Division of Behavioral Health - Joint Meeting
State Advisory Committee on Mental Health Services
State Advisory Committee on Substance Abuse Services
State Committee on Problem Gambling
May 6, 2010- 8:30 a.m. to 4:00 p.m.
Country Inn and Suites, 5353 No. 27th Street, Lincoln, NE 68521

DRAFT

OPEN MEETING - 8:30 AM		
Welcome	Jim Harvey	Call to order
Attendance-Determination of Quorum of Committees	Alexandra Castillo	Roll Call
Housekeeping	Jim Harvey	Inform
Introductions		All
Approval of Feb 2-4, 2010 Minutes	Bev Ferguson-Ann Ebsen	General Consent

Nebraska Dept. of Health & Human Services — Kerry Winterer, CEO

Points of View

Jerome Barry - Service Provider
Kevin Karmazine - Consumer
Cody Manthei - Consumer

Top Issues and Commonalities to Co-Occurring Disorders

MH Advisory Committee	Bev Ferguson
SA Advisory Committee	Ann Ebsen
Problem Gambling Committee	Dennis McNeilly

Research Experts Related to Co-Occurring Disorders

University of Nebraska Medical Center	Shinobu Watanabe-Galloway
University of Nebraska Medical Center (Gambling)	Dennis McNeilly
Co-OccurringTask Force (Omaha)	Tara Muir

WORKING LUNCH 12:15 pm

PUBLIC COMMENT 12:30 pm

a. Each person wishing to speak at the meeting needs to sign up on the Public Comment Sign-in Sheet.
b Each person will be called on from the Public Comment Sign-in Sheet. Each person may have 5 minutes (unless the Chair grants more time) to provide comments.
c. Public comments not provided verbally may be mailed to the Division of Behavioral Health Services, Attention: Alexandra Castillo.

Review Speakers' Key Points	ALL
Break Out Groups to Identify Priorities for DBH Strategic Planning	Denise Bulling
Break Out Groups' Reports	ALL

Recommendations & Questions to Division of Behavioral Health — ALL

ADJOURN - 4:00 p.m. — ALL

This agenda is kept continually current, and is readily available for public inspection at the Division of Behavioral Health during normal business hours. The Division of Behavioral Health is located on the 3rd floor of the Nebraska State Office Building, 301 Centennial Mall South, Lincoln, Nebraska, 68509

Updated: 4/16/10

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May 6, 2010 – 8:30 a.m. to 4:00 p.m.
Country Inn & Suites – 5353 No. 27th St. Lincoln, NE
MINUTES

Mental Health Committee Members Present (18):
Adria Bace, Beth Baxter, Chelsea Chesen, Roxie Cillessen, Pat Compton, Cheryl Crouse, Sharon Dalrymple, Bev Ferguson, Scot Ford, Dwain Fowler, Chris Hanus, Clint Hawkins, Kathy Lewis, Cody Manthei, Kasey Moyer, Mark Schultz, Joel Schneider, Pat Talbott, Diana Waggoner

Mental Health Committee Members Absent (4):
Roxie Cillessen, Dave Lund, Vicki Maca, Jerry McCallum

Substance Abuse Committee Members Present (8):
Corey Brockway, Ann Ebsen, Jay Jackson, Linda Krutz, Delinda Mercer, Brenda Miner, Randy See, Rand Wiese

Substance Abuse Committee Members Absent (4):
Subhash Bhatia, Shree Ezell, Vicki Maca, Laura Richards

DHHS Staff Present:
Scot Adams, Alexandra Castillo, Maya Chilese, Carol Coussons de Reyes, Jim Harvey, Nancy Heller, Eric Hunsberger, Ashley Nielsen, Blaine Shaffer.

Speakers and Guests Present:
Jerome Barry, Jerry Bauerkemper, John Bekins, Denise Bulling, C. J. Johnson, Kevin Karmazin, Cora Micek, Dennis McNeilly, Tara Muir, Joshua Robinson, Julie Scott, Kate Speck, Shinobu Watanabe-Galloway, Kate Watkins

I. CALL TO ORDER

Meeting was called to order at 8:30 a.m. and roll call was conducted for both advisory committees. The roll call determined a quorum was met for both committees.

Each member briefly introduced themselves by sharing the reason they were attending this meeting and one other thing of interest to them, either personal or business related.

II. Housekeeping and Summary of Agenda

Mr. Harvey pointed out the location of the rest rooms, plans for lunch, the need to use the microphone and briefly summarized the agenda by explaining the plan as; a panel of speakers will make their 10 minute presentation and then questions will be answered. Break out group will be conducted in the afternoon with Denise Bulling as the lead person. Comment will be collected. **Attachment 1**

III. Points of View/Take Home Messages

Jerome Barry—Service Provider **Attachment 2**

1) We need to move toward integrated treatment options for individuals with co-occurring disorders, without losing the value and unique competencies of LADC's who are not interested in pursuing dual licensure.
2) Individualized care should be the underlying theme in all that we do:
   - Assessment
   - Treatment planning
   - Length of stay
   - Family involvement, and
   - Co-Occurring Disorders

Kevin Karmazin—Consumer

1) To thrive, a person must have HOPE!

Cody Manthei—Consumer

1) Remember we all have a story that is deep within us—recovery from Mental Illness and Substance Abuse comes from that place. Recovery is possible.
2) When we allow ourselves to be open to someone else's experience without judgments and expectations, healing is inevitable and the human experience occurs.

Top Issues and Commonalities to Co-Occurring Disorders

Pat Talbott—Mental Health Advisory Committee **Attachment 3**

1) Recovery—**Recovery--RECOVERY**
2) Top Priorities are:
    - Transition Age Youth
    - Children's Mental Health
    - Juvenile and Adult Criminal Justice
3) Eliminate stigma

Rand Wiese—Substance Abuse Advisory Committee **Attachment 4**

1) Recovery is a reality in Nebraska—it is possible.
2) Never give up—change will happen; there are various factors involved in change, depending on the individual
3) Recovery does work – people do get better

Dennis McNeilly—Problem Gambling Committee **Attachment 5**

1) Nebraska has kept (some forms of) gambling out of the state, but gambling is still a problem; there are other venues available other than casinos, as well as people access gambling in other states.
2) What we know about gambling is still relatively new—we are still studying and learning about the various types of gambling: problem gambling, pathological gambling, and episodic gambling.

Research Experts Related to Co-Occurring Disorders

Shinobu Watanabe-Galloway—University of Nebraska Medical Center (Data)

1) Education and Needs Assessment
    - Education is very important for: the public, policy-makers, and the general population.
2) Data needs to be used

Dennis McNeilly—University of Nebraska Medical Center (Gambling)

1) People with gambling problems get into a lot of trouble—especially deep debt.
2) We need to look at the best ways to treat problem gamblers.

Tara Muir—Co-Occurring Task Force **Attachment 6**

1) Adopt a set of operating principles:
    a) Co-occurring disorders (COD) are to be expected in all behavioral health settings, and system planning must address the need to serve people with COD in all policies, regulations, funding mechanisms, and programming.
    b) An integrated system of mental health and addiction services that emphasizes continuity and quality is in the best interest of consumers, providers, programs, funders, and systems.
    c) The integrated system of care must be accessible from multiple points of entry (i.e., no wrong door), and be perceived as caring and accepting by the consumer.
    d) The system of care must reflect the importance of the partnership between science and service, and support both the application of evidence- and consensus-based practices for persons with COD and evaluation of the efforts of existing programs and services.

e) Behavioral health systems must collaborate with professionals in primary care, human services, housing, criminal justice, education, and related fields in order to meet the complex needs of persons with COD.
f) Co-occurring disorders must be expected when evaluating any person, and clinical services should incorporate this assumption into all screening, assessment, and treatment planning.
g) Within the treatment context, both co-occurring disorders are considered primary.
h) Empathy, respect, and belief in the individual's capacity for recovery are fundamental provider attitudes.
i) Treatment should be individualized to accommodate the specific needs, personal goals, and cultural perspectives of unique individuals in different stages of change.
j) The special needs of children and adolescents must be explicitly recognized and addressed in all phases of assessment, treatment planning, and service delivery.
k) The contribution *of the community* to the course of recovery for consumers with COD and the contribution of consumers with COD *to the community* must be explicitly recognized in program policy, treatment planning, and consumer advocacy.

2) Adopt a purpose/mission statement:
   a) In the context of statewide infrastructure development for services to individuals and families with co-occurring psychiatric and substance use disorders, and in recognition of the high prevalence, poor outcomes, and high cost of sequential treatment services, the Division of Behavioral Health has developed this bulletin to accomplish the following objectives:
      - to move the entire behavioral health system toward the achievement of core competency to serve individuals with co-occurring psychiatric and substance use disorders who are already engaged in a facility program.
      - to provide the framework for delineating objective criteria for defining Co-Occurring Disorder Competency for any facility within the State licensed by the Division of Behavioral Health, and
      - to describe the process by which licensed facilities can achieve Co-Occurring Disorder Competency.

IV. Public Comment

None

V. Break Out Groups – Identify Priorities for DBH Strategic Planning — Attachment 7

Attendees were asked to form 3 break out groups to give input to the three questions. They were allowed 10 minutes on each question and then moved on the next question. The questions and summary notes are listed:

♦ What do we need to do to provide access and standards for access to behavioral health services?

Discussion within the groups included an expression of the need to balance access with quality. In addition, there were comments about inequities in access in rural areas of the state that many perceived to be related to funding mechanisms. A common funding concern related to access was the limitation placed on service provision during times of transition (e.g., from one level of service to another). Providers wanting to improve access are also faced with balancing open access with maintaining a steady stream of customers – right now that is accomplished through waiting list management. The need for standards related to waiting list maintenance was also brought up in this discussion group.

1. Identify Problems: Expense, Willingness, Stigma
2. Expand Technology: Expand services access, Utilize and maximize technology use, Expand the use of Tele-health, Use technology to communicate with the rural population
3. Improve Communications: Prevent Misunderstanding using awareness, Create a flow system
4. Improve Cultural Competency: Create or maintain services for other cultures with a support system
5. Provide an answer to transportation: creating or utilizing transportation services in rural areas
6. Increase funding and access to funding

7. Provide Support: Create a statewide peer support line, maintain equal support across the state, create a safety net of support
8. Set Service Standards: Make standards consumer-based, consumer-driven, and evidence based; create a grading system based on standards; create a standard assessment and standard training in order to maintain quality assurance
9. Improve access to government programs: improve access for non-Medicaid eligible consumers
10. Standardize the waiting list: Create and centralized waiting list and/or Standardize the waitlist length for short term
11. Improve Training for staff: create training standards based on respect and emphatic attention to recovery

♦ **What information do you want to see as part of a regular, transparent report of performance for the BHS?**

The current reporting requirements for block grants, federal funds and legislative priorities were identified as a place to start with reporting. Some people in this group wanted more transparency on the regular reporting that is already occurring. Discussion in this group included a desire for the Division of Behavioral Health to incentivize system change by tying outcomes to provider performance in a way that encourages adoption of effective practices.

1. Report on Individuals between high school and age 22 with monitoring after age 22 to report on transition-aged youth. Include the growth of substance use in transition-aged youth and beyond, success beyond graduation, rates of expulsion/truancy, teen pregnancy, employment, housing, and suicide. Report on the number of individuals accessing other supports. Report if the stigma factor decreases.
2. Utilize family involvement and invest money in young children and families.
3. Integrate overall wellness in physical, mental, behavioral, and spiritual wellness; increase prevention and early intervention; decrease morbidity.
4. Define progress markers, success, long term recovery, and costs. Create a cost-benefit analysis and public reports. Identify individual recovery measures that state and regional providers have access to.
5. Increase satisfaction by increasing access, transportation, quality of life and meeting individual needs.
6. Identify the results of the provided services with baseline homelessness, criminal justice measures, comparing youth vs. adult data, employment measures, examining youth education, utilizing data previously collected, utilize consumer-led data collecting measures.
7. Plan using cluster-based planning and system planning.
8. Complete Wraparound Training.

♦ **Ideas to INCREASE Public Behavioral Health Cost-effectiveness/efficiencies**

It was recognized that regardless of the efficiencies that are discussed, the workforce in behavioral health is not sufficient in numbers or in ability to carry out "integrated" care successfully. Investments in workforce development were viewed as crucial in bringing the system to a point where treatment of co-occurring disorders via integrated treatment is possible. The need for data to drive system change and to serve as benchmarks was repeated by many people in this group. The State Division of Behavioral Health was generally looked to as a leader in developing the system structures poised to take advantage of technology like video /phone service delivery. The State was also viewed as the leader for standards and benchmarks that would allow consumers to rate or choose providers.

1. Provided cafeteria-style benefits to allow individuals to select what they need from an array of services and tie funding to an individual.

2. Promote a choice in service provider, the use of trauma-informed care, cross-training collaborative training among systems using technology, integrated services for co-occurring disorders, and personal responsibility.
3. Encourage service providers to *integrate* care
4. Calculate the human costs when considering cost-effectiveness using outcomes of "Quality of Life" and "Healthy Persons." Keep the individual in mind.
5. Re-route ineffective services cost to effective services and cut the cost of medicine by partnering with industry, for example.
6. Involve partners include faith organizations, peer-support services, and families to increase consumer-based input and community-based care.
7. Save on costs by using prevention efforts and quickly identifying co-occurring problems.
8. Use continuous recovery-oriented care systems. The State should support this via evaluation and data.
9. Maintain common standards by using: common terminology, public consensus on what cost effectiveness is within BH, strong assessment tools at entry to service, progressive services, joint interpretation of Medicaid regulations (could be improved)
10. Reexamine the value associated with the use or non-use of Magellan consider efficiencies by not using a managed care company (or reducing reliance on it) (consider voucher model used in probation), flexibility in services to meet needs of consumer (flexibility in accessing service array), reduce 'red tape' in disability determinations and other service areas
11. Catch up on technology by using it effectively/ensuring tech is adequate, increase efficiency thru its use, "active" use of data, be sensitive to preferences not to use technology
12. Introduce and require things that work (fidelity to EBP's), thorough, effective assessment, calculate long term costs/savings when considering effectiveness

VI. Questions to DBH

After the break out group sessions were completed, Director Scot Adams opened the meeting for comments and questions. There were some general comments and questions, but no formal recommendations to DBH were made.

VII. Next Meeting Agenda Items

- Routine committee items will be completed.
- Mental Health Block Grant Application review

VIII. Plus/Delta

Break out worked great & very effective
Flow was smooth
Variety of stories
Combined Committees-helped understand the role of MH
Good number people participated
Difficult to down load Block grant materials on the DHHS website

IX. Adjournment & Next Meeting

Meeting adjourned at 4:20 pm.

The next meeting dates are:

MH Advisory Committee - Thursday, August 12, 2010 at Country Inn and Suites.
SA Advisory Committee - Tuesday September 21, 2010 at Country Inn and Suites.

Prepared by: Alexandra Castillo, Staff Assistant

Approved by _____ Date _____

Federal Resource Manager
Division of Behavioral Health

7-20-10 ac

Nebraska Behavioral Health Services Act

Neb. Rev. Stat. §§ 71-801 to 71-830

The Nebraska Behavioral Health Services Act defines **BEHAVIORAL HEALTH DISORDER** as mental illness or alcoholism, drug abuse, problem gambling, or other addictive disorder [Neb. Rev. Stat. §71-804(1)].

71-813 Repealed. Laws 2006, LB 994, § 162.
(The State Behavioral Health Council created under LB1083/2004 Section 13)

71-814 **STATE ADVISORY COMMITTEE ON MENTAL HEALTH SERVICES**; created; members; duties. (1) The State Advisory Committee on Mental Health Services is created. Members of the committee shall have a demonstrated interest and commitment and specialized knowledge, experience, or expertise relating to the provision of mental health services in the State of Nebraska. The committee shall consist of twenty-three members appointed by the Governor as follows: (a) One regional governing board member, (b) one regional administrator, (c) twelve consumers of behavioral health services or their family members, (d) two providers of behavioral health services, (e) two representatives from the State Department of Education, including one representative from the Division of Vocational Rehabilitation of the State Department of Education, (f) three representatives from the Department of Health and Human Services representing mental health, social services, and medicaid, (g) one representative from the Nebraska Commission on Law Enforcement and Criminal Justice, and (h) one representative from the Housing Office of the Community and Rural Development Division of the Department of Economic Development.

(2) The committee shall be responsible to the division and shall (a) serve as the state's mental health planning council as required by Public Law 102-321, (b) conduct regular meetings, (c) provide advice and assistance to the division relating to the provision of mental health services in the State of Nebraska, including, but not limited to, the development, implementation, provision, and funding of organized peer support services, (d) promote the interests of consumers and their families, including, but not limited to, their inclusion and involvement in all aspects of services design, planning, implementation, provision, education, evaluation, and research, (e) provide reports as requested by the division, and (f) engage in such other activities as directed or authorized by the division.

Source: Laws 2004, LB 1083, § 14; Laws 2006, LB 994, § 93; Laws 2007, LB296, § 460.

"(2) (a) serve as the state's mental health planning council as required by Public Law 102-321" means ...meet the requirements for the **FEDERAL COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT**

REQUIREMENTS FOR THE STATE MENTAL HEALTH PLANNING COUNCIL

Section 1914:

The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.

(b) The duties of the Council are:

(1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;

(2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and
(3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

(A) the principle State agencies with respect to:
(i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and
(ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;
(B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;
(C) adults with serious mental illnesses who are receiving (or have received) mental health services; and
(D) the families of such adults or families of children with emotional disturbance.

(2) A condition under subsection (a) for a Council is that:
(A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and
(B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

71-815 STATE ADVISORY COMMITTEE ON SUBSTANCE ABUSE SERVICES; created; members; duties.
(1) The State Advisory Committee on Substance Abuse Services is created. Members of the committee shall have a demonstrated interest and commitment and specialized knowledge, experience, or expertise relating to the provision of substance abuse services in the State of Nebraska. The committee shall consist of twelve members appointed by the Governor and shall include at least three consumers of substance abuse services.

(2) The committee shall be responsible to the division and shall (a) conduct regular meetings, (b) provide advice and assistance to the division relating to the provision of substance abuse services in the State of Nebraska, (c) promote the interests of consumers and their families, (d) provide reports as requested by the division, and (e) engage in such other activities as directed or authorized by the division.

Source
Laws 2004, LB 1083, § 15; Laws 2005, LB 551, § 5; Laws 2006, LB 994, § 94.

71-816 Legislative findings; STATE COMMITTEE ON PROBLEM GAMBLING; created; members; duties; division; duties; joint report.

(1) The Legislature finds that the main sources of funding for the Compulsive Gamblers Assistance Fund are the Charitable Gaming Operations Fund as provided in section 9-1,101 and the State Lottery Operation Trust Fund as provided in section 9-812 and Article III, section 24, of the Constitution of Nebraska. It is the intent of the Legislature that the Compulsive Gamblers Assistance Fund be used primarily for counseling and treatment services for problem gamblers and their families who are residents of Nebraska.

(2) The State Committee on Problem Gambling is created. Members of the committee shall have a demonstrated interest and commitment and specialized knowledge, experience, or expertise relating to problem gambling in the State of Nebraska. The committee shall consist of twelve members appointed by the Governor and shall include at least three consumers of problem gambling services. The committee shall appoint one of its members as chairperson of the committee and other officers as it deems appropriate. The committee shall conduct regular meetings and shall meet upon the call of the chairperson or a majority of its members to conduct its official business.

(3) The committee shall develop and recommend to the division guidelines and standards for the distribution and disbursement of money in the Compulsive Gamblers Assistance Fund. Such guidelines and standards shall be based on nationally recognized standards for problem gamblers assistance programs.

(4) In addition, the committee shall develop recommendations regarding (a) the evaluation and approval process for provider applications and contracts for treatment funding from the Compulsive Gamblers Assistance Fund, (b) the review and use of evaluation data, (c) the use and expenditure of funds for education regarding problem gambling and prevention of problem gambling, and (d) the creation and implementation of outreach and educational programs regarding problem gambling for Nebraska residents. The committee may engage in other activities it finds necessary to carry out its duties under this section.

(5) Based on the recommendations of the committee, the division shall adopt guidelines and standards for the distribution and disbursement of money in the fund and for administration of problem gambling services in Nebraska.

(6) The division and the committee shall jointly submit a report within sixty days after the end of each fiscal year to the Legislature and the Governor that provides details of the administration of services and distribution of funds.

Source
Laws 2004, LB 1083, § 16; Laws 2005, LB 551, § 6; Laws 2006, LB 994, § 95; Laws 2008, LB1058, § 1; Laws 2009, LB189, § 1. Effective Date: August 30, 2009

History/Continuum: SA Providers & Co-Occurring Disorders - 5/6/10

Jerome R. Barry, LADC, LMHP

1. SA Providers do not admit clients diagnosed with co-existing mental disorders.
2. SA Providers admit clients diagnosed with co-existing mental disorders into their services, as long they are not taking psychotropic medications and are sufficiently stable so to focus exclusively on their addictions issues.
3. SA Providers admit clients diagnosed with co-existing mental disorders into their services and let them take psychotropic meds, as long as they are stable on these meds, so to focus primarily on their addictions issues. Mental health issues do not interfere with active addictions treatment.
4. SA Providers work together with a MH Provider to provide concurrent parallel services, whereby the client spends some time with a mental health provider and some time with a SA provider. Treatment plans remain distinct and separate.
5. SA Providers develop policies and procedures so clients are screened, assessed and diagnosed for possible co-existing mental disorders. Contractual arrangements are developed to provide psychiatric oversight to allow medications to be prescribed and monitored. Some dually licensed staff is hired to more competently screen and assess clients. Continue to have primary interventions directed at the addiction issues. Some special programming is developed specific to those clients with co-occurring disorders.
6. SA Providers fully recognize co-occurring disordered clients. Staff are hired and trained with the scope of practice to assess & treat both disorders in an integrated fashion; develop an integrated treatment plan addressing both issues concurrently. Active treatment interventions integrate both mental health and addictions related issues. Length of stay and intensity of care vary with each client in same level of care.

ASAM Description of Services:

- Addictions Only Services (1, 2, & 3)
- Dual Capable (5)
- Dual Enhanced (6)

Observations:

- Majority of SA providers today fall into #'s 2, 3, & 5 above.
- "Packaged Care" versus "Individualized Care"
- Claiming to provide co-occurring disorder services does not mean this is what is happening in real time with the client. The treatment plan and corresponding progress notes will evidence what is actually occurring with the client.
- 2008 SAMHSA Survey: 39% of admissions to SA Providers have co-occurring disorders.

Take Home Messages:

1. We need to move toward integrated treatment options for the co-occurring without losing the value and unique competencies of LADC's who are not interested in pursuing dual licensure.

2. Individualized care should to be the underlying theme in all that we do: assessment, treatment planning, length of stay, family involvement, & co-occurring disorders.

The top priorities of the committee include:

1. Recovery (for all ages)
2. Transition Age Youth Services and Supports
3. Children's Mental Health
4. Individuals (juveniles and adults) who have a behavioral health disorder who are incarcerated and/or cycle into the correctional system frequently.
5. Education to eliminate the stigma related to mental illnesses.

Members are requesting a balance regarding adult, transition age and children's services.

We want to ensure the reform in Children's services addresses the need of children and their families and, as the kinks are worked out, ensure that children are not "falling through the cracks". The committee agrees that if we invested more money in prevention and early intervention, we would have fewer homeless, fewer incarcerations and less adults living with serious mental illness. For children, education and preparation/transition to adult living is critical and needs to be addressed by the Committees.

There are many individuals living with behavioral health disorders. Two priorities identified for the adult population are homelessness/ risk of homelessness and access to mental health/substance abuse services. Safe, affordable housing is critical to recovery as well as access to services that meet the individual where they are at. Often one is ready for treatment and services are non- existent, too costly, or have long waiting lists.

Many people who experience serious mental illness turn to alcohol and drugs to help relieve the symptoms they experience. Substance abuse can lead to serious mental health disorders. Depression is common with substance abuse. Depression, with or without substance abuse, can lead to suicide. The highest rates of suicide involve people who are depressed, even though not all suicides are completed by depressed people. By removing the stigma related to these issues, more people will be able to reach out for help before a tragedy occurs than cannot be reversed. Suicide is a permanent solution to a temporary problem. These issues span all ages from the very young (as young as 5 years old) to the elderly. The adult male over age 85 is at one of the highest risks for a completed suicide.

May 6, 2010 Report to the Joint Committees of Mental Health Services, Substance Abuse and Gambling

71-814 The Nebraska State Advisory Committee on Mental Health Services consists of twenty-three members appointed by the Governor. The members shall have a demonstrated interest and commitment and specialized knowledge, experience, or expertise relating to the provision of mental health services in the state. The committee consists of one regional governing board member, one regional administrator, twelve consumers of behavioral health services or their family members, two providers of behavior health services, two representatives from the State Department of Education, including one representative from the Division of Vocational Rehabilitation of the State Department of Education, three representatives from the Department of Health and Human Services representing mental health, social services, and Medicaid, one representative from the Nebraska Commission on Law Enforcement and Criminal Justice, and one representative from the Housing Office of the Community and Rural Development Division of the Department of Economic Development

The committee shall be responsible to the division and shall serve as the state's mental health planning council as required by Public Law 102-321, conduct regular meetings, provide advice and assistance to the division relating to the provision of mental health services in the State of Nebraska, including, but not limited to,, the development, implementation, provision, and funding of organized peer support services, promote the interest of consumers and their families, including, but not limited to, their inclusion and involvement in all aspects of services design, planning, implementation, provision, education, evaluation, and research, provide reports as requested by the division, and engage in such other activities as directed or authorized by the division.

The committee is responsible for reviewing the Mental Health Block Grant and submitting and recommendations to DHHS. The committee serves as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotion problems. The Committee monitors, reviews and evaluates, not less than once each year, the allocation and adequacy of mental health services within the Sate.

The Committee receives reports at each quarterly meeting from a variety of sources including reports from each Region regarding their services offered, consumer reports, peer support services, Trauma Informed Care, CIT training, Behavioral Health Jail Diversion Services, Supported Employment programs and the progress being made to move Nebraska into a fully recovery-oriented state.

Substance Abuse Committee – Rand Wiese

As provided by statute, the purpose of the State Advisory Committee on Substance Abuse Services (SACSAS) is to provide advice and assistance to the Division of Behavioral Health relating to the provision of substance abuse services in the State of Nebraska and such other activities as directed or authorized by the Division.

(Nebraska Revised Reissued Statutes Section 71-815)

Rather than detail the work of the Committee over the past years and months, let us instead focus on the future.

As an Advisory Committee we bring a wide range of knowledge and experience to assist the Division as it does the work of helping Nebraskans with Behavioral Health problems. Although our mandate concerns prevention, treatment and recovery from substance abuse, dependence and addiction, we also know that many of our citizens suffer from a number of behavioral health issues. We understand the solutions can be complex and as varied as the disorders which affect so many.

While working to advise the Division on Substance Abuse Services in Nebraska, we endeavor to assist in sustaining quality prevention, treatment and recovery programs for our state. The work is important and vital. We have so many problems created by abuse, dependence and addiction to alcohol and other drugs. The Division continues to provide excellent leadership and thoughtful stewardship of funds as we work as a state community toward finding solutions to these often life-ending issues. The work is vital, important and can save lives.

An example is the discussions we will have today on Co-Occurring Disorders. Data has shown we can no longer treat one issue and delay treatment for another. We must begin to treat the whole individual and deal with substance abuse issues as we work on mental health issues. It is now obvious we must work toward assisting the complete person toward long-term recovery from all the behavioral problems each person is experiencing. I believe our committee values all the positive initiatives taken by the Division to insure the behavioral health of all Nebraskans is a priority.

Each of our committees has the mandate to focus on one of the 3 legs of the stool that comprises the Behavioral Health System in Nebraska. As we do so, it is important to understand that all 3 aspects must collaborate and work together or the stool will become unstable. I would encourage us to work together, especially in this time of uncertainty over funding services, availability and other issues.

It has become apparent to those of us on the Advisory Committee on Substance Abuse Services that people needing services for substance issues will also need an array of other services to help them begin and to stay in recovery. It has also become apparent that all behavioral health problems are important and solutions must be found to help Nebraskans with these problems.

We would ask the same passion we each hold for our particular constituency becomes transformed into a passion for all those who suffer from behavioral health disorders and their families. Our goal should always be help all those who suffer. We bring a wealth of experience and knowledge, let us agree to help all who need help.

Attachment 5

Problem Gambling:
A National Problem
A Problem for Nebraska

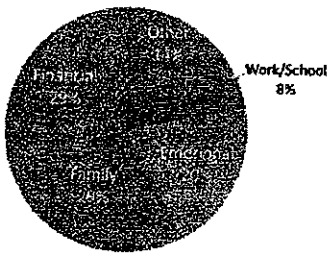
Problem Gambling is gambling that causes mental, emotional, social and/or financial harm to a person, family, and/or group (work environment, school environment, community).

Nebraska Data

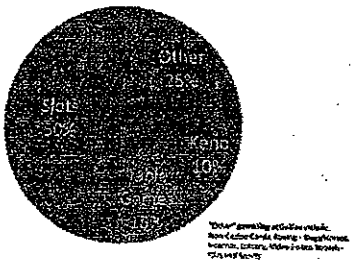
Prevalence of problem gambling in Nebraska

According to the Nebraska Problem Gambling Helpline, problems/activities associated with gambling during FY2009 included the following:

Problems Associated with Gambling



Preferred Gambling Activity



According to the Magellan Data System services during FY2009, consumer demographics include:

a) 57.1% were male and 42.9% female
b) The average age at admission was 42.8 (SD: 13.6, Min: 16, Max: 75; average age males: 40.5 vs. average age females: 46, $p < .05$)
c) The sample was predominantly white (88.1%)
d) 62.4% of clients have more than 12 years of education and 29.1% have a GED diploma
e) Over 60% were employed full time

Current Nebraska trends of substance abuse and compulsive gambling co-occurring disorders parallel historical national trends:

According to the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) revealed that reported that three quarters of pathological gamblers had an alcohol use disorder (73.2%).

Findings in Nebraska showed that 36.8% (n = 134 of 364) of GAP consumers treated reported problems related to substance use. Specifically, over 85% of clients live in metropolitan areas, and the cities of Lincoln and Omaha concentrate 73.9% of the clients with substance abuse problems. The most frequent substance used by GAP clients is alcohol (53.7%), followed by marijuana/hashish/pot (17.2%) and Methamphetamine (14.2%).

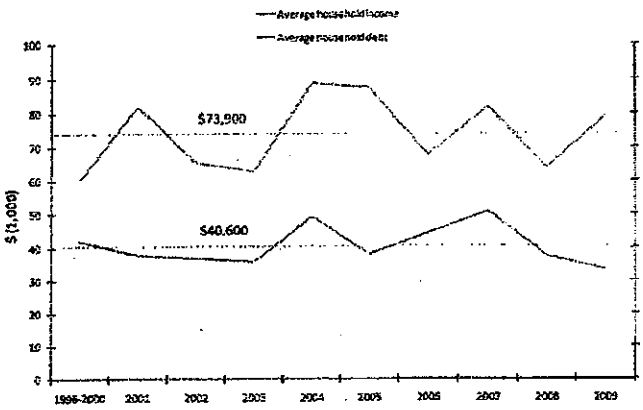
For more information contact Eric Hunsberger at Eric.Hunsberger@nebraska.gov

Nebraska Social and Economic Cost

An estimated 3% of adults (42,267) in Nebraska experience gambling problems each year for an approximated annual cost over $200 million dollars.

The average gambling debt is $20,594, whereas average household debt is $73,900 (annual household income is $40,600). On average, gambling debt represents over one-third of total household debt. Female and male debts related to gambling are not significantly different ($p > .05$). Male clients have a significantly greater number of employers than females ($p = .03$).

Household Income vs. Household Debt Related to Gambling



According to local records, the table below reports percentage rates among suicide attempts, mental health issues, and financial problems among consumers who received outpatient treatment services related to gambling addictions from 1996 to 2007 in Nebraska. Percentage rates determined within approximately thirty days of intake.

Problems Related to Gambling				
	Mental Health			
Financial Problems	Depression	Anxiety	Suicide Attempt	Other
19.2%	5.4%	2.2%	1.1%	0.7%
N =1,765 from 1996 to 2007				

Note: Between years 2004 to 2009 an average of 283 clients have been treated annually. In FY2009, a total of 252 clients received treatment.

If you answer yes to any of these questions you may have a gambling problem.

- Have you ever gambled for longer than you intended?
- Have you ever borrowed money to gamble?
- Have you ever felt remorseful after gambling?
- Have you ever lied about how much you gambled?
- Have you ever bet more than you intended?

If you or someone you know has a gambling problem, call the 24/7:
Nebraska Problem Gambling Helpline: 1-800-522-4700

For more information contact Eric Hunsberger at Eric.Hunsberger@nebraska.gov

State Committee on Problem Gambling

A brief history...

HISTORY

- **1992** - The Gamblers Assistance Program (GAP) created as part of the Nebraska Lottery Act.
  - GAP administered by the Department of Revenue
- **1995** – GAP transferred to the Division on Alcoholism, Drug Abuse and Addiction Services in the Department of Public Institutions.
- **1997** - Merger of 5 state agencies, GAP transferred to the Division of Behavioral Health in the Nebraska Department of Health and Human Services.

A brief history

HISTORY

- The Nebraska Lottery Act also created the **Nebraska Advisory Commission on Compulsive Gambling**
  - 11 members appointed by the governor, representing all areas of the state.
  - Commission's role: To provide input and advice about planning and funding decisions made on the allocation of GAP funds.

A brief history

HISTORY

- **2004** – As a result of the Behavioral Health Reform Act (LB 1083), the **Nebraska Advisory Commission on Compulsive Gambling was eliminated and replaced** by the State Advisory Committee on Problem Gambling and Addiction Services (Committee) -- a component of the broader State Behavioral Health Council (Council) [an advisory group to the Division of Behavioral Health].
  - **12 governor-appointed members**
  - **10 of whom also serve on the Council.**
  - **2/12 members must be consumers of problem gambling services.**

Brief History of GAP

- **2009** - State Committee on Problem Gambling created.
- Members shall have a demonstrated interest, commitment & specialized knowledge, experience, or expertise relating to problem gambling.
  - 12 governor appointment members
  - 3/12 consumers of problem gambling services.
- The committee shall develop & recommend to the division guidelines and standards for the distribution and disbursement of money in the Compulsive Gamblers Assistance Fund. Such guidelines and standards shall be based on nationally recognized standards for problem gamblers assistance programs.

Brief History of GAP

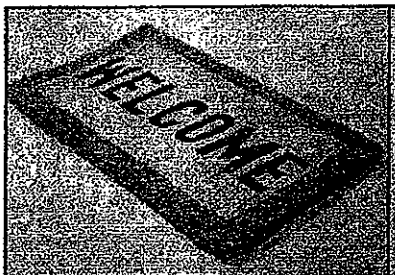
- Committee shall develop recommendations regarding
  1. evaluation & approval process for provider applications and contracts for treatment funding from the Compulsive Gamblers Assistance Fund,
  2. review and use of evaluation data
  3. use & expenditure of funds for education regarding problem gambling & prevention of problem gambling
  4. creation & implementation of outreach and educational programs regarding problem gambling for Nebraska residents.
- Committee may engage in other activities it finds necessary to carry out its duties under this section.
- Based on committee recommendations, the division shall adopt guidelines & standards for the distribution & disbursement of money in the fund & for administration of problem gambling services in Nebraska.

GAP Mission

- GAP is an administrative program that **utilizes expertise from:**
  - **an advisory committee**
  - service providers
  - and consumers
- to **coordinate activities, manage resources, direct services** and reduce the impact of problem gambling for all Nebraskans.

GAP Goals

- Reflects a public health model who's focus is: access to services, treatment, outreach, and public education.
- **"To reduce the negative impact of problem gambling in Nebraska."**
- **Specific goals:**
  1. Train counseling professionals to provide services to those affected by problem gambling.
  2. Establish a statewide network of providers.
  3. Provide instant access to services across the state.
  4. Ensure provision of high quality services.



The Co-Occurring Task Force

A subcommittee of the Metro Area Continuum of Care for the Homeless

The metro area service providers listed below believe every person can recover from the challenges of mental illness and/or substance use disorders. Recovery can be a long journey, and we want to be a partner with you on this journey.

Therefore, you will be welcomed at every agency listed without judgment, respected for your many strengths, and if one agency can not provide you the service you need, it will partner with others to insure you get what you need. We're glad you're here.

Members (signed Memo of Understanding):

- Alegent Health Mental Health Services & Psychiatric Associates
- Catholic Charities
- Community Alliance
- Creighton University Department of Psychiatry
- Douglas County Community Mental Health Center
- Eastern Nebraska Community Action Partnership
- Friendship Program
- Good Neighbor Foundation/Oxford House
- Heartland Family Service
- Lutheran Family Services
- NAMI Nebraska
- Nebraska Coalition for Women's Treatment
- Nebraska Department of Health and Human Services Division of Behavioral Health
- Nebraska Urban Indian Health Coalition
- NOVA Therapeutic Community
- Open Door Mission
- Region 6 Behavioral Healthcare
- Salvation Army Homelessness Prevention Services
- Santa Monica
- Siena/Francis House
- Stephen Center Substance Abuse Treatment Center
- UNMC Department of Psychiatry
- Veterans Administration Nebraska Western Iowa Health Care System
- YWCA Omaha

Participants:

- Douglas County Probation
- Douglas County Corrections
- Douglas County Community Corrections
- Individual Consumers & Family Members
- Nebraska AIDS Project (NAP)
- Phoenix House

Steering Committee:

Aileen Brady, Chief Operating Officer, Community Alliance
Erin Porterfield, LCSW, Executive Director, Metro Area Continuum of Care for the Homeless
Kathleen Grant, M.D., Dept. of Psychiatry (UNMC & Creighton) & Dept. of Internal Medicine (UNMC)
Rod Bauer, MS, LADC, PLMHP, Day Program Director, Siena/Francis House
Jeannette Winkler, BS, Director of Housing, Salvation Army
Taren Petersen, MPA, Director of Network Services, Region 6 Behavioral Healthcare
Ken Timmerman, Consumer representative, Region 6
Stephen Spelic, Government Affairs & Community Outreach Strategist, Alegent Health Mental Health Services & Psychiatric Associates

For more information, call Tara Muir, JD, the Co-Occurring Task Force Manager 402.341.5128 July 2009
c/o Community Alliance, 4001 Leavenworth, Omaha, NE 68105, email: tmuir@commall.org

The Co-Occurring Task Force

A subcommittee of the Metro Area Continuum of Care for the Homeless

MEMORANDUM OF UNDERSTANDING
CO-OCCURRING PSYCHIATRIC & SUBSTANCE USE DISORDERS

The Co-Occurring Task Force, a sub-committee of the Metro Area Continuum of Care for the Homeless (MACCH) implemented a system change initiative to address co-occurring disorders among the homeless and now this initiative has grown to include the homeless and behavioral health community of provider organizations throughout Omaha. The vision has not substantially changed since the beginning in 2005, but has broadened.

We seek integrated treatment of mental illness and substance use disorders, in an effort to prevent homelessness, as well as provide the most efficient and effective array of services in the metro area no matter the level of "care" being provided. Further, we intend to ensure that this vulnerable population and their families are welcomed whenever and wherever they present for care. We ask you to join us in continuing to create a system of behavioral health care and support services in the Omaha and Council Bluffs area capable of appropriately responding to the needs of people with co-occurring disorders.

Welcoming Statement

In July 2009, members of the Task Force adopted the following welcoming statement as a group of provider organizations, and committed to its implementation throughout the community, and within each organization.

> *"The metro area service providers listed below believe every person can recover from the challenges of mental illness and/or substance use disorders. Recovery can be a long journey, and we want to be a partner with you on this journey.*
>
> *Therefore, you will be welcomed at every agency listed without judgment, respected for your many strengths, and if one agency can not provide you the service you need, it will partner with others to insure you get what you need. We're glad you're here."*

Implementation

It is recognized that many organizations have made efforts in the past several years toward the vision of the Task Force. This Memorandum of Understanding is seeking continued and renewed efforts. The following benefits and work effort areas are established for implementation for the Task Force and the provider organizations who sign this Memorandum of Understanding:

BENEFITS	WORK EFFORT
➢ Access to Minkoff/Cline self-assessment tools o Assess the following: ▪ philosophy, ▪ access to services, ▪ identifying co-occurring disorders, ▪ integrated treatment relationships, ▪ treatment content and programming ▪ psychopharmacology ▪ discharge planning, ▪ staff competency and training, ▪ and much more	➢ Use the self-assessment tools to help identify specific and measurable objectives for your agency. ➢ Initiate your own internal working committee or quality improvement team to lead efforts to improve delivery of services within your agency. Commit staff time & resources to the effort. Include people you serve. ➢ Review your own policies, procedures and training to make sure you are providing or moving toward providing co-occurring capable services. ➢ Display and train to the welcoming statement in your organization and work with the Task Force to make it meaningful to those we serve. Create your own welcoming statement.

➢ Access to monthly discussions on progress being made in our community. Ability to contribute to annual progress reports for the community.	➢ Share ideas, support, and strategies on work plans. ➢ Participate in special work groups of the Task Force when system wide objectives are identified that will improve our services and service delivery as a community.
➢ Access to reduced cost (and some free) training for agency staff	➢ Join the Task Force listserve and receive the latest updates on training possibilities and national research.
➢ Access to compilation of statistics on the prevalence of co-occurring disorders using a common screen and language (GAIN-SS) in our area	➢ Option to participate in the collection of prevalence data for our area and facilitate communication between providers, using the GAIN-SS.
➢ Access to current updates of the SOAR Project to assist individuals in applying for disability	➢ Make referrals to and request SOAR specialists to visit can visit your organization for education and outreach.

Scope

Systems, institutions, agencies, facilities and individuals who proceed with this MOU recognize:

- Co-occurring disorders are the expectation, not the exception, in behavioral health and homeless services.
- Staff, agencies and funding streams are often inadequate to effectively treat these persons with complex problems.
- Persons with co-occurring disorders are best treated using evidence–based integrated practices, and there is no single correct co-occurring program or intervention.

Goals

- Integrated treatment of persons with co-occurring disorders. Each system, agency, facility will have, within the context of its resources and mission, integrated services for individuals and families with co-occurring disorders.
- Every practitioner will be co-occurring competent, within the context of their program design, specific job description and licensure and
    - provide integrated treatment, coordination and continuity of care during each episode and across multiple levels of care;
    - ensure individualized and stage-matched treatment to the individual's diagnoses, phase of recovery and the stage of change;
    - integrate cultural competency, trauma-informed care and consumer and family participation at all levels of care.

Summary

Please sign this Memorandum of Understanding that you agree to work within your own agency and collaborate with other area provider agencies to utilize the principles stated above to continue the development of a quality improvement process that will result in attainment of integrated treatment over a period of years and will commit staff time and resources to the process.

_____ _____

Agency Signature Agency Name

_____ _____

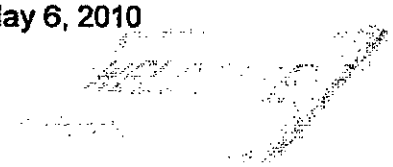
Title Date

Received by Co-Occurring Task Force on _____ by _____

(date) (signature)

The Co-Occurring Task Force is funded, in part, by Region 6 Behavioral Healthcare and foundation grants to support the change initiative and improve the provision of integrated services to people with co-occurring disorders.

Division of Behavioral Health Joint State Committees Meeting May 6, 2010



Tara L. Muir, J.D.
Manager, Co-Occurring Task Force, Metro Area Continuum of Care for the Homeless

The Co-Occurring Task Force

Mission:

Improving systems of care in the metropolitan area for people with co-occurring substance use and mental health disorders and their families

July 2005

Local Omaha/CB screening with GAIN-SS

Oct. 2008-Sept. 2009

Likelihood of Disorder:	10 Local Agencies 3398 screens	Local Homeless Programs Only 707 screens	National Data from CHAB(SAMHSA)* (130,000 screens from COSIG states)
Co-Occurring	47%	58%	50.1%
Mental Health only	35%	33%	36%
Substance Use Only	10%	3%	9.7%
No disorder	8%	6%	

Overload of resources

BENEFITS	WORK EFFORT
➢ Access to Minkoff/Cline self-assessment tools o Assess the following: • philosophy, • access to services, • identifying co-occurring disorders, • integrated treatment relationships, • treatment content and programming • psychopharmacology • discharge planning, • staff competency and training, • and much more	➢ Use the self-assessment tools to help identify specific and measurable objectives for your agency. ➢ Initiate your own internal working committee or quality improvement team to lead efforts to improve delivery of services within your agency. Commit staff time & resources to the effort. Include people you serve. ➢ Review your own policies, procedures and training to make sure you are providing or moving toward providing co-occurring capable services. ➢ Display and train to the welcoming statement in your organization and work with the Task Force to make it meaningful to those we serve. Create your own welcoming statement.
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A subcommittee of the Metro Area Consortium of Care for the Homeless

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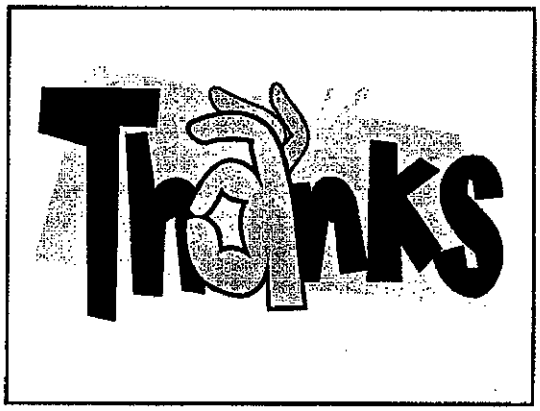
July 2009

Recommendations

- Adopt guiding principles
- Adopt purpose statement



Recommendations for **Division of Behavioral Health Joint State Committees Meeting May 6, 2010**

ADOPT set of operating principles:

1. Co-occurring disorders are to be expected in all behavioral health settings, and system planning must address the need to serve people with COD in all policies, regulations, funding mechanisms, and programming.
2. An integrated system of mental health and addiction services that emphasizes continuity and quality is in the best interest of consumers, providers, programs, funders, and systems.
3. The integrated system of care must be accessible from multiple points of entry (i.e., no wrong door) and be perceived as caring and accepting by the consumer.
4. The system of care for COD should not be limited to a single .correct. model or approach.
5. The system of care must reflect the importance of the partnership between science and service, and support both the application of evidence- and consensus-based practices for persons with COD and evaluation of the efforts of existing programs and services.
6. Behavioral health systems must collaborate with professionals in primary care, human services, housing, criminal justice, education, and related fields in order to meet the complex needs of persons with COD
7. Co-occurring disorders must be expected when evaluating any person, and clinical services should incorporate this assumption into all screening, assessment, and treatment planning.
8. Within the treatment context, both co-occurring disorders are considered primary.
9. Empathy, respect, and belief in the individual's capacity for recovery are fundamental provider attitudes.
10. Treatment should be individualized to accommodate the specific needs, personal goals, and cultural perspectives of unique individuals in different stages of change.
11. The special needs of children and adolescents must be explicitly recognized and addressed in all phases of assessment, treatment planning, and service delivery.
12. The contribution *of the community* to the course of recovery for consumers with COD and the contribution of consumers with COD *to the community* must be explicitly recognized in program policy, treatment planning, and consumer advocacy.

ADOPT purpose statement:

In the context of statewide infrastructure development for services to individuals and families with co-occurring psychiatric and substance use disorders, and in recognition of the high prevalence, poor outcomes, and high cost of sequential treatment services, the Division of Behavioral Health has developed this bulletin to accomplish the following objectives:

- to move the entire behavioral health system toward the achievement of core competency to serve individuals with co-occurring psychiatric and substance use disorders who are already engaged in a facility program
- to provide the framework for delineating objective criteria for defining Co-Occurring Disorder Competency for any facility within the State licensed by the Division of Behavioral Health, and
- to describe the process by which licensed facilities can achieve Co-Occurring Disorder Competency.

RESOURCES

Division of Behavioral Health Joint State Committees Meeting May 6, 2010

1 overview of many, many, resources and research

on the web: **coce.samhsa.gov**

- The Co-Occurring Disorders Initiative
  - Definitions, Terminology, Classification
  - Evidence and Consensus Based Practices
  - Screening and Assessment
  - Services Integration
  - **Systems Change**
  - Treatment Planning and Approaches
  - Workforce Development and Training

- Co-Occurring State Incentive Grants (COSIGs) Product Library: Laws, program guidelines, protocols, evaluation examples

2 Integrated Treatment for Co-Occurring Disorders

on the web:
http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/cooccurring/

- SAMHSA's Evidence Based Practices KIT: **Integrated Treatment for Co-Occurring Disorders-CD/DVD Version EPB KIT** How to Use the Evidence-Based Practices KITs
  - Getting Started with Evidence-Based Practices
  - Building Your Program
  - Training Frontline Staff
  - Evaluating Your Program
  - Using Multimedia to Introduce Your EBP
  - Brochure (English), Brochure (Spanish)
  - The Evidence
- Drake's Study: Implementing dual diagnosis services for clients with severe mental illness. **Drake**, R. E., Essock, S. M., Shaner, A., Carey, K. B., Minkoff, K., Kola, L., et al. (2001). *Psychiatric Services, 52*(4), 469-476.

Drake: "Successful implementation needs changes at several levels":

1. clear policy directives with consistent organizational and financing supports
2. program changes to incorporate the mission of addressing co-occurring substance abuse
3. supports for the acquisition of expertise at the clinical level, and
4. availability of accurate information to consumers and family members.

3 Dual Diagnosis Capability in Addiction Treatment Services or Mental Health Treatment

on the web: **http://cooccurring.org/public/research_ddcat.page**

• Assessing the dual diagnosis capability of addiction treatment services: The Dual Diagnosis Capability in Addiction Treatment Services (DDCAT) Index. **McGovern**, M. P., Matzkin, A. L., & Giard, J. L. (2007). Journal of Dual Diagnosis, 3(2), 111-123.

•The Dual Diagnosis Capability in Mental Health Treatment (DDCMHT), developed by Gotham, Brown, Comaty and McGovern, is an adaptation of the DDCAT for application in mental health settings.

•The DDCMHT framework and method are identical to the DDCAT, but it is intended for use to evaluate the capacity of mental health services policy, practice and workforce to address people with co-occurring disorders.

4 Comprehensive, Continuous, Integrated System of Care for people with Co-occurring disorders

on the web: **http://www.kenminkoff.com/ccisc.html**

•Dr. Ken Minkoff, also an author of Drake's study listed above, is also co-author of Re-designing the system: CCISC process: Comprehensive, Continuous, Integrated System of Care for people with Co-occurring disorders (Minkoff & Cline, 2004, 2005).

•Our task force took his CCISC "tools" to start the conversation about change in helping people with COD:

–CO-FIT Sept. 2008, Florida expert facilitated

–COMPASS various agencies, multiple reviews/action plans

–CODECAT - clinician/employee competencies

5 OTHER RESOURCES

•SAMHSA's TIP 42 summarizes state-of-the-art treatment of co-occurring disorders.
on the web: **ncadistore.samhsa.gov/catalog/productDetails.aspx?ProductID=17910**

•

•NE Division of Behavioral Health started Co-Occurring Disorders Service Delivery: Quality Initiative Workgroup

Nebraska Behavioral Health Strategic Planning

Summary of Notes

May 6, 2010 Joint Advisory Committee Meeting

What do we need to do to provide access and standards for access to behavioral health services?

Discussion within the groups included an expression of the need to balance access with quality. In addition, there were comments about inequities in access in rural areas of the state that many perceived to be related to funding mechanisms. A common funding concern related to access was the limitation placed on service provision during times of transition (e.g., from one level of service to another). Providers wanting to improve access are also faced with balancing open access with maintaining a steady stream of customers – right now that is accomplished through waiting list management. The need for standards related to waiting list maintenance was also brought up in this discussion group.

1. Identify Problems: Expense, Willingness, Stigma
2. Expand Technology: Expand services access, Utilize and maximize technology use, Expand the use of Telehealth, Use technology to communicate with the rural population
3. Improve Communications: Prevent Misunderstanding using awareness, Create a flow system
4. Improve Cultural Competency: Create or maintain services for other cultures with a support system
5. Provide an answer to transportation: creating or utilizing transportation services in rural areas
6. Increase funding: Increase funding and access to funding
7. Provide Support: Create a statewide peer support line, maintain equal support across the state, create a safety net of support
8. Set Service Standards: Make standards consumer-based, consumer-driven, and evidence based; create a grading system based on standards; create a standard assessment and standard training in order to maintain quality assurance
9. Improve access to government programs: improve access for non-Medicaid eligible consumers
10. Standardize the waiting list: Create and centralized waiting list and/or Standardize the waitlist length for short term
11. Improve Training for staff: create training standards based on respect and emphatic attention to recovery

What information do you want to see as part of a regular, transparent report of performance for the BHS?

The current reporting requirements for block grants, federal funds and legislative priorities were identified as a place to start with reporting. Some people in this group wanted more transparency on the regular reporting that is already occurring. Discussion in this group included a desire for the Division of Behavioral Health to incentivize system change by tying outcomes to provider performance in a way that encourages adoption of effective practices.

1. Report on Individuals between high school and age 22 with monitoring after age 22 to report on transition-aged youth. Include the growth of substance use in transition-aged youth and beyond, success beyond graduation, rates of expulsion/truancy, teen pregnancy, employment, housing, and suicide. Report on the number of individuals accessing other supports. Report if the stigma factor decreases.
2. Utilize family involvement and invest money in young children and families.

3. Integrate overall wellness in physical, mental, behavioral, and spiritual wellness; increase prevention and early intervention; decrease morbidity.
4. Define progress markers, success, long term recovery, and costs. Create a cost-benefit analysis and public reports. Identify individual recovery measures that state and regional providers have access to.
5. Increase satisfaction by increasing access, transportation, quality of life and meeting individual needs.
6. Identify the results of the provided services with baseline homelessness, criminal justice measures, comparing youth vs. adult data, employment measures, examining youth education, utilizing data previously collected, utilize consumer-led data collecting measures.
7. Plan using cluster-based planning and system planning.
8. Complete Wraparound Training.

Ideas to INCREASE Public Behavioral Health Cost-effectiveness/efficiencies

It was recognized that regardless of the efficiencies that are discussed, the workforce in behavioral health is not sufficient in numbers or in ability to carry out "integrated" care successfully. Investments in workforce development were viewed as crucial in bringing the system to a point where treatment of co-occurring disorders via integrated treatment is possible. The need for data to drive system change and to serve as benchmarks was repeated by many people in this group. The State Division of Behavioral Health was generally looked to as a leader in developing the system structures poised to take advantage of technology like video /phone service delivery. The State was also viewed as the leader for standards and benchmarks that would allow consumers to rate or choose providers.

1. Provided cafeteria-style benefits to allow individuals to select what they need from an array of services and tie funding to an individual.
2. Promote a choice in service provider, the use of trauma-informed care, cross-training collaborative training among systems using technology, integrated services for co-occurring disorders, and personal responsibility.
3. Encourage service providers to *integrate* care
4. Calculate the human costs when considering cost-effectiveness using outcomes of "Quality of Life" and "Healthy Persons." Keep the individual in mind.
5. Re-route ineffective services cost to effective services and cut the cost of medicine by partnering with industry, for example.
6. Involve partners include faith organizations, peer-support services, and families to increase consumer-based input and community-based care.
7. Save on costs by using prevention efforts and quickly identifying co-occurring problems.
8. Use continuous recovery-oriented care systems. The State should support this via evaluation and data.
9. Maintain common standards by using: common terminology, public consensus on what cost effectiveness is within BH, strong assessment tools at entry to service, progressive services, joint interpretation of Medicaid regulations (could be improved)
10. Reexamine the value associated with the use or non-use of Magellan consider efficiencies by not using a managed care company (or reducing reliance on it) (consider voucher model used in probation), flexibility in services to meet needs of consumer (flexibility in accessing service array), reduce 'red tape' in disability determinations and other service areas
11. Catch up on technology by using it effectively/ensuring tech is adequate, increase efficiency thru its use, "active" use of data, be sensitive to preferences not to use technology
12. Introduce and require things that work (fidelity to EBP's), thorough, effective assessment, calculate long term costs/savings when considering effectiveness