

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

November 8, 2012 / 9:00 am – 4:00 pm  
Lincoln, NE – Country Inn & Suites

Meeting Minutes

**I. Call to Order and Roll Call**

*Jim Harvey*

Jim Harvey, Division of Behavioral Health Committee Facilitator, welcomed committee members, and others present, to the meeting. Vice Chairperson Kasey Moyer, State Advisory Committee on Mental Health Services, and Second Vice Chairperson Randy See, State Advisory Committee on Substance Abuse Services, called the meeting to order at 9:04 am, on Thursday, November 8, 2012. 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; Kathy Boroff; Susan Buettner; Pat Compton; Sharon Dalrymple; Sheri Dawson; Brad Hoefs; Jette Hogenmiller; Jerry McCallum; Kasey Moyer; Rachel Pinkerton; Joel Schneider; Jill Schreck; Mark Schultz; Diana Waggoner; Cameron White

**State Advisory Committee on Mental Health Services Absent:** Adria Bace; Robert Donlan; Bev Ferguson; Kathleen Hanson; Linda Krutz; Joyce Sasse

**State Advisory Committee on Substance Abuse Services Attending:** Corey Brockway; Sheri Dawson; Ingrid Gansebom; Jay Jackson; Janet Johnson; Cody Manthei; Michael Phillips; Randy See; Jorge Rodriguez-Sierra

**State Advisory Committee on Substance Abuse Services Absent:** Ann Ebsen; Delinda Mercer; Debra Shoemaker

**II. Housekeeping and Summary of Agenda**

*Jim Harvey*

Jim Harvey confirmed the order of the agenda, noting Director Pristow and Director Adams will be moved to later on the Agenda due to a meeting scheduled with Governor Heineman. Jim explained the location of facilities around the building and described the logistics of the day.

**III. Approval of Minutes**

*Kasey Moyer ; Randy See*

Motion was made and seconded to approve the [date] minutes. The motion was carried by general consent.

Kasey Moyer, State Advisory Committee on Mental Health Services, asked comments on or approval of the August 7, 2012 minutes. One change was noted on page 3 under the Children's Behavioral Health discussion. Kasey requested a motion to approve the amended minutes. Motion was made by Sharon Dalrymple and seconded by Karla Bennetts to approve the amended minutes. The motion carried.

Randy See, State Advisory Committee on Substance Abuse Services, asked for comments on or approval of the September 6, 2012 minutes. There were none. Randy requested a motion to approve the minutes. Motion was made by Ingrid Gansebom and seconded by Jorge Rodriguez-Sierra to approve the minutes. The motion carried.

**IV. Public Comment**

- a) Alan Green, Executive Director of the Mental Health Association, announced the date and location of the 2013 Behavioral Health Conference to be held in Lincoln, NE on May 13, 14, and 15, 2013.

Alan stated there are three (3) educational/information tracks—Mental Health, Substance Abuse, and Problem Gambling. Continuing Education Units (CEUs) will be available.

**V. Consumer Workforce – Peer Recovery Supports – Peer Support**

*Carol Coussons de Reyes*

(Attachment A)

Carol Coussons de Reyes is the Administrator of the Office of Consumer Affairs. Carol handed out a document summarizing the points of the Family and Adult Peer Support Workforce. Carol reported much work has been accomplished to educate the public on the significance and importance of Peer Support. In addition, individuals have worked hard to encourage consumers to understand they have something of value to give to other consumers. Physicians, Therapists, and Psychiatrists are more frequently asking consumers if they have a peer support group and/or Wellness Recovery Action Plan (WRAP) for reference.

Committee comments included:

- Recovery Coaches/Peer Support help individuals understand their struggles;
- Peer Support helps humanize the individual and are important with relationships in the community;
- Peer Support helps reduce stigma for families with a child with mental illness;
- Certification for Peer Support Specialists currently exists for adult peer support, and work is being done on family peer support;
- Concern about creating another bureaucratic layer and causing more costs and paperwork for individuals who just want to help others;
- Excited for the potential for Peer Support to become Medicaid billable, however don't want to be controlled by appointment times and time constraints; need to move forward cautiously;
- law enforcement officers are excited about the possibilities peer support provides;
- There is a need to educate all professional levels, including employers, to de-stigmatize mental illness and substance abuse behaviors and the benefits of peer support;
- The Veterans' Administration is increasing Peer Support.

**VI. DHHS-Division of Children and Family Services**

*Scot Adams for Thomas Pristow*

Scot Adams is the Director of the DHHS-Division of Behavioral Health (DBH). Scot provided information on the DHHS-Division of Children and Family Service (CFS), in the absence of Thomas Pristow, Director of DHHS-CFS. Scot reported Director Pristow is excited to be in Nebraska, and stated it is fun to see him be so happy in his work. Scot reported there has been a steady decrease of children designated as State Wards and currently Nebraska is at a twelve (12) year low. As a result of the decrease in State Wards there is more flexibility to fund needed services. Scot reported that an amendment to the Social Security Act allows for funding for residential treatment services. There is also an emphasis on earlier intervention to allow for in home services instead of out of home care. Scot reported that Director Pristow has worked closely with the behavioral health sector in his other work experiences, particularly children's behavioral health. Scot is excited about the possibilities of DBH working more closely with CFS.

Response to Committee questions included:

- The decrease in State Wards is due to a variety of factors such as, it is a priority to get children out of the system;
- There has been a sense of mistrust among of the multiple partners associated with children's services, but under Director Pristow's leadership trust is developing within the system so that some partners have requested to be released from their work with cases.

Committee comments included:

- The implementation of the Structured Decision-Making model has made a difference in how CFS cases are handled.

## **VII. DHHS-Division of Behavioral Health**

*Scot Adams*

Scot Adams is the Director of the DHHS-Division of Behavioral Health (DBH). Scot stated he is happy about the CFS initiatives and that they are reaching out to DBH as there are many opportunities to collaborate and affect outcomes. For example, the Professional Partner Program wrap-around services to help families before problems escalate, and there is work being done to integrate the Child Abuse Hotline and the Nebraska Family Helpline so more information is being exchanged and callers feel more comfortable calling for help. Scot stated while there is a need to retain and maintain a specific focus on Mental Health and Substance Abuse, the Block Grants are encouraging movement to Behavioral Health Planning Councils/Advisory Committees. He stated he respects some folks desire to meet separately, we also need to come together in common language/focus because recovery encompasses all sides.

Response to Committee questions included:

- It is still too early to tell the exact effects of HealthCare Reform on the work of DBH and the Advisory Committees, but there will be a range of opportunities that will require continued policy discussion which will make the Committees' work more important;
- The system is becoming more aware of the effects of trauma and there are more people experiencing trauma due to war injuries, therefore providers are looking for it and have the ability to recognize it.

Committee comments included:

- Thankful to see more integration among the services and DBH and CFS, which will hopefully keep children out of the adult services in 20-25 years;
- Develop peer communication with DBH and CFS;
- Consider full integration of behavioral health and physical health so there are no system barriers to allowing payments (i.e., a behavioral health issue and a physical issue on the same day); this is a billing issue, not a system issue therefore Medicaid and providers need to communicate with each other;
- Although more people are more aware of trauma there is still a lot of work to do to de-stigmatize it;
- Need better understanding of how Post-Traumatic Stress Disorder (PTSD) changes the chemistry of the brain; the effects of PTSD don't show up immediately, especially with retiring veterans who have more time to think;
- To truly integrate, must move past the concept of primary diagnosis because the individual is a person, not their diagnosis;

## **VIII. SAMHSA Block Grant Implementation Report – Financial Reports**

*Karen Harker*

(Attachment B)

Karen Harker is the DBH Fiscal and Federal Resource Administrator. Karen reviewed her power point presentation. She reported DBH continues to have two (2) Maintenance of Effort (MOE) documents in place for which the purpose is to ensure as federal funds increase, State funds don't decrease (this is referred to as supplanting). Karen reported the expenditures for Independent Peer Review in FY12 were lower than normal due to a project revising the peer review tools and process.

Response to Committee questions included:

- Although the Strategic Prevention Framework-State Incentive Grant (SPF-SIG) is coming to a close, Nebraska is eligible for other grants to continue the prevention work;
- Although the Block Grant Application is combined, the underlying federal statutes did not change and the funding continues to be awarded and distributed separately.

**IX. SAMHSA Block Grant Implementation Report – State Priorities & Performance Indicators Heather Wood**

(Attachment C)

Heather Wood is the DBH Quality Improvement and Data Performance Administrator. Heather reviewed the 2012 Block Grant Priorities handout. Heather noted for Priority 10 on Supported Employment, the Performance Indicator was modified: *from* “Complete fidelity monitoring on 100% of the DBH funded Supported Employment providers by June 30, 2013” *to* “Create process for fidelity monitoring by June 30, 2013”.

Heather reported the only Priority that was Not Achieved is the Retailer Violation Rate (RVR) for tobacco sales to youth under the Synar requirements. The goal was to maintain a 10.6% rate as reported in FY11. The RVR for Calendar Year 2012 was 14%. The Federal standard is below 20 percent. DBH is continuing to review this data and looking for strategies to improve and meet this goal.

(Attachment D and Attachment E)

Renee Faber is the DBH Prevention Coordinator. She further discussed the Synar program and the RVR rate. There are limited resources to operate the Synar program and recruiting youth is becoming more difficult.

Renee also reported DBH was awarded the State Epidemiological Outcomes Workgroup (SEOW) Grant on November 1, 2012. It is worth \$200,000 for ten (10) months and will be used to sustain the Epidemiological Workgroup formed under the SPF-SIG.

(Attachment F)

Heather Wood reviewed the Block Grant Implementation Report Review – SA/MH Data handout.

Committee comments included:

- Under the Permanent Supportive Housing goal the idea is to provide Rental Assistance until a Section 8 voucher is available—how is this working? (Jim Harvey will e-mail this data to Committee members.);
- Why does the number of pregnant injecting drug users remain constant over time? Are there any commonalities among the users, such as same household, same location, same ethnicity?
- Some Region Behavioral Health Authorities have funded their Regional Prevention Coalition;
- School resource officers are used to help recruit youth;
- The Tobacco Free Nebraska Coalition conducts retailer training on tobacco sales laws;
- Suggest the Synar results be published in the newspaper like the restaurant health inspections are published, as well as publish the retailers who did well with Synar inspections;
- Suggest publish tobacco inspection results on the DBH website;
- Alcohol violations are handled by the state Liquor Control Commission, but tobacco violations are handled by the court system;
- Need standardized process across the state for tobacco licensing.

**X. 2013 Meeting Schedule**

***Jim Harvey***

(Attachment G)

Jim Harvey, Division of Behavioral Health Committee Facilitator, reviewed the Meeting Schedule for 2013 for the State Advisory Committee on Mental Health Services and the State Advisory Committee on Substance Abuse Services. The Committees agreed to the proposed schedule after some discussion.

Committee comments included:

- Like the blend of joint meetings along with separate Committee meetings;
- Prefer to keep the autonomy of each Committee, but also like the idea of joint meetings;
- Understand the need for joint meetings to review the Block Grant Application;
- The State Advisory Committee for Substance Abuse Services is smaller and concern they may lose their vote against the larger State Advisory Committee for Mental Health Services.

## **XI. Election of Officers**

*Jim Harvey*

The State Advisory Committee on Mental Health Services held election of Officers. The 2013 Officers are as follows:

- Chairperson—Bev Ferguson
- Vice Chairperson—Kasey Moyer
- Secretary—Dianna Waggoner

The State Advisory Committee on Substance Abuse Services held election of Officers. The 2013 Officers are as follows:

- Chairperson—Ann Ebsen
- Vice Chairperson—Randy See
- Second Vice Chairperson—Cody Manthei

## **XII. SAMHSA Block Grant Application – Break Out Groups and Report**

*Jim Harvey/Heather Wood*

(Attachment H, Attachment I and Attachment J)

Jim Harvey reviewed the groundwork for the next Block Grant Application for 2014-2015. Heather Wood explained DBH uses the most relevant and recent data collected from the Behavioral Health Regions across the State, as well as uses national comparison data. Heather reported on a Quality Initiative that recently began due to the increase in the Length of Stay at the Lincoln Regional Center. The initiative will look at barriers to moving individuals to community-based services.

Committee comments included:

- Youth Consumer Survey produced a lower rating than Adult Survey; do a Needs Assessment to improve services
- Consider changing language of primary substance to drug of choice because question that asks first time used primary substance may provide different information than question that asks first time used drug of choice; question that asks age of onset may also provide different information
- There are different causes of trauma, e.g., psychological, physical, system; psychological trauma is not as easy to identify/define as physical trauma

Committee members, as well as the public attendees, broke out into five (5) groups to discuss Step 3: Prioritize State Planning Activities and Step 4: Develop Objectives, Strategies, and Performance Indicators of the Block Grant Planning Steps. Following are the ideas captured from each group:

### **Group 1:**

1. Parental education/support of young children (less than 7 years old through Junior High/Middle School age)
  - Education – youth Behavior skits
  - Education – parenting skits
  - How to better address youth/parenting – prevention
  - Explore research and what works
2. Veterans (special population)
  - Relationship – link State/Federal
  - Service/Resource connection to address fragmentation
  - Address urban/rural needs and services
  - Telehealth
  - Family support addressed
3. Aging/Senior individuals who have Depression (Special Population)
  - Medications from primary care professional but need service/resource connection for treatment

- Educate primary care professional
- Other approach beyond medications
- 4. Individuals with co-occurring complex needs (mental health/substance abuse/physical)
  - What are policy/strategies and data to support system change and prevention?
- 5. Criminal Justice (Department of Corrections) behavioral health population
  - What process/services needed to help successful reintegration?
  - Consider services within prison system, but also coming out/release (e.g., Veterans services)
- 6. Synar
  - Need training requirement for businesses (similar to alcohol system/beverage service training)
  - Consider strategy for posting Synar violations – State versus local posting
  - Research and know what will most likely impact cigarette access for youth

**Group 2:**

1. Synar-Tobacco Prevention
  - How many coalitions are actually addressing youth tobacco prevention?
  - Increase recruitment of youth inspectors
  - Increase positive reinforcement efforts
2. Youth Prevention Activities
  - Target ages 10-13
  - Study County/Community averages
3. Service Definitions for Peer Support
  - Define, set standards, criteria for funded positions – want to be inclusive of existing workforce
4. Housing (e.g. Supported Housing)
  - How can we avoid duplication?
  - Use limited funding in a more streamlined effort
5. Vocation Rehabilitation
  - Active employment leads to increased self-worth, decreased mental health symptoms, etc.
  - Need to expand scope of services to serve the current population
6. Priority Populations
  - Limited: what about chronic, “repeat offenders”
  - Denial of treatment should be re-evaluated
7. Re-traumatization
  - Evaluate on a system-wide level

**Group 3:**

1. Substance Use Prevention for 10-11 years old
  - Schools
  - Communities
  - Measure statistics – increase age
  - Parent education
2. Peer Support
  - Peer “Bridgers”
  - Promote/increase education about peer support
  - Increase access
  - Increase number of certified peers working
3. Mental Health and Traumatic Brain Injury
  - Screen and Assess
  - Is it physical or mental?

4. Trauma
  - War
  - Institutional
  - Divorce
  - Broken friendships
  - Screening
5. Supported Employment
  - Increase Quality/Fidelity
6. Professional workforce enlightened/burnout
7. Criminal Justice and Juvenile Justice
  - Increase number of inmates leaving prison
  - Co-Occurring/Homelessness
  - Number served – Supported Employment/Supported Housing/Mental Health/Substance Abuse
8. Children/Youth mental health prevention
  - Wellness Action Recovery Plan (WRAP)/Coping Skills
  - Number of children staying in home
  - Increase support groups for parents
  - Increase aftercare when children come home – parent peer “bringer”

**Group 4:**

1. Cultural Competency
  - Increase cultural competency services
  - Cultural Competency = rural/urban/poverty/middle-class/wealthy
  - Increase minorities to work in treatment centers/Probation offices
  - Increase in Peer Support
  - Interpretation services are expensive
2. Children with Severe Emotional Disturbance
  - Access to services—must become a State Ward to get services
  - Prevention is huge—avoid adult system
  - Identification and Access
3. Continue with Trauma-Informed Care
  - Dig deeper—further hone the delivery system
  - Not only Trauma-Informed—also focused trauma education/treatment
  - Not only focus on current behavior—look at trauma component
  - Trauma “Action”—place to go to specifically work on trauma issues
  - Trauma-Informed interventions—friendly—entire treatment environment
  - Resources to turn to—Plan
  - Knowing what to do versus doing it
4. Transition Age Youth
  - Age appropriate treatment services
  - Division of Children and Family Services and Division of Behavioral Health collaborate to grow services
5. Peer Recovery Support (Adult and Family)
  - Culturally Competent
  - Located in a Cultural Center (e.g., Indian, Asian, Malone, Veterans Administration)
6. Co-Occurring Disorders
  - Authenticate/monitor/enhance Co-Occurring services
  - Continue and go deeper with #7 on the Yellow Sheet (Co-Occurring Disorders on Block Grant Priorities)

- Develop Standards to meet Co-Occurring Disorders services

**Group 5:**

1. Tobacco usage reduction
  - Education on second hand smoke (e.g., in cars)
2. Access to services for Transition Age Youth – Mental Health/Substance Abuse
  - 18-19 years old – not in youth services – not yet an adult
3. Youth involvement/leadership in Prevention activities (youth groups)
  - Peer workforce
4. Alcohol use decreased in children
  - Education
  - Surround yourself with others who have positive/same beliefs
  - Surround yourself with adults who have positive/same beliefs
5. More/better training for trauma informed care
6. Decrease marijuana use / Change perception of use
  - Increase collaboration with community resources and public/private education
7. Co-Occurring services development
8. Client directed care
  - Its importance
  - Educate on
  - System recognition
9. Increase peer involved/peer enhanced services
10. Prevention focus - DHHS

**XIII. Public Comment**

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- a) Jonah Deppe, representing the National Alliance on Mental Illness (NAMI), encouraged the Committee to consider children’s mental health a priority. She reported there are currently more adult services than children's services.

**XIV. Committee Recommendations and Comments**

*Committee Members*

- due to the Governor’s directive that there will be no expansion of Medicaid under the Affordable Care Act, a State and Federal partnership will be necessary to cover new individuals eligible for Medicaid coverage;
- it makes good sense for partners to work together; it is good to know silos are being removed through work between DBH, CFS, and Medicaid;
- the number of Transition Age Youth being served has increased, but also need to strive to ensure the services these youth are receiving are developmentally appropriate and effective;
- appreciate DBH staff work to prepare for Committee meetings; good feeling about getting a lot of work accomplished during meetings;
- appreciate time and energy it takes for everyone to prepare for and participate in Committee meetings; always learn new information and ideas;
- feel more comfortable about concept of Peer Support, but still need to narrow down the definition;
- always learn new information from data presented;
- helpful to listen and learn from each other;
- appreciate having Joint Committee meetings, and also appreciate keeping the historical perspective of mental health and substance abuse work separate at times;

- Veterans experience both PTSD and Substance Abuse issues, therefore appreciate Joint Committee meetings; need to be aware that more veterans coming home from war are dying due to suicide than are dying in war combat;
- appreciate the collaboration and work being done between DBH and CFS;
- always learn a lot from all discussion during meetings;
- gaining a better understanding of Peer Support work and that it is different than 12-Step work;
- More than Trauma-Informed Care as a program – need to pursue trauma as more than a program to manage symptoms, but to expand it to individual lives and get to the core of behavior choices; include focused trauma education/treatment. Member handed out “How to Manage Trauma” (Attachment K).
- the focus of the evaluation of services and processes is to help all clients get better;
- appreciate the diversity in expertise and knowledge of Committee membership;
- it is a privilege to serve on the Advisory Committee; appreciate the progress DBH and the Committees have made in previous years; all new concepts and processes take a while to work through

**XV. Items for next agenda**

*Committee Members*

- a) SAMHSA Block Grant Plan and Application

**XVI. Adjournment and next meeting**

- The meeting adjourned at 3:55 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 Thursday, March 14, 2013 from 9:00 am to 4:00 pm.

**Content Summary for November 8<sup>th</sup> Meeting: Family and Adult Peer Support Workforce**

A) Peer Support is Paid and Unpaid, Both are Important
B) Consumer Operated Programming is Valuable
C) There are many roads to Mental Health and/or Addiction recovery, Peer Support is one
D) Peer Support is a complement to clinical services providing lived experience
E) Peers were instrumental in building the recovery model
F) Family Peer Support is valuable for families navigating systems/supporting child development
G) Youth Peer Support is valuable for understanding transition to adulthood
H) Peer Support also exists in Respite Services, Hospital Diversion, Wellness Coaching, Health Homes, and Federally Qualified Health Centers
I) Adult Peer Support provided by Peer Support and Wellness Specialists is supported by certification, draft job description, co-supervision, and continuing education
J) Family Peer Support is supported by training, and the development of a certification process is forthcoming.
K) It would be a dual relationship to act as a 12 Step Mentor and a Peer Support Specialist for the same person
L) Peer Support is not about cheap labor
M) Peer Support may one day be also Medicaid Billable with introduction of At-Risk Managed Care

# Financial Information

For December 1, 2012 Implementation  
Report

## Community Mental Health Block Grant

- ▶ Period: July 1, 2011 – June 30, 2012 (SFY12)
- ▶ Maintenance of Effort:
  - Amount of State Funds Expended for Mental Health Services
    - ~~Must meet or exceed average of prior two years~~
    - **Must be no less than a 5% decrease from the average expenditures of prior two years**
  - Amount of State Funds Expended for Children's Mental Health Services
    - ~~Must meet or exceed amount of funds expended in 1994~~
    - **2008**

## Community Mental Health Block Grant

### ▶ State Expenditures for Mental Health Services

- Must be no less than a 5% decrease from the average expenditures of prior two years

- SFY10 = \$60,728,294
- SFY11 = \$61,285,737
- 2 year average = \$61,007,015

**FY12 Expenditures = \$59,736,524**

NIS FY12 Summary of Expenditures

(1,270,491 reduction from average = 2.1%)

## Community Mental Health Block Grant

### ▶ Amount of State Funds Expended for Children's Mental Health Services

- Meet or exceed 2008 Level: \$4,108,818

### ▶ SFY12 Expenditures: \$6,923,617

DBH FY12 State Reconciliation/FY12 Summary of Expenditures w/adjustment

## Community Mental Health Block Grant

### ▶ Federal Block Grant Funds: July 1, 2011 - June 30, 2012

◦ Adult Services	\$942,331	(49%)
◦ Children Services	\$850,225	(44%)
◦ Peer Review/Training	\$105	(<1%)
◦ Administration	\$131,374	(7%)

DBH FY12 State Reconciliation

## Community Mental Health Block Grant

### ▶ State Funds for Aid to or for Individuals:

July 1, 2011 - June 30, 2012

◦ Adult Services	\$52,677,838	(88%)
◦ Children Services	\$6,923,617	(12%)
	<small>(does not includes Children's hotline \$1,291,426)</small>	

DBH FY12 Reconciliation & NIS FY12 Summary of Expenditures (268)

## Substance Abuse Prevention & Treatment Block Grant

- ▶ Period: July 1, 2011 – June 30, 2012
- ▶ Maintenance of Effort:
  - Amount of State Funds Expended for Substance Abuse Services
    - Must meet or exceed average of prior two years expenditures
  - Amount of State & Federal Funds Expended for Pregnant Women & Women With Dependent Children Services
    - Must meet or exceed amount of funds expended in 1994

## Substance Abuse Prevention & Treatment Block Grant

- ▶ Other Requirements:
  - A minimum of 20% of every SAPTBG award must be spent on Primary Prevention
  - No more than 5% of any SAPTBG award may be used for administration expenses.

## Substance Abuse Prevention & Treatment Block Grant

- ▶ State Expenditures for Substance Abuse Services
  - ▶ Must meet or exceed average of prior two year expenditures
    - SFY10 = \$23,539,822
    - SFY11 = \$24,870,295
    - 2 year average = \$24,205,059

**FY12 Expenditures = \$24,562,390**

▶ NIS FY12 Summary of Expenditures

## Substance Abuse Prevention & Treatment Block Grant

- ▶ Amount of State & Federal Funds Expended for Pregnant Women & Women With Dependent Children Services
  - ▶ Meet or exceed 1994 Level: \$753,713
- ▶ SFY12 Expenditures: \$2,357,202

▶ NIS FY12 Summary of Expenditures

## Substance Abuse Prevention & Treatment Block Grant

- ▶ A minimum of 20% of the every Federal SAPTBG award must be spent on Primary Prevention

▶ Treatment Services:	\$5,127,219	(64.7%)
▶ Women Services:	\$595,669	(7.5%)
▶ Primary Prevention:	\$1,689,710	(21.3%)
▶ Peer Review & SA Training:	\$160,532	(2.0%)
▶ Administration:	<u>\$347,000</u>	(4.4%)
▶ Total Federal Award:	\$7,920,131	

Federal FY10 Award, NIS Grant Project Status

## Substance Abuse Prevention & Treatment Block Grant

### State Funds for Aid to or for Individuals

July 1, 2011 - June 30, 2012

▶ Treatment Services:	\$22,661,593	(92.3%)
▶ Women Services:	\$1,787,834	(7.3%)
▶ Primary Prevention:	\$112,963	(.5%)

DBH FY12 State Reconciliation & NIS FY12 Summary of Expenditures

## For more information:

Karen Harker  
Federal & Fiscal Performance Administrator  
Office: 402-471-7796  
Cell: 402-416-7262  
Email: [Karen.harker@nebraska.gov](mailto:Karen.harker@nebraska.gov)



Not Achieved  
Achieved  
In Progress



# 2012 Block Grant – Priorities\*

**\*Not in order of priority**

Draft as of November 1, 2012

Prioritize State Planning Activities	Goal & Performance Indicator
<p>1 – Substance Abuse Prevention</p> <p><b>Achieved</b></p>	<p><u>Goal:</u> To complete a Strategic Plan for Prevention.</p> <p><u>Performance Indicator:</u> Contingent upon when Technical Assistance is received, the Strategic Plan for Prevention will be completed by the target date of 9-30-12.</p>
Footnote: DBH has an approved plan.	
<p>1 – Substance Abuse Prevention</p> <p><b>Not Achieved</b></p>	<p><u>Goal:</u> To reduce the sale of tobacco to youth.</p> <p><u>Performance Indicator:</u> The total number of sales to minors (Retailer Violation Rate – RVR). Nebraska’s RVR was 10.6% in FY11 and will maintain this percentage in FY12 and FY13.</p>
Footnote: NE RVR for CY2012 was 14%. The national standard is below 20 percent. The trends are reported on DBH website [see <a href="http://dhhs.ne.gov/publichealth/Pages/hew_sua_synar.aspx">http://dhhs.ne.gov/publichealth/Pages/hew_sua_synar.aspx</a> ]. In CY2009 the rate was 13.5; in CY2010 it was 10.7 and 10.7% in CY2011. DBH will further review the data to understand this reported increase.	
<p>1 – Substance Abuse Prevention</p> <p><b>Achieved</b></p>	<p><u>Goal:</u> To reduce underage drinking and excessive drinking by adults through the use of environmental strategies.</p> <p><u>Performance Indicator:</u> A total of 28 of environmental activities related to the reduction of underage and excessive drinking by adults were performed and funded by DBH in FY11. In the FY12, the number will be increased to 40 and 55 in FY13.</p>
Footnote: In FY12, the number of environmental activities performed that relate to reduction of underage and excessive drinking by adults was 87.	
<p>2 – Consumer Workforce</p> <p><b>Achieved</b></p>	<p><u>Goal:</u> To increase the peer support workforce.</p> <p><u>Performance Indicator:</u> Total Number of trained Peer Support and Wellness Specialists. Baseline as of June 30, 2011 for the total number of trained Peer Support and Wellness Specialists was 17. This will increase to 75 by June 30, 2013.</p>
Footnote: As of May 1, 2012—76   As of July 20, 2012—91	
<p>3 – Peer Recovery Supports</p> <p><b>In Progress</b></p>	<p><u>Goal:</u> To increase the number of peer recovery supports.</p> <p><u>Performance Indicator:</u> Total number of behavioral health services with a peer recovery support component. Define peer recovery supports &amp; establish the baseline number of BH services with a peer recovery support component by June 30, 2012. Increase this number by <u>June 30, 2013</u>.</p>
Footnote: Honed Draft definition with the OCA People's Council. Presented to advisory committees with questions on August 7, 2012 and September 6, 2012 to determine how to count: by service or by person; funded or unfunded staff; as well as how the data will be obtained.	
<p>4 – SA Treatment – Women’s Set Aside Services</p> <p><b>In Progress</b></p>	<p><u>Goal:</u> To ensure services for Pregnant Women and Women with Dependent Children are trauma informed and trauma specific.</p> <p><u>Performance Indicator:</u> Percent of WSA providers who have completed TIC tool. Baseline percent of WSA providers who have completed TIC tool is 56% as of January 1, 2012. This will increase to 100% by <u>June 30, 2013</u>.</p>
Footnote: Seven (7) out of nine (9) WSA agencies (77.8%) completed TIC assessment as of 8/13/2012.	
<p>5 – Transition Age Youth and Young Adult</p> <p><b>In Progress</b></p>	<p><u>Goal:</u> To increase access to services for young adults/youth transitioning to adulthood. <u>Performance Indicator:</u> Total number of persons age 16-24 served. Baseline for total number of persons age 16-24 served on June 30, 2011 was 6,110. This will increase to 6,500 by June 30, 2013.</p>

Prioritize State Planning Activities	Goal & Performance Indicator
Footnote: Total number of persons age 16-24 served between July 2011 and June 2012 was 6,668.	
6 – Professional Partners Program <div style="background-color: #6aa84f; color: white; padding: 5px; text-align: center; width: fit-content; margin: 10px auto;">Achieved</div>	<u>Goal:</u> To implement Wrap Around in the Professional Partners Program with integrity. <u>Performance Indicator:</u> WFI measures as compared to WFI national benchmarks. Establish the baseline across 11 WFI measures by September 30, 2012. Increase the number of measures at which we are meeting or exceeding the national benchmarks.
Footnote: Wraparound Fidelity Instrument (WFI) version 4. WFI Data was received by July 31, 2012. Five (5) Regions submitted the WFI-4.0 data for FY12. One Region will start using WFI-4.0 on 7/1/2012 and be able to report on WFI-4.0 in FY13. WFI measures for FY12 will be shared with the Regions first before bring to the public.	
7 – Co-Occurring Disorder Services <div style="background-color: #6aa84f; color: white; padding: 5px; text-align: center; width: fit-content; margin: 10px auto;">In Progress</div>	<u>Goal:</u> To increase the capacity of the public behavioral health workforce to be able to deliver effective prevention and treatment in recovery-oriented systems of care for people with co-occurring disorders. <u>Performance Indicator:</u> Total number of behavioral health providers that are dual capable and dual enhanced. Baseline is zero as of January 1, 2012. One hundred percent (100%) of the providers under contract with the six RBHAs will complete the COMPASS-EZ by January 1, 2013.
Footnote: Trainings were held with COMPASS-EZ developers June 5, 11& 12, 2012. Regions will submit the COMPASS-EZ assessment data from contracted providers (except Prevention) no later than December 15, 2012. Results should include 3 to 5 “action items” for improvement and a statement on what was learned about the program.	
8 – Trauma Informed Care (TIC) <div style="background-color: #6aa84f; color: white; padding: 5px; text-align: center; width: fit-content; margin: 10px auto;">In Progress</div>	<u>Goal:</u> To develop a service system that understands the effects of trauma and avoids re-traumatizing those who seek services (trauma-informed). <u>Performance Indicator:</u> Total number of providers assessed using the TIC tool. Baseline as of January 2012 is 63%. By June 30, 2013 this will increase to 100%.
Footnote: 45 of 77 agencies (58.4%) completed TIC assessment as of 8/13/2012.	
9 – Permanent Supportive Housing <div style="background-color: #6aa84f; color: white; padding: 5px; text-align: center; width: fit-content; margin: 10px auto;">Achieved</div> <div style="background-color: #6aa84f; color: white; padding: 5px; text-align: center; width: fit-content; margin: 10px auto;">In Progress</div>	<u>Goal:</u> To improve the Permanent Supportive Housing services. <u>Performance Indicator:</u> Define what Permanent Supportive Housing services means in Nebraska by January 2013. Create process for fidelity monitoring by June 30, 2013. Total number persons served in Permanent Supportive Housing baseline as of June 30, 2011 was 817. This will increase.
Footnote: Evidence Based Practices Workgroup recommended on June 21, 2012 Permanent Supportive Housing, for the purposes of fidelity monitoring be limited to NE Program – Housing Related Assistance. The number of persons served in NE Housing Related Assistance in 2012 was 825. Fidelity monitoring process in development.	
10 – Supported Employment <div style="background-color: #6aa84f; color: white; padding: 5px; text-align: center; width: fit-content; margin: 10px auto;">In Progress</div>	<u>Goal:</u> To improve the quality of Supported Employment services. <u>Performance Indicator:</u> Complete fidelity monitoring on 100% of the DBH funded Supported Employment providers by June 30, 2013.
Footnote: - EBP Workgroup addressing focus on SE issues on May 10, 2012. Training from Dartmouth Supported Employment Center (Lebanon, NH) on Individual Placement and Support (IPS) model June 13, 2012. SE providers completed IPS online training in 2012. Working with Vocational Rehabilitation on method for fidelity monitoring.	
11 – Intravenous Drug Abusers <div style="background-color: #6aa84f; color: white; padding: 5px; text-align: center; width: fit-content; margin: 10px auto;">Achieved</div>	<u>Goal:</u> To Serve Intravenous Drug Abusers. <u>Performance Indicator:</u> Count of persons served who are Intravenous Drug Abusers. In FY2011, the unduplicated count persons served who were Pregnant Injecting Drug Users was 34 and the Injecting Drug Users was 1,559. DBH will maintain this service level through June 30, 2013.
Footnote: Unduplicated Count persons served FY12: Pregnant Injecting Drug Users = 36   Injecting Drug Users = 1,599.	
12 – Tuberculosis (TB) <div style="background-color: #6aa84f; color: white; padding: 5px; text-align: center; width: fit-content; margin: 10px auto;">Achieved</div>	<u>Goal:</u> To Screen for TB. <u>Performance Indicator:</u> Maintain the contractual requirements of the six Regional Behavioral Health Authorities to conduct the TB screenings.
Footnote: The contractual requirements of the six Regional Behavioral Health Authorities to conduct the TB screenings were maintained.	

## **NEBRASKA**

### **ANNUAL SYNAR REPORT – 2012 Compliance**

- DHHS Division of Behavioral Health is the State agency designated by the Governor for oversight of the Synar requirements and responsible for conducting random, unannounced Synar inspections.
- The State agency responsible for enforcing youth tobacco access laws is the Nebraska State Patrol.
- There have been no changes or additions to the State tobacco statutes relating to youth access since the last reporting year.
- The State agency responsible for tobacco prevention activities (receiving the Centers for Disease Control and Prevention's National Tobacco Control Program funding) is the DHHS Division of Public Health, Health Promotion Unit, Tobacco Free Nebraska.

#### **Progress for FFY 2012:**

- Number of inspections completed was **310**
- Completion Rate of **93.9%**
- The number for violations of youth access to tobacco laws was **43**
- This year's Retailer Violation Rate (**RVR**) is **14%**.
- Federal Requirement is achieve an RVR of 20% or less.

#### **Following are a number of contributing factors that influence the annual RVR:**

##### *Limited Resources for Law Enforcement of Youth Access Laws -*

While the Nebraska State Patrol is a statewide law enforcement agency, given the size of our State, amount of personnel is limited. Synar inspections are carried on through a voluntary overtime basis. In 2011, the Nebraska Legislature reduced the appropriation from the Nebraska Health Care Cash Fund for comprehensive tobacco prevention and cessation by 17%. This cut has resulted in a reduction of the tobacco prevention efforts in the state including a reduction in non-Synar tobacco compliance checks. Local community coalitions continue to work with local law enforcement for the enforcement of youth access laws. While many of these organizations have been instrumental in tobacco cessation efforts, there remains a gap in the continuity of prevention effort.

##### *Difficulties Recruiting Youth Inspectors -*

The availability of youth to travel with police officers has not increased. This most likely is attributed to the fact that travel distance and time can be arduous, especially when teams must travel 3-4 hours to conduct one or two inspections. In more urban areas, inspections and youth recruitment suffer from competing school and work activities. Officers are requested to have inspections conducted by youth proportionate by age to the youth in the area.

##### *Age distribution -*

This is another factor in the recruitment of inspectors. The revised requirements of 40 percent maximum in each three different age groups (15, 16, and 17) by both males and females are difficult to accomplish. This is reportedly due to lack of youth in more rural areas (either physically or interest). Beginning in 2009, an ongoing requirement was added to the Nebraska

State Patrol and Omaha contract for Synar checks to meet the goal of achieving approximately 34 % of inspectors being aged 15, 34 % being age 16 and 34 % the age of 17. In the contract the goal is stated as “Not more than 40 percent of the checks may be made in any single age group”. At this time, Nebraska continues to strive for an even 50/50 split between genders in any age group.

*Geographic, Demographic, and Logistical Considerations in Conducting Inspections-* Distances between communities, especially in western Nebraska, make conducting inspections by only the Nebraska State Patrol particularly difficult. The 400 plus visits for the Synar program are conducted over a four-month period. It is common for many communities to have just one inspection in which the drive to and from the inspection are over an hour from the patrol officers base location. Officers are on overtime status to conduct these inspections.

**Plans to reduce the target rate for Synar inspections to be completed in FFY 2013:**

DHHS will continue to educate decision makers about Synar including the importance of a centralized, continuously updatable, tobacco licensing system for Nebraska and to improve the listings from which we draw the tobacco retailers. DBH will again contact all 93 country clerks with an extra reminder of the annual expiration date for tobacco licensee as part of our pre-notification that a list of all retailers with this license will be requested after the start of the New Year.

DBH had recently launched a five year strategic for the Prevention System which includes the Synar program. As a part of strategic planning, DHHS will explore additional resources and opportunities to streamline processes for local tobacco and substance abuse prevention coalitions. DBH will continue a specific measurable goal in the FY15-15 Uniform Block Grant application to increase efforts that support the completions of Synar compliance checks completed and reduction of the RVR.

**Additional activities conducted in Nebraska to support enforcement and compliance with State tobacco access law includes all of following:**

- Merchant education and/or training
- Incentives for merchants who are in compliance (e.g., positive reinforcement)
- Community education regarding youth access laws
- Media use to publicize compliance inspection results
- Community mobilization to increase support for retailer compliance with youth access laws
- Ensuring that youth tobacco access strategies are part of the State’s comprehensive tobacco control plan
- Utilizing coalition members to conduct nonenforcement compliance checks of tobacco retailers in which compliant retailers are rewarded and noncompliant retailers are warned about the law
- Approach to Policy

For more information, please contact *Renee Faber*, Prevention System Coordinator, DHHS Division of Behavioral Health at 402-471-7772 or [renee.faber@nebraska.gov](mailto:renee.faber@nebraska.gov).



## **Synar Program Factsheet - Description and Background**

### **Overview:**

In July 1992, Congress enacted the Alcohol, Drug Abuse, and Mental Health Administration Reorganization Act (P.L. 102-321), which includes an amendment (section 1926) aimed at decreasing youth access to tobacco. This amendment, named for its sponsor, Congressman Mike Synar of Oklahoma, requires States (i.e., all States, the District of Columbia, and the 8 U.S. Territories) to enact and enforce laws prohibiting the sale or distribution of tobacco products to individuals under the age of 18.

The Synar program is the set of actions put in place by States, with the support of the Federal Government, to implement the requirements of the Synar Amendment. The Amendment was developed in the context of a growing body of evidence about the health problems related to tobacco use by youth, as well as evidence about the ease with which youth could purchase tobacco products through retail sources. The Synar program is a critical component of the success of youth tobacco use prevention efforts.

### **Synar Legislation:**

The Synar legislation requires States to do the following: enact laws prohibiting the sale and distribution of tobacco products to minors; enforce such laws in a manner that can reasonably be expected to reduce the availability of tobacco products to youth under the age of 18; conduct random, unannounced inspections of tobacco outlets; and report these annual findings to the Secretary of the U.S. Department of Health and Human Services.

Because it plays a lead Federal role in substance abuse prevention, SAMHSA was charged with implementing the Synar Amendment. In January 1996, SAMHSA issued the synar Regulation to provide guidance to the States. The regulation requires that States:

- Have in effect a law prohibiting any manufacturer, retailer, or distributor of tobacco products from selling or distributing such products to any individual younger than age 18;
- Enforce this law;
- Conduct annual, unannounced inspections in a way that provide a valid probability sample of tobacco sales outlets accessible to minors;
- Negotiate interim targets and a date to achieve a noncompliance rate of no more than 20 percent (SAMHSA required that each State reduce its retailer violation rate (RVR) to 20 percent or less by FFY 2003); and
- Submit an annual report detailing State activities to enforce its law.

### **Synar Programmatic Requirements:**

SAMHSA/CSAP is charged with overseeing States' implementation of the Synar requirements and provides technical assistance to States on both the Synar requirements and youth tobacco access issues in general.

Since the inception of the Synar program, SAMHSA/CSAP has worked with States to assist them in complying with and attaining the goals of the Synar Amendment and has issued programmatic requirements and guidance documents to assist States in their efforts.

For example, CSAP has provided a great deal of guidance to States regarding the conduct of random, unannounced inspections. Specifically, in conducting their annual Synar surveys States must:

- Develop a sampling frame that includes both over the counter and vending machine locations accessible to youth;
- Ensure that their sampling frame includes, at a minimum, 80 percent of the tobacco outlets in the State (CSAP requires States that use a list frame to conduct and report the results of a coverage study designed to assess the completeness of the sampling frame);
- Design a sampling methodology and implementation plan that are based on sound survey sampling methodology;
- Sample a large enough number of outlets to meet SAMHSA's precision requirement (one-sided 95% confidence interval);
- Obtain a completion rate of 90 percent or better;
- Record the actual steps of the survey process in the field and keep records of all sources of sample attrition in the field; and
- Weight the results of the Synar survey to account for unequal probabilities of selection, differences in percentages of eligible outlets between strata or clusters, and other deviations from the intended design.

### **Penalties for Noncompliance:**

In addition to setting targets for State, the Synar Amendment established penalties for noncompliance. The penalty for a State is loss of up to 40 percent of its Substance Abuse Prevention and Treatment (SAPT) Block Grant funds. Since these funds account for a large percentage of all State expenditures for substance abuser prevention and treatment, imposition of this penalty could present a severe problem for a State. From FFY 1997 to FFY 2005, there were 18 instances involving 14 States in which that penalty could have been imposed.

In lieu of this penalty, in every year since 2000, Congress has provided an alternative penalty (Section 214/Section 218/Section 213/Section 212) mechanism by which a State can avoid the 40% reduction in its SAPT Block Grant if the State stipulates that it will spend its own funds to improve compliance with the law. Specifically, under the alternative penalty, a State that fails to meet Synar requirements can avoid the 40-percent penalty against its SAPT Block Grant by taking the following steps:

- Committing additional State funds to ensure compliance with youth tobacco access laws in an amount equal to 1 percent of its current fiscal year's Block Grant for each percentage point by which the State failed to meet the retailer violation target rate for the previous fiscal year;
- Certifying that these additional State funds will be used to supplement and not supplant funds used for tobacco prevention programs and compliance activities in the fiscal year preceding the fiscal year to which the section applies;
- Providing reports to the Secretary of Health and Human Services on all State resources spent in the previous fiscal year and obligated in the current fiscal year for tobacco prevention and compliance activities by program activity.

The alternative penalty also stipulates that SAPT BG funds can not be withheld from a U.S. Territory that receives less than \$1,000,000 in Substance Abuse Prevention and Treatment (SAPT) Block Grant funds for failing to meet the Synar requirements.

# Block Grant Implementation Report Review – SA/MH Data

Joint Advisory Committee Meeting  
November 8, 2012



## SA Performance Indicators Treatment Episode Data Set (TEDS)

- Employment/Education
- Stability in Housing
- Criminal Justice
- Reduced Morbidity – Abstinence from Alcohol Use / Drug Use
- Social Support of Recovery
- Retention –Length of Stay (Days)

## SA Performance Indicators Prevention

- Prevalence from NSDUH
  - Reduced Morbidity
  - Employment/Education
  - Criminal Justice
  - Social Connectedness
- Prevention Work
  - Retention – Prevention Messages
  - Programs and Strategies

3

## MH Performance Indicators 1/2 Uniform Reporting System (URS) Tables

- Receiving Services including EBPs
  - Serious Mental Illness (SMI)
  - Serious Emotional Disturbances (SED)
- Employment/Education
- Living Situation
- Consumer Evaluation of Care
  - Social Connectedness
  - Improved Functioning

4

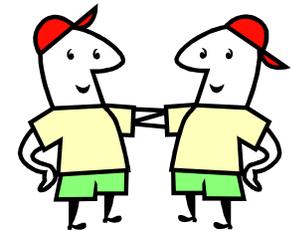
## MH Performance Indicators 2/2

### Uniform Reporting System (URS) Tables

- Criminal Justice
- Readmission Rates (30/180 Days)
  - State Hospital
    - Non-forensic
    - Forensic
  - Psychiatric Inpatient Care Unit

5

## Similarities



6

## National Outcome Measures (NOMs)

- Episode of Care – Average Length of Stay
- Retention
- Access Capacity
- Reduced Morbidity
- Criminal Justice
- Stability in Housing
- Employment/Education

7

## Differences



8

## Not Apples to Apples

- Service Types
  - TEDS: SA & Dual
  - URS: MH & Dual
- Time Frame
  - URS – FY 12 (Active T1 to T2)
  - TEDS – CY 11 (Adm to D/C)
- Client Level Data
  - Have been submitting for SA
  - New for MH starting FY 2012
    - Historically aggregated data provided
    - Submission deadline Dec. 2012



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## Profile



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### Total Number of Persons Served

	<u>Youth</u>		<u>Adult</u>		<u>Total</u>		<u>Total</u>
	Male	Female	Male	Female	Male	Female	
<i>Mental Health</i>	1,067	683	10,806	10,979	11,873	11,662	23,535
- <i>SED</i>	835	505	-	-	835	505	1,340
- <i>SMI</i>	-	-	7,240	7,852	7,240	7,852	15,092
<i>Substance Abuse</i>	159	134	9,875	5,376	10,034	5,510	15,544

Data source:

1. MH: FY12 URS table 2A, 14A
2. SA: 2013 SABG Behavioral Health Report table 12

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### EBP Measures – SMI and SED Only

<u>Service</u>	<u>Youth</u>	<u>Adult</u>
<i>Multi-Systemic Therapy</i>	21	
<i>Supported Housing</i>		825
<i>Supported Employment</i>		716
<i>Assertive Community Treatment</i>		277
<i>Integrated Treatment for Co-occurring Disorders (MH/SA)</i>		426
<i>Medication Management</i>		6,427

Data source: FY12 URS table 16, 17

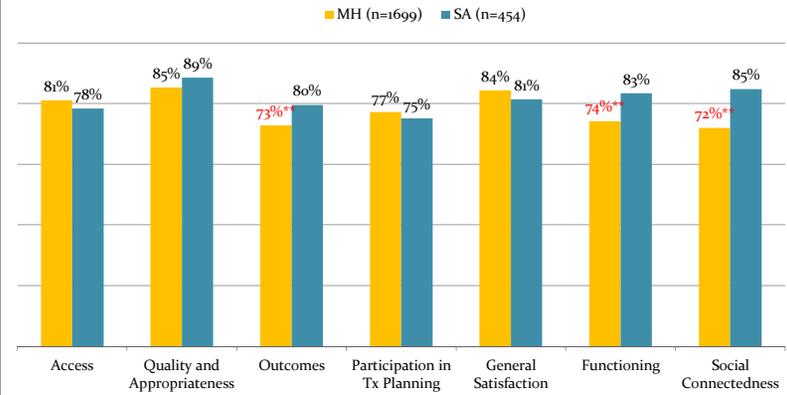
12

# Examples of Outcomes



13

## Consumer Survey Results - Adult



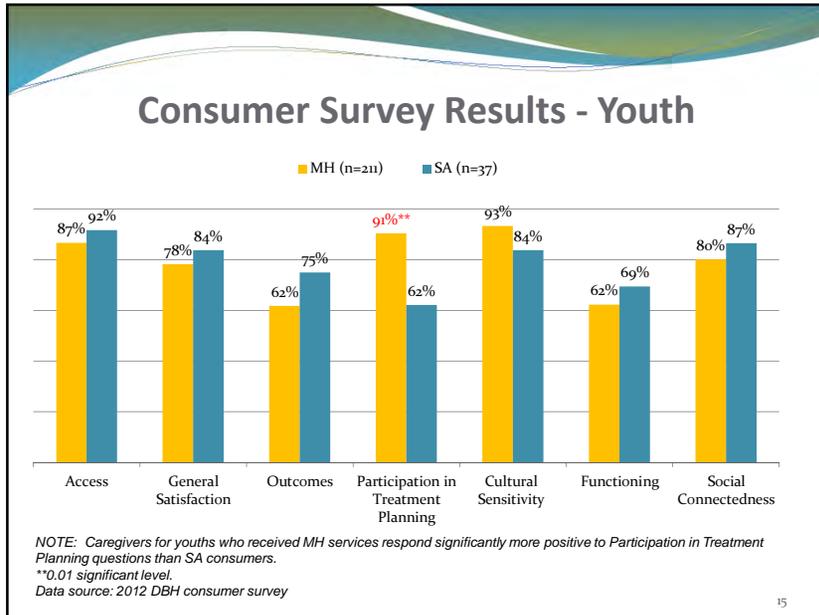
NOTE: Consumers who received SA services respond significantly more positive to Outcomes, Functioning, and Social Connectedness questions than MH consumers.

\*0.05 significant level.

\*\*0.01 significant level.

Data source: 2012 DBH consumer survey

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# Examples of Outcomes - MH

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### Readmission to Any State Psychiatric Inpatient Hospital Within 30/180 Days of Discharge

	Total number of Discharges in Year	Number of Readmissions to ANY STATE Hospital within		Percent Readmitted	
		30 days	180 days	30 days	180 days
Non-Forensic Patients	99	2	5	2.02%	5.05%
Forensic Patients	114	1	8	0.88%	7.02%

*\*NOTE: Readmission to Regional Center only. Forensic includes court-ordered and sex offenders from certain building locations.  
Data source: FY12 URS table 20A, 20B*

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### Readmission to Any State Psychiatric Inpatient Care Unit Within 30/180 Days of Discharge

	Total number of Discharges in Year	Number of Readmissions to ANY Psychiatric Inpatient Care Unit within		Percent Readmitted	
		30 days	180 days	30 days	180 days
Non-Forensic Patients	4,203	334	703	7.95%	16.73%

*\*NOTE: Readmission to Regional Center and hospitals.  
Data source: FY12 URS table 21*

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## Performance Indicators and Accomplishments - MH

	<u>% at T2</u>
<i>Employment of Those in Labor Force</i>	55.2%
<i>School Attendance (Youth under 18) - No Suspension or Expulsion</i>	78.2%
<i>Stability in Housing</i>	94.6%
<i>Criminal Justice – No Arrest</i>	96.9%

*Data source: FY2012 URS table 4, 15, 19a, 19b*

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## Examples of Outcomes - SA

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## Performance Indicators and Accomplishments - SA

<b>Intensive Outpatient</b>	<b>% at Admission</b>	<b>% at Discharge</b>
<i>Employment/Education</i>	35.6%	47.7%
<i>Stability of Housing</i>	96.3%	97.2%
<i>No Criminal Justice Involvement</i>	93.5%	97.4%
<i>Abstinence – Alcohol Use</i>	58.6%	87.5%
<i>Abstinence – Other Drug Use</i>	69.1%	86.5%

Data source: 2013 SABG Behavioral Health Report table 16 - 20

21

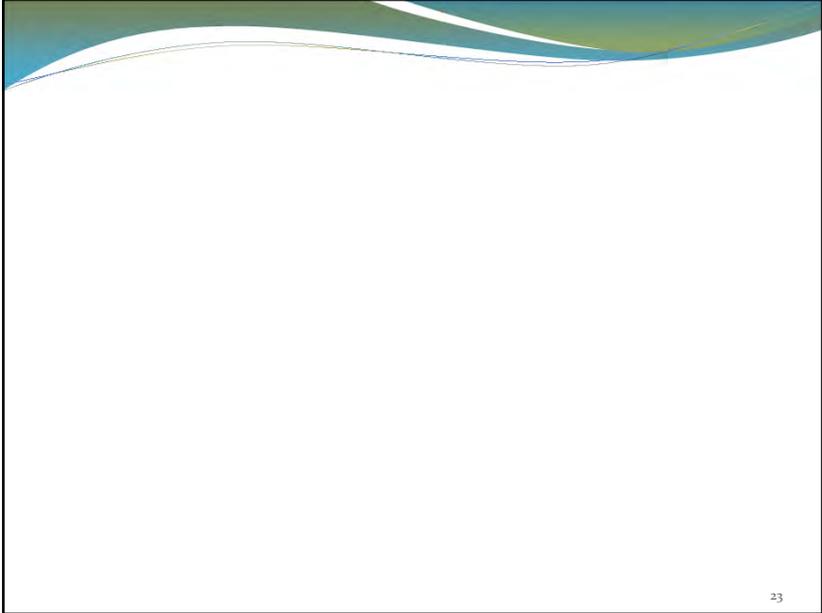
## Thank you!

Questions?  
Comments?  
Feedback?



Heather Wood, MS  
Quality Improvement and Data Performance Administrator  
Office Phone: (402) 471-1423  
Email: heather.wood@nebraska.gov





# Additional Examples by SA NOMs

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## Performance Indicators and Accomplishments - SA

<b>Employment/Education Status</b>	<b>% at Admission</b>	<b>% at Discharge</b>
<i>Short-term Residential</i>	12.9%	12.0%
<i>Long-term Residential</i>	10.8%	43.8%
<i>Outpatient</i>	43.8%	48.5%
<i>Intensive Outpatient</i>	35.6%	47.7%

*Data source: 2013 SABG Behavioral Health Report table 16  
NOTE: TEDS report include only SA services. All persons admitted AND discharged in CY12. (Excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated).*

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## Performance Indicators and Accomplishments – SA (Cont.)

<b>Stability of Housing</b>	<b>% at Admission</b>	<b>% at Discharge</b>
<i>Short-term Residential</i>	83.7%	87.9%
<i>Long-term Residential</i>	81.3%	76.6%
<i>Outpatient</i>	95.5%	96.5%
<i>Intensive Outpatient</i>	96.3%	97.2%

Data source: 2013 SABG Behavioral Health Report table 17

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## Performance Indicators and Accomplishments – SA (Cont.)

<b>No Criminal Justice Involvement</b>	<b>% at Admission</b>	<b>% at Discharge</b>
<i>Short-term Residential</i>	89.0%	97.9%
<i>Long-term Residential</i>	90.2%	96.5%
<i>Outpatient</i>	92.9%	95.9%
<i>Intensive Outpatient</i>	93.5%	97.4%

Data source: 2013 SABG Behavioral Health Report table 18

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## Performance Indicators and Accomplishments – SA (Cont.)

<b>Abstinence - Alcohol Use</b>	<b>% at Admission</b>	<b>% at Discharge</b>
<i>Short-term Residential</i>	30.1%	84.6%
<i>Long-term Residential</i>	64.5%	85.3%
<i>Outpatient</i>	66.8%	81.2%
<i>Intensive Outpatient</i>	58.6%	87.5%

Data source: 2013 SABG Behavioral Health Report table 19

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## Performance Indicators and Accomplishments – SA (Cont.)

<b>Abstinence - Other Drug Use</b>	<b>% at Admission</b>	<b>% at Discharge</b>
<i>Short-term Residential</i>	37.5%	82.4%
<i>Long-term Residential</i>	66.6%	85.9%
<i>Outpatient</i>	78.9%	85.8%
<i>Intensive Outpatient</i>	69.1%	86.5%

Data source: 2013 SABG Behavioral Health Report table 20

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Nebraska Division of Behavioral Health  
 § 71-814 | State Advisory Committee on Mental Health Services [MH]  
 § 71-815 | State Advisory Committee on Substance Abuse Services [SA]

## Meeting Schedule for 2013

Location: Country Inn and Suites, 5353 No. 27th Street, Lincoln, NE 68521

Time: 9:00 A.M. to 4:00 P.M.

<b>March 14, 2013</b>	SAMHSA Block Grant Plan and Application - Joint Session   MH & SA Review and Comment from the MH & SA - serving as <i>State Behavioral Health Advisory Council</i> per SAMHSA Block Grant requirements. Lincoln Room – All Day
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**Time: 9:00 A.M. to 1:00 P.M.**

**Joint Session | MH & SA  
 to address common concerns, joint conversations**

**Time: 1:00 P.M. to 4:00 P.M.**

**Separate MH & SA Committee Meetings  
 Opportunity for Committee Specific  
 Duties**

<b>June 11, 2013</b>	DBH Strategic Planning Event Lincoln Room – All Day Capitol Room 1-5 pm	Working Lunch	MH Advisory Committee (1-4 p.m.) SA Advisory Committee (1-4 p.m.)
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<b>September 19, 2013</b>	DBH Strategic Planning Event Lincoln Room – All Day Capitol Room 1-5 pm	Working Lunch	MH Advisory Committee (1-4 p.m.) SA Advisory Committee (1-4 p.m.)
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<b>November 14, 2013</b>	SAMHSA Block Grant Implementation Report Lincoln Room – All Day Capitol Room 1-5 pm	Working Lunch	MH Advisory Committee (1-4 p.m.) SA Advisory Committee (1-4 p.m.)
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**Working Lunch:** Lunch is served between 12:00 to 12:15. Thirty (30) minute program topics relevant to both MH & SA are done during lunch. Topics may include Regional Behavioral Health Authority presentations, report from Lincoln Medical Education Partnership (LMEP) on Training for Addiction Professionals (TAP), behavioral health videos, update from the State Epidemiological Outcome Workgroup (SEOW), and other related topics.





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



## 2014 and 2015 Uniform SAMHSA Block Grant Application

Substance Abuse and Mental Health Services Administration (SAMHSA)  
 - Community Mental Health Services Block Grant (MHBG) CFDA Number: 93.958  
 - Substance Abuse Prevention and Treatment Block Grant (SABG) CFDA Number: 93.959

Federal Register /Vol. 77, No. 196 /Wednesday, October 10, 2012  
 Uniform Application for the Mental Health Block Grant and Substance Abuse Block Grant  
 FY 2014–2015 Application Guidance and Instructions (OMB No. 0930–0168)— Revision

SAMHSA Block Grants <http://www.samhsa.gov/grants/blockgrant/>

### **SAMHSA – block grant funds to be directed toward four purposes:**

- 1) To fund priority treatment and support services for individuals without insurance or who cycle in and out of health insurance coverage;
- 2) To fund those priority treatment and support services not covered by Medicaid, Medicare or private insurance offered through the exchanges and that demonstrate success in improving outcomes and/or supporting recovery;
- 3) To fund universal, selective and targeted prevention activities and services; and
- 4) To collect performance and outcome data to determine the ongoing effectiveness of behavioral health prevention, treatment and recovery support services and to plan the implementation of new services on a nationwide basis.

### **Statutory Populations**

Community Mental Health Services Block Grant

- Adults with Serious Mental Illness (SMI)
- Children with Severe Emotional Disturbance (SED)

Substance Abuse Prevention & Treatment Block Grant

- Pregnant Injecting Drug Users
- Pregnant Substance Abusers
- Injecting Drug Users
- Women with Dependent Children

Plus: Substance Abusers infected with HIV or who have Tuberculosis (TB) ...  
 NE not a designated HIV state

### **NE Allocation under SAMHSA Block Grant**

Federal Fiscal Year	Mental Health	Substance Abuse	TOTAL
FY2010	\$1,943,546	\$7,920,131	\$9,863,677
FY2011	\$1,922,173	\$7,849,944	\$9,772,117
FY2012	\$2,079,360	\$7,833,059	\$9,912,419

Note: Division of Behavioral Health | FY13 Budget: \$162,750,652  
 SAMHSA percentage (%) of DBH Total Budget = 6%

## Uniform SAMHSA Block Grant Application | Behavioral Health Assessment & Plan

### A. Framework for Planning—Mental Health and Substance Abuse Prevention and Treatment Populations required to be included in the state's needs assessment for the MHBG or SABG.

Comprehensive community-based services for adults with SMI and children with SED:

- Children with SED and their families\*
- Adults with SMI\*
- Older Adults with SMI\*

Services for persons with or at risk of having substance use and/or mental disorders:

- Persons who are intravenous drug users (IDU)\*
- Women who are pregnant and have a substance use and/or mental disorder\*
- Parents with substance use and/or mental disorders who have dependent children\*

Services for persons with or at risk of contracting communicable diseases:

- Individuals with tuberculosis\*
- Persons living with or at risk for HIV/AIDS – This applies to States whose rate of AIDS is 10 or more per 100,000 individuals [NE is not an HIV state at 4.5].

[http://www.tie.samhsa.gov/HIV\\_Early\\_Intervention/index.html](http://www.tie.samhsa.gov/HIV_Early_Intervention/index.html)

### B. Planning Steps - For each of the populations and common areas, states should follow the planning steps outlined below:

- Step 1: Assess the strengths and needs of the service system to address the specific populations.
- Step 2: Identify the unmet service needs and critical gaps within the current system.
- Step 3: Prioritize state planning activities
- Step 4: Develop objectives, strategies, and performance indicators.

Targeted/required populations. Indicate the population(s) required in statute for each Block Grant as well as those populations encouraged:

- SMI—Adults with serious mental illness,
- SED—Children with a serious emotional disturbance,
- PWWDC—Pregnant women and women with dependent children,
- IVDU—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, and/or
- Other: Specify (Refer to section 3a of the Assessment and Plan).



# 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 provides leadership and resources for systems of care that promote and facilitate resilience and recovery for Nebraskans.

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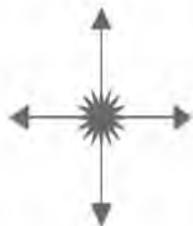
## 2011-2015 Goals:

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. The Division of Behavioral Health will use financing mechanisms which support innovative service content, technology and delivery structures (e.g., telehealth; in-home acute services; Peer Support Services).
3. The Division of Behavioral Health 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 - The Division Will:

- 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.



HELPING PEOPLE LIVE BETTER LIVES



# Block Grant Planning Steps – for discussion at the Joint Advisory Committee Meeting on November 8, 2012

## Step 1: Strengths and Needs of the Service System to Address Specific Populations

### *Profile of Individuals Receiving Service:*

- In FY2012, there were 23,535 individuals who were served in MH services and 15, 544 individuals who were served in SA services.
- There were 15, 092 adults served with SMI; 1,340 youth with SED. SMI and SED consumers received 8, 692 Evidence Based Practice services.
- The readmission rate to any state run psychiatric inpatient hospital is extremely low; only 2% within 30 days and 5% within 180 days for non-forensic and less than 1% within 30 days and 7% within 180 days for forensic.
- We have continued to experience an increase in our response rates to the annual consumer survey. 50% of adult consumers and youth caregivers surveyed provided feedback regarding their behavioral health care. A majority of adult consumers (83.6%) were generally satisfied with services compared to those who were dissatisfied with the services they received (6.5%); the remainder were neutral.
- In FY2011, employment for adult consumers in NE (in the labor force) was much higher than the national average (53% Nebraska vs. 35% US).
- There has been tremendous work and success toward the FY2012/2013 priorities. (See Block Grant – Priorities Handout).

## Step 2: Needs Assessment

### *Considerations related to current priorities:*

- The rate of underage drinking appears to be on the rise particularly for males. Recent Nebraska Young Adult Alcohol Opinion Survey results revealed that the rate of males ages 19 to 20 that binge drink is at 40% (FY2012); up from 26% just two years ago (FY2010). Additionally for this group, 78% showed an increase in their perception that there is little to no risk in binge drinking once or twice a week. National data shows that 56% of adolescents report using their first primary substance between 12 and 14.
- Consumers who report trauma continues to increase. 42% of individuals receiving services reported a history of trauma during FY2012 compared to 28% in FY2010. Nationally it is estimated that 55 to 99% of women in substance use treatment and from 85 to 95% of women in the public mental health system report a history of trauma. Trauma is now considered to be a near universal experience for those with behavioral health problems.
- The number of individuals served in both a mental health and substance abuse or dual service has risen to nearly 10% in FY2012. NAMI reports that roughly 50% of individuals with severe mental disorders are affected by substance abuse while 37% of alcohol abusers and 53% of drug abusers also have at least one serious mental illness. Comparison of FY2011 data shows that Nebraska has a higher than national rate of adults and children served who have co-occurring disorders (26% Nebraska vs. 21% US).

### *Additional Considerations:*

- The length of stay based on discharge data at LRC has increased from 2011 to 2012. A quality improvement initiative began in October 2012 to identify causes and make improvements.
- 2010 data shows that Nebraska tends to be consistent with the national average for serious thoughts of suicide in the general public (4% for both Nebraska and US). Research shows that more than 90% of patients who die by suicide have mental illnesses or substance use disorders. Both Whites and American Indian/Alaskan Natives have higher suicide rates than other racial groups. Rural areas have also have shown higher suicide rates than metropolitan areas.
- Homelessness in FY2011 was higher in Nebraska (5.1%) than the US average (3.1%). In FY2012, 5.8% receiving services reported homelessness.
- 40% of individuals served in FY2012 live in rural areas. National data suggests that rural admissions to behavioral health services are more likely to be referred by criminal justice and report alcohol as their primary substance.
- 6% served in FY2012 reported themselves as military personnel.
- When asked whether they smoke cigarettes on the 2012 consumer survey, 40% of mental health consumers indicate that they smoke every day. Likewise, 56% of consumers with substance use disorders report smoking every day. These numbers are compared to 15% of the NE general population who report daily smoking.
- Caregiver reports through the youth consumer survey show that in FY2011 67% were satisfied with access to services for NE youth compared to the US rate of 83%.

**Step 3: Prioritize State Planning Activities**

**Step 4: Develop Objectives, Strategies, and Performance Indicators**

Priority	Goal	Strategy & Performance Indicator

# How to Manage Trauma

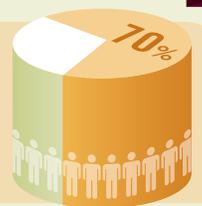
Trauma occurs when a person is overwhelmed by events or circumstances and responds with intense fear, horror, and helplessness. Extreme stress overwhelms the person's capacity to cope. There is a direct correlation between trauma and physical health conditions such as diabetes, COPD, heart disease, cancer, and high blood pressure.

## TRAUMA CAN STEM FROM



## HOW COMMON IS TRAUMA?

70% of adults in the U.S. have experienced some type of traumatic event at least once in their lives. That's **223.4 million people.**



**+90%**

In public behavioral health, **over 90%** of clients have experienced trauma.

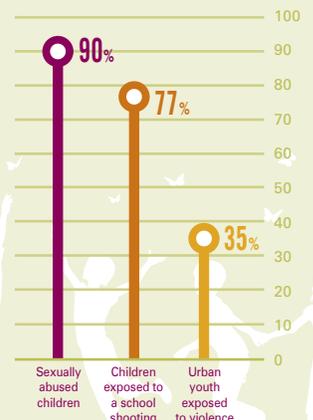
**Trauma is a risk factor** in nearly all behavioral health and substance use disorders.

In the United States, a woman is **beaten every 15 seconds**, a forcible rape occurs every 6 minutes.



More than **33% of youths** exposed to community violence will experience Post Traumatic Stress Disorder, a very severe reaction to traumatic events.

Nearly all children who witness a parental homicide or sexual assault will develop Post Traumatic Stress Disorder. Similarly, 90% of sexually abused children, 77% of children exposed to a school shooting, and 35% of urban youth exposed to community violence develop Post Traumatic Stress Disorder.



Post-traumatic stress disorder (PTSD) is a mental health condition that's triggered by a terrifying event. Symptoms may include flashbacks, nightmares and severe anxiety, as well as uncontrollable thoughts about the event.

*People can and do recover from trauma*



## SYMPTOMS OF TRAUMA CHECKLIST

- Headaches, backaches, stomachaches, etc.
- Sudden sweating and/or heart palpitations
- Changes in sleep patterns, appetite, interest in sex
- Constipation or diarrhea
- Easily startled by noises or unexpected touch
- More susceptible to colds and illnesses
- Increased use of alcohol or drugs and/or overeating
- Fear, depression, anxiety
- Outbursts of anger or rage
- Emotional swings
- Nightmares and flashbacks — re-experiencing the trauma
- Tendency to isolate oneself or feelings of detachment
- Difficulty trusting and/or feelings of betrayal
- Self-blame, survivor guilt, or shame
- Diminished interest in everyday activities

## HOW TO TALK TO YOUR DOCTOR

- Make your doctor aware that you have experienced trauma, past or recent
- Help them understand what is helpful to you during office visits, i.e., asking permission to do a procedure, staying as clothed as possible, explaining procedures thoroughly, or having a supporter stay in the room with you
- Ask for referrals to therapy and behavioral health support



## HELPFUL COPING STRATEGIES

- Acknowledge that you have been through traumatic events
- Connect with others, especially those who may have shared the stressful event or experienced other trauma
- Exercise — try jogging, aerobics, bicycling, or walking
- Relax — try yoga, stretching, massage, meditation, deep muscle relaxation, etc.
- Take up music, art, or other diversions
- Maintain balanced diet and sleep cycle
- Avoid over-using stimulants like caffeine, sugar, or nicotine
- Commit to something personally meaningful and important every day
- Write about your experience for yourself or to share with others

## ASK YOUR HEALTHCARE PROFESSIONAL ABOUT TREATMENTS

### TRADITIONAL TREATMENTS

Cognitive Behavioral Therapy  
Eye Movement Desensitization and Reprocessing (EMDR) Therapy  
Talk Therapy  
Exposure Therapy  
Group Therapy

### ALTERNATIVE TREATMENTS

Energy Processing  
Hypnotherapy  
Neuro-Linguistic Programming  
Massage Therapy  
Pet or Equine Therapy  
Trauma and Recovery Peer Support Groups  
Wellness Recovery Action Planning (WRAP)



This organization is a proud member of the National Council Trauma-informed Care Learning Community



**NATIONAL COUNCIL**  
FOR COMMUNITY BEHAVIORAL HEALTHCARE



For more information, interviews, and research on trauma check out the National Council's magazine edition on the topic

[www.TheNationalCouncil.org](http://www.TheNationalCouncil.org)