Nebraska Division of Behavioral Health

State Advisory Committee on Mental Health Services (SACMHS)

State Advisory Committee on Substance Abuse Services (SACSAS)

August 23, 2018 - 9:00 am - 3:00 pm Lincoln, NE - Country Inn & Suites

Meeting Minutes

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

Ann Ebsen, Substance Abuse Committee Chair and Ryan Kaufman, Mental Health Committee acting Chair, welcomed committee members, guests, staff and others to the meeting.

The Open Meetings Law: was posted in meeting room; all presented handouts were available for public review.

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

State Advisory Committee on Mental Health Services:
Members in Attendance: Margaret Damme, Suzanne Day, Bev Ferguson, Laurie Holman, Ryan Kaufman, Kristin Larsen*(non-voting), Phyllis McCaul, Pamela Otto, Ashley Pankonin, Rachel Pinkerton, Nancy Rippen, Stacy Scholten, Mary Thunker.

Members Absent: Susanna Batterman, Karla Bennetts, Lindy Foley, Bradley Hoefs, Patty Jurjevich, Amy Rhone, Rebecca Tegeler, Diana Waggoner, Michael Williams.

State Advisory Committee on Substance Abuse Services:
Members in Attendance: Ann Ebsen, Jeffrey Courtier, Victor Gehrig, Janet Johnson, Dusty Lord, Kimberly Mundil, Michael Phillips, Daniel Rutt, Randy See. Members Absent: Ingrid Gansebom, Jay Jackson, Diana Meadors.

Motion to Approve Minutes:
State Advisory Committee on Mental Health Services Chair Ann Ebsen, presented the May 17, 2018, minutes for review. Asking for and receiving no corrections or comments, it was motioned and seconded to approve the minutes as written; the motion passed with a unanimous voice vote.

State Advisory Committee on Substance Abuse Services acting Chair, Ryan Kaufman, presented the May 17, 2018, minutes for minutes for review. Asking for and receiving no corrections or comments, it was motioned and seconded by Victor Gehrig to approve the minutes as written; the motion passed with a unanimous voice vote.

DHHS Staff in Attendance:
Susan Adams, Sheri Dawson, Tamara Gavin, Brett Long, Iliana Martin, Brenda Moes, John Trouba, Linda Wittmuss, Heather Wood. Guest Presenter for Lunch and Learn: Connie Nelson, SMART Recovery.

II. Public Comment

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

III. Legislative Update *Linda Wittmuss*

Linda Wittmuss, Deputy Director, reported on DBH legislative proposals, two of which only require language clean up and two that are the same as submitted last year. The latter includes a change to allow Outpatient Competency Restoration and extend protection for healthcare workers. Discussion followed regarding why these changes were sought, statistics supporting these changes, and the ramifications to individuals being treated in mental health and substance use disorder settings. Linda was requested to provide additional information regarding these concerns as able.

IV. Director's Update *Sheri Dawson*

Sheri Dawson, Director, began her update by thanking committee members for their time and continuing service to assist the Division in its efforts to accomplish the goals of the Division Strategic Plan.

Director Dawson introduced the newly hired Office of Consumer Affairs Administrator, Brenda Moes. Brenda

stated that she has been working in behavioral health for the past 20 years and is excited to be in her new position. Brenda provided information for the upcoming Recovery Month activities in September, which will feature recognition and awareness events, and Mental Health Illness week which begins the first of October.

Director Dawson reported the annual consumer survey is underway and it has more questions regarding support services and how well individuals are able to deal with crisis after receiving services. She provided highlights of this year's annual DHHS Business Plan for the Division, with special focus on the Children's System of Care (SOC), mental health in schools and continued work with partners in the system. She noted the data return for SOC, which Tamara Gavin and Bernie Hascall have helped lead, shows over 700 youth have received Crisis Response services and on average 75% of youth receiving services have been able to stay in their homes. The business plan also includes activities to addressing opioid use, for which DBH is awarded federal funding under the State Targeted Response to the Opioid Crisis Grant dollars through SAMHSA.

Discussion included the challenge of working across the systems of care, concerns about recent changes in the way CFS handles parental drug testing and concerns that children and/or parents may not be receiving the services they need. CFS representative Stacy Scholten acknowledged the change in practice and stated a need to balance the use of drug testing as one tool to understand a parents' needs but indicated drug testing should not be used to restrict contact between parents and children or be used as the only means of gauging parenting safety. Other comments cited concern that not using drug testing limits the legal system's ability to assess if drug or alcohol use is a factor in cases brought forward. Director Dawson remarked continued conversations between all partners and stakeholders will help us arrive at better solutions.

Director Dawson announced that there will be opioid-related conferences in Omaha and Kearney next spring. Efforts continue to recruit additional prescribers for Medication-Assisted Treatment (MAT) services to increase access to SUD treatment. Discussion followed regarding barriers and stigma for the SUD community; that medication is not normalized as with other chronic diseases; treatment may be a life-long process; there is not one solution for everyone; and, safe affordable housing is also an identified need of the SUD community.

V. Break

VI. 2019 SAMHSA Block Grant Mini Application — *John Trouba /Heather Wood*

John Trouba and Heather Wood, led the review of the presentation on the Block Grant Mini Application. States must make an annual application for funds for the two-year planning cycle. The second year Mini Application gives the states an opportunity to identify any updates. The Joint Advisory Committee, acting as the planning council, is requested to make recommendations on the Mini Application and any plan modification(s). The JAC will be asked to make a recommendation on a plan modification to revise Planning Table 1 Priority Areas and Annual Performance Indicators, Priority #8 – First Episode Psychosis – establish baseline and revise second-year target/outcome measurement. The following comments were noted during the discussion:

- Members commended DBH efforts to increase collaboration among Crisis Response providers, the RHBAs and DBH to reduce reliance on higher levels of care due to MH and SU disorders among youth and adults, as recorded for First-year target/outcome measurement of Planning Priority Area #2 – Reliance on Higher Levels of Care Due to Mental Health and/or Substance Use Disorders Among Youth and Adults.
- Members encouraged DBH to continue to explore ways to help Consumers secure permanent housing especially given demand for affordable housing exceeds supply.
- Members expressed concern about the percentage of Consumers discharged to homelessness and homeless shelters as identified in DBH statistics and encouraged DBH to continue to share such data with the Regions to address this concern.
- Members noted the availability of affordable housing is a big issue – rising housing costs mean there are additional challenges to maintaining existing housing, building new affordable housing and an increased housing cost burden faced by more Consumers.
- FEP Pilot Programs at Region 6 in Omaha and Region 3 in Kearney were based on needs at the time and served youth that qualified. Bipolar was not part of the OnTrackNY model used. The JAC requested information about both programs be sent to the group.

VII. Lunch & Learn: SMART Recovery — *Connie Nelson*

Connie Nelson, Guest Presenter, introduced Self-Management And Recovery Training (SMART), which is a mutual help group, has local face-to-face meetings as well as online meetings, is accepted by court/probation, and

is a partnership of professionals and peers, which is non-profit and meetings are free. SMART Recovery can be used in addition to or instead of 12-step groups, is abstinence-oriented for behaviors & substances, uses a self-empowering approach and features 24/7 online recovery information and support. It has a 4-Point Program centers on: 1: Building and Maintaining Motivation, 2: Coping with Urges, 3: Managing Thoughts, Feelings, and Behaviors, 4: Living a Balanced Life.

VIII. Public Comment

Sadie Thompson, Director of Peer Services at CenterPointe addressed the Peer Support Service Definition as defined by Medicaid. Ms. Thompson stated that Peer Support is not a clinical service and the Medicaid service definition makes it seem that way. She urged DBH to not accept that definition. She offered that Peer Support is not billed socialization, nor fee for service one or two hours a week but is learning how to live in a community, is outreach and sharing lived experience. It is not a therapy.

IX. Peer Support Definition *Susan Adams*

Susan Adams led the discussion requesting input/feedback regarding Medicaid's Peer Support Service Definition proper vs. Peer Support Services to enhance recovery. Some members offered that Medicaid's definition seemed too clinical, prescriptive; peer support has as its basis mutually lived experience, installation of hope and meeting individuals at their point in recovery. Medicaid's definition takes away the real benefit and is not what the peer support experience is about, which is modeling practices and behavior for others to follow to recovery.

It was expressed that the clinical approach curtails the intent of peer support, attempts to turn it into a job with steps that peer support providers would need to follow, and for which they may not be qualified to provide, such as completing IDIs. Authentic peer support does not dictate the type of services outlined in the presented definition and is in conflict with the SAMHSA definition and best practices. Some committee members stated DBH should not adopt Medicaid's definition of peer support, but should seek their own with input from the community, peer support workers and providers.

Tamara Gavin clarified for the group that it is not intended for Peer Support providers to develop IDI's, etc., but that certain processes need to have been set in place in order for Peer Support providers to have information contained in the IDI, for example. In order for DBH to use Federal funds, certain levels of treatment, audit standards and rates must be justified. Service expectations should be seen in terms of what a treatment provider would be responsible for, such as the IDI, and what the Peer Support person would be responsible for while guiding the patient within the plan, allowing the client to have their voice heard with the help of Peer Support. The JAC is welcome to make recommendations on the definition as presented.

A motion was made by Randy See that DBH not simply accept or ratify the definition from Medicaid in how DBH defines Peer Support services; take the information to providers, consumers and peers to help define what the definition of Peer Support DBH should use should be, and seconded by Mike Phillips for the State Committee on Substance Abuse Services vote: Motion passed on the vote of eight affirmatives, zero abstentions, and zero negatives.

A motion was made by Pamela Otto that DBH not simply accept or ratify the definition from Medicaid in how DBH defines Peer Support services; take the information to providers, consumers and peers to help define what the definition of Peer Support DBH should use should be, and seconded by Ashley Pankonin for the State Committee on Mental Health Services vote: Motion passed on the vote of nine affirmatives, three abstentions and zero negatives.

More discussion followed regarding treatment plans and treatment plan implementation and the role of peers in the process. If an organization is offering treatment services, there should be no requirement for certain conditions to be completed prior to involving peer support, as peers should encourage and plan along with the individual and clinician using their own experience as a basis for more informed decisions and plans. There is a need to clarify that Peer Support may assist a client in the development of a treatment plan; they are not responsible for the development of a treatment plan.

Upon further discussion, there was a formal recommendation to amend the first two bullets in the Service Expectations section of the Medicaid Service Definition, Title 471 chapter 32 and 20:

- Complete an Initial Diagnostic Interview (IDI) if one has not been completed within the 12 months prior to initiating peer support services. The IDI will serve as the initial treatment plan until the comprehensive plan of care is developed. An IDI is not necessary if peer support services are provided for treatment of a

substance use disorder. An IDI must be completed by a licensed clinician authorized to perform that service;
- Complete a Substance Use Disorder (SUD) assessment, if one has not been completed by a licensed clinician prior to initiating peer support services. A SUD assessment is not necessary if peer support services are provided for treatment of a mental health disorder;

A motion was made by Victor Gehrig to strike the following language in the service expectation bullets one and two: *prior to initiating peer support services*, and seconded by Mike Phillips for the State Committee on Substance Abuse Services vote: Motion passed on the vote of seven affirmatives, one abstention, and zero negatives.

A motion was made by Ryan Kaufman to strike the following language in the service expectation bullets one and two: *prior to initiating peer support services*, and seconded by Mary Thunker for the State Committee on Mental Health Services vote: Motion passed on the vote of ten affirmatives, two abstentions and zero negatives.

There was also a formal recommendation to amend the bullets three and four in the Service Expectations section of the Medicaid Service Definition, Title 471 chapter 32 and 20:

- The treatment plan is to be developed through shared decision making inclusive of the individual and must identify specific areas to be addressed; clear and realistic goals and objectives; strategies, and recovery support services to be implemented; criteria for achievement; target dates; methods for evaluating the individual's progress; a discharge plan, wellness plan, and crisis prevention plan that includes defining early warning signs and triggers;
- The individual treatment plan shall be completed within 30 days following admission, reviewed and updated every 90 days, or as often as clinically necessary thereafter while receiving services. The individual shall sign the plan to indicate involvement in the planning; refusal to sign will be noted on the treatment plan. The supervisor is responsible for reviewing and signing off on the treatment plan;

A motion was made by Victor Gehrig to amend the language in the service expectation bullet three to strike: *The treatment plan is to be* and replace with: *To help implement any treatment plan*, and to preface bullet number four with: *Pursuant to Service Definition, Title 471 chapter 32 and 20, DBH will incorporate the same language in its definition of terms used in Peer Support Services*, and seconded by Ann Ebsen for the State Committee on Substance Abuse Services vote: Motion passed on the vote of six affirmatives, one abstention, and zero negatives.

A motion was made by Phyllis McCaul to amend the language in the service expectation bullet three to strike: *The treatment plan is to be* and replace with: *To help implement any treatment plan*, and to preface bullet number four with: *Pursuant to Service Definition, Title 471 chapter 32 and 20, DBH will incorporate the same language in its definition of terms used in Peer Support Services*, and seconded by Mary Thunker for the State Committee on Mental Health Services vote: Motion passed on the vote of eight affirmatives, two abstentions, and one negative.

X. Break

XI. 2019 SAMHSA Block Grant Mini Application Recommendation *John Trouba /Heather Wood*

John Trouba and Heather Wood led review and discussion on development of the FEP Program Outcome and Assessment Set to establish a baseline measurement indicator of improved functioning for youth and young adults with a first episode of psychosis, a First-year and Second-year target/outcome measurement, and the MIRECC-GAF Expanded pre- and post-treatment outcome score by scale and by total average of scales (scale totals, percentage change, absolute change).

The joint advisory committee, acting as the state mental health planning council, upon review of the First Episode Psychosis pilot program MIRECC-GAF Expanded pre- and post-treatment outcome scores, both individual scale scores and average total score difference across scales, hereby recommends:

The Nebraska Uniform Application FY 2018/2019 State Behavioral Health Assessment and Plan be revised via a plan modification to the Planning Table 1 Priority Areas and Annual Performance Indicators, Priority #8 – First Episode Psychosis as follows:

- Revise the Baseline Measurement from "Will establish a baseline through pilot program use of MIRECC-GAF Expanded assessment tool." to "Average Total Score Difference = 45.75," and,
- Revise the Second-year target/outcome measurement from "To be determined after baseline established." to "Average Baseline Total Score Difference = 65.0."

The joint committee passed a recommendation to revise Planning Table 1 – Priority Area #8 First Episode Psychosis to establish the 2017 Baseline based on the pilot program use of MIRECC-GAF assessment tool (per First-year target) and establish the Second-year target/outcome measurement. Recommendation to establish 2017 Baseline: "Average Total Score Difference = 45.75" and establish Second-year target: "Average Total Score Difference = 65." The joint committee recommendation supports a request for a Block Grant Plan Modification to revise Planning Table 1 – Priority Areas-Priority Area #8 First Episode Psychosis.

The chair accepted a motion by Bev Ferguson, seconded by Dusty Lord, for the Planning Council to recommend the Block Grant Mini Application as presented, with the note of current housing barriers. The JAC, acting as the Planning Council, passed the motion with a unanimous voice vote.

XII. Wrap Up: Announcements, Comments, Observations

The agenda item Peer Workforce across DBH will be addressed in the next meeting, as well as review of draft version of Block Grant Annual Reports.

XIII. Adjournment and Next Meeting

The meeting was adjourned at 2:39 p.m. The next Joint meeting of the State Advisory Committee on Mental Health Services and the State Advisory Committee on Substance Abuse Services is scheduled on Thursday, November 15, 2018.

Combined Block Grant
Mini Application and Priority Area Review FY2018-FY2019

August 23, 2018

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1

Purpose of Block Grant

SAMHSA

The **Substance Abuse and Mental Health Services Administration** (**SAMHSA**) is a branch of the U.S. Department of Health and Human Services. It is charged with improving the quality and availability of treatment and rehabilitative services in order to reduce illness, death, disability, and the cost to society resulting from substance abuse and mental illnesses.

- **Fund** priority treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time.
- **Fund** those priority treatment and support services not covered by Medicaid, Medicare or private insurance for low income individuals and that demonstrate success in improving outcomes and/or supporting recovery.
- **Fund** primary prevention- universal, selective and indicated prevention activities and services for persons not identified as needing treatment.
- Collect performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment and recovery support services and plan implementation of new services on a nationwide basis.

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Estimated Expenditures SAPTBG Combined FY18-FY19 & MHBG FY2019

Activity	FY18-19 SAPTBG	FY19 MHBG	Medicaid (Federal, State, Local)	Other Federal funds	State funds
SA Prevention & TX					
Preg Women and WDC	$ 1,129,872			–	$ 3,663,834
All other	10,195,713			$2,046,000	48,976,420
Primary Prevention					
SA Primary Prevention	3,178,931			2,138,950	545,568
MH Primary Prevention				–	$ 47,981
Turberculosis Services	0			–	
HIV Early Intevention	0			–	
State Hospital				–	–
Other 24 hour care		$ 116,039	–	–	12,381,103
Ambulatory/Comm Non-24 hour care		1,930,536	–	$3,310,483	47,340,554
FEP Set Aside (10%)		240,774	–	–	–
Admin (excluding program/provider level)	763,395	120,387	–	–	–
Subtotal (Prev, Tx, etc)	$14,504,516	$ 2,287,349	$ –	$3,310,483	$ 59,769,638
Subtotal (Admin)	763,395	120,387	–	–	–
Total	**$15,267,911**	**$ 2,407,736**	**$ –**	**$3,310,483**	**$ 59,769,638**
			2Yr SAPTBG	= $4,184,950	$ 53,185,822

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Projected SAPTBG Prevention Expenses by Strategy FY2019 SA Block Grant Award

Information Dissemination	Universal	$	49,103
	Selective	$	37,377
	Indicated	$	
	Unspecified		
Subtotal		**$**	**86,480**
Education	Universal	$	340,693
	Selective	$	19,888
	Indicated	$	
	Unspecified		
Subtotal		**$**	**360,581**
Alternatives	Universal	$	37,375
	Selective	$	
	Indicated	$	
	Unspecified		
Subtotal		**$**	**37,375**
Problem Identification	Universal	$	46,291
	Selective	$	106,500
	Indicated	$	
	Unspecified		
Subtotal		**$**	**152,791**

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Projected SAPTBG Prevention Expenses by Strategy FY2019 SA Block Grant Award

Community Based	Universal	$	271,203
	Selective	$	
	Indicated	$	
	Unspecified		
Subtotal		**$**	**271,203**
Environmental	Universal	$	747,761
	Selective	$	1,200
	Indicated	$	
	Unspecified		
Subtotal		**$**	**748,961**
Other	Universal		
	Selective		
	Indicated		
Subtotal		**$**	**-**
Section 1926 - Tobacco	Universal	$	51,585
	Selective		
	Indicated		
Subtotal		**$**	**51,585**
Total		**$**	**1,708,976**

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MHBG & SAPTBG Planned Resource Expenditures FY2019

	MHBG	Treatment SABG	Prevention SABG
Information Systems			
Infrastructure Support			
Partnerships, community outreach, and needs assessment			
Planning Council Activities			
Quality Assurance & Improvement	$12,039	$13,471	
Research & Evaluation			
Training & Education		$100,363	
Total	**$12,039**	**$113,834**	**$0**

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Purpose of Block Grant

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- Fund those priority treatment and support services not covered by Medicaid, Medicare or private insurance for low income individuals and that demonstrate success in improving outcomes and/or supporting recovery.
- Fund primary prevention- universal, selective and indicated prevention activities and services for persons not identified as needing treatment.
- **Collect performance and outcome data** to determine the ongoing effectiveness of behavioral health promotion, treatment and recovery support services and plan implementation of new services on a nationwide basis.

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SAMHSA Guidance

- Priorities should include the core federal aims and goals for the MHBG and should address the required target populations (SMI/SED) and any other priority populations.
- The priorities should be based on an unmet need or critical gap.
- For each priority, there must be at least one goal, objective, strategy, and performance indicator.
- A goal is a general characterization of what the state plans to accomplish.
- An objective is a concrete, precise, and measurable statement.

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SAMHSA Guidance Continued

- A strategy is the step(s) the state will take to meet the goal.
- A performance indicator is the specific information that the state will use to measure change over time. Performance indicators include a baseline (current year), Year 1 (end of first year of the application), and Year 2 (the end of the second year of the application).
- Data source – where will the measures come from – SMHA data system, training records, interagency agreements, etc.
- Description of data – what data elements will be used for measurement
- Data issues/potential caveats – changes in reporting systems, move to managed care, new providers

Got it, so now what?

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General Notes on Priority Measures

- Multiple goals, objectives, strategies, and performance indicators can make sense.
- Goals should articulate aspirations and represent positive change. They should also be formulated to be achievable.
- Goals generally reflect positive movement toward a better outcome. However, maintenance goals may be appropriate when funding is reduced. The goal may reflect what you are going to save rather than what you are going to add.
- Performance Indicators do not have to be numbers.
- You may complete a strategy in one year, or you may not begin or complete a strategy until the second year.

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Review of Progress After Year 1 – What Can Go Wrong

Pretty much anything. *What to do if the wheels come off?*

- You can request a plan modification through your State Project Officer at any time, citing justification for removal or modification of the content in Table 1.
- The plan modification request should be justified based on significant, unexpected changes that make it unlikely or certain that proposed actions cannot be accomplished.
  - Example: Expected quantity needs to be reduced due to a budget cut.
  - Example: Unexpected reorganization will delay completing administrative tasks.
  - Examples: Natural or man-made disasters, lawsuits, shift in focus due to new administration, etc.
- The plan modification request must be approved by the Planning Council.

AKA – YOU!

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FEDERAL COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

Block Grant Requires…

REQUIREMENTS FOR THE STATE MENTAL HEALTH PLANNING COUNCIL MEMBERSHIP

- Section 1914: The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.
- The **duties** of the council are:
- to **review plans** provided to the council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the council for modifications to the plans;
- (2) to serve as an **advocate** for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and
- (3) to **monitor, review, & evaluate**, not less than once each year, the allocation and adequacy of mental health services within the State.

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Block Grant Requires…

Nebraska, as part of its Behavioral Health Services Act, assigns the duty of a Planning Council (AKA Joint Advisory Committee) to the:

State Advisory Committee on Mental Health Services
Neb. Rev. Stat. §71-8014

State Advisory Committee on Substance Abuse Services
Neb. Rev. Stat. §71-8014

- ✓ Every Committee member is Governor appointed for a specific term or APOG
- ✓ Each Committee is required to include consumers
- ✓ Each Committee has their own By-Laws
- ✓ These are public meetings, thus Open Meetings Act applies

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Block Grant Requires…

As reviewed at JAC on August 24, 2017

Needs Assessment for MHBG & SABG:

- Strengths and needs
- Unmet service needs/critical gaps
- Identify priority areas addressing targeted populations and other priority populations
- Establish goals, objectives, strategies and performance indicators

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Proposed and Accepted Priority Areas and Goals for Combined Block Grant FY2018-FY2019

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Alcohol Use Among Youth and Young Adults

According to the United Health Foundation for American's Health Rankings 2014 Nebraska has a very high prevalence of binge drinking.

- 20% of Nebraska adults report binge drinking placing it at the 44th rank among the 50 states.

Underage alcohol consumption continues to be a problem among youth in Nebraska.

- The National Survey of Drug Use and Health (NSDUH) indicates youth alcohol use rates, and binge drinking in particular, are higher in Nebraska compared to national rates.
- According to 2013-2014 survey results, 24.1% of people aged 12 or older in Nebraska reported having binge drank in the past month compared to the national average of 22.9%.

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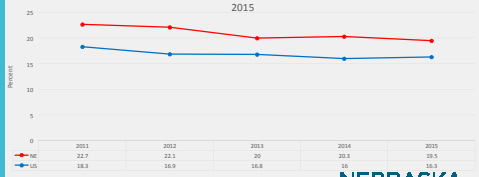
Alcohol Use Among Youth and Young Adults Continued

Additional trends further show the need to prioritize prevention efforts targeting underage and binge drinking amongst Nebraska youth and young adults.

Percentage of Adults* Indicating Binge Drinking in past 30 days, NE vs US 2011-2015



*Adults 18 and over reporting drinking 4/5 alcohol beverages at one occasion during the 30 days preceding the survey. Source: Behavioral Risk Factor Surveillance Survey (BRFSS)

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Prevention: Alcohol Use Among Youth and Young Adults

Priority Type: SAP

Population(s): Other

- **Goal of the priority area:** Reduce underage and harmful alcohol use among youth and young adults.
- **Objective:** Reduce the prevalence of underage drinking by high school students and the prevalence of binge drinking by young adults ages 19 to 25.
- **Indicator #1:** Reduce the prevalence of underage drinking by high school students.
- **Indicator #2:** Reduce the prevalence of binge drinking by young adults aged 19 to 25.

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Indicator #1: Reduce the prevalence of underage drinking by high school students

- **Data Source:**
  1) Centers for Disease Control and Prevention (CDC), Youth Risk Behavior Survey (YRBS), 2001–2015
- **Description of Data:**
  1) The Youth Risk Behavior Surveillance System is a national school-based survey conducted by the CDC and state, territorial, tribal, and local education and health agencies and tribal governments. This survey monitors six types of health-risk behaviors that contribute to the leading causes of death and disability among youth and adults, including behaviors that contribute to unintentional injuries and violence, sexual behaviors that contribute to unintended pregnancy and sexually transmitted diseases, including HIV infection, alcohol and other drug use, tobacco use, unhealthy dietary behaviors, inadequate physical activity and the prevalence of obesity and asthma among youth and young adults.
- **Baseline Measurement:**
  1) Percentage of students in 9th-12th grade who reported drinking in the past month was 22.7% in 2015.

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Indicator #2: Reduce the prevalence of binge drinking by young adults aged 19 to 25.

- **Data Source:**
  2) Nebraska Youth Adult Alcohol Opinion Survey (NYAAOS)
- **Description of Data:**
  2) Nebraska Youth Adult Alcohol Opinion Survey is a state-wide survey conducted by the Nebraska Division of Behavioral Health and administered by the University of Nebraska-Lincoln Bureau of Sociological Research. The primary purpose of the survey is to (1) enhance understanding of alcohol use, impaired driving, and attitudes and perceptions related to alcohol among 19 to 25 year old young adults in Nebraska and (2) to provide data to community coalitions in Nebraska working to reduce binge drinking among young adults.
- **Baseline Measurement:**
  2) Percentage of young adults who reported having more than five drink for males and more than four drinks for females on one occasion was 37.6 % in 2012.

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Prevention: Alcohol Use Among Youth and Young Adults

Priority Type: SAP

Population(s): Other

- **Strategies to attain the objective:** Work with prevention coalitions across state to continue engaging in partnerships with local schools, colleges and community groups to facilitate trainings and educational activities; enhance awareness of the risks associated with alcohol use. Support increased use of evidence-based interventions in prevention practices.
- First-year target/outcome measurement: N/A
- **Second-year target/outcome measurement:**
  1) Reduce underage drinking by high school students to less than 12.6% by June 30, 2019.
  2) Reduce the prevalence of binge drinking by young adults to 35.6% by June 30, 2019.

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Reliance on higher levels of care due to MH and SU Disorders among youth and adults

- Between 2007 and 2014 there were a total of 85,047 hospitalizations due to mental health disorders. Depressive and episodic mood disorders were the most common diagnoses regardless of the age group. For substance disorders there was a total of 9,672 hospitalizations between 2007 and 2014

Utilization of inpatient and residential services – DBH funded services

	State Fiscal Year (FY)											
	FY2013			FY2014			FY2015			FY2016		
Agency	Received inpatient or residential services	Total Youth Served	% utilized inpatient or residential services	Received inpatient or residential services	Total Served	% utilized inpatient or residential services	Received inpatient or residential services	Total Served	% utilized inpatient or residential services	Received inpatient or residential services	Total Served	% utilized inpatient or residential services
Behavioral Health Youth*	113	1,730	6.5%	115	1,898	6.1%	83	1,789	4.6%	74	1,792	4.1%
Behavioral Health Adult**	9,212	27,958	32.9%	9,073	25,782	35.2%	8,843	26,475	33.4%	8,233	25,504	32.3%

* Under 19 years old

** 19 and older

Reliance on higher levels of care due to MH and SU Disorders among youth and adults

Priority Type: SAT, MHS

Population(s): SMI, SED, PWWDC, PWID, HIV EIS, TB

- **Goal of the priority area:** Increase access to community-based services
- **Objective:** Reduce utilization of residential and inpatient behavioral healthcare for youth and adults.
- **Indicator 1:** Reduce utilization of residential and inpatient behavioral healthcare for youth.
- **Indicator 2:** Reduce utilization of residential and inpatient behavioral healthcare for adults.

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Reliance on higher levels of care due to MH and SU Disorders among youth and adults

Priority Type: SAT, MHS

Population(s): SMI, SED, PWWDC, PWID, HIV EIS, TB

- **Data Source:** Nebraska DHHS Division of Behavioral Health Centralized Data System (CDS).
- **Description of Data:** Consumer treatment data from CDS. CDS collects consumer level information to report to the Treatment Episode Date Set (TEDS) of MH and SU Disorders consumers receiving Division funded services, either directly or through regional contracts. CDS warehouses all the data entered so that it can be analyzed at any time.
- **Baseline Measurement:** Percentage of youth and adults receiving residential and inpatient behavioral healthcare in 2016.

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Reliance on higher levels of care due to MH and SU Disorders among youth and adults

Priority Type: SAT, MHS

Population(s): SMI, SED, PWWDC, PWID, HIV EIS, TB

- **Strategies to attain the objective:** Increase collaboration among Crisis Response providers, the RBHAs and DBH to ensure individuals receive the most appropriate levels of care.
- **First-year target/outcome measurement:** Utilization of residential and inpatient behavioral healthcare will decrease according to the baseline. Youth baseline 4.1% and first-year target 3.9%. Adults baseline 32.3% and first-year target 31.8%. FY2018: Youth IP/Res = 1.5% FY2018: Adult IP/Res = 27.9%
- **Second-year target/outcome measurement:** Utilization of residential and inpatient behavioral healthcare will decrease for youth - second-year target 3.7% - and for adults second-year target 31.3%.

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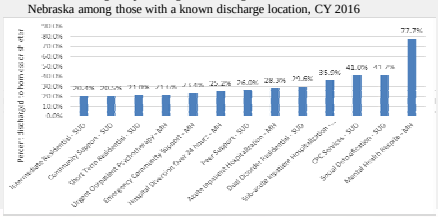
Consumers secure and sustain permanent housing in the community

- The lack of safe and affordable housing is a significant barrier to recovery from mental health and/or substance use disorders.

Services with the highest percentage of discharges to homeless or shelter in Nebraska among those with a known discharge location, CY 2016



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26

Consumers secure and sustain permanent housing in the community

Priority Type: SAT, MHS

Population(s): SMI, SED, PWWDC, ESMI, PWID, HIV EIS, TB

- **Goal of the priority area:** Consumers have permanent and stable housing.
- **Objective:** Increase the number of consumers and their families who have stable housing upon discharge from behavioral health services.
- **Indicator:** Increase support for consumer access to permanent housing.

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27

Consumers secure and sustain permanent housing in the community

Priority Type: SAT, MHS

Population(s): SMI, SED, PWWDC, ESMI, PWID, HIV EIS, TB

- **Data Source:** Nebraska DHHS Division of Behavioral Health Centralized Data System (CDS).
- **Description of Data:** Consumer treatment data from CDS. CDS collects consumer level information to report to the Treatment Episode Date Set (TEDS) of MH and SU Disorders consumers receiving Division funded services, either directly or through regional contracts. CDS warehouses all the data entered so that it can be analyzed at any time.
- **Baseline Measurement:** Statewide measure of the number of consumers and their families who have stable housing upon discharge from behavioral health services.

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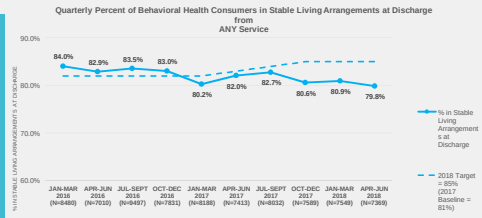
Consumers secure and sustain permanent housing in the community



Data source: CDS - encounter data from living arrangement for persons discharged from ANY service.

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Consumers secure and sustain permanent housing in the community

Priority Type: SAT, MHS

Population(s): SMI, SED, PWWDC, ESMI, PWID, HIV EIS, TB

- **Strategies to attain the objective:** Increase system and community-level planning efforts to focus on targeted resource for priority populations.
- **First-year target/outcome measurement:** Statewide measure of the number of consumers and their families who have stable housing upon discharge from behavioral health services – Baseline 83.3% and first-year target 84.0%. FY2018 Stable Living = 81.0% 24,747 out of 30,539 discharges
- **Second-year target/outcome measurement:** Statewide measure of the number of consumers and their families who have stable housing upon discharge from behavioral health services – second-year target 85.0%.

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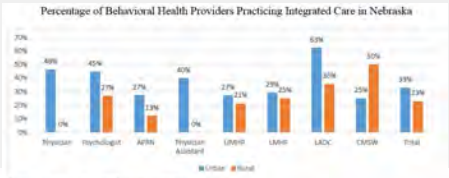
Integrated primary and behavioral health care in community settings

- Barriers to primary care can be a major obstacle for early detection and treatment of chronic illnesses and lifestyle modifications. Integration of behavioral health in the primary care setting can increase access to medical care services among people with mental health and substance use disorders. Integration can also expand the use of behavioral health screening and treatment among people in the general population.



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Integrated primary and behavioral health care in community settings

Priority Type: SAT, MHS

Population(s): SMI, SED, PWWDC, ESMI, PWID, HIV EIS, TB

- **Goal of the priority area:** Increase access to and use of behavioral health services in community settings to promote integrated primary and behavioral health care.
- **Objective:** Increase the number of behavioral health providers who report practicing in a setting that is integrated with primary care.
- **Indicator:** Increase integrated primary and behavioral health care in community settings

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Integrated primary and behavioral health care in community settings

Priority Type: SAT, MHS

Population(s): SMI, SED, PWWDC, ESMI, PWID, HIV EIS, TB

- **Data Source:** Health Professional Tracking Survey
- **Description of Data:** Annual survey of health care professionals conducted by the University of Nebraska Medical Center.
- **Baseline Measurement:** 2016 Health Profession Tracking Service survey asking behavioral health providers in the state whether they were currently practicing in an integrated care setting – 30.2%.

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Integrated primary and behavioral health care in community settings

Priority Type: SAT, MHS

Population(s): SMI, SED, PWWDC, ESMI, PWID, HIV EIS, TB

- **Strategies to attain the objective:** Collaborate with system partners to identify and promote opportunities for integrating primary and behavioral health care in community settings.
- **First-year target/outcome measurement:** Statewide measure of the number of behavioral health providers who report practicing in a setting that is integrated with primary care – Baseline 30.2% and first-year target 31.0%.

  Results of 2018 survey – Not yet available.
- **Second-year target/outcome measurement:** Statewide measure of the number of behavioral health providers who report practicing in a setting that is integrated with primary care –second-year target 32.0%.

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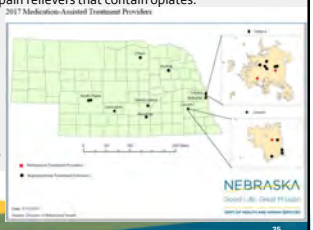
Prescribers provide Medication-Assisted Treatment

- Medication-Assisted treatment (MAT) is the use of counseling and behavioral therapies combined with the use of medications to treat substance use disorders and prevent pain reliever and the use of illicit drug overdose.
- MAT is primarily used for the treatment of addiction to opioids such as heroin and prescription pain relievers that contain opiates.
- With 28% of Nebraska residents living in rural areas, access to treatment facilities can be difficult for many residents; additionally, sustainability for treatment clinics can also be challenging for providers exploring new business opportunities.



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Prescribers provide Medication-Assisted Treatment

Priority Type: SAT

Population(s): PWWDC, PWID, HIV EIS, TB

- **Goal of the priority area:** Increase the number of prescribers providing Medication-Assisted Treatment.
- **Objective:** Increase the number of prescribers providing Medication-Assisted Treatment.
- **Indicator:** Increase the number of prescribers providing Medication-Assisted Treatment.

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Prescribers provide Medication-Assisted Treatment

Priority Type: SAT

Population(s): PWWDC, PWID, HIV EIS, TB

- **Data Source:** SAMHSA's Buprenorphine Treatment Practitioner Locator
- **Description of Data:** Listing by SAMHSA of providers who provide Medication-Assisted Treatment.
- **Baseline Measurement:** SAMHSA 2016 listing of providers who provide Medication-Assisted Treatment – 22 prescribers.

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Prescribers provide Medication-Assisted Treatment

Priority Type: SAT

Population(s): PWWDC, PWID, HIV EIS, TB

- **Strategies to attain the objective:** Coordinate and provide Medication-Assisted Treatment training for prescribers.
- **First-year target/outcome measurement:** Statewide measure of the number of prescribers providing Medication-Assisted Treatment – Baseline 22 and first-year target 25.
  FY2018 MAT Providers = 25
- **Second-year target/outcome measurement:** Statewide measure of the number of prescribers providing Medication-Assisted Treatment – second-year target 28.

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Requirements Regarding Tuberculosis

In 2016, Nebraska had 28 cases of active TB, for a rate of 1.5 cases per 100,000 people. This represents a 26% decrease from the 38 cases of active TB in 2014.

- The large majority of TB cases (79%) occurred with individuals who were foreign born as indicated in the chart below.

Reported Tuberculosis Cases in Nebraska with High Risk Factors 2010-2016

	2010	2011	2012	2013	2014	2015	2016
	27	23	22	21	38	43	28
	1.5	1.3	1.2	1.2	2	1.7	1.47
	2	2	1	0	1	0	Not Available
	21	14	13	13	31	25	23
	0	1	1	0	1	0	Not Available
	0	2	2	0	0	0	Not Available
	0	0	1	0	3	4	Not Available

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Tuberculosis

Priority Type: SAT

Population(s): TB

- **Goal of the priority area:** Meet federal requirements regarding screening for Tuberculosis.
- **Objective:** As required through the contracts with the Regional Behavioral Health Authorities, tuberculosis screening is provided to all persons entering a substance abuse treatment service. Additional services and/or referrals for services are made available to those individuals whose screening indicates "high risk" for TB.
- **Indicator:** Signed contracts between the Nebraska Department of Health and Human Services - Division of Behavioral Health and the six Regional Behavioral Health Authorities.

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Tuberculosis

Priority Type: SAT

Population(s): TB

- **Data Source:** The Nebraska Department of Health and Human Services - Division of Behavioral Health contracts with the six Regional Behavioral Health Authorities.
- **Description of Data:** Signed contracts between the Nebraska Department of Health and Human Services - Division of Behavioral Health and the six Regional Behavioral Health Authorities.
- **Baseline Measurement:** Maintain the contract requirement with the Regional Behavioral Health Authorities for tuberculosis screening provided to all persons entering a substance abuse treatment service.

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Requirements Regarding Tuberculosis

- **Strategies to attain the objective:** Regional Behavioral Health Authorities will comply with contract requirements for tuberculosis screening to be provided to all persons entering a substance abuse treatment service.
- **First-year target/outcome measurement:** Maintain the contract requirement with the Regional Behavioral Health Authorities for tuberculosis screening provided to all persons entering a substance abuse treatment service.
- **Second-year target/outcome measurement:** Maintain the contract requirement with the Regional Behavioral Health Authorities for tuberculosis screening provided to all persons entering a substance abuse treatment service.

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First Episode Psychosis (FEP) - Pilot Programs

The Nebraska FEP CSC Pilot Program was implemented in two of the six behavioral health service regions of the state. The two separate, independent FEP CSC Pilot Program teams are located in the Omaha metropolitan area (Region 6; population 900,000) and in the Kearney micropolitan area (Region 3; population 150,000). The two teams are separated by 190 miles. These areas were selected because of concentration of youth identified as experiencing FEP as well an existing concentration of specialty youth services.

Statewide Count Total Enrolled in FEP Pilot Programs			
Year	New Admissions	Enrolled in Programs	Discharged
FY2016	7	7	0
FY2017	11	18	4
FY2018	11	12	7
Total	29	Overlaps	11

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First Episode Psychosis (FEP)

Priority Type: MHS

Population(s): SMI, ESMI

- **Goal of the priority area:** More people are being provided the behavioral health services they need earlier and in a voluntary capacity through self-entry into the service system.
- **Objective:** Improve functioning for youth and young adults who have experienced a first episode of psychosis.
- **Indicator:** Providers will help improve functioning for youth and young adults with a first episode of psychosis.

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First Episode Psychosis (FEP)

Priority Type: MHS

Population(s): SMI, ESMI

- **Data Source:** Mental Illness Research, Education, and Clinical Center version of the Global Assessment of Functioning Scale (MIRECC-GAF Expanded).
- **Description of Data:** The MIRECC GAF Expanded measures occupational functioning, social functioning, and symptom severity on three subscales. Scores for each of the three subscales will be recorded and collected to evaluate change in functioning during FEP treatment.
- **Baseline Measurement:** Will establish baseline through pilot program use of MIRECC-GAF Expanded assessment tool.

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First Episode Psychosis (FEP)

Priority Type: MHS

Population(s): SMI, ESMI

Three Domains are assessed on the MIRECC GAF Expanded:

- **Symptom Scale**
- **Occupational Functioning Scale**
- **Social Functioning Scale**

Scores based on participant's average level of functioning over the last month.

- Fully functional (70 – 100);
- Borderline functional (50 – 69);
- Dysfunctional (20 – 49);
- Dangerous (1 – 19);
- No information (0)

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First Episode Psychosis (FEP)

Priority Type: MHS

Population(s): SMI, ESMI

- **Strategies to attain the objective:** Continue to develop recovery-oriented services and increase use of evidence-based practices which help individuals stabilize and maintain stabilization in community settings. Support Mental Health trainings to improve early intervention and support.
- **First-year target/outcome measurement:** To be determined after baseline established.
- **Second-year target/outcome measurement:** To be determined after baseline established.

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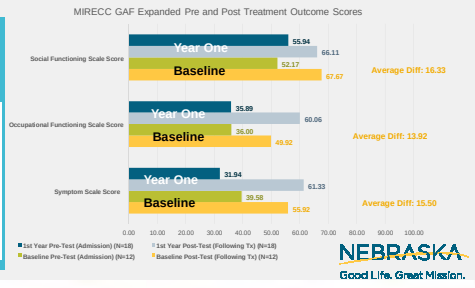
First Episode Psychosis (FEP)

Baseline Average Total Score Pre-test = 127.75

Baseline Average Total Score Post-test = 173.50

Average Baseline Total Score Difference = 45.75



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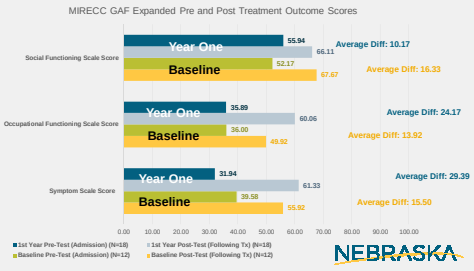
First Episode Psychosis (FEP)

First Year Average Total Score Pre-test = 123.77

First Year Average Total Score Post-test = 187.50

Average First Year Total Score Difference = 63.73

Target? =



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Interim Services are provided to women's set-aside SAPTBG

DBH operates a capacity management and waiting list systems for all services. DBH is moving our waitlist process into the CDS during 2017. As a result during the next block grant (FY18/FY19) we will only be able to classify individuals according to the highest priority population they qualify for.

- Persons in this population receive priority admission into treatment services or if treatment is not immediately available offered priority placement on the waiting list and provided interim services within 48 hours of the request for treatment.

Persons Placed on a Waitlist for Admission to SUD Services by Priority Population, FY 2016

Priority Population by Type	Number
Unknown	1
Pregnant and Current Intravenous Drug Using Women	1
Pregnant Substance Abusers	9
Injecting Drug Users	140
Women with Dependent Children	112
Mental Health Social Commitment	41
Total	314

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Interim Services are provided to women's set-aside SAPTBG

Priority Type: SAT

Population(s): PWWDC, PWID, HIV EIS, TB

- **Goal of the priority area:** Interim services are being provided for consumers who are placed on waitlist for services by all network providers.
- **Objective:** As required through the contracts with the RBHAs, interim services will be provided for consumers who are placed on waitlist for services.
- **Indicator:** Interim services are provided to consumes who are placed on waitlist for services.

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Interim Services are provided to women's set-aside SAPTBG

Priority Type: SAT

Population(s): PWWDC, PWID, HIV EIS, TB

- **Data Source:** The Nebraska DHHS – DBH contracts with the six Regional Behavioral Health Authorities.
- **Description of Data:** Signed contracts between the Nebraska DHHS – DBH and the six RBHAs.
- **Baseline Measurement:** Maintain the contract requirement with the RBHAs for interim services provided to all persons entering a substance abuse treatment waitlist.

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Interim Services are provided to women's set-aside SAPTBG

Priority Type: SAT

Population(s): PWWDC, PWID, HIV EIS, TB

- **Strategies to attain the objective:** Regional Behavioral Health Authorities will comply with contract requirements for providing interim services for consumers who are placed on waitlist for services.
- **First-year target/outcome measurement:** The contract requirement was maintained with the RBHAs for interim services provided to all persons entering a substance abuse treatment waitlist.
- **Second-year target/outcome measurement:** The contract requirement was maintained with the RBHAs for interim services provided to all persons entering a substance abuse treatment waitlist.

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What recommendations for FEP baseline measure and targets do you have?

What other recommendations for target adjustments do you have?

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Thank you!

Questions?
Comments??
Recommendations???

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Primary Prevention Activities Supported by SAPTBG

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Primary Prevention Activities Supported by SAPTBG

Definitions -

Primary Prevention Strategies

Grantees must develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance abuse. The program must include, but is not limited to, the following strategies:

- **Information Dissemination** provides knowledge and increases awareness of the nature and extent of alcohol and other drug use, abuse, and addiction, as well as their effects on individuals, families, and communities. It also provides knowledge and increases awareness of available prevention and treatment programs and services. It is characterized by one-way communication from the information source to the audience, with limited contact between the two.
- **Education** builds skills through structured learning processes. Critical life and social skills include decision making, peer resistance, coping with stress, problem solving, interpersonal communication, and systematic and judgmental capabilities. There is more interaction between facilitators and participants than there is for information dissemination.

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Primary Prevention Activities Supported by SAPTBG

Definitions – Cont.

- **Alternatives** provide opportunities for target populations to participate in activities that exclude alcohol and other drugs. The purpose is to discourage use of alcohol and other drugs by providing alternative, healthy activities.
- **Problem Identification and Referral** aims to identify individuals who have indulged in illegal or age-inappropriate use of tobacco or alcohol and individuals who have indulged in the first use of illicit drugs. The goal is to assess if their behavior can be reversed through education. This strategy does *not* include any activity designed to determine if a person is in need of treatment.
- **Community-based Process** provides ongoing networking activities and technical assistance to community groups or agencies. It encompasses neighborhood-based, grassroots empowerment models using action planning and collaborative systems planning.
- **Environmental** establishes or changes written and unwritten community standards, codes, and attitudes. Its intent is to influence the general population's use of alcohol & other drugs.

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Primary Prevention Activities Supported by SAPTBG

Definitions – Cont.

Grantees should use a variety of strategies that target populations with different levels of risk. Specifically, prevention strategies can be classified using the Institute of Medicine Model of Universal, Selective, and Indicated, which classifies preventive interventions by targeted population. The definitions for these population classifications are:

- **Universal:** The general public or a whole population group that has not been identified on the basis of individual risk
- **Selective:** Individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average
- **Indicated:** Individuals in high-risk environments who have minimal but detectable signs or symptoms foreshadowing disorder or have biological markers indicating predispositions for disorder but do not yet meet diagnostic levels

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Thank you!

Questions?
Comments??
Recommendations???

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Discover the Power of Choice!

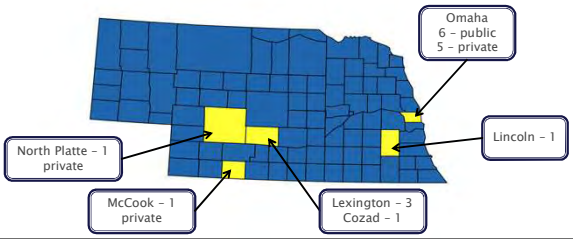
What is… SMART Recovery®?

by Connie R Nelson, BSN, BSW, RN
anticipated MSN (PMHNP) July 2020

SMART Recovery® Meetings

- 1,508 in USA weekly – meetings in 49 states
- 17 in Nebraska weekly

(as of March 2018)



What is SMART Recovery®?

Self
Management
And
Recovery
Training

Mutual Help Group [MHG]

- Local face to face meetings
- Online meetings
- Accepted by court/probation
- Partnership of professionals and peers
- Non-profit 501(c)(3)
- Meetings are FREE!

What is SMART Recovery®?

- Can be used in addition to or instead of 12-step groups
- Abstinence-oriented
  - ✓ Behaviors
  - ✓ Substances
- Self-empowering approach
- 24/7 online recovery information and support

4-Point Program®

Point 1: Building and Maintaining Motivation

Point 2: Coping with Urges

Point 3: Managing Thoughts, Feelings, and Behaviors

Point 4: Living a Balanced Life

Point 1: Building and Maintaining Motivation

SMART tools:

- Hierarchy of Values
- Cost/Benefit Analysis
  - Costs/Benefits of continuing behavior or substance use
  - Costs/Benefits of stopping behavior or substance use
  - Look at short and long-term costs/benefits
- Change Plan Worksheet
- Brainstorming—for problem solving

Point 2: Coping with Urges

Some SMART tools:

- Discuss common misconceptions about urges
- DISARM, DEADS
- Urge log
- Play the tape forward ("doing and not doing" addictive behavior)
- Support of new friends at SMART Recovery® Meetings
- Acceptance of:
  - Urges as a normal part of change
  - Yourself (Unconditional Self-Acceptance or *USA*), others (Unconditional Other Acceptance or *UOA*), and life (Unconditional Life Acceptance or *ULA*)

Point 3: Managing Thoughts, Feelings, and Behaviors

- ABCs to Dispute Unhelpful Beliefs
- Enhanced Frustration Tolerance / Problem of Instant Gratification
- Vocabulary Exchange
- Journaling
- Relaxation
- Brainstorming
- Planning

Point 4: Living a Balanced Life

- Develop a VACI (Vital Absorbing Creative Interest)
- Lifestyle Balance Pie
- When "recovery" feels good we are much more likely to continue
- Volunteer with SMART Recovery®
- May graduate with time – individual choice to continue or discontinue attendance

Facilitators and Hosts

- Host training is online and free
  - More scripted
  - Predetermined discussion topics
- Facilitator training is online – 30 CEUs
  - Stages of change
  - Group facilitation skills
  - Motivational interviewing techniques
  - Cognitive Behavioral Therapy concepts
  - And more…

Facilitators and Hosts

- About 300 trainees a month
- Currently about 70% are professionals
- Recovery meetings for all volunteers worldwide online—twice monthly
- Meeting Management meetings for facilitators & hosts worldwide online—3x weekly

What is a meeting like?

- "Facilitated" or "Hosted"
- Opening Statements
- Check-in
  - name
  - recovery-based icebreaker
  - current success
  - concern or topic
- Agenda setting

- Topic discussion
- Pass the hat
- Homework assignments
- Checkout
  - Something you gained from meeting?
  - Action you plan to take in the next week?

In meetings we encourage:

- Discussion amongst participants
- SMART tools to be used on topics addressed
- Present & future focus
- Thinking SMART – using the tools

In meetings we discourage:

- "war stories"
- Negative focus
- Romanticizing addiction
- Bashing other programs
- Labels such as "alcoholic" or "addict"
- Anything which is not helpful to recovery

What about relapse?

- Differentiate between a "lapse" and a "relapse"
- Come discuss what happened
- Do not start over at day zero with lapse
- Less emphasis on time, more on recovery
- Change more like an upward spiral than straight line

Why are there no sponsors in SMART?

- Decrease dependency
- Avoid abuse of relationship
- Self-directed recovery, choice, self-empowerment, self-efficacy
- Unable to ensure sponsor qualifications
- Therapist, recovery coach, peer support specialist if needed

SMART Recovery® has been endorsed as "evidence-based" by:

- National Association of Drug Court Professionals
- And many others (see handouts)

Refusal Self-Efficacy

- Significantly higher rates with 3 or more months of attendance
- Significantly higher rates with 10 or more meetings per month than those who attended less

(O'Sullivan, Watts, Xiao, & Bates-Maves, 2016)

Other findings…

SMART Recovery® participants:

- Higher readiness for change
- Attended significantly less meetings
- Duration of attendance may be shorter
- Had more future orientation, coping skills, less conflict, and higher social support
- Had at least the sobriety of other forms of mutual aid

(Beck, et al., 2017)

Recommendations

- Clinical guidelines recommend tailoring support to the goals of the individual (Beck, et al., 2017)
- While 12-step approaches are an appropriate recommendation for many, other available approaches should also be suggested (Mendola & Gibson, 2016)

Publications and Resources

www.smartrecovery.org

Free resources online

- Essays
- Worksheets
- Meetings—text & voice
- Forums
- 24/7 chatroom
- Blog – weekly on Tuesdays
- Podcasts
- Info for courts & professionals

Publications and Resources

www.smartrecovery.org

- *SMART Recovery® Handbook* (available in 13 languages)
- *Motivational Guide and Workbook for Recovering Healthcare Professionals*
- *Family and Friends Handbook*
- *SMART Recovery® Teen & Youth Handbook*
- "*InsideOut*"—for correctional facilities

SMART Recovery®

Discover the Power of Choice!

Want to refer a client?

Tuesdays 6:45-8:00p
1640 L Street, Suite C (inside Parallels)
www.facebook.com/SMARTRecovery.Lincoln
connie.smartfaci@gmail.com
402-853-2812 (professional calls only)

Like us on Facebook!

What did participants like about *their* current MHG?

12-step	SMART Recovery®
• Supportive environment	• Internal locus of control
• Fellowship	• Supportive environment
• 12-steps give sense of direction or purpose	• Many tools / resources for relapse prevention
• People have common problem	• Scientific nature
• Availability of groups	• Non-judgemental

(Beck, et al., 2017)

What did participants dislike about *prior* 12-step MHGs?

- Negative attributes of members
- Disparity among groups
- Repetitious
- Lack of seriousness
- Frequent relapses
- Higher power
- Powerlessness
- Dogmatic, authoritative
- Labeling
- People with poor boundaries

(Beck, et al., 2017)

What did participants dislike about *prior* SMART Recovery® MHGs?

- Lack of sponsorship
- Felt like counseling or advice
- Same stories repeated
- Easy to be facetious online

(Beck, et al., 2017)

Reasons for Dropout from 12-step MHGs

- Less or no religious beliefs; *Religious or spiritual beliefs are not required, can be helpful to recovery if desired*
- Less or no belief in the "disease" concept; *No position on disease concept*
- Less motivation to change; *Tools to promote & maintain motivation*
- Need for psychiatric medication; *Supports responsible use of prescribed medication*

(Kelly & Moos, 2003; Kelly, Kahler, & Humphreys, 2010)

Recidivism in offenders

- Participants in a SMART Recovery®-informed intervention had consistently lower recidivism rates than controls on all indices.
- Attendees of the intervention and SMART Recovery MHGs were even lower on all indices.

(Beck, et al., 2017)

Cognitive Behavioral Skill Usage

- Most participants reported using cognitive restructuring and behavioral activation techniques
- Quality of facilitation linked with higher group cohesion
- Group cohesion linked with more frequent cognitive restructuring
- Increased behavioral activation linked with homework assignments which could be completed in the week between meetings

(Kelly, Deane, & Baker, 2015)

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(Images from Pixabay.com & SMARTRecovery.org)

SMART Recovery® FAST FACTS

Self-Management and Recovery Training

SMART Recovery is the world's largest and fastest-growing community of mutual support group meetings using science and self-empowerment to help people overcome addiction problems with drugs, alcohol and behavior such as gambling. Tens of thousands of people gather weekly at more than 2,600 meetings in 24 countries,[1] including more than 1,500 in the U.S. alone. People anywhere in the world can attend another 30 weekly meetings online and receive support through 24/7 chatrooms and message boards.

The *SMART Recovery Handbook* has been published in 13 languages: Arabic, Danish, English, Farsi, French, German, Mandarin Chinese, Polish, Portuguese, Spanish, Swedish and Vietnamese, along with the dialect spoken by Australian Aborigines.

SMART stands for Self-Management and Recovery Training. It uses principles, practices and tools from disciplines with proven effectiveness in treating problematic addictive behavior, such as Cognitive-Behavioral Therapy and Motivational Interviewing. Many meetings help people with special needs in specific venues:

Schools – SMART meetings help teenagers and young adults address addiction problems at an early age.

InsideOut in Correctional Facilities – For more than two decades, SMART has helped inmates address problematic addictive and criminal behavior with meetings adapted for their use.

Family & Friends – Spouses, parents and partners with loved ones engaging in problematic addictive behavior learn to cope with these challenging relationships while trying to help them seek treatment in a positive, loving and nonjudgmental manner. These meetings use tools from regular SMART meetings and the evidence-based approach known as Community Reinforcement and Family Training (CRAFT).

SMART Recovery 4-Point Program® Based on Self-Empowerment

SMART is designed to help people find the power to change within themselves. The discussion at meetings is centered around the SMART 4-Point Program:

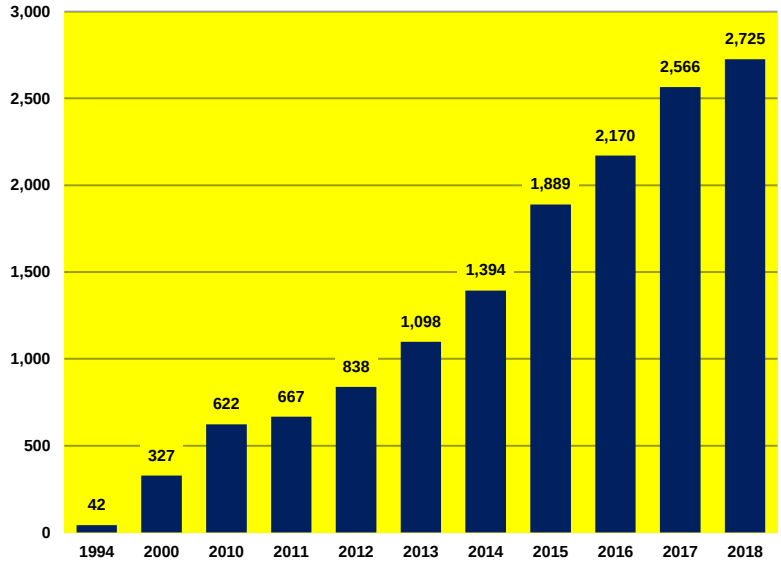
1. **Build and Maintain Motivation.**
2. **Cope with Urges.**
3. **Manage Thoughts, Feelings and Behaviors.**
4. **Lead a Balanced Life.**

Facilitators and Hosts Lead Highly Interactive Meetings

SMART meetings are led by facilitators who complete a rigorous 30-hour training course or by hosts who undergo less rigorous training and lead simpler meetings. All meetings are highly interactive, conversational and educational, enabling all participants to share their successes and challenges and receive guidance and support from others. Meetings are action-oriented, positive and focus on the present and future.

These self-empowering discussions include science-based tools for change that enable participants to become increasingly self-reliant in their efforts to change, and to lead lives that are more meaningful, productive and connected.

SMART Meeting Growth Since Its Founding



Notes: The 2018 number is current through March.

The majority of meetings are free and open to the public. SMART-oriented meetings are held in correctional and military facilities, schools, hospitals and treatment centers. These figures do not include 30 weekly meetings held online.

[1] Australia, Canada, China (and Hong Kong), Denmark, India, Iran, Ireland, Kenya, Malaysia, Mexico, Namibia, New Zealand, Nigeria, Panama, Russia, Singapore, South Africa, Spain, Sweden, Thailand, United Kingdom, United States, Uzbekistan and Vietnam.

Participants learn from each other about specific tools and how to apply them in various situations. SMART's tools evolve as scientific findings evolve. SMART meetings themselves are the ongoing subject of scientific inquiry. Findings suggest that SMART meetings are as effective as any other mutual help meetings for resolving problematic addictive behavior.[2, 3]

Other research has revealed the importance of choice in the types of meetings available for individuals with different orientations, such as spiritual vs. scientific.[3] This follows the emphasis in modern treatment on offering people multiple pathways for recovery.[4]

SMART Works to Destigmatize Addiction

In our meetings we discourage using labels such as "addict" and "alcoholic," because such labels can undermine motivation for many people. SMART views addiction as a behavioral problem that can be corrected, not a condition that defines a person's identity.

The SMART organization is operated almost entirely by volunteers. Meeting participants are encouraged to become volunteers in order to enhance their own gains and experience the satisfaction of helping others. SMART is also supported by ongoing relationships worldwide with mental health professionals and psychological scientists, who help SMART stay current with relevant professional and scientific developments. Our International Advisory Council includes some of the world's leading addictive behavior scientists.

SMART is a widely recognized pathway for recovery support and change. It is recommended by leading government and medical institutions worldwide, including:

Australia – the Government Department of Health and Ageing and Government National Health and Medical Research Council.

United Kingdom – National Institute for Health and Care Excellence and Public Health England.

United States – National Institute on Drug Abuse, National Institute on Alcohol Abuse and Alcoholism, Substance Abuse and Mental Health Services Administration and Federal Bureau of Prisons.

Founded in 1994 as a 501(c)(3) non-profit organization, SMART works as a partnership between professionals and peers (people who've had addictions or family members with addictions).

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[2] Sarah E. Zemore, Ph.D., et al., "A Longitudinal Study of the Comparative Efficacy of Women for Sobriety, LifeRing, SMART Recovery, and 12-step Groups for Those with AUD," *Journal of Substance Abuse Treatment*. 88 (2018) 18-26. This study found that participation in LifeRing, SMART Recovery, Twelve-Step and Women for Sobriety groups are equally effective in helping people overcome alcohol use disorders. "An optimal care plan may thus involve facilitating involvement in a broad array of mutual help support groups and encouraging abstinence motivation and social networks that are supportive of abstinence." 24

A 2017 study by Zemore et al., "Comparison of 12-Step Groups to Mutual-Help Alternatives for AUD in a Large, National Study: Differences in Membership Characteristics and Group Participation, Cohesion, and Satisfaction," *Journal of Substance Abuse Treatment* 73 (2017) 16-26, found that "high levels of participation, satisfaction, and cohesion among members of the mutual help alternatives suggest promise for these groups in addressing addiction problems." 16

[3] Zemore's studies follow research published in 2007 by Randolph G. Atkins, Ph.D., and James E. Hawdon, Ph.D., "Religiosity and Participation in Mutual-Aid Support Groups for Addiction," *Journal of Substance Abuse Treatment* 33 (2007) 321-331. This research concludes: "Because religiosity influences group participation and outcomes, client religiosity must be considered in treatment planning…. For [individuals] with low levels of religiosity, and especially who have a secular or 'scientific' worldview, it may be very difficult to fit in with spiritually based recovery programs. Individuals with this type of personal philosophy are more likely to feel that sense of belonging in secular support groups that do not use a spiritual approach, such as SOS or SMART, and are more likely to continue participating in these secular groups, thus improving their prognosis for long-term abstinence.

"This study provides more evidence that, in recovery, 'one size does not fit all' and that matching clients to appropriate support groups according to their individual beliefs can have a positive impact on their program involvement and, ultimately on their treatment outcomes. As White and Kurtz (2005, p. 39) point out, 'It is time that the multiple pathways and styles of recovery fully permeated the philosophies and clinical protocols of all organizations providing addiction treatment and support services.' We could not agree more." 329, 330.

[4] U.S. Surgeon General Vivek H. Murthy, M.D., emphasizes the need for multiple recovery choices in the landmark 2016 report *Facing Addiction in America*: "We have learned that recovery has many pathways that should be tailored to fit the unique cultural values and psychological and behavioral health needs of each individual." v-vi. U.S. Department of Health and Human Services (HHS), Office of the Surgeon General, *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health*, Washington, DC: HHS, November 2016.

Examples of SMART Tools and Strategies

Cost Benefit Analysis – This exercise motivates people to stop an addictive behavior by weighing the short-term benefits of, for example, abusing pain pills (feeling good, relaxed and happy for a short time) against the long-term harmful costs (ruined relationships, lost jobs, wasted money, ill health). The purpose is to help people decide for themselves to change, which is the most effective way for them to do so. Most people do not respond well to coercion.

Cost-Benefit Analysis Worksheet | Four Questions About My Addiction: A Cost/Benefit Exercise

A Cost-Benefit Analysis for Alcohol Addiction

Addictive Drinking

Advantages (benefits and rewards)			Disadvantages (costs and risks)		
Relieve anxiety	Easier to socialize	Overcome boredom	Lose job	Costs a lot of $$$	Health problems–cirrhosis, cancer
Celebrate success	Fun with friends		Lose respect of friends, family	DUI/Lose Driver's License	Hangovers/ blackouts

Quitting/Abstaining

Advantages (benefits and rewards)			Disadvantages (costs and risks)		
Clear thinking, good health	Save a lot of $$$	High self esteem	Boredom	Have to make new friends	Trouble sleeping
Job success/ advancement	Good marriage & family life	No hangovers, feel good in a.m.	Harder to socialize	Harder to cope with stress	

The next step is to label each item either "short-term (ST)" or "long-term (LT)," and people discover that all the advantages of drinking are short term and the disadvantages long term. In addition, the benefits of not drinking are long-term and the disadvantages can be overcome with some effort but will not last that long.

Urge Log – In the early stages of resolving a problematic addictive behavior, people benefit by identifying all the events, sights, smells and settings that trigger urges and cravings to use. Keeping a daily log of these triggers helps people avoid using and learn that urges are temporary and grow less intense the longer they abstain.

Urge Log

Date	Time	Rate 1-10	Length	What triggered my urge?	Where/who was I with	How I coped, feel-ings about coping	Alternative Activities

ABC – The basis for this exercise is learning how our beliefs govern our experiences, including what we feel and how we act. We may think our actions and feelings are caused by outside forces or events we cannot control. These outside factors – call them Activating or Adverse events, the A – play a role, but it is what we Believe – the B – that decides what we experience. When our beliefs are irrational, extreme or exaggerated, the resulting actions and feelings – the Consequences or C – can be harmful. The ABC exercise reveals rational and realistic beliefs that help us relieve anxiety and refrain from harmful and unhealthy behavior.

ABCs – A Crash Course | Finding the ABCs

Global Support for SMART

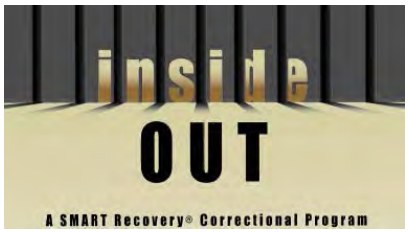
U.S. Government and Professional Endorsements

National Institute on Drug Abuse
Advancing Addiction Science

Understanding Drug Abuse and Addiction: What Science Says
Self Help and Drug Addiction Treatment

Self-help groups can complement and extend the effects of professional drug addiction treatment. The most prominent groups are those affiliated with Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and … and SMART Recovery. Most drug addiction treatment programs encourage patients to participate in a self-help group during and after formal treatment.[1]

SMART's InsideOut program for correctional facilities was funded by $1 million in NIDA Small Business Innovation Research Grants. SMART offers the court-mandated nonreligious recovery support that meets the best practice standards set by the National Association of Drug Court Professionals (NADCP). Major research has established that the program significantly reduces reconviction rates.[2]



National Institute on Alcohol Abuse and Alcoholism

Understanding the Impact of Alcohol on Human Health and Well-Being
Medical Attention | The Patient is Drinking

Encouraging patients to go to mutual-support groups such as AA or SMART Recovery is the first-line response in this situation. Although some patients will inform you early on that they have no intention of attending these meetings because of previous negative experiences or a fear of groups, encourage them to try these groups by stressing that a different type of group could be helpful (e.g., going to SMART Recovery instead of AA ….).[3]

NIH funded CheckUp & Choices (www.smartrecovery.org/checkupandchoices), an evidence-based web app based on SMART's 4-Point Program that helps people stop drinking, which was developed under the leadership of Reid Hester, Ph.D. After NIAAA-funded research proved its effectiveness, new apps were developed for opioids, stimulants, marijuana and compulsive gambling.

NIAAA ALCOHOL TREATMENT NAVIGATOR
Pointing the way to evidence-based care

CARETAKER SUPPORT RESOURCES

Just as the needs of each person with alcohol use disorder are different, each family's needs are also different. Several resources are available to help you while your loved one is in treatment, and afterwards.

- **Family therapy –** often offered as part of a patient's treatment. If not—or if you need additional or continuing support—you can use the *Navigator's* search guides to find a licensed addiction therapist who offers family therapy.
- **SMART Recovery for Family and Friends –** a research-based support program that focuses on building skills needed to support recovery. Visit SMART Recovery (www.smartrecovery.org) to learn more and to find an in-person or online support meeting.

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[1] NIDA, February 2016, www.drugabuse.gov/publications/teaching-packets/understanding-drug-abuse-addiction/section-iv/5-self-help-drug-addiction-treatment.

[2] In a study of 6,000 inmates, reconviction rates for violent crimes were 42 percent lower for the 3,000 who attended SMART meetings while incarcerated, according to research conducted in Australia by Chris Blatch et al., "Getting SMART, SMART Recovery Programs and Reoffending," *Journal for Forensic Practice*, 2016, Vol. 18 Iss: 1, 3-6.

[3] NIAAA, *COMBINE: Medical Management Treatment Manual – A Clinical Treatment Manual for Medically Trained Clinicians Providing Pharmacotherapy as Part of the Treatment for Alcohol Dependence*, 39, https://pubs.niaaa.nih.gov/publications/combine/Combine_2.pdf.

- **Al-Anon –** peer-led mutual support groups for family members and others affected by a person's drinking. Meetings focus on the 12 steps (adapted from AA), and sharing personal experience. Visit Al-Anon (al-anon.alateen.org) to learn more and to find nearby meetings.[4]

NIAAA ALCOHOL TREATMENT NAVIGATOR
Pointing the way to evidence-based care

LONG-TERM RECOVERY SUPPORT

For someone involved in treatment, it can be challenging to establish a routine free from alcohol or other substance use and away from the situations and social networks that used to support their drinking.

Participating in a **mutual support group** can reinforce and extend the benefits of professional treatment and provide much-needed social support over the long term.

There are several groups to consider:

- **Alcoholics Anonymous (AA) –** the most common mutual help group, with meetings in most communities and online. Meetings involve participants sharing their personal histories with drinking and recovery, and encourage progress along "12 steps" that have a strong spiritual component. Because group dynamics can vary from meeting to meeting, people often visit several meetings before they find one where they feel comfortable. Visit Alcoholics Anonymous (www.aa.org) to learn more and find a meeting nearby.
- **LifeRing –** a secular (nonreligious) peer support network supporting abstinence from alcohol and other drugs. Visit LifeRing (http://lifering.org) to learn more and to find an in-person or online meeting.
- **Secular Organizations for Sobriety –** an alternative to spiritual support groups, this is a network of local and online groups dedicated to helping people achieve and maintain sobriety. Visit Secular Organizations for Sobriety (www.sossobriety.org) to learn more.
- **SMART Recovery –** a research-based support program that focuses on empowering members to build four sets of skills: motivation to abstain, coping with urges, problem solving, and lifestyle balance. Visit SMART Recovery (www.smartrecovery.org) to learn more and find an in-person or online meeting.
- **Women for Sobriety –** a self-help program designed by and for women, focusing on emotional and spiritual growth. Visit Women for Sobriety (http://womenforsobriety.org) to learn more and find a meeting or online message board.[5]

Substance Abuse and Mental Health Services Administration
SAMHSA

An Introduction to Mutual Support Groups for Alcohol and Drug Abuse

Mutual support (also called self-help) groups are an important part of recovery from substance use disorders (SUDs). … The most widely available are 12-step groups such as Alcoholics Anonymous (AA), but other mutual support groups such as Women for Sobriety (WFS), SMART Recovery and Secular Organizations for Sobriety/Save Our Selves (SOS) are also available.

Clients who are "philosophically well matched" to a mutual support group are more likely to actively participate in that group. Thus, the best way to help a client benefit from mutual support groups is to encourage increased participation in his or her chosen group. …For example, having strong religious beliefs is related to greater participation in the spiritually based 12-step programs and WFS. In contrast, religiosity was less effective in increasing participation in SMART Recovery groups and decreased participation in SOS.[6]

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[4] https://alcoholtreatment.niaaa.nih.gov/support-through-the-process/caretaker-support-resources

[5] https://alcoholtreatment.niaaa.nih.gov/support-through-the-process/long-term-recovery-support

[6] Substance Abuse in Brief Fact Sheet, Spring 2008, 1, 4 (http://162.99.3.213/products/brochures/pdfs/saib_spring08_v5i1.pdf). This guidance is based on the paper by Randolph G. Atkins, Jr., Ph.D., and James E. Hawdon, Ph.D., "Religiosity and Participation in Mutual-Aid Support Groups for Addiction," *Journal of Substance Abuse Treatment* 33 (2007). This research concludes: "Because religiosity influences group participation and outcomes, client religiosity must be considered in treatment planning…. For [individuals] with low levels of religiosity, and especially who have a secular or 'scientific' worldview, it may be very difficult to fit in with spiritually based recovery programs. Individuals with this type of personal philosophy are more likely to feel that sense of belonging in secular support groups that do not use a spiritual approach, such as SOS or SMART, and are more likely to continue participating in these secular groups, thus improving their prognosis for long-term abstinence," 329, 330.

SMART RECOVERY®
National Recovery Month Planning Partner

This international nonprofit organization offers free, self-empowering, science-based mutual help groups for abstaining from any substance or activity dependence. SMART stands for Self-Management and Recovery Training. The SMART Recovery 4-Point Program® helps people recover from all types of dependency behaviors, including alcohol, drugs, substance misuse, gambling, and dependence on other substances and activities.[7]

Behavioral Health Treatment Services Locator
Peer Support … Self-Help Groups

Lists SMART Recovery and 12-step groups.[8] SAMHSA funded training for facilitators of SMART and InsideOut meetings, and the video "How to Facilitate a Basic SMART Recovery Meeting."

Adult Court Best Practice Standards, Volume I
Substance Abuse Treatment Peer Support Groups

Participants regularly attend self-help or peer support groups in addition to professional counseling. The peer support groups follow a structured model or curriculum such as the 12-step or SMART Recovery models.[9]

Seven U.S. Appellate and three State Supreme Court rulings found that 12-step programs are religious, and court mandates to attend such meetings violate the First Amendment freedom-of-religion clause.[10]

The Drug Court Judicial Bench Book
Self-Help Recovery Programs

One important concern about 12-step programs is that they do rely on recognition of a higher spiritual power, which has been interpreted by appellate courts to have religious significance that may trigger First Amendment objections. Appellate courts have held that the State cannot mandate attendance in these groups unless it also offers a secular alternative. Several secular alternatives may be offered to drug court participants. For example, SMART Recovery (www.smartrecovery.org) and Save Our Selves (SOS) (www.sossobriety.org) have a scientific or cognitive orientation as opposed to a spiritual or religious orientation.[11]

Federal Bureau of Prisons: Self-Help Groups

The Federal Bureau of Prisons (BOP) Residential Drug Abuse Program (RDAP) offers treatment based on Cognitive Behavioral Therapy and self-empowerment quite similar to SMART's InsideOut program. After inmates are released, the BOP recommends SMART meetings for "… participants [who] immediately reject AA and NA as a result of the spiritual component of these programs and/or as a result of the fact that these programs subscribe to the disease model of addiction. The disease model assumes that you are powerless over your addiction. The disease model can conflict with the bio-psychosocial model that is utilized in RDAP, which asserts that although there are many factors (genetics, personality, societal influences, family environment, etc.) that contributed to one's addiction, the individual is ultimately responsible for all the choices made in his life."[12]

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[7] SAMHSA list of Planning Partners for National Recovery Month (September), March 30, 2017, www.recoverymonth.gov/organizations-programs/smart-recovery®

[8] SAMHSA, Self-Help Groups (Addiction), *Behavioral Health Treatment Services Locator*, https://findtreatment.samhsa.gov.

[9] NADCP, 2013, www.nadcp.org/sites/default/files/2014/D-22.pdf, Chapter V. Substance Abuse Treatment, Section I. Peer Support Groups, 40, including footnote 19, which states, "Drug Courts must offer a secular alternative to 12-step programs such as Narcotics Anonymous because appellate courts have interpreted these programs to be deity-based, thus implicating the First Amendment."

[10] See the presentation by SMART President Joe Gerstein at the 2017 NADCP Training Conference, "The Power of Choice in Achieving Recovery" (www.smartrecovery.org/courts/), slides 6-10. In a 2013 case (Hazle v. Crowfoot), the court ordered the State of California and a treatment provider to pay $2 million in damages to an inmate for failing to observe this First Amendment right.

[11] Eds. Douglas B. Marlowe, J.D., Ph.D., Judge William G. Meyer (Ret.), 2011, www.ndci.org/sites/default/files/nadcp/14146_NDCI_Benchbook_v6.pdf, 75.

[12] RDAP Law Consultants, *RDAP: The Bureau of Prisons Alcohol, Narcotic and Prescription Drug Abuse Program*, 2014, 4.

UK Government Standards and Guidelines

NICE National Institute for Health and Care Excellence

NICE Quality Standard, Drug Use Disorders in Adults
Quality Statement 7: Recovery and Reintegration

People in drug treatment are offered support to access services that promote recovery and reintegration including housing, education, employment, personal finance, healthcare and mutual aid.
Mutual aid services include SMART (Self-Management and Recovery Training) and those based on 12-step principles, for example Narcotics Anonymous, Alcoholics Anonymous and Cocaine Anonymous.[13]

NICE Guideline, Alcohol-Use Disorders: Diagnosis, Assessment and Management of Harmful Drinking and Alcohol Dependence

1.3.1 General principles for all interventions …
1.3.1.7 For all people seeking help for alcohol misuse:

- give information on the value and availability of community support networks and self-help groups (for example, Alcoholics Anonymous or SMART Recovery) and
- help them to participate in community support networks and self-help groups by encouraging them to go to meetings and arranging support so that they can attend.[14,15]

Public Health England

A Briefing on the Evidence-Based Drug and Alcohol Treatment Guidance Recommendations on Mutual Aid

One of Public Health England's priorities is to improve recovery rates from drug dependency. To achieve this, a commitment has been made to increase the number of areas that have fostered effective links between treatment services and relevant community and mutual aid groups with the aim of enhancing social integration and wellbeing.

The most common mutual aid groups in England include 12-step fellowships and SMART Recovery…. SMART Recovery applies cognitive behavioural techniques and therapeutic lifestyle change to its mutual aid groups to help people manage their recovery.

Recovery Orientated Drug Treatment Expert Group – Promote choice by ensuring people in treatment have a range of peer-support options including 12-step, SMART Recovery and other local peer-support services.

Advisory Council on the Misuse of Drugs – The report *What Recovery Outcomes Does the Evidence Tell We Can Expect?* underscores the valuable role played in recovery by mutual aid, including AA, NA and SMART Recovery.[16]

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[13] NICE Quality Standard, Drug Use Disorders in Adults, November 19, 2012, 26-27, www.nice.org.uk/guidance/qs23/resources/drug-use-disorders-in-adults-2098544097733.

[14] NICE Guideline, Alcohol-Use Disorders: Diagnosis, Assessment and Management of Harmful Drinking and Alcohol Dependence, February 23, 2011, 17-19, www.nice.org.uk/guidance/cg115/resources/alcoholuse-disorders-diagnosis-assessment-and-management-of-harmful-drinking-and-alcohol-dependence-35109391116229.

[15] NICE guidelines state treatment should include a motivational component, which is much the same as the motivational aspects of SMART.

[16] Public Health England, *A Briefing on the Evidence-Based Drug and Alcohol Treatment Guidance Recommendations on Mutual Aid,* December 2013, 3-5, www.nta.nhs.uk/uploads/mutualaid-briefing.pdf.

Australian Government Guidelines

Australian Government
Department of Health and Ageing

Guidelines for the Treatment of Alcohol Problems

8. Self-Help Programs

Lists Alcoholics Anonymous and SMART Recovery, including:

SMART Recovery adopts a Cognitive Behavioural Therapy framework and diverges from AA in that it eliminates the focus on spirituality inherent to the AA 12-step approach.

It uses a four-point recovery program designed to enhance members' motivation and teaches techniques that help manage lifestyle and behavioural difficulties. Skills training involves exposure to (among other things) cost-benefit analyses, identifying and rectifying irrational thoughts, and role-playing.

Table 8.1: The SMART Recovery 4-Point Program

Point 1	*Enhancing and maintaining motivation to abstain*
Point 2	*Coping with urges*
Point 3	*Problem solving (managing thoughts, feelings and behaviours)*
Point 4	*Lifestyle balance (balancing momentary and enduring satisfactions)*

People who are uncomfortable with AA's spiritual focus may find the more secular approach of SMART Recovery a useful self-help alternative.

It is noteworthy that SMART Recovery is listed since the program was formally established in Australia in 2007, two years before the guidelines were issued. At the time, there were about 50 meetings in the country, compared with four times as many today.[17]

Australian Government
National Health and Medical Research Council

Centre of Research Excellence in Mental Health and Substance Use | National Drug and Alcohol Research Center, University of South Wales

Guidelines on the Management of Co-Occurring Alcohol and Other Drug and Mental Health Conditions in Alcohol and Other Drug Treatment Settings

Self-Help Groups

Reviews in the research literature suggest that some clients of AOD (alcohol and other drug) services will benefit from joining a self-help group, such as Alcoholics Anonymous, Narcotics Anonymous, SMART Recovery or alternative self-help groups.[18]

[17] Australian Government Department of Health and Ageing, *Guidelines for the Treatment of Alcohol Problem*, June 2009, 110-111, www.health.gov.au/internet/main/publishing.nsf/ Content/0FD6C7C289CD31C9CA257BF0001F96BD/$File/AustAlctreatguidelines%202009.pdf.

[18]National Health and Medical Research Council (NHMRC), Centre of Research Excellence in Mental Health and Substance Use, National Drug and Alcohol Research Center, University of South Wales, *Guidelines on the Management of Co-Occurring Alcohol and Other Drug and Mental Health Conditions in Alcohol and Other Drug Treatment Settings,* 2nd Edition, 2016, 105, https://comorbidity.edu.au/sites/default/files/National%20Comorbidity%20Guidelines%202nd%20edition_0.pdf.

SMART Recovery® Meeting List *(Always check www.SMARTRecovery.org for the most up-to-date information)*

Lincoln

Tuesday	6:45 to 8:00 p.m.	Adult/Public	1640 L St. #C Inside Parallels (park in a Parallels spot)	Connie & Justin Facilitators	Connie.SMARTfaci@gmail.com

Omaha

Sunday	2 to 3 p.m.	Public	Progeny Enterprises – Powersports 1458 S 16th Street	Blair Host	402-670-8316
Monday	6:30 to 7:30 p.m.	Public	Arbor Family Counseling 11605 Arbor St. Suite 102	Scott Wendel Facilitator	scottwendel@q.com
Tuesday	7 to 8 p.m.	Public	Halo Counseling 8998 L St., Suite #110,	Brianne Rinkenberger Facilitator	402-650-6405 b_gilstrom@yahoo.com
Wednesday	10 to 11 a.m.	**Private/**Female/Inmates Only/correctional facility	Douglas County Correction Center 710 S 17th St.	Sheryl Facilitator	
Wednesday	12:15 to 1:15 p.m.	**Private/**Male/Inmates Only/correctional facility	Douglas County Correction Center 710 S 17th St.	Sheryl Facilitator	
Wednesday	1 to 2:30 p.m.	**Private/**Clients Only	Campus for Hope (CenterPointe) 1490 North 16th Street	Ryan Carruthers Facilitator	
Wednesday	1:30 to 2:30 p.m.	**Private/**Work Release Inmates Only	Re-entry Assistance Program 1709 Jackson St.	Sheryl Facilitator	
Wednesday	3:45 to 4:45 p.m.	**Private/**Clients Only	Campus for Hope (CenterPointe) 1490 North 16th Street	Aaron Polak Facilitator	
Wednesday	6:30 to 8 p.m.	Public/Adults	Campus for Hope (CenterPointe) 1490 North 16th Street Room #10	Ian Severs Facilitator	402-415-8470 aisevers@gmail.com
Wednesday	7:15 to 8:30 p.m.	Public	Halo Counseling 8998 L St., Suite #110,	John Czapenski Facilitator	(402) 651-5404 halocounseling@outlook.com
Thursday	12 to 1 p.m.	Public	New Leaf Therapy Associates 10840 Old Mill Road, Suite 300	Heather Hruby Contact Person **Contact #2:** Sue Morrison Host **Contact #3:** Don Carney Host	402-253-9936 hhruby@gmail.com 402-672-9469 seespots@outlook.com 636-485-7231 doncarney@cox.net

Lexington

Tuesday	4 to 5 p.m.	Public/Teens	Club 180 210 West 7th Street	Heather Devine Facilitator	308-325-6497 director@club180lex.com
Tuesday	7 to 8:30 p.m.	Public/Adult	Club 180 210 West 7th Street	Heather Devine Facilitator	308-325-6497 director@club180lex.com
Thursday	7 to 8 p.m.	Public/Adult	Club 180 210 West 7th Street	Heather Devine Facilitator	308-325-6497 director@club180lex.com

Cozad

Thursday	7 to 8:30 p.m.	Public/Adult	American Lutheran Church 200 E. 12th Street	Debra Anderson Facilitator	308-746-5605 smartscne@gmail.com

McCook

Thursday	3 to 4 p.m.	**Private/**Students Only	Mid-Plains Community College 1205 East 3rd St. Room 118, Downstairs Von Riesen Library	Lyn Battreall Facilitator	(402) 707-7255

North Platte

Wednesday	5:30 to 6:30 p.m.	**Private/**Students Only	Mid-Plains Community College 601 West State Farm Rd. Room 118, Downstairs Von Riesen Library	Lyn Battreall Facilitator	(402) 707-7255

Service Name	**PEER SUPPORT**
Setting	Peer support services may be provided in an outpatient office/clinic, individual's home and/or community setting.
Facility License	As required by DHHS Division of Public Health.
Basic Definition	Peer support services are provided by individuals who have lived experience with Mental Health or Substance Use Disorders (SUD). The service is designed to assist individuals in initiating and maintaining the process of long-term recovery and resiliency to improve their quality of life, increase resiliency, health, and wellness by living self-directed lives and striving to reach their full potential. Peer support is person centered and supports dignity, self-advocacy, and empowerment. The core element of this service is the development of a relationship based on shared lived experience and mutuality between the provider and individual. This service can be provided to Medicaid eligible individuals and their families in individual and group settings.
Service Expectations : For more detail see Title 471 chapter 32 and 20	◦ Complete an Initial Diagnostic Interview (IDI) if one has not been completed within the 12 months prior to initiating peer support services. The IDI will serve as the initial treatment plan until the comprehensive plan of care is developed. An IDI is not necessary if peer support services are provided for treatment of a substance use disorder. An IDI must be completed by a licensed clinician authorized to perform that service; ◦ Complete a Substance Use Disorder (SUD) assessment, if one has not been completed by a licensed clinician prior to initiating peer support services. A SUD assessment is not necessary if peer support services are provided for treatment of a mental health disorder; ◦ The treatment plan is to be developed through shared decision making inclusive of the individual and must identify specific areas to be addressed; clear and realistic goals and objectives; strategies, and recovery support services to be implemented; criteria for achievement; target dates; methods for evaluating the individual's progress; a discharge plan, wellness plan, and crisis prevention plan that includes defining early warning signs and triggers; ◦ The individual treatment plan shall be completed within 30 days following admission, reviewed and updated every 90 days, or as often as clinically necessary thereafter while receiving services. The individual shall sign the plan to indicate involvement in the planning; refusal to sign will be noted on the treatment plan. The supervisor is responsible for reviewing and signing off on the treatment plan; ◦ Development of a mutual set of expectations for the peer relationship within one month of admission; ◦ Peer support services are provided in conjunction with one or more behavioral health services. ◦ Peer support services are based on the relationship between the Certified Peer Support Provider and the individual. Activities of the peer support provider are to serve and support individuals through sharing their knowledge, beliefs and experiences that promote recovery and wellness are possible, and that the individuals being served have the ability to manage their behavioral health symptoms successfully;

	◦ Peer support services are designed as a means of supporting individuals on their recovery journey as that individual defines it by utilizing the following recovery support services as applicable: o Peer coaching to facilitate system navigation, accessing community resources, and engagement with formal and informal resources and supports, all of which are designed to enhance the individual's resilience and ability to achieve their individual goals; o Building on current strengths of the individual to empower them with advocacy and self-help skills to enhance their process of recovery and increase their capacity to utilize wellness options available; o Assist clients to locate and join existing self-help groups; o Educating the individual about the peer support relationship to include topics such as healthy personal boundaries, individual rights, and the significance of shared decision making; o Sharing of experiences, skills, strengths, supports, and resources used in order to benefit the individual by demonstrating wellness through their own effective symptom management; o Meeting the individual "where they are at" in their recovery process and encouraging engagement into services; o Model and present self-help activities that cultivate the individual's ability to make informed, independent choices and decisions as well as activities designed to assist in developing a personal network of support, enhance problem solving abilities, and to build the personal confidence necessary to enhance and improve health and well-being; o Serve as a recovery agent by providing the opportunities and advocating for any effective services that will aid in daily living, coping, or symptom management; o Collaborate with the individual served as a treatment team member to develop a person centered treatment plan that incorporates the elements identified above and assist by determining the steps needed in order to achieve the goals identified in the treatment plan; o Specific to youth services: the peer support provider will include the individual's caregiver/family in order to help them understand the role of the peer support provider in their child's care. ◦ Peer support providers are expected to have received training on Trauma Informed Care and be able to incorporate that training into their interactions with the individuals; ◦ Supervision between the supervising practitioner and the peer support provider must occur at least twice per month for clinical consultation; ◦ The supervising practitioner must conduct at least one face to face contact with the individual within 30 days of the individual being assigned a peer support provider and no less frequently than every 60 days thereafter to monitor the individual's progress and the effectiveness of the peer support services; ◦ Group setting: the peer support provider develops relationships with individuals to share their experiences, skills, strengths, supports and resources used in order to show that recovery is an achievable lifelong process; and model and share problem solving skills;

	◦ Exploration of community resources related to the individual's independence and recovery, and assist the individual through the relationship developed to become empowered to work towards goals as defined by the individual.
Length of Service	As identified by the individual, the treatment team, and as determined medically necessary.
Staffing	The peer support provider must meet the following criteria: • Be 19 years of age or older; • Self-identify as having lived experience as an individual diagnosed with a mental health/substance use disorder or as a parent to a child with a mental health/substance use disorder; • Be able to demonstrate, via attestation, one year navigating a personal recovery and resiliency journey using relevant indicators such as ongoing use of illicit drugs or alcohol, or avoidance of frequent inpatient levels of care; • Have a high school diploma or equivalent with a minimum of two years of paid or volunteer experience working in a human service field; • Obtain state and/or national certification as a peer support provider; • Maintain state and/or national certification by completing continuing education requirements as identified by the certifying organization. The supervising practitioner assumes professional responsibility for the services provided by the peer support provider. Supervising practitioners must be licensed as one of the following: • Psychiatrist; • Licensed Psychologist; • Provisionally Licensed Psychologist; • Advanced Practice Registered Nurse (APRN) or Nurse Practitioner (NP); • Licensed Independent Mental Health Practitioner (LIMHP); • Licensed Mental Health Practitioner (LMHP); • Provisionally Licensed Mental Health Professional (PLMHP); • Licensed Alcohol and Drug Counselor (LADC) for substance use only; and • Provisionally Licensed Alcohol and Drug Counselor (PLADC) for substance use only.
Staffing ratio	The ratio for supervising practitioner to peer support provider is 1:6. Caseloads for peer support providers must not exceed 1:25. Groups are a minimum of three and a maximum of 12.
Hours of Operation	Peer support services will be available during times that meet the need of the individual and when applicable the individual's family/caregiver, which may include evenings, weekends or both. The peer support provider must ensure the individual and their parent/caregiver (if applicable) have on call access to a licensed mental health or substance use counselor 24 hours a day, seven days per week.
Desired Individual Outcome	• The individual has achieved maximum benefit from the service or no longer wishes to receive the service; • The precipitating condition and relapse potential is stabilized such that the individual's condition can be managed without professional or external supports and interventions;

	• The individual demonstrates the ability to identify their strengths, needs, access resources and successfully navigate various systems to engage with those resources; • The individual has formal and informal supports in place; • The individual has developed a discharge plan that can be sustained post discontinuation of service.
Admission guidelines	• An established DSM (current edition) diagnosis which requires and will respond to therapeutic intervention; • Presence of a mental health and/or a substance use disorder diagnosis that would benefit from this service; • The individual is enrolled in active behavioral health services; • The services must meet medical necessity as outlined in regulations NAC 471 Chapter 1; • Presents with symptoms and/or functional deficits that interfere with the individual's ability to aid in their own recovery; • To receive family peer support the parent/guardian must have a child who meets the criteria listed above.
Continued stay guidelines	• The individual continues to meet the admission guidelines for peer support services; • There is reasonable likelihood of substantial benefit as a result of active continuation of this service as demonstrated by objective behavioral measurements of improvements; • The individual is making progress toward goals and is actively participating in the interventions.