

Nebraska Division of Behavioral Health
Joint Committee Meeting
State Advisory Committee on Mental Health Services
State Advisory Committee on Substance Abuse Services

March 14, 2013 / 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 Thursday, March 14, 2013. Roll call was conducted and a quorum was determined for the State Advisory Committee on Mental Health Services and the State Advisory Committee on Substance Abuse Services.

State Advisory Committee on Mental Health Services Attending: Beth Baxter; Karla Bennetts; Pat Compton; Bev Ferguson; Brad Hoefs; Linda Krutz; Jerry McCallum; Rachel Pinkerton; Joel Schneider; Mark Schultz; Diana Waggoner; Cameron White.

State Advisory Committee on Mental Health Services Absent: Adria Bace; Kathy Boroffs; Susan Buettner; Sheri Dawson; Robert Donlan; Kathleen Hanson; Jette Hogenmiller; Kasey Moyer; Jill Schreck.

State Advisory Committee on Substance Abuse Services Attending: Ann Ebsen; Ingrid Gansebom; Jay Jackson; Janet Johnson; Cody Manthei; Delinda Mercer; Michael Phillips; Randy See; Jorge Rodriguez-Sierra.

State Advisory Committee on Substance Abuse Services Absent: Corey Brockway; Sheri Dawson.

II. Housekeeping and Summary of Agenda

Jim Harvey

Jim Harvey confirmed the order of the agenda, noting Sue Adams' presentation will be moved to the morning and Renee Faber's presentation will be moved to the afternoon. Jim explained the location of facilities around the building and described the logistics of the day.

III. Approval of Minutes

Bev Ferguson

Bev Ferguson asked for comments on or approval of the November 8, 2012 minutes of the Joint Advisory Committees on Mental Health and Substance Abuse Services. Motion was made by Jorge Rodriguez-Sierra and seconded by Cody Manthei to approve the minutes. The motion carried.

IV. Public Comment

Bev Ferguson, State Advisory Committee on Mental Health Services, displayed a book of poetry written by a consumer over the past 20 years on her journey with mental illness. Bev asked the Committee for advice on publishing the book.

V. SAMHSA Block Grant status

Jim Harvey

(Attachment A and Attachment B and Attachment C)

Jim Harvey, Division of Behavioral Health Block Grant Coordinator, reviewed the FY2014-2015 Block Grant Application Priorities and Statewide Goals. Jim explained the listing of the priorities are in no particular order of priority. Jim reported the Application Submission of April 1, 2013 was changed. The statutory submission dates of September 1st for the Community Mental Health Services Block Grant (CMHSBG) and October 1st for the Substance Abuse Prevention and Treatment Block Grant (SAPTBG) are in effect. The Division of Behavioral Health (DBH) plans to submit the Joint Mental Health and Substance Abuse Services Block Grant Application on or about May 1, 2013. During this meeting, the

Joint Advisory Committee on Mental Health (MH) and Substance Abuse (SA) Services will review and provide comments on these Block Grant priorities. In addition, the committee members are invited to submit additional comments during the two-week public comment time period after the Block Grant Application is posted on the Department of Health and Human Services (DHHS) website.

VI. DBH Priorities

Scot Adams

Scot Adams is the Director of the DHHS-Division of Behavioral Health (DBH). Scot spoke to the Committee about additional DBH priorities, in no particular order, to help the members with their work today. Scot explained the effects, as currently understood, of the federal Sequestration on the DBH budget and reported across the board reductions to the federal funds DBH receives.

**Response to Committee questions included:

- There are few directions on how to make the reductions, other than the percentage and that they will be retroactive to the beginning of the federal fiscal year.
- On the National level, the Substance Abuse and Mental Health Services Administration (SAMHSA) provides notice of the cuts. On the State level, DBH will determine ways to reduce the Federal funds in consultation with the Regions.

*Scot reported on the status of the At Risk Managed Care (ARMC) Request for Proposal (RFP) that has been posted to the State website as a notice of intent to contract, which means negotiations on contract terms are still being finalized. Scot explained this contract will provide opportunities and change. Managed care assumes all risk for individuals who are Medicaid eligible. If there is an increase in claims, Magellan pays, but if there is a decrease in claims, Magellan returns the unspent funds to the State of Nebraska. Currently DBH pays for services for individuals who are not Medicaid eligible and who don't have insurance coverage, but it is unclear and undefined which individuals will be covered by ARMC. ARMC will help solve the Institutions for Mental Diseases (IMD) issue, will allow for creation of new services, and will increase the flexibility of what services can be paid in the future. For more information on IMDs please refer to the Nebraska Medicaid website:

http://dhhs.ne.gov/medicaid/Pages/med_imds.aspx.

*In a related issue, Scot explained that federal Health Care Reform also adds to the changes in service coverage. Medicaid expansion is being debated in the Legislature, and this outcome is uncertain at this time.

**Response to Committee questions included:

- As far as DBH knows, there has been no comparison to unemployment rates and the number of individuals with health insurance. At one time, Nebraska was the most insured State—had the most individuals with healthcare insurance.

*Scot discussed the opportunities possible with the healthcare changes. If most individuals are fully covered by insurance exchanges, DBH could expand services to different types of coverage than we typically have provided funding for. i.e., a range of housing options, new kinds of technology options. Measurement and Outcomes are important moving into the future.

** Response to Committee questions included:

- Behavioral health care needs to cover gap in services, and work to eliminate the barriers for individuals and families to get the help they need.

VII. SAMHSA Block Grant Priorities

Heather Wood

(Attachment A)

Heather Wood is the DBH Quality Improvement and Data Performance Administrator. Heather explained the purpose and function of the Block Grant Priorities, Goals, and Indicators and how DBH arrived at this list. The Block Grant Priorities are a narrowed list and because federal funds are tied to our goals/performance we developed the indicators to measure success. She said during this meeting, DBH staff will explain the priorities in more depth to help committee members better understand the rationale of each priority, and members will be asked to provide feedback.

VIII. Adverse Childhood Experience (ACE) – Nebraska 2011

Kristin Yeoman, MD, MPH

(Attachment D and Attachment E)

Kristin Yeoman is a Medical Doctor from the Centers for Disease Control (CDC) and is working on a project with the DHHS-Division of Public Health (DPH) through June 30, 2013. The project is comparing the effects of ACE and childhood development. Kristin reviewed the findings of the ACE study and the Power Point slides.

Conclusions from this study are:

- ACEs common among Nebraskans
- ACEs associated with multiple adverse health behaviors and outcomes
- No existing surveillance systems to monitor many ACEs
- ACEs contribute to adverse health trajectories

Recommendations from this study are:

- Develop real-time metrics to monitor and intervene in adverse childhood events—before adoption of risky behaviors and development of adverse health outcomes
- Coordinate strategies to improve detection and intervention in ACEs

**Committee comments included:

- Groups in the education and justice systems need to work together to determine how intrusive measures need to be. Awareness, education, and family support services are necessary.
- The removal of a child from their home often causes additional trauma. Education on ACE may provide additional information to help the child and family.
- Ten or eleven other states opted to participate in the ACE study, so hopefully as more states participate in the future better information can be shared among states and interested groups.
- Surveillance and privacy can be delicate to carry out effectively.

IX. Youth: Improved Family Functioning

Sue Adams

Sue Adams is the DBH Network Services Administrator. Sue referred to Priority #2 on the FY2014-2015 Block Grant Application Priorities and Statewide Goals handout. Sue explained that Nebraska currently uses the Professional Partner Program (PPP) as a Wrap-Around service, which includes some Division of Children and Family Services and Juvenile Justice System services. Nebraska invested in the Wrap-Around Model as a Community-Support service to decrease the number of children being removed from their home and to increase the success of children remaining at home to receive needed services. DBH continues to evaluate the program, through the collection of data and reviewing program fidelity and outcomes, to ensure the program is as effective as possible. The Professional Partner Program is implemented when a youth is diagnosed with a behavioral health disorder, or if a family needs assistance whether or not a youth is diagnosed with a behavioral health disorder. The Improved Family Functioning priority will not only focus on whether or not a youth in services is showing improvement, but will also focus on a family having the resources they need to help them function better. DHHS has contracted with Tri-West, national experts in wrap-around services, to identify a Family Functioning Tool and to develop a cost model payment for these services. The timeline for this block grant goal is to select the family functioning tool, train providers on using the tool, collect data and report it to the federal government. Time 1 establishes a baseline for data, and Time 2 will hopefully provide data that indicates at least a 50% family functioning improvement after 90 days of enrollment in services.

**Response to Committee questions included:

- The definition of the improved function a family experiences will depend on the tool selected.
- Currently providers observe improved family function, but a tool is needed to assess and measure to answer specific questions on function. We are currently collecting data, but will be able to use data to direct specific services.
- Currently the PPP provides evidence the youth and family functioning are better, but the new tool will be preventative in nature and allow DBH and providers to take care to a higher level of effectiveness.

**Committee comments included:

- Providers have used a related tool to assist with developing the Individual Family Service Plan (IFSP).
- Evidence-Based Practices are effective.

X. Peer Support

Carol Coussons de Reyes

(Attachment F and Attachment G and Attachment H)

Carol Coussons de Reyes is the Administrator of the Office of Consumer Affairs (OCA).

*Carol reported the Title 206 Peer Support Draft Regulations (Attachment F) will be scheduled for another hearing in the near future. She reported the current draft is nearing finalization and is projected to be approved in May or June 2013. They are not changeable at this point in the approval process. However, if Committee members have suggestions for changes, they can be considered in the next revision of the regulations.

*Carol announced the registration for the Behavioral Health Conference, “Success, Hopes, and Dreams”, is still open.

*Carol reported a job opening in the OCA for a Program Specialist. The position details are on the Nebraska Jobs website.

* Carol explained the #5 Block Grant priority on Peer Support (Attachment A). She reports last year the number of Peer Support Specialists (PSSs) was measured. The OCA People’s Council has recommended the use of PSSs be measured by the number of services utilizing PSSs. OCA is developing an implementation plan to increase Peer Support, and the data will tell us what information needs to be included in the implementation plan. Carol asked the Committee members for comments on what elements are missing from the Peer Support definition, and once defined, what is needed to increase the capacity of the system to utilize Peer Support? Carol reported a decision needs to be made regarding definitions for Adult Peer Support and Family Peer Support—will these be separate definitions, or will they be one definition with multiple types?

*Carol reviewed the format for OCA Service Definitions (Attachment G).

*Carol reviewed the description of Intentional Peer Support (IPS) (Attachment H).

*Carol asked Committee members to consider the following discussion points:

- What elements are missing from the Peer Support Definition?
- Once Peer Support is defined, what do we need in policy to increase the capacity of the system to use Peer Support?
- Definitions for Adult Peer Support and Family Peer Support are needed for the next draft of the Title 206 Regulations.
- The Peer Support funding structure is needed.

**Responses to Committee questions included:

- The Peer Support Regulations will lead to credentialing of Peer Support workers. The current Draft Peer Support Regulations do not include credentialing, but it will be included in the next draft.
- Certification of Adult Peer Support has been implemented and Intentional Peer Support is utilized in the training component.
- The IPS includes an easy-to-use skill set that can be used across age groups and specialty populations. The IPS skill set works in all environments.
- Peer Specialists who are also licensed in Alcohol-Drug and/or Mental Health can work in both functions. The individual needs to be aware of each situation and the function required.
- There is a continuum of care involved with no regulation at one end and IPS, as a branded program, at the other end. If an individual is paid for their work, then some kind of regulation is required. Reliability and validity also need to be considered as the details are worked out.

- The Transformation Transfer Initiative (TTI) Grant will assist in determining the best approach to Peer Support for Nebraska. Other models and options will be compared. The University of Nebraska-Public Policy Center is responsible for evaluating the reliability and validity.
- An individual's certification is not removed if they become inactive for a period of time. To remain active in providing peer support an individual needs to accumulate six (6) Continuing Education Units per year.

**Committee comments included:

- Request that OCA consider integrating the Transition to Independence Process (TIP) System, which is a Community-Based Model for Improving the Outcomes of Youth and Young Adults with Emotional/Behavioral Difficulties (EBD). For more information on the TIP System, please refer to the following website: <http://www.tipstars.org/OverviewofTIPModel.asp>.
- There is some confusion on the requirements for certification of Peer Specialists at the Veterans Administration, and is what is required for re-certification.
- Is Nebraska utilizing the correct model for peer support? Is there a national consensus on the certification requirements for peer support?

XI. Working Lunch- Viewing of OCA Video- "Picture Recovery" *Carol Coussons de Reyes*

XII. Projects for Assistance in Transition from Homelessness (PATH) *Nancy Heller*

(Attachment I)

Nancy Heller is the State PATH Grant Contact for DBH. Nancy reviewed the PATH program handout pointing out the grant amounts DHHS contracts for with each provider. She also reviewed the primary PATH services of Outreach and Case Management, and the future focus on Prevention, Evidenced-Based Practices, work with the Regional Housing Coordinators, and the Homeless Management Information System (HMIS).

**Responses to Committee questions included:

- PATH serves adults with serious mental health illnesses or co-occurring substance use disorders who are homeless or at imminent risk of becoming homeless. Adult is defined, according to the federal definition of individuals diagnosed with Serious Mental Illness, as eighteen (18) years of age or older.

**Committee comments included:

- Perhaps DBH will consider providing similar services for individuals diagnosed with Substance Use Disorder, as it is often difficult for these individuals to rent due to their diagnosis.

XIII. Co-Occurring Disorders, Compass EZ, Trauma Informed Care *Heather Wood*

Heather Wood updated the Committee on the work of the Co-Occurring Workgroup and a Contractor who developed the Co-Occurring Disorder (COD) Roadmap. She explained that the FY2012-2013 Block Grant Application priority is to develop the capacity to deliver services for the COD population. The FY2014-2015 Block Grant Application will continue this work with Quality Improvement as a Network goal with emphasis on COD and Trauma Informed Care (TIC).

*Heather reviewed Priority #3 on the Block Grant Priorities (Attachment A). The Compass EZ tool will be utilized to measure the need to increase the behavioral health workforce capacity for COD treatment.

*Heather reviewed Priority #4 on the Block Grant Priorities (Attachment A). The Statewide Trauma Initiative along with data collected through Magellan indicate the need for a trauma-informed self-assessment. She explained that the FY2012-2013 Block Grant Application priority is that all DBH providers go through a process of evaluating how trauma-informed their agency is. The data are due June 30, 2013. The FY2014-2015 Block Grant Application will continue this work.

XIV. Prevention: Alcohol Use Among Youth

Renee Faber

(Attachment J)

Renee Faber is the DBH Prevention Coordinator. Renee reviewed her handout with the Committee.

**Responses to Committee questions included:

- The National Survey on Drug Use and Health (NSDUH) surveys adults in face-to-face interviews; the Centers for Disease Control and Prevention (CDC) - Behavioral Risk Factor Surveillance System (BRFSS) surveys individuals 12 years of age and older in a phone interview; the CDC - Youth Risk Behavior Surveillance System (YRBSS) is an on paper survey of high school students. For more information, please refer to the following websites: NSDUH: <https://nsduhweb.rti.org/>; BRFSS: <http://www.cdc.gov/brfss/>; YRBSS: <http://www.cdc.gov/HealthyYouth/yrb/index.htm>.
- The higher alcohol use rates in the North Central section of the United States may be due to culture of hard-working and relax with a beer; unsure of all the reasons.
- The Block Grant Prevention is to continue to focus on high school age youth, and the message techniques that work.
- Prevention activities are more accurate when divide the population by age groups rather than to focus on the entire lifespan.

**Committee comments included:

- Recommend the Prevention data be correlated with declines in alcohol-related traffic accidents to determine if there is a relationship.
- The decline in drinking and driving data is encouraging, but we can't sit back and rest—the prevention work needs to continue.
- Although the prevention focus is on youth, there is also a concern about the next age group showing an increase; education still needed because this age group may be thinking that prevention no longer applies since I am now of legal age to drink.
- Parents and educators need to open lines of communication with youth to start asking questions and change expectations from previous generations; also promote resilience and learn life skills.
- Consider how the data is reported (in reference to the slide “Binge Drinking among Nebraska Residents compared to US Rates”)—did alcohol use increase from age 17 and older, or did it increase from 10 years ago?

XV. Impact of Sequester cuts on SAMHSA Block Grants

Karen Harker

(Attachment K)

Karen Harker is the DBH Fiscal and Federal Resources Administrator. Karen explained what a Sequester is and how it impacts the DBH budget. She explained these are not one-time cuts and will accelerate over the next ten (10) years. Karen reported SAMHSA applied 5% reductions to the Substance Abuse Prevention and Treatment Block Grant (SAPTBG), the Community Mental Health Services Block Grant (CMHSBG), and the PATH Grant retroactive to October 1, 2012. Karen reported that decisions have not been made on how or where to apply these reductions and the Region Administrators will be included in the discussions to determine reduction decisions.

XVI. Impact of Affordable Care Act on Behavioral Health Services

Karen Harker

(Attachment L and Attachment M)

Karen Harker explained the Affordable Care Act will have additional impact on how DBH funds services. Karen reviewed two handouts with the Committee. She reported the impact of the Affordable Act on DBH funding has many moving parts that have not been clearly defined. In addition, if Medicaid is expanded per current Legislative Bill, it will not define what services are funded, but what populations are eligible for services. Karen explained the population DBH currently serves are those individuals who are not eligible for Medicaid and who do not have health insurance coverage. Karen explained DBH has

been asked to submit to SAMHSA the number of individuals expected to be covered by DBH services, which is difficult to determine due to the unknown outcome of Medicaid eligibility, the uncertainty of what services are eligible for DBH funding, and predicting the number of individuals who may qualify for services in the future. Once all of the questions are understood, then DBH can collect data to answer the questions. The primary question that needs to be answered is 'How many uninsured individuals will DBH serve in FY2014 with federal funds'? Karen reported that in 2012, DBH served approximately 35,000 individuals, and 86% of those were in Recovery Based Services, not covered by medical necessity criteria.

Karen stated it is exciting to be able to focus on Recovery and Prevention only services. Karen encouraged the Committee to consider the following questions: 'What if DBH had more money for Recovery-Based services?' 'What if we don't need to spend funds on treatment services?' 'How will the Regions continue to spend federal funds'?

**Responses to Committee questions included:

- The requirements are the same for the federal healthcare exchange and if Nebraska establishes its own exchange.
- The Affordable Care Act services meet medical necessity and are provided if it is necessary for an individual to get better. DBH has many services that do not involve the medical necessity.
- The federal government does not set the priorities, the State does. However, the federal government provides the focus areas, therefore the six Strategies of Information Dissemination, Education, Alternatives, Problem Identification, Community-Based, and Environmental must be used. Some Strategies are more effective when coupled with other Strategies, and some are ineffective over time.
- DBH won't apply the reductions across the board due to the mixture of federal funds in the services, but a determination on how to apply the reduction has not yet been determined.
- The At Risk Managed Care (ARMC) Request for Proposal (RFP) is also included in the determination, even though the ARMC only includes services that are medically necessary, if there is a profit the funds are re-invested in Value Added services, which may also impact the services DBH provides.
- Data collection and demonstration of outcomes will be emphasized more in the future, and may determine how services are funded.
- Services and programs are being grouped at the national level, and DHHS Divisions are beginning to discuss how to share funds rather than compete with each other for funds.

**Committee comments included:

- Invite a State Senator, perhaps from the Health and Human Services Committee, to attend an Advisory Committee meeting.
- Karen did a good job of laying out this complicated situation, including the Sequester. Appreciate being able to better understand the challenges and opportunities.
- Providers will need to be creative and think outside of the box to determine future services.

XVII. Committee Recommendations

Committee Members

Jim Harvey reviewed Planning Step #4 questions on Attachment A.

Following are the six Priority Areas selected for the SAMHSA 2014-2015 Block Grant Application for Planning Steps b. 3 and 4:

- #1. Prevention: Alcohol Use Among Youth
- #2. Youth: Improved Family Functioning
- #3. Co-Occurring Disorders
- #4. Trauma-Informed Care
- #5. Peer Support
- #6. Tuberculosis (TB)

Committee members were asked the following questions on these Priority Areas and Ideas for Annual Performance Indicators:

Question #1: Is it realistic to expect that these priorities will help move the system in the right direction?

Question #2: Is it realistic to expect we can accomplish these priorities by end of SFY2015?

Question #3: What might be reasonable mid-point goals (June 30, 2014)?

Question #4: What other recommendations do you have?

**Committee responses are as follows:

- Question #1: Is it realistic to expect that these priorities will help move the system in the right direction? – Unanimous “Yes”.
- Question #2: Is it realistic to expect we can accomplish these priorities by the end of SFY2015? – “Yes”, with hard work and partnerships.
- Question #3: What might be reasonable mid-point goals (June 30, 2014)? – Discussion on the definition of capacity for Priority #3 was held—does it mean volume or ability?
 - If capacity is determined through self-assessment, does that indicate the provider is capable of service delivery?
 - Suggest re-word the Goal to read: Increase Behavioral Health workforce efficiency to deliver effective treatment and recovery services for persons with COD.
 - The Goal and Indicator don’t match—the capability of providers to deliver services can’t be determined by the score of the Compass EZ.
 - Suggest use capability instead of capacity in the Goal. Suggest the Indicator read ‘Providers demonstrate better ability to understand COD’ so it indicates the score will not improve but the provider is better in providing services.
 - Suggest capacity be changed to ability or proficiency or capability in the Goal.
 - Suggest change Goal to read ‘Increase the BH workforce education to provide trauma-informed care.
- Discussion on Priority #4 was held—the same question about capacity was raised.
 - Suggest the number of providers using the tool will increase instead of the number of people responding to TIC.
 - As the scores increase it will reflect the ability to provide TIC.
 - The TIC Tool will be used to establish baseline data, and other information from self-assessments, etc. will become the focus for the Block Grant priority.
 - Suggest change capacity to ability in the Goal.
 - Understands the intention of this Indicator is to increase the use of the TIC tool and to utilize the information gathered to increase success.
 - Recognize that development of care includes results of the TIC Tool.
 - Priority #4 is moving DBH from a process outcome to a performance outcome. The appropriate assessment tool is the process to move to performance.
- Discussion on Priority #5 was held—the same question about capacity was raised.
 - Is capacity the number of providers, or increased knowledge?
 - The priority reflects not only increasing the number of individuals providing Peer Support, but also increasing the use of Peer Support.
 - What is 25% of Plan? Is it 25% of a number or 25% of the plan in place, but we don’t know what the plan is? It is 25% of the plan.
 - Suggest add to the Indicator that 25% of the plan include the number of Peer Support allocated to individuals or families.
- Discussion on Priority #1 was held.
 - Like the focus on the perception of risk.

- Discussion on Priority #2 was held.
 - By June 30, 2015, the family functioning tool will be fully implemented and utilized.
 - This is a good, understandable measure?
- Question #4: What other recommendations do you have?

**Other Committee recommendations/comments included:

- The Intentional Peer Support model is appropriate and should be used solely for training Peer Support staff.
- Although much of the information is overwhelming, the expertise of presenters is appreciated to help understand.
- Peer Support volunteers have been very beneficial to the Veterans' Administration and recommend this workforce be included in DBH.
- The Block Grant Priorities and Goals are good; understand DBH is doing the best they can with changes they are facing.
- Appreciate the Sequester presentation and explanation.
- Peer Support is and will be a huge part of future DBH services.
- There are three parts of healing—Therapy-Medication-Peer Support—want to see Peer Support valued and promoted.
- Believe in Recovery services because they relate more to the quality of life of an individual.
- It is scary to not know where are going with behavioral health services.
- The community-based providers and DBH must collaborate to look at the funding challenges so providers know who to call with questions and suggestions.
- Appreciate the relationships being built in the Committees and with DBH. These meetings are a safe place to express questions/concerns and to receive information.
- Need to address the gaps and broken parts of the mental health system in Nebraska. Individuals needing care aren't being told what they need to know to access appropriate services, because they have not learned the system, or because clinicians aren't telling them, or because clinicians aren't sharing information about the individual. Where and how do the broken pieces get addressed?
- Agree with the emphasis on the Youth Priority, but suggest that 100% of youth will be assessed be changed to 99% or a range to allow some flexibility in meeting the goal.
- Request a glossary of acronyms used to help understand the discussions.
- Excited to serve on the Committee as a parent and an employee of an agency. As a parent, it can get frustrating because the system affects daily life.
- The ACE study is interesting and provides information we need to do our work. Suggest funding be established to support the Home Visitation program.
- Although some new members may be feeling frustrated about how long it takes to change the DBH system, as a long-term member it is satisfying to see how far the system has come in the past fourteen years starting with mental health reform and the closing of the Regional Centers to move individuals to community-based services. Hopefully, more individuals will receive appropriate services with the implementation of increased Peer Support.
- It is helpful to have open discussions because things get done when people can talk through issues.
- This has been a very informative meeting. Appreciate having the Mental Health and Substance Abuse Committees meet together. Hopefully all of the comments made today will move forward to improve the quality of services for individuals.

**Jim Harvey reminded the Committee members the draft SAMHSA 2014-2015 Block Grant Application will be posted on the DBH website. A reminder e-mail message will be sent to members when the comment period is active. Please do take the time to make comments on the draft Block Grant Application.

XVIII. Adjournment and next meeting

- The meeting adjourned at 4:18 pm.
- The next meeting is a Joint Meeting of the State Advisory Committee on Mental Health Services and the State Advisory Committee on Substance Abuse Services and is scheduled for Tuesday, June 11, 2013 from 9:00 am to 4:00 pm. The format for the meeting is the Committees will meet jointly in the morning, and meet separately in the afternoon.

Minutes prepared by the Division of Behavioral Health, Nebraska Department of Human Services. Minutes are intended to provide only a general summary of the proceedings.

03-14-2013 Meeting Minutes



*Behavioral Health is Essential to Health
Prevention Works - People Recover
Treatment is Effective*

Substance Abuse and Mental Health Services Administration FY 2014-2015 Block Grant Application
b. Planning Steps | Step 3: Prioritize State Planning Activities

Nebraska Division of Behavioral Health’s Block Grant Priorities
Draft as of: March 14, 2013



#1 FY2014 Region Budget Plan Guidelines – Statewide Goals

Priority Area:	Prevention: Alcohol Use Among Youth
Goal:	Reduce binge drinking among youth up to age 17.
Indicator:	Percentage of students in 9th-12th grade who reported having five or more drinks on at least one occasion in the past 30 days will decrease to 15%.

#2 FY2014 Region Budget Plan Guidelines – Statewide Goals

Priority Area:	Youth: Improved Family Functioning
Goal:	Families and youth receiving services will experience improved family functioning.
Indicator:	100% of youth under the age of 18 / Families admitted to the Professional Partner Program (PPP) will be assessed using the designated tool for family functioning to establish a baseline measure of family functioning.

#3 FY2014 Region Budget Plan Guidelines – Statewide Goals

Priority Area:	Co-Occurring Disorders
Goal:	Increase the BH workforce capacity to deliver effective treatment and recovery services for persons with Co-Occurring Disorders (COD).
Indicator:	Statewide score on selected sections of the Compass EZ will increase according to the baseline.

#4 FY2014 Region Budget Plan Guidelines – Statewide Goals

Priority Area:	Trauma-Informed Care
Goal:	Increase the BH workforce capacity to provide trauma-informed care.
Indicator:	Statewide score on selected sections of the Falloot and Harris Trauma Informed Care (TIC) tool will increase according to the baseline to be developed after June 30, 2013 self-assessment deadline for providers.

#5 Office of Consumer Affairs | DBH Strategic Plan 2011-2015

Priority Area:	Peer Support
Goal:	Increase the capacity of the system to use Peer Support
Indicator:	Use of Peer Support to provide Recovery Supports in Nebraska (Year One: develop Plan. Year Two: Implement 25% of Plan)

#6 SAPTBG Core Requirement

Priority Area:	Tuberculosis (TB)
Goal:	As required through the contracts with the Regional Behavioral Health Authorities, tuberculosis screening is provided to all persons entering a substance abuse treatment service. Additional services and/or referrals for services are made available to those individuals whose screening indicates “high risk” for TB. The Tuberculosis Program in the NE Division of Public Health provides the overall coordination for the State of Nebraska.
Indicator:	Regional Behavioral Health Authorities will comply with contract requirements for tuberculosis screening to be provided to all persons entering a substance abuse treatment service.

FY 2014-2015 SAMHSA Block Grant Application

Substance Abuse and Mental Health Services Administration (SAMHSA)

- Community Mental Health Services Block Grant (MHBG)

- Substance Abuse Prevention and Treatment Block Grant (SABG)

Priority Area (based on an unmet service need or critical gap) as established in Step 2.

Population(s) [Targeted / required populations] means:

SMI—Adults with Serious Mental Illness

SED—Children with a Serious Emotional Disturbance

PWWDC—Pregnant Women and Women with Dependent Children

IVDUs—Intravenous Drug Users

HIV EIS—Persons with or at risk of HIV/AIDS who are in treatment for substance abuse

TB—Persons with or at risk of TB who are in treatment for substance abuse

Other: Specify

SFY – State Fiscal Year – July 1 to June 30

Planning Step b. 4: Develop Objectives, Strategies, and Performance Indicators

Questions on Priority Areas and Ideas for Annual Performance Indicators

Is it realistic to expect that these priorities will help move the system in the right direction?
Is it realistic to expect we can accomplish these priorities by end of SFY2015?
What might be reasonable mid-point goals (June 30, 2014)?
What other recommendations do you have?

To see the FY 2014-2015 Block Grant Application requirements go to: <http://www.samhsa.gov/grants/blockgrant/>

***Department of Health and Human Services
Division of Behavioral Health***

**FISCAL YEAR 2014
REGION BUDGET PLAN GUIDELINES**



February 1, 2013

STATEWIDE GOALS

NETWORK

Goal #1: Increase the number of behavioral health programs/providers able to deliver effective prevention and treatment ROSC for persons with COD.

Indicator #1: Statewide average score on selected sections of the Compass EZ will increase according to the baseline.

Goal #2: Increase the knowledge of trauma-informed care within the behavioral health workforce.

Indicator #2: Statewide average score on selected sections of the Falliot and Harris Trauma Informed Care tool will increase according to the baseline.

EMERGENCY

Goal: Consumers experiencing a BH crisis will be served at the most appropriate and least restrictive LOC.

Indicator: The percentage of consumers served by crisis response programs taken into custody by law enforcement will decrease by 2%.

PREVENTION

Goal: Increase the perception of risk related to alcohol use among all age groups.

Indicator #1: The percentage of persons aged 18 or older reporting binge alcohol use will decrease to 20%.

Indicator #2: Percentage of students in 9th-12th grade who reported having five or more drinks on at least one occasion in the past 30 days will decrease to 15%.

YOUTH

Goal: Families and youth receiving services will experience improved family functioning.

Indicator: The number of youth in the PPP under the age of 18 will be assessed using the designated tool for family functioning to establish a baseline measure of family functioning.

HOUSING

Goal: Behavioral health consumers will experience an increase in stability of housing.

Indicator: The overall percentage of consumers discharging from care as “homeless” will decrease by 2%.

***Department of Health and Human Services
Division of Behavioral Health***

**FISCAL YEAR 2014
REGION BUDGET PLAN GUIDELINES**



February 1, 2013



DIVISION PRIORITIES

Nebraska Division of Behavioral Health Strategic Plan ~ 2011-2015

Vision – The Nebraska public behavioral health system promotes wellness, recovery, resilience and self-determination in a coordinated, accessible consumer and family-driven system

Mission – The Division of Behavioral Health (DBH) provides leadership and resources for systems of care that promote and facilitate resilience and recovery for Nebraskans.

2011-2015 Goals:

1. The public behavioral health workforce will be able to deliver effective prevention and treatment in recovery-oriented systems of care for people with co-occurring disorders.
2. DBH will use financing mechanisms which support innovative service content, technology and delivery structures (e.g., telehealth; in-home acute services; Peer Support Services).
3. DBH will reduce reliance on the Lincoln Regional Center for general psychiatric services.
4. An effective system to safely manage sex offenders in outpatient settings will be ready for implementation.

Strategies

- Strategy 1: Insist on Accessibility – Increase access to appropriate and effective integrated behavioral health services, particularly for vulnerable populations.
- Strategy 2: Demand Quality – Improve the quality of public behavioral health services for children and adults.
- Strategy 3: Require Effectiveness – Improve outcomes for children and adults through the use of effective services.
- Strategy 4: Promote Cost Efficiency – Develop flexible and balanced funding to support an efficient and accountable person-centered, recovery oriented system of services.
- Strategy 5: Create Accountable Relationships – Encourage transparent, accountable relationships with and among system stakeholders.

Prevention Goals

DBH will prevent and reduce a wide range of substance use behaviors, including:

- Underage drinking
- Binge drinking
- Prescription drug abuse
- Marijuana use
- Illegal sale of tobacco products to minors

Adverse Childhood Experiences (ACE) — Nebraska, 2011

Table 1: BRFSS questions and responses that qualified for each of 8 ACE categories

ACE Category	BRFSS Question	Response
Physical abuse	“How often did a parent or adult in your home ever hit, beat, kick, or physically hurt you in any way? Do not include spanking.”	“Once” or “More than once”
Sexual abuse	1. “How often did anyone at least five years older than you or an adult ever touch you sexually?”	“Once” or “More than once” to any of the 3 questions
	2. “How often did anyone at least five years older than you or an adult try to make you touch them sexually?”	
	3. “How often did anyone at least five years older than you or an adult force you to have sex?”	
Verbal abuse	“How often did a parent or adult in your home ever swear at you, insult you, or put you down?”	“More than once”
Household mental illness	“Did you live with anyone who was depressed, mentally ill, or suicidal?”	“Yes”
Household substance abuse	1. “Did you live with anyone who used illegal street drugs or who abused prescription medications?”	“Yes” to either question
	2. “Did you live with anyone who was a problem drinker or alcoholic?”	
Divorce	“Were your parents separated or divorced?”	“Yes”
Witness abuse	“How often did your parents or adults in your home ever slap, hit, kick, punch, or beat each other up?”	“Once” or “More than once”
Household incarceration	“Did you live with anyone who served time or was sentenced to serve time in a prison, jail, or other correctional facility?”	“Yes”

Table 2: Prevalence of adverse childhood experience (ACE) count by demographic characteristic in 1.37 million Nebraska adults, 2011 (race/ethnicity not included due to low numbers)

Demographic characteristic	ACE Count			
	0	1-2	3-4	≥5
	%	%	%	%
Overall	47.0	33.6	11.7	7.7
Sex				
Men	49.3	34.5	11.3	4.9
Women	44.9	32.7	12.0	10.4
Age				
18-24	50.0	30.5	11.7	7.8
25-34	35.9	38.7	11.7	13.7
35-44	39.6	34.5	15.6	10.2
45-54	42.9	35.7	14.0	7.4
≥55	57.4	30.5	8.6	3.5
Education				
Did not graduate high school	41.1	32.0	14.9	12.0
Graduated high school	49.3	31.3	12.4	7.0
Attended college/technical school	44.5	34.4	11.9	11.9
Graduated college/technical school	49.9	35.7	9.5	4.9

Table 3: Prevalence of individual adverse childhood experience (ACE) by demographic characteristic in 1.37 million Nebraska adults, 2011

Demographic characteristic	Physical abuse	Sexual abuse	Verbal abuse	Household mental illness	Household substance abuse	Divorce	Witness abuse	Prison
	%	%	%	%	%	%	%	%
Overall	15.2	9.1	25.8	15.5	25.3	19.6	13.8	6.2
Sex								
Men	14.9	4.4	25.7	10.9	22.8	18.9	12.5	5.0
Women	15.6	13.6	26.0	19.8	27.7	20.3	15.1	7.4
Age								
18–24	13.3	3.6	21.2	18.3	22.3	24.4	10.4	12.4
25–34	19.2	9.8	32.4	23.9	32.9	28.9	15.9	10.5
35–44	18.9	10.8	31.7	16.2	29.1	29.2	19	7.2
45–54	15.6	12.3	30.5	15.5	29.1	17.7	15.9	3.8
≥55	12.2	8.4	19.1	9.5	18.9	9.2	10.8	2.3
Education								
Did not graduate high school	22.1	15.3	26.9	13.6	33.9	26.4	20	11.3
Graduated high school	15.2	7.2	24.2	13.8	25.1	20.5	14.1	5.2
Attended college/technical school	15.6	10.5	27.3	17.5	26.9	22.0	14.1	7.3
Graduated college/technical school	12.2	6.9	25.4	15.4	20.1	12.7	10.8	3.9

206 Draft of Peer Support Regulations

CHAPTER 2-000 DEFINITIONS

Peer Support Services means: ~~persons with behavioral health disorders as defined by Nebraska law meeting as equals with others with similar issues to give them the benefit of their learned experiences, encouragement, and support to help them resolve those issues~~ individualized, recovery-focused services, based on a mutual relationship between consumers that allows a consumer the opportunity to learn to manage his/her own recovery and advocacy process. Activities of Peer Support serve to move the individual to a place of wellness and recovery through demonstration that recovery and wellness are possible, sharing of wellness planning tools, group facilitation, empowering the individual with advocacy and self-help skills and supports, relaxation response training, engaging individuals with natural supports, understanding the importance of shared decision-making, self-advocacy, communication, creating relationships of quality, and education of training staff about the importance of the individual's needs to enhance wellness and recovery. Unique services include but are not limited to peer perspective crisis prevention, smoking cessation, peer-run respite, support groups, relaxation response training, and warm lines.

5-007 Peer Support Staff

5-007.01 Purpose: Peer Support is provided by consumers in recovery to mentor others in wellness and recovery through mutual sharing of experiences and stories. The desired outcome is to provide support to consumers by Peer Support Staff who have experience with serious mental illness and/or addiction, including gambling.

5-007.02 Description: Peer Support Staff provide an organized, confidential interaction between a consumer and the Peer Support Staff recognized as a process involving listening to a consumers' challenges, sharing recovery skills, acknowledging where the consumer is on his/her personal recovery path, mutual sharing of recovery experiences and challenges, and providing information and education desired on topics relevant to recovery experience, including all aspects of community living. This support may include training, personal assistance, advocacy, and provision of information on the experience of recovery and behavioral health services available in Nebraska.

5-007.03 Services Provided: Peer Support Staff may provide support through a variety of consumer run service program designs which may include but are not limited to: drop-in center, peer support groups, one-on-one peer support, education, benefits advisement, or newsletters that are solely authored by consumers or other related services within the limitations of Federal, State, and/or local statutes and regulations. Peer Support Staff may also be provided within other behavioral health services such as Day Rehabilitation, Assertive Community Treatment (ACT), Recovery Support, Supported Employment, Day Support, Crisis Respite, Intensive Case Management, etc.

5-007.04 Services Not Provided by Peer Support Staff: Peer Support Staff do not provide:

1. Assessment, diagnosis, and/or treatment of, ~~or education on~~, mental disorders or addictions (including gambling) covered in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association;
2. Individual, group, and/or family therapy;
3. Written assessments and treatment plans;
4. Administration or oversight of medications; or

206 Draft of Peer Support Regulations

5. Work for a behavioral health provider (landscaping, clerical tasks, cleaning, etc.) that does not involve sharing of the lived experience of recovery.

5-007.05 Experience and Abilities: Peer Support Staff must have:

1. Experience with significant challenges or diagnosis of serious mental illness or addiction, including gambling;
2. Ability to relate well with a variety of people and of differing cultures, including those with developmental and disabilities;
3. Ability to plan, initiate, organize, and carry out goal-directed activities;
4. Ability to mentor and role model the value of every consumer's recovery, including effective coping techniques and self-help strategies, accessing natural supports, and obtaining decent and affordable housing of choice in the least restrictive setting; and
5. Ability to lead organizations and consumers in accessing recovery knowledge relevant to the recovery process, person-centered planning, cultural competency, advocacy, providing recovery-based services, and speaking language that promotes easy understanding and valuing of human experience.

5-007.06 On-going Qualifications: Peer Support Staff must demonstrate on-going qualifications including:

1. Receiving annual continuing education and researching the latest trends in peer support; and
2. Providing current personal work contact information including name, address, and phone number to the Office of Consumer Affairs; and
3. Acting consistently with Division of Behavioral Health Office of Consumer Affairs Code of Ethics. (attachment)

5-007.07 Peer Support Office Environment: Peer Support Staff must be provided with an environment conducive to providing peer support to consumers including:

1. Office space adequate for peer support activities;
2. An area for confidential one-on-one peer support;
3. An area for small group meetings;
4. Access to office resources; and
5. An organized record keeping system with the capacity to document all peer support activities.

5-007.08 Age-Related Peer Support Provision: Peer support is provided by Peer Support Staff with relevancy to the consumer's age.

1. Peer support for an adult can only be provided by an adult who is able to mentor independent living skills; and
2. Peer support is provided to the entire family of a child with serious emotional disturbance or addiction, with the focus being on empowering the child to grow in a recovery skill set and ways the family can support the child's recovery. Peer support to a family is provided by a person with experience in navigating the children's behavioral health system.

5-007.09 Culture-Related Peer Support Provision: Peer Support Staff must reflect the recovery culture of the consumers receiving peer support as the workforce relates to skills based on life experience not academic degrees. A Peer Support Staff with life experiences with mental health issues could not support a consumer with addiction issues or visa-versa. A Peer Support Staff with co-occurring mental health and addiction challenges can provide support for either recovery culture.

What is Intentional Peer Support (IPS)?

The Four Tasks of IPS:

Peer support is intentional because we come into the relationship with a specific goal and purpose. The intention is to purposefully communicate in ways that help both people step outside their current story while assuming healthy characteristics of relationships. There are four central tasks of intentional peer support.

Connection- This is the foundation of peer support. The connection is the foundation of the relationship, the magical moment when you realize that someone else “gets it”.

Worldview- This task is where we think about personal experiences, cultural backgrounds, family backgrounds, and all of the other experiences that have shaped our knowledge and the way we view the world.

Mutuality- Peer support relationships are intentional and reciprocal, meaning both people within the relationship are gaining valuable learning experiences and growth from one another.

Moving towards- When helping people move away from what is not working (problems and solutions), they stay tied to the problem. Intentional peer support relationships help each other move towards what we want (vision and action).

Key Points on IPS:

IPS is a **Trauma-Informed-** it begins with the fundamental question “what happened to you”.

Addresses Systemic Trauma- A fundamental challenge of becoming involved with systems is that you expect others to solve your problems- IPS challenges you to be an active participant in all relationships and goals.

Insists on Mutuality- Natural relationships in communities are based on mutuality and this is a key theme of IPS, to create mutual goals, shared responsibility, and mutual relationships.

Learn about Flexible Boundaries- To engage in relationships of mutuality, a person must have the essential skill of understanding how to name what is flexible and what is not.

Addresses Suicide- The language of suicide is addressed, because many of us use suicide as a language of pain. We will never learn from these crises unless people have the skills to address pain differently.

Learning from Crisis- The big push of IPS that makes it so wildly popular in respite environments is that it gives us the tools to address crisis differently- as a time to learn.

The broad overarching goal of Intentional Peer Support is that people that engage in IPS will be able to create a peer support relationship based on mutuality and from there engage in real mutual relationships with others in the community. When people can rely on communities versus systems via relationships of mutuality, true independence and recovery becomes a reality.

References

Mead, S. (2010). Systems advocacy. In Mead, S., *Nebraska peer support training workbook for participants*. New Haven, C: Yale-PRCH.

Service Name
Setting
Facility license
Basic definition
Services
Programming
LOS
Staffing
Peer to Client Ratio
Hours of Operation
Consumer Need
Consumer Outcome
Rate

Joint Committee Meeting
State Advisory Committee on Mental Health Services
State Advisory Committee on Substance Abuse Services
March 14, 2013

Projects for Assistance in Transition from Homelessness (PATH)

- The PATH Program was created as part of the Stewart B. McKinney Homeless Assistance Amendments Act of 1990.
- The PATH Program is administered by the Center for Mental Health Services (CMHS) a component of the Substance Abuse and Mental Health Services Administration (SAMHSA), within the U.S. Department of Health and Human Services.
- Since 1991, the PATH Formula Grant funds the 50 States, the District of Columbia, Puerto Rico, and four United States Territories (the U.S. Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands).
- Nebraska currently receives \$300,000 per year; DBH contracts with four Regions who sub-contract with five providers across the State. The allocations are determined according to population and number of homeless individuals in the geographic location.
 - ✓ *Region 1-Cirrus House in Scottsbluff receives approximately \$11,000*
 - ✓ *Region 3-Goodwill in Grand Island receives approximately \$11,000*
 - ✓ *Region 5-CenterPointe and Community Mental Health Center both in Lincoln receives approximately \$65,000*
 - ✓ *Region 6-Community Alliance in Omaha receives approximately \$230,000*
- The goal of the PATH Program is to reduce or eliminate homelessness for individuals with serious mental illnesses or co-occurring substance use disorders who are homeless or at imminent risk of becoming homeless.
- PATH funds are used to provide a menu of allowable services, including street outreach, case management, and support services which are not supported by mainstream behavioral health programs, such as limited housing services, habilitation and rehabilitation, employment.
- The focus of Outreach = develop a relationship with an individual to assist him/her move toward readiness for change
- The focus of Case Management = access to housing and maintenance services

Future Focus

- Are PATH providers involved in any homelessness Prevention activities?
- Are PATH providers using Evidenced-Based Practices in PATH services?
- How well are PATH providers and the Regional Housing Coordinators coordinating their activities?
- Are we doing enough to connect PATH with SOAR (SSI/SSDI Outreach, Access, and Recovery)?
- The PATH Program is moving toward a Homeless Management Information System (HMIS) as soon as practicable. PATH recently requested providers to report on the type of system on which they currently collect their data and will use this information to determine the level of training on HMIS needed by each provider.

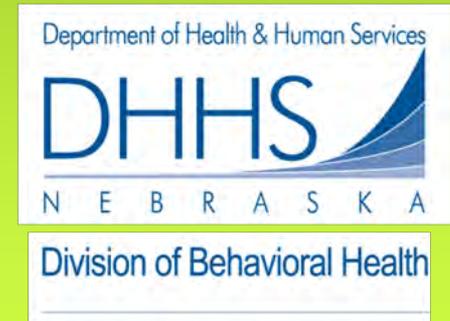
Prevention: *Alcohol Use Among Youth*

State Advisory Joint Committee Meeting

March 14th, 2013

Presented by: Renee Faber

Prevention System Coordinator



Block Grant Statewide Prevention Goal

Priority Area

- * Alcohol Use Among Youth

Goal

- * Reduce binge drinking among youth up to age 17.

Indicator

- * Percentage of students in 9th-12th grade who report having five or more drinks on at least one occasion in the past 30 days will decrease to 15%.

Why We Should Worry About Underage Drinking?

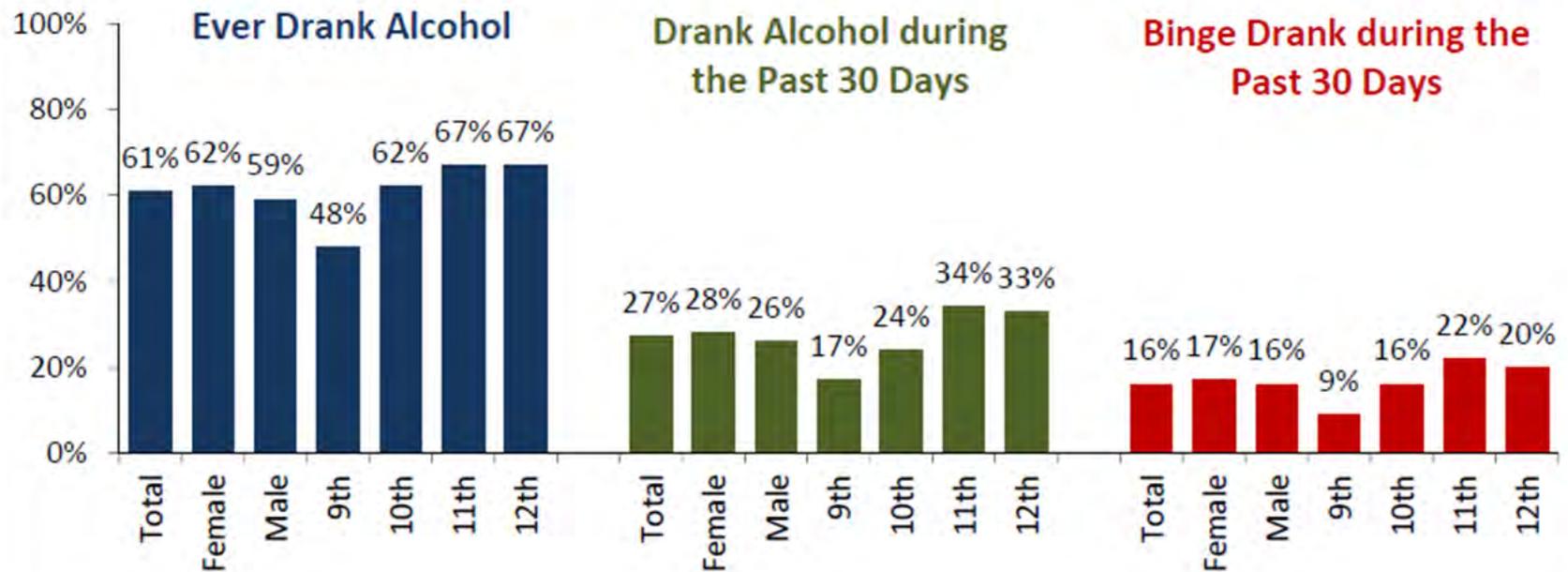
- * Many young people drink.
- * When they drink, they often binge drink.
- * Underage drinking can have a range of acute and long-term consequences both for drinkers and for those around them.
- * The long-term consequences include increased risk for alcohol problems later in life.
- * Underage drinking has the potential to interfere with brain development.

Substance Use in Nebraska

- * **Alcohol** is the PRIMARY substance of choice statewide and has many contextual Influences.
- * Binge drinking among Nebraska residents was higher than residents nationally for adults over 12, and adults 18 and over, based on self-reported surveys.
- * In 2011, more than 1 in every 4 students (26.6%) drank alcohol during the past month, about 1 in every 7 smoked cigarettes (15%), and approximately 1 in every 8 used marijuana (12.7%).
- * During 2011, 3 in 5 students (61%) reported that they drank alcohol during their lifetime .
- * **Over 1 in 4 students (27%) reported drinking alcohol during the past 30 days while 1 in 6 (16%) reported binge drinking during the same period.**

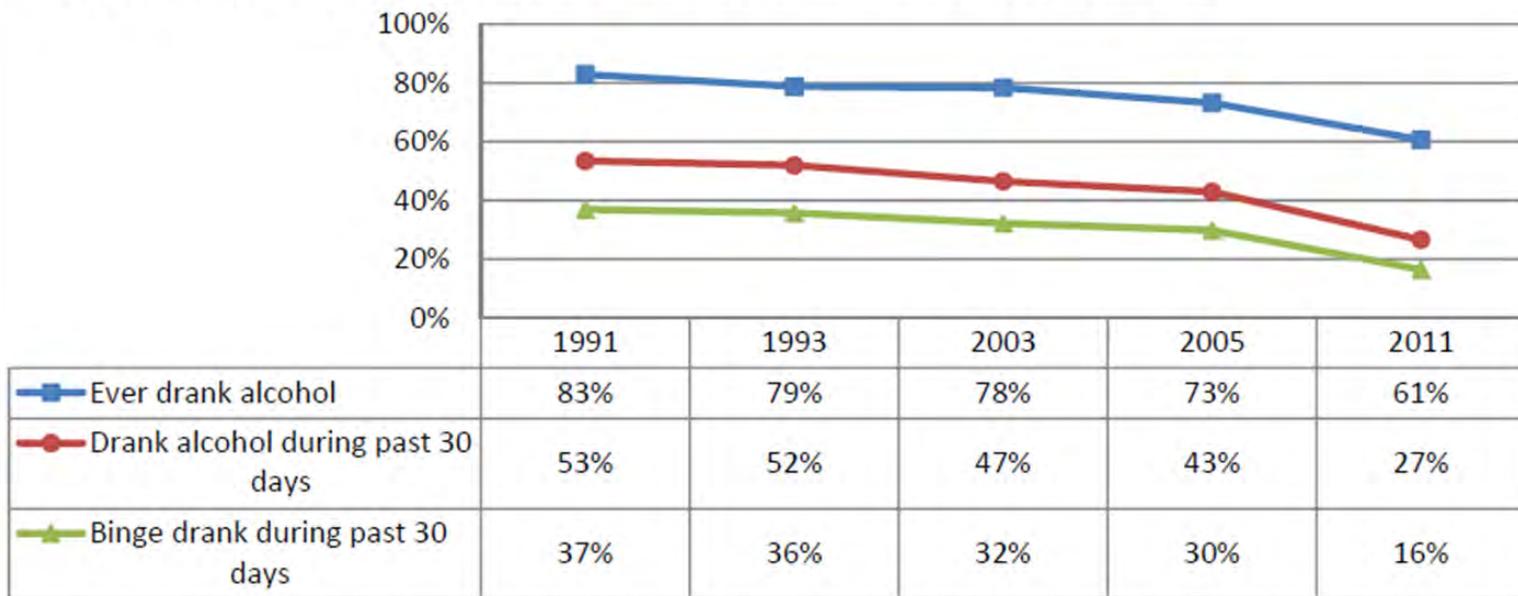
State of Nebraska 2011 Youth Risk Behavior Survey

Figure 18: Alcohol Use among Nebraska High School Students, by Gender and Grade, 2011



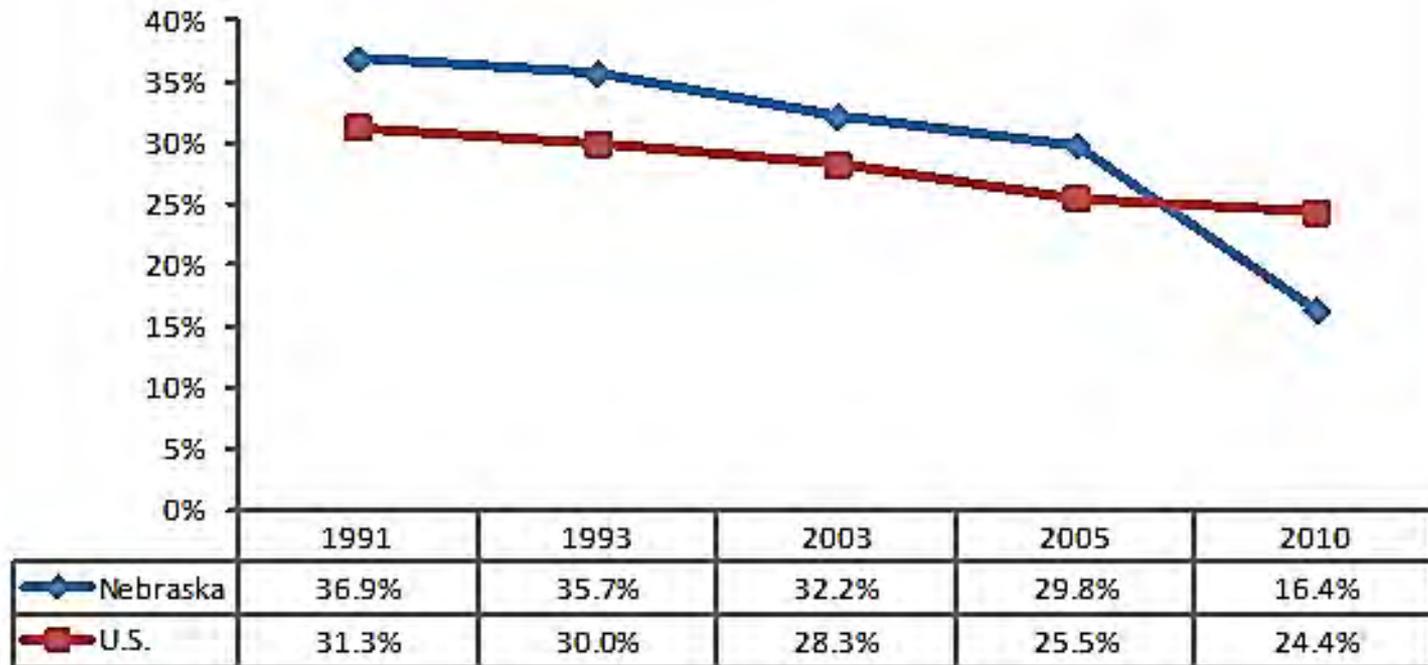
2011 Nebraska YRBS Results

Figure 17: Alcohol Use among Nebraska High School Students, from 1991 to 2011



NOTE. Only years with weighted data are displayed here. See Methodological Overview section for details.

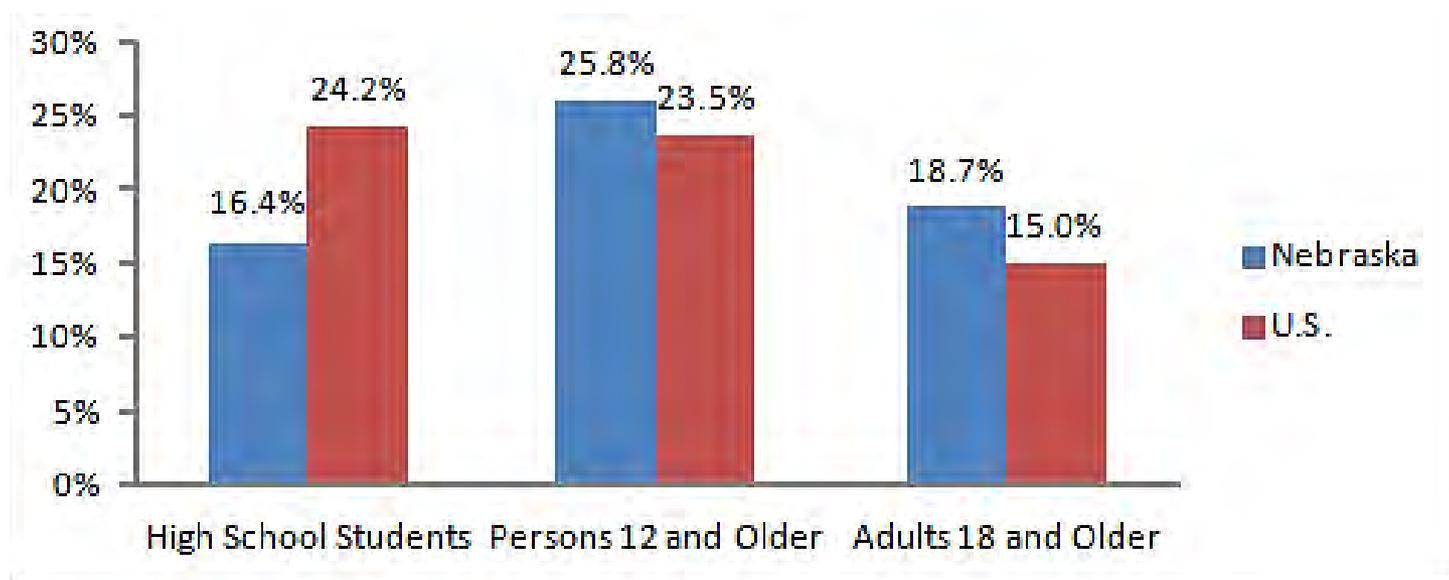
High School Students Reporting having 5 or more Drinks in a Row within a Couple of Hours*



*During the 30 days preceding the survey, among students who reported alcohol consumption

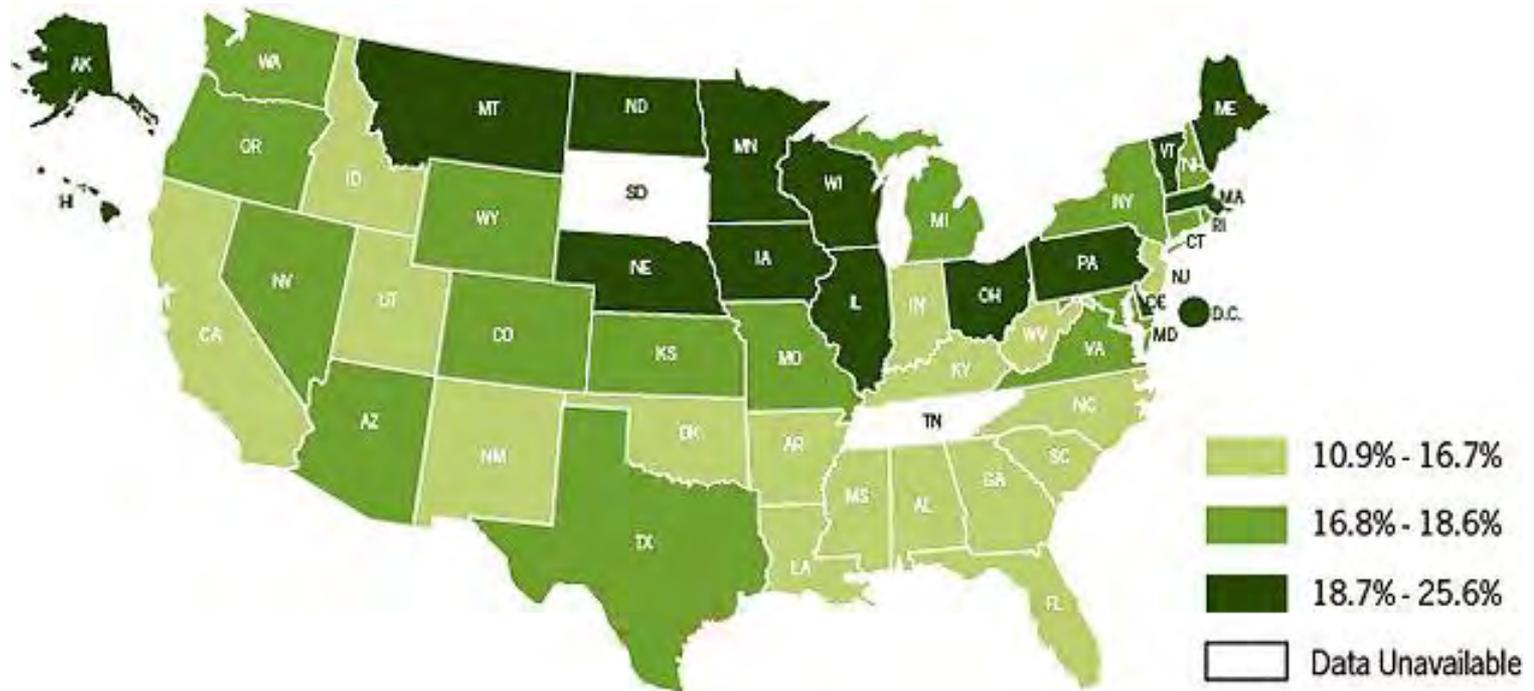
Source: Nebraska Youth Risk Behavior Survey

*Binge Drinking among Nebraska Residents compared to US Rates



***The BRFSS definition consists of five or more drinks for men and four or more drinks for women while the YRBS and NSDUH consist of five or more drinks for both genders.**

Prevalence of Past Month Binge Drinking (ages 12 and older)



*Source: 2008/2009 NSDUH

What can we do?

Increase protective factors

- * Positive Peer Groups
- * Presence of a Caring Adult
- * Alternative Activities
- * Open Lines of Communication With Parents
- * Parental Monitoring
- * Appropriate Policies and Consequences and Consistent Enforcement
- * Screening





Parents Matter

- * Children whose parents monitor their activities, and exert control and consistent discipline along with warmth and responsiveness, fare better.
- * Parents should never serve alcohol to someone else's child or host a party for teens where alcohol is available.
- * Teens DO listen to their parents. According to one survey, 80% felt that parents should have a say in whether they drink alcohol.
- * If parents and other family members choose to drink, they should always model responsible alcohol consumption.

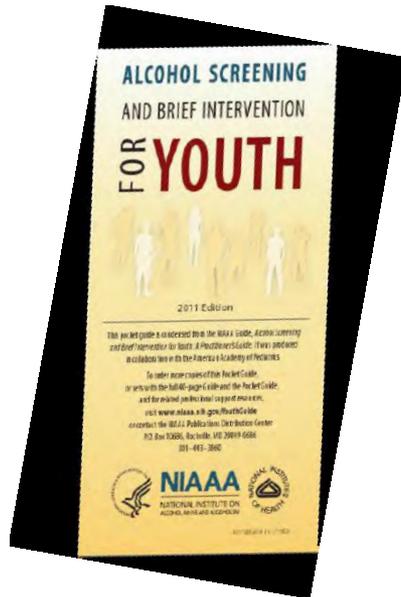
Why screen children and adolescents?



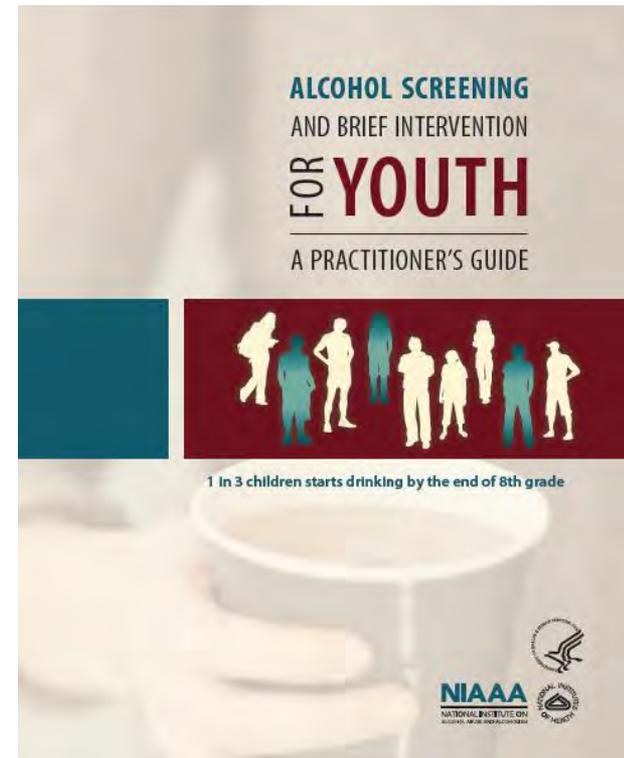
- * Helps influence children and teens one at a time.
- * Helps change expectations — kids and their parents will expect to be asked about alcohol use.
- * Sends a message of concern.
- * Is an opportunity for youth to ask knowledgeable adults about alcohol.
- * Is an opportunity to intervene before or after drinking starts, as well as before or after problems develop.

NIAAA's Screening Guide

* Alcohol Screening and Brief Intervention for Youth: A Practitioner's Guide



www.niaaa.nih.gov/YouthGuide



Questions???

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Impact of Sequestration



Budget Control Act of 2011

- ▶ Budget Control Act of 2011 allows for debt ceiling to be raised up to \$2.8 trillion, AND reduce the deficit by \$2.3 trillion over 10 years
- ▶ Achieved by:
 - Series of mandatory caps on categories of spending over the next 10 years; effect will be to decrease discretionary spending by \$841 billion
 - “Super Committee” deficit reduction plan – can cut spending (including mandatory programs like Medicare and Social Security), raise revenue or implement a combination of both

Sequestration

Originally a legal term referring generally to the act of valuable property being taken into custody by an agent of the court and locked away for safekeeping, usually to prevent the property from being disposed of or abused before a dispute over its ownership can be resolved. But the term has been adapted by Congress in more recent years to describe a new fiscal policy procedure originally provided for in the Gramm–Rudman–Hollings Deficit Reduction Act of 1985 -- an effort to reform Congressional voting procedures so as to make the size of the Federal government's budget deficit a matter of conscious choice rather than simply the arithmetical outcome of a decentralized appropriations process in which no one ever looked at the cumulative results until it was too late to change them. If the dozen or so appropriation bills passed separately by Congress provide for total government spending in excess of the limits Congress earlier laid down for itself in the annual Budget Resolution, and if Congress cannot agree on ways to cut back the total (or does not pass a new, higher Budget Resolution), then an "automatic" form of spending cutback takes place. This automatic spending cut is what is called "sequestration."

Sequestration cont.

- ▶ Under sequestration, an amount of money equal to the difference between the cap set in the Budget Resolution and the amount actually appropriated is "sequestered" by the Treasury and not handed over to the agencies to which it was originally appropriated by Congress. In theory, every agency has the same percentage of its appropriation withheld in order to take back the excessive spending on an "across the board" basis. However, Congress has chosen to exempt certain very large programs from the sequestration process (for example, Social Security and certain parts of the Defense budget), and the number of exempted programs has tended to increase over time -- which means that sequestration would have to take back gigantic shares of the budgets of the remaining programs in order to achieve the total cutbacks required, virtually crippling the activities of the unexempted programs.

Sequestration

Sequestration is mechanism through which automatic, across the board spending cuts are made.

- ▶ March 1, 2013 = \$44 Billion cuts went into effect (were postponed from October 1, 2012)
- ▶ October 1, 2013 = additional \$62 Billion cuts are scheduled to occur
- ▶ These cuts accelerate over the 10 year period to \$119 Billion in cuts in 2021

Additional specific program reductions are also possible.

Source: OMB Watch, *The Budget Control Act of 2011 (Debt Ceiling Deal, Frequently Asked Questions)*. www.ombwatch.org

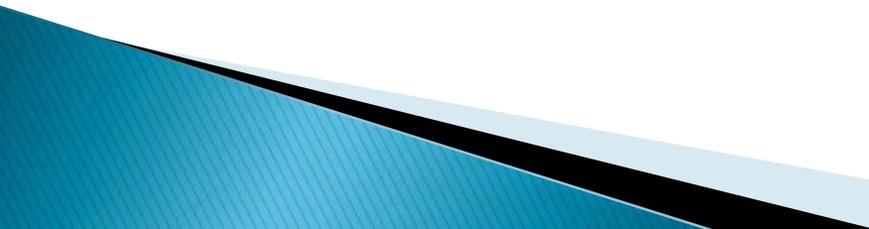
Discretionary Spending

- ▶ One of categories hardest hit by reductions
- ▶ Does not include programs like food stamps, Social Security, or Medicare
- ▶ Does include:
 - Community Mental Health Services Block Grant
 - Substance Abuse Prevention & Treatment Block Grant
 - PATH
 - Most, if not all, other grants addressing substance use or mental health disorder treatment services and prevention activities

Impact from March 1st Cuts for Nebraska

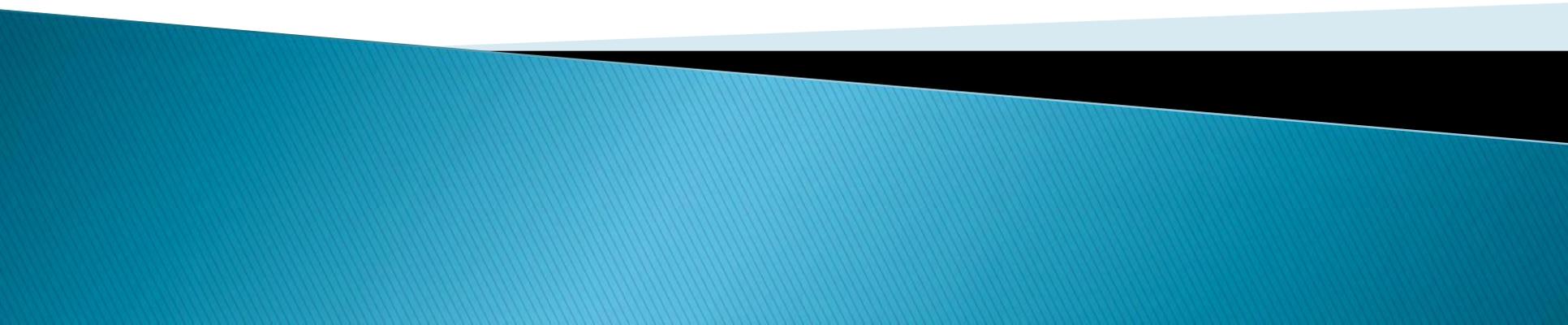
- ▶ SAMHSA has notified all grantees the FY13 awards will be reduced:
 - Community Mental Health Services Block Grant by approximately \$124,000
 - Substance Abuse Prevention & Treatment Block Grant by approximately \$470,000
 - PATH by approximately \$15,000
- ▶ High probability for cuts to continue and increase each year

What does this mean?

- ▶ Reduction in services funded with Federal dollars
 - ▶ Target dollars to SAMHSA purpose areas:
 - Priority tx & support services for those without insurance, Medicaid or other payment source
 - Priority tx & support services that demonstrate success in improving outcomes and/or supporting recovery
 - Primary prevention
 - Data collection to determine the ongoing effectiveness of behavioral health promotion, treatment and recovery support services
- 

FY2014 & FY2015 Block Grant Application

Financial Information



Estimated Expenditures

Activity	SAPTBG	MHBG	Medicaid (Federal, State, Local)	Other Federal funds	State funds
SA Prevention & TX					
Preg Women and WDC	\$ 300,000			-	\$ 800,000
All other	5,183,141			-	23,152,804
Primary Prevention	1,958,265	-		-	300,000
Turberculosis Services	0			-	
HIV Early Intevention	0			-	
State Hospital		-		-	-
Other 24 hour care		271,990		-	8,905,497
Ambulatory/comm non-24 hour care		1,693,640		288,000	50,464,485
Admin (excluding program/provider level)	391,652.95	103,454	-	-	-
Subtotal (Prev, Tx, etc)	\$ 7,441,406	\$ 1,965,630	\$ -	\$ 288,000	\$ 83,622,787
subtotal (Admin)	391,653	103,454	-	-	-
Total	\$ 7,833,059	\$ 2,069,084	\$ -	\$ 288,000	\$ 83,622,787

▶ Does not reflect Sequestration reduction

Projected SAPTBG Prevention Expenses by Strategy

Information Dissemination	Universal	\$	85,516
	Selective	\$	34,820
	Indicated	\$	17,458
	Unspecified		
Subtotal		\$	137,794
Education	Universal	\$	134,519
	Selective	\$	73,858
	Indicated	\$	47,137
	Unspecified		
Subtotal		\$	255,513
Alternatives	Universal	\$	33,396
	Selective	\$	27,595
	Indicated	\$	17,492
	Unspecified		
Subtotal		\$	78,483
Problem Identification	Universal	\$	12,738
	Selective	\$	140,188
	Indicated	\$	24,456
	Unspecified		
Subtotal		\$	177,383

Projected SAPTBG Prevention Expenses by Strategy

Community Based	Universal	\$ 485,698
	Selective	\$ 140,932
	Indicated	\$ 29,657
	Unspecified	
Subtotal		\$ 656,286
Environmental	Universal	\$ 398,821
	Selective	\$ 132,495
	Indicated	\$ 16,380
	Unspecified	
Subtotal		\$ 547,695
Other	Universal	
	Selective Indicated	
Subtotal		\$ -
Section 1926 – Tobacco	Universal	\$ 105,110
	Selective Indicated	
Subtotal		\$ 105,110
Total		\$ 1,958,265

SAPTBG Planned Resource Expenditures

	Prevention SA	Treatment SA
Planning Coordination, and needs assessment	\$ 33,103	
Quality assurance	\$ 33,103	\$ 33,103
Training (post-employment)		\$ 94,519
Education (pre-employment)		\$ 63,013
Program Development	\$ 66,207	\$ 33,103
Research & Evaluation		
Information Systems	\$ 26,331	\$ 11,769
Total	\$ 158,745	\$ 235,507

MHBG Planned Resources Expenditures

	MHBG
MHA Tech Assistance	
MHA Planning Council Assistance	
MHA Administration	\$ 103,454
MHS Data Collection/Reporting	
MHS Activities Other than Above	\$ 99,000
Total Non Direct	\$ 202,454
Comments on Data:	Peer review
	wkforce training

Projected Services to be Funded

?

What could the Affordable Care Act mean for DBH funded services?

Services that are likely to be covered by insurance after January 1, 2014 for some individuals:

Mental Health

Acute
Sub-Acute
Crisis Inpatient Youth
Assessments
Outpatient
Assertive Community Treatment
Community Support
Day Treatment
Intensive Outpatient
Medication Management
Indigent Drug (LB95)

Substance Abuse¹

Community Support
Outpatient
Assessment
Intensive Outpatient

Services that are likely to NOT be covered by Insurance after January 1, 2014:

Mental Health

Secure Residential
Psych Res Rehab
Dual Residential
Therapeutic Consultation

24 hour Crisis lines
Day Support
Day Rehabilitation
Respite Care
Peer Involved services
Supported Employment
Supported Housing
Flex funding
Crisis Response Teams
Crisis Respite
Emergency Protective Custody (?)
Professional Partner
Emergency Community Support
Hospital Diversion
Other similar recovery services

Substance Abuse¹

Dual Residential
Halfway House
Intermediate Residential
Short Term Residential
Therapeutic Community
Methadone Maintenance
24 hour Crisis lines
Social Detox/CPC
Peer involved services
Recovery Housing alternatives
Flex funding
Emergency Community Support
Prevention activities
Other similar recovery services

¹ There is conflicting information in the Nebraska's Benchmark Plan documents if 'alcoholism' is covered. At this time, appears coverage limited to amount required by law (30 days inpatient/year; 2 inpatient events per lifetime; 60 outpatient sessions during lifetime of policy)

SFY13 Contracted Amounts

FEDERAL FUNDED SERVICES REFLECTED ONLY	SAPTBG Funds Reported ONLY	MHBG Funds Reported ONLY
SAMHSA List	DBH Service Equivalent	DBH Service Equivalent
Prevention (including Promotion)		
Screening, Brief Intervention & Referral to TX	\$1,712,359 (Alt act; comm based; envir; info disse; prob id; Reg prev; educ; trng)	
Brief Motivational Interviews		
Screen & Brief Intervention on-Tobacco Cessation		
Parent Training		
Facilitated Referrals		
Relapse Prevention/Wellness Recovery Support		
Warm Line		
Engagement Services		
Assessment	\$33,605 (Assessment Only/Assessment/Justice Assessment/Youth assess)	Assessments
<i>Specialized Evaluations (Psychological & Neurological)</i>		
Service Planning (inc Crisis planning)		
Consumer/Family Education		\$638,539 (Prof Partners)
Outreach	\$393,582 (Block grant coord; remainder region prev coor; training)	
Outpatient Services		
<i>Individual evidence based therapies</i>	\$1,258,342 (Outpatient)	\$377,551 (Outpatient)
<i>group therapy</i>	in Outpatient	in Outpatient
<i>family therapy</i>	in Outpatient	in Outpatient
<i>multi-family therapy</i>	in Outpatient	in Outpatient
consultation to caregivers		\$68,800 (Therapeutic Consultation)
Medication services		
<i>Medication management</i>		\$37,467 (Medication Management)
pharmacotherapy (including MAT)	\$1,048,000 (Methadone Management)	
Laboratory services		

Italicized - Likely to be covered by insurance after January 1, 2014.

Red - Potential targeted use of additional Federal dollars

SFY13 Contracted Amounts

FEDERAL FUNDED SERVICES REFLECTED ONLY	SAPTBG Funds Reported ONLY -	MHBG Funds Reported ONLY -
SAMHSA List	DBH Service Equivalent	DBH Service Equivalent
Community Support (Rehabilitative)		
Parent/Caregiver support		
skill building (social, daily living, cognitive)		\$191,298 (Day Rehab; Day Support; Day Treatment)
<i>case management</i>	\$256,648 (Community Support)	\$143,062 (Community support)
continuing care		
behavior management		
supported employment		\$64,726 (Supported employment)
permanent supportive housing		Supportive living
recovery housing		
therapeutic mentoring		
Traditional healing services		
Recovery Supports		
Peer Support		
Recovery Support Coaching		
Recovery Support Center Services		
Supports for Self Directed Care		
Other Supports (Habilitative)		
Personal Care		
Homemaker		
Respite		
Supported education		
Transportation		
assisted living services		
recreational services		
trained behavioral health interpreters		
interactive communication-technology devices		
Intensive support services		
<i>Substance Abuse Intensive Outpatient (IOP)</i>	\$255,556 (Intensive Outpatient)	\$41,141 (Intensive Outpatient)
<i>Partial hospital</i>		
<i>assertive community tx</i>		
<i>intensive home based services</i>		
<i>multi-systemic therapy</i>		\$50,131 (Home Based MST)
<i>intensive case management</i>		

Italicized - Likely to be covered by insurance after January 1, 2014.

Red - Potential targeted use of additional Federal dollars

SFY13 Contracted Amounts

FEDERAL FUNDED SERVICES REFLECTED ONLY	SAPTBG Funds Reported ONLY -	MHBG Funds Reported ONLY -
SAMHSA List	DBH Service Equivalent	DBH Service Equivalent
out of home residential services		
crisis residential/stabilization		
adult substance abuse residential	\$1,906,797 (Dual res, halfway house; Inter res; STR; Therapeutic Comm)	
Adult mental health residential		\$215,000 (Dual Res; psych res rehab)
youth substance abuse residential		
children's residential mental health services		
therapeutic foster care		
Acute Intensive Services		
Mobile crisis		
peer based crisis services		
urgent care		EPC
23 hr observation care	\$392,280 (CPC/Detox)	
medically monitored intensive-outpatient		
24/7 crisis hotline services		
Other		
Peer reviews	20,000	20,000
statewide training	164,210	133,677

Italicized - Likely to be covered by insurance after January 1, 2014.

Red - Potential targeted use of additional Federal dollars