

Department of Health & Human Services

DHHS

N E B R A S K A

Division of Behavioral Health



ANNUAL REPORT FISCAL YEAR 2015

Community-Based and
Regional Center Services

Division of Behavioral Health

The Division of Behavioral Health (DBH) is the chief behavioral health authority for the State of Nebraska and directs the administration and coordination of the public behavioral health system. Its role includes the integration and coordination of services and comprehensive statewide planning for the provision of an appropriate array of community-based services.* To do this, the Division collaborates with partners and other stakeholders in the health care system. The goals below serve as a statement of intent for the Division of Behavioral Health by communicating major areas of emphasis for the years 2011-2015.

The Division of Behavioral Health's 2011-2015 Strategic Plan is found at http://dhhs.ne.gov/behavioral_health/Documents/BHSP-Final-02-17-11.pdf

The Strategic Plan Progress Report can be found at http://dhhs.ne.gov/behavioral_health/Documents/DBH-Strategic-Plan-Update-August-2012.pdf

□ **Strategic Plan 2011-2015 Goals:**

- The public behavioral health workforce will be able to deliver effective prevention and treatment in recovery-oriented systems of care for people with co-occurring disorders.
- The Division of Behavioral Health will use financing mechanisms which support innovative service content, technology and delivery structures (e.g., telehealth; in-home acute services; peer support services).
- The Division of Behavioral Health will reduce reliance on the Lincoln Regional Center for general psychiatric services.

□ **Regional Service Network and Federal Block Grant Goals:**

- Prevention¹ : Reduce binge drinking among youth up to age 17.
- Youth¹: Families and youth receiving services will experience improved family functioning.
- Co-occurring Disorders¹: Increase the behavioral health workforce capacity to deliver effective treatment and recovery services for persons with co-occurring disorders (COD).
- Trauma-informed Care¹: Increase the behavioral health workforce capacity to provide trauma-informed care.
- Peer Support²: Increase the capacity of the system to use peer support.
- Housing³: Increase stability in housing for behavioral health consumers.
- Emergency³: Consumers experiencing a behavioral health crisis will be served at the most appropriate and least restrictive level of care.

*Neb. Rev. Stat. §71-806

1. Block Grant and Network Goal; 2. Block Grant Goal Only; 3. Network Goal Only

Division of Behavioral Health Fiscal Year 2015 Leadership

- The Division of Behavioral Health includes a central office in Lincoln and three Regional Centers in Lincoln, Norfolk and Hastings. The central office includes Community-Based Services, the Office of Consumer Affairs, and the Office of the Chief Clinical Officer.
- The Office of Consumer Affairs focuses on consumer/peer support services, relationships, planning, research, and advocacy for all consumers.
- The Chief Clinical Officer provides clinical leadership to the Division and works with the Regional Centers and community partners to promote quality behavioral health policies, services and education.



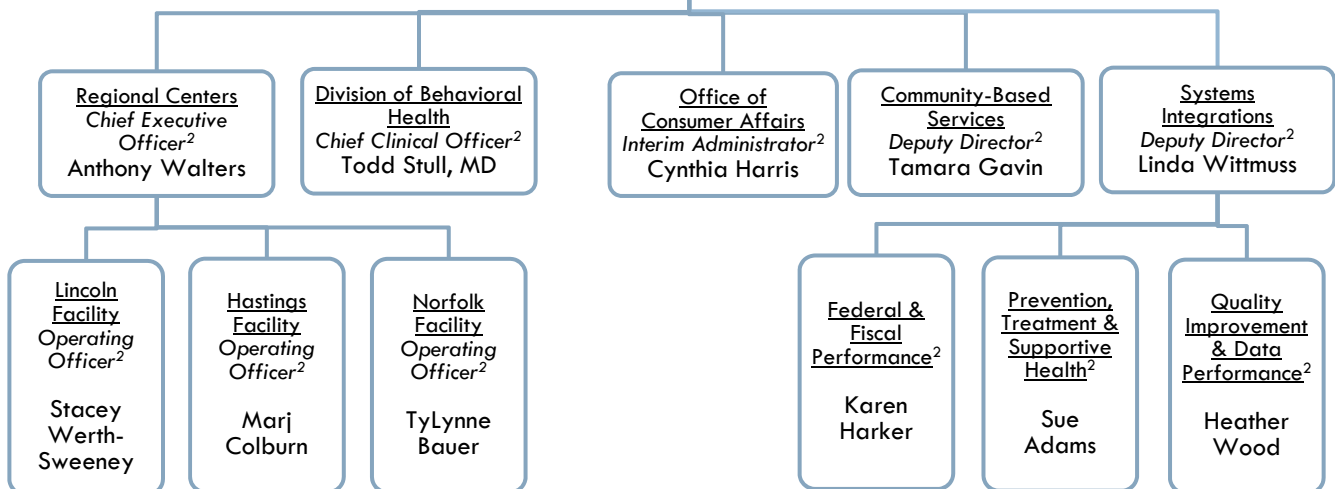
Courtney Phillips, CEO

Department of Health and Human Services¹
Chief Executive Officer (CEO)
Courtney Phillips

Division of Behavioral Health¹
Director
Sheri Dawson



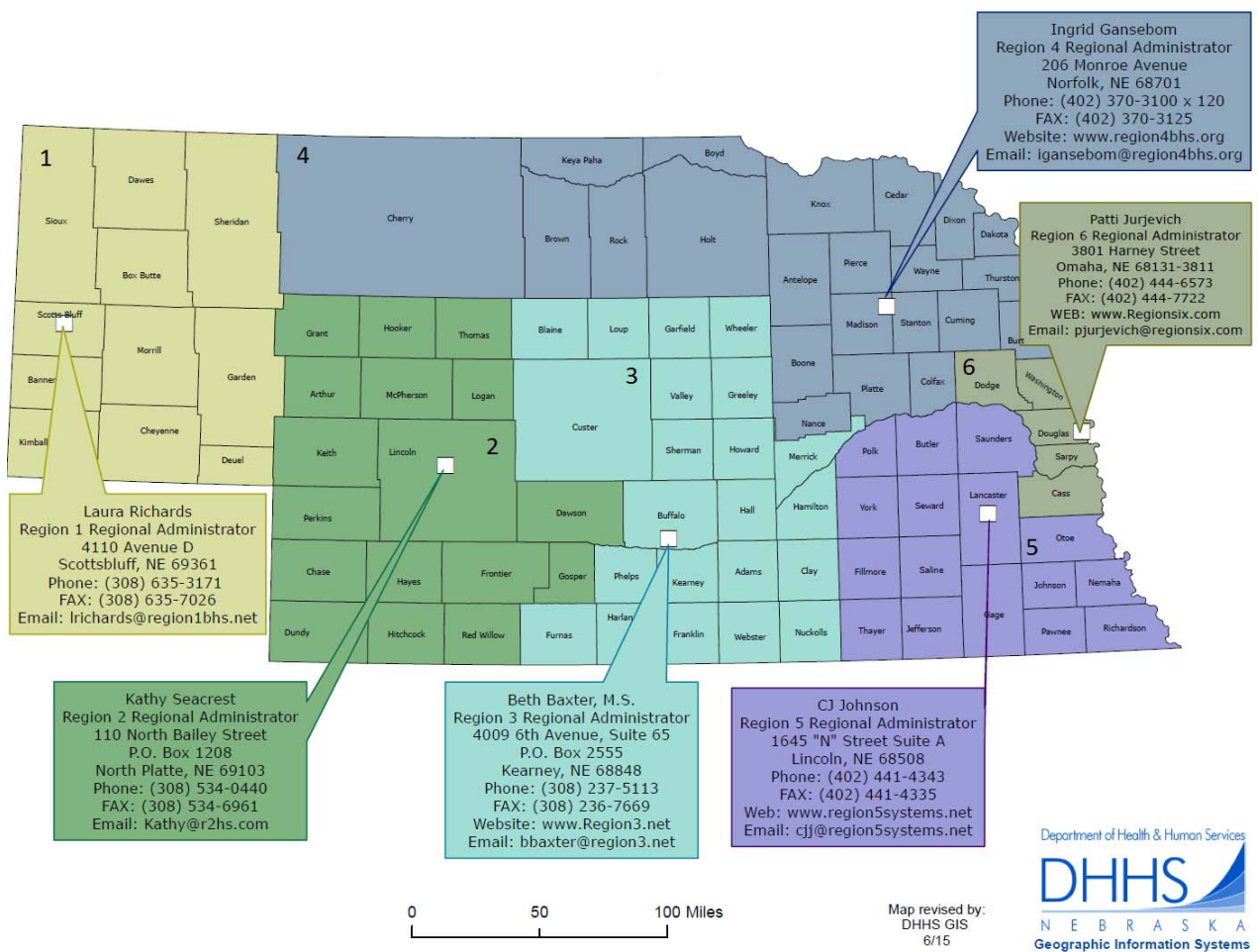
Sheri Dawson, Director



¹Gubernatorial Appointee. ²Director Appointee.
Reflects staff as of December 2015.

Division of Behavioral Health Oversight and Network of Care

The Division of Behavioral Health (DBH) provides funding, oversight and technical assistance to the six local Behavioral Health Regions. DBH contracts with the Regions who contract with local programs to provide publicly funded inpatient, outpatient, and emergency services and community mental health and substance use disorder services.



Vision:

The Nebraska public behavioral health system promotes wellness, recovery, resilience and self-determination in a coordinated, accessible consumer and family-driven system.

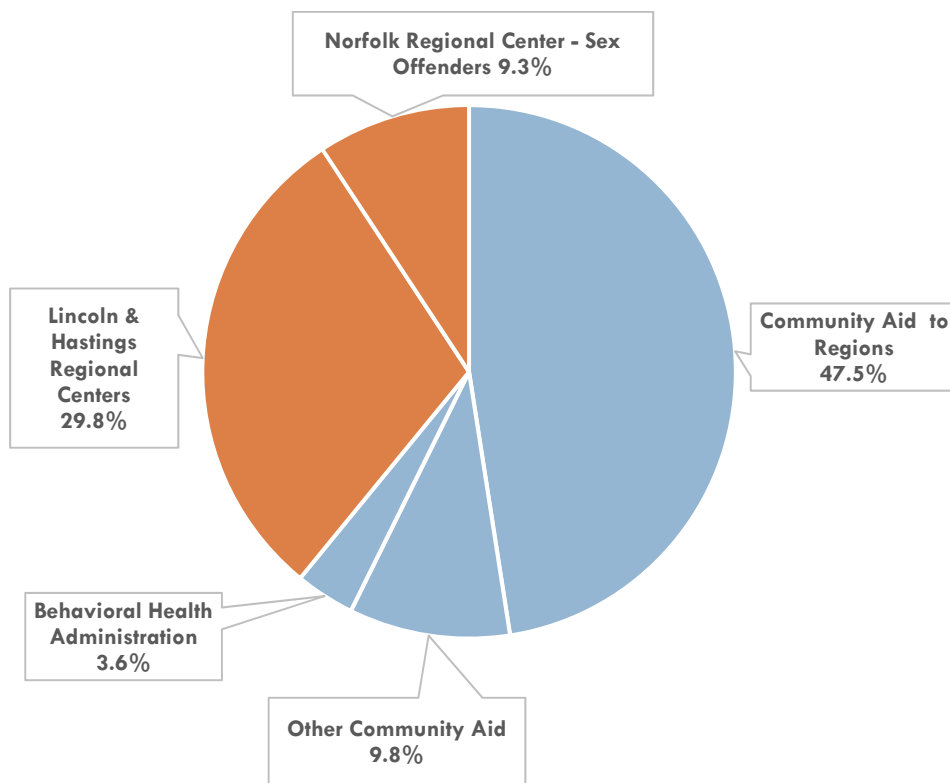
Mission:

The Division of Behavioral Health provides leadership and resources for systems of care that promote and facilitate resilience and recovery for Nebraskans.

Division of Behavioral Health Fiscal Year 2015 at a Glance

Distribution of Expenditures

The Community-Based Services section of the Division of Behavioral Health expended 60.92% of the Division's spending overall. Over \$94,000,000 of the overall budget helped to fund community aid in Nebraska.



Community Aid to Regions	\$73,651,411	47.5%
Other Community Aid	\$15,142,759	9.8%
Behavioral Health Administration	\$5,593,637	3.6%
Community-based Services Subtotal	\$94,387,807	60.9%
Lincoln & Hastings Regional Centers	\$46,177,458	29.8%
Norfolk Regional Center - Sex Offenders	\$14,370,298	9.3%
Regional Centers Subtotal	\$60,547,756	39.1%
Grand Total	\$154,935,563	100.00%

Results-Based Accountability

FY15 Nebraska DHHS Division of Behavioral Health Services (DBH) developed performance measures for a subset of its programs using Results-Based Accountability (RBA). To accomplish this, training and technical assistance was provided via webinars and on-site trainings to build the capacity of DBH and its contracted Regions to use RBA for its Performance Accountability System.

RBA is used by organizations to improve the performance, accountability and transparency of their programs or services. Developed by Mark Friedman and described in his book Trying Hard is Not Good Enough, RBA is being used throughout the United States and in many other countries to produce measurable change in people's lives.

It uses a data-driven decision-making process to help communities and organizations get beyond talking about problems to taking action aimed at solving problems. It is a simple, common sense framework that everyone can understand. RBA starts with the desired ends and works backward, towards means. The "end" or difference you are trying to make looks slightly different if you are working on a broad community level or are focusing on your specific program or organization.

This process helps organizations identify the role they play in community-wide impact by identifying specific customers who benefit from the services the organization provides. For programs and organizations, the performance measures focus on whether customers are better off as a result of services received. These performance measures look at the quality and efficiency of services. RBA asks three simple questions to get at the most important performance measures: (1) How much did we do? (2) How well did we do it? (3) Is anyone better off?

Once organizations identify the most powerful measure(s) to improve, RBA provides a step-by-step process to get from ends to means called "Turn the Curve" thinking.

The benefits of Results-Based Accountability (RBA) can be summarized by five key points:

1. It gets from talk to action quickly.
2. It is a simple, common sense process that everyone can understand.
3. It helps groups to surface and challenge assumptions that can be barriers to innovation.
4. It builds collaboration and consensus.
5. It uses data and transparency to ensure accountability for both the well-being of people and the performance of programs.

Results-Based Accountability for DBH

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Below are the FY16 Division of Behavioral Health State Priorities for RBA:

Result – Statewide Population

Definition: A condition of well-being for children, adults, families, or communities.

1. **Nebraskans are physically and emotionally healthy.**

Indicators - Statewide Population

Definition: A measure which helps quantify the achievement of a result.

1. **Decrease in substance use:**
 - ❑ Binge drinking 12-17^{1, 2}
 - ❑ Binge drinking 18+¹ /19+³
 - ❑ Marijuana use 12-17^{1, 2}
2. **Decrease in Nebraskans needing involuntary emergency inpatient care:**
 - ❑ Involuntary hospitalizations through EPC admissions⁴
 - ❑ Mental Health Board commitments^{4, 5}

Performance Measures – Region/Program Level

Definition: A measure of how well a program, agency, or service system is working.

1. **How well do we do it?**
 - ❑ % positive response to general satisfaction with services received⁶
 - ❑ % positive response to staff sensitive to trauma⁶
 - ❑ % programs with improvement in trauma informed scores⁷
 - ❑ % programs with improvement in co-occurring capable/enhanced scores⁸
 - ❑ % consumers discharged with treatment completed status⁴
2. **Is anyone better off?**
 - ❑ #/% positive response to improved QOL⁶
 - ❑ #/% positive response to improvement in symptoms⁶
 - ❑ Average # days / % of consumers who binge drank in last 30 days⁶
 - ❑ #/% decrease in substance use⁴

References

¹ National Survey on Drug Use and Health

² Youth Risk Behavior Survey

³ Young Adult Alcohol Opinion Survey

⁴ Provider Entered Treatment Data

⁵ Electronic Commitment Reporting Application

⁶ Consumer Survey Data

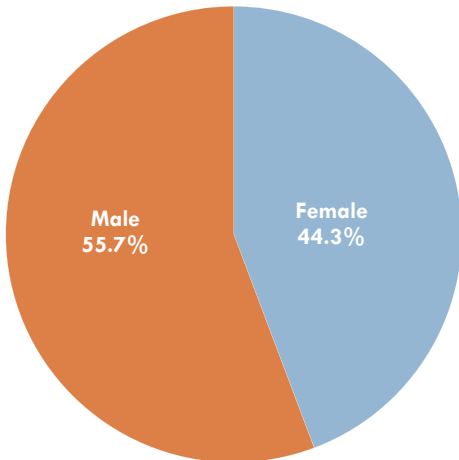
⁷ Trauma-Informed Program Self-Assessment Scale by FalLOT & Harris

⁸ COMPASS-EZ™ by ZiaPartners, Inc.

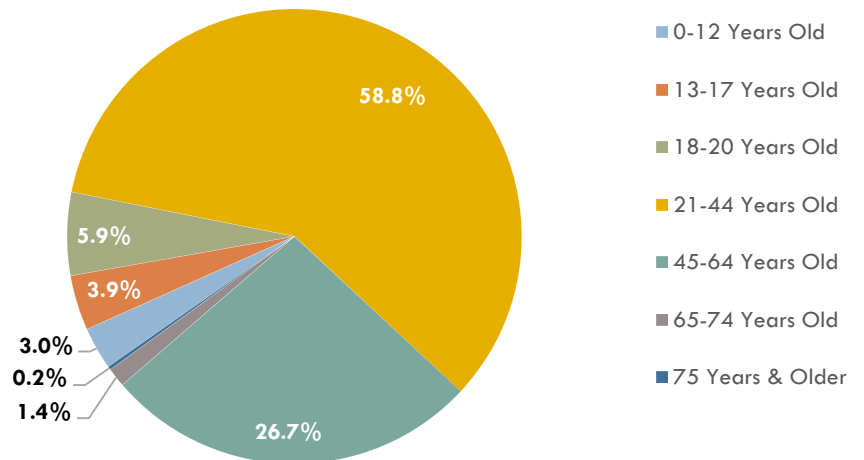
Demographics of Persons Served in Community-Based Services

In Fiscal Year 2015 (FY15), the Division of Behavioral Health funded community-based services for 28,116 individuals. Demographic breakouts of this count are below. Of those individuals: 17,433 people received mental health services, 11,773 people received substance use disorder services, and 653 people received dual disorder services (please note that individuals can receive services in multiple service types, therefore the sum of the service types is greater than the total count reported).

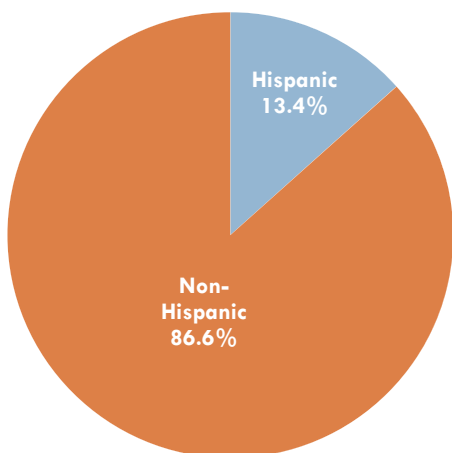
Persons Served by Gender



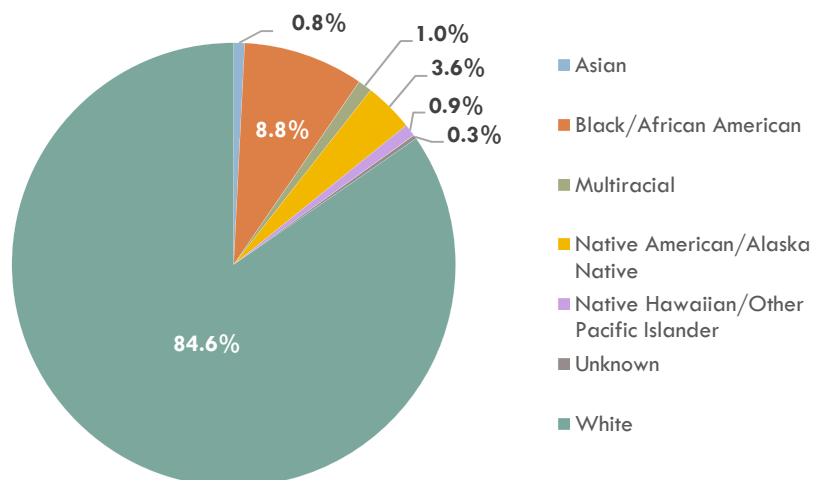
Persons Served by Age Group



Persons Served by Ethnicity



Persons Served by Race



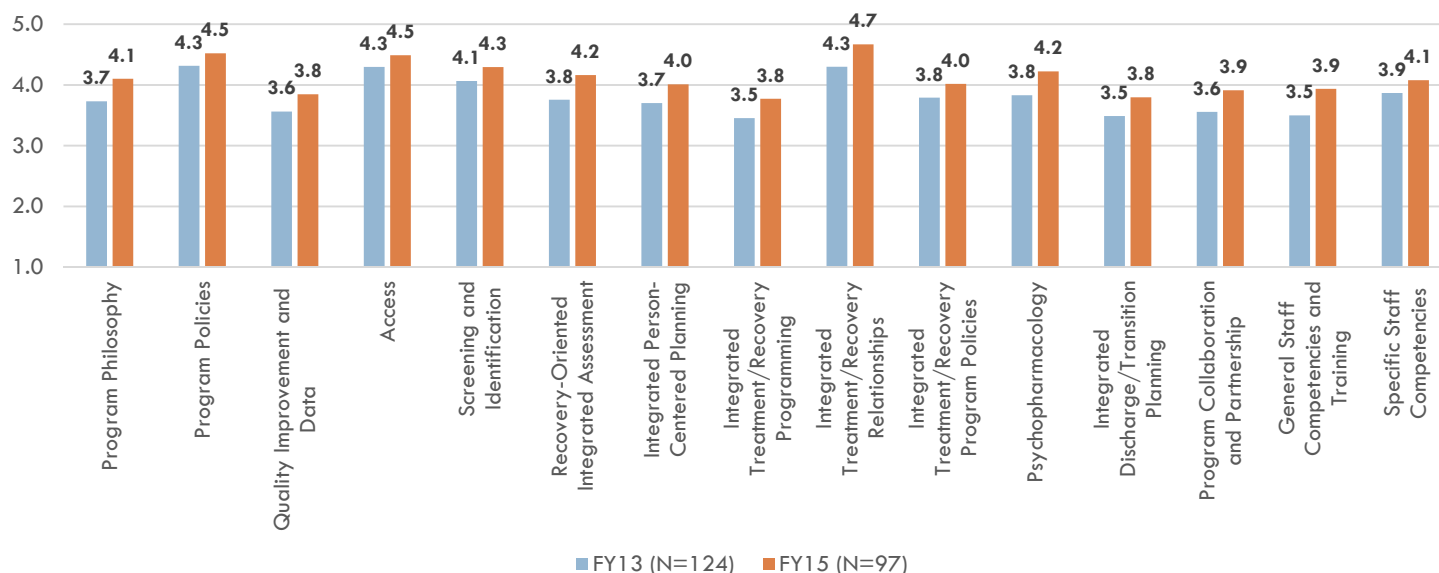
Source: FY15 Consumer Treatment Data (This report only includes treatment data as tracked through use of the Magellan Data System; exact data source used is the 08.15 Magellan Extract.)

Network Services: Co-occurring Disorders

Co-Occurring Disorders (COD) : Refers to co-occurring substance use and mental health disorders.

- In 2011, a COD workgroup completed a roadmap to guide the transformation of the system of care and integrate COD services for Nebraska. The roadmap is integral to Nebraska’s larger strategic planning for behavioral health.
- Phase II began in FY13 to increase the capacity of the behavioral health workforce and the behavioral health programs able to deliver prevention and treatment for persons with co-occurring disorders. This work included providers completing a self-assessment using the COMPASS-EZ™ to provide a statewide baseline of recovery-oriented, co-occurring capability as the first step in a continuous quality improvement process.
- In 2015 providers completed the COMPASS-EZ™ and results compared to 2013 baseline showed improvement in every area.
- Work from the roadmap was further carried out in FY14 to better identify and address co-occurring needs of consumers. Statewide and regional competency training was continued with ZiaPartners, creators of the COMPASS-EZ™.
- Data in FY15 showed 19% of reasons for admission into a mental health service included an indication of a substance use disorder treatment need. Likewise, 13% of reasons for admission into a substance use disorder service included an indication of a mental health treatment need. Improvements in data collection continue to be explored in order to identify better ways to fully understand co-occurring needs.

Compass-EZ - State FY13 Compared to State FY15

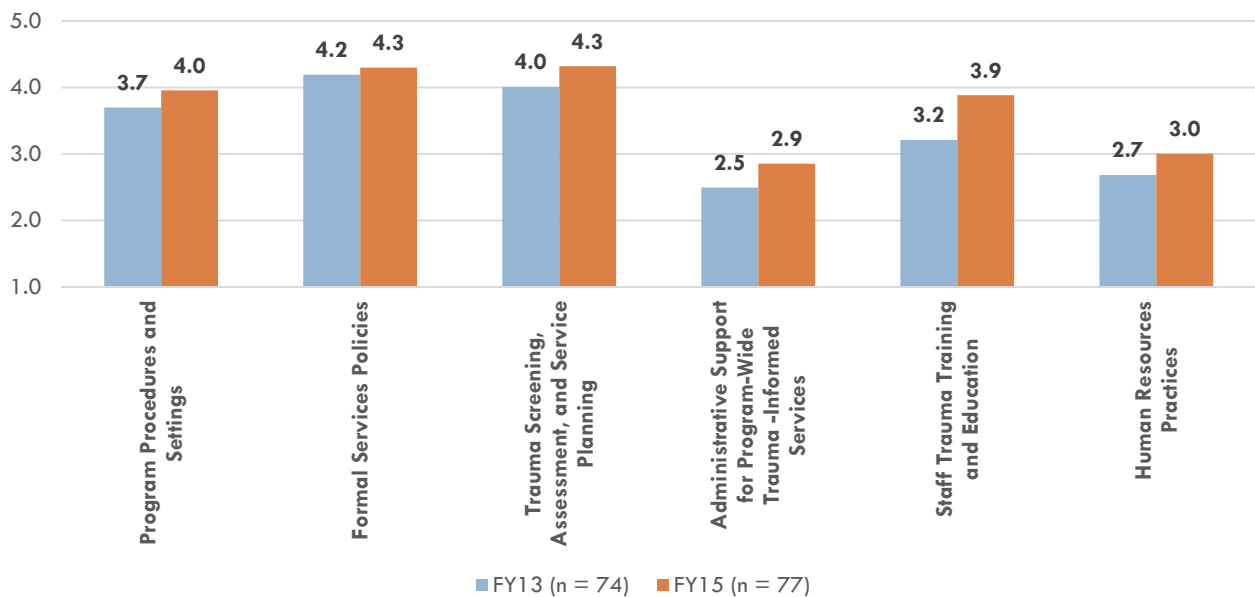


Network Services: Trauma-informed Care

Trauma Informed Nebraska (TIN): An initiative that promotes trauma-informed care statewide.

- TIN’s mission is to oversee the development and implementation of a statewide, consumer-driven, recovery-oriented, trauma-informed system that ensures all behavioral health providers are informed about the effects of psychological trauma and are aware of the origin and effects of trauma on survivors. Improving access to a trauma-informed delivery system includes increasing the number of behavioral health providers who have utilized a Trauma-Informed Care (TIC) self-assessment so that policy and procedures incorporate trauma-informed and trauma-specific practices.
- The Trauma-Informed Self-Assessment scale, developed by Roger D. Fallot, Ph.D. and Maxine Harris, Ph.D., is used by programs to self-assess their own practices and understanding of trauma-informed services. The scale assists in providing clear, consistent guidelines for agencies or programs interested in facilitating trauma-informed modifications in their service systems. It is a tool to use in the development, implementation, evaluation, and ongoing monitoring of trauma-informed programs. Below is the statewide baseline from the first round of program self-assessments completed in FY13.
- Throughout FY15, programs across the state have used the results of their self-assessments to improve their ability to deliver trauma-informed services.
- In comparing the state domain averages from FY13 to FY15, the state has improved on all measures.

TIC - State FY13 Compared to State FY15



First Episode Psychosis

The Nebraska First Episode Psychosis Coordinated Specialty Care (FEP CSC) Pilot Program is utilizing the evidence-based practice Coordinated Specialty Care model. The FEP CSC Pilot Program will provide enhanced services serving first episode psychosis in youth and young adults ages 15 through 25 in the behavioral health system by strengthening interactions between providers and optimizing treatment and alliances. The goals of the FEP CSC Pilot Program are to develop and implement an individualized, person-centered plan that will help the consumer manage symptoms, identify any co-morbid conditions that should be treated, provide for on-going risk assessment, provide education so clients and families can learn to manage the illness and develop coping skills, and focus on consumer goals and recovery.

- There are no existing first episode psychosis-focused teams in Nebraska so building teams involves inter-agency collaborations to bring together expertise for intensive integrated FEP specialty care and develop a network to coordinate their interaction. This involves existing local providers and the Region Behavioral Health Authority (RBHA).
- The FEP CSC Pilot Program is being implemented in two of the six behavioral health service regions of the state, based on the target population of adolescents and young adults, where they are located and where services are being delivered. The two separate, independent FEP CSC Pilot Program teams are located in Region 6 RBHA in the Omaha metropolitan area (population 900,000) and in Region 3 RBHA in the Kearney micropolitan area (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 as availability of providers to offer FEP related services.
- Key ingredients of the team model being developed and supported by the FEP CSC Pilot Program are training for team members, focusing on both process and programmatic outcomes, shared decision making by the team, low dose anti-psychotic medication, individual therapy, family education and support, in addition to supported employment and education services.
- Team roles include a team leader (Masters level clinician), Individual therapist, family therapist, supported employment/education specialist (SEES), and prescriber. No role will be full time (FTE). Shared decision making within the team will be facilitated through weekly meetings including the team leader, SEES, prescriber, and therapist(s).
- Expert consultation and support will be available to each FEP CSC team and team members specific to each team role through consultation calls with program experts at the Center for Practice Innovations through the first twelve months following the pilot program start-up.

System of Care



System of Care is designed to deliver comprehensive, flexible and effective services and supports to youth and their families. In 2013, the Substance Abuse and Mental Health Services Administration (SAMHSA) awarded a twelve-month planning grant to develop a strategic plan for a Children's Mental Health System of Care. When implemented, the strategic plan will build on partnerships, include full participation of youth and families, and create an integrated process across all of Nebraska's child-serving systems to achieve positive outcomes for youth with serious emotional and behavioral health needs and their families. The planning process included support and involvement of leaders across the state's many child-serving systems.

2015 Highlights of Nebraska's System of Care (NeSOC) implementation process include:

- An informal SOC workgroup was convened through June 2015 to address elements necessary to operationalize the 2014 SOC strategic plan.
- Gaps and opportunities identified in the 2014 needs assessment were prioritized. An environmental scan was conducted that highlights the strengths of the existing infrastructure by identifying current system of care initiatives occurring across the state. An ad hoc work team convened to address NeSOC governance and funding approaches. The teams identified state-level commissions with areas of focus corresponding to NeSOC goals, strategies and priorities.
- Action steps for youth and family partners in the implementation process were investigated. An ad hoc group was convened to look at ways to incorporate youth and family as equal partners during the course of NeSOC implementation.
- Eight strategies were identified as priorities which can be implemented at low/no cost from amongst the 93 strategies listed in the NeSOC Strategic Plan. Informal workgroups were tasked with developing draft work plans specific to one or more of the eight strategies.

Positive outcomes associated with System of Care implementation nationwide include:

- Improvements in the lives of children and youth, such as decreased behavioral and emotional problems, suicide rates, substance use, and juvenile justice involvement. Systems of care also increase individual strengths, school attendance and grades, and stability of living situation.
- Improvements in the lives of families, such as reduced caregiver strain and improved family functioning. Families also receive increased education, support services, and peer support.
- Improvements in service delivery systems, such as an extensive array of home and community-based services and supports, individualization of services, increased family and youth involvement in services, and increased use of evidence-based practices.
- Improvements in the cost and quality of care, including decreased utilization of inpatient and residential services, and increased cross-system collaboration.

Youth and Family System

Professional Partner Program

- Since 1995, the Professional Partner Program (PPP) in Nebraska has been serving youth diagnosed with emotional and/or behavioral disturbance. The program coordinates services and supports for youth and their families through a high fidelity wraparound approach. Within core services and supports for youth, the PPP offers flexibility in its approach in working with Transition Aged Youth (ages 16-26). Barriers that these youth face are unique, and at times the coordinated, person-centered services for this age group can seem few. The Transition Age Youth PPP successfully fills this void, and as these youth make the transition toward becoming fully self-sufficient adults, the program adjusts its focus rapidly and accordingly in support of individual successes.

Nebraska Behavioral Health Helpline

- In effect since January 2010, the Nebraska Behavioral Health Helpline offers single-point access to children’s behavioral health services. Parents, guardians, and primary caretakers of youth who experience behavioral health challenges comprise the primary target population, with resources focused upon addressing urgent behavioral health situations, identifying immediate safety concerns and providing recommendations and/or referrals for services. **During FY15**, the Helpline received **4,164 calls**, with **2,669** unique families served, resulting in **4,556** referrals for a range of services. **Since its inception, the Helpline has received a total of 20,939 calls from 14,308 unique families.** Previous marketing campaigns focused on establishing the Helpline’s presence statewide as a unique behavioral and mental health resource for parents, guardians, and third parties. Utilizing caller data and feedback, the Helpline has developed a preventive marketing approach, using attention-grabbing visuals and voiceovers. The “Future Babies” campaign, launched in 2013, showed babies in conjunction with descriptions of future behaviors they may engage in, such as bullying, stealing, running away, and substance use. The goal was to encourage parents to call in at the first sign of problem behaviors, before they felt as if the situation has spiraled out of control. A review of caller data showed the ads had the desired effect: the share of parents calling about identified children ages 12 and under grew from 35 percent prior to the campaign to 51 percent by August 2015. With the start of a new contract period on July 1, 2015, the Helpline intends to launch an updated campaign that builds on the award-winning success of the “Future Babies” campaign.



Family Navigation and Family Peer Support

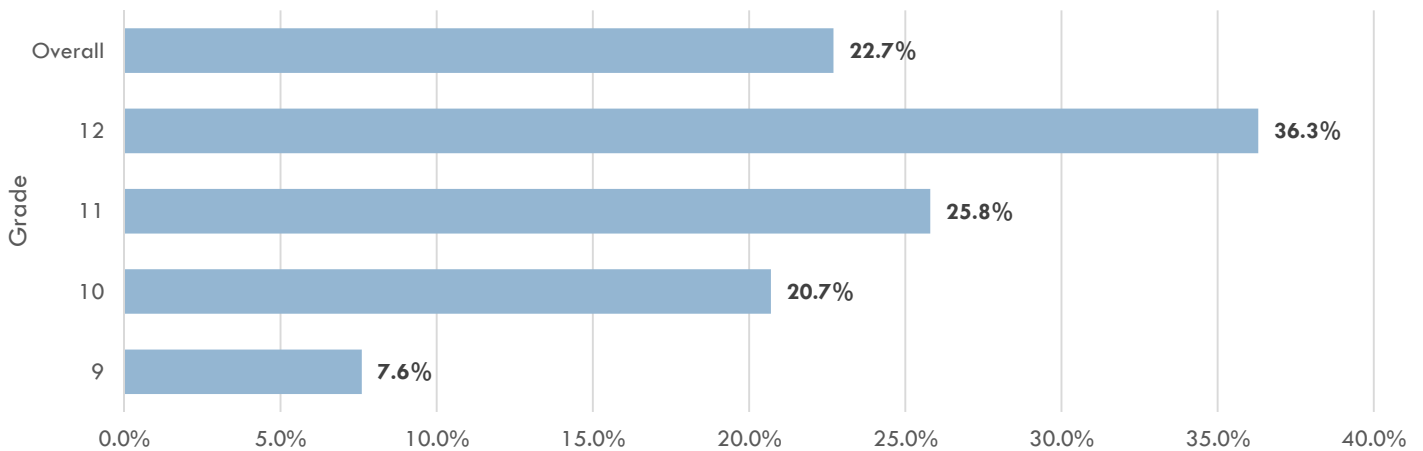
- Family Navigator and Family Peer Support is designed for eligible families who choose to stay engaged and receive continuous care through the same agency following a referral by the Helpline. In FY15, 442 families were connected to Family Navigator Services and 413 families received Family Peer Support Services. **84 percent of Navigator** and **100 percent of Peer Support** parents completing the program demonstrated an **increase** in their overall **knowledge of parenting and child development** (PFS measure).

Prevention System

Over the course of Fiscal Year 2015 more than **142,000** Nebraska youth ages 12-17 were impacted by prevention activities including a combination of individual based and population based strategies.

One of the priority areas is the prevention of alcohol use among youth. A significant number of youth consume alcohol in Nebraska. The 2014-2015 Youth Risk Behavior Survey indicated that 23% of high school youth reported consuming alcohol in the past 30 days and 14% reported that they drank five or more drinks at one occasion in the past 30 days.

Nebraska Youth who Currently Consume Alcohol



Source: Youth Risk Behavioral Survey 2015

Parental involvement is one of the most impactful strategies to prevent underage drinking. In fact, research shows that youth pay close attention to the attitudes and values of their parents when it comes to their own decision-making about when to begin drinking. The statewide media prevention campaign, “Take Timeout to Talk about Underage Drinking” encourages parents to talk to their children about the dangers of alcohol and provides resources about how to start the talk early.

The Nebraska Community Alcohol Opinion Survey found that **81%** of adults reported hearing, reading, or watching an advertisement about the prevention of alcohol abuse within the past 12 months. In addition, **75%** of parents of children ages 12 to 20 year old have talked to their children about the dangers of alcohol in the past 12 months.

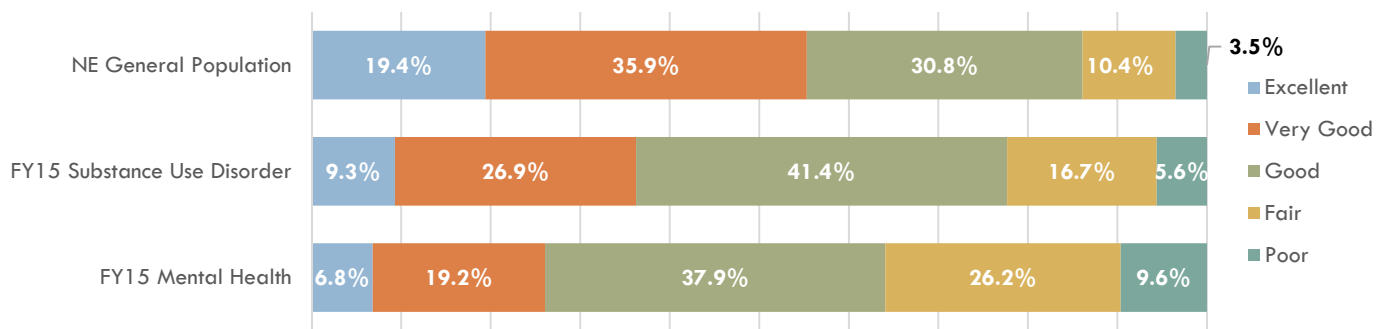


Measurements of Recovery

SAMHSA has delineated four major dimensions that support a life in recovery: Health, Home, Purpose, and Community.

Health: *Overcoming or managing one’s disease(s) or symptoms.* For example, abstaining from use of alcohol, illicit drugs, and non-prescribed medications if one has a substance use disorder and, for everyone in recovery, making informed, healthy choices that support physical and emotional well-being.

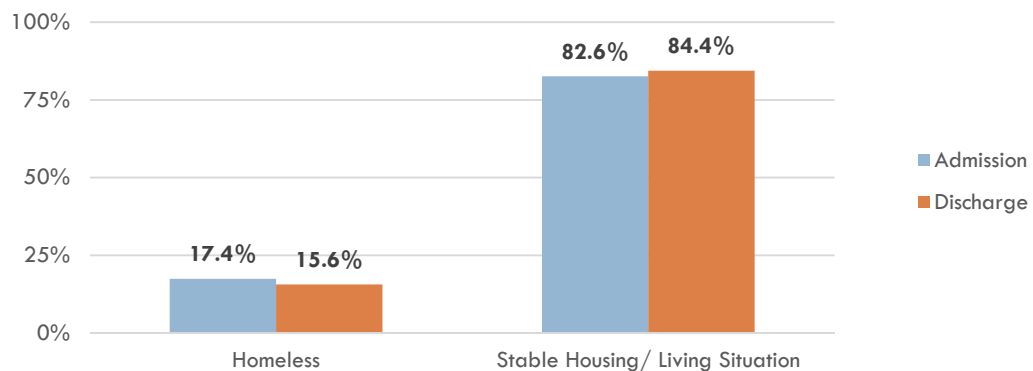
General Health Status of Adult Consumers



Source: FY15 Consumer Survey Report; General Population statistics are from 2015 BRFSS

Home: *Having a stable and safe place to live.* The Housing Related Assistance Program and Housing Coordination continue to address client needs with regard to establishing stable and safe housing. During FY15, there was a decrease in the percent of clients who reported being homeless at discharge compared to admission. Data also showed an increase in the percent who had a stable living situation by the time they discharged compared to admission.

Percent of Consumers Homeless and Percent in Stable Housing/Living Situations at Admission and at Discharge

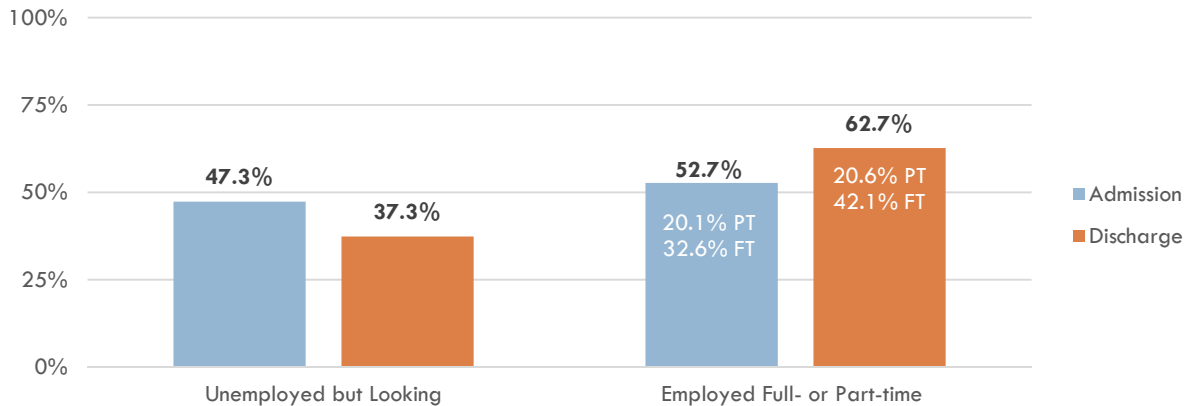


Source: FY15 Consumer Data for Those with Admission and Discharge Housing Data (08.12.2015 Magellan Extract)

Measurements of Recovery

Purpose: Having meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society. In FY15, there was an increase in employed consumers between admission to discharge, particularly in full time employment (35 or more hours/week).

Consumer Employment Percentages at Admission and at Discharge
(includes only clients who were or were seeking to be in the labor force)

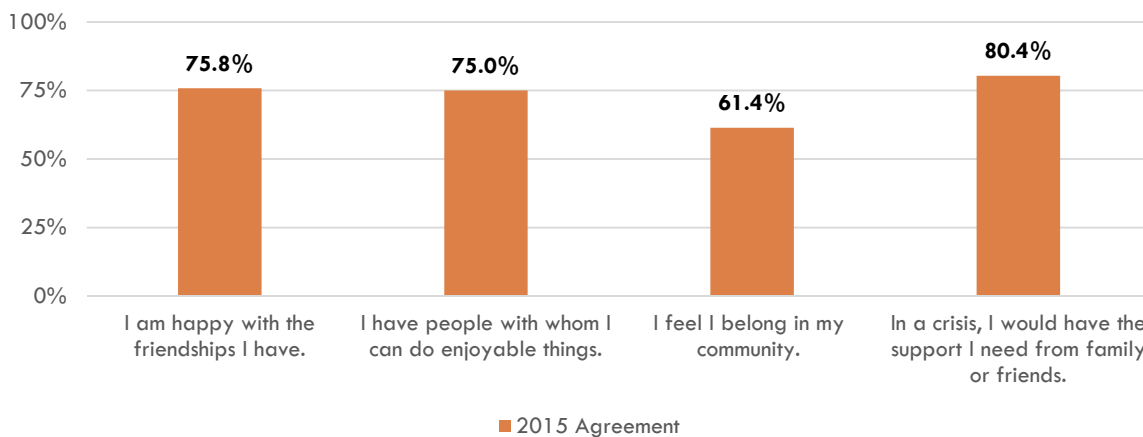


*“Employed Full- or Part-Time” includes consumers persons who reported being employed and/or in the Armed Forces. “Unemployed but Looking” includes only persons seeking to be in the labor force and does not include those who have chosen other means of purposeful work such as through school, volunteerism, or at home.

Source: FY15 Consumer Data for Those with Admission and Discharge Employment Data (08.15 Magellan Extract)

Community: Having relationships and social networks that provide support, friendship, love, and hope.

Percent of Consumers who Indicate Agreement with the Following Annual Consumer Survey Questions



Source: FY15 Consumer Survey Report

Office of Consumer Affairs

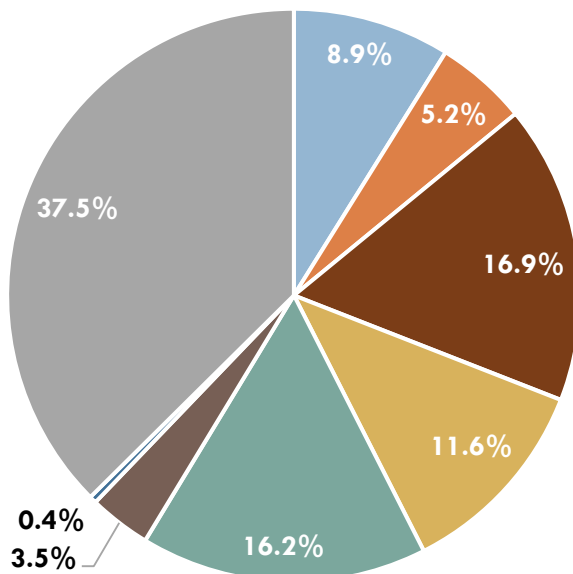
The Office of Consumer Affairs (OCA) helps people who have experienced mental illness and/or substance use disorders to pursue a journey of recovery which will allow him or her to live a meaningful life in a community of his or her choice, while striving to achieve his or her full potential. OCA staff are committed to fairness, respect and safety regarding all people. OCA works to reduce stigma, model recovery, and educate consumers, family members, service providers, state workers and the public about the value and potential of people, and recognize their strides toward recovery.

Peer Support

- Peer Support Services provide on-going support to behavioral health consumers by behavioral health consumers.
- The Certified Peer Support and Wellness Specialist Training grew out of a Transformation Transfer Initiative from SAMHSA in 2009.
- As of the end of FY15, there were 288 certified Peer Support and Wellness Specialists in Nebraska.
- The Behavioral Health Education Center of Nebraska created training curricula and hosted training events for Family and Adult Peer Support Specialists on Trauma 101 and Compassion Fatigue.

FY15 Events

- The OCA also held numerous meetings and trainings throughout FY15 to further promote consumer wellness and workforce efforts. These events included People’s Council meetings, Peer Support Facilitator Circle meetings, Peer Support and Facilitator trainings, Peer Support Credentialing Steering Committee meetings, and further work towards the Peer Support Implementation Plan.
- In FY15, there were nearly 125,000 visits to the Nebraska Network of Care website.
- In FY15, OCA contracted with the Mental Health Association of Nebraska to host the Annual Nebraska Behavioral Health Conference: Success, Hopes, and Dreams



Office of Consumer Affairs Funding Helps Support:

- Behavioral Health Education Center of NE
- League of Human Dignity
- Mental Health Association of NE
- National Alliance on Mental Illness
- Partners in Recovery
- Public Policy Center
- QPR Training - Suicide Prevention
- Trilogy Network of Care

Hastings Regional Center

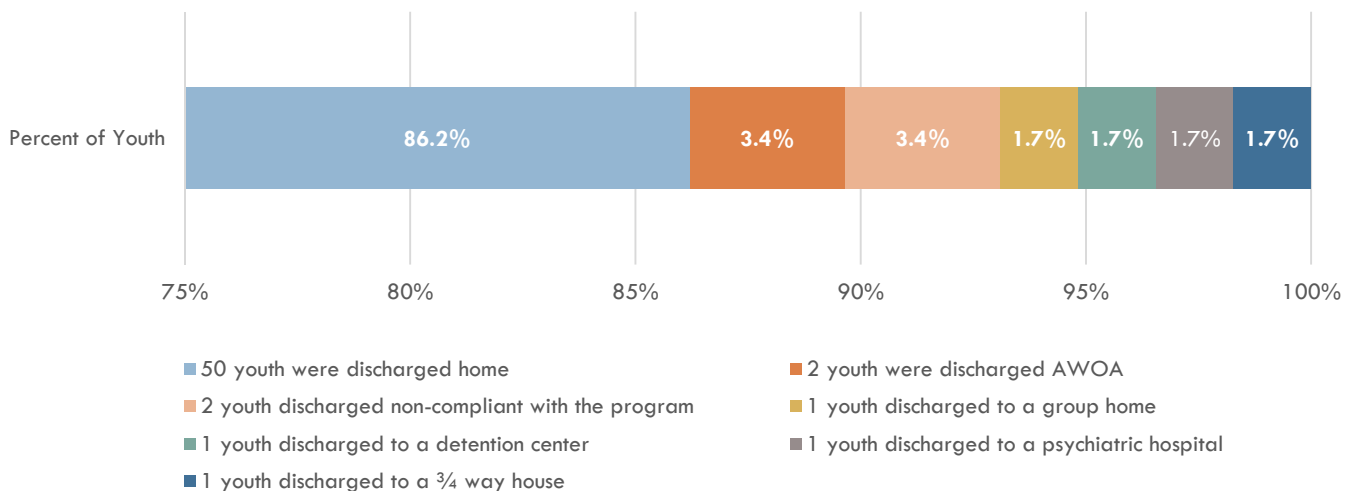
Hastings Regional Center (HRC), a Joint Commission accredited facility, offers adolescent residential substance abuse treatment to young men paroled from the Youth Rehabilitation Treatment Center in Kearney, Nebraska. The Hastings Juvenile Chemical Dependency (HJCD) Program is licensed for 40 beds. On average, young men stay approximately 3 to 6 months for treatment. During FY15, the average length of stay was 96 days. The average age of youth admitted to the HJCD Program was 17 years old. Ken Zoucha, M.D., certified by both the American Board of Pediatrics and the American Board of Addiction Medicine, is the program’s medical director.

During FY15, the Juvenile Chemical Dependency Program admitted 58 youth and discharged 67 youth. Successful discharge for youth involves:

- 1) Showing self-control and adhering to the program’s core behaviors;
- 2) Staying open to recovery ideas;
- 3) Practicing new recovery tools;
- 4) Participating in the daily schedule; and
- 5) Working with your coaches and therapist.

Youth also develop a plan to prevent relapse that includes continued treatment in the community setting, planned attendance at mutual support or 12-step meetings, school and work involvement, and planned fun activities with peers who choose a sober lifestyle. These principles and activities are demonstrated by completion of successful therapeutic home visits.

FY15 Discharges from the Hastings Juvenile Chemical Dependency Program



Norfolk Regional Center

Norfolk Regional Center (NRC), a 150 bed state psychiatric hospital, is operated by the Nebraska Department of Health and Human Services. NRC's Sex Offender Treatment Program provides treatment for individuals who have been adjudicated under the Nebraska Convicted Sex Offender Act or have been committed to inpatient treatment by a county Mental Health Board for treatment of a paraphilia. The Program is evidence based and utilizes research to guide treatment programming. The Nebraska Sex Offender Treatment Program is focused on the reduction of dangerousness and reduction of risk of re-offense for patients involved in treatment.

During FY15, the Norfolk Regional Center admitted 33 patients and discharged 32 patients. Successful discharge for patients involves:

- 1) Acknowledging that a problem exists concerning sexual behavior;
- 2) Accepts responsibility for sexual deviancy by not projecting blame and/or presenting self as powerless to control behaviors;
- 3) Consistently complies with program rules and regulations;
- 4) Identifies behaviors that need to be changed;
- 5) Sets treatment goals and has developed plans to obtain those goals;
- 6) Consistently interacts with the unit staff members in socially appropriate ways;
- 7) Therapeutic recreation requirements are consistently met;
- 8) Consistently participates in all assigned therapy groups;
- 9) Displays the ability to accept feedback constructively without being argumentative and/or defensive; and
- 10) Describes some of the negative/harmful consequences that behaviors have on victim(s) and others.

Patients who successfully complete the Norfolk program are transferred to the Lincoln Regional Center for the final steps in treatment and transition.

Lincoln Regional Center

Lincoln Regional Center (LRC), a 250 bed Joint Commission accredited state psychiatric hospital, is operated by the Nebraska Department of Health and Human Services. It serves people who need very specialized psychiatric services and provides services to people who, because of mental illness, require a highly structured treatment setting. Psychiatric Services and Adult Sex Offender Services are provided at the Lincoln Regional Center Campus and sex offender services for youth at the Whitehall Campus. For the third consecutive year, LRC was named Top Performer with The Joint Commission, recognized for its excellence on accountability measures and performance.

LRC has had many other successes during FY15, including:

Training

- LRC has 22 Registered Nurses who are American Nurses Credentialing Center (ANCC) Psychiatric Certified. This training has helped them feel more confident in their skills and develop greater expertise managing crisis situations and maintaining safety for everyone.
- Staff have been trained by a trauma expert in the delivery of trauma informed care and Zia Partners provided a workshop to develop welcoming behaviors and programs at LRC.
- Over 30 Security Specialists were trained as Medication Aides to help mitigate the nursing coverage and needs in the hospital licensed programs.

Collaborations

- Work has been done collaboratively with Corrections staff to assist on difficult mental health cases that staff have been struggling with in their facility.
- LRC, the Office of Consumer Affairs, and the Public Policy Center have developed and will implement a Peer Bridger Program to help consumers as they transition from LRC to community living.
- Integration between LRC and community organizations, such as OMNI, PIER, TASC and other community-based service providers, has been implemented to help address consumers' unique needs prior to their discharge. This has resulted in a small group of very long term patients being successfully discharged this past year.
- Expanded efforts to promote education in the field of mental health for future clinicians continues with UNL Psychology Doctoral Program and the UNMC Medical Program.

Therapeutic Treatment

- Work with Envy, the LRC's Therapy Dog, has demonstrated successful integration of trauma support and therapeutic treatment during and after discharge. Envy, has successfully participated in discharge planning and has visited with a past long-term client to help bridge the client's discharge and maintain success in her community placement.



Contact Information

If you are in need of services, please visit Nebraska Network of Care:
dhhs.ne.gov/behavioral_health/Pages/networkofcare_index.aspx
and/or call

Nebraska Family Helpline: **888.866.8660**
National Suicide Prevention Lifeline: **800.273.TALK (8255)**

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Appendix

Definitions of Terms

- **Emergency Services** – Each behavioral health network includes the capacity throughout the region to refer and/or serve persons who need combined medical and psychiatric and/or substance use disorder care in acute situations. These emergency services will provide medical services to persons who may need treatment such as medical detoxification or medical treatment for a drug overdose prior to entry into the mental health and substance use disorder system.
- **Inpatient Services** - Inpatient services are delivered in a hospital setting with close medical supervision, and shall provide stabilization of acute symptomology, active therapeutic management, use of psychotropic medication when appropriate, and the availability of medical consultation 24 hours per day. Dependent upon consumer needs, services provided within an acute inpatient program should focus on outcomes which lead to referral to less intensive levels of care or a rapid return to community living with appropriate supports, as necessary.
- **Residential Services** - Residential services are facility-based services that require less intensive and less restrictive treatment or rehabilitation than inpatient care. The service provides 24-hour staff supervision with varying levels of scheduled mental health, substance use disorder, and/or dual mental illness/substance use disorder services dependent upon consumer need. Programmatic and/or therapeutic activity focus on rehabilitative interventions that will allow the consumer to overcome or maximally compensate for the deficits produced by the mental illness and/or chemical dependency. The service has the capacity to provide medical consultation 24 hours per day. Dependent upon consumer needs, services provided within a residential program should focus on outcomes which lead to a referral for less intensive levels of care or a rapid return to more normalized community living with appropriate supports, as necessary.
- **Non-residential Services** - Non-residential services are services that fit the unique and varying needs of consumers for most of their mental illness and/or substance use disorder treatment and rehabilitation experiences. These services provide a comprehensive array of support services to reduce episodes of decompensation, relapse, crisis, emergency room utilization, to shorten lengths of stay at more restrictive residential and inpatient service levels, and to promote the recovery of the individual. Multiple service options shall be available and flexible enough to offer services which can meet a multitude of varying consumer treatment needs. Non-residential services should be based solely upon their success in delivering the desired outcome for the consumer.
- **Dual Disorders** - The term dual disorder (or diagnosis) refers to co-occurring substance-related and mental health disorders. Clients are said to have dual disorders if they have one or more substance-related disorders as well as one or more mental disorders. Dual disorder can also be referred to as co-occurring disorder.

Appendix

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Current Behavioral Health Services

Mental Health Services

Acute Psychiatric Inpatient
Assertive Community Treatment
Assessment/Evaluation Only
Community Support
Crisis Assessment/Evaluation
Crisis Inpatient - Youth
Crisis Stabilization/Treatment
Day Rehabilitation
Day Support
Day Treatment
Emergency Community Support
Emergency Protective Custody
Intensive Community Support/
Intensive Case Management
Intermediate Residential
Medication Management
Mobile Crisis Response
Outpatient Therapy
Post-Commitment Treatment
Psych Residential Rehab
Psych Respite
Psychological Testing
Recovery Support
Secure Residential
Sub-Acute Inpatient Care
Supported Employment
Supported Housing
Supportive Living
Urgency Assessment/Evaluation
Youth - Assessment/Evaluation Only
Youth - Day Treatment
Youth - Intensive Outpatient Therapy
Youth - Medication Management
Youth - Multi-Systemic Therapy
Youth - Outpatient Therapy
Youth - Professional Partners
Youth - Respite Care

Substance Use Disorder Services

Assessment/Evaluation Only
Civil Protective Custody
Community Support
Crisis Assessment
Detox
Group Therapy
Halfway House
Intensive Community Support/
Intensive Case Management
Intensive Outpatient Therapy
Intermediate Residential
Opioid Replacement Therapy
Outpatient Therapy
Partial Care
Post Commitment Treatment
Short-Term Residential
Therapeutic Community
Urgent Assessment/Evaluation
Youth - Therapeutic Community
Youth - Assessment/Evaluation
Youth - Community Support
Youth - Halfway House
Youth - Intensive Outpatient Therapy
Youth - Outpatient Therapy

Dual Disorder Services

Dual Residential Treatment
Dual Outpatient Therapy
Youth - Outpatient Therapy