

October 1, 2012-September 30, 2013

Activity	MHBG	Medicaid	Other Fed Funds	State Funds
State Hospitals				
Other 24 hour care	\$187,163	\$2,942,237		\$8,193,699
Ambulatory/Community				
Non 24hr care	\$1,788,249	\$7,565,753	\$288,000	\$54,834,754
Administration (excluding program/provider level)	\$103,968			
<b>Totals</b>	<b>\$2,079,380</b>	<b>\$10,507,990</b>	<b>\$288,000</b>	<b>\$63,028,453</b>

<b>FY12 Amounts</b>	<b>\$1,922,173</b>	<b>\$10,302,209</b>	<b>\$288,000</b>	<b>\$62,840,235</b>
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## Projected Expenditures for Treatment & Recovery Supports

October 1, 2012-September 30, 2013

Category	MHBG FY13	FY12
Healthcare Home/Physical Health	NA	NA
Engagement Services	NA	NA
Outpatient Services	10-25%	10-25%
Medication Services	<10%	<10%
Community Support (Rehab)	10-25%	10-25%
Recovery Support	<10%	NA
Other Supports (Habilitative)	NA	NA
Intensive Support Services	26-50%	26-50%
Out of Home Residential	<10%	10-25%
Acute Intensive	<10%	NA
Prevention	<10%	10-25%
System Improvement	<10%	<10%
Other (Administration)	<10%	<10%

Only Services purchased with Federal dollars are reflected on this chart.

Additional services in each category are purchased with State funds.

## Mental Health Community Services Block Grant Reimbursement Strategy

Strategy	Service
<b>Encounter Based</b> <i>Fee for unit of service</i>	Day Rehabilitation; Day Residential; Psychological Residential Rehabilitation; Day Treatment; Medication Management
<b>Grant/Contract Reimbursement</b> <i>periodic payments for services</i>	Outpatient, Intensive Outpatient; Day support, Supported Employment, Therapeutic Consultation; Children's Day Treatment, Children's Multi-Systemic Therapy, prevention; Provider training;
<b>Risk based</b> <i>case rate payment (monthly or other timeframe)</i>	Community Support, Professional Partner Wraparound
<b>Innovative</b>	
<b>Other:</b>	