

**State Advisory Committee on Substance Abuse Services**  
**September 21, 2010 - 9:00AM to 3:00PM**  
**Country Inn/Suites, 5353 North 27<sup>th</sup> Street, Lincoln, NE**  
**Draft Minutes**

**Present :**(9) Ann Ebsen, Jay Jackson, Linda Krutz, Vicki Maca, Delinda Mercer, Brenda Miner, Laura Richards, Randy See, Rand Wiese

**Absent (3):** Corey Brockway, Shree Ezell, Linda Krutz Laura

**DHHS Staff Present:** Scot Adams, Sue Adams, Sheri Dawson, Renee Faber, Jim Harvey, Nancy Heller

**Guests Present:** Denise Bulling, Judith Moorehouse, Julie Scott, Joshua Robinson

**Welcome/Introductions**

Chairperson Ann Ebsen called the meeting to order at 9:03 a.m. Committee members briefly introduced themselves.

**Attendance – Determination of Quorum**

Roll call taken by Christine Newell and quorum was met.

**Approval of February 2, 2010 Minutes**

Motion made by Rand Wiese to approve minutes, seconded by Randy See. Motion adopted by unanimous voice vote.

**Approval of Agenda**

Motion made by Laura Richards to approve today's agenda, seconded by Rand Wiese. Motion adopted by unanimous voice vote.

**Future Meeting Dates**

2011 SACSAS Meeting dates were proposed to the committee as; March 8, 2011, May 3, 2011, September 20, 2011 and December 6, 2011. Jim Harvey explained the Division plans a Mental Health, Problem Gambling and Substance Abuse joint meeting on May 3, 2011.

Motion was made by Rand Wiese approve the 2011 meeting dates and seconded by Laura Richards. Motion adopted by unanimous voice vote.

The new meeting dates for 2011 are: March 8, May 3, September 20 and December 6, 2011.

**Public Comment**

No public comment.

**Updates**

**Strategic Planning – Denise Bulling- UNL Public Policy Center**

**Attachment A**

Ms. Denise Bulling stated the work group has laid the ground work and has reviewed all the documents developed. The work group met with three national experts for consultation. The experts are; Monica Oss from Open Minds, Dr. Thomas Kirk a Healthcare consultant from Connecticut and Sherry Mead a consultant from New Hampshire. Ms. Mead leads a mental health consumer peer support movement and an online survey which had about 300 responses. The Strategic Plan will be centered on 5 strategies related to; accessibility, accountability, quality, effectiveness and cost efficiency. The broad strategies will guide the Division to set them up to respond to the changes of healthcare reform and the changing economy. PPC will have a working draft including the Division's comments and strategies that will be distributed to all committee members. The Division plans to set-a-side 45 minutes at the November 4 2010 Mental Health Advisory meeting via Tele-conferencing to present the draft and after that public hearings will be scheduled.

### **Independent Peer Review Contract - Dennis Vollmer**

The Peer Review Contract is with Nebraska Association of Behavioral Health Organizations (NABHO). Mr. Vollmer reported all peer reviewers go through an entire day of training and offer a refresher training. There are 5 areas covered in the reviews and this year NABHO added Trauma Informed Care training. The reviewers need to be very thorough looking at patient's records, care and trauma history. They meet with administrative staff, board members and tour the facility. They interview youth, clients and staff. The review lasts a full day and upon completion they have an exit interview with the facility administrators. The facilities they reviewed are: Human Services in Alliance, Good Will in Grand Island, Mary Lanning in Hastings, Heartland in O' Neill, Lancaster Mental Health Center and NOVA in Omaha. A specified percent of providers are required to be reviewed each year. Peer Reviews are not scheduled the same year for facilities/organizations going through CARF accreditation review. The Peer Review function is required by the Mental Health and Substance Abuse block grants, specifically Goal 5 of the SABG. Mr. Vollmer stated he will bring the final report to the next SA meeting in December.

### **In-Depth Technical Assistance (IDTA) – Vicki Maca**

Ms. Maca reminded the committee the Division partnered with Probation, Juvenile Courts, Medicaid Long Term Care, and Children and Family Services (CFS) to apply for National In-Depth Technical Assistance in hopes of improving the delivery system for parents who have an addiction and are within the CFS System. Treatment for the parent of a child involved in CFS is sometimes paid by providers using the sliding fee scale, other times full cost is paid for by CFS or their lead agency.

The TA goal is to know how many parents have state wards/non court involved, how many are currently being served, how many are not being served, to get data, cost totals and pay for treatment via DBH to lead agencies. DBH does have some services but needs to know what services are needed. So if we decide to serve those parents we need to have access to services for those parents and know the cost to serve these individuals. There may be a need for treatment services within a certain amount of time. There is a waiting list now and needs to be the priority population. The lead agencies are struggling with funds. Cedars and VISINET no longer contracts with CFS.

### **Lincoln Medical Education Partnership (LMEP) Contract - Josh Robinson Attachment B**

Mr. Robinson explained LMEP has offered 18 classes via Video Conferencing. Some classes were cancelled due to low participation so it's sometimes a problem to schedule classes in smaller towns such as North Platte or Scottsbluff. Laura Richards, Region 1 stated they have video conferencing available and the room that could be utilized would be free. See hand out for detailed information about the classes offered.

The basic class information given was:

- Enrollment in all core classes has increased
- Universal Criminogenic on-line trainings are being maxed out
- Working with Mid-Atlantic ATTC on training related to lesbian, gay and transgendered
- Talking to Magellan about a question and answer session.
- Working on trauma informed care training
- There are more requests for ASI and CASI training
- Need more Criminogenic/ASAM courses
- Clinical Supervision in the 12 Core Functions are declining.
- Looking for more instructors and curriculum for medical/psychosocial training.

LMEP will send out ASI/CASI training letters to individuals, providers and probation.

### **DBH's Probation Partnership – Julie Scott**

### **Attachment C**

Ms. Scott represents the Criminal Justice System which includes individuals in parole and problem solving courts. She reviewed the hand out on the web-based training concept as a means for committees to work together and tie together concepts that crossover. One of the collaborative ways is to look at some courses that are beginning foundation classes to be done via web based such as Criminogenic training. A document sheet on Criminogenic Standards was distributed. There are future plans to have Standardized Model online. Ms. Scott met with DHHS licensing department regarding Criminogenic training in hopes for the training to be approved by licensing and Criminal Justice.

**Quality Initiatives – Sheri Dawson****Attachment D**

Ms. Dawson gave an update on the 206 Behavioral Health Regulations and Service Definitions. The regulation and definitions went to hearing August 19, 2010. Internally comments are being reviewed and forwarded to Director Scot Adams for his approval. Service definitions meetings with Medicaid and the Regions will begin on September 22, 2010.

The two quality initiatives are Consumer Survey process, and weekly data call. The goal for the consumer survey is to gather all surveys being used, analyze them with the goal of getting outcomes and having a consistent process that is consumer friendly. Ms. Dawson distributed the schedule of data calls through December 2010 and reviewed a power point document showing quarterly reports on SA/MH capacity and waiting lists.

**Primary Prevention – Renee Faber****Attachment E**

Ms. Faber covered material related to the Substance Abuse Prevention Treatment Block Grant (SAPTBG) goal number 2. Ms. Faber distributed information on the objective for the prevention plan for the next three years and gave an overview of how prevention is funded. DBH works with the Regions to fund coalitions and other contracts such as SYNAR, training curriculum, SCIP, NPIRS, and Orion. DBH is scheduled for a prevention and treatment site review in October. The site visit is a two part site review, Prevention and Treatment. The review will provide information to understand our needs, strengths, weaknesses and infrastructure. They will review the SYNAR program and five sites in Omaha.

**Criminal Justice Data – Jim Harvey****Attachment F**

Mr. Harvey reviewed Form 7 of the Substance Abuse Prevention and Treatment Block Grant (SAPTBG). The 5 goals of the SAPTBG are listed in the handout. Crisis Intervention Training (CIT) is for law enforcement officers to deal with behavioral health issues and will help to address situation so it will not end in arrest. A workgroup of 8-9 officers will convene at the Grand Island Law Enforcement Training Academy to develop a 3-4 hour curriculum that may be placed online or on DVD to allow rural and statewide access to CIT training. Law Enforcement and Emergency Behavioral Health workers that are at the scene will be trained on crisis intervention based on a SAMHSA tool called the Green Book. Jail Diversion programs are expanding into all the Regions. Working on a discharge planning for people leaving the criminal Justice systems to include supported housing, employment and medical issues. Keya House has been used instead of arrest. DBH has formed partnerships with Department of Correctional Services, Crime Commission and Probation Administration to engage and move forward in the criminal justice areas. The Criminal Justice Grant ends 8-21-2011.

**Substance Abuse Prevention Treatment Block Grant (SAPTBG) – Jim Harvey****Attachment G**

Core Technical Review (CTR) team is coming October 18-22 to review how Nebraska implemented treatment review, financial and data components. The 2007 CTR resulted in Nebraska not meeting the acceptable standards ("we flunked") and was on a formal corrective action plan. DBH staff has been working hard and is ready for the review team.

Jim Harvey reviewed the SAPTBG with brief explanations but specifically Form 7. Page 4 states Block Grant funds are not allowed to be used to provide substance abuse treatment to individual in correction or penal systems.

Nebraska committed to 11 priorities around Health Reform January 2014 and would like more input from this committee.

**Goal 2- Prevention activities comments**

Renee Faber heard from the prevention field that the Division needs to take on a public leadership role and be more in the fore front with prevention. The coalitions have led this system for many years and each region does prevention differently. NE Partners in Prevention (NE-PIP) should be the driver for cohesive and consistent services. Committee members strongly encourage DBH to take the leadership in prevention.

The Oxford House \$4000 start-up loan can be used to buy supplies, furniture, down payment, utilities, etc. For an Oxford House to exist there needs to be at least 8 people in each home to pay the rent. The spending authorization is \$40,000. More money was added to the contract with the Good Neighbor Foundation, so they can hire someone to train and work the other half of the state.

The Individual Peer Review contract with NABHO will be changing the contract period so they can report and make presentations to committees. Also to increase the communication with Regions to better inform them of review dates. To eliminate duplication of audits DBH is looking at what the statutory mandates for COA, JAHCO and CARF require.

Vicki Maca suggested adding priority 12 to read, "DBH through strategic planning and other efforts puts focus on ensuring Nebraska is positioned for healthcare reform implementation to begin in January 2014."

Jim Harvey asked the committee to take a position on the priorities reviewed.

\*Committee felt the review presentation of the SAPTBG and questions during the presentation were captured very well.

\*ASI/CASI is not a good assessment tool and there is no benefit for everyone using it. The promise to Probation was for everyone to use the ASI/CASI assessment tool to collect/measure consistent data information in order to compare data and create reports that break down by regions.

\*suggestion to DBH to continue with priority #5 and start a movement of all these groups to look at a better assessment instrument.

\*suggestion to take out Priority #5

\*suggestion to take out the name of ASI/CASI and change priority #5 to read "data utilization partnership ASI/CASI or other instrument."

Motion was made by Rand Wise and seconded by Randy See to edit priority # 5 to read, "data utilization partnership ASI/CASI or other instrument" and to add priority #12 to read "DBH through strategic planning and other efforts puts focus on ensuring Nebraska is positioned for healthcare reform implementation to begin in January 2014." Motion adopted by unanimous voice vote.

Committee members were encouraged to read the Substance Abuse Block Grant thoroughly and provide comments to DBH, Jim Harvey. The document is to be submitted October 1, 2010.

Agenda Items for December 7, 2011 Meeting:

Individual Peer Review-Dennis Vollmer

Strategic Planning

Probation-ASI/CASI update – Julie Scott

SAPTBG – Review Results

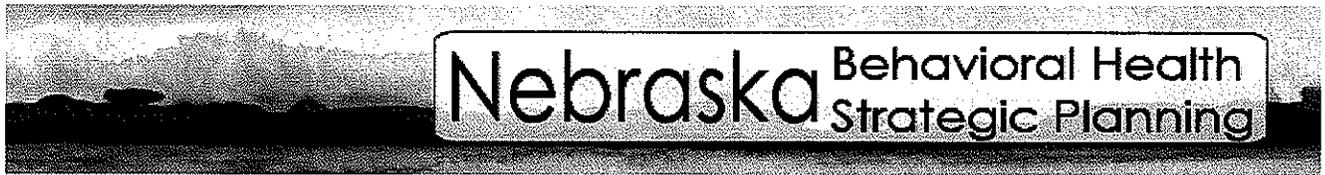
Motion to adjourn meeting was made by Randy See and seconded by Brenda Miner. Motion adopted by unanimous voice vote. Meeting Adjourned 3:05 p.m.

The next meeting date is December 7, 2011.

Prepared by: Alexandra Castillo, Staff Assistant

Approved by \_\_\_\_\_  
Federal Resources Manager  
Division of Behavioral Health

Date \_\_\_\_\_



**Division of Behavioral Health Strategic Planning Update**

**September 21, 2010**

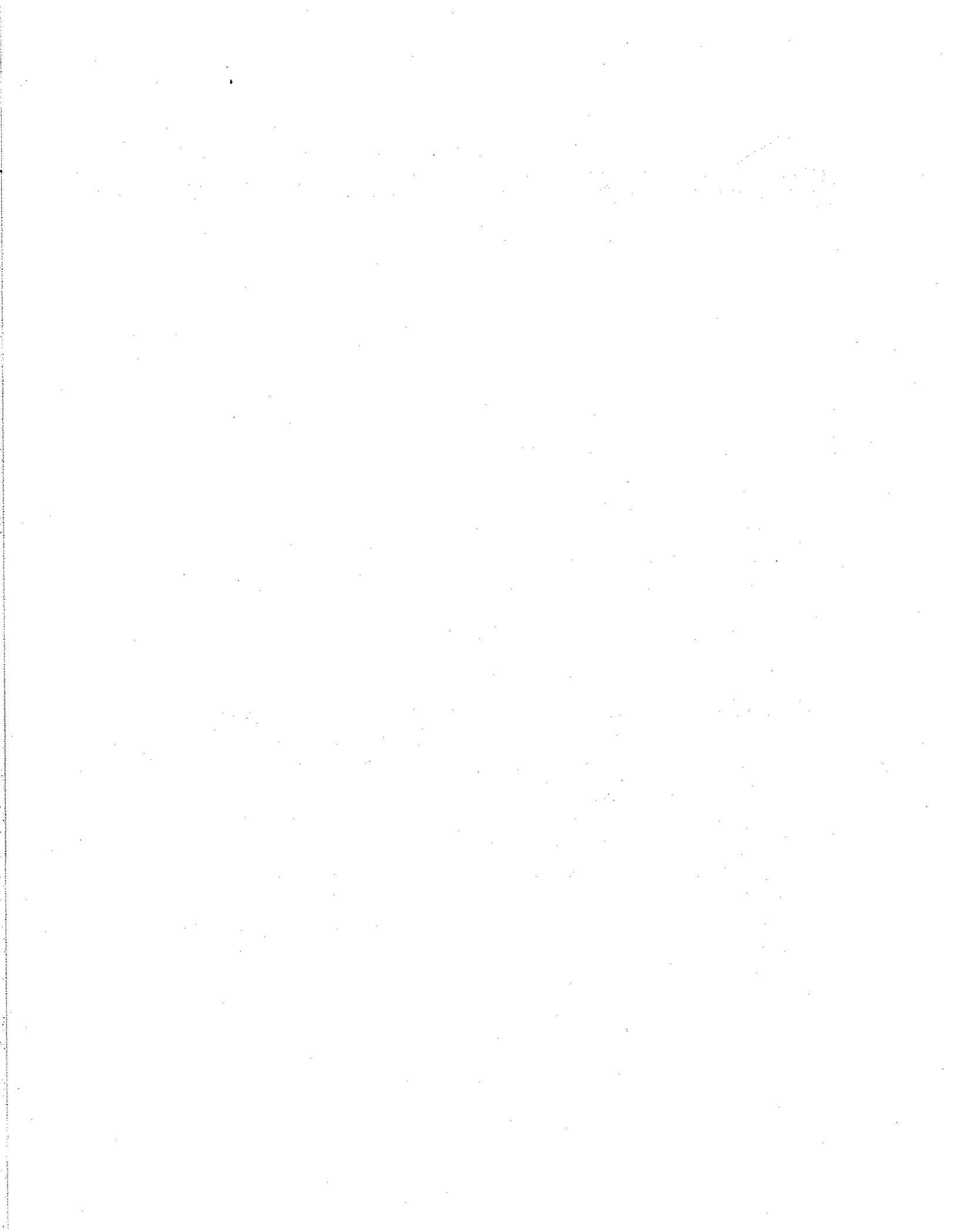
*Joint Strategic Planning Working Group activities (May – September 2010)*

- Reviewed past Nebraska planning documents
- Reviewed strategic planning input from the Joint Advisory Committee Meeting
- Reviewed plans from other states
- Met with three national experts retained for consultation by the Division of Behavioral Health (Monica Os; Dr. Thomas Kirk; Shery Mead)
- Completed an on-line survey to get stakeholder input on planning priorities

*Next Steps*

- A draft plan is being prepared by the Division of Behavioral Health based on recommendations from the Joint Strategic Planning Working Group
- The draft plan will be reviewed by the Joint Strategic Planning Group after October 14, 2010
- Arrangements are being made to present the plan for review to the Advisory Committees via a teleconference/webinar format (TBD)
- The Draft Strategic Plan will be released for broad review and comment (public hearings)
- Revisions to the draft will be made based on public input and a final dynamic document released

For more information: <http://www.bhstrategicplanning.nebraska.edu>





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**DHHSBH-10-TRNG-01 Review****NARRATIVE:**

The Training for Addiction Professionals (TAP) program continues to fulfill its current commitment to Health and Human Services, *Division of Behavioral Health* by completing our second year of the two year contract to provide substance abuse training.

The TAP Program continues to seek new and experienced instructors to bring current and interesting topics to our counselors. In order to continue to be relevant with the growing studies in this field, we have expanded our continuing education and criminal justice topics into areas such as Gender Specific, Trauma-Informed, Co-Occurring Disorders and Multicultural Dialogue.

Because of the need for participants in all areas of the state to receive ample training efficiently, the TAP Program has partnered with the Nebraska Video Conferencing Network (NVCM) to implement video conferencing for their Continuing Education courses. This technology allows for multiple site interactions between the instructor and the participants.

**Section 1 – Core Education Courses**

The TAP program offered **645 hours** of core education for alcohol/drug counselor licensure. All core education courses required for licensure were offered a minimum of two times this contract year. A minimum of one core education course was offered per month. None of the core education courses were offered by teleconference or interactive video.

The three alcohol specific classes must be offered three times each fiscal year and each training must be offered in Region I, II, or III a minimum of once each fiscal year. In November 2009, *Clinical Treatment Issues in Chemical Dependency* was offered in Grand Island. *Alcohol/Drug Assessment, Case Planning & Management* was offered in North Platte in December 2009. In May 2010, *Medical & Psychosocial Aspects of Alcohol/Drug & Addictions* was offered in Kearney.

No core education trainings were postponed/rescheduled.

**A total of 645 hours of core education** were completed in fiscal year 2010.

***A complete description of the core education courses can be found in Attachment 1.***

**Section 2 – Continuing Education Courses**

The TAP Program provided **108 hours** of continuing education for alcohol/drug abuse counselors to renew licensure. Of the 108 hours, the following requirements have been met:

- a) **Thirty-six (36) hours** must be designated to criminal behaviors, criminal thinking and substance abuse.
- b) **Six (6) hours** must be designated to clinical supervision of licensed Substance Abuse Counselors
- c) The remaining **66 hours** must be other alcohol and drug specific topics including Core Functions and Exam Preparation courses.

These courses were offered through video conferencing; to the extent possible, in Regions I, II, III, IV and VI. A minimum of five (5) participants must be registered in each specific region or that region's video conference site will be cancelled. All courses that are offered through video conferencing will be hosted at the Nebraska Video Conferencing Network (NVCN) main site in Lincoln, NE unless otherwise notified.

**Thirty-six (36) hours** were designated to criminal behaviors, criminal thinking and substance abuse. The average attendance in these criminal justice trainings were 30 participants. New trainings are continually being developed in the area for next year.

A **six (6) hour** training entitled *Clinical Supervision in the 12 Core Functions* was offered in December. Eleven (11) participants attended which was one more than the previous contract year.

**Sixty-six (66) hours** of other alcohol and drug specific continuing education were offered. These courses were all offered through video conferencing will be hosted at the Nebraska Video Conferencing Network (NVCN) main site in Lincoln, NE unless otherwise notified. Specific courses will be developed according to, but not limited to the following topic areas, and will be offered once each fiscal year.

- Gender and Cultural Competence
- Screening and Referral
- Co-Occurring Disorders
- Evidence-Based Treatment
- Trauma-Informed

All **108 hours** of required continuing education hours were completed by June 30, 2010. Average attendance per continuing education training this fiscal year was 18 participants, which is up from our last contract year with an average of 14. Of the 18 continuing education courses offered, two (2) full courses were cancelled due to low registration numbers, and 14 satellite sites were cancelled due to lower registration numbers as a requirement of the contract states that a minimum of five (5) participants must be registered in each specific region or that region's video conference site will be cancelled.

**For a complete list, please see Attachment 2.**  
**Section 3 – ASI/CASI Continuing Education Courses**

The ASI/CASI trainings are being offered to provide substance abuse professionals the opportunity to be eligible for the Substance Abuse/Criminal Justice Approved Provider List. The TAP program was contracted to provide **up to 100 hours** of ASI Trainings and **up to 80 hours** of CASI Training.

The TAP Program planned and provided **80 hours** of the ASI Trainings and **60 hours** of the CASI Trainings. This year because of the demand of the ASI Training, TAP had to start a Waiting List for interested participants. If a participant backed out of the ASI, we would then call the next person on the list to take their position. This list has helped out and the list has decreased during this period.

**Attachment 3 provides a complete list of ASI/CASI trainings for this fiscal year.**

#### **Section 4 - Other Education Initiatives and Topics**

The TAP Program and the Division have decided to add a course titled *An Entry into ASAM Criteria*. The TAP Program will offer this course twice per fiscal year for a total of 12 hours of continuing education. The TAP Program will host this course at a main Lincoln site in Region V and video conference this course to Regions I, II, III, IV and VI, subject to venue availability. A minimum of five (5) participants shall be registered in each specific region, or that specific region's video conference site will be cancelled. This course was held for the first time on September 10, 2010 under the new DHHS-BH-FY11-SA Counselor TRNG Contract, and 22 participants attended.

*The Core Functions of Licensed Drug and Alcohol Counselor* course has been redeveloped as *The Roles & Responsibilities of the Substance Abuse Counselor*. A majority of this course will remain the same but will have a few new objectives added to cater to the changes made with the removal of the oral examination. The TAP Program will offer this course twice per fiscal year for a total of 12 hours of continuing education. This course will be offered up to four weeks before two of the four written examination dates during the fiscal year.. The TAP Program will host this course at a main Lincoln site in Region V and video conference this course to Regions I, II, III, IV and VI, subject to venue availability. A minimum of five (5) participants shall be registered in each specific region, or that specific region's video conference site will be cancelled.



September 21, 2010

## Criminogenic CEU Standards

### “Conceptual Document”

**Definition of Criminal Justice Focused Training:** Criminogenic training shall include education pertaining to substance related or co-occurring disorders and its application to the criminal justice population. Criminogenic is defined as relating to characteristics or factors identified by research as predictors of crime and/or recidivism.

Provider skill enhancement trainings related to the criminal justice population would be included as criminogenic trainings (i.e. Motivational interviewing with the Juvenile Offender).

**Criminogenic Needs** – Criminogenic needs are attributes of offender/juveniles that are directly linked to criminal behavior.

**Criminogenic Risks** – Those offender/juvenile characteristics that are directly related to researched causation of crime.

### Criminogenic Approval Requirements

Trainings seeking criminogenic approval must be submitted 30 days prior to training facilitation, include agency in-house training. Materials to be provided must include:

1. Copy of the program agenda indicating actual presentation times, lunch, and breaks;
2. Description of the program content and objectives;
3. Description of the education, experience, and training of each presenter;
4. Number of hours for which approval is requested;
5. Name, address, and telephone number of the person or organization submitting the application;
6. Description of the process the training program provider will use to document and monitor attendance;
7. Date, time, town/city, state, and location of the program;
8. Title of the program and name of presenting organization/person; and
9. Signature of the person submitting the application.

A continuing education program is approved specifically for the date of the program. If an identical program (same content, agenda, objectives and presenter) is presented again within the biennial renewal period, the provider will not be required to complete the entire application for approval of continuing education. The provider must submit the application completing the program title, date of program, location of program, provider contact information and representative signature, and include a statement that the program is identical to a previously approved program providing the prior approved number.

- DHHS form requesting ceu approval could be adjusted to include a check box at top if seeking Criminogenic training
- Second form, to be added posing questions on how this training would increase knowledge of working with criminal justice offenders addressing substance related or co-occurring disorders.
- Met with Licensing Division to see about process of tracking – a link could be added on Licensing Division website directing providers to Criminogenic Approved CEU's.
- Licensing Division posing partnership with Licensing Board, as next step

September 21, 2010

## Web-based Training Concept

**Theme:** Over the next three years, develop web-based training for workforce development in substance use/co-occurring disorders and the criminal justice system.

**Why:**

- Creates a foundation training available for providers to access in all areas of the state
- Allows contracted dollars to be utilized for more skills based training
- Taps into Substance Abuse Prevention and Treatment Block Grant
  - Goal 11: An agreement to provide continuing education for the employees of facilities which provide prevention activities or treatment services.
- Strengthens partnerships between multi-systems
  - Trainings could be used by: providers, judges, attorneys, law enforcement, local jails, HHS workforce and other related stakeholders.

### Example of Universal Criminogenic On-line Training

- 1<sup>st</sup> six (6) hours of criminogenic training would be created as on-line/webinar trainings
  - Broke up into two three-hour classes
  - Proposed 1<sup>st</sup> training to include
    - 8 EBP principles
    - Crim. Risk/Needs; Criminogenic defined
      - How assessment assists in providing information
    - How Risk/Need information benefits providers
      - Targeted Interventions
      - Responsivity principles into lowering risk
  - Proposed 2<sup>nd</sup> training to include:
    - Responsive Case Management – Probation perspective
      - How this connects with Provider case management
    - Levels of Engagement
      - Expectations from providers and officers
    - Monthly progress reports (vouchers and non-monetary)
      - Levels of Engagement
    - Highlight – Juvenile and Adult Specific Interventions
    - 2<sup>nd</sup> training may include an interactive webinar piece
    - Define future training approval

### Proposed non-criminogenic on-line training topics could include:

- Standardized Model
- Criminal Justice Processes and Procedures (Probation, Parole, Problem-solving Courts)
- ASAM Criteria and Stages of Change
- Cognitive Group Facilitation

Attachment D

WELCOME TO THE SEPTEMBER 21, 2010  
TUESDAY DATA CALL

SUBSTANCE ABUSE and MENTAL HEALTH CAPACITY  
and  
WAITING LIST REPORT

Sheri Dawson, R.N.  
Managed Care and Quality Improvement Administrator  
Division of Behavioral Health  
Department of Health & Human Services

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Quarter 3 State Fiscal Year 2010  
Statewide Substance Abuse Capacity

*Executive Summary*

- Ten of the 21 substance abuse services the RBHAs report to the DBH are consistently above 90% available regional capacity. However, agency capacities for these services are not necessarily above 90%, which may allow the RBHAs opportunity to purchase additional units if needed.
- The remaining eleven substance abuse services fall below 90% region capacity, some far below. Regions may choose to review the Microsoft Access report "Substance Abuse Capacity" for the agency and region capacity for particular services and providers in their regions to evaluate their current purchased capacity.
- There were 325 people identified as priority populations who were waiting for services during the thirteen week reporting period, 21 of which were waiting for more than one type of service or service from multiple providers.

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Quarter 3 State Fiscal Year 2010  
Statewide Substance Abuse Capacity

*Priority Populations*

The majority of the identified priority populations waiting for substance abuse service were:

- ❖ women with dependent children (44.9%, n=146)
- ❖ intravenous drug users (37.5%, n=122)
- ❖ mental health board commitments (17.2%, n=56)
- ❖ pregnant women (5.8%, n=19)
- ❖ pregnant intravenous drug users (0.6%, n=2)

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**Quarter 3 State Fiscal Year 2010  
Statewide Substance Abuse Capacity**

*Priority Populations/Waiting For Substance Abuse Service*

Most people identified as priority populations waiting for substance abuse service were:

- ❖ waiting for admission into short-term residential services (50.7%, n=175)
- ❖ therapeutic community services (21.2%, n=73)
- ❖ dual disorder residential services (9.6%, n=33)
- ❖ outpatient services (7%, n=24)
- ❖ intensive outpatient services (5.2%, n=18)

Less than 5% of people waiting for service were:

- ❖ waiting for halfway house (3.2%, n=11)
- ❖ intermediate residential (1.4%, n=5)
- ❖ outpatient dual (0.9%, n=3)
- ❖ therapeutic community for youth (0.9%, n=3)

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**Quarter 3 State Fiscal Year 2010  
Statewide Substance Abuse Capacity**

*Average Wait*

The average wait for persons identified as priority populations waiting to enter substance abuse treatment is 29.82 days.

- ❖ Women with dependent children have the longest average wait at 35.3 days
- ❖ intravenous drugs users at 26.34 days
- ❖ pregnant women at 25.47 days
- ❖ mental health board commitments at 24.21 days
- ❖ pregnant intravenous drug users at 10.5 days

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**Quarter 3 State Fiscal Year 2010  
Statewide Substance Abuse Capacity**

*Longest Waits*

On average, the longest waits for substance abuse services are for:

❖ outpatient services (62.58 days)	❖ short-term residential (23.36 days)
❖ outpatient dual (44.33 days)	❖ intensive outpatient (18.83 days)
❖ therapeutic community (37.07 days)	❖ intermediate residential (15.2 days)
❖ halfway house (34.36 days)	❖ youth therapeutic community services (10.33 days)
❖ dual disorder residential (29.8 days)	

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**Quarter 3 State Fiscal Year 2010  
Statewide Mental Health Capacity**

*Executive Summary*

- Eighteen of the 34 mental health services the RBHAs report to the DBH are consistently above 90% available regional capacity. However, agency capacities for six of these services are not necessarily above 90%, which may allow the RBHAs opportunity to purchase additional units if needed.
- The remaining sixteen mental health services fall below 90% region capacity some far below. Regions may choose to review the Microsoft Access report "Mental Health Capacity" for the agency and region capacity for particular services and providers in their regions to evaluate their current purchased capacity.

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**Quarter 3 State Fiscal Year 2010  
Statewide Mental Health Capacity**

*Priority Populations*

On average, there are 57 people identified as priority populations waiting to receive mental health service from month to month. The majority of these people are:

- ❖ mental health board commitments (45.6%, n=26)
- ❖ current clients of the behavioral health system (25.4%, n=17)
- ❖ persons discharged from a Regional Center (20.3%, n=12)
- ❖ persons who would be admitted into a Regional Center but could be served in the community instead (3.5%, n=2)

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**Quarter 3 State Fiscal Year 2010  
Statewide Mental Health Capacity**

*Waiting for Services*

- ❖ 40.6% (n=23) of the people on the waiting list were waiting for secure residential services
- ❖ 13.4% (n=8) were waiting for community support services
- ❖ 10.4% (n=6) were waiting for day rehabilitation services
- ❖ 8.7% (n=5) were waiting for psychiatric respite services
- ❖ 8.1% (n=5) were waiting for medication management services
- ❖ 7.8% (n=5) were waiting for outpatient services
- ❖ 7.4% (n=4) were waiting for psychiatric residential rehabilitation
- ❖ 3.5% (n=2) were waiting for intensive community

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**Quarter 4 State Fiscal Year 2010  
Statewide Substance Abuse Capacity**

**Executive Summary**

- Eleven of the 20 substance abuse services the RBHAs report to the DBH are consistently above 90% available regional capacity. However, agency capacities for these services are not necessarily above 90%, which may allow the RBHAs opportunity to purchase additional units if needed.
- The remaining nine substance abuse services fall below 90% region capacity, some far below. Regions may choose to review the Microsoft Access report "Substance Abuse Capacity" for the agency and region capacity for particular services and providers in their regions to evaluate their current purchased capacity.
- There were 275 people identified as priority populations who were waiting for services during the thirteen week reporting period, 11 of which were waiting for more than one type of service or service from multiple providers.

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**Quarter 4 State Fiscal Year 2010  
Statewide Substance Abuse Capacity**

**Priority Populations**

The majority of identified priority populations waiting for substance abuse service were:

- ❖ women with dependent children (40.7%, n=112)
- ❖ intravenous drug users (37.1%, n=103)
- ❖ mental health board commitments (20.7%, n=57)
- ❖ pregnant women (3.3%, n=9)
- ❖ pregnant intravenous drug users (1.1%, n=3)

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**Quarter 4 State Fiscal Year 2010  
Statewide Substance Abuse Capacity**

**Waiting for Substance Abuse Service**

Most people identified as priority populations were waiting for substance abuse service were:

- ❖ waiting for admission into short-term residential services (48.1%, n=136)
- ❖ therapeutic community services (20.8%, n=59)
- ❖ dual disorder residential services (12.0%, n=34)
- ❖ intensive outpatient services (9.9%, n=28)
- ❖ outpatient services (5.7%, n=16)

Less than 5% of people waiting for service were:

- ❖ waiting for intermediate residential (1.4%, n=4)
- ❖ halfway house (1.1%, n=3)
- ❖ community support (0.4%, n=1)
- ❖ social setting detox (0.4, n=1)
- ❖ therapeutic community for youth (0.4%, n=1)

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**Quarter 4 State Fiscal Year 2010  
Statewide Substance Abuse Capacity**

**Average Wait**

The average wait for persons identified as priority populations waiting to enter substance abuse treatment is 25.54 days.

- ❖ Women with dependent children have the longest average wait at 31.57 days
- ❖ mental health board commitments at 23.68 days
- ❖ intravenous drugs users at 20.5 days
- ❖ pregnant women at 20.11 days
- ❖ pregnant intravenous drug users at 8.67 days

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**Substance Abuse and Mental Health Capacity and Waiting List Report  
Quarter 4 State Fiscal Year 2010 – cont'd**

**Longest Waits**

On average, the longest waits for substance abuse services are for:

❖ therapeutic community (41.86 days)	❖ therapeutic community for youth (12 days)
❖ dual disorder residential (30.74 days)	❖ outpatient (10.5 days)
❖ short-term residential (21.05 days)	❖ intermediate residential (10 days)
❖ intensive outpatient (20.44 days)	❖ social detox setting (8 days)
❖ halfway house (14.33 days)	❖ community support services (1 day)

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**Substance Abuse and Mental Health Capacity and Waiting List Report  
Quarter 4 State Fiscal Year 2010 – cont'd**

**Statewide Mental Health Capacity**

- Nineteen of the 33 mental health services the RBHAs report to the DBH are consistently above 90% available regional capacity. However, agency capacities for four of these services are not necessarily above 90%, which may allow the RBHAs opportunity to purchase additional units if needed.
- The remaining fourteen mental health services fall below 90% region capacity, some far below. Regions may choose to review the Microsoft Access report "Mental Health Capacity" for the agency and region capacity for particular services and providers in their regions to evaluate their current purchased capacity.

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**Substance Abuse and Mental Health Capacity and Waiting List Report  
Quarter 4 State Fiscal Year 2010 – cont'd**

**Waiting**

On average, there are 24 people identified as priority populations waiting to receive mental health service from month to month. The majority of these people are:

- ❖ persons discharged from a regional center (76.6%, n=18.5)
- ❖ persons in a community inpatient setting awaiting discharge (20.4%, n=4.9)
- ❖ persons committed to outpatient care by a MHB (3.0%, n=0.7)

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**Substance Abuse and Mental Health Capacity and Waiting List Report  
Quarter 4 State Fiscal Year 2010 – cont'd**

**Waiting for Service**

- ❖ 70.5% (n=17) of the people on the waiting list were waiting for secure residential services
- ❖ 12.4% (n=3) were waiting for intensive community services
- ❖ 6.6% (n=1.6) were waiting for medication management services
- ❖ 6.3% (n=1.51) were waiting for outpatient services
- ❖ 2.6% (n=0.63) were waiting for day rehabilitation
- ❖ 1.6% (0.38) were waiting for community support services

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**Annual Summary**

- There were only 9 weeks during the reporting period in the 2<sup>nd</sup> quarter, while there were 13 weeks during the reporting period in the 3<sup>rd</sup> and 4<sup>th</sup> quarter.

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**Annual Summary**

**Substance Abuse Capacity**

- There were fewer people identified as priority populations waiting for substance abuse services in the 4<sup>th</sup> quarter (n=275) than there were in the 3<sup>rd</sup> quarter (n=325). In the 2<sup>nd</sup> quarter, 182 persons identified as priority populations were on the waiting list.
- In the 3<sup>rd</sup> (44.9%, n=146) and 4<sup>th</sup> (40.7%, n=112) quarters, the majority of the identified priority populations waiting for substance abuse services were women with dependent children. In the 2<sup>nd</sup> quarter, most people were waiting for substance abuse services were intravenous drug users (40.7%, n=74)
- In all three quarters, most people identified as priority populations waiting for substance abuse service were waiting for admission into short-term residential services (37.9% (n=74) in the 2<sup>nd</sup> quarter, 50.7% (n=175) in the 3<sup>rd</sup> quarter, and 48.1% (n=136) in the 4<sup>th</sup> quarter, respectively).

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**Annual Summary**

**Substance Abuse Capacity**

- The average length of wait for individuals waiting to enter substance abuse treatment decreased from the 2<sup>nd</sup> quarter (31.7 days) to the 4<sup>th</sup> quarter (25.5 days) by 6 days.
- Women with dependent children had the longest average wait in all three quarters, 41 days, 35 days and 32 days, respectively.
- The longest waits for substance abuse services were for outpatient services in the 2<sup>nd</sup> (55 days) and 3<sup>rd</sup> (63 days) quarters. The longest waits in the 4<sup>th</sup> quarter were for therapeutic community services (42 days).

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**Annual Summary**

**Mental Health Capacity**

- There were fewer people identified as priority populations waiting for mental health services in the 4<sup>th</sup> quarter (n=24) than there were in the 3<sup>rd</sup> quarter (n=57).
- Most people identified as priority populations waiting for mental health service were waiting for secure residential services in the 3<sup>rd</sup> (41%, n=23) and 4<sup>th</sup> (71%, n=17) quarters. In the 2<sup>nd</sup> quarter, most people were waiting for community support services (48.3%, n=14.5).

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**Statewide Substance Capacity SFY 2010 – cont'd**

Service	% of Total Agency Capacity Used	% of Region Capacity Used	Threshold
OP Detox	41%	60%	
Detox/Intensive	59%	42%	
Partial Setting Detox	47%	54%	
CI	60%	71%	
OP (Youth)	46%	52%	
OP (Youth)	26%	18%	Less than 50%
Independent-IA Assess only	8%	18%	
Medical Detox w/ Med Comp	42%	39%	

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**Co-Occurring Disorders Service  
Delivery Quality Initiative Workgroup**

Committee Chair: Blaine Shaffer  
Co-Chair: Sheri Dawson  
Facilitator: Mary O'Hare  
DBH Team Support: Tammy Westbrook

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**Mission Statement**

- The Co-Occurring Disorders Quality Initiative will improve services to Nebraska adults with co-occurring mental health and substance use disorders and their families.

**Goal**

- The Co-Occurring Disorders Workgroup will produce a roadmap to a statewide, integrated co-occurring service delivery system.

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**SAMSHA's Co-Occurring Disorders Initiative**

- The Co-Occurring Disorders Initiative (CODI) supports the Substance Abuse and Mental Health Services Administration's (SAMHSA) goal to improve the quality of life for persons with mental health and substance abuse disorders. CODI provides information and resources to promote access to effective integrated services for persons with co-occurring disorders.
- <http://coce.samhsa.gov/about/>

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### State Incentive Grants

- COCE provided technical assistance to the Policy Academy States as one of its target audiences.
- As part of the SAMHSA Policy Academy initiative, States have developed plans for addressing co-occurring disorder at a systems level. These plans provide excellent examples for other States who may be interested in advancing their systems of care for co-occurring disorders.
- [http://coce.samhsa.gov/cod\\_resources/pas\\_action\\_plans.aspx](http://coce.samhsa.gov/cod_resources/pas_action_plans.aspx)



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### SAMHSA's Core Content Areas

- Screening, Assessment, Treatment Planning, and Treatment Service
- Workforce Issues
- Systems Issues
- Prevention and Early Intervention
- Evaluation and Monitoring



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### SAMHSA's Overview Papers

- No. 1 - Definitions and Terms Relating to Co-Occurring Disorders
- No. 2 - Screening, Assessment, and Treatment Planning for Persons with Co-Occurring Disorders
- No. 3 - Overarching Principles To Address the Needs of Persons With Co-Occurring Disorders
- No. 4 - Addressing Co-Occurring Disorders in Non-Traditional Service Settings



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- No. 5 - Understanding Evidence-Based Practices for Co-Occurring Disorders
- No. 6 - Services Integration for Persons With Co-Occurring Disorders
- No. 7 - Systems Integration Relevant to Co-Occurring Disorders
- No. 8 - The Epidemiology of Co-Occurring Disorders

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Work Plan			
Subcommittee	Category	Due Date to Workgroup	Action Plan Draft Complete
All	COD Definitions	May 2010	N/A
All	Overarching Principles	June 2010	August 2010
All	Epidemiology	July/August 2010	
Screening, Assessment, Treatment Planning, and Treatment Service	*Evidence and Consensus-Based Practices *Screening, Assessment and Treatment Planning *Special Setting	August 2010 September 2010 October 2010	
Workforce Issues	COD Workforce	November 2010	
All	*Systems Integration *Services Integration *Housing Treatment Services	December 2010 January 2011 January 2011	
Prevention and Early Intervention	Prevention and Early Intervention	February 2011	
Evaluation and Monitoring	Evaluation and Monitoring	March 2011	
All	Development of Action Plan	April 2011	

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- ### Subcommittee Responsibilities
- Review COCE Content Framework Related Information
  - Research other literature related to topic area
  - Review other states' progress in the area
  - Present findings to the larger workgroup
  - Propose statewide strategies
  - Lead discussion with larger workgroup
  - Seek feedback from other stakeholders

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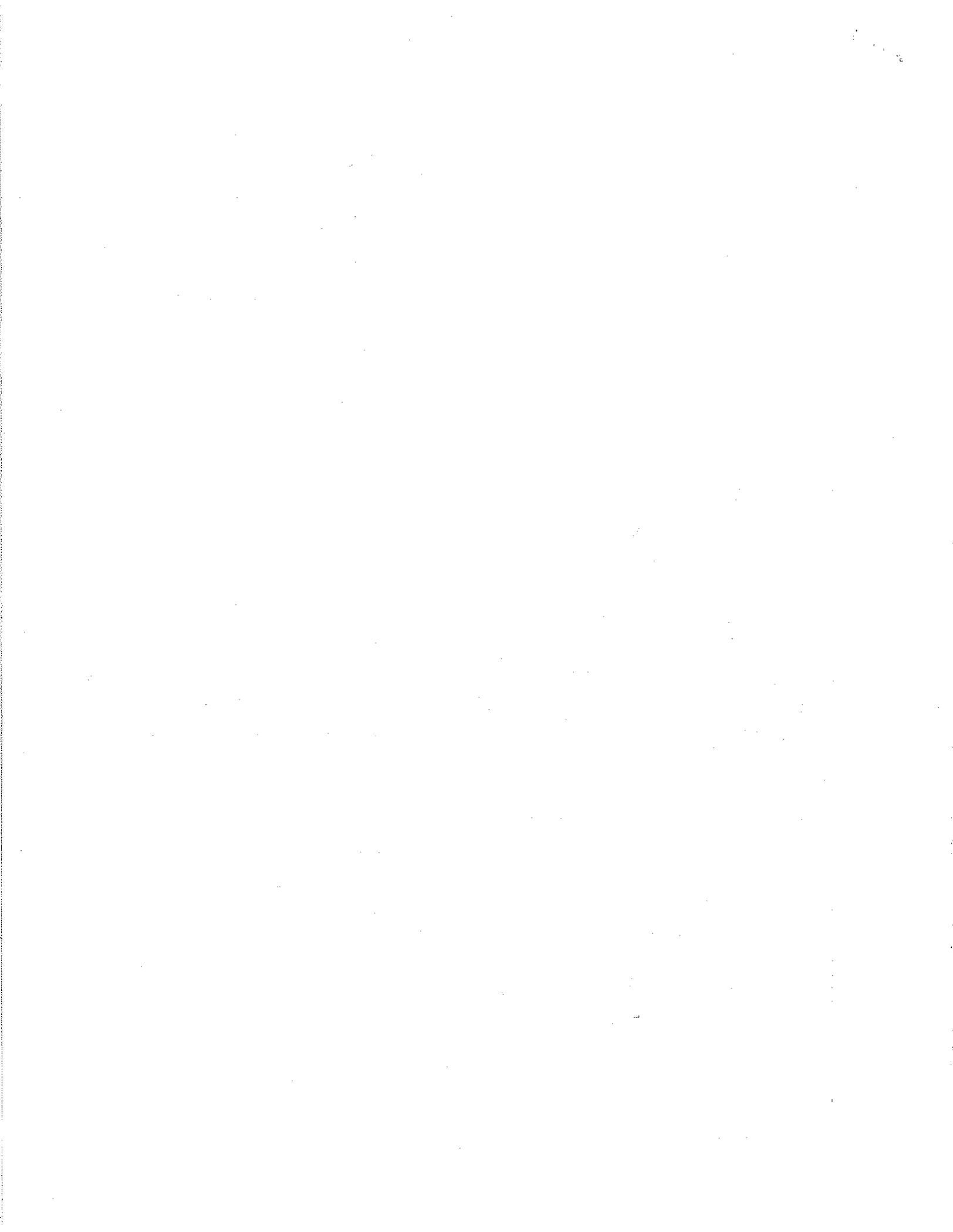
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**DBH Tuesday Data Call Schedule  
9:00 AM to 10:00 AM (CST)**

<u>DATE</u>	<u>SAPTBG WAITING LIST REVIEW</u>	<u>DATA CALL TOPIC (45 minutes)</u>
September 7, 2010	15 minutes	Magellan List of Reports, Web Access, and Avg LOS Report
September 14, 2010	15 minutes	Magellan Annual Reports
September 21, 2010	15 minutes	SAPTBG Capacity and Waiting List Quarterly and Annual Report
September 28, 2010	15 minutes	QI Coordinator Regional Overviews Regions 1 and 5
October 5, 2010	15 minutes	<u>Quarterly SOMMS Report</u> MHBG Performance Indicators originally scheduled however reviewed in Sept SQIT
October 12, 2010	15 minutes	Magellan Web Access/Admission Summary and Discharge Summary
October 19, 2010	15 minutes	Magellan Utilization and Magellan Trauma Report
October 26, 2010	15 minutes	QI Coordinator Regional Overviews Regions 2 and 3
November 2, 2010	15 minutes	Professional Partner (Maya)
November 9, 2010	15 minutes	SQIT FY2010 Performance Measure and DBH Annual Consumer Survey
November 16, 2010	15 minutes	Magellan Emergency System Reports and Summary of Movement of Populations
November 23, 2010	15 minutes	DBH Statewide Emergency Report (Sarah)
November 30, 2010	15 minutes	QI Coordinator Regional Overviews Regions 4 and 6
December 7, 2010	15 minutes	Magellan NOMS Report Overview
December 14, 2010	15 minutes	GAP Reports
December 21, 2010	15 minutes	Monthly Report and Summary Discussion - Keep? Pitch and Ditch?
December 28, 2010	15 minutes	QI Coordinator Discussion - Next steps



**GOAL # 2. INTENDED USE PLAN for FY2011-2013**

Providing Primary Prevention services: An agreement to spend not less than 20 percent of the SAPT Block Grant on a broad array of primary prevention strategies directed **at individuals not identified to be in need of treatment**. Comprehensive primary prevention programs should include activities and services provided in a variety of settings for both the general population, and targeted sub-groups who are at high risk for substance abuse.

*2.1 -- The Division of Behavioral Health will contract with the Regional Behavioral Health Authorities for Prevention System Coordination, training and technical assistance via a Regional Prevention Coordinator in each of the six regions.*

*2.2 -- The Division of Behavioral Health, Division of Public Health and Regional Prevention System Coordination will provide opportunities for training and technical assistance to local community coalitions and prevention professionals to strengthen their capacity to deliver effective prevention programs, policies, and practices.*

*2.3 -- In support of Workforce Development, the Division of Behavioral Health will research the credentialing processes for Prevention Specialists and identify a potential program for Nebraska.*

*2.4 -- The Division of Behavioral Health and the Division of Public Health will work to improve the Nebraska Prevention Information Reporting System (for SAPTBG and SPF-SIG funding recipients) and prepare it for use as a statewide prevention reporting system available for use by other funded prevention agencies/coalitions.*

*2.5 -- In effort to provide statewide coordinated Prevention Leadership, the Division of Behavioral Health will collaborate with Regional and State prevention staff to develop an updated statewide strategic prevention plan.*

*2.6 -- In support of increasing capacity level and to evaluate progress, each SPF-SIG and SAPTBG funded community coalition, in cooperation with the Regional Prevention Coordinator, will conduct a self assessment using the online Coalition Capacity Survey.*

*2.7 -- The Division of Behavioral Health will research Fee for Service (FFS) Prevention Systems and make recommendations for Nebraska's Prevention System.*

## **DAY 1, TUESDAY, OCTOBER 5, 2010 STATE PREVENTION SYSTEM REVIEW**

The State Project Officer (SPO) will provide an overview of SAMHSA, national progress toward reaching the National Outcome Measures (NOMs), and the purpose and process of the review. DBH will provide an overview of:

- The vision, mission, and overarching frameworks and principles of the prevention system, including use of the Strategic Prevention Framework (SPF) or other planning models
- How the State prevention system is organized, including key partners and collaborations
- How prevention needs assessment is conducted
- The prevention workforce development and capacity development initiatives
- The SSA or State strategic plans for substance abuse prevention
- How SAPTBG and other prevention funds are allocated, including priorities, special initiatives, key strategies, and persons served
- How NOMs data are collected and reported
- The amounts and primary sources of prevention funding (State, other Federal, etc.)
- The evaluation and monitoring processes and tools
- The key contextual conditions that impact substance abuse prevention in the State
- The State's strengths and notable practices, as well as challenges and desired areas for development

### **SSA and State Prevention System Development and Organization**

Discussion of prevention system development, organization, and substance abuse trends.

### **Prevention Compliance and Compliance Support**

Discussion of prevention compliance and compliance support, including SAPTBG expenditures, comprehensive prevention program, and NOMs reporting.

### **Prevention Operations**

Discussion of prevention operations, including needs assessment; workforce development and capacity building; strategic planning; prevention funding, contracting, and subrecipients; needs assessment and evaluation; and State policies.

## **DAY 2, WEDNESDAY, OCTOBER 6, 2010 SYNAR PROGRAM**

The SPO will provide an overview of the Synar program, national tobacco-related outcomes, and strategies for reducing youth access to tobacco. DBH will provide the system review team with:

- State's vision of the future of the Synar program as it will affect the retailer violation rate (RVR) and other State outcomes, and any key issues that may enhance or hinder vision
- Review of the Synar RVR and issues affecting the rates
- Overview of the State budget and expenditures for the Synar program, includes SAPTBG
- Progress in applying the categories of the SPF or other planning model to the Synar program
- Summary of main components of State's Synar program performance management system

### **Synar Program Organization and Support**

Discussion based on the presite assessment of State Synar program organization and support, including program organization, budget, strategic plan for tobacco access and Synar, policy development and education, and State strategies for youth access prevention support.

### **State Synar Program Compliance**

Discussion based on the presite assessment of Synar compliance, including laws; enforcement; random, announced inspections and valid probability sample; RVR compliance; and reporting.

### **Verification of Synar Procedures**

Review the most recent year's Synar inspection forms. Observe five complete Synar inspections.

## **Form 7 – State Priorities**

### **FY 2011 - SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT**

Here is what the SAPTBG requires ...

Page 31 – The specific priorities that the State has established should be reported in Form 7. State priorities should include, but are not limited to the set of Federal program goals specified in the Public Health Service Act. In addition, provide any necessary explanation of the way your State records data or interprets the indices in columns 6 and 7, Form 4.

#### **Page 43 – Form 7 – State Priorities**

How to complete Form 7: Report the State's top services priorities, up to twelve (12), based on needs assessment and performance management information. While it must be acknowledged that the 17 Federal Goals are service goals for your State program, not necessarily each and every one on the 17 Federal Goals is reflective of the specific service needs and target population identified by the State in its prioritization of State needs. Therefore, complete this form based on the State's informed planning process and indicate the State's self-identified service needs. If referencing a Federal Goal as a service need that matches the State's identified services need, use only one specific Federal Goal per line.

<b>State Priorities - FY 2011 to FY 2013</b>	
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The 17 Goals under SAPTBG.....	5
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SAPTBG Priorities based on FY2011 Contracts .....	7
Crime Data 2006 to 2009 .....	8

## Form 7 – SAPTBG Priorities (Not in order of priority)

1. **Access/ Block Grant Requirement – Priority Populations** – Ensure immediate access to substance abuse treatment for individuals from the four priority populations (Pregnant Injecting Drug Users, Pregnant Substance Abusers, Injecting Drug Users, & Women with Dependent Children).

Goal 1: Maintain a continuum of SA treatment services.

Goal 3: FY 1994 ... Pregnant Women and Women with Dependent Children

Goal 4: Intravenous Drug Users (IVDUs)

Goal 9: Each pregnant woman be given preference in admission to treatment facilities ... Capacity Management and Waiting List Systems

Goal 10: Referring individuals to the treatment modality that is most appropriate for the individual.

2. **Access/ Block Grant Requirement – Interim Services Within 48 Hours** – Ensure that individuals from the four priority populations receive Interim Services within 48 hours and are placed on the Substance Abuse Waiting List when substance abuse treatment is not immediately available.

Goal 3: FY 1994 ... Pregnant Women and Women with Dependent Children

Goal 4: Intravenous Drug Users (IVDUs)

Goal 9: Each pregnant woman be given preference in admission to treatment facilities ... Capacity Management and Waiting List Systems

3. **Access /System Coordination** – Ensure that individuals from the four priority populations have access to a Substance Abuse Evaluation – appointment within 48 hours of request – Evaluation completed within 7 business days of appointment.

Goal 4: Intravenous Drug Users (IVDUs)

Goal 9: Each pregnant woman be given preference in admission to treatment facilities ... Capacity Management and Waiting List Systems

4. **Enhance Continuing Education / Capacity & Partnerships** - Improve statewide access to Continuing Education for substance abuse providers. Division of Behavioral Health and the Office of Probation Administration will continue to partner by exploring web-based training platform opportunities.

Goal 11: Provide continuing education ... prevention activities or treatment services.

5. **Data Utilization / Partnership / ASI-CASI** - The Addiction Severity Index (ASI) and the Comprehensive Adolescent Severity Inventory (CASI) are designed to be used as a face-to-face structured interview guide for the evaluation of substance abuse treatment. Continue to partner with Probation to implement data strategy for ASI/CASI aggregate data to be utilized by substance abuse providers and Division of Behavioral Health (DBH)/Probation.

Goal 3: FY 1994 ... Pregnant Women and Women with Dependent Children  
Goal 4: Intravenous Drug Users (IVDUs)  
Goal 9: Each pregnant woman be given preference in admission to treatment facilities ... Capacity Management and Waiting List Systems

6. **Focus on Prevention** – Enhance state leadership with SA Prevention by development of a Prevention Strategic Plan. DBH, as the Single State Agency, in partnership with Division of Public Health, to improve prevention statewide leadership. DBH will contract with Regional Behavioral Health Authorities for prevention system coordination, training and technical assistance. The Nebraska Information Reporting System (NPIRS) will be improved. Technical Assistance may be requested.

Goal 2: 20 percent on primary prevention programs

7. **Access and Retention / Technical Assistance** – Continue to implement the strategies identified in the In Depth Technical Assistance (IDTA) that are designed to improve the systems (DBH, Division of Medicaid and Long-Term Care (DMLTC), Division of Children and Family Services (DCFS), Probation, Juvenile Courts) response to serving children in the CFS system whose parents are substance users.

Goal 12: Coordinate prevention activities and treatment services with other ... services.

8. **Waiting List / Data Management** – Improve the Capacity Management Information System (CMIS) process of tracking Substance Abuse Waiting List/Interim Services by exploring the feasibility of “real time” data software.

Goal 1: Maintain a continuum of SA treatment services.  
Goal 3: FY 1994 ... Pregnant Women and Women with Dependent Children  
Goal 4: Intravenous Drug Users (IVDUs)  
Goal 9: Each pregnant woman be given preference in admission to treatment facilities ... Capacity Management and Waiting List Systems  
Goal 10: Referring individuals to the treatment modality that is most appropriate for the individual.

9. **Co-Occurring System of Care** - Continue to promote a statewide Recovery Oriented System of Care that is capable of serving individuals with co-occurring disorders.

On May 6, 2010 the Division of Behavioral Health held the first Joint Meeting of the State Advisory Committee on Mental Health Services and the State Advisory Committee on Substance Abuse Services. Representatives from the State Committee on Problem Gambling also attended. This meeting helped to further document the unmet needs of people who have a co-occurring mental health, substance abuse, and gambling problems. The Division of Behavioral Health has chartered a Co-Occurring Disorders Quality Initiative. This initiative will promote recovery of individuals and families by creating a statewide road map to a statewide, integrated co-occurring service delivery system.

Goal 10: **Information, Education / Access** – An agreement to improve the process in the State for referring individuals to the treatment modality that is most appropriate for the individual.

Goal 12: Coordinate prevention activities and treatment services with other ... services.

10. **Justice Behavioral Health** – Continue to partner with the Department of Corrections to ensure that individuals with substance abuse disorders receive information and referrals to community-based substance abuse treatment services.

NOTE: Restrictions on Expenditure of Grant, Section 1931 [§ 96.135(b) (2)] restricts expenditure of SAPTBG for the purpose of providing treatment services in penal or correctional institutions of the State.

Goal 10: An agreement to improve the process in the State for referring individuals to the treatment modality that is most appropriate for the individual.

Goal 12: Coordinate prevention activities and treatment services with other ... services.

11. **Data Management** – Continue to ensure for the accurate and timely submission (admission and discharge) of data required for SAPTBG data reporting.

Goal 1: Maintain a continuum of SA treatment services.

Goal 2: 20 percent on primary prevention programs

Goal 3: FY 1994 ... Pregnant Women and Women with Dependent Children

Goal 4: Intravenous Drug Users (IVDUs)

Goal 5: Tuberculosis services

Goal 9: Each pregnant woman be given preference in admission to treatment facilities ... Capacity Management and Waiting List Systems

Goal 10: Referring individuals to the treatment modality that is most appropriate for the individual.

Goal 12: Coordinate prevention activities and treatment services with other ... services.

Goal 13: Assessment of the need for both treatment and prevention ... by locality and State.

## The SAPTBG Priority Populations

As you think about these priorities, please remember the SAPTBG Priority Populations are

- 1) Pregnant Injecting Drug Users
- 2) Pregnant Substance Abusers
- 3) Injecting Drug Users
- 4) Women with Dependent Children

## The 17 Goals under SAPTBG

The 17 Goals under the Uniform Application for the Substance Abuse Prevention and Treatment Block Grant (FYs 2011-2013) are below. Goal 6 does not apply to NE.

- Goal 1: The State shall expend block grant funds to maintain a continuum of substance abuse treatment services that meet these needs for the services identified by the State.
- Goal 2: An agreement to spend no less than 20 percent on primary prevention programs for individuals who do not require treatment for substance abuse, specifying the activities proposed for each of the six strategies. Additional instructions: Prevention (checklist)
- Goal 3: An agreement to expend not less than an amount equal to the amount expended by the State for FY 1994 to establish new programs or expand the capacity of existing programs to make available treatment services designed for pregnant women and women with dependent children; and, directly or through arrangements with other public or nonprofit entities, to make available prenatal care to women receiving such treatment services, and, while the women are receiving services, child care. Additional instructions: Programs for Pregnant Women and Women with Dependent Children
- Goal 4: An agreement to provide treatment to intravenous drug abusers that fulfills the 90 percent capacity reporting, 14-120 day performance requirement, interim services, outreach activities and monitoring requirements. Additional instructions: Programs for Intravenous Drug Users (IVDUs) and Program Compliance Monitoring
- Goal 5: An agreement, directly or through arrangements with other public or nonprofit private entities, to routinely make available tuberculosis services to each individual receiving treatment for substance abuse and to monitor such service delivery.
- Goal 6: An agreement, **by designated States (Nebraska is not a HIV Designated State)**, to provide treatment for persons with substance abuse problems with an emphasis on making available within existing programs early intervention services for HIV in areas of the State that have the greatest need for such services and to monitor such service delivery. Additional instructions: Tuberculosis (TB) and Early Intervention Services for HIV
- Goal 7: An agreement to continue to provide for and encourage the development of group homes for recovering substance abusers through the operation of a revolving loan fund. Additional instructions: Group Home Entities and Programs
- Goal 8: An agreement to continue to have in effect a State law that makes it unlawful for any manufacturer, retailer, or distributor of tobacco products to sell or distribute any such product to any individual under the age of 18; and, to enforce such laws in a manner

that can reasonably be expected to reduce the extent to which tobacco products are available to individuals under age 18.

- Goal 9: An agreement to ensure that each pregnant woman be given preference in admission to treatment facilities; and, when the facility has insufficient capacity, to ensure that the pregnant woman be referred to the State, which will refer the woman to a facility that does have capacity to admit the woman, or if no such facility has the capacity to admit the woman, will make available interim services within 48 hours, including a referral for prenatal care. Additional instructions: Capacity Management and Waiting List Systems
- Goal 10: An agreement to improve the process in the State for referring individuals to the treatment modality that is most appropriate for the individual.
- Goal 11: An agreement to provide continuing education for the employees of facilities which provide prevention activities or treatment services.
- Goal 12: An agreement to coordinate prevention activities and treatment services with the provision of other appropriate services.
- Goal 13: An agreement to submit an assessment of the need for both treatment and prevention in the State for authorized activities, both by locality and by the State in general.
- Goal 14: An agreement to ensure that no program funded through the block grant will use funds to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs.
- Goal 15: An agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers that receive funds from the block grant. Additional instructions: Independent Peer Review
- Goal 16: An agreement to ensure that the State has in effect a system to protect patient records from inappropriate disclosure.
- Goal 17: An agreement to ensure that the State has in effect a system to comply with 42 U.S.C. §300x-65 and 42 C.F. R. part 54.

## **SAPTBG Funds only – Regions only – FY2011 Contracts**

Based on Total Allocation of \$7,170,439 (100%)

The top ten allocations cover 76% (\$5,462,000) of total funds allocated to the Regions. This includes seven services and three prevention categories.

--The services component of the top ten covers \$4,069,513 (56.9%) of the SAPTBG allocations to the Regions covering Outpatient, Methadone Maintenance, Social Detox, Short Term Residential, Intermediate Res, Intensive Outpatient, and Halfway House.

--The prevention component of the top ten covers \$1,392,487 (19.3%) of the SAPTBG allocations to the Regions covering Prevention - Environmental, Prevention Coordination, and Prevention - Community Based.

--No Women's Set Aside categories are in the top ten.

Women's Set Aside allocation is 6.34% of the funds to Regions (\$454,291).

The Prevention Totals cover 26.9% (\$1,938,226) of the SAPTBG allocation to the Regions in FY2011.

**Top Ten Items for SAPTBG based on FY2011 allocations**

Outpatient	\$933,734	13.0%
Methadone Maintenance	\$818,611	11.4%
Social Detox	\$782,025	10.9%
Short Term Residential	\$534,202	7.5%
Intermediate Res	\$484,799	6.8%
Intensive Outpatient	\$259,507	3.6%
Halfway House	\$256,635	3.6%
Prevention - Environmental	\$583,663	8.1%
Prevention Coordination	\$548,008	7.6%
Prevention – Community Based	\$260,816	3.6%
<b>Top Ten Total Allocations</b>	<b>\$5,462,000</b>	<b>76.1%</b>

**SAPTBG Priorities based on FY2011 Contracts**

Goals	Topic	Funding	Percent	Including
Goal 1:	total Non-Residential	\$1,529,464	20.6%	[Outpatient, Intensive Outpatient, Community Support, Children Outpatient, Children Community Support, Children Intensive Outpatient]
Goal 1:	total Residential	\$1,524,363	20.5%	[including Short Term Residential, Intermediate Residential, Halfway House, Therapeutic Community, Dual Residential, and Children Therapeutic Community]
Goal 1:	Social Detox	\$782,025	10.5%	
Goal 1:	total Assessment	\$123,459	1.7%	[including Youth Assessment, Assessment/Evaluation Only, and Assessment)
Goal 2	Prevention	1,938,226	26.1%	
Goal 4:	Methadone Maintenance - Intravenous Drug Users (IVDUs)	818,611	11.0%	
Goal 3	Woman's Set Aside (FY 1994 ... Pregnant Women and Women with Dependent Children)	454,291	6.1%	
Goal 11:	provide Continuing Education ... prevention activities or treatment services.	\$170,426	2.3%	
Goal 8:	Synar - Tobacco Products ... to any individual under the age of 18 (Synar Report)	\$80,000	1.1%	
Goal 15:	Independent Peer Review	\$4,500	0.1%	
	<b>Totals</b>	<b>\$7,425,365</b>	<b>100.0%</b>	

**Goal 1: Maintain a Continuum of SA Treatment Services.****Goal 2: 20 percent on Primary Prevention Programs****Goal 3: FY 1994 ... Pregnant Women and Women with Dependent Children****Goal 4: Intravenous Drug Users (IVDUs)****Goal 8: Tobacco Products ... to any individual under the age of 18 (Synar Report)****Goal 15: Independent Peer Review**

**Crime Data 2006 to 2009**

<b>Query Results / Year VS Offense</b>						
YEAR(s): 2006, 2007, 2008, 2009						
AGE: ADULT & JUVENILE / Result Set: 366,892 records found (Aug 13, 2010)						
<b>Offense</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>Total</b>	<b>% of total</b>
All Other Offenses (except traffic)	20,594	19,500	17,607	16,817	74,518	20.311%
<b>Driving Under the Influence</b>	<b>13,528</b>	<b>13,532</b>	<b>13,989</b>	<b>13,635</b>	<b>54,684</b>	<b>14.905%</b>
<b>Liquor Laws</b>	<b>12,831</b>	<b>12,472</b>	<b>12,986</b>	<b>11,681</b>	<b>49,970</b>	<b>13.620%</b>
<b>Drug Abuse Violations</b>	<b>10,588</b>	<b>10,508</b>	<b>10,588</b>	<b>10,129</b>	<b>41,813</b>	<b>11.397%</b>
Simple Assault	9,401	9,527	9,364	9,554	37,846	10.315%
Larceny	7,961	8,514	8,353	9,108	33,936	9.250%
Disorderly Conduct	4,394	4,673	4,400	4,222	17,689	4.821%
Vandalism	3,181	3,068	2,753	3,032	12,034	3.280%
Fraud	1,829	1,896	1,722	1,599	7,046	1.920%
Offense Against Family and Children	1,715	1,683	1,571	1,505	6,474	1.765%
Aggravated Assault	1,152	1,349	1,400	1,419	5,320	1.450%
Weapons	1,141	1,118	1,118	925	4,302	1.173%
Burglary	1,045	938	939	936	3,858	1.052%
Stolen Property	1,100	924	840	765	3,629	0.989%
Sex Offenses (except rape and prostitution)	652	648	605	642	2,547	0.694%
Forgery and Counterfeiting	593	577	469	439	2,078	0.566%
Runaway (Juvenile only)	421	437	448	468	1,774	0.484%
Curfew (Juvenile only)	462	434	496	329	1,721	0.469%
Motor Vehicle Theft	369	435	389	370	1,563	0.426%
Robbery	328	303	398	381	1,410	0.384%
Prostitution	236	182	212	180	810	0.221%
Forcible Rape	163	155	150	162	630	0.172%
Arson	115	108	83	101	407	0.111%
Embezzlement	79	105	113	108	405	0.110%
Criminal Homicide	45	49	45	36	175	0.048%
Vagrancy	41	38	25	28	132	0.036%
Gambling	18	11	19	13	61	0.017%
Death by Negligence	16	16	7	6	45	0.012%
Unknown	2	6	0	3	11	0.003%
Suspicion	2	0	2	0	4	0.001%
<b>Totals</b>	<b>94,002</b>	<b>93,206</b>	<b>91,091</b>	<b>88,593</b>	<b>366,892</b>	<b>100%</b>

\* Liquor laws could be anything other than DUI so it could range from manufacturing to procuring for a minor. It is a general category but the Nebraska Crime Commission does not have any other breakdowns.

Source: Michael Overton, Chief, Information Services Division, Nebraska Crime Commission; September, 2010

**INSTRUCTIONS**

1. Leave No Blanks - Where appropriate code items:  
 X = question not answered  
 N = question not applicable  
 Use only one character per item.
2. Item numbers circled are to be asked at follow-up. Items with an asterisk are cumulative and should be rephrased at follow-up (see Manual).
3. Space is provided after sections for additional comments

**ADDICTION SEVERITY INDEX**

**SEVERITY RATINGS**

The severity ratings are interviewer estimates of the patient's need for additional treatment in each area. The scales range from 0 (no treatment necessary) to 9 (treatment needed to intervene in life-threatening situation). Each rating is based upon the patient's history of problem symptoms, present condition and subjective assessment of his treatment needs in a given area. For a detailed description of severity ratings' derivation procedures and conventions, see manual. **Note: These severity ratings are optional.**

Fifth Edition/1998 Version

**SUMMARY OF PATIENTS RATING SCALE**

- 0 - Not at all
- 1 - Slightly
- 2 - Moderately
- 3 - Considerably
- 4 - Extremely

G1. I.D. NUMBER

G2. LAST 4 DIGITS OF SSN

G3. PROGRAM NUMBER

G4. DATE OF ADMISSION

G5. DATE OF INTERVIEW

G6. TIME BEGUN  :

G7. TIME ENDED  :

G8. CLASS:  
 1 - Intake   
 2 - Follow-up

G9. CONTACT CODE:  
 1 - In Person   
 2 - Phone

G10. GENDER:  
 1 - Male   
 2 - Female

G11. INTERVIEWER CODE NUMBER

G12. SPECIAL:  
 1 - Patient terminated   
 2 - Patient refused   
 3 - Patient unable to respond

**GENERAL INFORMATION**

NAME \_\_\_\_\_

CURRENT ADDRESS \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

G13. GEOGRAPHIC CODE

G14. How long have you lived at this address?  YRS.  MOS.

G15. Is this residence owned by you or your family?

0 - No 1 - Yes

G16. DATE OF BIRTH

G17. RACE

1 - White (Not of Hispanic Origin)  
 2 - Black (Not of Hispanic Origin)  
 3 - American Indian  
 4 - Alaskan Native  
 5 - Asian or Pacific Islander  
 6 - Hispanic - Mexican  
 7 - Hispanic - Puerto Rican  
 8 - Hispanic - Cuban  
 9 - Other Hispanic

G18. RELIGIOUS PREFERENCE

1 - Protestant 4 - Islamic  
 2 - Catholic 5 - Other  
 3 - Jewish 6 - None

G19. Have you been in a controlled environment in the past 30 days?

1 - No  
 2 - Jail  
 3 - Alcohol or Drug Treatment  
 4 - Medical Treatment  
 5 - Psychiatric Treatment  
 6 - Other \_\_\_\_\_

G20. How many days?

**ADDITIONAL TEST RESULTS**

G21. Shipley C.Q.

G22. Shipley I.Q.

G23. Beck Total Score

G24. SCL-90 Total

G25. MAST

G26. \_\_\_\_\_

G27. \_\_\_\_\_

G28. \_\_\_\_\_

**SEVERITY PROFILE**

9									
8									
7									
6									
5									
4									
3									
2									
1									
0									
PROBLEMS	MEDICAL	EMP/SUP	ALCOHOL	DRUG	LEGAL	PAMISOC	PSYCH		

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**MEDICAL STATUS**

\* M1. How many times in your life have you been hospitalized for medical problems?     (Include o.d.'s, d.t.'s, exclude detox.)

M2. How long ago was your last hospitalization for a physical problem   YRS.   MOS.

M3. Do you have any chronic medical problems which continue to interfere with your life?  
0 - No   
1 - Yes  Specify \_\_\_\_\_

M4. Are you taking any prescribed medication on a regular basis for a physical problem?  
0 - No  1 - Yes

M5. Do you receive a pension for a physical disability? (Exclude psychiatric disability.)  
0 - No   
1 - Yes  Specify \_\_\_\_\_

M6. How many days have you experienced medical problems in the past 30?

M7. How troubled or bothered have you been by these medical problems in the past 30 days?

M8. How important to you now is treatment for these medical problems?

M9. How would you rate the patient's need for medical treatment?

**INTERVIEWER SEVERITY RATING**

**CONFIDENCE RATINGS**

Is the above information significantly distorted by:

M10. Patient's misrepresentation? 0 - No  1 - Yes

M11. Patient's inability to understand? 0 - No  1 - Yes

FOR QUESTIONS M7 & M8 PLEASE ASK PATIENT TO USE THE PATIENT'S RATING SCALE

Comments \_\_\_\_\_

**EMPLOYMENT/SUPPORT STATUS**

\* E1. Education completed (GED = 12 years)   YRS.   MOS.

\* E2. Training or technical education completed   MOS.

E3. Do you have a profession, trade or skill?  
0 - No   
1 - Yes  Specify \_\_\_\_\_

E4. Do you have a valid driver's license?  
0 - No  1 - Yes

E5. Do you have an automobile available for use? (Answer No if no valid driver's license.)  
0 - No  1 - Yes

E6. How long was your longest full-time job?   YRS.   MOS.

\* E7. Usual (or last) occupation. \_\_\_\_\_  
(Specify in detail)

E8. Does someone contribute to your support in any way?  
0 - No  1 - Yes

E9. (ONLY IF ITEM E8 IS YES) Does this constitute the majority of your support?  
0 - No  1 - Yes

E10. Usual employment pattern, past 3 years.   
1 - full time (40 hrs/wk)  
2 - part time (reg. hrs)  
3 - part time (irreg., daywork)  
4 - student  
5 - service  
6 - retired/disability  
7 - unemployed  
8 - in controlled environment

E11. How many days were you paid for working in the past 30? (include "under the table" work.)

E12. Employment (net income)

E13. Unemployment compensation

E14. DPA

E15. Pension, benefits or social security

E16. Mate, family or friends (Money for personal expenses).

E17. Illegal

E18. How many people depend on you for the majority of their food, shelter, etc.?

E19. How many days have you experienced employment problems in the past 30?

FOR QUESTIONS E20 & E21 PLEASE ASK PATIENT TO USE THE PATIENT'S RATING SCALE

E20. How troubled or bothered have you been by these employment problems in the past 30 days?

E21. How important to you now is counseling for these employment problems?

**INTERVIEWER SEVERITY RATING**

E22. How would you rate the patient's need for employment counseling?

**CONFIDENCE RATINGS**

Is the above information significantly distorted by:

E23. Patient's misrepresentation? 0 - No  1 - Yes

E24. Patient's inability to understand? 0 - No  1 - Yes

Comments \_\_\_\_\_

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**DRUG/ALCOHOL USE**

PAST 30 Days    LIFETIME USE Yrs.    Rt of adm.

D1 Alcohol - Any use at all			
D2 Alcohol - To Intoxication			
D3 Heroin			
D4 Methadone			
D5 Other opiates/analgesics			
D6 Barbiturates			
D7 Other sed/hyp/tranq.			
D8 Cocaine			
D9 Amphetamines			
D10 Cannabis			
D11 Hallucinogens			
D12 Inhalants			

D13 More than one substance per day (Incl. alcohol).

Note: See manual for representative examples for each drug class

\* Route of Administration: 1 = Oral, 2 = Nasal, 3 = Smoking, 4 = Non IV inj., 5 = IV inj.

D14 Which substance is the major problem? *Please code as above or 00-No problem; 15-Alcohol & Drug (Dual addiction); 16-Polydrug; when not clear, ask patient.*

D15. How long was your last period of voluntary abstinence from this major substance? (00 - never abstinent)   MOS.

D16. How many months ago did this abstinence end? (00 - still abstinent)

How many times have you:

\* D17 Had alcohol d.t.'s

\* D18 Overdosed on drugs

How many times in your life have you been treated for:

\* D19 Alcohol Abuse:

\* D20 Drug Abuse:

How many of these were detox only?

\* D21 Alcohol

\* D22 Drug

How much would you say you spent during the past 30 days on:

D23 Alcohol

D24 Drugs

Comments

D25 How many days have you been treated in an outpatient setting for alcohol or drugs in the past 30 days (include NA, AA).

How many days in the past 30 have you experienced:

D26 Alcohol Problems

D27 Drug Problems

FOR QUESTIONS D28-D31 PLEASE ASK PATIENT TO USE THE PATIENT'S RATING SCALE

How troubled or bothered have you been in the past 30 days by these:

D28 Alcohol Problems

D29 Drug Problems

How important to you now is treatment for these:

D30 Alcohol Problems

D31 Drug Problems

INTERVIEWER SEVERITY RATING  
How would you rate the patient's need for treatment for:

D32 Alcohol Abuse

D33 Drug Abuse

CONFIDENCE RATINGS  
Is the above information significantly distorted by:

D34 Patient's misrepresentation? 0 - No 1 - Yes

D35 Patient's inability to understand? 0 - No 1 - Yes



**FAMILY/SOCIAL RELATIONSHIPS**

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**F1** Marital Status

1 - Married  
2 - Remarried  
3 - Widowed

4 - Separated  
5 - Divorced  
6 - Never Married

**F2** How long have you been in this marital status?   YRS.   MOS.  
*(If never married, since age 18).*

**F3.** Are you satisfied with this situation?

0 - No  
1 - Indifferent  
2 - Yes

\* **F4.** Usual living arrangements (past 3 yr.)

1 - With sexual partner and children  
2 - With sexual partner alone  
3 - With children alone  
4 - With parents  
5 - With family  
6 - With friends  
7 - Alone  
8 - Controlled environment  
9 - No stable arrangements

**F5.** How long have you lived in these arrangements.   YRS.   MOS.  
*(If with parents or family, since age 18).*

**F6.** Are you satisfied with these living arrangements?

0 - No  
1 - Indifferent  
2 - Yes

Do you live with anyone who:  
0 = No 1 = Yes

**F7.** Has a current alcohol problem?

**F8.** Uses non-prescribed drugs?

**F9.** With whom do you spend most of your free time:  
1 - Family 3 - Alone  
2 - Friends

**F10** Are you satisfied with spending your free time this way?  
0 - No 1 - Indifferent 2 - Yes

**F11** How many close friends do you have?

Direction for F12-F26: Place "0" in relative category where the answer is clearly no for all relatives in the category; "1" where the answer is clearly yes for any relative within the category; "X" where the answer is uncertain or "I don't know" and "N" where there never was a relative from that category.

Would you say you have had close, long lasting, personal relationships with any of the following people in your life:

**F12.** Mother

**F13.** Father

**F14.** Brothers/Sisters

**F15.** Sexual Partner/Spouse

**F16.** Children

**F17.** Friends

Have you had significant periods in which you have experienced serious problems getting along with:

	0 - No	1 - Yes	PAST 30 DAYS	IN YOUR LIFE
<b>F18</b> Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
<b>F19</b> Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
<b>F20</b> Brothers/Sisters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
<b>F21</b> Sexual partner/spouse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
<b>F22</b> Children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
<b>F23</b> Other significant family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
<b>F24</b> Close friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
<b>F25</b> Neighbors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
<b>F26</b> Co-Workers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>

Did any of these people (F18-F26) abuse you: 0 = No, 1 = Yes

	0 - No	1 - Yes	30 DAYS	LIFE
<b>F27.</b> Emotionally (make you feel bad through harsh words)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
<b>F28.</b> Physically (cause you physical harm)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
<b>F29.</b> Sexually (force sexual advances or sexual acts)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>

How many days in the past 30 have you had serious conflicts:

**F30** with your family?

**F31** with other people? (excluding family)

*FOR QUESTIONS F32-F35 PLEASE ASK PATIENT TO USE THE PATIENT'S RATING SCALE*

How troubled or bothered have you been in the past 30 days by these:

**F32** Family problems

**F33** Social problems

How important to you now is treatment or counseling for these:

**F34** Family problems

**F35** Social problems

**INTERVIEWER SEVERITY RATING**

**F36.** How would you rate the patient's need for family and/or social counseling?

**CONFIDENCE RATINGS**

Is the above information significantly distorted by:

**F37** Patient's misrepresentation? 0 - No 1 - Yes

**F38.** Patient's inability to understand? 0 - No 1 - Yes

Comments

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**PSYCHIATRIC STATUS**

How many times have you been treated for any psychological or emotional problems?

\* P1 In a hospital 


\* P2 As an Opt. or Priv. patient 


P3. Do you receive a pension for a psychiatric disability?

0 - No 1 - Yes

Have you had a significant period, (that was not a direct result of drug/alcohol use), in which you have:

0 - No 1 - Yes

PAST 30 IN  
DAYS YOUR  
LIFE

P4. Experienced serious depression		
P5. Experienced serious anxiety or tension		
P6. Experienced hallucinations		
P7. Experienced trouble understanding, concentrating or remembering		
P8. Experienced trouble controlling violent behavior		
P9. Experienced serious thoughts of suicide		
P10. Attempted suicide		
P11. Been prescribed medication for any psychological emotional problem		

P12 How many days in the past 30 have you experienced these psychological or emotional problems? 

--	--

FOR QUESTIONS P13 & P14 PLEASE ASK PATIENT TO USE THE PATIENT'S RATING SCALE

P13 How much have you been troubled or bothered by these psychological or emotional problems in the past 30 days?

P14 How important to you now is treatment for these psychological problems?

THE FOLLOWING ITEMS ARE TO BE COMPLETED BY THE INTERVIEWER

At the time of the interview, is patient:  
0 - No 1 - Yes

P15 Obviously depressed/withdrawn

P16 Obviously hostile

P17 Obviously anxious/nervous

P18 Having trouble with reality testing thought disorders, paranoid thinking

P19 Having trouble comprehending, concentrating, remembering.

P20 Having suicidal thoughts

Comments

**INTERVIEWER SEVERITY RATING**

P21 How would you rate the patient's need for psychiatric/psychological treatment?

**CONFIDENCE RATINGS**

Is the above information significantly distorted by:

P22 Patient's misrepresentation?   
0 - No 1 - Yes

P23 Patient's inability to understand?   
0 - No 1 - Yes

**Nebraska**

**UNIFORM APPLICATION  
FY2011**

**SUBSTANCE ABUSE PREVENTION AND TREATMENT  
BLOCK GRANT**

**42 U.S.C.300x-21 through 300x-66**

OMB - Approved 07/20/2010 - Expires 07/31/2013

(generated on 9/20/2010 11:24:58 AM)

**Substance Abuse and Mental Health Services Administration**

**Center for Substance Abuse Treatment**

**Center for Substance Abuse Prevention**

**Refer to your copies mailed to you**