Division of Behavioral Health – Joint Meeting
State Advisory Committee on Mental Health Services
August 12, 2010 – 8:30 a.m. to 4:00 p.m.
Country Inn & Suites – 5353 No. 27th St. Lincoln, NE
MINUTES

Mental Health Committee Members Present (20):
Adria Bace, Beth Baxter, Cheryl Crouse, Sharon Dalrymple, Bev Ferguson, Scot Ford, Dwain Fowler, Jette Hogenmiller, Melanie Lantis, Kathy Lewis, Dave Lund, Vicki Maca, Ed Matney, Jerry McCallum, Kasey Moyer, Mark Schultz, Joel Schneider, Pat Talbott, Diana Waggoner, Cameron White

Mental Health Committee Members Absent (3):
Roxie Cillessen, Pat Compton, Colleen Manthei

DHHS Staff Present:
Scot Adams, Alexandra Castillo, Maya Chilese, Carol Coussons de Reyes, Sheri Dawson, Jim Harvey, Nancy Heller, Ashley Nielson, Blaine Shaffer

Speakers and Guests Present:
Jack Buehler, Denise Bulling, Tammy Fiala, Alan Green, Danielle Hill, James Russell, Peter Seiler, Peggy Williams

I. Call to Order

Meeting was called to order at 9:00 a.m. Roll call was conducted and determined a quorum was met.

There are now 4 new committee members. Jette Hogenmiller is from Fort Calhoun and is a family member of an adult with SMI, Melanie Lantis is from Upland Nebraska and family member of a child with SED, Ed Matney is with the Division of Children and Family Services in Lincoln and Cameron White is with the Department of Correction in Lincoln.

II. Approval of February 4 and May 6, 2010 MINUTES

√ Motion was made by Jette Hogenmiller and seconded by Scot Ford to approve the February 2 and May 6, 2010 minutes as submitted. Voice vote was in favor of the motion, Jette Hogenmiller abstained from voting. Motion carried.

III. Approval of Agenda

√ Motion was made by Sharon Dalrymple and seconded by Melanie Lantis to accept the August 12, 2010 agenda as submitted. Voice vote was unanimous and motion carried.

IV. 2011 Meeting Dates

The suggested meeting dates for the 2011 Mental Health Advisory committee are all on Thursday; February 3rd, May 3rd, August 11th and November 3rd. The May 3rd date is scheduled to be the Mental Health and Substance Abuse joint meeting. (notice the May 2011 date has changed to May 3, 2011.)

√ Motion was made by Dwain Fowler and seconded by Jerry McCallum to approve the 2011 meeting dates as submitted. Voice vote was in favor of the motion. Motion carried.

V. Public Comments

Alan Green - Executive Director of the Nebraska Mental Health Association
He is concerned with the process of the Title 206 (Rules & Regulations) for a few reasons: the monetary recommendations should be removed; they are interrelated to Peer Support. Mr. Green also asked the Advisory Committee members to voice an opinion regarding the Public Health Regulations regarding Mental Health Practice stating that his opinion is that providers should focus on the people they are serving and refer clients for whatever reason, moral or other, if the provider is not qualified or able to provide therapeutic service to the individual.

Peggy Williams – Nebraska Commission on the Deaf and Hard of Hearing **Attachment 1**

The service delivery system in Nebraska is not adequate for children who are deaf or hard of hearing. Providers are often not aware of the special needs of children. Assessment tools need to be modified to include cultural norms and values related to the deaf community. A 2008 position paper recommended the need for more trained staff (case management, residential facilities, providers, etc.) in sign language and deaf and hard of hearing culture. Nebraska needs to recruit, train, and hire more licensed deaf providers; this is more than hiring an interpreter for therapy sessions. More members of the deaf community need to be involved in policy-making and strategic planning in determining the mental health needs of deaf and hard of hearing individuals. There is a need for communicating with the deaf community where/how to get services. Deaf and Hard of Hearing needs to be added to the Mental Health Block Grant as a gap in services in the cultural competency and linguistic section along with other cultural groups.

Dr. Pete Sieler – Executive Director of the Nebraska Commission on the Deaf and Hard of Hearing. Members of the deaf community have actually been told to go to another state because Nebraska doesn't have services for them. School children can't access School Counselors. There are approximately 150,000 deaf and hard of hearing citizens in Nebraska. No one represents the deaf and hard of hearing community on the Mental Health Advisory Committee.

VI. BH Division Reports

NABHO Peer Review - Mary Barry-Magsamen

Mary Barry-Magsamen, Executive Director of St. Monica's Women's Treatment Services and Chairperson of the Nebraska Association of Behavioral Health Organizations Board - Peer Reviews

Peer reviews are done by peers for peers. In the past reviewers were not receiving pay but the contract has been altered to include a per diem rate for peer reviewers. Providers are not included in a peer review if they have/had an accreditation review within the year. There is more focus on trauma and the review forms were changed to improve the feedback received from reviewers. Peer reviews are intended for peers to learn from other peers so all services are enhanced. A final report will be submitted to the Division and will be shared with the Committee at a later date.

Lincoln Police Department – Joe Wright **Attachment 2**

Captain Joe Wright – Lincoln Police Department

Anyone can do what law enforcement officers do related to community policing and mental health, but only law enforcements can place an individual in Emergency Protective Custody. Law enforcement officers need to be trained in mental health so persons with mental illness aren't EPC'd (Emergency Protective Custody) or jailed unnecessarily. The national average of suicide rates of those who have been EPC'd is 29-30, while Lincoln's rate is 0. If EPC's can be reduced, this will also reduce the % of suicides. In small communities, the police officers are the eyes and ears of the community. It is important for police officers to ask if the individual has a WRAP (Wellness Recovery Action Program) plan to help as a solution to the crisis.

Support Employment Evaluation **Attachment 3**

Nancy Liu, DBH Intern reported on the Supported Employment study conducted for the Division of Behavioral Health and funded by the Data Infrastructure Grant (DIG) for Quality Improvement. Fidelity is an important predictor of outcomes. The study has shown that fidelity is a statewide problem that needs to be addressed. There is a need for network providers and community support workers to receive Supported Employment education. The desired outcome of Supported Employment is that an individual has achieved and maintained competitive employment for 120 days. Supported employment is proven to be good for recovery. SAMHSA has a special tool kit that provides an efficient way to monitor fidelity of Supported Employment sites.

Question: Why is Problem Gambling excluded from the Supported Employment study? DBH responded, Gambling services are funded differently. The Mental Health and Substance Abuse funding goes through the Regional Behavioral Health authorities.

Vicki Maca suggested to explore the funding of Problem Gambling with Co-Occurring issues.

The Committee recommended that the Division utilize the SAMHSA Tool Kit to strengthen the data, and improve resources to produce a better correlation with outcomes and recommended that the Division pursue additional training from national experts to better serve the behavioral health with supported employment needs.

√ Motion was made by Pat Talbott and seconded by Dwain Fowler to continue the employment data collection using the SAMHSA Tool kit, if funding is available, and follow the recommendation from Nancy Liu's study: "Implementation can be improved using a sustained training program. The SAMHSA Tool Kit provides an efficient way to monitor fidelity of Supported Employment sites".

Strategic Planning Efforts – Denise Bulling, UNL- Public Policy Center **Attachment 4**
Denise Bulling stated Nebraska invited three national consultants to provide guidance in the Strategic Planning process. The consultants are; Monica Oss from Open Minds, Dr. Thomas Kirk a Healthcare consultant from Connecticut and Sherry Mead a consultant from New Hampshire. These individuals were invited to participate to provide expertise regarding planning for the changes expected due to Health Care Reform. A draft of the Strategic Plan will be available in the Fall of 2010.

RentWise Report – Danielle Hill, **Attachment 5**
Danielle Hill – Nebraska Housing Developers Association - RentWise Program
A business plan was developed, six networks were established, and currently 300 – 500 individuals have been trained in RentWise, 50 people are actively delivering training, and 300 people are trained to be a trainer of RentWise. The RentWise program is for anyone, it is not restricted to individuals experiencing mental illness. The RentWise program will be featured on the Not Alone radio program sponsored by the Kim Foundation. The NHDA Board has agreed to serve as the lead agency for RentWise.

Sheri Dawson – DHHS-DBH, Managed Care & Quality Improvement Manager Attachment 6
Ms. Dawson reviewed and discussed the performance measures and asked for comments and suggestion on the measures she discussed.
The question, "Has your quality of life improved?" has been added to surveys.
The outcome of persons graduating from services needs to be included.
Employment can be a quality of life indicator.
Measure the changes made to different levels of care/services
Track what happens to youth in the transition from youth to adult services—do they succeed, relapse or stabilize?
Include basic living skills when working with Transition Age Youth

Scot Adams – Director of the DHHS-Division of Behavioral Health asked the Committee for their thoughts about transferring $100,000 (not this specific amount, but for example) from services to evaluation activities.

Committee members responded:
--prefer to pay for services over evaluation.
--prevention affects treatment in the long-term, and because treatment is more expensive it is more cost effective to determine treatment based on evaluation.
--a baseline for treatment services is developed through evaluation, and baselines determine future funding for services. Also, treatment needs to morph and change because if we provide the same services we have always done, we will miss the target—important, necessary services.
--evaluation is important to determine services, but if services decreased there will be someone who will disagree; also current providers are experiencing revenue problems.
--if more evaluation is done, we also need to track outcomes.
--an alternative/addition to services is increased utilization of tele-behavioral health; also –increase monitoring of trauma-informed care through Magellan.
--we don't want to increase the EPC mess by decreasing services
--does someone collect the information already so there is no duplication of evaluation?
--what services already provided are evidence-based? Focus on evidence-based services.

--are we doing enough with co-occurring services?

Cameron White is with the Dept. of Correction and will replace the position held by Chelsea Chesen on the Co Occurring Work Group

Ms. Dawson asked for a volunteer as a Mental Health Representative for the Co-Occurring Work Group.

Pat Talbott volunteered as a MH Representative and the committee agreed in favor of having Pat Talbott represent the Mental Health Committee at the Co-Occurring Work Group meetings.

Carol Coussons de Reyes, Administrator-Office of Consumers Affairs (OCA)
Ms. Coussons de Reyes distributed and briefly discussed the brochure on Network of Care and the invitation to a free webinar: "Understanding Recovery & Creating Revolutionary Care with Peer Support." Web Site address is: www.networkofcare.org

Transformation Transfer Initiative (TTI) Grant is a SAMHSA grant and OCA is managing the contract. OCA is responsible for promoting consumer and family involvement across the state. The TTI Grant will be used to develop Peer Support and the six Regions are allocated funding for Consumer Specialist positions and each Region will address the consumer and family involvement issues.

Ms. Coussons de Reyes stated Sheri Mead was selected to provide a curricula and training for facilitators. There are now 15 person trained as Peer Support trainers. The Keya House and publication of "Nebraska's Consumer Voice" was also reviewed and is included in the Grant.

Mental Health Block Grant Review
Committee comments collected are:

--documentation regarding stigma will be added to the consumer information

In regard to Children's Behavioral Health Services//Suicide Prevention, the Division needs to address the following:
--need to pay more attention to Transitional Age Youth
--there is a philosophical difference between Children's Behavioral Health and Child Welfare; we need to follow some of the models being developed in Child Welfare, such getting young people involved in leadership and mentoring others with behavioral health system experiences.
--as Health Care Reform unfolds, would like to see the Block Grant funding more supportive and community-based services.

--continue attention on Criminal Justice & Behavioral Health regarding the release of inmates from jail; would like to see more emphasis on judicial training on behavioral health in the rural areas of the State.
--address the fact that families are not aware of where to go for resources/services; schools are not informed on behavioral health resources; would like to see more education in the school system on behavioral health issues and signs and symptoms awareness; need more collaboration with the school system
--there good initiatives and forward thinking going on across the State; focus on cost saving—need to modify approach to services; future focus on best practice and efficiency to maximize funding
--would like to add more Living Skills services for Transitional Age Youth (i.e., budgeting, renter education, nutrition, health care, etc.)
--continue focus on Criminal Justice – appreciates the increased collaboration between criminal justice and behavioral health, especially around discharge planning
--good work on Criminal Justice and Behavioral Health discharge planning, but need more work on employment services
--get the Veterans' Administration more involved with BH Services for veterans'
--good to see increased Peer Support, but need more at all levels (individuals, children, families); Peer Support provides hope by helping others

--it is interesting to see how far the State has come in providing behavioral health services; would like the State to be responsive to the gaps indicated in Supported Employment services
--jail diversion collaboration is good, but more needs to be done
--need to educate school personnel on mental illness and behaviors to better detect issues
--need better collaboration with the school system—too many children are placed in Special Education that don't need to be, and too many are sent to the Principal's office to address behavior alone; lack of understanding the possible connection with mental illness
--focus attention on future behavioral health needs for the behavioral health system
--need to better manage individuals in crisis who end up in the emergency system; too many people are placed in jail who should not be there
--need to place more emphasis on WRAP (Wellness Recovery Action Plan) training and educating others about its availability, especially law enforcement and some providers
--continue behavioral health education in the legal community (i.e., attorneys, law enforcement officers); educate on difference between treatment and a jail cell

Public Comment:
Tammy Fiala, Region 3 Consumer Specialist, talked about her work with consumer wellness. Tammy attended a conference, "Critical Conditions", where states were encouraged to embrace models of mental health and physical health care. The program is more than addressing nutrition and cigarettes, but also focuses on poverty, employment, congregate living, and other factors in relation to health issues. The program also focuses on an individual's readiness to change. Region 3 invited Larry Fricks and Ike Powell to assist Tammy and Beth Baxter, Region 3 Behavioral Health Administrator, in traveling across to present change readiness, setting personal goals, facilitating support groups, and teaming peers to monitor each other's goals. Peer Specialists are teaching the concept across the State.

Carol Coussons de Reyes, The Office of Consumer Affairs, the Regional Consumer Specialists, and other advocacy groups are planning an anti-smoking conference in conjunction with the National Great American Smoke out in November, 2010.

VII. Recommendation/Agenda Items for Next Meeting:
MH Block Grant Implementation Report
Performance Measures and Uniform Tables
Suicide Prevention report
Child Service Definition – Not funded by Medicaid
Insurance issues- SOAR- what benefits are/are not covered.
Report on Jail Diversion – Travis Parker
Regional Report – Region 6

VIII. Plus/Delta:
--it is very encouraging to have new committee members contribute at their first meeting
--good job of organizing the materials for review; the entire day was very organized
--consider changing the configuration of the tables to sit East-West rather than North-South
--need fly swatters

IX. Adjournment & Next Meeting
Meeting adjourned at 3:50 pm

The next meeting date is; Thursday, November 4, 2010 at Country Inn and Suites.

Prepared by: Alexandra Castillo, Staff Assistant

Approved by _____ Date _____
Federal Resource Manager
Division of Behavioral Health

State Advisory Committee on Mental Health Services
August 12, 1010
Public Comment

My name is Peggy Williams, Mental Health Specialist for the Nebraska Commission for the Deaf and Hard of Hearing. With me today is Dr. Pete Seiler, Executive Director for the Nebraska Commission for the Deaf and Hard of Hearing and Ben Sparks, PIO/Interpreter for the Commission.

Thank you for giving me the opportunity to speak with you today to address statewide concerns and issues that impact both deaf and hard of hearing children and adults receiving mental health services in the State of Nebraska.

Mental Health Services for Children

In 2008 the National Association of the Deaf (NAD) wrote a position statement on mental health services for Deaf children which provides the framework for optimal mental health care for deaf children in this country.

Deaf children with mental health needs face a service delivery system that is solely inadequate and too often fraught with ideological and monetary battles between multiple agencies (Hamerdinger & Hill, 2005). Additionally, because deaf children are a low incidence population, providers are typically unaware of the specialized needs and training required to work with this population, resulting in misdiagnoses of mental retardation or thoughts disorders (Morgan & Vernon, 1994; Hindley, 1999). Assessment tools are not modified to take into account the linguistic characteristics of this population, as well as cultural norms and values.

It is recommended that states need to ensure that:

1. Case management staff members are cognizant of and trained to coordinate culturally affirmative and linguistically accessible mental health services to deaf children.
2. Develop resources to ensure that deaf children receive appropriate therapy from clinicians who are linguistically fluent and culturally affirmative. While not the optimal means of therapy, the shortage of ASL-fluent clinicians necessitates the interim use of sign language interpreters trained to work in mental health settings.
3. Develop resources and training for state and local agencies that provide family education services to work with deaf children, including ensuring that services provided take into account the linguistic and cultural needs of the child and family.

A continuum of residential alternatives which must include, at a minimum

- Wraparound providers
- Therapeutic foster homes and foster placement
- Group homes
- Residential treatment facilities

According to the NAD position statement which the Nebraska Commission for the Deaf and Hard of Hearing supports, states need to take proactive steps to address the critical and urgent needs of deaf children who require mental health treatment. Three recommendations are proposed:

1. Develop regional programs to serve the needs of the relatively small number of deaf children needing inpatient hospitalization or residential treatment.

2. Encourage the recruitment, training, and licensure of members of the deaf community to serve as therapeutic and respite foster home personnel.
3. Invest in research priorities which focus on the linguistic, cultural, and systemic needs of this population.

For the past several years the Commission has been meeting with Boys Town National Research Hospital RTC administrators proposing this program provide equal access for deaf and hard of hearing children. Discussion on establishing a program specifically for deaf and hard of hearing children is still being discussed.

Mental Health Services for Adults

Delivering mental health services to people who are deaf and hard of hearing is a complex issue. It involves much more than hiring an interpreter or having flashing lights to make sure the person is aware when his/her alarm goes off in the morning. Mental health policymakers, planners, and providers need to develop services that are sensitive to the needs, wishes and goals of the Deaf Community. The Deaf Community needs to be involved in the process of developing effective programs for this population.

Public mental health systems have done a poor job of responding to the cultural and communication needs of people who are deaf, assuming that interventions, techniques, and services that work for the general public are also appropriate and effective for people who are deaf. In order for services to be effective for a person who is deaf, the program needs to be structured to meet the special needs of the deaf, i.e., one-on-one communication with a therapist, assessments that are appropriated tools to be used for the deaf and peer support within the treatment setting.

By not having specialized services for the deaf means that many deaf people who experience mental illness in Nebraska are not receiving adequate mental health services in this State.

In closing, I would like to tell you what a prominent Deaf man explained to me in 1982 when the Commission began looking at the lack of Mental Health and Substance Abuse Services in Nebraska. He said, "If you are Deaf, live in Nebraska and have mental health issues move". (Dr. George Propp). Is this what we want for citizens of Nebraska, to have to leave their community and move to another State where adequate services are offered?

It is the Commission's hope that during you strategic planning process mental health needs are considered and implemented in to your plan. If you have further questions please do not hesitate to contact me at 402-471-3593.

Peggy A. Williams, NCDHH Mental Health Specialist

Attachment 2

LINCOLN POLICE DEPARTMENT
Problem Oriented Policing Project Summary

Team/Unit: Lincoln Police Department ***Employee:*** Wright #713

Project Location: City of Lincoln
Project Dates: 9-1-2009 to 9-1-2010

Organizations and Persons Involved:

Lincoln Police Department
Blue Valley Mental Health/ Targeted Adult Services Coordination (TASC)

Problem Description:

Police officers are often in contact with people who are under a great deal of stress. Depending on the situation, referrals can be hard to make. Consumers of mental health services can be especially hard to help as officers are never aware of all the different programs available. Officers often leave their calls wishing they could do more for people but have no way accessing many of the programs which exist in Lincoln.

Strategies Employed:

After a pilot program was conducted which suggested a city wide program is feasable, all officers of the Lincoln Police Department were asked to refer individuals to TASC when the officer felt a person would benefit from additional behavioral health resources. Officers were asked to send an email with a brief description of each situation to TASC. After receipt of the information, a TASC caseworker attempted to contact and provide resources to each person referred by the police. TASC sent an email message back to the officer after contact was made in order to give the officer feedback that something was done about his/her concerns.

Results:

During the 2009-2010 fiscal year officers made 168 referrals to TASC. 34% of the people referred during the project declined any assistance. TASC was unable to contact 32% of the people referred. TASC was able to establish that 16% of the individuals were currently utilizing a resource of some type. 15% of the people referred by the police were enrolled into TASC and 3% were elevated to a higher level of care.

We feel this project was a huge success. 18%, almost one in five people identified by police as someone in need of assistance, were proactively contacted by a mental health professional and enrolled in a program or accepted enhanced resources.

The Lincoln Police Department plans to contine this program indefinitely with the goal of making more referrals during the 2010-2011 timeframe.

Lincoln Police Department Referral

During fiscal year 2009/2010 the TASC case mangers followed up on 128 referrals for service from the Lincoln Police Department. Of the 128, 65 were females and 63 males. Below is a breakdown of calls per month.

Month	# of Calls	Declined Assistance	Unable to Contact	Current resources utilized	TASC enrollment	Higher Level of Care
July	10	4	4	2	0	0
August	21	4	7	3	6	1
September	9	4	1	1	3	0
October	11	4	3	1	3	0
November	15	8	1	5	0	1
December	10	3	6	1	0	0
January	15	2	6	2	4	0
February	9	3	3	1	1	1
March	9	3	3	3	0	0
April	5	4	1	0	0	0
May	8	3	3	1	1	0
June	6	2	2	1	1	0
Total	128	44	40	21	19	3
Percentage		*34%*	*32%*	*16%*	*15%*	*3%*

The above calls came from 73 different Lincoln Police Officers.

Unknown	1	**Fencl**	1	**Lopez**	1	**Simens**	1
Agnew	2	**Fields**	1	**Lore**	1	**Spilker**	2
Aksmit	1	**Flynn**	1	**Luce**	3	**Stephenson**	1
Aksnip	1	**Fosler**	2	**Lueden**	1	**Voss**	1
Amen	2	**Fran**	1	**Messersmith**	1	**Wagner**	1
Arp	1	**Genoways**	1	**Moore**	1	**Wambold**	1
Barry	2	**Grell**	1	**Nichols**	1	**Weary**	1
Brodd	1	**Hansen**	8	**Noordhoek**	3	**Wesch**	4
Carmichael	1	**Helmuth**	1	**Norton**	3	**Wiggins**	2
Cleland	1	**Hollman**	2	**Parker**	2	**Wilkensen**	4
Cue	1	**Howe**	1	**Petersen**	1	**Winkler**	3
Dale	1	**Hruza**	1	**Pickering**	2	**Witzel**	2
Dillsaver	10	**Hubka**	2	**Powell**	1	**Wright**	2
Dittman	2	**Hurley**	1	**Quandt**	1	**Yindrick**	2
Dlouhy	1	**Jacobs**	3	**Roh**	1		
Dolberg	1	**Jensen**	4	**Schaaf**	3		
dvheovhoe	1	**Kaufman**	1	**Schmidt**	2		
Ehrhorn	1	**Koso**	2	**Schwochow**	2		
Engel	1	**Kospa**	1	**Seeman**	1		
Ernst	3	**Kwandt**	1	**Shamberg**	1		

LINCOLN POLICE DEPARTMENT
Problem Oriented Policing Project Summary

Team/Unit: Southeast Team ***Employee:*** J. Wright #713

Project Location: St. Elizabeth Regional Medical Center
Project Dates: March 30, 2010-July 1, 2010

Organizations and Persons Involved:

Lincoln Police Department--Joseph Wright
St. Elizabeth Regional Medical Center--Libby Raetz
Region V Systems--Kristen Nelson
Blue Valley Mental Health/Targeted Adult Services Coordination (TASC)--Arnold Remington

Problem Description:

St. Elizabeth Emergency Department staff call LPD for assistance when mentally ill people come to their hospital seeking help. Law Enforcement officers have no authority or obligation to participate in the care of people seeking assistance and should not be asked to be involved in their treatment. These scenarios create frustration for hospital staff and LPD employees. More importantly, mental health consumers are adversely affected by the confusion created when law enforcement becomes inappropriately involved in their treatment.

Strategies Employed:

Calls for service which were related to mental health issues were reviewed with the manager of St. Elizabeth's Emergency Department; Region V Systems and Blue Valley Mental Health participated in this review to decribe what types of outcomes would be most desirable for the patients involved. A 90 day pilot program was designed which created a method for hospital staff to contact TASC for screening and referral services for patients who come to the hospital with mental health concerns. The pilot was conducted between March 30 and July 1, 2010 with the goal of directing mentally ill people at St. Elizabeth's to services which fit their needs and to not 'criminalize' the patient's issues by calling uniformed police officers to the hospital.

Results:

Prior to this pilot, St. Elizabeth staff called LPD 37 times between January 1 and August 24, 2009. 36 of these requests for police assistance were inappropriate. During the pilot program, TASC was called to the hospital 17 times. In all 17 cases an appropriate outcome was developed for the patient and LPD was never called.

The results from this project will be used to help educate St. Elizabeth staff regarding why and when they should call for law enforcement assistance. Calls at the hospital will be monitored to look for long term improvement.

SAINT ELIZABETH PILOT

The TASC Program Crisis Response Teams participated in a 90 day pilot program with St. Elizabeth Hospital and the Lincoln Police Department. The pilot officially ran April 1 to June 30th, however our first call was received March 30th and the last one on July 1st. The pilot did identify needs but based on the call data, the needs were not suited for a crisis response model as the majority of the calls did not pertain to patients at risk of EPC but rather general behavioral health problems and linking to resources to meet those needs. Funding was also another factor in discontinuing the pilot.

The summary of calls is as follows: March 2010 (1), April 2010 (5), May 2010 (4), June 2010 (5) and July 2010 (1) for a total of 16 calls.

Here are the call details:

Date	**Gender**	**Admission reason**	**Disposition**
3/30/10	Male	Hernia Pain	Drug seeking, left hospital AMA
4/8/10	Male	Injury to arm	Admitted injury was a suicide attempt, LPD involved, voluntary admit to BryanLGH West.
4/19/10	Male	Depression	Involved with LPD on 4/18 for domestic disturbance, Currently working with EAP provider
4/25/10	Female	Pregnant, lack of memory, tested positive for drugs	Connected with OBGYN and voices of hope
4/27/10	Female	Juvenile, got in trouble at school, wrote a suicide note	Currently connected with a therapist, mom involved, problems appear to be behavioral
4/29/10	Female	Juvenile, overdose, fight with boyfriend	Reconnected with counselor
5/2/10	Male	Racing thoughts, suicide thoughts	Actively working with therapist, transfer to BryanLGH West for voluntary admit.
5/4/10	Male	Mental health	Inappropriate, no suicide ideation
5/7/10	Female		Call cancelled, Dr. decided assistance was not necessary
5/11/10	Female	Juvenile, overdose	Discussed resources, family to work with primary care physician
5/19/10	Female		Call cancelled by nurse
6/2/10	Female	Bipolar disorder	Continue working with psychiatrist
6/4/10	Male	Suicide ideation	Voluntary admit to BryanLGH West
6/9/10	Male	Anxiety	Inappropriate, Nurse wanted referrals
6/17/10	Female	Felt bugs and worms were crawling out of her skin	Person wanted help, encouraged voluntary transfer to ByranLGH West
6/19/10	Female	Suicide attempt	Denied ideation but wanted help, voluntary transport to BryanLGH West
7/1/10	Female		Inappropriate, pilot had ended

Process for Affidavit/Emergency Protective Custody outside of Business Hours

After business hours is defined as timeframe of 48 hour notice expiration as it coincides with court not being in session. Weekends and Holidays are the identified times.

Procedure from the Mental Health Areas:

1. If patient signs 48 hour notice and this timeframe will expire prior to the County Attorney being able to file a Mental Health Board Warrant due to court not being in session, please take the following steps.
2. Lancaster County is where current dangerousness is occurring as pt is refusing to remain in the hospital for voluntary treatment.

STOP

DO NOT USE THIS PROCESS IF CUSTODY CAN BE OBTAINED THROUGH AFFIDAVIT PROCESS WITHIN 48 HOURS.

A. Attending physician will complete the Mental Health Board Affidavit and have it notarized
B. Call will be placed to the County Attorney. Cell phone number is 432-4219.
C. Evidence contained in the affidavit will be shared with the County Attorney.
D. If County Attorney states she/he has intent to file, let her/him know that contact will be made with LPD to place pt in EPC.
E. **IF COUNTY ATTORNEY DOES NOT GIVE INTENT TO FILE, STOP PROCESS.**
F. Fax completed Affidavit to County Attorney. Fax number is 441-7336.
G. Contact LPD dispatch at 441-6000 and request an officer come out to place pt in EPC.
H. When LPD responds, give officer copy of the Affidavit and connect officer with County Attorney if necessary.
I. LPD will place pt in EPC due to intent to file given in Step D by County Attorney. Copy of Affidavit will be attached to EPC.
J. LPD will move pt to Crisis Center if bed is available.
K. All other steps will be followed per procedure once pt is in custody.
L. Keep **copy of EPC** on chart with **Original Affidavit**. Send Original EPC Certificate and Copy of Affidavit with transfer packet.
M. Physician completing affidavit will be testifying party at hearing.

Procedure from Inpatient Medical Areas:

After hours is defined as after 4 p.m. Monday through Friday, Weekends and Holidays as court is not in session.

DO NOT USE THIS PROCESS UNLESS PT MEETS STATUTORY CRITERIA FOR EPC AND AN AFFIDAVIT HAS BEEN COMPLETED AND CONTACT WITH THE COUNTY ATTORNEY HAS BEEN DONE. COUNTY ATTORNEY MUST BE CONTACTED PRIOR TO CALLING LPD AND MUST GIVE INTENT TO FILE. NO EXCEPTIONS!!

1. Statute does not allow a 48 hour hold to be used if pt has not presented voluntarily for mental health or substance treatment. Therefore, the following steps will take place after hours.
    a. If patient has received a psychiatric consultation and is refusing voluntary treatment and has been deemed by the physician to be a danger to themselves or others and is mentally ill or substance dependent, follow the Emergency Protective Custody Procedure.
    b. Physician will complete the Mental Health Board Affidavit and have it notarized
    c. Call will be placed to the County Attorney. Cell phone number is 432-4219.
    d. Evidence contained in the affidavit will be shared with the County Attorney.
    e. If County Attorney states she/he has intent to file, let her/him know that contact will be made with LPD to place pt in EPC.
    f. **IF COUNTY ATTORNEY DOES NOT GIVE INTENT TO FILE, STOP PROCESS.**
    g. Fax completed Affidavit to County Attorney. Fax number is 441-7336.
    h. Contact LPD dispatch at 441-6000 and request an officer come out to place pt in EPC.
    i. When LPD responds, give copy of Affidavit to officer and connect officer with County Attorney if necessary.
    j. LPD will place pt in EPC due to intent to file given in Step D by County Attorney. Copy of the Affidavit will be attached to EPC by officer.
    k. LPD will move pt to Crisis Center if bed is available and pt is "fit for confinement." If this criteria is not met, may move to Adult Psychiatry.
    l. All other steps will be followed per procedure once pt is in custody.
    m. Keep copy of EPC on chart with Original Affidavit. Send Original EPC Certificate and Copy of Affidavit with transfer packet.
    n. Physician completing affidavit will be testifying party at hearing.

LINCOLN POLICE DEPARTMENT

Problem Oriented Policing Project Summary

Team: Southeast Team

Employee: Emily Noordhoek

Project Location: City of Lincoln

Dates: February 2010-Present

Problem Description:

Emergency Protective Custody of Dangerous Sex Offenders is a new statute which the Lincoln Police Department is working to implement to protect those with mental illness/dangerous behavior and to ensure the overall safety of the community. To implement this statute, the dangerous behavior must be exhibited in addition to articulating the person suffers from a mental illness. Officers sometimes have difficulty articulating what mental illness a person suffers from, especially if the person is unwilling to self disclose this information and there is no other source of information available. The mental health diagnosis is crucial to articulate in order to take a person into emergency protective custody, which in turn gets a mentally ill person back into a system of care and hopefully prevents a criminal action/citizen victimization.

Strategies Employed:

To meet all statute criteria, the Lincoln Police Department requested assistance from the Nebraska Department of Corrections to assist in providing information about dangerous sex offenders when crucial to an EPC investigation. Many sex offenders have been previously incarcerated for a criminal offense and are likely to have received a mental health evaluation or diagnosis/treatment while incarcerated. Three meetings have been held with representatives from the Nebraska Dept of Corrections, Lincoln Police Department, Nebraska Parole Board, Health and Human Services, legal advisors, and mental health professionals to discuss options in implementing the Dangerous Sex Offender EPC.

Results:

The Dangerous Sex Offender EPC statute was reviewed and several options were discussed about how to implement it and what criteria was needed. A court order has been drafted so that if necessary, access to mental health records can be obtained from the Nebraska Department of Corrections who treated mentally ill persons while in custody. This will be done only in emergency situations and only to meet the criteria of an EPC investigation. Cautions were taken to protect the rights/confidentiality of the mentally ill person and the goal is to get this individual back into a system of care and prevent criminal offenses from occurring. Communication has increased with all agencies involved and further work will continue regarding sex offenders.

IN THE DISTRICT COURT OF LANCASTER COUNTY NEBRASKA

IN THE MATTER OF AN ORDER TO PRODUCE MENTAL HEALTH RECORDS OF A FORMER INMATE OF THE NEBRASKA DEPARTMENT OF CORRECTIONAL SERVICES	)))))	MOTION FOR PRODUCTION OF RECORDS AND SEALED ORDER

COMES NOW, _____, for the City of Lincoln, Lancaster County, Nebraska, and on behalf of the Lincoln Police Department, moves the Court for an Order that the State of Nebraska Department of Correctional Services search its records and state whether or not _____ has an Axis I or II diagnosis.

At the time of taking, a person is believed to be mentally ill and dangerous or a dangerous sex offender, a police officer must execute a written certificate identifying the mental status and behaviors supporting the allegations. Neb. Rev. Stat. § 71-919. There is a threat to life, serious bodily injury, or endangerment to a third party which outweighs _____'s right to privacy in the information sought, and that good cause exists to enter an Order under Neb. Rev. Stat. § 83-178, as amended. The City of Lincoln must obtain access to mental health records in order to place the above-referenced person into temporary civil protective custody. In support of this motion, an affidavit of the investigating officer is attached hereto and made part hereof by reference.

It is requested that State of Nebraska Department of Corrections provide disclosure of such records as soon as practicable as emergency conditions exists and that such records may disclose as necessary to detain the person in protective custody.

Furthermore, it requests that this motion and order be sealed from public access.

DATED _____

CITY OF LINCOLN, LINCOLN POLICE DEPARTMENT

_____

5. The records of this Court proceeding are hereby ordered to be sealed from public access and shall not be accessible to anyone committed to the Department of Correctional Services under Neb. Rev. Stat. § 83-178, as amended.

BY THE COURT:

_____

Judge of the Lancaster County District Court

Order prepared by attorneys:
George Green, Department of Corrections
Tonya Peters, Lincoln Police Department

IN THE DISTRICT COURT OF LANCASTER COUNTY NEBRASKA

IN THE MATTER OF AN ORDER TO PRODUCE MENTAL HEALTH RECORDS OF A FORMER INMATE OF THE NEBRASKA DEPARTMENT OF CORRECTIONAL SERVICES	)))))	SEALED ORDER OF THE COURT

This matter came upon the Motion of the City of Lincoln on behalf of the Lincoln Police Department, supported by the application of _____, a police officer with the Lincoln Police Department, for an Order that the State of Nebraska Department of Correctional Services search its records and state whether or not _____ has an Axis I or II diagnosis.

Based upon the Motion and the supporting affidavit, the Court finds that there is a threat to life, serious bodily injury, or endangerment to a third party which outweighs _____'s right to privacy in the information sought, and that good cause exists to enter an Order under Neb. Rev. Stat. § 83-178, as amended.

THEREFORE, the Court hereby orders the following:

1. The State of Nebraska is ordered to produce a statement of a licensed mental health practitioner employed by the Department of Correctional Services stating whether or not records kept by the Department show that _____ has an Axis I or II diagnosis, and the date of the diagnosis.

2. The State of Nebraska is ordered to produce the information contained in this Order immediately upon service of the Order on the Health Care Administrator for Behavioral Health or his or her designee.

3. The Lincoln Police Department shall be allowed to disclose such records as necessary to detain the person in protective custody and only to disclose them to persons involved in the protective custody proceedings.

4. Because emergency conditions exist, the State of Nebraska Department of Correctional Services is ordered to produce this statement as soon as practicable.

LINCOLN POLICE DEPARTMENT
Problem Oriented Policing Project Summary

Team/Unit: NW Team ***Employee:*** Domanski #1399

Project Location: NW team area, Schoo Middle School, Goodrich at Dawes Middle School

Project Dates: Sprint 2010 until Fall 2010

Organizations and Persons Involved:

NW day shift squad S/M/T 2nd Sat, Domanski #1399

Problem Description:

Officers often respond to juvenile mental health consumers in crisis or conduct investigations resulting from parents of juvenile mental health consumers attempting to conduct parenting and encountering conflicts due to the mental illness, such as, disturbances, legal but physical encounters between parents and children, or other investigations launched stemming from these incidents such as child abuse/neglect investigations.

Strategies Employed:

Utilizing training obtained during BETA training provided by the Lincoln Police Department and Region V to give fellow squad members additional tools and understanding to have a greater impact on encounters with juvenile mental health consumers and their families. Traditionally, many of these families provide little support from law enforcement due to current statutes or the conflicts seen are determined to be legal once investigated. Often we see return calls for service since the originating situation has not changed over time. Parents in this situation often are navigating the mental health and health care system with little support. Additionally they may be navigating the juvenile criminal justice system and possibly the Lincoln Public School system due do disciplinary action or behavior manifestations at school if their children are diagnosed with a behavior disorder.

Results:

Using information obtained from BETA I was able to share that information with fellow officers to utilize during calls for service in domestic situations with juvenile mental health consumers. I had a juvenile mental health consumer at Schoo Middle School where I had previously launched two child abuse investigations where it was determined physical contact with the father and daughter was legal and justified. The real issues were the parent learning how to manage, communicate and effectively parent a juvenile with a mental illness. With information I obtained from BETA I was able to put both the parent and the juvenile in touch with an advocate that put them in touch with a much larger support system. I was contacted later by the juvenile who informed me the relations between her father and her were better and that she was very happy with her advocate.

I responded on numerous occasions on a juvenile mental health consumer that was a student at Arnold Elementary. I had responded both to situations at the school and also at the private residence. The parents had reached a point that they wanted law enforcement interdiction at school for fear of harm to themselves and staff. After having attended BETA training I also made referrals for this family and have not had contact for a disturbance since.

Working with counselors at both my middle schools I was able to pass information to them that they could use to assist families that they worked with prior to when situations may develop that would require a criminal investigation or immediate police involvement. Situations where law enforcement was able to bridge the gap to greater support rather than temporarily restore order has been valuable to the family that receives assistance, their view of law enforcement and possibly the reduction in 911 calls for service or investigations that were not necessary. BETA has been a value on all levels.

KEARNEY POLICE DEPARTMENT
TRAINING BULLETIN
3/28/2010

Sgt. Koetters recently attended Behavioral Threat Assessment – Advanced Training for Law Enforcement hosted by the Lincoln Police Department and Region V Systems. The training focused on mental health and possible ways for law enforcement to improve our approach in dealing with people in crisis. It is interesting to note that the city of Lincoln has reduced the number of EPC's by 50% in the last 8 years. They obviously have more resources than Kearney and are able to place people in alternative programs available in their community, however, I did learn some valuable information that may help us in dealing with consumers who have been EPC'd in the past and use services offered by Region 3.

This training bulletin will focus on what is known as a Wellness Recovery Action Plan or WRAP plan. A WRAP plan is a system for monitoring, reducing, and eliminating uncomfortable or dangerous physical symptoms and emotional feelings experienced by those suffering from mental illness, however, anyone who wants to create positive change in the way they feel, or increase their enjoyment in life can develop a personal WRAP plan.

A WRAP plan is basically a crisis plan that the consumer fills out when he/she is feeling well and can be a tremendous tool for Officers' dealing with consumers who have been EPC'd in the past and are in crisis again. It would be very helpful to ask an individual in this situation if he/she has completed a WRAP plan. The plan will most likely include people to contact and people not to contact, medications the consumer is currently taking, community support workers who are part of the consumers ongoing treatment, what the consumer is like when feeling well, preferred treatment facilities, and things that have helped and hindered treatment in past times of crisis.

WRAP plans are very individualized and contain 7 sections. The sections include a wellness toolbox, daily maintenance plan, triggers, early warning signs, when things are breaking down, crisis plan, and post crisis plan. Participants in WRAP workshops are encouraged to put the crises plan in a specific place such as on top of the refrigerator. The crises plan is the only section of the plan that needs to be shared with others and often crises plans are distributed to supporters so they know when to take over get help or offer additional support.

There are consumers in Kearney who have developed WRAP plans and if Officers will take the time to ask it may be very helpful. A requirement for certification in this training is documenting that the training was shared and to keep statistics on how many officers' were able use the information in the field so if you talk to a consumer and they have a WRAP plan, please let Sgt. Koetters know and also advise if the information in the plan was helpful to you in developing a solution to the crisis.

I hope this information helps you in the field and look forward to the possibility that we may bring some training on dealing with mental health calls to Kearney and, in conjunction with Region 3 and South Central Behavioral Services , we plan to use more crisis intervention teams in the future when dealing with potential EPC's. The goal is to reduce the number of mental health calls that the police department needs to respond to because the consumer in crisis will have other resources that can provide assistance. We will always have EPC's and will not hesitate to use EPC when needed, however, there is potential to reduce the number and that benefits the consumer as well as the police department.

Supported Employment in the State of Nebraska: A Preliminary Report

Nancy H. Liu, M.A.

State Advisory Committee on Mental Health Services
August, 12 2010 - Lincoln, Nebraska

OBJECTIVE

The primary objective of this project is to conduct a program evaluation of the Supported Employment (SE) program in the State of Nebraska. The main goal is to examine the fidelity, employment outcomes and populations served of SE programs implemented during Fiscal Years 2008 and 2009 (July 1, 2007-July 30, 2009).

SERVICE DEFINITION OF SE

"Evidence-based service designed to promote rehabilitation and return to productive employment for persons with behavioral health disorders age 5[3] or older. Behavioral health disorders are mental illness or alcoholism, drug abuse, or related addictive disorder. Problem gambling is specifically excluded. The service employs a team approach for treatment with the employment specialists responsible for carrying out all vocational services from intake through follow-along. Job placements are: community-based (not sheltered workshops, not onsite at SE or other treatment agency offices, employment in enclaves or pre-vocational training, competitive (I.e., jobs are not exclusively reserved for SE consumers, but open to public), in normalized settings and utilize multiple employers. The team is assertive in engaging and retaining consumers in treatment, especially utilizing face-to-face community visits, rather than phone or email contacts. The SE team consults/works with family and significant others as appropriate. SE services are coordinated with Vocational Rehabilitation."

-Division of Behavioral Health, Approved January 5, 2007

METHOD

Phase I: Employment Outcomes and Populations Served

Comparison of employment outcomes from Division of Behavioral Health (DBH) and Vocational Rehabilitation databases

- *Pre-SE:* Fiscal Years 2005-2007
- *Post-SE:* Fiscal Years 2007-2009

Primary outcomes of interest:	
• Populations served o Total persons served o Diagnostic information	• Employment outcomes o Outcomes attained

Phase II: Fidelity Monitoring

This is the first time to measure SE fidelity in the State of Nebraska. Fidelity monitoring consisted of day-long, on-site visits; interviews with staff, clients and consumers; observation of team meetings and activities; and review of case files. All ratings were completed by two independent raters. These were conducted at the following 9 Nebraska SE sites during April 2010-June 2010:

1. Cirrus House - Scottsbluff, NE
2. Goodwill Industries of Greater Nebraska - Grand Island, NE
3. Goodwill Industries of Greater Nebraska - Hastings, NE
4. Goodwill Industries of Greater Nebraska - Kearney, NE
5. Goodwill Industries of Greater Nebraska - Lexington NE
6. Rainbow Center - Columbus, NE
7. Liberty Centre Services - Norfolk, NE
8. Mental Health Association - Nebraska, Lincoln, NE
9. Community Alliance - Omaha, NE

Primary outcomes of interest:	
• SE IPS Fidelity Scale o SE Fidelity (SAMHSA Community Mental Health Tool-Kit)	• Comprehensive Inventory of Recovery and Rehabilitation Services o Assesses the recovery orientation of services

PRELIMINARY RESULTS

Source: DBH Database as of August 2, 2010

- A total of 1,233 individuals have been served by the SE program from FY2006-FY2009. Of those individuals, 999 (81%) are different individuals and 234 (19%) are individuals who have returned to the SE program.
- Approximately 52% are women 49.4% have never been married. The average age is 38.8 (standard deviation=11.6).
- The number of persons served is as follows:
  - *Pre-SE:* Fiscal Years 2005-2007: 423
  - *Post-SE:* Fiscal Years 2007-2009: 790
- Of the persons served in the SE programs, a majority of persons (58.7%) have a diagnosis of Bipolar or Mood Disorders; 22.0% have a diagnosis of Schizophrenia-Spectrum Disorders; 18.4% have Other Diagnoses (i.e., Substance Abuse, Anxiety Disorder, PTSD, etc.). Approximately 69% have an SPMI diagnosis.

Source: Vocational Rehabilitation as of August 9, 2010

- In FY 2009, a total of 786 consumers were served and 204 (25.9%) of those reached 120 days of successful employment.
- Although beyond the purview of our study, in FY 2010, a total of 738 consumers were served and 187 (25.3%) of those reached 120 days of successful employment, suggesting similar outcomes.

CONCLUSIONS

- SE programs in Nebraska appears to be serving mostly individuals with diagnoses of Major Depression or Anxiety-related disorders
- Strengths of the SE programs on the Fidelity Scale include the following:
  - Caseload size: Employment specialists manage caseloads of up to 25 individuals
  - Rapid search: The search for competitive jobs occurs rapidly after program entry
  - Follow-along supports: Individualized follow-along supports are provided to employer and individuals on a time-unlimited basis
- Needs of the SE programs on the Fidelity Scale include the following:
  - Integration with Mental Health Treatment: Employment specialists are part of the mental health treatment teams with shared decision-making. They attend regular treatment team meetings (not replaced by administrative meetings) and have frequent contact with treatment team members
  - Zero-exclusion: No eligibility requirements such as job readiness, lack of substance abuse, no history of violent behavior, minimal intellectual functioning and mild symptoms
  - Community-based: Employment specialists spend more than 80% of time in the community
- The overall profiles of these programs suggest variance in the 9 SE programs
- Nebraska SE outcomes appear somewhat lower than those reported by research; however there appears to be significant variance in outcomes at the provider-level

RECOMMENDATIONS

- Implementation can be improved using a sustained training program (Rosenheck 2007)
- SAMHSA Tool-Kit provides an efficient way to monitor fidelity of SE sites

Table 5. **Comparisons**

	NEBRASKA	COMPARISON
POPULATION SERVED		Research studies
Persons w/Schizophrenia-spectrum disorders	22%	• 80% (Burns et al., 2007) • 50% (Cook et al., 2005) • 60 % (Crowther et al., 2001)
Age (years)	38.8	• 37.8 (Burns et al., 2007) • 38.5 (Cook et al., 2005)
FIDELITY		Maine HHS (Yoe & Glew, 2008)
Statewide average score	3.6 out of 5	3.9 out of 5
Fidelity & employment outcomes	TBD	*High Fidelity:* 77% employed *Low Fidelity:* 23% employed
Fidelity & hourly wages earned	TBD	*High Fidelity:* $8.57/hour *Low Fidelity:* $7.73/hour
Fidelity & monthly hours worked	TBD	*High Fidelity:* 75.8 hours/mo. *Low Fidelity*: 60.8 hours/mo.
*OUTCOMES ACHIEVED**		Research studies
Obtained competitive employment	25%	• 55% in SE IPS vs. 28% in traditional vocational services (Burns et al., 2007) • 55% in SE IPS vs. 34% in vocational services (Cook et al., 2005) • 35% in SE IPS vs. 12% in prevocational training (Crowther et al., 2001)

*Note: Nebraska SE outcome=120 days of successful employment; Burns et al. 2007 IPS SE outcome=worked at least 1 day, average=130 days employment; Cook et al., 2005 outcome=achieved competitive employment and cumulatively employed 40+ hours over a 24-month period; Crowther et al., 2001 outcome=competitively employed at 12 months.

REFERENCES

Burns, T., Catty, J., Becker, T., Drake, R.E., Fioritti, A., Knapp, M., Lauber, C., et al. (2007). The effectiveness of supported employment for people with severe mental illness: a randomized controlled trial. *Lancet, 7[1]4,* 1146-1152.

Cook, J.S., Leff, S., Blyler, C.R., Gold, P.B., Goldberg, R.W., Mueser, K.T., Toprac, M.G., McFarlane, W.R., et al. (2005). Results of a multisite randomized trial of supported employment interventions for individuals with severe mental illness. *Archives of General Psychiatry, [0]6,* 505-512.

Crowther, R.E., Marshall, M., Bond, G.R., & Huxley, P. (2001). Helping people with severe mental illness to obtain work: systematic review. *British Medical Journal, 766,* 204-208.

Rosenheck, R.A. & Mares, A.S. (2007). Implementation of supported employment for homeless veterans with psychiatric or addiction disorders: two-year outcomes. *Psychiatric Services, 9²*, 325-333.

Yoe, J.T., & Glew, K. (2008). *Supported employment services in Maine: evaluating fidelity, service use and outcomes.* Maine Department of Health and Human Services: Quality Improvement Services.

Figure 5. **Average Fidelity Scores across Items**

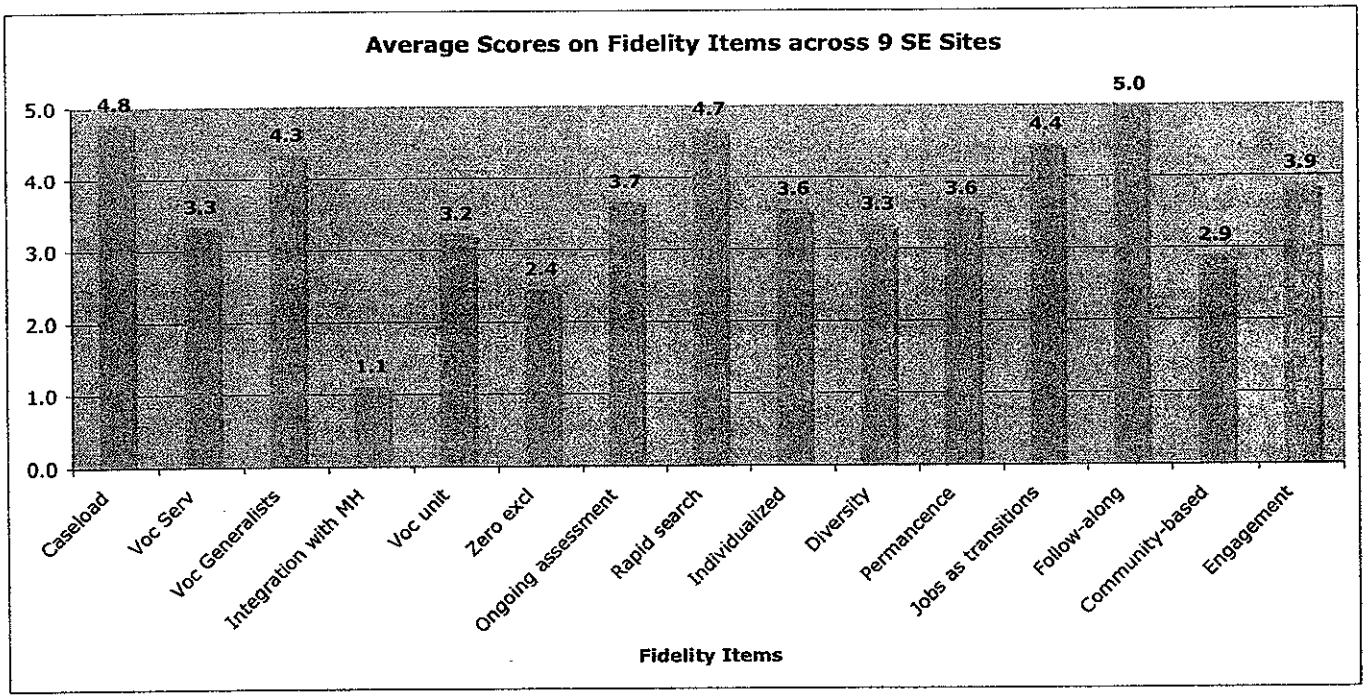
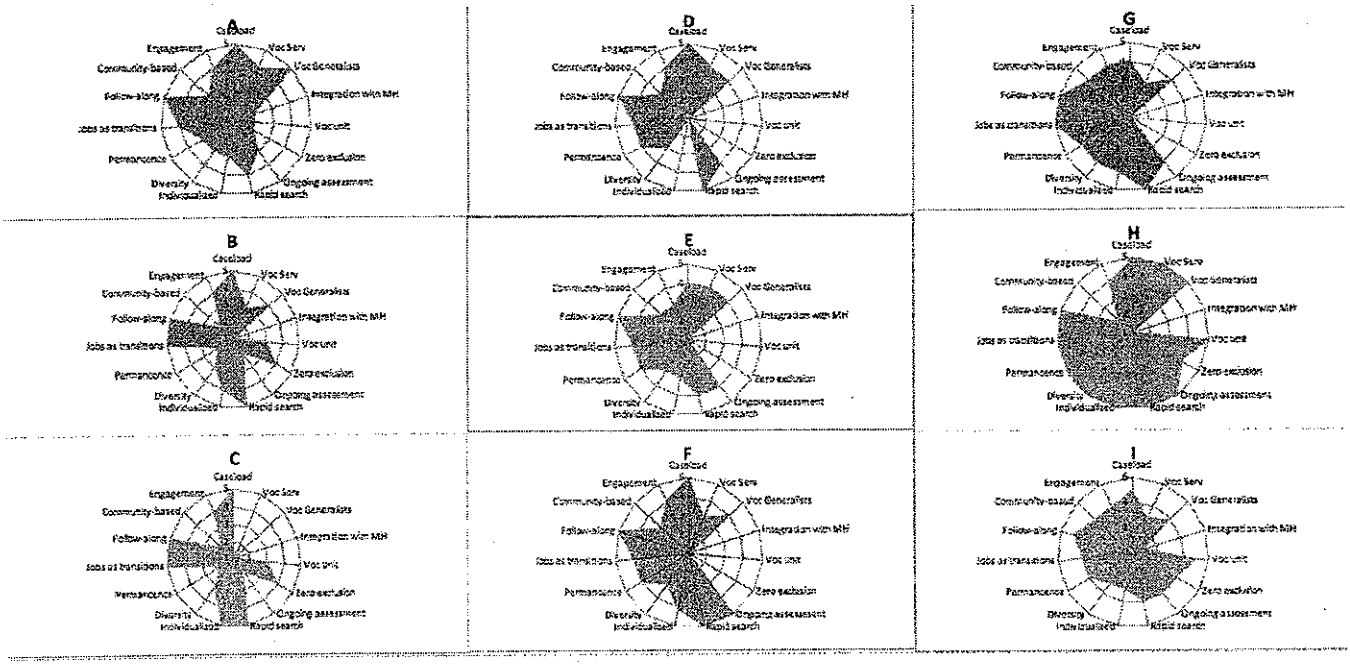


Figure 2. **Fidelity across 9 SE Programs in Nebraska**



Division of Behavioral Health

Strategic Planning Update

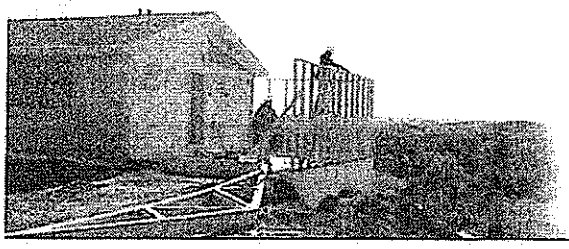
Joint Strategic Planning Working Group activities May – August 11, 2010

- Reviewed strategic planning input from the Joint Advisory Committee Meeting
- Reviewed examples of other State Behavioral Health Strategic Plans
- Met with two of the three national experts retained for consultation by the Division of Behavioral Health (Monica Os & Dr Thomas Kirk – Shery Mead is scheduled with the group on August 23, 2010)
- Launched an on-line survey (http://bhstrategicplanning.nebraska.edu) The Survey is still active and will remain open through August 2010.

Next Steps

- Recommendations for goals in the strategic plan will be prepared and reviewed by the Joint Strategic Planning Group based on plan reviews, survey information, national consultations and Advisory Committee input – Early September
- These recommendations will be reviewed and incorporated in a draft document by the Division of Behavioral Health – Early September
- The Draft Strategic Plan will be reviewed by the Joint Strategic Planning Group – Mid September
- The Draft Strategic Plan will be released for broad review and comment (public hearings)
- Revisions will be made based on public input and a final dynamic document released

Attachment 5



NEBRASKA Housing Developers ASSOCIATION

Affordable Housing Builds Strong Communities

August 12, 2010

Jim Harvey
Department of Health & Human Services
Division of Behavioral Health
PO Box 95026
Lincoln, NE 68509

RE: Final Report - DHHSBH-FY10-RentWise Contract

Dear Mr. Harvey:

On June 24, 2010 I submitted the final disbursement request for the above-referenced contract. The invoice with supporting documentation reflected we met all the conditions of the contract.

It is my pleasure to inform you the Nebraska Housing Developers Association will continue to support RentWise Nebraska and serve as the Lead Agency for RentWise. As you are aware the primary purpose of entering into a contract with the Association was to develop a sustainable statewide coordination mechanism to support RentWise. The Association is committed to coordinating RentWise and confident we will secure ongoing funding to do so. The Board of Directors for the Nebraska Housing Developers Association has indicated their desire for the Association to provide leadership to RentWise through their last two strategic planning sessions.

I have met with both Steve Peregrine and Ted Simpson from the Nebraska Investment Finance Authority (NIFA) in an effort to get RentWise included in NIFA's budget. I also provided input on NIFA's Qualified Allocation Plan relative to the Low Income Housing Tax Credit (LIHTC) program recommending the Association be eligible to receive a contribution from LIHTC developers desiring to do so in order to score more points on their LIHTC application. There was support for this concept from many of the developers that make these contributions, specifically to support RentWise. Additionally, I submitted a $40,000 grant proposal to the Nebraska Department of Economic Development that will support the Association's work in providing training and technical assistance that includes the coordination of RentWise. The DHHS Medicaid and Longterm Care provided $3,820 for Train the Trainer materials and training materials for RentWise Networks to use.

EQUAL HOUSING OPPORTUNITY

There are currently six (6) RentWise Networks in various stages of formation: Heartland Family Services, Coordinating Agency for Omaha RentWise Network; Lincoln Housing Authority, Coordinating Agency for Lincoln RentWise Network; Community Action Partnership of Mid-Nebraska, Coordinating Agency for Southwest Nebraska Network; Center for Independent Living, Coordinating Agency for South Central Nebraska Network; Community Action Partnership of Western Nebraska, Coordinating Agency for the Nebraska Panhandle; and Goldenrod Hills Community Action, Coordinating Agency for Northeast Nebraska RentWise. There are 50 trainers actively delivering RentWise curriculum and more than 300 trainers trained to deliver training.

Thank you for your support of RentWise. The funding provided via this contract has helped position RentWise to continue to meet the demand for tenant education and statewide coordination of RentWise.

Sincerely,

Danielle Hill

Danielle Hill
Executive Director

Community Mental Health Services Block Grant / Performance Indicators

Attachment 6

Adult NOMs Implementation Report Indicators

1. Increased Access to Services
2. Reduced Utilization of Psychiatric Inpatient Beds - 30 days
3. Reduced Utilization of Psychiatric Inpatient Beds - 180 days
4. Evidence Based - Number of Practices
5. Evidence Based - Adults with SMI Receiving Supported Housing
6. Evidence Based - Adults with SMI Receiving Supported Employment
7. Evidence Based - Adults with SMI Receiving Assertive Community Treatment
8. Evidence Based - Adults with SMI Receiving Family Psychoeducation
9. Evidence Based - Adults with SMI Receiving Integrated Treatment of Co-Occurring Disorders (MISA)
10. Evidence Based - Adults with SMI Receiving Illness Self-Management
11. Evidence Based - Adults with SMI Receiving Medication Management
12. Client Perception of Care
13. Adult - Increase/Retained Employment
14. Adult - Decreased Criminal Justice Involvement
15. Adult - Increased Stability in Housing
16. Adult - Increased Social Supports/Social Connectedness
17. Adult - Improved Level of Functioning

Adult State Implementation Report Indicators

18. Maintain Comprehensive Community-Based Mental Health Service Systems
19. Maintain if not increase the number of people receiving Mental Health Services
20. Maintain per Capita State Expenditures for Community Mental Health Services
21. Targeted Services to Rural Populations with the Rural Mental Health Program

Child NOMs Implementation Report Indicators

1. Increased Access to Services
2. Reduced Utilization of Psychiatric Inpatient Beds - 30 days
3. Reduced Utilization of Psychiatric Inpatient Beds - 180 days
4. Evidence Based - Number of Practices
5. Evidence Based - Children with SED Receiving Therapeutic Foster Care
6. Evidence Based - Children with SED Receiving Multi-Systemic Therapy
7. Evidence Based - Children with SED Receiving Family Functional Therapy
8. Client Perception of Care
9. Child - Return to/Stay in School
10. Child - Decreased Criminal Justice Involvement
11. Child - Increased Stability in Housing
12. Child - Increased Social Supports/Social Connectedness
13. Child - Improved Level of Functioning

Child State Implementation Report Indicators

14. Maintain capacity of Professional Partner Program
15. Maintain number of persons age 0-17 receiving services through the Nebraska Behavioral Health System
16. Maintain per capita State Expenditures for Community Mental Health Services
17. Maintain services to all children with serious emotional disorders in non-Metropolitan areas
18. Provide a system of integrated services for all children with serious emotional disorders who have multiple and complex needs