

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

September 6, 2012 / 9:00 am – 3:00 pm
Country Inn & Suites, Lincoln, NE

Meeting Minutes

I. Call to Order and Roll Call

Randy See

Jim Harvey, Division of Behavioral Health Committee Facilitator, welcomed everyone to the meeting. He explained the Chairperson, Ann Ebsen, will arrive later in the morning due to work commitments, and the Vice Chairperson, Brenda Miner, is no longer a member of the Committee, therefore the Second Vice Chairperson, Randy See, will conduct the meeting business until Ann Ebsen arrives. Second Vice Chairperson, Randy See, called the meeting to order at 9:02 AM, on Thursday, September 6, 2012. Roll call was conducted and quorum determined.

Committee Members Present: Sheri Dawson, Ann Ebsen, Ingrid Gansebom, Jay Jackson, Janet Johnson, Cody Manthei, Delinda Mercer, Michael Phillips, Randy See, Jorge Rodriguez-Sierra

Committee Members Absent: Corey Brockway, Debra Shoemaker

DHHS Staff Attending: Jim Harvey, Nancy Heller, Scot Adams, Carol Coussons de Reyes, Suzanne Eggert, Renee Faber, Karen Harker, Blaine Shaffer, Chelsea Taylor, and Heather Wood

II. Housekeeping and Summary of the Agenda

Jim Harvey

Jim Harvey provided an orientation to the building facilities, explained lunch plans, and confirmed the order of the agenda. New committee members were welcomed and all committee members introduced themselves.

III. Approval of Minutes

Randy See

Randy See requested a motion to approve the minutes. Motion was made by Jorge Rodriguez-Sierra and seconded by Delinda Mercer to approve the May 3, 2012 minutes of the Joint Meeting of the State Advisory Committee on Mental Health Services, the State Advisory Committee on Substance Abuse Services, and the State Committee on Problem Gambling. The motion carried.

Voting Yea: Sheri Dawson, Ingrid Gansebom, Jay Jackson, Janet Johnson, Cody Manthei, Delinda Mercer, Michael Phillips, Randy See, Jorge Rodriguez-Sierra.

Voting Nay: None.

IV. Public comment

a) None

V. DBH Committees – Feedback Survey Results

Cody R. Meyer

(Attachment A)

Cody R. Meyer is a Statistical Analyst with the Data Section of the DHHS-Division of Behavioral Health. Cody thanked the committee for participating in the 2012 Advisory Committee Survey. The results of the survey were reviewed. Overall, positive responses were received. This survey served as a baseline, and future surveys will indicated trends and determine the need for appropriate action.

Committee comments included: consider including committee members that match the changing population of Nebraska, such as growing Hispanic population; balancing urban, rural, and frontier backgrounds; more clearly defining the role of the committee and committee members; provide more cross-education between all three State Advisory Committees; holding Joint Advisory Committee meetings, while maintaining the identity of each committee.

VI. Update on EBP Workgroup

Blaine Shaffer

(Attachment B)

Blaine Shaffer is the Chief Clinical Officer with the DHHS-Division of Behavioral Health. He provided a brief update on the work of the Evidence Based Practices (EBP) Workgroup. The purpose of the workgroup is primarily to develop and clarify a process by which fidelity of behavioral health services is monitored. The information received from fidelity monitoring is reported to the federal government as part of Block Grant fund monitoring. Fidelity monitoring is necessary to ensure the State is getting the necessary services outcomes for the funding received.

VII. DBH Strategic Plan

Scot Adams

Scot Adams is the Director of the DHHS-Division of Behavioral Health. The Division of Behavioral Health Strategic Plan covers the timeframe of 2011 through 2015. We are one-third of the way through the Strategic Plan period. A mid-term report is due to the Unicameral in September, and will be posted on the DBH website, and copies will be sent to all Advisory Committee members. Scot reported the federal agency, Substance Abuse and Mental Health Services Administration (SAMHSA), recently reported concerns related to increased prescription drug abuse as one of the most rapidly growing issues of drug abuse. Scot reported another growing concern of over-prescribing psychotropic medications for State Wards receiving Medicaid services. Scot discussed the national Health Care Reform Act and its implications for DBH. Scot asked committee members to pay attention to issues not stated in the mid-term report that are important and need to be addressed.

Committee comments included: Depending on the outcome of Health Care Reform and funding changes, DBH should consider spending additional funds on workforce development; is it possible for Legislative Committee Chairpersons of the Health and Human Services, Appropriations, and Criminal Justice Committees to attend an Advisory Committee meeting; recommend DHHS provide an update on key Legislative issues.

VIII. Community Corrections Conference & BH Inmates in State Correctional System

Jim Harvey

(Attachment C and Attachment D)

Jim Harvey, DBH Federal Resources Manager, provided a Save-the-Date handout on the 2012 Community Corrections Conference October 15-17 at the Ramada Inn and Convention Center in Kearney, Nebraska. Jim announced the Community Corrections Division within the Nebraska Commission on Law Enforcement is the former Community Corrections Council.

Jim reviewed the handout prepared by Cameron White, Behavioral Health Administrator at the NE Department of Correctional Services (DCS) and member of the State Advisory Committee on Mental Health Services. Discussion on Sex Offender Commitment Act and Sex Offender Treatment resulted from information presented in Table 4—Number of Sex Offenders Released and Recommended for Civil Commitment in FY2012.

IX. Peer Support Roles, paid versus not paid - Discussion

Carol Coussons de Reyes

(Attachment E and Attachment F and Attachment G)

Carol Coussons de Reyes is the Administrator of the Office of Consumer Affairs (OCA). Carol invited Committee members to participate in two upcoming events. A Proclamation signing for Alcohol and Drug Abuse Recovery month are September 13th at 10:30 AM in the State Capitol Building-Warner Chamber, and the 10th Annual Recovery Rally is September 23rd from 1:00 PM to 3:00 PM at Antelope Park in Lincoln.

Carol reports there is both paid and not paid Peer Support, and both are important. Some peers choose to volunteer versus seeking paid positions. Peer Support staff help with a variety of issues because recovery has many roads and there is not one way for everyone. Recovery varies for each individual according to their need. Peer Support and Wellness Specialists can be utilized in addition to the traditional 12-Step Model of Alcohol Anonymous. Peer Support positions are utilized in Wellness

Coaching, in Health Homes, and in Federally Qualified Health Centers. Some addiction related peer support services are Medicaid billable.

Committee comments included: Individuals who recovered through Alcoholics Anonymous understand the need for paid Peer Support; concern about burnout if peers are overloaded; a level of professionalism is achieved with certification and training; need to stay true to the fidelity of Peer Support (don't dilute the concept with issue about paid versus not paid); consumer operated services are important to move forward as a State especially in rural and frontier counties with a limited workforce; the first peer-run services paid for with State funds were Halfway Houses for substance abuse; there is a need to get the word about peer-run services; peer support used to be a blanket term for technicians, line staff, etc.; concern about paying Peer Support staff when Provisionally Licensed Mental Health Practitioners are not Medicaid billable; concern that if the peer specialist role is not clearly defined, Peer Specialists will erroneously be placed into roles trained professionals should be directing but it's cheaper labor than a licensed counselor; desire the Peer Specialist role to be clarified so professional counselors don't expect more than the Peer Specialist can offer, as well as the Peer Specialist having a clear understanding of their role and function; trained professional peers are not allowed to sponsor others in Alcoholics Anonymous because it is considered a dual relationship; who supervises Peer Support staff? (DHHS responded that the OCA workforce is bound by a Code of Ethics and participates in co-supervision with peers and through the OCA; the OCA is willing to meet with employers and employees to discuss the role of Peer Support); there is a need to ensure everyone involved understands the role and function of Peer Support.

X. Substance Abuse Prevention

Renee Faber

(Attachment H and Attachment I)

Renee Faber is the DBH Prevention Coordinator. Renee discussed information related to the overarching Prevention goal of preventing and reducing a wide range of substance use behaviors including: underage drinking, binge drinking, prescription drug abuse, marijuana use, and illegal sale of tobacco products to minors. Renee reported Nebraska applied for a new grant, the Strategic Prevention Framework (SPF)-Partnerships for Success II (PFS II). It is a three-year grant for \$600,000 each year to address underage drinking among persons aged 12 to 20 and prescription drug misuse and abuse among persons aged 12 to 25. Renee reported marijuana use data shows a slight decrease while national use data shows an increase. The prevention focus for marijuana is mostly on education to decrease use and decrease the number of people trying it for the first time. Renee discussed Mental Health Promotion is an initiative to link prevention with positive image and healthy behaviors. As the SPF Grant ends, the Advisory Council will also end.

Committee recommendations included: Motion was made by Ann Ebsen and seconded by Jorge Rodriguez-Sierra that the State Advisory Committee on Substance Abuse Services supports the creation of a Substance Abuse Prevention Advisory Sub-Committee or Adjunct Committee. The motion carried. Voting Yea: Sheri Dawson, Ann Ebsen, Ingrid Gansebom, Jay Jackson, Janet Johnson, Cody Manthei, Delinda Mercer, Michael Phillips, Randy See, and Jorge Rodriguez-Sierra.

Voting Nay: None

The last meeting of Nebraska Partners in Prevention (NePip) is Tuesday, September 11, 2012 from 10:00 AM to 2:00 PM at the Cornhusker Hotel.

Renee provided the Committee with a Draft of the Prevention Statewide Strategic Plan and asked members to e-mail her with any recommendations and/or questions.

Committee comments included: change wording on the first slide on page 12 of the handout—the focus is not to increase the perception of harm associated with marijuana, but to increase the knowledge that marijuana use is harmful; not aware of billboards related to marijuana prevention (DHHS response: because the focus is mostly on education, the information is in the school system and on the Coalitions' websites; also it is driven by funding); DHHS needs to do more to decrease the use of marijuana due to health effects, and the mixed message of medical marijuana use; some school

systems in Nebraska are doing random drug tests for students participating in extra-curricular activities; drug testing creates a concern for an underfunded system for treatment;

XI. SAMHSA Block Grant – review of the Priority Indicators & Budget

Jim Harvey

(Attachment J and Attachment K and Attachment L and Attachment M and Attachment N)

--Jim Harvey reviewed the SAMHSA Block Grant 2011 – 2013 priorities (Table 3 Step 4: Objectives, Strategies and Performance Indicators).

--Renee Faber reviewed the Prevention priorities during her presentation on Substance Abuse Prevention (see Section X. of this document).

--Carol Coussons de Reyes reviewed the Draft definitions of Peer-Run and Peer Recovery/Resiliency Supports. Carol announced statewide training on the Transition to Independence Process (TIP) Model used for Transition Age Youth will be held in October. Carol explained some of the criteria for the Child services are being revised to reflect the clinical supervision requirement.

Committee comments included: For Adult services, adjust criteria 3--may or may not have Clinical Supervision--for Peer Recovery Support for an Adult and for Family-Peer Resiliency Supports for a Child. (DBH response: This revised definition will be used to determine the count of programs meeting criteria.)

Committee recommendations included: Motion was made by Ann Ebsen and seconded by Jay Jackson to agree the count will be done by the Division of Behavioral Health Data Team based on the definitions per the Peer-Run and Peer Recovery/Resiliency Supports Draft document. The motion carried.

Voting Yea: Sheri Dawson, Ann Ebsen, Ingrid Gansebom, Jay Jackson, Janet Johnson, Cody Manthei, Delinda Mercer, Michael Phillips, Randy See, Jorge Rodriguez-Sierra

Voting Nay: None.

--Sheri Dawson, DBH Deputy Director, explained that Transition Age Youth (TAY) and Young Adult are included in Block Grant performance indicators because DBH has initiatives funded for TAY.

--Heather Wood, DBH Quality Improvement and Data Administrator, explained DBH partnered with nursing students from the University of Nebraska Medical Center to review Wrap Around Fidelity in the Professional Partners Program. Not all Behavioral Health Regions were using the Wraparound Fidelity Instrument (WFI) 4.0. All Regions will implement WFI 4.0 and will report using it in FY13.

--Sheri Dawson explained some DBH funded Substance Abuse services are Dual Capable, some are Dual Enhanced, and some are Substance Abuse treatment only. Training was conducted on the COMPASS-EZ tool which will be used in the Quality Improvement framework to determine how capable providers are to serve individuals in a Co-Occurring manner.

--Sheri Dawson explained the Trauma Informed Care (TIC) tool determines how trauma informed a service is. It will be used at both the agency level and the State level to measure the level of being trauma informed and will provide a baseline for becoming fully trauma informed. Trauma Informed is the practice of providing a welcoming environment to individuals affected by a variety of traumatic events.

--Jim Harvey explained the Block Grant performance indicator and goal is to define what Permanent Supportive Housing (PSH) in Nebraska is and to improve services related to PSH. Currently, Housing Related Assistance (HRA) Program is the PSH service.

--Jim Harvey stated the challenge for Supported Employment (SE) is which Fidelity Monitoring Tool to use—the Dartmouth Individual Placement and Support (IPS) or the SAMHSA Evidence-Based Practice Toolkit. The IPS is newer and more sophisticated and is Evidence-Based.

--Jim Harvey explained information on Intravenous Drug Abusers and Tuberculosis is required. These items reflect Substance Abuse Prevention & Treatment Block Grant priorities.

--Karen Harker, DBH Fiscal and Federal Resources Administrator, explained the DBH goal is to use Block Grant funds the most cost effectively as possible. Last year, a two-year budget plan was submitted with the combined Substance Abuse Prevention and Treatment and Community Mental Health Services Block Grant Application. The two-year budget is a projection of dollars spent on treatment, primary

prevention, and administration. The Block Grant also requires DBH to report how much of the funding is spent on various categories. This includes not only Block Grant funds, but also State dollars. In addition, DBH is required to use 20% of the Block Grant funds for primary prevention and report on projected spending by prevention strategy and what populations are reached by each strategy.

XI. Public comment

- a) None

XII. Committee recommendations and comments

Committee Members

Committee comments included:

- a) DBH inform the Committee on Legislation for the upcoming session.
- b) DBH update the Committee at the March, 2013 meeting on Legislation related to DHHS and DBH.
- c) DBH consider inviting the Nebraska Association of Behavioral Health Organizations (NABHO) to a future meeting to discuss their function.

XIII. Items for next agenda

Committee Members

- a) Thomas Pristow, DHHS-Children and Family Services Director
- b) Block Grant Implementation Report
- c) Peer Support continued discussion
- d) Election of Officers
- e) 2013 Meeting Schedule

XIV. Adjournment and next meeting

- Motion to adjourn the meeting was made by Randy See and seconded by Ingrid Gansebom. The motion carried and the meeting was adjourned at 3:15 PM.
- The next meeting of the Joint Committee of the State Advisory Committee on Substance Abuse Services and the State Advisory Committee on Mental Health Services is scheduled for Thursday, November 8, 2012 from 9:00 AM to 4:00 PM at the Country Inn & Suites in Lincoln, NE.

State Advisory Committee on Substance Abuse – 2012 Survey Results

Cody Meyer – Statistical Analyst II-Division of Behavioral Health
September 6, 2012

Department of Health & Human Services

 N E B R A S K A
 Division of Behavioral Health

About the Survey...

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

Which advisory committee are you currently a member of?		
Mental Health	17	54.84%
Substance Abuse	10	32.26%
Problem Gambling	4	12.90%

State Advisory Committee Survey

This survey is designed to better understand the way in which our advisory committees function. As a committee member, your participation in this survey is highly valued. We thank you in advance for your time!

Please indicate "Yes" or "No" to the following statements. Mark only one response per statement.

1. What was the ORIGINAL reason(s) you sought appointment to this advisory committee?

YES NO

I have expertise regarding behavioral health services.

I was specifically asked to consider becoming a committee member.

It gives me a feeling of accomplishment.

It supports my personal interests.

To improve the quality of life for consumers.

To be a voice for consumers and promote their interests.

To improve consumer access to services.

To improve behavioral health services.

To provide assistance and recommendations to the Division of Behavioral Health.

To evaluate organized peer support services.

To promote peer support services.

It supports my professional development.

Other: if yes to above Questions, please specify:

2. Which advisory committee are you currently a member of?

Mental Health Substance Abuse Problem Gambling

3. How long have you been a member of this committee?

Less than a year 1-2 years 3-4 years 5 years or more

4. What, if any, are your suggestions for improving committee effectiveness?

Please continue to back page → → →

Thank you for your participation! We appreciate your help!

Please indicate your level of agreement by marking one response for each of the following statements.

	Completely Agree	Mostly Agree	Slightly Agree	Slightly Disagree	Mostly Disagree	Completely Disagree
I understand the purpose of this committee.	<input type="radio"/>					
I understand the statutes and bylaws governing this committee.	<input type="radio"/>					
I understand my responsibilities as a member of this committee.	<input type="radio"/>					
There is sufficient diversity amongst the members in terms of voices being represented.	<input type="radio"/>					
Roles of each committee members are clearly defined.	<input type="radio"/>					
I am knowledgeable about behavioral health service programs.	<input type="radio"/>					
I follow trends and important developments related to my committee.	<input type="radio"/>					
I attend the committee meetings regularly.	<input type="radio"/>					
I prepare for committee meetings in advance.	<input type="radio"/>					
Materials are distributed sufficiently in advance of committee meetings.	<input type="radio"/>					
Meeting agendas are clear.	<input type="radio"/>					
The meetings are conducted according to the agenda.	<input type="radio"/>					
Meetings start and end on time.	<input type="radio"/>					
The meetings allow ample time for discussion.	<input type="radio"/>					
I feel free to voice my opinion even if I may be the minority vote.	<input type="radio"/>					
The public comment periods provide valuable information.	<input type="radio"/>					
The committee uses data to inform any recommendations provided.	<input type="radio"/>					
Recommendations are made with equal input from committee members.	<input type="radio"/>					
Recommendations are made with mutual understanding.	<input type="radio"/>					
Recommendations are made respectfully.	<input type="radio"/>					
The minutes reflect a summary of attendance, matters discussed, voting outcomes, and recommendations.	<input type="radio"/>					
The committee has a process for handling any urgent matters between meetings.	<input type="radio"/>					
The committee accomplishes its intended purpose.	<input type="radio"/>					
I value being able to serve on this committee.	<input type="radio"/>					
I would be willing to do more for my committee if asked.	<input type="radio"/>					

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

Substance Abuse Advisory Committee ***Combined results – all committees

Reason	No	Yes	Missing / Not Marked
I was specifically asked to consider becoming a committee member	0 (0%) (9.7%)	10 (100%) (90.3%)	0 (0)
To improve the quality of life for consumers	0 (0%) (0%)	9 (100%) (100%)	1 (3)
To improve behavioral health services	0 (0%) (3.4%)	9 (100%) (96.6%)	1 (2)
To improve consumer access to services	0 (0%) (3.8%)	8 (100%) (96.2%)	2 (5)
It supports my personal interests	0 (0%) (8%)	8 (100%) (92%)	2 (6)
To provide assistance and recommendations to the Division of Behavioral Health.	1 (12.5%) (3.7%)	7 (87.5%) (96.3%)	2 (4)

Note: %s reflect only valid cases (i.e. "Missing / Not Marked" responses are not calculated in the %s)

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

Substance Abuse Advisory Committee ***Combined results – all committees

Reason	No	Yes	Missing / Not Marked
To be a voice for consumers and promote their interests	1 (12.5%) (11.5%)	7 (87.5%) (88.5%)	2 (5)
It gives me a feeling of accomplishment	1 (12.5%) (20.8%)	7 (87.5%) (79.2%)	2 (7)
It supports my professional development	1 (12.5%) (32%)	7 (87.5%) (68%)	2 (6)
I have expertise regarding behavioral health services	2 (22.2%) (24.1%)	7 (77.8%) (75.9%)	1 (2)
To evaluate organized peer support services	6 (75%) (57.7%)	2 (25%) (42.3%)	2 (5)
To promote peer support services	7 (87.5%) (53.8%)	1 (12.5%) (46.2%)	2 (5)

Descriptive Statistics

- 25 items. Respondents were asked to indicate their agreement / disagreement to several statements
- Responses options: Likert scale (1-6). Responses were coded so that higher values indicate greater agreement

Completely Disagree = 1

Mostly Disagree = 2

Slightly Disagree = 3

Slightly Agree = 4

Mostly Agree = 5

Completely Agree = 6

Descriptive Statistics

*** Combined averages (all 3 committees) in red

	N	Min.	Max.	Mean
The meetings are conducted according to the agenda	10	5	6	5.9 (5.77)
The minutes reflect a summary of attendance, matters discussed, voting outcomes, and recommendations	10	5	6	5.9 (5.61)
Meetings start and end on time	10	5	6	5.8 (5.81)
I value being able to serve on this committee	10	5	6	5.8 (5.6)
I feel free to voice my opinion even if I may be the minority vote	10	5	6	5.8 (5.57)
There is sufficient diversity amongst the members in terms of voices being represented	10	5	6	5.7 (5.16)
Recommendations are made respectfully	10	5	6	5.7 (5.52)
Meeting agendas are clear	10	5	6	5.7 (5.43)

*Note: Highest average level of agreement (on 6-point scale).

Descriptive Statistics

*** Combined averages (all 3 committees) in red

	N	Min.	Max.	Mean
I attend the committee meetings regularly	10	5	6	5.6 (5.58)
I understand the purpose of this committee	10	5	6	5.5 (5.39)
I understand my responsibilities as a member of this committee	9	5	6	5.44 (5.27)
The committee accomplishes its intended purpose	10	5	6	5.4 (5.39)
Materials are distributed sufficiently in advance of the committee meetings	10	5	6	5.3 (5.26)
Recommendations are made with mutual understanding	10	4	6	5.3 (5.03)
The meetings allow ample time for discussion	10	3	6	5.2 (5.26)
The committee uses data to inform any recommendations provided	10	5	6	5.2 (5.1)

Descriptive Statistics

*** Combined averages (all 3 committees) in red

	N	Min.	Max.	Mean
I prepare for committee meetings in advance	10	5	6	5.2 (5.06)
I would be willing to do more for my committee if asked	10	4	6	5.1 (5.23)
I am knowledgeable about behavioral health service programs	10	4	6	5.1 (5.16)
I follow trends and important developments related to my committee	10	4	6	5.0 (5.13)
Recommendations are made with equal input from committee members	10	3	6	5.0 (5.06)
I understand the statutes and bylaws governing this committee	10	4	6	5.0 (5.0)
The committee has a process for handling any urgent matters between meetings	10	4	6	5.0 (4.64)
The public comment periods provide valuable information	10	3	6	4.8 (5.32)
Roles of each committee member are clearly defined	10	3	6	4.7 (4.87)

- Note 23 out of 25 (92%) items have an average agreement of at least 5 on a 6-point scale.

Suggestions from Committee to Improve Effectiveness – General Themes

- Committee members expressed interest in continued “cross-education” among all 3 Advisory Committees.
- Efforts should be made to clearly define the roles of each committee member.
- It was suggested to make the Committee meetings available by teleconference / webinar / other “distance-related” methods (Options will need to ensure compliance with the open meetings act).

DBH Questions for Discussion

- Does the information presented here generate additional questions? Items that should be addressed.
- Suggestions for frequency of survey administration...(annually? every 2 years?)
- Questions about the survey design or data analysis.

Thank you!

Questions?

Comments?

Feedback?

Please contact Cody Meyer:

Cody.r.meyer@nebraska.gov

402-471-7766

Or Heather Wood

Heather.Wood@nebraska.gov

402-471-1423



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

Report to State Advisory Committee on Substance Abuse Services (§71-815)
From: Blaine Shaffer, M. D., Chief Clinical Officer
Division of Behavioral Health (DBH) – Nebraska Department of Health & Human Services
September 6, 2012

EBP Workgroup Charge

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

SAMHSA Evidence Based Practices (EBP) Kits

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

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

Meeting Schedule

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

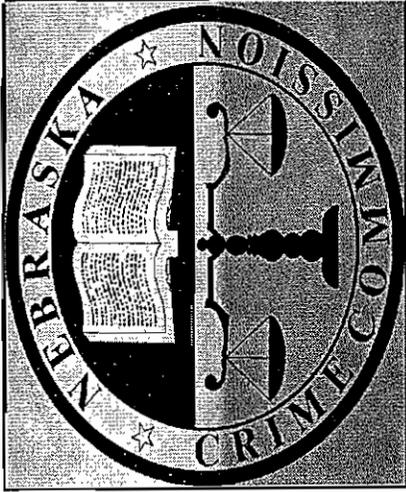
March 1, 2012	orientation to the task assigned to the EBP Workgroup
April 5, 2012	reviewed and discussed the EBP Workgroup assigned questions.
May 10, 2012	focus on Supported Employment (SE)*
June 21, 2012	focus on Permanent Supportive Housing (PSH)*
September 7, 2012	focus on Assertive Community Treatment (ACT)*
September 25, 2012	focus on MedTEAM (Medication Treatment, Evaluation, and Management)*

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

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

DBH Advisory Committees – Consumer Representation

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



Save the Date

October 15 - 17, 2012

Ramada Inn and Convention Center, Kearney, NE

2012 Community Corrections Conference

From Arrest to Re-Entry:

Evidence based decision making across criminal justice and behavioral health systems

Up to 10 hours of continuing education credit will be available for behavioral health treatment providers, including criminogenic training for registered providers

For registration, schedule and curriculum information please visit our website:

<http://portal.ncc.ne.gov/ccc/register/>

For all other inquiries, please contact:

Jeff Beaty
402-471-2259
Jeffry.beaty@nebraska.gov

Sponsored by the Community Corrections Division of the Nebraska Commission on Law Enforcement and Criminal Justice in collaboration with the Office of Probation Administration, the Department of Correctional Services, the Board of Parole, the Division of Behavioral Health, Region V Systems and the Nebraska State Patrol.

Behavioral Health Inmates in the State Correctional System FY 2012

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

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

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

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

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

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

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

	FY2005		FY2006		FY2007		FY2008	
Number of inmates with mental illness	341	16%	645	25%	768	31%	949	40%
Total Intakes	2,121		2,583		2,447		2,379	
	FY2009		FY2010		FY 2011		FY 2012	
Number of inmates with mental illness	656	29%	843	35%	824	32%	851	30%
Total Intakes	2,289		2,418		2,573		2,794	

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

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

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

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

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

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

	FY2005		FY2006		FY2007		FY2008	
Inmate population with a substance abuse or dependence diagnosis	1,743	82%	1,372	89%	1,782	86%	1,741	89%
Number of inmates screened	2,121		1,538		2,081		1,967	
	FY2009		FY2010		FY2011		FY2012	
Inmate population with a substance abuse or dependence diagnosis	1,496	78.6%	1,477	76%	1,666	77%	1,430	76%
Number of inmates screened	1,903		1,955		2,175		1,874	

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

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

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

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

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

Guide to Discussion on Peer Support

1. Paid Peer Support and Unpaid Peer Support

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

10 GUIDING PRINCIPLES OF RECOVERY

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

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

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

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

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

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

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

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

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

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

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

DEFINITION

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

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

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

Health

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

Home

A stable and safe place to live

Purpose

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

Community

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

SAMHSA'S WORKING DEFINITION OF RECOVERY

BACKGROUND

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

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

10 GUIDING PRINCIPLES OF RECOVERY

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

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



Substance Abuse and Mental Health Services Administration



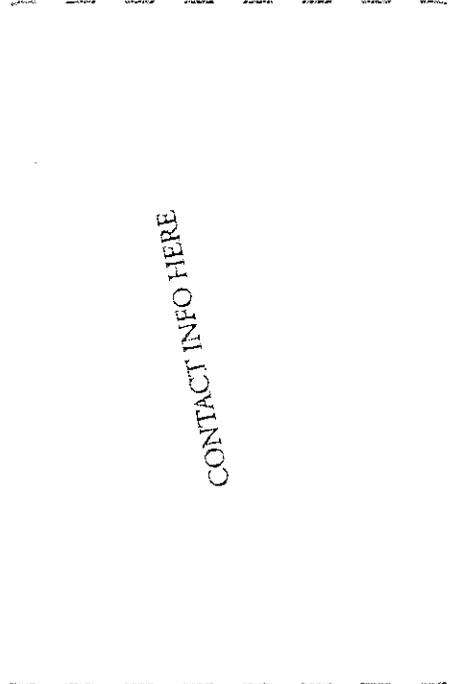
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

Consumer-Operated Services



*Recovery is real.
Claim it for yourself.*

Consumer-Operated Services Works!



CONTACT INFO HERE



EVIDENCE-BASED PRACTICES

KIT

Knowledge Informing Transformation

This document was prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA) by Associates, Inc. and Advocates for Human Potential, Inc., under contract number 280-2003-00020 and Work order contract number 270-03-6005 with SAMHSA, U.S. Department of Health and Human Services (HHS). Pamela Fischer, Ph.D., served as the Government Project Officer.

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

What are Consumer-Operated Services?



How do Consumer-Operated Services Help People?

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

What Makes Consumer-Operated Services Unique?

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

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

What services are offered?

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

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

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

DBH Prevention System FY12 Update

Presented by Renee Faber
Prevention Coordinator
September 7, 2012



Today's Overview:

- *Goals & Indicators (Includes Synar)*
- *SPF-PFS II Prevention grant application*
- *Prevention Strategic Plan
(Includes Marijuana & Prescription Drugs)*
- *Mental Health Prevention and Promotion*



Combined Block
Grant Application
2011-2013

Goals & Indicators

Priority #1 Prevention

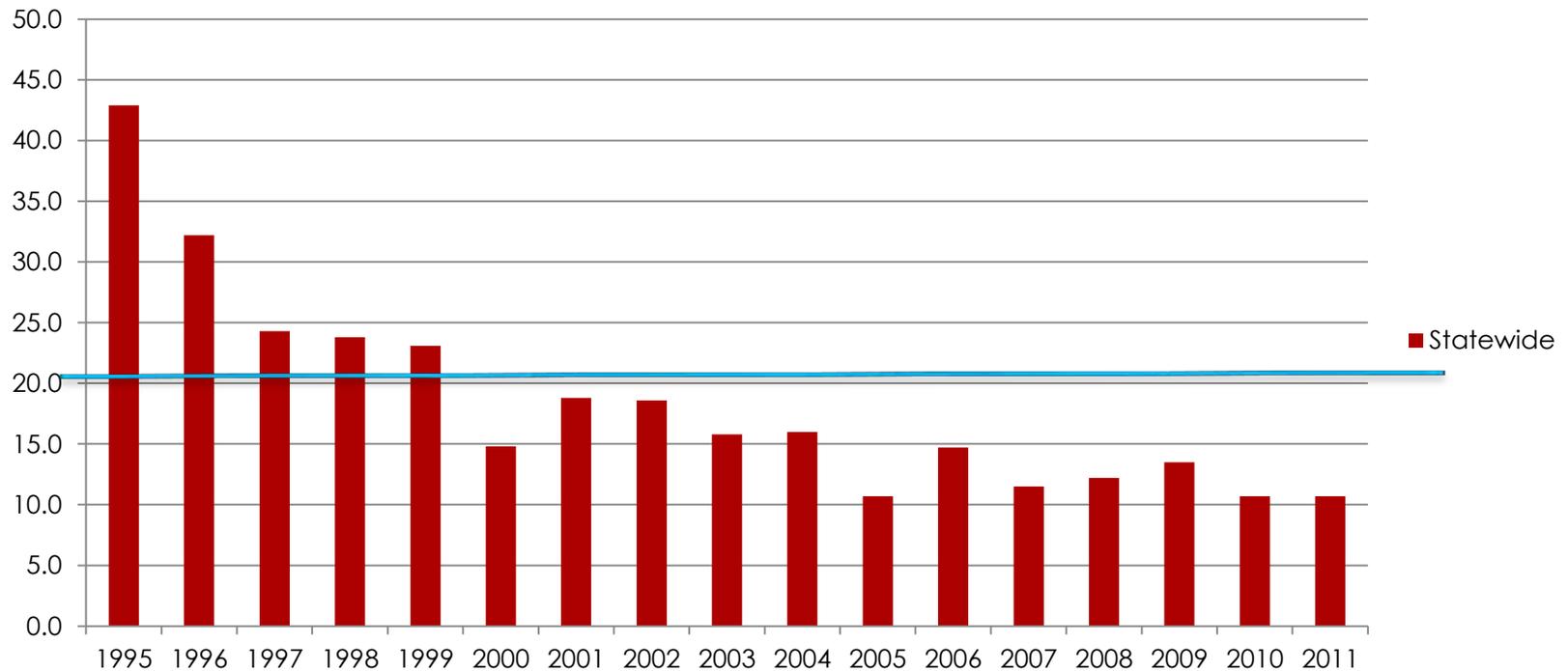
- To Complete a Strategic Plan for Prevention.
- Indicator: Finalize by 9-30-12.
 - Draft is out for review.

Priority #1 Prevention

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

Reduce the Sale of Tobacco to Youth

Nebraska's Statewide RVR for 17 years



Priority #1 Prevention

- Reduce Underage Drinking and Excessive Drinking by Adults through the use of Environmental Strategies.

- Indicator:

A total of 28 Environmental Activities were performed in FY11.

- This number was 87 for FY12!

Why Environmental Strategies?

- In a community these seek:

1. To bring about system-level change (physical space, local community policies, availability of drugs and alcohol, etc.)

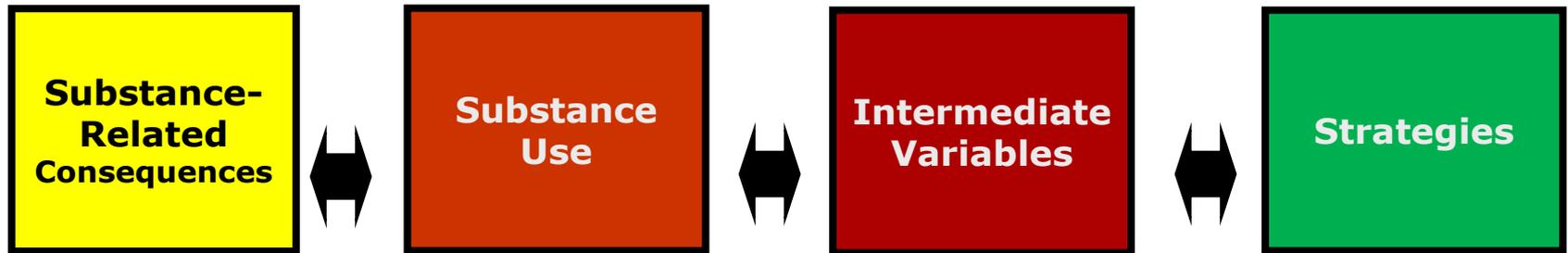
In order

2. To reduce substance abuse problems at the population level = **Public Health**.

- Must select environmental strategies that have been shown to work—that is, impact **key** intermediate variables

- **Conditions 1 and 2 must both be met to be effective.**

Sample Logic Model for Substance Abuse Prevention



Goal: Reduce underage drinking.

Level of retail availability of alcohol is a contributing factor.

Staff skill and practices in conducting age-checks and refusal of sales/service to underage persons is influencing the % of trained staff able to meet minimum acceptable standards

Responsible Beverage Server Training for staff:

Increase # of licensed establishments participating in training

Strategic Prevention Framework –

Partnerships for Success II

Purpose

The SPF-PFS II is designed to address two of the nation's top substance abuse prevention priorities:

- 1) underage drinking among persons aged 12 to 20
- 2) prescription drug misuse and abuse among persons aged 12 to 25.

Mission

Promotes the alignment and leveraging of prevention resources and priorities at all levels.

Prevention Strategic Plan

Vision

Develop a sustainable and effective prevention system that is committed to the reduction of substance abuse and its related consequences.

Mission

Promote safe and healthy environments that foster youth, family, and community development through the implementation of early intervention and substance abuse prevention best practices.

Overarching Goal

- The State of Nebraska will prevent and reduce a wide range of substance use behaviors, including:
 - Underage drinking
 - Binge drinking
 - Prescription drug abuse
 - Marijuana use
 - Illegal sale of tobacco products to minors

Guiding Principles

- *In order to create population level change communities must be targeted with prevention initiatives that demonstrate measurable change in behaviors or in important risk factors that lead to behavior change.*

Strategic Plan Initiatives:

- Assessment
- Capacity
- Planning
- Implementation
- Evaluation
- Reporting and Accountability

Strategic Plan Initiatives:

The Division of Behavioral Health will focus on individual elements of the State's prevention plan, including:

- Evidence-Based Practices
- Workforce Development
- Continuous Quality Improvement

Performance Indicators

- A reduction in substance use by Nebraskans will be accomplished through the implementation of the strategies and activities outlined in this plan.
 - Increasing the perception of risk
 - Increasing positive norms and policies associated with drug and alcohol free life choices
 - Increasing positive attachments to family, school, neighborhood and community
 - Reducing parental and peer group attitudes favorable toward the problem behavior or use

Mental Health Promotion

Linking Prevention with Positive Image & Healthy Behaviors

- 
- Positive Self Image
 - Physical Activity
 - Goal Setting Behaviors
 - Sleep
 - Healthy Eating
 - Stress Management

- 
- Alcohol Use
 - Tobacco Use
 - Drug Use
 - Stress
 - Academic Problems

Performance Measures

- *Reduce the prevalence of **Underage Drinking** by high school students by June 30, 2017 to less than 35%.*

Baseline: The percentage of Underage Drinking by high school seniors in 2011 was 41%, up from 35% in 2007.

Source: NRPFS Table 2

- *Reduce the prevalence of **Underage Drinking** by young adults aged 19-20 to less than 43% by June 30, 2017.*

Baseline: The percentage of young adults reporting underage drinking (30 day past use) was 43.1% in 2010 and 48.1% in 2012.

*Source: NYAAOS

Performance Measures

- *Reduce the prevalence of **Binge Drinking** by young adults aged 19 to 25 to less than 43% by June 30, 2017.*

Baseline: The percentage of young adults age 19 to 25 reporting binge drinking in 2010 was 43.8% and 47.3% in 2012.

Source: NYAAOS

- *Reduce the prevalence of **Binge Drinking** by males aged 19 and 20 to less than 45% by June 30, 2017*

Baseline: The percentage of males aged 19 and 20 reporting binge drinking in 2010 was 26.3% and 40.1% in 2012.

Source: NYAAOS

Performance Measures

- Reduce the rate of **prescription drug abuse** by high school students to 10% or less by June 30, 2017.

Baseline: The percent of high school students reporting prescription drug abuse in 2011 was 12%.

Source: YRBS Figure 24 Lifetime Prescription Drug Use

- Maintain a rate of **prescription drug abuse** by adults 18 and older by June 30, 2017 at a rate of 4% or less.

Baseline: The percent of adults of reporting prescription drug abuse in 2009 was 3.2%.

Source: NSDUH

State Prescription Drug Monitoring Programs (PDMPs)

- The operation of Nebraska's Prescription Monitoring Program is currently being facilitated through the state's Health Information Initiative.
- Participation by patients, physicians, and other health care providers is voluntary.
- According to a report by the CDC on rates of drug overdose death by nonmedical use of opioid pain relievers, Nebraska ranks **last** in the United States at 5.5%, well under the national average of 11.9%

Performance Measures

- *Reduce the prevalence of **marijuana use** by high school students by June 30, 2017.*

Baseline: The percent of high school students reporting marijuana use was in 13% 2007 and in 2011 was 12.7%.

It will be reduced to 11% *by June 30, 2017.*

Source: YRBS

Our Prevention Focus:

- Increase the perception of harm associated with marijuana use.
- Decrease the number of new initiates and delay onset of use.
- Prevent addiction and reduce likelihood of developing marijuana dependence.
- Decrease societal health and safety costs related to increased use and abuse.

Roles of DBH's Prevention System:

- Educate youth and adolescents about the risks of marijuana.
- Fund strategies aimed at providing alternative activities for youth that help create a healthy social environment.
- Collaborate with communities, law enforcement and schools to enforce policies against marijuana.
- These all have been shown to be a major factor in reducing and preventing use and misuse.

Considerations

- The effects of politics behind medical marijuana and the legalization of marijuana play on this issue .
- Marijuana use has not been a priority subject despite various sources about the significance of the issue.
- At this time there is no real evidence-based programs directed at marijuana prevention.
- We need effective strategies to mobilize.
- We need to track the trends, as of now they are showing that as meth use decreases, marijuana use increases.
- Parent's attitudes and use can be a contributing factor.

Observations about Marijuana

- Efforts to pass “medical” marijuana initiatives further normalize marijuana use among youth and thereby lessen the perceptions of its dangers and negative effects, which will result in increases in youth marijuana use.
- States that have “medical” marijuana programs have among the lowest perceptions of harm among youth in the nation.

Fast Facts about Marijuana

- Those who begin using the drug in their teens have approximately a 1-in-6 chance of developing marijuana dependence.
- Children and teens are 6 times likelier to be in treatment for marijuana than for all other illegal drugs combined.
- The 2010 NSDUH also shows an uptick in usage rates among youth, with rates among 12 to 17 year olds rising from 6.7% in 2006 to 7.4% in 2010.

Health Effects

The Journal of *Neuropsychopharmacology* suggests:

- Exposure to known carcinogens (marijuana smoke contains up to 70% more carcinogenic hydrocarbons than tobacco smoke).
- Impaired ability to create new memories.
- Episodes of acute psychosis (if a large dose is ingested), which can include “hallucinations and a loss of personal identity.”
- Increased risk of chronic cough and bronchitis.

Economic Effects

- Marijuana has a negative impact on productivity and earning power. According to NIDA, marijuana's adverse effect on cognition and memory formation means users, "may be functioning at a reduced intellectual level all or most of the time," with negative consequences for both school and work.
- A review of marijuana research printed in the journal *Addiction* found that, "Increasing levels of cannabis use have been associated with lower grade point averages, less satisfaction with school, negative attitudes towards school and poor school performance."

Economic Effects

Increased use has been directly linked to:

- Absences
- Tardiness
- Accidents
- Workers' Compensation Claims
- Job Turnover



Mental Health Prevention and Promotion

- Health promotion is the process of enabling people to increase control over, and to improve, their health.
- It moves beyond a focus on individual behavior towards a wide range of social and environmental interventions.

What is Health Promotion?

"A state of complete physical, mental and social well-being, and not merely the absence of disease".

- It is related to the promotion of well-being, the prevention of mental disorders, and the treatment and rehabilitation of people affected by mental disorders.

What is
Mental Health
Promotion?

- By 2020, mental and substance use disorders will surpass all physical diseases as a major cause of disability worldwide.
- The annual total estimated societal cost of substance abuse in the U.S. is \$510.8 billion, with an estimated 23.5 million Americans aged 12 and older needing treatment for substance use.
- More than 34,000 Americans die every year as a result of suicide, approximately one every 15 minutes.
- Half of all lifetime cases of mental and substance use disorders begin by age 14 and three-fourths by age 24- in 2008, 9.8 million adults in the U.S. had a serious mental illness.

What is Behavioral Health?

It is the state of mental/emotional being and/or choices and actions that affect wellness.

(Substance abuse and misuse are one set of behavioral health problems)

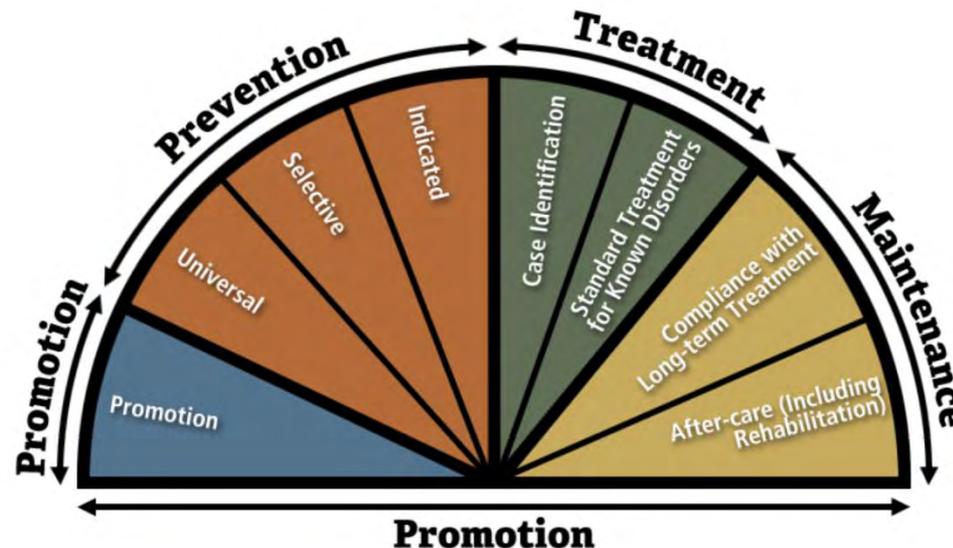
- In prevention it is our responsibility to be mindful of the connection between mental, physical health.
- Our goal should be to improve overall health.
- By collaboratively working across disciplines, pooling resources, and reaching people in those various settings we can have the most impact.

Mental and Physical Health: A Collaboration

Good mental health often contributes to good physical health.

Continuum of Care

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

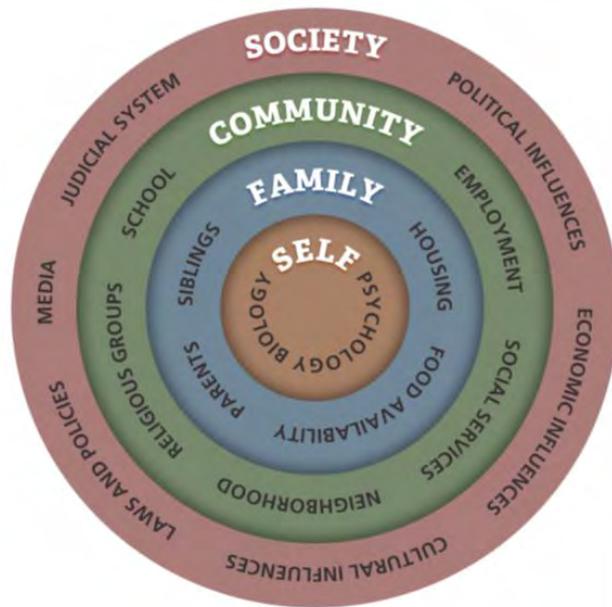


- **Risk factors** are characteristics at the biological, psychological, family, community, or cultural level that precedes and is associated with a higher likelihood of problem outcomes.
- **Protective factors** are characteristics associated with a lower likelihood of problem outcomes or that reduce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

Levels of Risk, Levels of Intervention

Risk and protective factors.

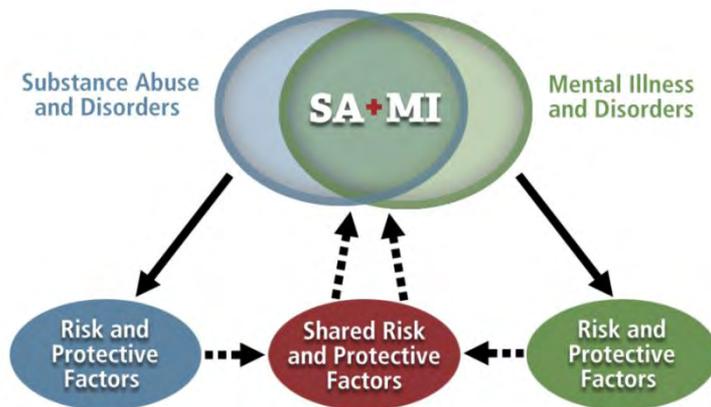
- Risk and protective factors occur in multiple contexts.
- The effects of risk and protective factors can be correlated and cumulative.



Prevention Approaches with Risk and Protective Factors

Utilizing universal, selective and indicated prevention interventions.

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



Risk and Protective Factors

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

The Developmental Framework

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

Questions???

Contact

Renee Faber

402.471.7772

renee.faber@nebraska.gov



Five-Year Substance Abuse Prevention Statewide Strategic Plan

State of Nebraska

Department of Health and Human Services

Division of Behavioral Health

FY13-FY17

DRAFT

Department of Health & Human Services



N E B R A S K A

Five-Year Substance Abuse Prevention Statewide Strategic Plan

STATE OF NEBRASKA

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90-day Priority Action Plan

- Publish performance indicators and targets for five-year change and create plan to assess annual performance
- Establish Division of Behavioral Health leadership position with the Substance abuse prevention advisory committee and ensure on-going utilization of the Strategic Prevention Framework
- Identify workforce needs and create plan that will increase competencies and breadth of skills for State and Regional prevention staff

INTRODUCTION

BEHAVIORAL HEALTH IS ESSENTIAL TO HEALTH: PREVENTION WORKS, TREATMENT IS EFFECTIVE, PEOPLE RECOVER

Nebraska's **Division of Behavioral Health (DBH)** promotes activities that improve the quality of behavioral health practices and services and increase opportunities to maintain wellness for all. It is one of six Divisions within the Department of Health and Human Services. DBH administers, oversees, and coordinates the State's public behavioral health system to address the prevention and treatment of mental health, substance abuse and problem gambling disorders.

DBH provides funding and contract management to six Behavioral Health Authorities, or "Regions," and a variety of providers to ensure community-based mental health, substance abuse, and problem gambling prevention and treatment services are available. The Nebraska Behavioral Health Services Act, Neb. Rev. Stat. §§ 71-807 to 71-809 revised the regional administration of the Nebraska Behavioral Health System. Each Region is governed by a Regional Governing Board consisting of one county board member (locally-elected official) from each county in the Region. Each Region has a Prevention System Coordinator, known as a Regional Prevention Coordinator (RPC), who provides training and technical assistance to community partners regarding prevention needs and solutions.

DBH strives to ensure their services meet the complex needs of individuals with co-occurring disorders. DBH is actively engaged in a Strategic Plan for 2011-2015 with the goal of developing a behavioral health system that is trauma-informed, recovery-oriented and person-centered through the delivery of effective prevention and treatment.

Nebraska's Five Year Strategic Prevention Plan will support DBH's overarching strategic goals and will focus statewide prevention efforts on a prioritized set of behaviors – their selection was data driven, and results of activities can be measured over time to demonstrate the success of state initiatives. These priorities are aligned with those of the Substance Abuse Prevention and Treatment Block Grant (SAPTBG). The plan will guide prevention prioritization, decision-making, and policy development at the State, Region and community level. DBH will collaborate with Regional and community partners to enhance current capacity and plan for and develop newer systems and infrastructures where they are just emerging. This work will strengthen, expand and sustain systems and infrastructure at all levels.

Under the auspices of the *Nebraska Partners in Prevention (NePiP)*, the State's substance abuse prevention advisory council, DBH works with state agencies and organizations who have been coming together for almost a decade to build prevention capacity and develop prevention infrastructure throughout Nebraska. NePiP is actively chaired by the Lt. Governor, Rick Sheehy, and has broad participation from agencies and organizations across the state with a stake in prevention.

NePiP defines prevention as "the active process of creating conditions and personal attributes that promote the well-being of people," and has adopted a three-part philosophy: 1) local people solve local problems best; 2) people support what they help create, and 3) science matters (Lofquist, 1983). NePiP recognizes that substance abuse is a pervasive and complex social and public health issue that affects individuals of all ages; defies social, cultural, or economic categorization; and spans organizational boundaries. Accordingly, NePiP believes that no single agency, organization, or individual can effectively prevent or reduce substance abuse, but rather that effective prevention requires a targeted, coordinated,

and multi-disciplinary response. NePiP was originally convened to provide leadership for the Nebraska State Incentive Cooperative Agreement and the Nebraska Strategic Prevention Framework State Incentive Grant. It will continue to have a vital role in future statewide activities.

Director Scot Adams serves as Nebraska's **Single State Agency (SSA)** representative for substance abuse and mental health. He provides leadership to DBH working both with the Regional Centers and community-based partners to promote quality behavioral health policies, services and education across the state. Director Adams' goal is to improve and enhance all elements of a comprehensive behavioral health system including a renewed emphasis on prevention as part of a healthy environment.

Renee Faber, DBH's Prevention System Coordinator and the state's representative to the **National Prevention Network (NPN)**, is dedicated to enhancing the capacity and collaboration of an effective and comprehensive system of sustained, monitored, and evaluated prevention services that promote overall wellness.

Vision

Develop a sustainable and effective prevention system that is committed to the reduction of substance abuse and its related consequences.

Mission

Promote safe and healthy environments that foster youth, family, and community development through the implementation of early intervention and substance abuse prevention best practices.

To be successful, Nebraska's prevention systems must involve partnerships of agencies, organizations, and individuals that are committed to decreasing substance abuse through a collaborative and coordinated process of: (1) comprehensive planning for and evaluation of outcomes; (2) promoting evidence-based strategies; (3) allocating resources; and (4) enhancing workforce skills and knowledge.

The Division of Behavioral Health will improve the lives of Nebraskans through the provision of strong, effective prevention programming, implemented throughout the six Regions of the state. One major task is to elevate prevention and its potential impacts on behavioral health in Nebraska to a more public and prominent position.



GOALS AND OBJECTIVES

The State of Nebraska will prevent and reduce a wide range of substance use behaviors, including:

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

GUIDING PRINCIPLES

In order to create population level change, high risk, densely populated communities must be targeted with prevention initiatives that demonstrate measurable change in behaviors or in important risk factors that lead to behavior change

- The Strategic Prevention Framework will be comprehensively utilized for all planning and decision making processes.
- All prevention activities will be culturally relevant.
- Nebraska will shape substance abuse prevention policy, quality improvement, and agency participation through cross-agency advisory groups.
- DBH will coordinate and support the work of the State’s substance abuse prevention advisory council, and will actively recruit and educate partners who can contribute to this important work.
- Each Region will identify its highest risk subpopulations and will develop a plan to enhance or build community responses.
- Each community coalition will create a plan to maximize and sustain its outcomes, and will choose strategies that can be sustained for at least five years.

The Division of Behavioral Health will focus on individual elements of the State’s prevention plan, including:

- Evidence-Based Practices
- Workforce Development
- Continuous Quality Improvement



PARTNERS

Nebraska will ensure strong and productive state-level partnerships with health, criminal justice, juvenile justice, child welfare, and education to focus on shared priorities and shared responsibility for action and for success. Key partners include but are not limited to:

Office of the Lieutenant Governor

DHHS Division of Public Health

DHHS Division of Children and Family Services

Regional Behavioral Health Authorities

Nebraska Department of Education

Nebraska Office of Highway Safety

Nebraska Liquor Control Commission

Nebraska Commission on Law Enforcement and Criminal Justice

Nebraska Commission on Indian Affairs

Nebraska Collegiate Consortium

University of Nebraska - Bureau of Sociological Research

University of Nebraska - Behavioral Health Education Center of Nebraska

University of Nebraska Medical Center - Center of Health Policy

Center for the Application of Prevention Technology

Other State and local prevention organizations



PERFORMANCE INDICATORS

A reduction in substance use by Nebraskans will be accomplished through the implementation of the strategies and activities outlined in this plan. Like all strategies that the State, Regions and communities implement, key strategies involve:

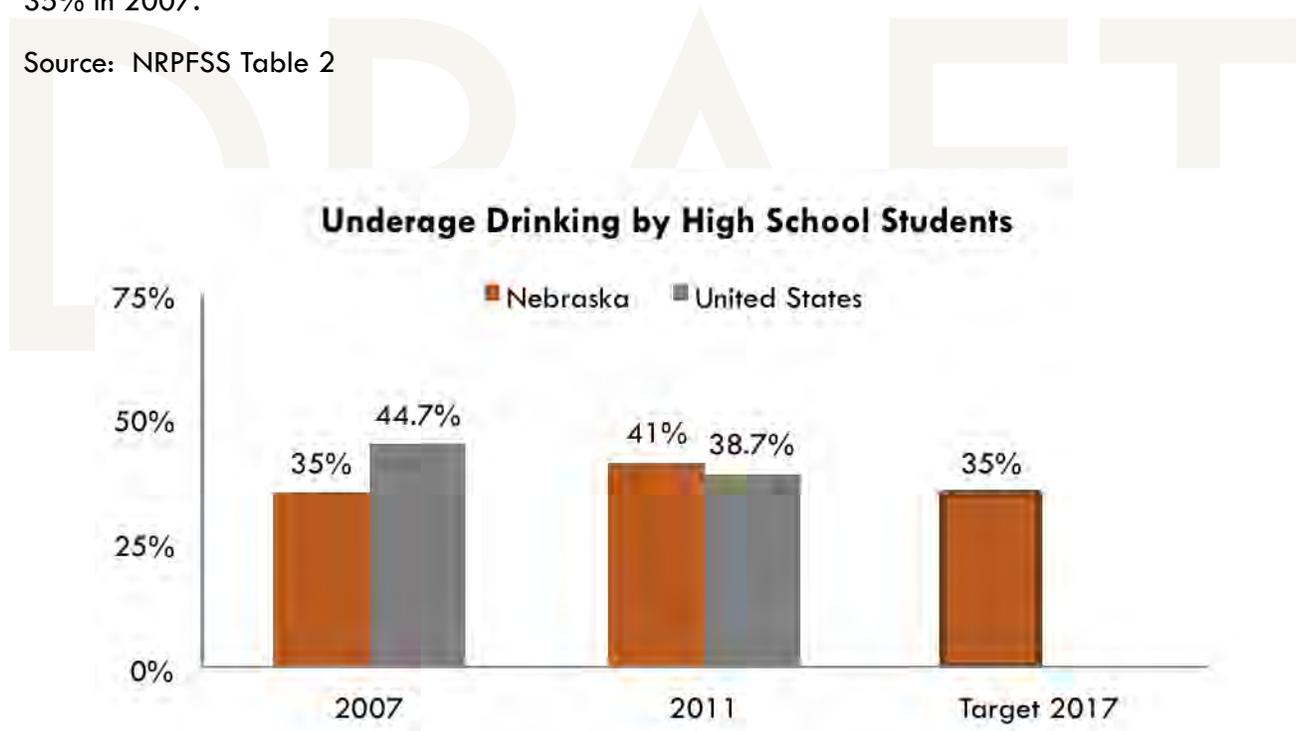
- Increasing the perception of risk
- Increasing positive norms and policies associated with drug and alcohol free life choices
- Increasing positive attachments to family, school, neighborhood and community
- Reducing parental and peer group attitudes favorable toward the problem behavior or use

Underage Drinking

The State of Nebraska will reduce the prevalence of **Underage Drinking** by high school students to less than 35% by June 30, 2017.

Baseline: The percentage of Underage Drinking by high school seniors in 2011 was 41%, up from 35% in 2007.

Source: NRPFS Table 2

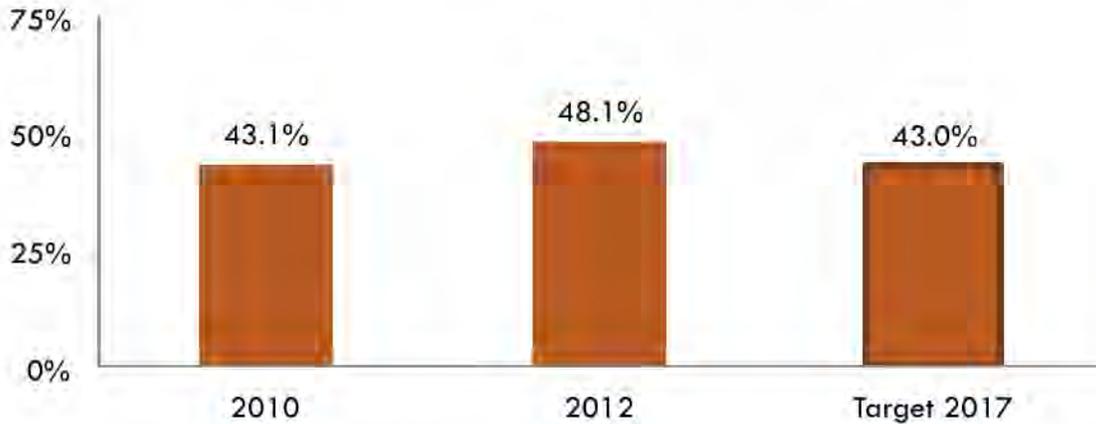


The State of Nebraska will reduce the prevalence of **Underage Drinking** by young adults aged 19-20 to less than 43% by June 30, 2017.

Baseline: The percentage of young adults reporting underage drinking (30 day past use) was 43.1% in 2010 and 48.1% in 2012.

Source: NYAAOS

Underage Drinking by Youth Adults Age 19-20



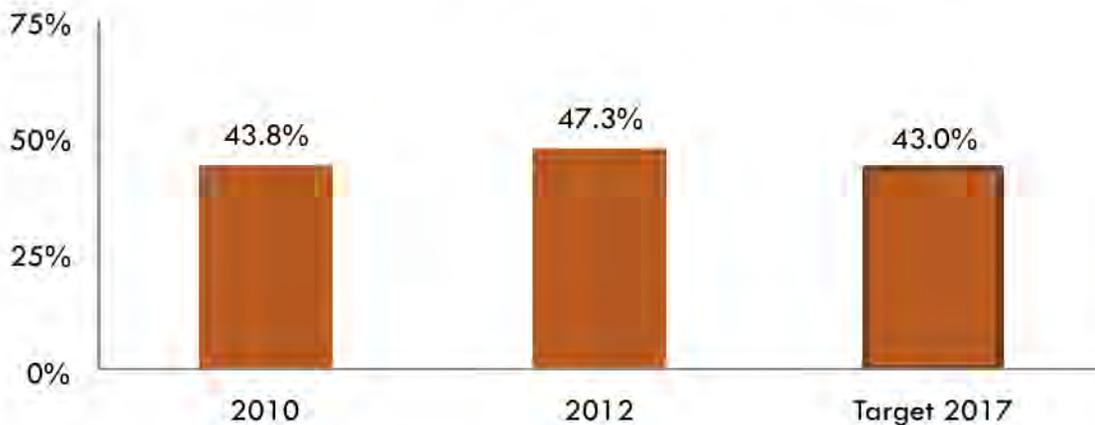
Binge Drinking

The State of Nebraska will reduce the prevalence of **Binge Drinking** by young adults aged 19 to 25 to less than 43% by June 30, 2017.

Baseline: The percentage of young adults age 19 to 25 reporting binge drinking in 2010 was 43.8% and 47.3% in 2012.

Source: NYAAOS

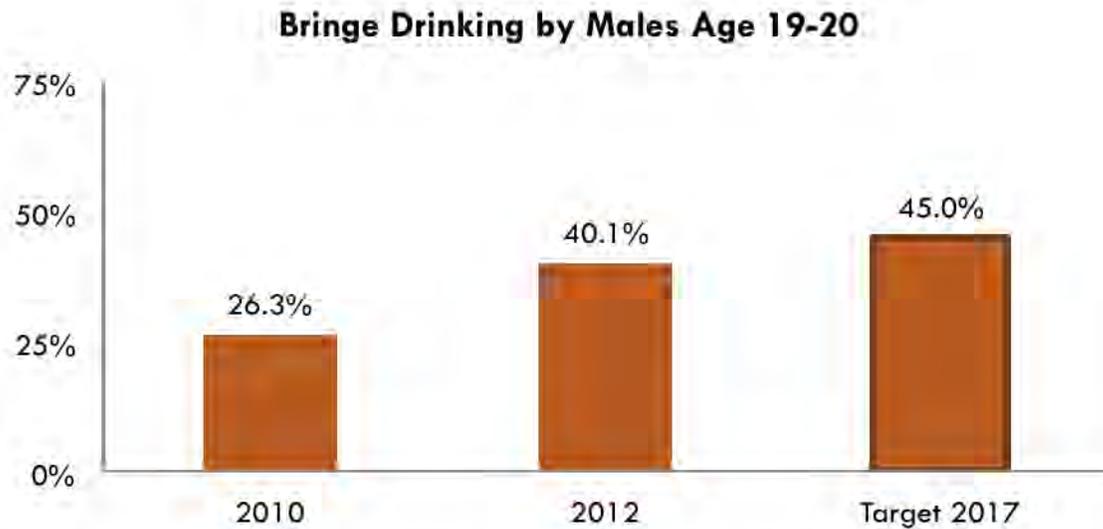
Bringe Drinking by Youth Adults Age 19-25



The State of Nebraska will reduce the prevalence of **Binge Drinking** by males aged 19 and 20 to less than 45% by June 30, 2017

Baseline: The percentage of males aged 19 and 20 reporting binge drinking in 2010 was 26.3% and 40.1% in 2012.

Source: YRBS

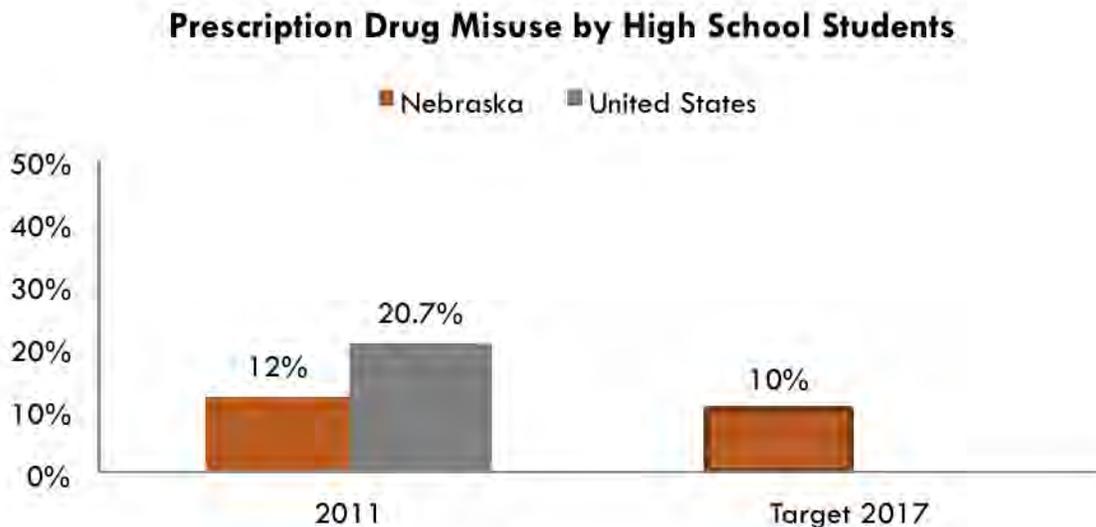


Prescription Drug Use

The State of Nebraska will reduce the rate of **prescription drug abuse** by high school students to 10% or less by June 30, 2017.

Baseline: The percent of high school students reporting prescription drug abuse in 2011 was 12%.

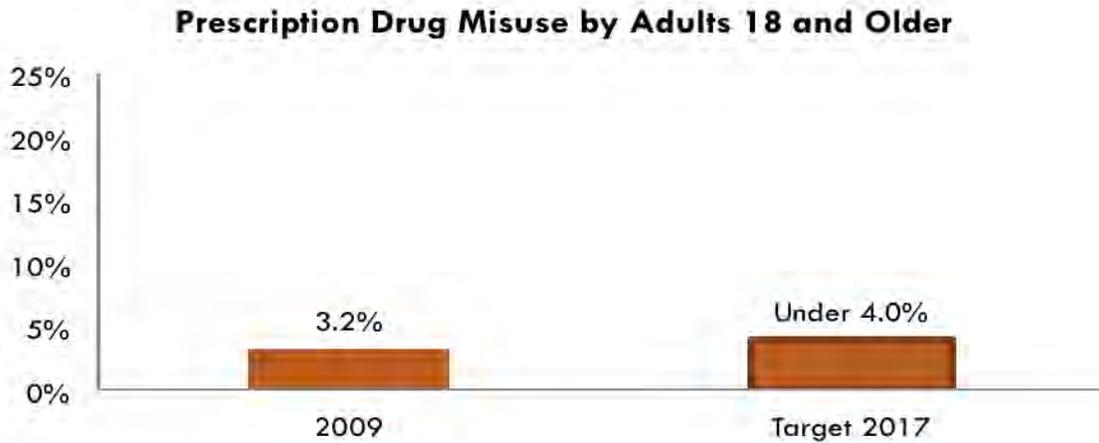
Source: YRBS Figure 24 Lifetime Prescription Drug Use



The State of Nebraska will maintain a rate of **prescription drug abuse** by adults 18 and older at a rate of 4% or less by June 30, 2017.

Baseline: The percent of adults of reporting prescription drug abuse in 2009 was 3.2%.

Source: NSDUH

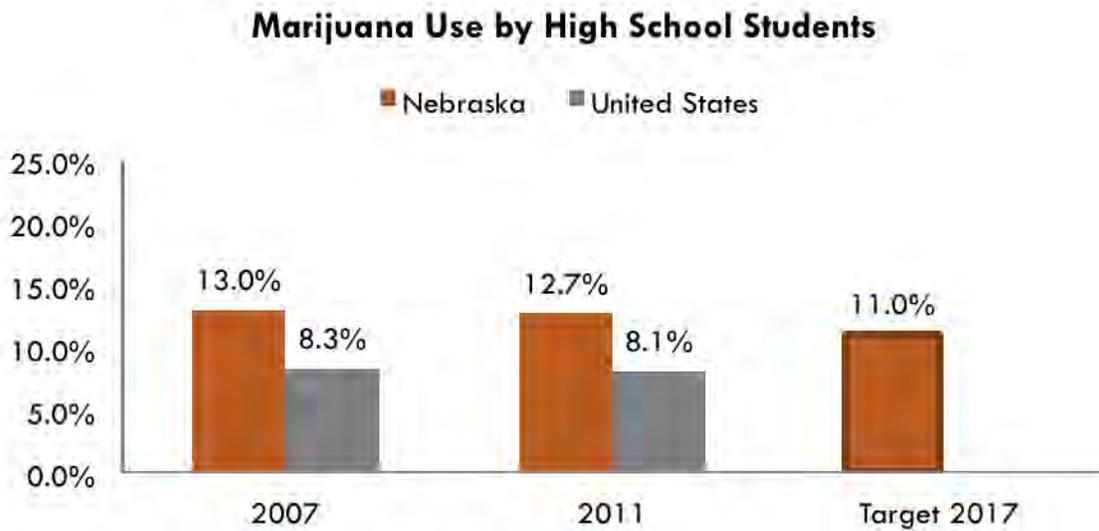


Marijuana Use

The State of Nebraska will reduce the prevalence of **marijuana use** by high school students to 11% by June 30, 2017.

Baseline: The percent of high school students reporting marijuana use was in 13% 2007 and in 2011 was 12.7%.

Source: YRBS



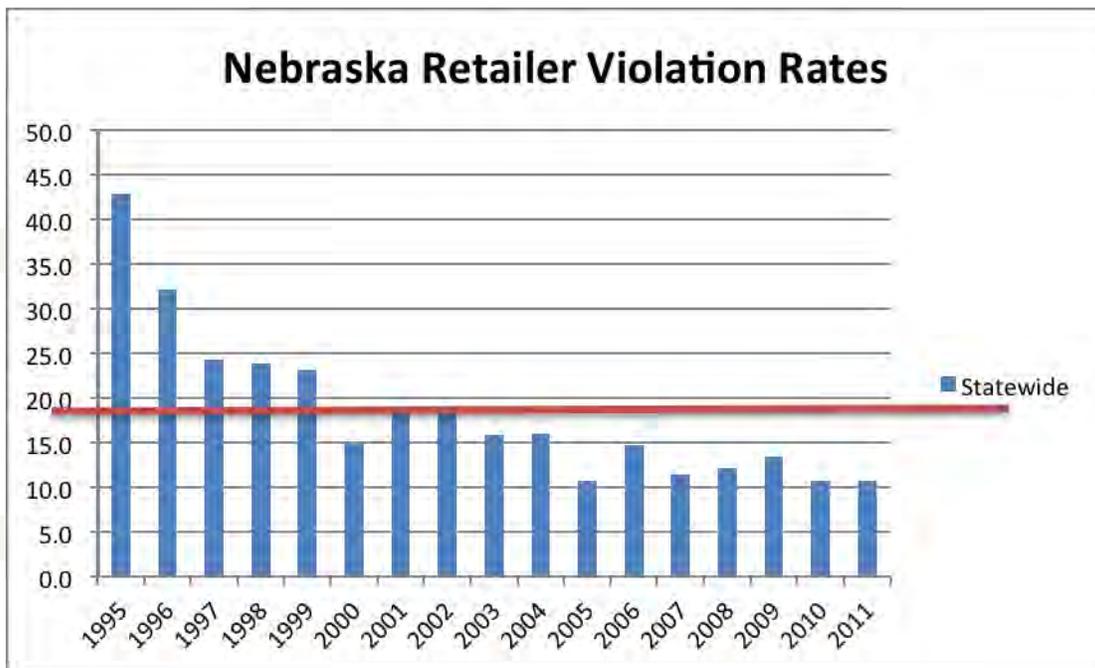
Tobacco Sales to Minors

The State of Nebraska will demonstrate a consistent rate of **retailer compliance with tobacco sales laws for minors** (Synar requirements) by maintaining or reducing its compliance rate at 10% or less every year through 2017.

Baseline: The rate of illegal sales to minors of tobacco products in Nebraska was 10.6% in 2011.

Source: Nebraska Annual Synar Report 2011

Shown below as the minimum standard, the Retailer Violation Rate must be below 20% to meet the requirements of the State's SAPTBG.



ASSESSMENT

STRATEGIC INITIATIVE:

ENSURE A SOUND PREVENTION DATA SURVEILLANCE SYSTEM IS IN PLACE THAT RELIABLY MEASURES POPULATION-LEVEL SUBSTANCE ABUSE AND MENTAL HEALTH ISSUES IN NEBRASKA.

Surveillance of substance abuse and mental health indicators must continue, and expand where insufficient data are available to monitor for high-risk behaviors and risk factors, and for new and emerging trends.

Existing surveillance processes include:

- Student Health And Risk Prevention (SHARP), which combines 3 high school surveillance instruments
 - Youth Risk and Behavior Survey (YRBS)
 - Youth Tobacco Survey (YTS)
 - Nebraska Risk and Protective Factor Student Survey (NRPFS)
- Nebraska Young Adult Alcohol Opinion Survey (NYAAOS)
- Behavior Risk Factor Surveillance System (BRFSS)

Activity 1:

By January 2013, DBH will create a plan that prioritizes and sustains these surveys and ensures sufficient sample sizes in each Region of the State to obtain reliable Region level data by July 1, 2015.

Activity 2:

DBH will work with partner agencies to sustain and coordinate the Nebraska Statewide Epidemiology and Outcomes Workgroup (SEOW).

- DBH will work with the SEOW to gather, aggregate, and publish in a consistent format substance abuse and mental health data that can be used for planning, demonstrating accountability, and measuring outcomes.
- DBH will ensure the publication of an annual report on substance abuse and other behavioral health trends and related risk and protective factors at state and region levels.

Activity 3:

DBH will evaluate trends and survey data annually, and will monitor local and statewide data to identify new and important evolving substance abuse and mental health issues.

CAPACITY

STRATEGIC INITIATIVE:

ENHANCE LEADERSHIP, INFRASTRUCTURE AND WORKFORCE AT THE STATE AND REGIONAL LEVELS TO SUPPORT STRONG PREVENTION COALITIONS AND THEIR VOLUNTEER MEMBERS.

Activity 1:

Ensure sound structure, active membership, and on-going leadership role of the State's substance abuse prevention advisory council.

Activity 2:

Promote leadership through technical assistance and training to establish statewide priorities for Regions and communities.

- Define and contract for Regional leadership competencies.
- Develop a plan by September 2013 to create and sustain a professionalized workforce within each Region.
- Develop minimum standards for coalition and other prevention organizations.
- Build Regional approaches to link existing intervention and treatment services to existing problem identification and referral mechanisms.

Activity 3:

Support State and Regional Continuous Quality Improvement (CQI) prevention teams to improve fidelity, practices, and measurable outcomes.



PLANNING

STRATEGIC INITIATIVE:

ENSURE DATA-DRIVEN AND COMPREHENSIVE PLANNING AT THE STATE, REGION, AND COMMUNITY LEVEL.

Activity 1:

Standardize outcome-based Regional action plans that are reviewed and reported upon semi-annually.

- Collaborate and create joint action plans with the Division of Public Health, and the Division of Children and Families that integrate funding, workforce, strategies and outcome measurement for initiatives that focus on substance abuse prevention and risk factor reduction/protective factor enhancement.

Activity 2:

Ensure the State's substance abuse prevention advisory council maintains a lead role in state planning efforts.

- Create a strategic collaboration with educational and research institutions to support state level prevention initiatives.
- Create a plan to identify and divert youth who are at risk of addiction or substance-related delinquency into programs that can successfully intervene, thereby reducing their risk of further involvement with addiction or law enforcement.

Activity 3:

Require strategies that are designed to create environments and conditions that support the overall wellness of individuals and their ability to withstand challenges.

- Promote healthy lifestyles by working collaboratively across disciplines and communicating strong prevention messages.

IMPLEMENTATION

STRATEGIC INITIATIVE:

NEBRASKANS SHALL HAVE ACCESS TO EFFECTIVE PREVENTION SERVICES THAT PRODUCE MEASURABLE OUTCOMES AND USE RESOURCES EFFICIENTLY.

Activity 1:

Develop prevention policies for Evidence-Based Practices, Continuous Quality Improvement (CQI), Workforce Development, and other prioritized issues by January 2014.

Activity 2:

Utilize CQI processes, across the state, to examine issues and factors that influence programming choices, and make recommendations for change. One CQI cycle will be completed in each Region by July 1, 2014.

Activity 3:

Monitor state and regional level performance measures at least annually, utilizing this information for CQI and other processes.

Activity 5:

Ensure all funded initiatives identify and link the specified problem with an appropriate prevention strategy to achieve the desired outcome by July 1, 2014.

- Promote use of promising, best and Evidence-Based practices as determined by the National Registry of Evidence-based Programs and Practices (NREPP).

EVALUATION

STRATEGIC INITIATIVE:

EVALUATE ALL FUNDED PREVENTION INITIATIVES; ASSESS FOR THEIR EFFECTIVENESS AND SEEK OPPORTUNITIES FOR IMPROVEMENT.

Activity 1:

Strengthen the formal partnerships to efficiently evaluate programs and practices funded by the Division of Behavioral Health.

- Ensure fidelity of programs and practices annually.

Activity 2:

Build a strong, statewide approach to evaluation of program results.

- Utilize evaluation results to improve practice.
- Publish evaluation results annually.

Activity 3:

Prioritize and fund prevention programs and practices that produce desired individual and community outcomes.

REPORTING AND ACCOUNTABILITY

STRATEGIC INITIATIVE:

PROVIDE REGULAR REPORTS OF PROGRESS AND ACCOMPLISHMENTS, AS WELL AS LESSONS LEARNED, TO STAKEHOLDERS.

Activity 1:

Publish an annual report of funded prevention initiatives, descriptions of regional and community infrastructures and measured outcomes.

Activity 2:

Provide at least one public forum in each Region annually for input and dialogue about the impact, reach, opportunities and promise of prevention for Nebraska.

- Combine awareness and educational information about the importance and effectiveness of prevention and its place in communities and strategically disseminate on a regular basis.



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

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

Prioritize State Planning	Goal & Performance Indicator	Implementation Progress as of June 30, 2012
2	Consumer Workforce	<p>Goal: To increase the peer support workforce.</p> <p>As of May 1, 2012--76 As of July 20, 2012--91</p> <p>Performance Indicator: 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>
3	Peer Recovery Supports	<p>Goal: To increase the number of peer recovery supports.</p> <p>Honed Draft definition with the OCA People's Council. Will present to advisory committees with questions on August 7 and September 6 to determine if we will count by service or by person; if we will count funded staff on unfunded staff; and how we will obtain our count.</p> <p>Performance Indicator: Total number of behavioral health services with a peer recovery support component. <u>Define peer recovery supports</u> & establish the baseline number of BH services with a peer recovery support component by June 30, 2012. Increase this number by June 30, 2013.</p>
4	SA Treatment – Women’s Set Aside Services	<p>Goal: To ensure services for Pregnant Women and Women with Dependent Children are trauma informed and trauma specific.</p> <p>Four (4) out of six (6) WSA agencies (66.7%) completed TIC assessment as of 8/3/2012. Two (2) Regions haven't sent their update yet.</p> <p>Performance Indicator: 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 June 30, 2013.</p>

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

Prioritize State Planning		Goal & Performance Indicator	Implementation Progress as of June 30, 2012
8	Trauma Informed Care (TIC)	Goal: To develop a service system that understands the effects of trauma and avoids re-traumatizing those who seek services (trauma-informed).	46 agencies (60.5%) completed TIC assessment as of 8/3/2012. Two (2) Regions haven't sent their update yet.
		Performance Indicator: 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%.	
9	Permanent Supportive Housing	Goal: To improve the Permanent Supportive Housing services.	- draft definition of Permanent Supportive Housing prepared - presented to State Committee on Mental Health Services on August 7, 2012 and the State Advisory Committee on Substance Abuse Services on September 6, 2012. - The Evidence Based Practices Workgroup is meeting to provide recommendations to DBH leadership by September 29, 2012 on a consistent and sustainable way of doing fidelity monitoring linked to outcomes on Evidence Based Practices (EBPs). On June 21, 2012 the focus of the EBP work group was on Permanent Supportive Housing (PSH). - the number of persons served in NE Housing Related Assistance in 2012 was 825.
		Performance Indicator: Define what Permanent Supportive Housing services means in Nebraska by January 2013. Create process for fidelity monitoring by June 30, 2013. Total number persons served in Permanent Supportive Housing baseline as of June 30, 2011 was 817. This will increase.	
10	Supported Employment	Goal: To improve the quality of Supported Employment services.	To improve the quality of Supported Employment services. - Evidence Base Practice Workgroup, Division of Behavioral Health is addressing Supported Employment issues. The EBP Workgroup meeting on May 10, 2012 focused on Supported Employment. The providers of Supported Employment participated. Work with the Dartmouth Supported Employment Center (Lebanon, NH): - Supported Employment providers to register 14 staff to complete the Online Course from the Dartmouth IPS Supported Employment Center (May 14, 2012 ending August 10, 2012). - June 13, 2012 the Supported Employment Individual Placement and Support (IPS) – Kick-Off Training was held from 8:30 – 5:00 at the Country Inn and Suites in Lincoln, NE. 48 signed the attendance sheet including Mark Schultz (Director, State Vocational Rehabilitation) and Scot Adams (Director, Division of Behavior Health). There were staff from each of the six Regional Behavioral Health Authorities, Supported Employment Providers (program supervisors and employment specialists), consumers from the Supported Employment providers, employment staff from the Assertive Community Treatment (ACT) teams, VR staff, & DBH staff.
		Performance Indicator: Complete fidelity monitoring on 100% of the DBH funded Supported Employment providers by June 30, 2013.	

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

Peer-Run & Peer Recovery/Resiliency Supports

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

Adult

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

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

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

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

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

- Keya House
- Hope Program
- Safe Harbor

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

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

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

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

Examples of Peer Recovery Supports in Nebraska for Adults:

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

Transition Age Youth (Age 17-26)

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

Child

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

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

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

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

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

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

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

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

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

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

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

- 1) Should we be counting by service or by person or both?**

- 2) Should we be counting funded staff or community volunteers related?**

- 3) How should we count? Magellan? Regional Consumer Specialists?
Other?**

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

Define What Permanent Supportive Housing Services Means in Nebraska

Draft – August 7, 2012

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

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

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

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

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

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

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

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

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

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

Housing Related Assistance Program Fidelity Monitoring Site Visits

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

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

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

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

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

SUPPORTED EMPLOYMENT

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

UTILIZATION GUIDELINES - ADMISSION GUIDELINES

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

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

Title 206 Nebraska Administrative Code - Behavioral Health Services

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

DBH Service Definitions: an attachment to the 206 Regulations

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

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

Supported Employment (SE) Fidelity Scale

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

Projected State Agency Expenditure Report

October 1, 2012-September 30, 2013

Activity	SAPTBG	Medicaid	State Funds
Treatment, Research & Non-Primary Prevention	\$5,278,926	\$1,096,974	\$25,846,954
Primary Prevention	1,962,486	-	178,352
Administration (includes program management cost)	592,642	-	-
Totals	\$7,834,054	\$1,096,974	\$26,025,306
FY12 Amounts	\$7,849,944	\$2,097,661	\$24,770,192

Resource Development

October 1, 2012-September 30, 2013

	Total
Planning, Coordination, and Needs Assessment	87,409
Quality assurance	87,409
Training (post-employment)	107,368
Education (pre-employment)	63,058
Program Development	-
Research & Evaluation	-
Information Systems	48,500
Total	\$292,734

Primary Prevention

October 1, 2012 – September 30, 2013

Category	FY12	FY13
Programs	\$ 423,865	\$ 20,174
Personnel	\$ 187,407	\$ -
Other	\$ 20,000	\$ -
Capital	\$ -	\$ -
Equipment	\$ -	\$ -
Information Technology	\$ -	\$ -
Travel	\$ -	\$ -
Telephone	\$ -	\$ -
Printing	\$ -	\$ -
Supplies	\$ -	\$ -
Professional Fees	\$ -	\$ -
Contractual	\$ -	\$ -
Other	\$ -	\$ -
Total	\$ 631,272	\$ 20,174
FY12 Available	\$ 631,272	\$ 20,174

Projected Expenditures for Treatment & Recovery Supports

October 1, 2012-September 30, 2013

Category	SAPTBG FY13	FY12
Healthcare Home/Physical Health	NA	NA
Engagement Services	15%	15%
Outpatient Services	10-25%	10-25%
Medication Services	< 10%	<10%
Community Support (Rehab)	< 10%	10-25%
Recovery Support	< 10%	NA
Other Supports (Habilitative)	NA	NA
Intensive Support Services	< 10%	10-25%
Out of Home Residential	10-25%	10-25%
Acute Intensive	<10%	NA
Prevention	10-25%	10-25%
System Improvement	<10 %	<10%
Other (Administration)	<10 %	<10%

Only Services purchased with Federal dollars are reflected on this chart.
 Additional services in each category are purchased with State funds.