

Nebraska Division of Behavioral Health  
**State Advisory Committee on Mental Health Services (SACMHS)**  
**State Advisory Committee on Substance Abuse Services (SACSAS)**  
August 18, 2016/ 9:00 am – 4:00 pm Lincoln, NE – Country Inn & Suites  
Meeting Minutes

**I. Call to Order/Welcome/Roll Call**

*Renee Faber*

*Renee Faber, Division of Behavioral Health (DBH) Advisory Committee Facilitator*, welcomed committee members and others present to the meeting. The Open Meetings Law was posted in the meeting room and all presentation handouts were available for public review.

Roll call was conducted and a quorum was determined to exist for both the State Advisory Committee on Mental Health Services and the State Advisory Committee on Substance Abuse Services.

State Advisory Committee on Mental Health Services Members in Attendance: Adria Bace, Karla Bennetts; Brenda Carlisle, Suzanne Day, Bob Doty; Bev Ferguson, Brad Hoefs; Linda Krutz; Vicki Maca, Phyllis McCaul; Lisa Neeman, Ashley Pankonin, Rachel Pinkerton; Nancy Rippen, Joel Schneider, Mark Schultz, Mary Thunker, Diana Waggoner, Stacey Werth-Sweeney. Members Absent: Kathleen Hanson, Patti Jurjevich, Ryan Kaufman, Kristin Larsen.

State Advisory Committee on Substance Abuse Services Members in Attendance: Roger Donovanick; Ann Ebsen; Ingrid Gansebom; Janet Johnson, Dusty Lord, Kimberly Mundil, Michael Phillips; Randy See; Mary Wernke. Members Absent: Jay Jackson.

DHHS Staff in Attendance: Sue Adams, Sheri Dawson, Jude Dean, Renee Faber, Sarah Fischer, Tamara Gavin; Karen Harker, Cynthia Harris, Jennifer Ihle, Deb Sherard, Todd Stull, Linda Wittmuss, Debra Sherard.

**II. Motion to Approve Minutes**

*Chairpersons Diana Waggoner and Ann Ebsen*

State Advisory Committee on Mental Health Services (SACMHS) Chairperson Waggoner welcomed members, guests and staff to the meeting and presented the minutes for review. Asking for and receiving no corrections or comments, SACMHS Chairperson Waggoner called for a motion to approve the June 23, 2016 meeting minutes as written. Moved by Doty and seconded by Thunker, the motion passed on a unanimous voice vote. In turn, Chairperson Ann Ebsen called for corrections or comments and receiving none, asked for a motion. Phillips moved to approve the June 23, 2016 meeting minutes as presented; Gansebom seconded and the minutes were approved unanimously.

**III. Public Comment**

There was no comment offered at the morning Public Comment opportunity.

**IV. Access Measures**

*Tamara Gavin*

*Tamara Gavin, Deputy Director of Community Based Services*, presented a handout detailing updates and addressing concerns expressed at the June meeting, plus additional information pertaining to several sets of access measures. Gavin verified the target measures identified for admission timelines into Supported Housing, Supported Employment, Short Term Residential and Medication Management and the 95% target measure for consumer satisfaction related to timely access to services remain the recommendation of the Division of Behavioral Health and Regional Administrators. Additionally, Gavin said the language had been clarified related to measuring appointment availability. After careful review, it was ascertained that the best way to capture data is by the date the receiving provider agrees they are appropriate for services. Gavin pointed out that these access measures will help monitor wait lists and target problem areas. Discussion followed regarding Short Term Residential access measures and clarification was given that the  $\leq 14$ -day target applies to priority populations while there remains a  $\leq 30$ -day target admission for all other populations.

Confirming that if these access measurements are adopted, they would be used across the board, Gavin reminded everyone that this is just a beginning step to understanding how well our system is doing. Gavin added that she is hoping to work with Medicaid to compare access measures. Additionally, when it is identified that a provider is not meeting these access standards, then technical assistance will be offered to improve the standards of that provider. Gavin explained that there will be data fields in the CDS where this will be reported, including the date

the service was first offered and the programmers will develop whatever new fields or processes necessary to capture this information. Gavin solicited questions and comments and with none forthcoming, she asked the Committee Chairs to request a motion to approve the access measures as presented. Chairperson Ebsen made sure all questions were answered and there was a brief discussion concerning meeting the standards but not the intent. Tamara clarified that she will regularly update the committees on progress results; her initial report out will be at the January 2017 meeting.

After having heard all discussion, Ebsen asked for a motion to accept and approve the access measures as presented. Phillips made the motion and See seconded; a voice vote was called and the following members voted in the affirmative: Bace, Bennetts, Day, Doty, Ferguson, Hoefs, Krutz, Maca, McCaul, Neeman, Pankonin, Pinkerton. Carlisle abstained; Hanson, Jones, Jurjevich, and Kaufman were absent from the meeting.

The following members of the Substance Abuse Advisory Committee voted in favor of approving the access measures as presented: Donovick, Ebsen, Gansebom, Johnson, Mundil, Phillips, See, Wernke. Lord abstained and Jackson was not present.

#### **IV. Director's Update**

*Sheri Dawson*

- *Director Sheri Dawson* took the floor and welcomed Kim Nelson from SAMHSA, whom she introduced as a great resource for DBH. After the block grant conference last week, Dawson noted that while Nebraska still faces some challenges in regard to access and funding, Nebraska is doing great at building a foundation for behavioral health integration.
- Director Dawson has been working with the Behavioral Health Task Force under LR413 and providing information on our bridger plan, emergency system review and mapping and the Technical Assistance Collaborative housing report. The results of the needs assessment study will be presented at the end of September.
- Director Dawson reported that all states are struggling with workplace shortages and in response, SAMHSA is bringing a workforce initiative workgroup together, kicking off with a September 7 webinar. It was noted that specifically, our psychiatric nurses' vacancy rate stands at 38 percent with 17 current openings. There will also be a nursing recruitment event on September 28.
- The new Children's System of Care will have its first leadership board meeting on August 23, 2016 and is seeking volunteers to serve on their advisory committee.
- Plans are being discussed to how to add and staff a 5th unit at the Norfolk Regional Center to alleviate overcrowding in Lincoln. The Norfolk Regional Center is also working towards becoming fully accredited.
- Director Dawson announced that Catholic Charities is discontinuing all government funded services provided statewide, impacting dual residential, youth residential and transition age youth residential. Workforce availability will be an issue moving forward as well as identifying providers statewide.
- Director Dawson commended Stacy Werth-Sweeny and Lincoln Regional Center staff for a beautiful graveside service held recently.

#### **V. SAMHSA**

*Kim Nelson, Regional Administrator*

*Kim Nelson, SAMHSA Regional Administrator*, introduced herself as a person in long term recovery, noting she has 25 years of sobriety. She announced this in order to help reduce discrimination and remove the stigma of mental health or substance abuse issues.

About ten years ago, SAMHSA developed 12 regional administrator positions and Nelson is the representative for the Midwest. Explaining that her role has no compliance features but rather for her to provide resources and technical support. She has made it a personal mission to spread the word that recovery is possible and one aspect to recovery is integration with the community.

Nelson added that priorities are not changing in the upcoming 2017 fiscal year, continuing to focus on recovery supports, workforce development and prevention. Nelson said that President Obama is allocating \$1 billion to combat opiate addiction and SAMHSA is dispersing \$900 million in discretionary funding. There is also an increased investment in suicide prevention, especially targeting adults and tribal youth. A Zero Suicide Initiative has been established, which in part, trains primary medical personnel about treatment options and patient safety. There is \$26 million allocated to the Zero Suicide Initiative, with \$5 million earmarked for tribes. Additionally, the set aside funding for First Episode Psychosis (FEP) has been raised from 5% to 10%, based on research showing the earlier the intervention, the better the outcomes.

Nelson added that SAMHSA recently hired Anita Everett, M.D., to serve as the Chief Medical Officer for their new Office of the Chief Medical Officer (OCMO), which will focus on effective and science-supported approaches to behavioral health.

## **VI. 2017 Block Grant Application**

*Karen Harker*

*Karen Harker, Division Financial Officer*, presented the plan of expenditures for mental health and substance abuse block grant funds for the upcoming fiscal year, which is in the middle of a 2-year funding period. Noting a slight increase of a little over \$200,000 overall, Harker pointed out that the threshold for FEP has moved from 5% to 10%. State general funds remain stable for mental health services.

There is also a slight increase in substance abuse services from both the federal and state levels. Harker explained that our Prevention program spends dollars across six (6) strategies along with our Synar program that targets sales of tobacco to underage minors. Substance abuse prevention and treatment funding address training, education, program development, planning coordination and quality assurance pieces. On the mental health side, funding is less in this area, with an allowed 5% allocation for administration.

## **VII. Strategic Planning**

*Linda Wittmuss, Mary O'Hare*

*Linda Wittmuss, Deputy Director for System Integration*, announced that we are a little past mid-year in our 2016 Bridger Plan, noting many of the activities listed were completed in July and the work on the needs assessment is in full swing. There have been over 2,200 responses to the online survey and 23 focus groups met across the state to offer input. The College of Public Health at UNMC is actively working on putting together the report, complete with recommendations. Noting that the Joint Advisory Committee was instrumental in identifying priorities and target areas grew into the chapters for the report. A final draft should be available for review at the end of August and will be shared prior to the next legislative cycle.

Wittmuss introduced Mary O'Hare, who prior to the meeting had facilitated several focus groups: Regional Administrators, DBH staff, the Advisory Committee and the People's Council, to gather what questions they hoped the needs assessment would answer. This feedback was grouped into several focus areas into which committee members were divided into groups and asked to rank by importance and priority. The results of this activity are included as an attachment to these minutes and will help drive the recommendations for development of the new strategic plan.

## **VIII. Peer Support Workforce Report**

*Cynthia Harris*

*Cynthia Harris, Deputy Director of Community Based Services*, presented the Peer Support Workforce Report, noting that while there is a national survey, there was not state specific data available. Thus, Nebraska conducted their own survey to produce these results. Some highlights of the report show that Nebraska peer support workers are well educated and well trained; with 87% of respondents participating in a 40+hour training, they are committed to improving services and an impressive number of Nebraska peer support workers have been certified as well.

Harris quoted the average hourly wage of a peer support worker in Nebraska is \$16.72, slightly higher than the national average. Number of people served is approximately 17 per week. The report also includes figures on age, military service, barriers and educational opportunities. If you would like a copy of the report, please contact Cynthia Harris.

## **XI. Committee General Comments, Observations, Announcements**

*All*

- Diana Waggoner reported several take away points from attending the National SAMHSA Block Grant conference, including how impressed she was that all attendees seemed to be experiencing the same frustrations as well as bragging rights.
- Joel Schneider announced that a new national cemetery for veterans is opening soon in Sarpy County and that NAMI is promoting a program called "Home Front" for veterans' family support, with their first meeting on September 8.
- Bob Doty gave us notice that he will be retiring from state service at the end of 2016 making November his last meeting. He added that he has been very impressed with the level of dedication and service, by the members of these committees.

- Cynthia Harris announced that September is National Recovery Month and urged everyone to find at least one way to celebrate!
- Karla Bennetts complimented the format of this meeting and added that she would like more information about juvenile sex offenders and treatment options.
- Mary Wernke said that the situation in White Clay continues to be of great concern. An update from the task force was requested as a future agenda item.

## **XII. Adjournment and Next Meeting**

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The meeting was adjourned at 3:44 p.m. The next Joint meeting of the State Advisory Committee on Mental Health Services and the State Advisory Committee on Substance Abuse Services is scheduled on Tuesday, November 18, 2016.

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

8-18-16 Meeting Minutes

## **Access Measures**

**Access:** All members will receive the service(s) they need at the right time.

### ***Supported Housing:***

- 1) Supported Housing voucher applications will be reviewed and determinations made within 3 days of receipt by the Regions. Consumers will be notified of determination within 5 days of receipt of the complete application.
- 2) Housing vouchers will be issued within 14 days of the application being approved.
- 3) Consumers will be offered a safe, stable housing option within 90 days of the voucher being issued
- 4) 95% of consumers admitted to Supported Housing will report satisfactory access to services.

### ***Supported Employment:***

- 1) Consumers referred to Supported Employment services will admit to Supported Employment services within 7 days of complete referral\* received.
- 2) 95% of consumers admitted to Supported Employment services will report satisfactory access to services.

### ***Short Term Residential:***

- 1) 95% of consumers meeting Priority Population Criteria will be offered admission to Short Term Residential services within 14 calendar days of referral\*.
- 2) 95% of all consumers will be offered admission to Short Term Residential services within 30 calendar days of referral\*.
- 3) 95% of consumers admitted to Short Term Residential will report satisfactory access to services.

### **Per provider survey feedback:**

**Provider A: 95% admitted within 7 days of referral**

**Provider B: 95% admitted within 14 days of referral**

**Provider C: 95% admitted within 14 days of referral**

**Average Wait list for Priority Populations in FY 2015= 72.8% (7 days); 98.6% (30 days)**

## **Medication Management**

- 1) 95% of consumers referred for Medication Management as an Inpatient post-discharge service will be offered an appointment date that is within 21 calendar days of discharge from the acute inpatient treatment episode.
- 2) 95% of consumers admitted to Medication Management will report satisfactory access to services.

### **Per provider survey feedback:**

Provider A: 80% admitted within 2 days of referral

Provider B: 92% admitted within 5 days of referral

Provider C: 85% admitted within 7 days of referral

Provider D: 95% admitted within 7 days of referral

Provider E: 95% admitted within 30 days of referral

Provider F: 85% admitted within 6 weeks of referral

Provider G: average wait time  $\leq$  22 days

Provider H: average wait time  $\leq$  14 days

\*Referral date is the date in which the provider has confirmed that the individual consumer meets clinical criteria for services.

Data will be collected in the Centralized Data System; providers of service will input dates to capture each data point listed above.

# FY2017 BLOCK GRANT APPLICATION

Updated Financial Information



## Estimated MH Expenditures SFY2017

Activity	FFY17 MHBG	Medicaid (Federal, State, Local)	Other Federal Funds	State Funds
24 hour care (Hospital & residential)	15,000	-	-	10,265,820
Am bulatory comm non-24 hour care	1,971,908	-	788,500	50,077,089
EBP Set Aside 10%	233,754	-	-	-
Admin (excluding programs/provider level)	116,877	-	-	-
Subtotal (Tx)	\$ 2,220,662	-	\$ 788,500	\$60,342,909
Subtotal (Admin)	\$ 116,877	-	-	-
<b>TOTAL</b>	<b>\$ 2,337,539</b>	-	<b>\$ 788,500</b>	<b>\$ 60,342,909</b>
FY2016 Award	\$2,103,021			



## Estimated SA Expenditures SFY2017

Activity	FFY17 SAPtBG	Medicaid (Federal, State, Local)	Other Federal Funds	State Funds
SA Prevention & TX	-	-	-	-
Preg Women and WDC	435,137	-	-	1,881,238
All other	5,069,253	-	-	25,044,591
Primary Prevention	1,754,789	-	1,078,929	275,692
Admin (excluding program/provider level)	382,062	-	-	-
Subtotal (Preg, Tx, Etc)	\$ 7,259,179	-	-	\$ 27,201,521
Subtotal (Admin)	382,062	-	-	-
<b>TOTAL</b>	<b>\$ 7,641,241</b>		<b>\$ 1,078,929</b>	<b>\$ 27,201,521</b>
FFY2016 Award	\$7,592,084			

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

Helping People Live Better Lives

## Projected SAPtBG Prevention Expenses by Strategy SFY2017

Information Dissemination	Universal	\$	
	Selective	\$	
	Indicated	\$	61,950
	Unspecified		
<b>Subtotal</b>		<b>\$</b>	<b>61,950</b>
Education	Universal	\$	168,401
	Selective	\$	9,455
	Indicated	\$	62,508
	Unspecified		
<b>Subtotal</b>		<b>\$</b>	<b>240,364</b>
Alternatives	Universal	\$	18,775
	Selective	\$	
	Indicated	\$	8,849
	Unspecified		
<b>Subtotal</b>		<b>\$</b>	<b>27,624</b>
Problem Identification	Universal	\$	15,847
	Selective	\$	32,361
	Indicated	\$	11,767
	Unspecified		
<b>Subtotal</b>		<b>\$</b>	<b>59,975</b>

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

Helping People Live Better Lives

## Projected SAPTBG Prevention Expenses by Strategy SFY2017

Community Based	Universal	\$	765,191
	Selective	\$	14,505
	Indicated	\$	35,348
	Unspecified		
<b>Subtotal</b>		<b>\$</b>	<b>815,044</b>
Environmental	Universal	\$	399,074
	Selective	\$	12,171
	Indicated	\$	63,499
	Unspecified		
<b>Subtotal</b>		<b>\$</b>	<b>474,744</b>
Other	Universal		
	Selective		
	Indicated		
<b>Subtotal</b>		<b>\$</b>	<b>-</b>
Section 1926 - Tobacco	Universal	\$	75,088
	Selective		
	Indicated		
<b>Subtotal</b>		<b>\$</b>	<b>75,088</b>
<b>Total</b>		<b>\$</b>	<b>1,754,789</b>



Helping People Live Better Lives

## SAPTBG Planned Resource Expenditures SFY2017

	Prevention SA	Treatment SA
Planning Coordination, and needs assessment	\$ 24,236	
Quality assurance	\$ 24,236	\$ 35,875
Training (post-employment)		\$ 100,000
Education (pre-employment)		\$ 80,000
Program Development	\$ 48,474	\$ 35,375
Research & Evaluation		
Information Systems	\$	\$
<b>Total \$</b>	<b>96,946</b>	<b>\$ 271,750</b>



Helping People Live Better Lives

## MHBG Planned Resources Expenditures SFY2017

<b>MHBG</b>	
MH Tech Assistance	
MH Planning Council Assistance	
MH Administration	\$ 116,877
MH Data Collection/Reporting	
MH Activities Other than Above	\$
<b>Total Non Direct</b>	<b>\$ 116,877</b>
Comments on Data	



### Karen Harker

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## Advisory Committee Meeting

### ✓ **Background**

- To ensure the needs assessment addresses important information needed to guide the strategic plan.
- Question Posed: "From your perspective, brainstorm and give me the top 10 questions you would hope the Needs Assessment would help answer."
- Questions were gathered from: People's Council, DBH Staff, and Regional Administrators.
- Questions were grouped according to Chapters/sub categories in the needs assessment.

### ✓ **Today's Activity:** To rank the questions in each of the categories from the most important to the least important.

### ✓ **Activity Process**

- Break into 4 groups by numbering off.
- Each group gets 3 categories of questions.
- Rank from most important question to least important question in each category. (45 minutes)
- ~~Write questions on card stock (Linda will develop).~~
- ~~Post results on sticky wall.~~
- Provide time for people to review the results.
- Ask each group to talk about their discussions.

### **Strategic Planning Process Going Forward**

- ✓ To gather a wide base of input, we will be sending out brief surveys to a larger audience to guide us in developing develop priorities, goals, and objectives.
- ✓ We will bring back to the Advisory Group in November a rough draft of priorities, goals & objectives.
- ✓ The final DRAFT will be completed by 12/31/16.
- ✓ From January to July 2017, the document will be refined and an internal work plan developed.

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- I. Introduction: Executive Summary**
- II. Methods**
  - A. Secondary Data Collection & Analysis
  - B. Primary Data Collection & Analysis
- III. Demographic Profile of Nebraska General Population**
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  - B. Nebraska Population Overview & Trends
  - C. Population Characteristics by Behavioral Health Regions
  - D. Diversity
  - E. Unemployment & Poverty
  - F. Summary
- IV. Behavioral Health Problems in Nebraska General Population**
  - A. Introduction
  - B. Estimates of Mental Disorders among Adults & Adolescents in Nebraska
  - C. Estimates of Alcohol Use among Adults & Adolescents in Nebraska
  - D. Estimates of Substance Use Disorders in Nebraska
  - E. Estimates of Behavioral Health Treatment Use in Nebraska
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- V. Hospitalizations Related to Mental Disorders & Substance Related Disorders among General Population in Nebraska**
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  - B. Hospitalization Related to Mental Disorders by Age
  - C. Hospitalization Related to Substance Disorders by Age
  - D. Time Trends of Hospitalization Related to Mental and Substance Disorders
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F. Summary

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C. Core Services, Network Management, & System Expectations

D. Evidence-Based Practice

E. Behavioral Health Consumers Served

F. Expenditures

G. Capacity Assessment

H. Assessment of Select Services

I. Information System

J. Mental Health National Outcome Measures

K. Consumer Satisfaction

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B. Population with Intellectual & Developmental Disabilities

C. Criminal Justice System Populations

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B. Longstanding & Emerging Issues in Behavioral Health Workforce

C. Types of Behavioral Health Professions

D. Nebraska Behavioral Health Workforce Analysis

E. Workforce Development Efforts

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**IX. Community Engagement**

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  - C. What is Integrated Care and Why Integrated Care Now?
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  - G. Telebehavioral Health in Different Regions of Nebraska
  - H. Other Examples of Telebehavioral Health in Nebraska
  - I. Summary

# Group 1

## **A. Estimates**

1. What is the need for MH or SU services in NE?
2. Are we meeting the need?
3. What are the primary indicators of health and well-being for our population and how are we doing?
4. What data is missing for us to be better informed for planning?
5. What is the suicide rate and are we doing enough to impact this?
6. What should be our long range vision? What do the population indicators tell us?

## **B. Expenditures**

1. Are we spending more or less on services?
2. Does our population and need for treatment services hold with how we fund / allocate \$ to Regions? Is our resource distribution equitable?
3. How much do we spend, per person, on services/treatment, by service?
4. What is our per capita expenditure?
5. What is NE per capita expenditure?
6. What is the cost for serving populations in rural areas vs urban areas? How does that impact services offered to an individual?
7. How much will it cost to improve services?

## **C. Core Services, Network Management, & System Expectations**

1. Where are services?
2. Are we fully utilizing services?
3. What are the holes in the service array?
4. How long are people in services?
5. How are we doing with health care change and taking BH forward?
6. How does the typical DBH network provider organization conduct outreach, eligibility determination, enrollment and re-enrollment to facilitate enrollment in ACA insurance plans? How successful are they/what is the impact these activities have on eligible individuals with behavioral health conditions?
7. How is DBH supporting efforts to address barriers, such as lack of health insurance, low income, cultural and language barriers, in across the state, including frontier, rural and urban areas?
8. What services does Medicaid cover in benefits? Is it enough?

# Group 2

## **D. Behavioral Health Consumers Served**

1. Who are we serving?
2. What are the impact of current social determinants on the system?
3. How many and what rate of DBH behavioral health service consumers are successful in obtaining mainstream services? How many cycle back to DBH behavioral health services?
4. What are the primary reasons consumers of MH and SA services cycle back to DBH behavioral health services? How does this compare to the universe of individuals with behavioral health needs and non-DBH behavioral health service consumers?

## **E. Assessment of Select Services**

1. Can people with BH issues access housing? What's missing?
2. Are people going back to school?
3. Are people employed?
4. Is there a transportation need?
5. How does the availability of Peer Support differ across the state? What explains any difference in availability? Can we identify any impacts due to the availability of Peer Support?
6. Is there a need for a PRTF treatment facility that is only for girls with mental health/substance use disorders?
7. What is the need for 'step down' treatment group homes for transitioning youth in the state?
8. How many youth are really being treated in facilities out of state and what are their diagnoses?
9. Prevalence of adverse childhood experiences and initiatives and services to address this
10. What do providers feel is the biggest hurdle(s) to providing services to youth in Nebraska?
11. How are we promoting resilience in youth?
12. Are prevention activities working?
13. What type of prevention activities are available?
14. How do we improve access to medication management and medication?

## **F. Public & Population-Based Approach to Increase Access and Use of Behavioral Health Services**

1. How well are we doing on integrating BH and primary care? How might that look different in the future?
2. How does the typical DBH network provider organization facilitate integrated care: coordinate care, co-locate care, or build primary care capacity in-house? (I'm thinking about how to address ACA questions that the Dept. of Insurance probably can't answer)
3. What Mental Health Promotion and Mental Illness Prevention projects are occurring across Nebraska?
4. What is needed to better meet the behavioral health needs of Nebraskans?

# Group 3

## **G. Behavioral Health Workforce**

1. Where are the most critical shortage areas of behavioral health professionals?
2. What are the provider gaps in the state for mental health and substance use disorder treatment-mostly for youth, but also for adults?
3. What barriers to mental health/substance abuse care are faced by people in designated mental health/substance abuse professional shortage areas?
4. What is needed to keep good providers in the state, especially out state Nebraska in the eyes of actual providers?
5. How many providers are able to prescribe medication assisted treatment for Opioid Use Disorder and how many are actually treating patients with these disorders?
6. Do providers feel that the compensation they receive to care for youth is enough to keep their doors open?
7. How can higher learning institutions help with work force needs-midlevel staff, therapists, etc.?
8. What is needed to recruit and retain an effective behavioral health work force?
9. Are people trained in peer services employed? If not, what is missing?

## **H. Consumer Satisfaction**

1. Are people getting better?
2. What are we doing well? What are we not doing well?
3. Are people accessing care when they need it? How do they feel about the care they are receiving?
4. How are people doing during and after services?
5. Why is it so hard to seek and access services?

## **I. Special Subpopulations: Issues and Needs**

1. What is the impact of DD, homeless, veteran, etc. on the public BH system?
2. How many people with MH/SUD are being served by our partners?
3. How do individuals served through homeless assistance programs compare to the general population in regards to attainment of services?
4. What is the identified need for housing and housing-related services for the behavioral health service population? For the DBH target population by region?
5. How are services being used in the penitentiary? Probation?

# Group 4

## **J. Capacity Assessment**

1. What is our capacity to serve and are we using it? If not, why not, and should we develop other capacity?
2. What are the holes in the service array? Is it geographic or across the state?
3. Do we have underserved areas?
4. Who should we be serving if need is greater than our capacity to serve?
5. Are we serving our target populations?
6. With the acuity level of clients in our communities, how do we create more and appropriate services?
7. With limited funding what are the top priorities?
8. Are people accessing care?
9. Is there a waitlist for services? If so, where and what service(s)?

## **K. Information System**

1. What measures and indicators will best describe the quality and effectiveness of the BH system?
2. What data is missing for us to be better informed for planning and evaluation?
3. How do outcomes for consumers in non-DBH systems compare with outcomes for DBH consumers?
4. Can you access Medicaid data as well to get a bigger picture?
5. What services does Medicaid cover in benefits? Is it enough?

## **L. Behavioral Health Disparities**

1. Where do we have key disparities?
2. Do we have underserved areas?
3. How many and what rate of DBH behavioral health service consumers are assisted in enrolling in ACA insurance plans? How many actually complete enrollment? How does this compare to the universe of individuals with behavioral health needs and non-DBH behavioral health service consumers?
4. What is the impact of diversity in populations on the system?
5. What are the primary indicators we should use going forward from a population management perspective?

**Summary of Needs Assessment Questions by Chapter-8/18/16**

<p><b>Chapter 3:</b> Demographic Profile of NE</p>	<p><b>A. Nebraska Population Overview &amp; Trends</b></p> <ol style="list-style-type: none"> <li>1. How many uninsured people do we have in NE?</li> <li>2. How many behavioral health service consumers are eligible for ACA insurance? How many are enrolled in ACA insurance plans? Are consumers who are enrolled in ACA insurance plans more likely to attain behavioral health services than consumers who are not enrolled in ACA insurance plans?</li> </ol>
<p><b>Chapter 4:</b> Behavioral Health Problems in Nebraska General Population</p>	<p><b>B. Estimates</b></p> <ol style="list-style-type: none"> <li>1. What are the primary indicators of health and well-being for our population and how are we doing?</li> <li>2. What data is missing for us to be better informed for planning?</li> <li>3. What is the need for MH or SU services in NE?</li> <li>4. What is the suicide rate and are we doing enough to impact this?</li> <li>5. Are we meeting the need?</li> <li>6. What should be our long range vision? What do the population indicators tell us?</li> <li>7. Rural vs Urban?</li> </ol> <p><b>C. Comparisons</b></p> <ol style="list-style-type: none"> <li>1. What is our per capita expenditure?</li> <li>2. How do we compare nationally?</li> <li>3. What does the data suggest we focus on?</li> </ol> <p><b>D. Behavioral Health Disparities</b></p> <ol style="list-style-type: none"> <li>1. Where do we have key disparities?</li> <li>2. Do we have underserved areas?</li> <li>3. What is the impact of diversity in populations on the system? (Barriers to service)</li> <li>4. What are the primary indicators we should use going forward from a population management perspective?</li> <li>5. How many and what rate of DBH behavioral health service consumers are assisted in enrolling in ACA insurance plans? How many actually complete enrollment? How does this compare to the universe of individuals with behavioral health needs and non-DBH behavioral health service consumers?</li> </ol>
<p><b>Chapter 5:</b> Hospitalization Related to Mental Disorders and Substance Related Disorders among General Population in Nebraska</p>	<p><b>E. Hospitalization Related to Mental Disorder/Substance Disorder by Age</b></p> <ol style="list-style-type: none"> <li>1. Who is accessing our services, especially emergency services?</li> </ol>

## Summary of Needs Assessment Questions by Chapter-8/18/16

Chapter 6:  
Nebraska Public  
Behavioral  
Health System

### **F. Core Services, Network Management, & System Expectations**

1. How is DBH supporting efforts to address barriers, such as lack of health insurance, low income, cultural and language barriers, across the state, including frontier, rural and urban areas?
2. What services does Medicaid cover in benefits? Is it enough?
3. What are the holes in the service array?
4. How does the typical DBH network provider organization conduct outreach, eligibility determination, enrollment and re-enrollment to facilitate enrollment in ACA insurance plans? How successful are they/what is the impact these activities have on eligible individuals with behavioral health conditions?
5. How are we doing with health care change and taking BH forward?
6. How long are people in services?
7. Are we fully utilizing services?
8. Where are services?

### **G. Evidence-Based Practice**

1. Are we implementing best practices? If so, what is the impact?
2. List of EBPs provided in the system.

### **H. Behavioral Health Consumers Served**

1. Who are we serving? Is it solely a MH/SA diagnosis/presenting problem? How do they find us-where do we see them first?
2. What are the primary reasons consumers of MH and SA services cycle back to DBH behavioral health services? What keeps them successful in avoiding cycling back?
3. What are the impact of current social determinants on the system?
4. How many and what rate of DBH behavioral health service consumers are successful in obtaining mainstream services? What is the follow up? Are there gaps?

### **I. Expenditures**

1. How much do we spend, per person, on services/treatment, by service, by diagnosis?
2. What is NE per capita expenditure by diagnosis?
3. Does our population and need for treatment services hold with how we fund/allocate \$ to Regions? Is our resource distribution equitable? By diagnosis?
4. What is the cost for serving populations in rural areas vs urban areas? How does that impact services offered to an individual? By diagnosis?
5. Are we spending more or less on services? By diagnosis? More or less than by year, by state?
6. How much will it cost to improve services?

### **J. Capacity Assessment**

#### Who

1. Who should we be serving if need is greater than our capacity to serve?
2. Are we serving our target populations?
3. With limited funding what are the top priorities?

## Summary of Needs Assessment Questions by Chapter-8/18/16

4. Are people accessing care? Are there waiting lists?

### What

1. With the acuity level of clients in our communities, how do we create more and appropriate services?

### Capacity

1. What is our capacity to serve and are we using it? If not, why not, and should we develop other capacity?
2. What are the holes in the service array? Is it geographic or across the state?
3. Do we have underserved areas?
4. Is there a waitlist for services? If so, where and what service(s)?

## **K. Assessment of Select Services**

### Youth/Transition Age

1. Are prevention activities working? What type of prevention activities are available?
2. How are we promoting resilience in youth?
3. What do providers feel is the biggest hurdle(s) to providing services to youth in Nebraska?
4. Prevalence of adverse childhood experiences and initiatives and services to address this.
5. How many youth are really being treated in facilities out of state and what are their diagnoses?
6. What is the need for 'step down' treatment group homes for transitioning youth in the state?
7. Is there a need for a PRTF treatment facility that is only for girls with mental health/substance use disorders?
8. What are the number of transition age youth?

### Adults

1. Can people with BH issues access housing? What's missing?
2. Are people going back to school?
3. Are people employed?
4. Is there a transportation need?
5. How do we improve access to medication management and medication?
6. How does the availability of Peer Support differ across the state? What explains any difference in availability? Can we identify any impacts due to the availability of Peer Support?

## **L. Information System**

1. What measures and indicators will best describe the quality and effectiveness of the BH system?
2. What data is missing for us to be better informed for planning and evaluation?
3. Can you access Medicaid data as well to get a bigger picture?
4. How do outcomes for consumers in non-DBH systems compare with outcomes for DBH consumers?

**Summary of Needs Assessment Questions by Chapter-8/18/16**

	<p><b>M. Mental Health National Outcome Measures</b></p> <p><b>N. Consumer Satisfaction</b></p> <ol style="list-style-type: none"> <li>1. Are people accessing care when they need it? How do they feel about the care they are receiving?</li> <li>2. Why is it so hard to seek and access services?</li> <li>3. How do they feel about the care they are receiving?</li> <li>4. Are people getting better?</li> <li>5. How are people doing during, after services?</li> <li>6. What are we doing well? What are we not doing well?</li> </ol> <p><b>O. Summary</b></p> <ol style="list-style-type: none"> <li>1. What are the strengths and challenges of the current BH system?</li> <li>2. What are the top 3 to 5 priorities for change and will the change required be fiscal, administrative or practice related?</li> <li>3. What is needed to better meet the behavioral health needs of Nebraskans?</li> </ol>
<p><b>Chapter 7:</b> Special Subpopulations: Issues and Needs</p>	<p><b>P. Special Subpopulations: Issues and Needs</b></p> <ol style="list-style-type: none"> <li>1. What is the identified need for housing and housing-related services for the behavioral health service population? For the DBH target population by region?</li> <li>2. How do individuals served through homeless assistance programs compare to the general population in regards to attainment of services?</li> <li>3. How many people with MH/SUD are being served by our partners?</li> <li>4. How are services being used in the penitentiary? Probation?</li> </ol>
<p><b>Chapter 8:</b> Behavioral Health Workforce</p>	<p><b>Q. Behavioral Health Workforce</b></p> <ol style="list-style-type: none"> <li>1. Where are the most critical shortage areas of behavioral health professionals?</li> <li>2. What are the provider gaps in the state for mental health and substance use disorder treatment-mostly for youth, but also for adults?</li> <li>3. What barriers to mental health/substance abuse care are faced by people in designated mental health/substance abuse professional shortage areas?</li> <li>4. What is needed to keep good providers in the state, especially out state Nebraska in the eyes of actual providers?</li> <li>5. What is needed to recruit and retain an effective behavioral health work force?</li> <li>6. Are people trained in peer services employed? If not, what is missing?</li> <li>7. How many providers are able to prescribe medication assisted treatment for Opioid Use Disorder and how many are actually treating patients with these disorders?</li> <li>8. Do providers feel that the compensation they receive to care for youth is enough to keep their doors open?</li> <li>9. How can higher learning institutions help with work force needs-midlevel staff, therapists, etc.?</li> </ol>

## Summary of Needs Assessment Questions by Chapter-8/18/16

<b>Chapter 9:</b> Community Engagement	<b>R. Community Engagement</b> <ol style="list-style-type: none"><li>1. What partnerships exist across the state (i.e. BH in the schools, BH and Probation, BH and CFS, BH and Corrections) and how do we support these and promote additional ones? What other partnerships need to be formed?</li></ol>
<b>Chapter 10:</b> Public and Population- Based Approach to Increase Access and Use of Behavioral Health Services	<b>S. Public &amp; Population-Based Approach to Increase Access and Use of Behavioral Health Services</b> <ol style="list-style-type: none"><li>1. How well are we doing on integrating BH and primary care? How might that look different in the future?</li><li>2. What Mental Health Promotion and Mental Illness Prevention projects are occurring across Nebraska?</li><li>3. How does the typical DBH network provider organization facilitate integrated care: coordinate care, co-locate care, or build primary care capacity in-house? (I'm thinking about how to address ACA questions that the Dept. of Insurance probably can't answer.)</li><li>4. What is needed to better meet behavioral health needs?</li></ol>

1

The Nebraska Department of Health and Human Services Division of  
Behavioral Health  
Office of Consumer Affairs

## 2016 Nebraska Peer Support Workforce Report

State Advisory Committee on Mental Health Services (§ 71-814)  
State Advisory Committee on Substance Abuse Services (§ 71-815)  
August 18, 2016

**PRESENTED BY: CYNTHIA HARRIS & MAZEN SARWAR**



2

## Project History and Timeline

- ▶ In 2007, the International National Association of Peer Specialists (iNAPS) conducted a nationwide survey to gather data from peer specialists throughout the U.S.
- ▶ The goal was to determine the variety of tasks, how satisfied peer specialists were with their work, compensation levels, outlook for the future, and what motivated them in their work.
- ▶ In 2014, a follow-up survey was conducted with questions about location, education, training, and supervision added to the original 2007 survey ([https://na4ps.files.wordpress.com/2014/07/2007-2014\\_comparisonreport1.pdf](https://na4ps.files.wordpress.com/2014/07/2007-2014_comparisonreport1.pdf)).

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## Project History and Timeline

- ▶ In 2014 DBH Office of Consumer Affairs (OCA) conducted a peer support survey to learn more about what Peer Support Services may exist in Nebraska, what opportunities and barriers may exist to providing them and perspectives about the ongoing development and growth of peer support. A report of this data can be found in Attachment B of the report.
- ▶ During December 2015, OCA reached out to Peer Support Specialists across Nebraska to gather comparable state-specific workforce data as it relates to various topics, including: training, hours worked per week, number of people you support, job satisfaction, service provision, organization type, demographics

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## Project History and Timeline

OCA was interested in utilizing data collected from the Nebraska workforce survey to make comparisons to various national trends as identified through the surveys completed by iNAPS in 2007 and 2014. The Peer Support Workforce Survey collects data about the current workforce environment for

- ▶ Employed/volunteer peer support providers,
- ▶ Those who have worked in the past as a peer support provider,
- ▶ And those who are currently seeking a position as a peer support provider.

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## METHODOLOGY AND SAMPLE

- ▶ The sample for this survey is a convenience sample identified through postings on the OCA's CPSWS listserv and the Nebraska Peer Support Facebook Group.
- ▶ In addition, information about the survey was sent to Speak out, Families Care, Parent to Parent, Families Inspiring Families, Healthy Families Project, Nebraska Family Support Network, the Regional Behavioral Health Authorities, Mental Health Association of NE, NAMI-NE, Partners in Recovery, Women's Center for Advancement, Peer Run organizations in Nebraska, the Veterans Administration, Nebraska Children and Families Foundation, OCA People's Council, and the Mental Health and Substance Abuse Advisory Committees.

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## METHODOLOGY AND SAMPLE

- ▶ An estimate on the sample size of people receiving the link is about 600 individuals. Since the survey was sent through an open link it was not possible to determine an exact number of people who would have known about the survey. An original request for participation was delivered on December 8, 2015 via these sources, containing a link to the survey. Follow-up reminders to encourage participation were also sent. Data collection ended in January 11, 2016.
- ▶ There were a total of 106 completed or partially completed surveys. Data was analyzed using SPSS statistical software.
- ▶ It is important to remember that since this survey uses a convenience sample, the results are not necessarily generalizable to the peer support workforce in Nebraska. The results should be looked at as a general overview of survey participants.

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## METHODOLOGY AND SAMPLE

For purposes of this survey, peer support providers are inclusive of those who serve children, family, youth, adults, and/or veterans in the State of Nebraska while utilizing their personal lived experience with a behavioral health condition, as a parent of a child with behavioral health challenges, and/or trauma to support others. This survey assesses the following three groups.

- ▶ Employed/volunteer peer support providers
- ▶ Those who have worked in the past as a peer support provider
- ▶ Those who are currently seeking a position as a peer support provider

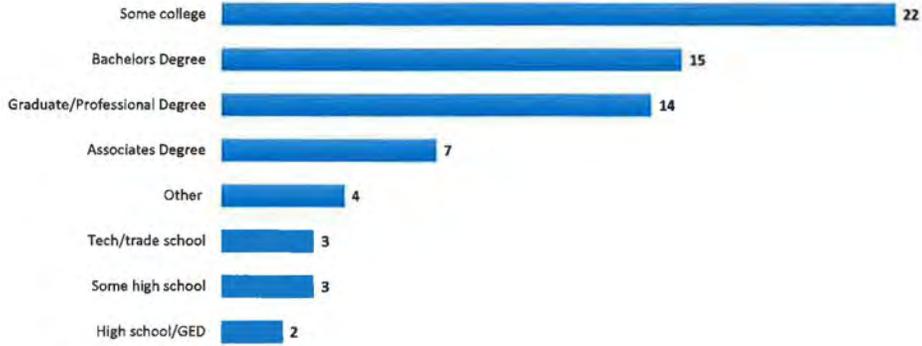
8

## DEMOGRAPHICS OF WORKFORCE

Region	Currently Employed/Volunteering (n=71)		All Respondents (n=91)	
	%	n	%	n
1	1%	1	2%	2
2	3%	2	2%	2
3	13%	9	12%	11
4	9%	6	9%	8
5	46%	33	46%	42
6	28%	20	29%	26

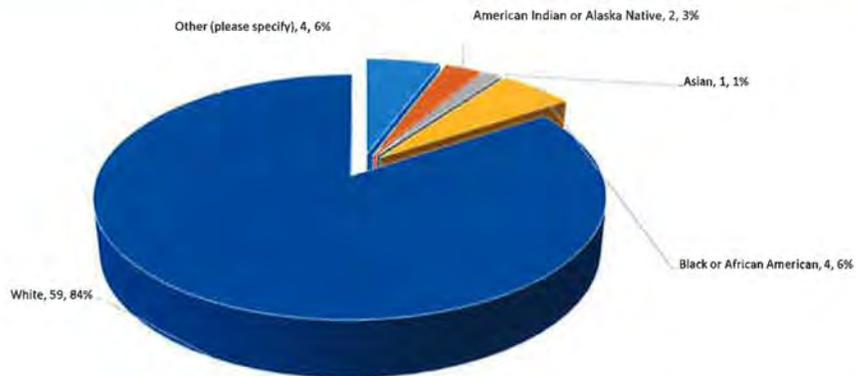
## Highest Level of Education (n =70)

9



## Race/Ethnicity/Hispanic Origin (n =70)

10



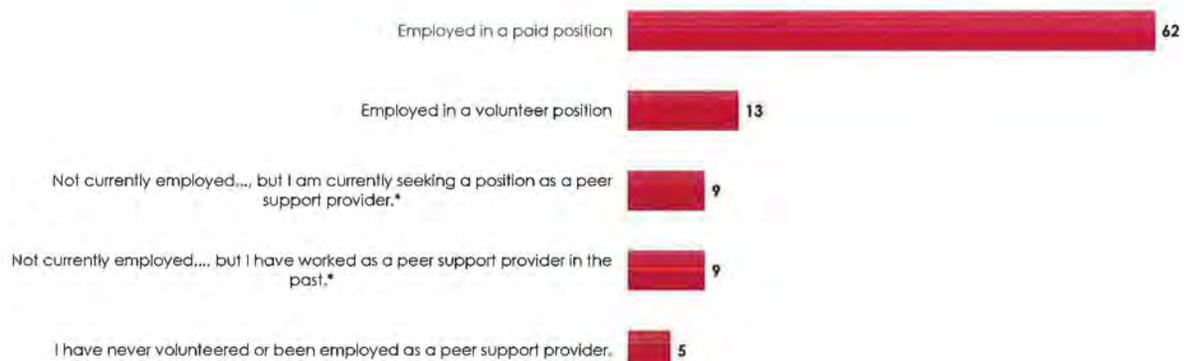
11

## PAID OR VOLUNTEER

- ▶ A little over three-fifths of survey respondents were currently employed in paid positions as peer support providers (63%, n=62) while 13% of respondents indicated that they are currently employed in volunteer positions (n = 13).
- ▶ About 9% of respondents indicated that they are not currently employed as a peer support provider, but have worked as one in the past (n=9).
- ▶ An additional 9% indicated that they are currently not employed as a peer support provider, but are currently seeking a position (n=9). 5% of respondents had never been employed as a peer support provider and were not looking for a position (n=5).

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## PAID OR VOLUNTEER



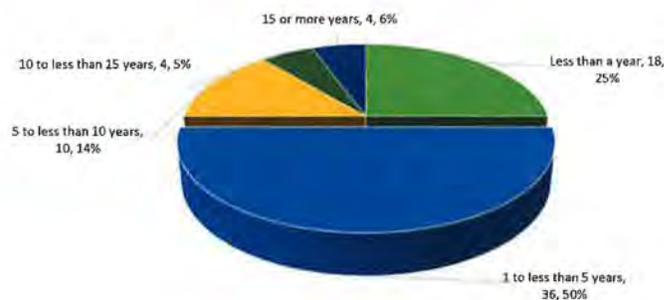
## Length of Time Working at Current Organization (n=72)

13

- ▶ Respondents were asked how long they have been working in their current organization. When removing cases where individuals reported working less than 1 year, the average length reported was 5.2 years. Answers ranged from one to thirty-six years. About a quarter of respondents indicated that they have worked for their current organization for less than year (24%, n=18).

## LENGTH OF TIME

14



15

## TRAINING



The vast majority of survey respondents have completed 40 hours of specialized peer support training (87%, n=65). 12% of respondents have not completed the training, but plan to do so in the future (n=9). Only one respondent indicated that they do not wish to pursue specialized training at this time. (Note: Excludes respondents not currently employed as peer support specialists.)

16

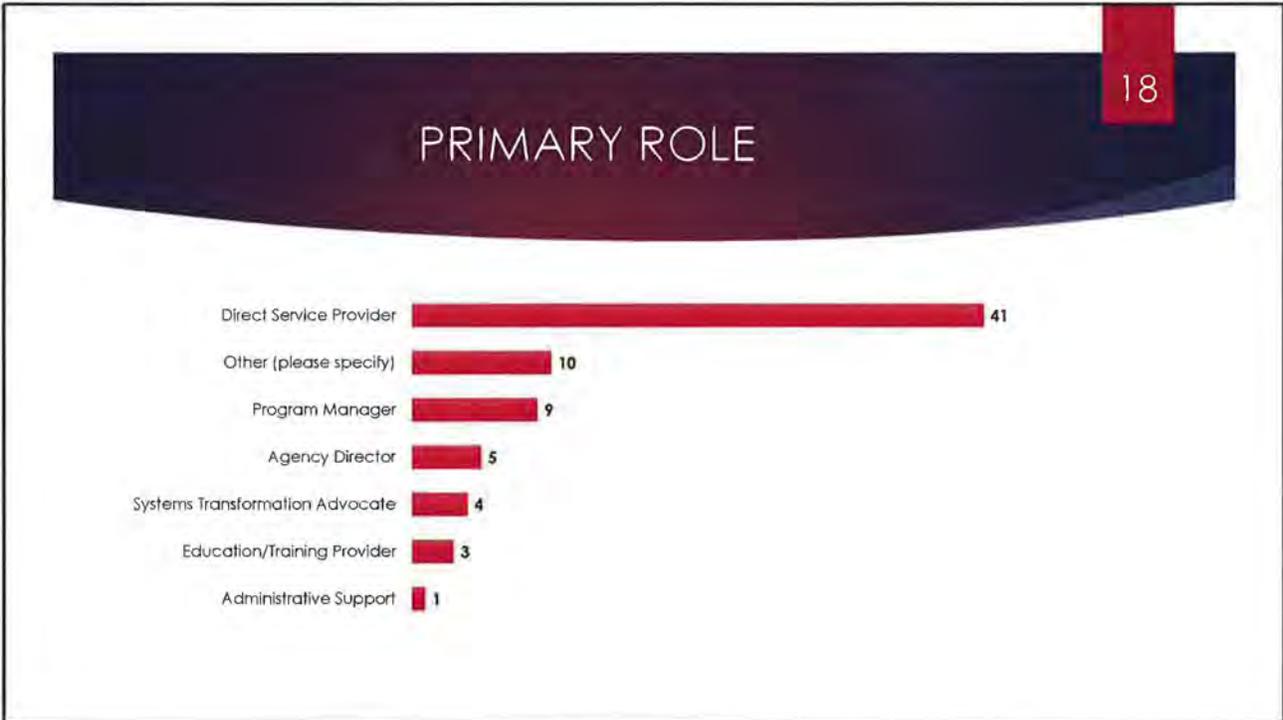
## CERTIFICATION

- ▶ When asked about certification, the most commonly earned certification noted by survey respondents was the Certified Peer Support and Wellness Specialist (CPSWS) certification, offered through the Nebraska Division of Behavioral Health Office of Consumer Affairs (71%, n=53).
- ▶ One respondent completed the Certification for Parent Support Providers (CPSP®) offered through the National Federation for Parent Support Providers.
- ▶ Other certifications earned by respondents include the Depression and Bipolar Support Alliance Peer Specialist Training (DBSA), Whole Health and Wellness, Middle Management Training, Voice Healers, Emotional CPR (eCPR), Wellness Recovery Action Plan (WRAP), and Individual Placement and Support (IPS).

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## PRIMARY ROLE

- ▶ When asked about their primary role within their current paid or volunteer position, the majority of survey respondents selected Direct Service Provider (56%, n=41). About 12% of respondents selected Program Manager (n=9), 7% selected Agency Director (n=5), 6% selected Systems Transformation Advocate (n=4), 4% selected Education/Training Provider (n=3), 1% selected Administrative Support (n=1) and 14% selected Other (n=10). Under the "Other" category, responses included youth support, support group facilitator, lead recreational activities, peer to peer support, and family advocate.



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## SERVICES PROVIDED



20

## WAGES AND PERSONS SUPPORTED EACH WEEK

### **Hourly Wage (n=52)**

- ▶ Hourly wage for survey respondents was quite variable. The average hourly wage reported was \$16.72 an hour and the median reported wage was \$16.00. 42% of survey respondents earned between \$10-14.99 hourly (n=22), 31% earned between \$15-19.99 hourly (n=16), and 27% earned \$20.00 or more hourly (n=14).

### **Number of People Supported Each Week (n=75)**

- ▶ When asked about the number of people supported each week, responses were quite variable. A number of respondents provided a range, indicating that for many respondents, the number of people supported each week can change depending on the week. Responses ranged from one to sixty individuals, with a mean of 17 individuals provided services a week.

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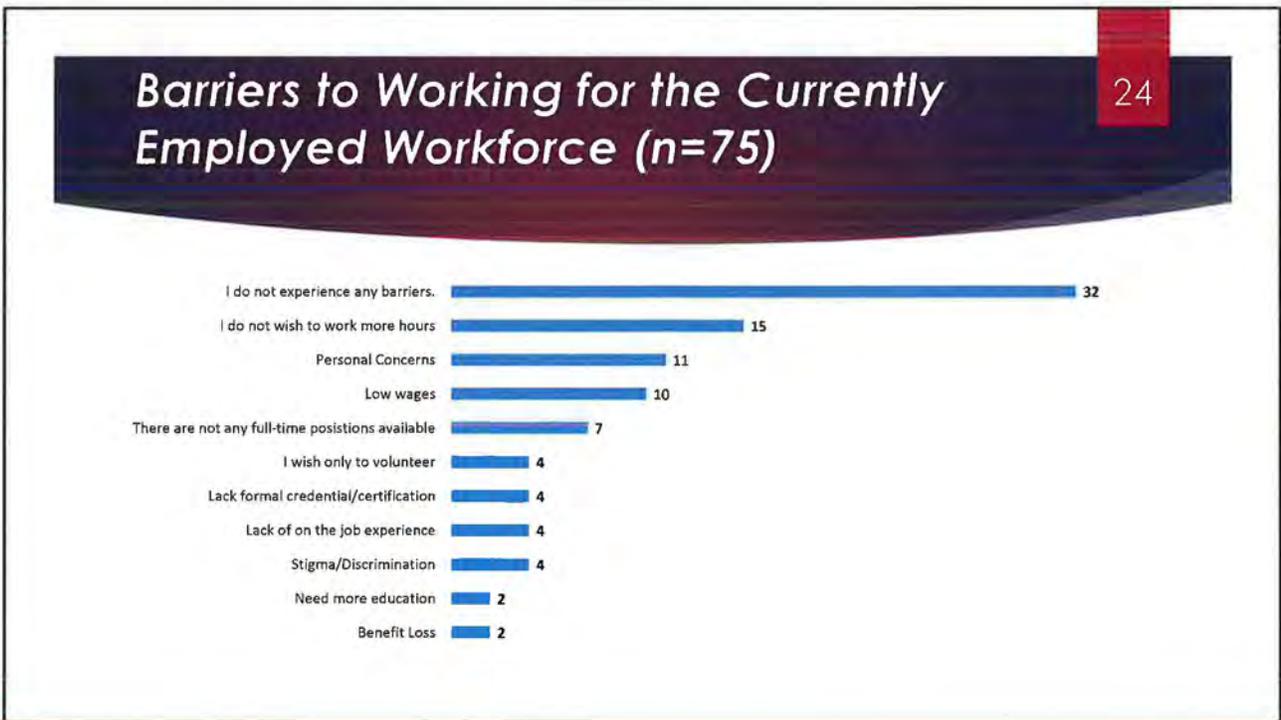
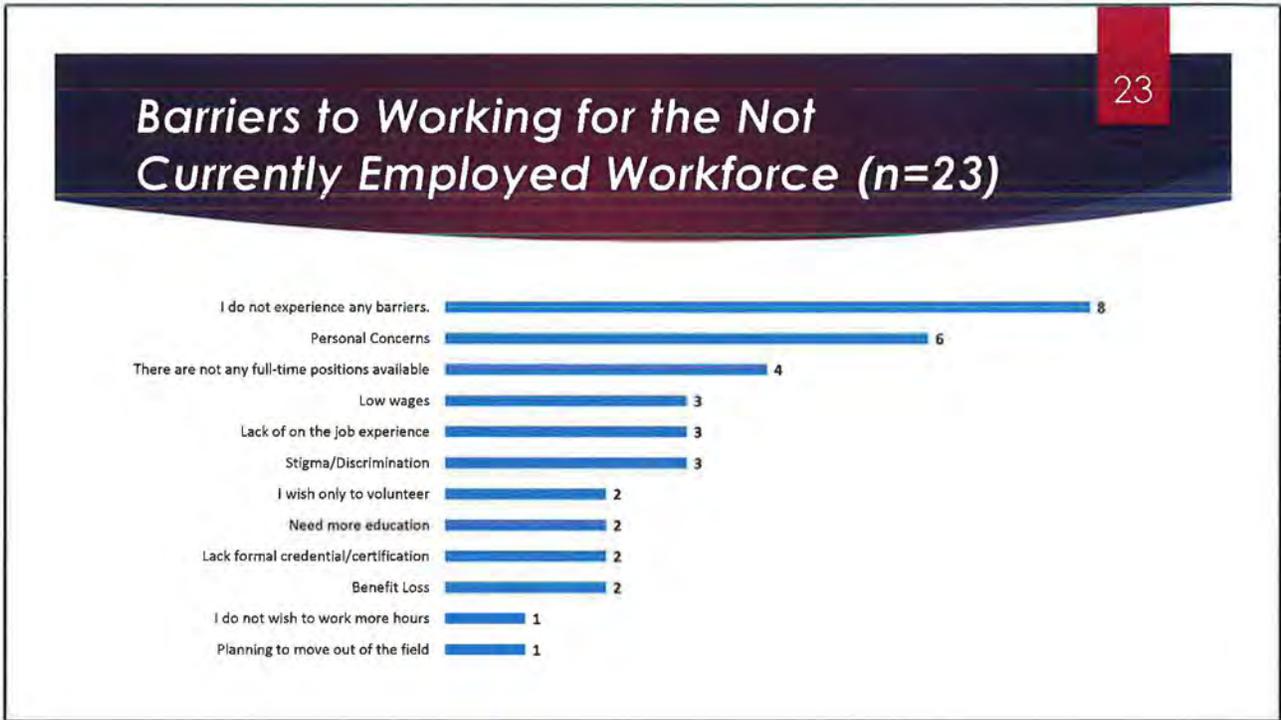
## CURRENT TITLE

Volunteer Manager **Recovery** Consumer Specialist  
**Program** Youth **Peer Support** Community  
 Executive Director Advocate

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## CURRENT TITLE n=65

- ▶ Addiction Support Peer Specialist
- ▶ Behavioral Health Outreach Advocate
- ▶ Certified peer support and wellness specialist
- ▶ CHFS
- ▶ Community Readiness Consultant
- ▶ Community Support Provider
- ▶ Consumer Affairs Manager
- ▶ Consumer Specialist
- ▶ Direct Care Staff
- ▶ Director of Consumer Recovery
- ▶ Employment Specialist
- ▶ Executive Director
- ▶ Family Advocate
- ▶ Family Navigator
- ▶ Family Peer Support Specialist
- ▶ Family Peer Support/Advocate
- ▶ Independence Coordinator
- ▶ Peer Companion
- ▶ Peer Partner
- ▶ Peer Recovery Facilitator
- ▶ Peer Support and Wellness Specialist
- ▶ Peer Support Specialist
- ▶ Peer support volunteer
- ▶ Peer Supporter
- ▶ Peer to Peer Mentor/Family Advocate
- ▶ Program Administrator
- ▶ Program Coordinator
- ▶ Program Specialist-Recovery Specialist
- ▶ REAL Program Coordinator
- ▶ Recovery specialist
- ▶ Recovery Support Specialist
- ▶ Recovery support team leader
- ▶ Statewide Program Manager
- ▶ Supervisor of Peer Support
- ▶ Support group co-facilitator
- ▶ Volunteer
- ▶ Volunteer - Freelance provider to military members, spouses, and teenage children as needed
- ▶ Youth Advisor
- ▶ Youth and Family coordinator
- ▶ Youth Peer Support Specialist



LOOKING FORWARD

25

**Educational Opportunities (n=106)**



COMPARISONS

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Survey	Average hourly wage	Average weekly hours	Average years on the job	Average # peers per week
<b>iNAPS, 2014</b>	\$13.53 (n=288)	32.2 (n=570)	3.8 (n=515)	19.75 (n=523)
<b>DHHS, 2016</b>	\$16.72 (n=52)	34.2 (n=72)	5.2 (n=72)	17 (n=75)

Peer Support Providers reported feeling respected by their supervisor and colleagues at work (as an equal member of the team and not a patient or client.)

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Survey	Strongly agree	Somewhat agree (iNAPS – agree)*	Neither Agree nor Disagree	Somewhat disagree (iNAPS-disagree)*	Strongly disagree
iNAPS, 2014, n=512	44.3% (n=226)	35% (n=180)	10.1 (n=52)	7.4% (n=38)	2.8% (n=14)
DHHS, 2016, n=70	64.0% (n=45)	14.0% (n=10)	11.0% (n=8)	7.0% (n=5)	3.0% (n=2)

## AGE

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Survey	18-24	25-34	35-44	45-64	65+
iNAPS, 2014, n=581	2.2% (n=13)	12.2% (n=71)	19.2% (n=112)	60.8% (n=353)	5.5% (n=32)
DHHS, 2016, n=68	4.4% (n=3)	13.2% (n=9)	27.9% (n=19)	51.5% (n=35)	2.9% (n=2)

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## MILITARY SERVICE

Survey	Yes	No
iNAPS 2014, n=587	17.2% (n=101)	82.8% (n=486)
DHHS, 2016, n=70	21.4% (n=15)	78.6% (n=55)

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## QUESTIONS

- ▶ What are some of the strengths of the peer support workforce ?
- ▶ What other educational opportunities may be beneficial for the peer support workforce?
- ▶ Are there areas that should be targeted based on the existing data?

## Comments?



For more information please contact  
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402-471-7766

Report can be found here  
[http://dhhs.ne.gov/behavioral\\_health/Documents/2016%20NE%20Peer%20Support%20Workforce%20Report%20DBH%20OCA.pdf](http://dhhs.ne.gov/behavioral_health/Documents/2016%20NE%20Peer%20Support%20Workforce%20Report%20DBH%20OCA.pdf)

# State Advisory Committee on Mental Health Services

## Election of Officers for 2017

The following excerpt from the Committee By-Laws may assist in the election process:

### **Article V – Officers**

#### **Section 1**

**Selection:** Officers of the Committee shall be a Chairperson, Vice-Chairperson and Secretary.

#### **Section 2**

**Duties:** The duties of the Officers shall be:

**Chairperson** – Preside at all Committee and Executive meetings and:

- (1) Attend annual technical assistance meeting on MH Block Grant
- (2) Represent Nebraska at the MH Block Grant application review
- (3) Write a letter representing the committee's point of view after reviewing the MH block grant application, to be attached and is due September 1.
- (4) Write a letter after reviewing Mental Health block grant implementation report due Dec. 1
- (5) Perform any other duties designated by the Committee.
- (6) Review attendance report and contact members as needed.

**Vice-Chairperson** – Shall act for the Chairperson in his/her absence. Shall perform other duties as designated by the Chairpersons or Committee.

**Secretary** – Shall act for the Chairperson and Vice-Chairperson in their absence. Shall perform other duties as designated by the Chairpersons or Committee and is designated to review meeting minutes prior to distribution to committee members.

#### **Section 3**

At the fall meeting the committee will select officers for one year. The new officers' term are January 1 through December 31. In the event of a vacancy, the Committee will elect a member to serve the unexpired term of office.

#### **Section 4**

**Executive Committee:** The Executive Committee shall consist of the Chairperson, Vice-Chairperson and Secretary. A Chairperson may call the Executive Committee together with the approval of the Division, at his/her discretion. If a meeting of the Executive Committee is held, the full Committee will be notified at the next regularly scheduled meeting. The Executive Committee may not vote or act for the full Committee.

# State Advisory Committee on Mental Health Services Elections will occur at November 2016 meeting.

*For annual leadership selection, may do voice vote or secret ballot.*  
Secret ballot total votes for a candidate must be reflected in the minutes even though how each member voted is not recorded.\*

	Nominees	Elected
<b>Chairperson</b>	1. _____	1. _____
	2. _____	
	3. _____	
<b>Vice Chairperson</b>	1. _____	1. _____
	2. _____	
	3. _____	
<b>Secretary</b>	1. _____	1. _____
	2. _____	
	3. _____	

\*Taken from DBH Advisory Committee Tips for Open Meetings and Roberts Rules;

# State Advisory Committee on Substance Abuse Services

## **Election of Officers for 2017**

The following excerpt from the Committee By-Laws may assist in the election process:

### **Article V – Officers**

#### **Section 1**

**Selection:** Officers of the Committee shall be a Chairperson, Vice-Chairperson and Second Vice Chairperson. Initial Officers shall be appointed by the Division of Behavioral Health at the first meeting and will be elected by the Committee annually thereafter. In the event of a vacancy, the Committee will elect a member to serve the unexpired term of office.

**Section 2:** The duties of the Officers shall be:

Chairperson – Preside at all Committee and Executive meetings and perform any other duties designated by the Committee.

Vice-Chairperson – Shall act for the Chairperson in his/her absence.

Second Vice Chairperson – Shall act for the Chairperson and Vice-Chairperson in their absence. Shall perform other duties as designated by the Chairperson or Committee.

#### **Section 3**

**Term:** At any time that a member cannot complete the term of office a new election shall be held to fill the vacancy.

#### **Section 4**

**Executive Committee:** The Executive Committee shall consist of the Chairperson, Vice-Chairperson and Second Vice Chairperson. A Chairperson may call the Executive Committee together with the agreement of the Division at his/her discretion. If a meeting of the Executive Committee is held, the full Committee will be notified at the next regularly scheduled meeting. The Executive Committee may not vote or act for the full Committee.

State Advisory Committee on Substance Abuse Services  
**Elections will occur at the November 2016 meeting.**

*For annual leadership selection, may do voice vote or secret ballot.*  
Secret ballot total votes for a candidate must be reflected in the minutes even though how each member voted is not recorded.\*

	Nominees	Elected
<b>Chairperson</b>	1. _____	1. _____
	2. _____	
	3. _____	
<b>Vice Chairperson</b>	1. _____	1. _____
	2. _____	
	3. _____	
<b>Second Vice Chairperson</b>	1. _____	1. _____
	2. _____	
	3. _____	

\*Taken from DBH Advisory Committee Tips for Open Meetings and Roberts Rules: