

Nebraska Division of Behavioral Health
Joint Committee Meeting
State Advisory Committee on Mental Health Services (SACMHS)
State Advisory Committee on Substance Abuse Services (SACSAS)

August 14, 2014 / 9:00 am – 4:00 pm
Lincoln, NE – Country Inn & Suites

Meeting Minutes

I. Call to Order/Welcome/Roll Call

Sue Adams

Susan Adams, Division of Behavioral Health Advisory Committee Facilitator, called the meeting to order and welcomed committee members and others present to the meeting. Roll call was conducted and a quorum was determined for the State Advisory Committee on Mental Health Services and the State Advisory Committee on Substance Abuse Services.

State Advisory Committee on Mental Health Services Attending: Adria Bace; Karla Bennetts; Cindy Buesing; Sheri Dawson; Bev Ferguson; Kathleen Hanson; Brad Hoefs; Jette Hogenmiller; Lara Huskey; Patti Jurjevich; Linda Krutz; Jerry McCallum; Phyllis McCaul; Kasey Moyer; Rachel Pinkerton; Jill Schreck; Mark Schultz; Mary Thunker; Diana Waggoner.

State Advisory Committee on Mental Health Services Absent: Mickey Alder; Ashley Pankonin; Joel Schneider; Cameron White.

State Advisory Committee on Substance Abuse Services Attending: Sheri Dawson; Ann Ebsen; Ingrid Gansebom; Janet Johnson; Dusty Lord; Kimberley Mundil; Michael Phillips; Todd Stull.

State Advisory Committee on Substance Abuse Services Absent: Paige Hruza; Jay Jackson; Randy See; Mary Wernke.

DHHS Attending: Scot Adams; Sue Adams; Marla Augustine; Carol Coussons De Reyes; Sheri Dawson; David DeVries; Renee Faber; Karen Harker; Cynthia Harris; Nancy Heller; Pat Roberts; Blaine Shaffer; John Trouba; Heather Wood.

General Sign In: Mark Darby from SAP National Guard

II. Public Comment

Sue Adams

No one signed in for Public Comment.

III. Housekeeping and Summary of Agenda

Sue Adams

Sue Adams provided housekeeping/logistics reminders and confirmation of the order of the agenda and Open Meetings Act.

IV. Motion of Approval of Minutes

Sue Adams

Invited comments on, or approval of, the May 13, 2014 minutes of the Joint State Advisory Committee on Mental Health Services and the State Advisory Committee on Substance Abuse Services.

Motion for Approval for the SACMHS made by Diana Waggoner and 2nd by Kathleen Hanson. Voting yes: (18) Adria Bace; Karla Bennetts; Cindy Buesing; Sheri Dawson; Bev Ferguson; Kathleen Hanson; Jette Hogenmiller; Lara Huskey; Patti Jurjevich; Linda Krutz; Jerry McCallum; Phyllis McCaul; Kasey Moyer; Rachel Pinkerton; Jill Schreck; Mark Schultz; Mary Thunker; Diana Waggoner.

Voting no: (0); Absent at time of vote: (5) Mickey Alder; Brad Hoefs; Ashley Pankonin; Joel Schneider; Cameron White. Motion to adopt carried: 18 – Yes, 0 – No, 5 – Absent. Quorum required is 13.

Motion for Approval for the SACSAS made by Sheri Dawson and 2nd by Kimberley Mundil. Voting yes: (8) Sheri Dawson; Ann Ebsen; Ingrid Gansebom; Janet Johnson; Dusty Lord; Kimberley Mundil; Michael Phillips; Todd Stull.

Voting no: (0); Absent at time of vote: (4) Paige Hruza; Jay Jackson; Randy See; Mary Wernke. Motion to adopt carried: 8 – Yes, 0 – No, 4 – Absent. Quorum required is 7.

V. Introduction of John Trouba

Karen Harker

Karen Harker, Federal and Fiscal Performance Administrator for the Division of Behavioral Health, introduced John Trouba, Federal Aid Administrator II, he has joined the Division of Behavioral Health team and will be moderating the Advisory Committees in the future. John provided a short description of his work with community groups and governing bodies and expressed his appreciation for the Committee Members' leadership in addressing the mental health and substance abuse needs of Nebraskans.

VI. Advisory Committee Orientation

Karen Harker

(Attachment A - O)

Karen Harker, Federal and Fiscal Performance Administrator for the Division of Behavioral Health, provided information on Nebraska's behavioral health service system and the SACMHS and SACSAS, noting each member has been appointed by the Governor to serve in an advisory capacity. The orientation included information on each committee's enabling legislation and authority, By-Laws, the Open Meetings Act, expense reimbursement processes and committee logistics. All information that was presented was handed out and may be accessed online.

VII. Director's Update

Director Scot Adams

Director Adams noted SAMHSA is inviting public comment on their proposed 2015 – 2018 Strategic Plan. He encouraged members to provide comments on their website <http://www.samhsa.gov>. The deadline to provide comments is August 18, 2014.

In June 2014, Nebraska hosted the 2014 National Association Of State Alcohol/Drug Abuse Directors (NASADAD) Annual Meeting. Following are some highlights of the conference:

- An area of focus was underage drinking which is a big deal in this state. We have had remarkable success over time with decreases in underage drinking.
- 42CFR Part 2, Federal confidentiality makes HIPAA look simplistic. It is currently under review due to national movement for integration of behavioral health and physical health. NASADAD is currently reviewing; Director Adams does not have a particular position on this.
- Substance abuse in Kindergarten through college involvement on the student front.
- The increase of prescription drug addiction is a serious issue. Prescription drug abuse is seeing higher use rates than heroin in some states. Nebraska is fortunate to be lower than the national average.
- Marijuana was a topic that was discussed, particularly given its recent legalization in a couple states and the amount of tax revenue it has generated.

In July 2014, the National Association of State Mental Health Program Directors (NASMHPD) Annual 2014 Commissioners Meeting was convened (Director Adams is the current President of the organization) and he shared the following information:

- The commission is made up of Mental Health Directors of the state and territorial mental health departments, of these 55 directors 17 are new directors, average tenure is 2 years.
- Trauma Informed Care information that was provided brought us to tears and a great sense of hope.
- The U.S. Attorney General spoke to the people that have served. Jane Walker head of family.org gave us additional information to relate to family organizations.

- AL-Anon and substance abuse service providers in the states were encouraged to pay attention.
- A great deal of discussion on the Mental Health Block Grant 5% Evidence-based Practice set aside. There have been a series of programs at 16 other sites, which helped approximately 700 individuals to return to school or work and the rate of success has been very good. The costs however is substantial. The activities and creative thinking will help us in Nebraska to continue to move forward with our initiative.
- An Institute for Mental Disease (IMD) is defined as a free standing facility of more than 16 beds or a hospital with more than 51% beds dedicated to people with mental health disorder or being treated with a psychotropic medication regardless of diagnosis. This definition, while originally passed in 1960's as a way to stop large state institutions from operating, it has subsequently been applied to community based mental health and substance abuse agencies. There is some movement to change the law, but there is also concern that doing so will mean that individuals will be forced to live in non-integrated settings.

VIII. Marijuana Use in Nebraska

Renee Faber/David DeVries

(Attachment P)

Renee Faber, DBH Prevention Program Coordinator and David DeVries, DBH Epidemiology Surveillance Coordinator, provided information on recent trends and statistics of marijuana use in the State of Colorado. They reviewed trends in marijuana use in the State of Nebraska, noting most surveillance data is available through 2012. They described how Nebraska is using prevention research to guide prevention practices in the state. Two prevention coalitions are implementing the Strengthening Families Program.

Recommendation for Motion by the Substance Abuse Committee 'To track legislation or movement on marijuana regulation and report back to the committees' was made by Ingrid Gansebom and 2nd by Janet Johnson. Voting yes: (8) Sheri Dawson; Ann Ebsen; Ingrid Gansebom; Janet Johnson; Dusty Lord; Kimberley Mundil; Michael Phillips; Todd Stull.

Voting no: (0). Absent at time of vote: (4) Paige Hruza; Jay Jackson; Randy See; Mary Wernke. Motion to adopt carried: 8 – Yes, 0 – No, 4 – Absent. Quorum required is 7.

Recommendation for Motion by the Mental Health Committee 'To track legislation or movement on marijuana regulation and report back to the committees' was made by Brad Hoefs 2nd by Mary Thunker. Voting yes: (17) Adria Bace; Karla Bennetts; Cindy Buesing; Sheri Dawson; Bev Ferguson; Kathleen Hanson; Brad Hoefs; Jette Hogenmiller; Lara Huskey; Patti Jurjevich; Linda Krutz; Jerry McCallum; Kasey Moyer; Rachel Pinkerton; Jill Schreck; Mary Thunker; Diana Waggoner.

Voting no: (0). Absent at time of vote: (6) Mickey Alder; Phyllis McCaul; Ashley Pankonin; Joel Schneider; Mark Schultz; Cameron White. Motion to adopt carried: 17 – Yes, 0 – No, 6 – Absent. Quorum required is 13.

The Prevention Advisory Council will undertake this recommendation and report back to the committees.

IX. Working Lunch - Synthetic Drug Awareness/Suicide Prevention

Michael Smith/Kali Smith

(Attachment Q and R)

Michael Smith with TJ's Purple Project described how the organization was formed (October 2012) by the family and friends of Tyler J. Smith. Its purpose is to share Tyler's story and bring a message of hope through Synthetic Drug Awareness and Suicide Prevention. Michael presented information about the

history of synthetic drugs, how synthetic cannabinoids and synthetic cathinones are manufactured, the unregulated content of “synthetic marijuana” and the insidious distribution and marketing of synthetic drugs. The packaging of legally sold “synthetic marijuana” and “bath salts” products are stamped with the warning, ‘Not for consumption’.

- “Tyler’s Law”- (LB 298, 2013) Sponsored by state Senator Beau McCoy, is 48 pages of chemical names and compounds added to the state controlled substances schedules.
- LB811 (2014) Sponsored by state Senator Ken Schilz was an update to LB298 to add the current generations (7th and 8th) of synthetic drugs to the state controlled substances schedules.

To find more information on the Purple Project visit Facebook – The Tyler J. Smith Purple Project

tjspurpleproject@gmail.com or <http://ladymeo1.wix.com/tjs-purple-project>

Recommendation for Motion by the Substance Abuse Committee ‘To track legislation or movement on synthetic drugs and report back to the committees’ was made by Ingrid Gansebom and 2nd by Janet Johnson. Voting yes: (7) Sheri Dawson; Ann Ebsen; Ingrid Gansebom; Janet Johnson; Dusty Lord; Michael Phillips; Todd Stull.

Voting no: (0). Absent at time of vote: (5) Paige Hruza; Jay Jackson; Kimberley Mundil; Randy See; Mary Wernke. Motion to adopt carried: 7 – Yes, 0 – No, 5 – Absent. Quorum required is 7

Recommendation for Motion by the Mental Health Committee ‘To track legislation or movement on synthetic drugs and report back to the committees’ was made by Brad Hoefs 2nd by Mary Thunker.

Voting yes: (17) Adria Bace; Karla Bennetts; Cindy Buesing; Sheri Dawson; Bev Ferguson; Kathleen Hanson; Brad Hoefs; Jette Hogenmiller; Lara Huskey; Patti Jurjevich; Linda Krutz; Jerry McCallum; Kasey Moyer; Rachel Pinkerton; Jill Schreck; Mary Thunker; Diana Waggoner.

Voting no: (0). Absent at time of vote: (6) Mickey Alder; Phyllis McCaul; Ashley Pankonin; Joel Schneider; Mark Schultz; Cameron White. Motion to adopt carried: 17 – Yes, 0 – No, 6 – Absent. Quorum required is 13.

The Prevention Advisory Council will undertake this recommendation and report back to the committees.

Break into MH and SA Committees

X. State Advisory Committee on Substance Abuse Services (SACSAS) – By-Laws *Heather Wood*

(Attachment S)

Ann Ebsen, Chairperson of the State Advisory Committee on Substance Abuse Services, called the meeting to order. Roll call was conducted and a quorum was not determined due to 7 members present. According to the By-Laws we need to have 9 members present voting in the affirmative to adopt amendments to the By-Laws. The By-Laws will be addressed at the next meeting if there is a super majority present.

XI. State Advisory Committee on Mental Health Services (SACMHS) – By-Laws *Sue Adams*

(Attachment T)

Diana Waggoner, Chairperson of the State Advisory Committee on Mental Health Services, called the meeting to order. Roll call was conducted and a quorum was determined.

Committee members discussed several grammatical edits, but determined their primary focus for this meeting is to approve the SACMHS By-Laws as amended, and will propose grammatical edits for future discussion.

Recommendation for Motion by the Mental Health Committee 'To accept and adopt noted changes in the By-Laws of the State Advisory Committee on Mental Health Services as written' was made by Jill Schreck and 2nd by Jette Hogenmiller. Voting yes: (16) Adria Bace; Karla Bennetts; Cindy Buesing; Bev Ferguson; Kathleen Hanson; Brad Hoefs; Jette Hogenmiller; Lara Huskey; Patti Jurjevich; Linda Krutz; Jerry McCallum; Kasey Moyer; Rachel Pinkerton; Jill Schreck; Mary Thunker; and Diana Waggoner. Voting no: (0). Absent at time of vote: (7) Mickey Alder; Sheri Dawson; Phyllis McCaul; Ashley Pankonin; Joel Schneider; Mark Schultz; and Cameron White. Motion to Amend the By-Laws carried: 16 – Yes; 0 – No; 7 – Absent.

XII. State Advisory Committee Survey *Sue Adams/Heather Wood*

(Attachment U)

Asked the SACMHS and the SACSAS to complete the surveys and return.

XIII. DED Housing and Community Development Plan *Brian Gaskill/Lara Huskey*

(Attachment V and W)

Lara Huskey, Deputy Director of Nebraska Department of Economic Development (DED) introduced Brian Gaskill, Consolidated Plan Coordinator, Community & Rural Development Division, who described purpose of the DED Consolidated Plan and related activities.

The State of Nebraska is updating the Consolidated Plan which guides how the state uses federal funds serving low and moderate income residents. The planning process includes a Community Needs Survey that lets you tell the state what your community needs, and your responses are critically important to how State investments will be prioritized over the next five years. He encouraged members to take a few moments to share their opinions on the future of your community. For additional information about the Consolidated Plan, please visit:

<http://www.neded.org/community/grants/documentslibrary-a-forms/consolidated-plan>

Brian distributed additional copies of the Community Needs Survey, which were included in the member packets, and noted DED has already received approximately 240 responses and are continuing to gather data. He encouraged members to complete the survey online at

<http://www.neded.org/community/grants/documentslibrary-a-forms/consolidated-plan> or mail to: Brian Gaskill, Department of Economic Development, 301 Centennial Mall South, Lincoln, NE 68509-4666 or fax to: 402-471-8405, or email to brian.gaskill@nebraska.gov.

Spanish language versions of this survey are available online, or by calling Brian Gaskill at 402-471-2280.

Additional information on recent projects with special needs populations that DED and/or Nebraska Investment Financing Authority's (NIFA) Low Income Housing Tax Credits was provided (see handout).

XIV. Prevention Advisory Update *Patti Jurjevich*

(Attachment X)

Patti Jurjevich, Regional Administrator for Region 6 Behavioral Healthcare, provided a summary of the Prevention Advisory Council meeting that was held June 26, 2014; the meeting minutes are available online. The Prevention Advisory Council is a valuable behavioral health partner whose work will provide the following to the Mental Health and Substance Abuse Services committees:

- Information on the integration of mental health promotion, substance abuse prevention, trauma-informed care, and shared risk and protective factors
- Information on the importance of building capacity in prevention to garner greater investment in prevention work
- Annual report on Nebraska Behavioral Health Prevention Systems
- Recommendations based on our work and data

The next meeting of the Prevention Advisory Council will be held in Lincoln on September 30, 2014 at Pioneer Park Nature Center Conference Center.

XV. System of Care

Sheri Dawson

(Attachment Y and Z)

DBH Deputy Director Dawson reported DHHS DBH submitted its completed System of Care strategic plan to SAMHSA on August 11, 2014. After presenting an executive summary, she encouraged members to take a few moments to review the strategic plan, particularly pages 38 through 49, which is located on state website at <http://www.dhhs.ne.gov/soc>. She noted the strategic plan included a reference to an article written by former Mental Health Committee member Beth Baxter, Regional Administrator for Nebraska Region 3. For additional information please visit the state website.

XVI. Public Comments

Sue Adams

There was no public comment

XVII. Committee Comments and Future Agenda Items

all

** Response to Committee questions/comments included:

- Committee members expressed gratitude for the discussion on recommendations to the Prevention Advisory Council
- Kimberley Mundil announced that the Independence Center is having an Open House on September 12, 2014 from 2:00 p.m. to 7:00 p.m., ribbon cutting g is at 1:30 p.m. For more information go to <http://www.bryanhealth.com/new-bryan-independence-center>

Future Agenda Items include:

- Olmstead Act material that was presented by Kevin Martone
- Keep informed of current issues such as synthetic drugs

Plus/Delta of today's meeting:

- Plus = Opportunities for discussion were appreciated and agenda items were informative.
- Delta = Room table arrangement did not allow easy access.

XVIII. Adjournment and next meeting

The next Joint meeting of the State Advisory Committee on Mental Health Services and the State Advisory Committee on Substance Abuse Services is Thursday, November 13, 2014.

Minutes prepared by the Division of Behavioral Health, Nebraska Department of Human Services. Minutes are intended to provide a general summary of the proceedings.

08-14-2014 Meeting Minutes

Orientation for State Committee members

There Is No Health Without Behavioral Health.
Prevention Works. Treatment is Effective. People Recover.



Department of Health & Human Services



Overview

There is no Health without Behavioral Health. Prevention Works. Treatment is Effective. People Recover.

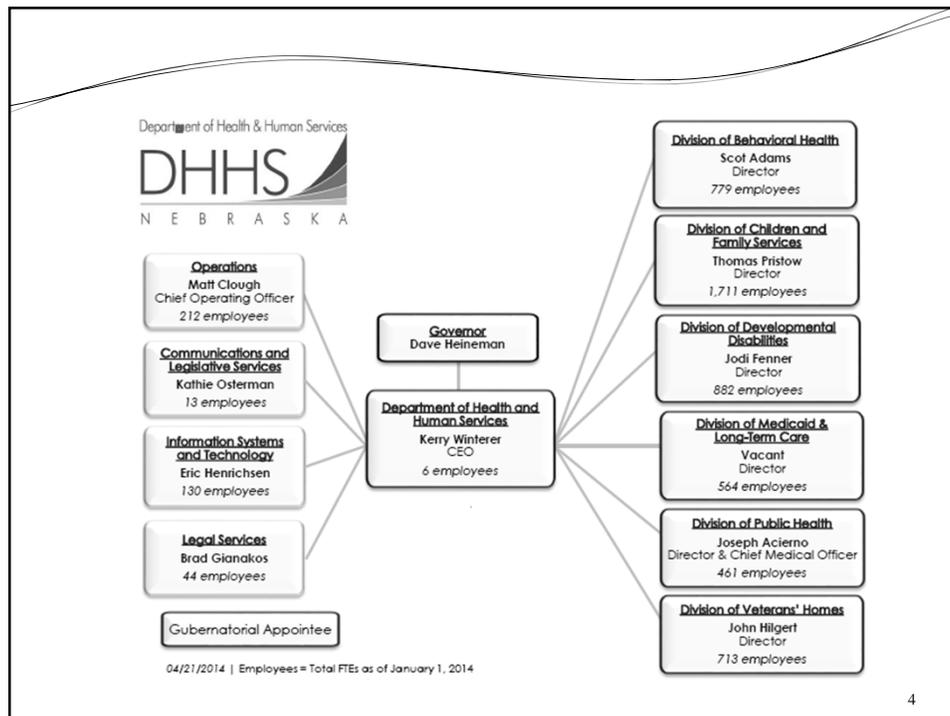
Division of Behavioral Health

Shall serve as the chief behavioral health authority for the State of Nebraska and shall direct the administration and coordination of the public behavioral health system.

Neb. Rev. Stat. 71-806

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3



4



Scot L. Adams, Ph.D., Director

Overview of the Division of Behavioral Health (DBH)

There is no Health without Behavioral Health. Prevention Works. Treatment is Effective. People Recover.

5

Public Behavioral Health System

Public behavioral health system; purposes.

The purposes of the public behavioral health system are to ensure:

- (1) The public safety and the health and safety of persons with behavioral health disorders;
- (2) Statewide access to behavioral health services, including, but not limited to, (a) adequate availability of behavioral health professionals, programs, and facilities, (b) an appropriate array of community-based services and continuum of care, and (c) integration and coordination of behavioral health services with primary health care services;
- (3) High quality behavioral health services, including, but not limited to, (a) services that are research-based and consumer-focused, (b) services that emphasize beneficial treatment outcomes and recovery, with appropriate treatment planning, case management, community support, and consumer peer support, (c) appropriate regulation of behavioral health professionals, programs, and facilities, and (d) consumer involvement as a priority in all aspects of service planning and delivery; and
- (4) Cost-effective behavioral health services, including, but not limited to, (a) services that are efficiently managed and supported with appropriate planning and information, (b) services that emphasize prevention, early detection, and early intervention, (c) services that are provided in the least restrictive environment consistent with the consumer's clinical diagnosis and plan of treatment, and (d) funding that is fully integrated and allocated to support the consumer and his or her plan of treatment.

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Neb. Rev. Stat. 71-803.6

Who we are:

DBH funds the Public Behavioral Health System

1. Mental Health (MH)
2. Substance Abuse (SA)
Primarily through contracts with the 6 Regional Behavioral Health Authorities (a.k.a. Regions)
3. Adults (primarily) and Children/Youth
4. In between role: not Medicaid and not insurance

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7

How is NBHS different from Medicaid Behavioral Health?

NBHS

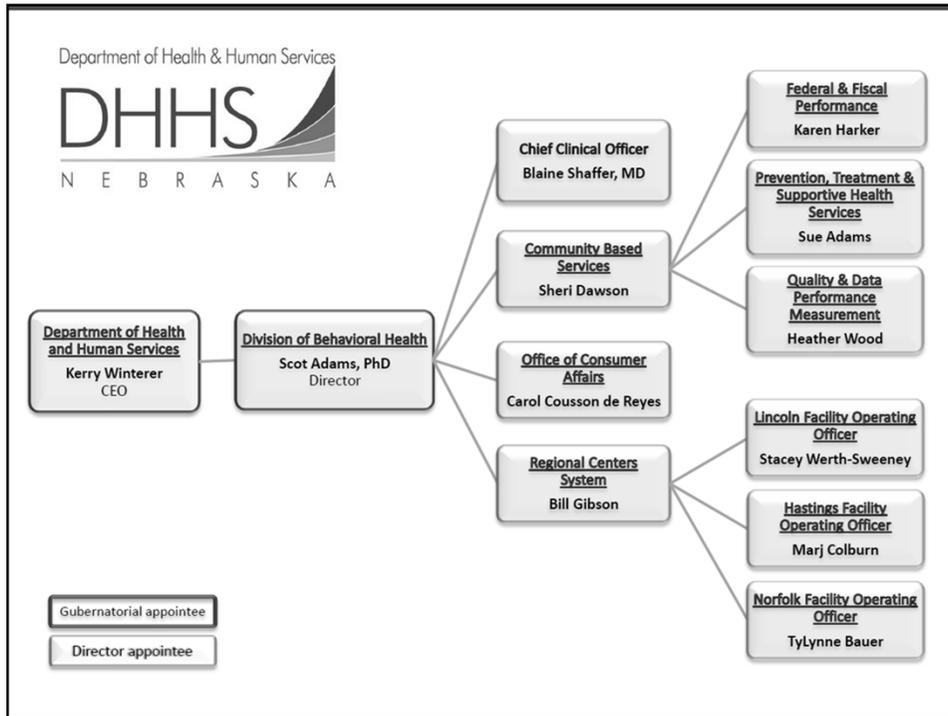
- More Funding for ADULTS (MH, SA)
- Funding capped; no entitlement
- Recovery and rehab service model
- Housing and employment
- Contracts for information system to collect data
- Through Regions

Medicaid

- Serves more CHILDREN than NBHS (limited services for children with SA needs)
- Entitlement, if eligible
- Medical model
- Has “*in-house*” information system to collect claims data
- Direct to providers

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8



DHHS Mission:
 Help People Live Better Lives

DBH Vision:
 The Nebraska public behavioral health system promotes wellness, recovery, resilience and self-determination in a coordinated, accessible consumer and family-driven system.
 -- *Simply put:* The Division of Behavioral Health strives to be the gold standard of BH care by facilitating hope, recovery and resiliency.

DBH Mission:
 The Division of Behavioral Health provides leadership and resources for systems of care that promote and facilitate resilience and recovery for Nebraskans.
 -- *Simply put:* DBH helps systems that help people recover.

2011-2015 Goals:

1. The public behavioral health workforce will be able to delivery effective prevention and treatment in recovery-oriented systems of care for people with co-occurring disorders.
2. 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).
3. The Division of Behavioral Health will reduce reliance on the Lincoln Regional Center for general psychiatric services.
4. An effective system to safely manage sex offenders in outpatient settings will be ready for implementation.

Chief Clinical Officer

Shall be a board-certified psychiatrist and shall serve as the medical director for the division and all facilities and programs operated by the division.

Neb. Rev. Stat. 71-805

- MHB Training Manual
- IDR Magellan Hearing Officer
(Informal Dispute Resolution)

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11

Office of Consumer Affairs

Shall be a consumer or former consumer of behavioral health services and shall have specialized knowledge, experience, or expertise relating to consumer-directed behavioral health services, behavioral health delivery systems, and advocacy on behalf of consumers of behavioral health services and their families.

Neb. Rev. Stat. 71-805

- Peer Specialists

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12

Regional Center System

Lincoln Regional Center (LRC)

- general psychiatric services – 90 beds
- forensic psychiatric services – 45 beds
- sex offender services – 85 beds
- Whitehall campus – 24 beds (adolescent male sex offenders)
- Court-ordered Forensic
- Adults committed by a Mental Health Board found to be a danger to self or others due to a mental illness
 - Dangerous Sex Offenders
 - Those that cannot be safely treated in a community hospital (violent or assaultive)

Norfolk Regional Center (NRC)

- sex offender services – 120 beds

Hastings Regional Center (HRC)

- adolescent residential substance abuse treatment (boys) – 24 beds

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13

| Regional Centers | | FY12 | FY13 | FY14 |
|------------------|--------------|------|------|------|
| NORFOLK | | 288 | 315 | 328 |
| HASTINGS | | 77 | 69 | 77 |
| LINCOLN | Forensic | 190 | 209 | 210 |
| | Psych IP | 125 | 84 | 95 |
| | Sex Offender | 61 | 53 | 63 |
| Total | | 741 | 730 | 773 |

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14

Central Office: Community Based Section

- Funding, oversight and technical assistance to the six (6) Regional Behavioral Health Authorities.
- Management for other behavioral health services via direct contracts such as American Indian Tribes, Rural Voucher Program, Recovery Home Loans, Training for Addiction Professionals and other related functions.
- Oversight and management of special grant funded projects such as Systems of Care or the Transformation Transfer Initiative
- Leadership in special initiatives and health system coordination via partnerships with related agencies, entities and stakeholders such as Trauma and Substance Abuse Prevention.

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15

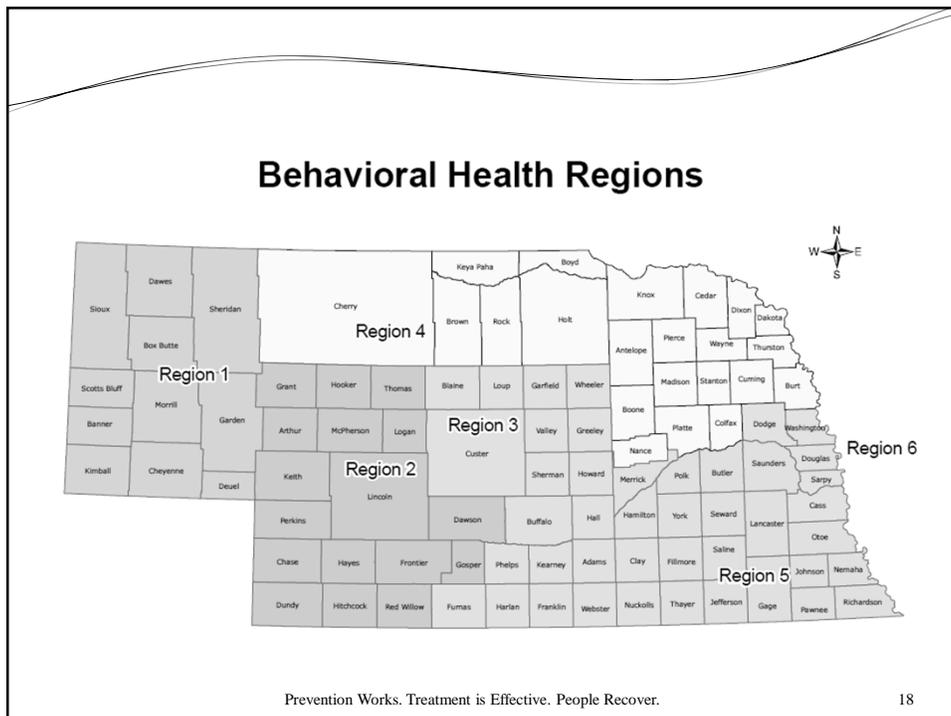
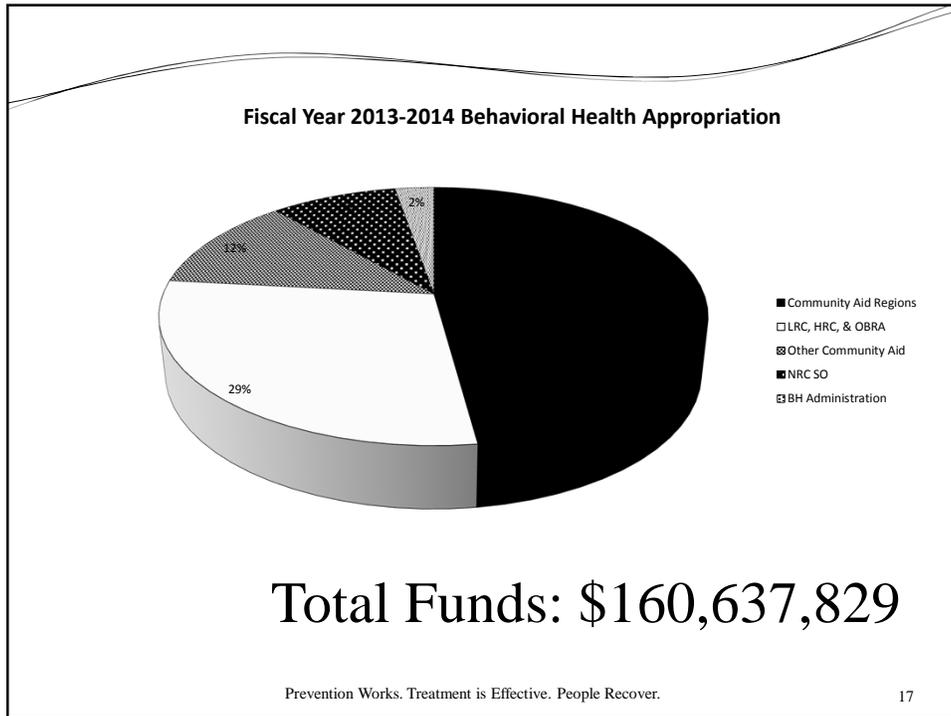
Community Based Section

- Each region contracts with a network of MH and SA providers – Nebraska Behavioral Health System= NBHS
- Network, Emergency, Youth, Prevention, Consumer
- Service array varies from Region to Region and are based on the unique needs of Nebraska’s communities – urban, rural, frontier
- Each service has a State approved service definition which are part of the Division regulations
- Eligibility criteria for services
 - financial (income and family size)
 - clinical (service definition)
- Individuals participating in Prevention services
- DBH contracts with Magellan for Admin Services Only (ASO) function (registration and authorization)*
- Magellan reviews for clinical criteria
- Providers review for financial criteria

* Medicaid contract with Magellan is different. It is an at-risk managed care contract.

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16



**Behavioral Health Community Based Services
Person Served – Unduplicated Count**

| FY2013 | Served in MH Service | Served in SA Service | Served in MH & SA Service | TOTAL |
|--|---------------------------------|---------------------------------|--|--------------|
| <u>Youth</u> (age 0-17) | 1,895 | 220 | 23 | 2,138 |
| <u>Adult</u> | 17,795 | 10,744 | 3518 | 32,057 |
| Total # of person served State Fiscal Year 2013 | | | | 34,195 |

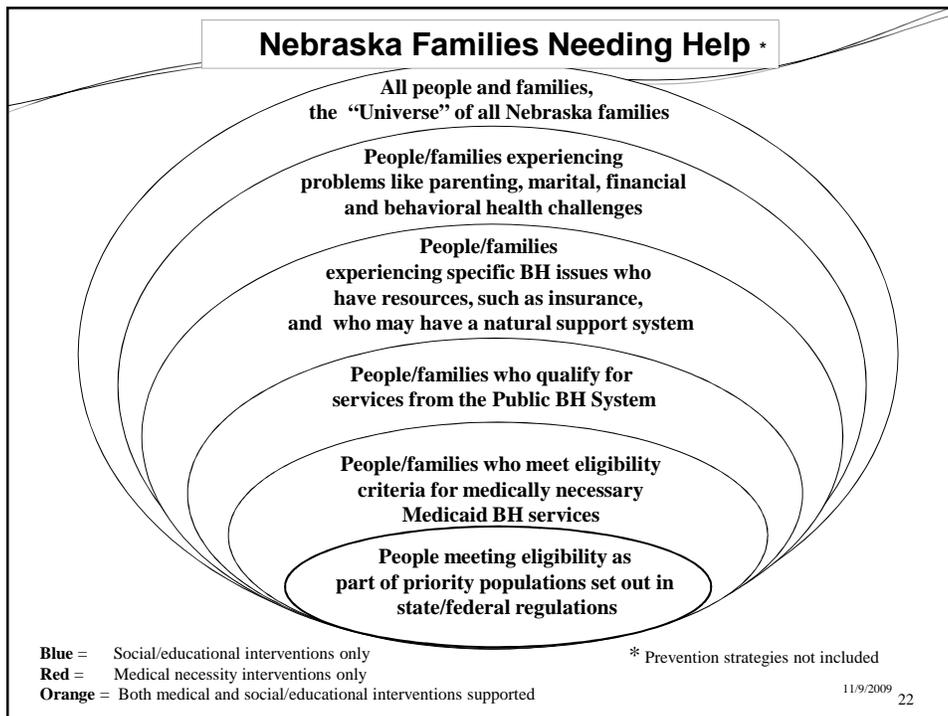
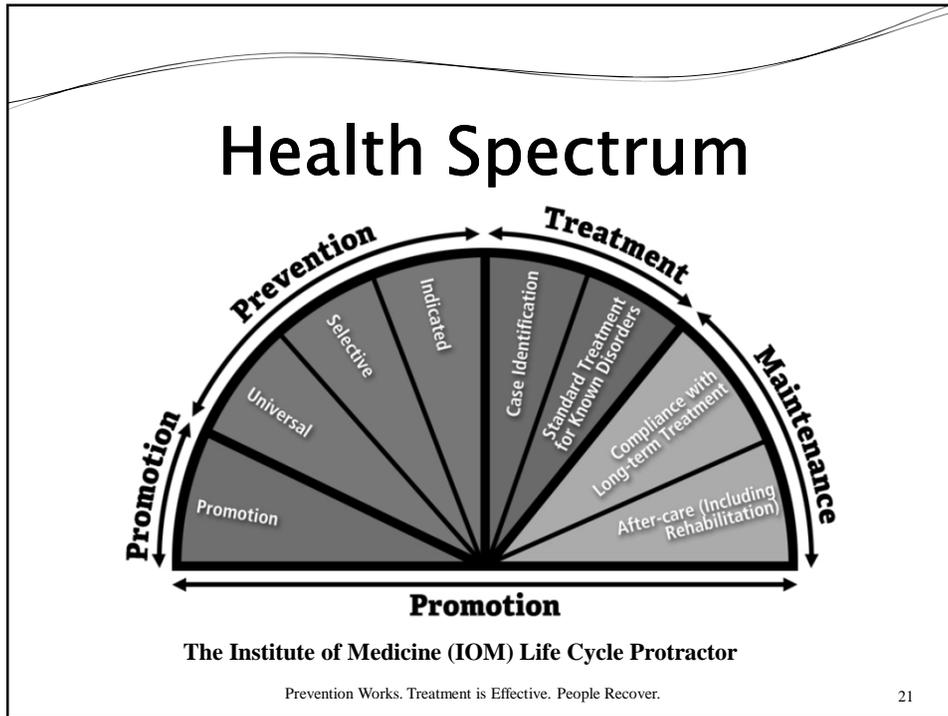
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**Nebraska Behavioral
Health Services Act**

Neb. Rev. Stat. §§ 71-801 to 71-830

The Act defines **BEHAVIORAL HEALTH DISORDER** as:
mental illness or alcoholism, drug abuse, or other
addictive disorder.
[Neb. Rev. Stat. §71-804(1)].

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Recovery Oriented Systems of Care

- ◆ Support prevention and early intervention
- ◆ Support recovery (housing, transportation, case management, employment, basic needs, faith-based, peer support, etc.)
- ◆ Identify and develop pathways to improved outcomes

"A 'ROSC' is a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resiliencies of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those with or at risk of alcohol and drug problems." – SAMHSA

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23

DBH Strategic Plan: 2011–2015

Posted to the Website: February 18, 2011

http://dhhs.ne.gov/behavioral_health/Documents/BHSP-Final-02-17-11.pdf

Co-Occurring Disorders and Prevention all have their own respective strategic plans as well to expand on specific relevant strategies.

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24

DBH Strategic Plan: 2011–2015

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 DBH provides leadership and resources for systems of care that promote and facilitate resilience and recovery for Nebraskans.

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25

DBH Strategic Plan: 2011–2015

Goals:

1. 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.
2. 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).
3. The Division of Behavioral Health will reduce reliance on the Lincoln Regional Center for general psychiatric services.
4. An effective system to safely manage sex offenders in outpatient settings will be ready for implementation.

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26

DBH Strategic Plan: 2011–2015

Strategies

The Division Will:

- »»Insist on Accessibility
- »»Demand Quality
- »»Require Effectiveness
- »»Promote Cost Efficiency
- »»Create Accountable Relationships

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27

State Committees

State Advisory Committee on Mental Health Services
State Advisory Committee on Substance Abuse Services

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28

Standard Information

- Every Committee member is Governor appointed for a specific term. Each committee is required to include consumers.
- Every Committee has their own By-Laws.
- Every Committee has respective topical focal points, but also share concern for the entire publicly funded behavioral health system and thus meet jointly at times.
- Open Meetings Act and Roberts Rules of Order are applicable and utilized in these public meeting forums.
- Committees has DBH staff liaison.

Statute and Authority

State Advisory Committee on Mental Health Services

Nebraska Revised Statute 71-814

-

Twenty-three Members

- (2) The committee shall be responsible to the division and shall:
- (a) serve as the state's mental health planning council as required by Public Law 102-321,
 - (b) conduct regular meetings,
 - (c) provide advice and assistance to the division relating to the provision of mental health services in the State of Nebraska, including, but not limited to, the development, implementation, provision, and funding of organized peer support services,
 - (d) promote the interests of consumers and their families, including, but not limited to, their inclusion and involvement in all aspects of services design, planning, implementation, provision, education, evaluation, and research,
 - (e) provide reports as requested by the division, and
 - (f) engage in such other activities as directed or authorized by the division.

State Advisory Committee on Mental Health Services

(2) (a) ... serve as the state's mental health planning council as required by Public Law 102-321,

FEDERAL COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT REQUIREMENTS FOR THE STATE MENTAL HEALTH PLANNING COUNCIL

Section 1914:

The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.

(b) The duties of the Council are:

- (1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;
- (2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and
- (3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

Statute and Authority

State Advisory Committee on Substance Abuse Services

Nebraska Revised Statute 71-815 - Twelve Members

(2) The committee shall be responsible to the division and shall:

- (a) conduct regular meetings,
- (b) provide advice and assistance to the division relating to the provision of substance abuse services in the State of Nebraska,
- (c) promote the interests of consumers and their families,
- (d) provide reports as requested by the division, and
- (e) engage in such other activities as directed or authorized by the division.

Open Meetings Act (OPA)

- Statute 84-1411 to 81-1413
- Key elements:
 - Advance publicized notice of meeting time, place and agenda. Agenda may not be altered 24 hours prior to meeting.
 - Agenda structure could be revised if necessary but no additional content may be added.
 - May not use teleconference; may use videoconferencing IF.....
 - Public has a right to attend speak; allotted agenda time for public should not be altered once established. Public comment can be limited to topics on agenda or by time limit. Public desiring to speak shall sign up; comments should not be solicited at random by Committee members, and no unsolicited comments should be made without appropriate public comment process to ensure all Committee and public access.

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33

Open Meetings Act (OPA)

- No power can be granted to a body lesser than the full committee (or quorum).
- Once committee in debate or motion, no further public comment shall be permitted on topic.
- Minutes must be kept indicating time, place, members present and absent and substance of matters discussed but should be very brief as not to complicate with recording 'discussion' but rather to capture motions made and voting record including all member responses.
- Minutes shall be made available for public inspection within ten working days of the meeting. Any recording will not be retained once printed material is finalized and available.
- At least one copy of all reproducible, written meeting materials must be present; a copy of OPA must also be present and cited.

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34

ADVISORY COMMITTEE LOGISTICS

- The meetings are scheduled for the following year at the last meeting of each year.
- Approximately one month before the meeting an email will be sent requesting an RSVP if you will be attending and if you need overnight accommodations.
- For planning purposes it is important to know whether you will be in attendance.
- Lunch will be provided for the Committee Members.
- Examples of the W-9_ACH Form and the Expense Reimbursement Form is in your packet.

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35

ADVISORY COMMITTEE LOGISTICS

- The agenda is posted on the website 10 days prior to each meeting. Per Section 84-1413(5) the minutes from the meeting will be posted within 10 business days from the meeting. The following are the links you may view the agenda and minutes for the Mental Health and Substance Abuse Committee:

http://dhhs.ne.gov/publichealth/Pages/hew_sua_sacsa.aspx

http://dhhs.ne.gov/behavioral_health/Pages/beh_mh_sacmhs.aspx

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36

EXPENSE REIMBURSEMENT DOCUMENT

MEALS:

- Meals will not be reimbursed for 1 day travel – (must be over night)
- Meals will not be reimbursed within 20 miles of home, receipts must be received per Statute

MILEAGE

- Current mileage rate as of January 1, 2014 is \$.56
- Must live outside of Lincoln (or city meeting is held) to receive reimbursement

LODGING

- Must reside 60 miles or more from meeting location
- Must contact HHS staff for overnight accommodations to ensure government rate and direct billing to the state agency

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37

EXAMPLE OF EXPENSE REIMBURSEMENT DOCUMENT

| SOCIAL SECURITY NUMBER/PTN | | TYPE CODE | STATE OF NEBRASKA NEBRASKA ACCOUNTING SYSTEM | | TRANSACTION TYPE | MEMBER/EMP | DOCUMENT NUMBER | | | |
|---------------------------------------|---|---------------------------------|---|---------|---------------------|----------------|-----------------|---------|--------|--------|
| ADBI | | | EXPENSE REIMBURSEMENT DOCUMENT | | MM | | | | | |
| PAYER NAME Fred Finstone | | | | | MEMBER/EMPLOYEE NO. | EMPLOYEE NO. | PAY DATE | | | |
| PAYER ADDRESS 1264 Flatrock Street | | | DESCRIPTION DHHHS-Division of Behavioral Health August 14, 2014 | | | | | | | |
| CITY Scottsbluff | | STATE ZIP CODE NE 12657 | TOTAL | | | | | | | |
| PAYER PHONE MHI Comm | | HEADQUARTER CITY Scottsbluff | | | | | | | | |
| AUTO OWNER same | | LICENSE NUMBER FFT 123 | | | | | | | | |
| DATE | PARTICULARS | TIME | MEALS | LODGING | TRANSPORTATION | MILEAGE | TOTAL | | | |
| 2014 | | | | | | | | | | |
| 08/14 | Travel to Lincoln for MH-BA-OCA Adv Mtg | 7:00 23:59 | | DB | | \$4 329 182.00 | 182.00 | | | |
| 08/14 | Return to Scottsbluff | 0:00 19:00 | | | | \$4 329 182.00 | 182.00 | | | |
| TOTALS | | | | | | | 364.00 | | | |
| AG | DR | FUND | PRD | SP | ACT | IDENTIFYER | ACCOUNT | DEBIT | CREDIT | |
| | | | | | | 23200172 | 874500 | 364.00 | | |
| | | | | | | | 871100 | | | |
| TOTAL | | | | | | | | | | |
| EXPENSE REIMBURSEMENT CODES | TRC NO. | IS | ES | FUND | PRD | SP | ACT | ACCOUNT | DEBIT | CREDIT |
| | | | | | | | | | | |
| TOTAL | | | | | | | | | | |

EXAMPLE ONLY

(I claim reimbursement from the STATE OF NEBRASKA for the above expenses incurred by me in the line of duty and declare that this is a true account of such expenses for which payment has not previously been made by the STATE OF NEBRASKA.)

Fred Finstone 08/14/2014
EMPLOYEE SIGNATURE () INDEPENDENT CONTRACTOR () OTHER DATE

SUPERVISOR APPROVAL DATE

I hereby certify that the above claim for reimbursement is proper under state statute, and that the claim for mileage, if any, for use of a privately owned vehicle, is authorized according to Section 84-1175.

AUTHORIZED SIGNATURE DATE

Expense Reimbursement Document (0-98) Distribution: Original - DHS Accounting Copies - Agency

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38

Five-Year Prevention Statewide Strategic Plan FY13-FY17

Department of Health and Human Services Division of Behavioral Health

Nebraska's Five Year Strategic Prevention Plan, which began the fall of 2012, supports the DHHS Division of Behavioral Health's overarching strategic goals and focuses statewide prevention efforts on a prioritized set of behaviors. The selection of the Prevention System goals is a data driven process and results of activities can be measured over time to demonstrate the success of state initiatives. These priorities are aligned with those of the Substance Abuse Prevention and Treatment Block Grant (SAPTBG) and utilize the Strategic Prevention Framework. DBH strives to fund evidence based prevention programs and those that designed specifically to promote the reduction of risk factors and processes, and enhancement of protective factors.

Vision

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

Mission

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

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

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

Combined Block Grant Statewide Prevention Goal:

- **Priority Area:** Alcohol Use Among Youth
- **Goal:** Reduce binge drinking among youth up to age 17.
- **Indicator:** Percentage of students in 9th-12th grade who report having five or more drinks on at least one occasion in the past 30 days will decrease to 15%.

Strategic Initiatives:

- **Assessment:** Ensure a sound prevention data surveillance system is in place that reliably measures population-level substance abuse and mental health issues in Nebraska
- **Capacity:** Enhance leadership, infrastructure and workforce at the state and regional levels to support strong prevention coalitions and their volunteer members.
- **Planning:** Ensure data-driven and comprehensive planning at the state, region, and community level.
- **Implementation:** Nebraskans shall have access to effective prevention services that produce measureable outcome and se resources efficiently.
- **Evaluation:** Evaluate all funded prevention initiatives, assess for their effectiveness and seek opportunities for improvement.
- **Reporting and Accountability:** Provide regular reports of progress and accomplishments, as well as lessons learned, and stakeholders.

September 5, 2013

- Nebraska Behavioral Health Services Act [Neb. Rev. Stat. Sections 71-801 to 71-831]
- 71-802 Purposes of act.
 - 71-803 Public behavioral health system; purposes.
 - 71-804 Terms, defined.
 - 71-805 Division; personnel; office of consumer affairs.
 - 71-806 Division; powers and duties; rules and regulations.
 - 71-807 Behavioral health regions; established.
 - 71-808 Regional behavioral health authority; established; regional governing board; matching funds; requirements.
 - 71-809 Regional behavioral health authority; behavioral health services; powers and duties.
 - 71-810 Division; community-based behavioral health services; duties; reduce or discontinue regional center behavioral health services; powers and duties.
 - 71-811 Division; funding; powers and duties.
 - 71-812 Behavioral Health Services Fund; created; use; investment. housing-related assistance
 - 71-814 State Advisory Committee on Mental Health Services
 - 71-815 State Advisory Committee on Substance Abuse Services
 - 71-821 to 71-827 Children and Family Behavioral Health Support Act.
 - 71-822 Children and Family Support Hotline
 - 71-823 Family Navigator Program
 - 71-828 to 71-830 Behavioral Health Workforce Act
 - 71-830 Behavioral Health Education Center

For more details on these statutes go to search of Nebraska laws:

<http://uniweb.legislature.ne.gov/laws/laws.php>

Regulations of the Nebraska Department of Health and Human Services are on line at:

http://dhhs.ne.gov/Pages/reg_regs.aspx

Title 203 -- Substance Abuse Services

Title 204 -- Community Mental Health Programs

Title 206 -- Chapters 1-10 of the Nebraska Administrative Code (NAC) are proposed new regulations for Behavioral Health Services (will replace Title 203 & Title 204)

Chapter 1: Scope and Authority

Chapter 2: Definitions

Chapter 3: Division Administration

Chapter 4: Contracting Requirements

Chapter 5: Requirements for Providers Contracting With RBHA's

Chapter 6: Standards of Care

Chapter 7: Mental Health Board Training

Chapter 8: Notification of Closure of a Behavioral Health Service at a Regional Center

Chapter 9: (Reserved for Peer Support)

Chapter 10: (Reserved for Certification of Peer Specialists)

Attachment: Behavioral Health Adult Service Definitions

Attachment: Financial Eligibility Policy

For more details see: http://dhhs.ne.gov/behavioral_health/Pages/dbhregs82013.aspx

September 5, 2013



Nebraska Division of Behavioral Health Strategic Plan ~ 2011-2015

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.

2011-2015 Goals:

1. 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.
2. 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).
3. The Division of Behavioral Health will reduce reliance on the Lincoln Regional Center for general psychiatric services.
4. An effective system to safely manage sex offenders in outpatient settings will be ready for implementation.

Strategies - The Division Will:

Strategy 1: Insist on Accessibility – Increase access to appropriate and effective integrated behavioral health services, particularly for vulnerable populations.

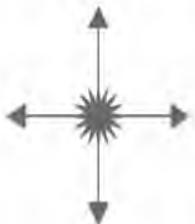
Strategy 2: Demand Quality – Improve the quality of public behavioral health services for children and adults.

Strategy 3: Require Effectiveness – Improve outcomes for children and adults through the use of effective services.

Strategy 4: Promote Cost Efficiency – Develop flexible and balanced funding to support an efficient and accountable person-centered, recovery oriented system of services.

Strategy 5: Create Accountable Relationships – Encourage transparent, accountable relationships with and among system stakeholders.

For more details see: http://dhhs.ne.gov/behavioral_health/Pages/2010BHStrategicPlan.aspx



HELPING PEOPLE LIVE BETTER LIVES



Nebraska Behavioral Health Services Act

Neb. Rev. Stat. §§ 71-801 to 71-830

The Nebraska Behavioral Health Services Act defines **BEHAVIORAL HEALTH DISORDER** as mental illness or alcoholism, drug abuse, or other addictive disorder [§71-804(1); amended per Laws 2013, LB6, § 13. Operative Date: July 1, 2013].

71-813 Repealed. Laws 2006, LB 994, § 162.

(The State Behavioral Health Council created under LB1083/2004 Section 13)

71-814 **STATE ADVISORY COMMITTEE ON MENTAL HEALTH SERVICES**; created; members; duties.

(1) The State Advisory Committee on Mental Health Services is created. Members of the committee shall have a demonstrated interest and commitment and specialized knowledge, experience, or expertise relating to the provision of mental health services in the State of Nebraska. The committee shall consist of twenty-three members appointed by the Governor as follows: (a) One regional governing board member, (b) one regional administrator, (c) twelve consumers of behavioral health services or their family members, (d) two providers of behavioral health services, (e) two representatives from the State Department of Education, including one representative from the Division of Vocational Rehabilitation of the State Department of Education, (f) three representatives from the Department of Health and Human Services representing mental health, social services, and medicaid, (g) one representative from the Nebraska Commission on Law Enforcement and Criminal Justice, and (h) one representative from the Housing Office of the Community and Rural Development Division of the Department of Economic Development.

(2) The committee shall be responsible to the division and shall (a) serve as the state's mental health planning council as required by Public Law 102-321, (b) conduct regular meetings, (c) provide advice and assistance to the division relating to the provision of mental health services in the State of Nebraska, including, but not limited to, the development, implementation, provision, and funding of organized peer support services, (d) promote the interests of consumers and their families, including, but not limited to, their inclusion and involvement in all aspects of services design, planning, implementation, provision, education, evaluation, and research, (e) provide reports as requested by the division, and (f) engage in such other activities as directed or authorized by the division.

Source: Laws 2004, LB 1083, § 14; Laws 2006, LB 994, § 93; Laws 2007, LB296, § 460.

“(2) (a) serve as the state's mental health planning council as required by Public Law 102-321” means ...meet the requirements for the **FEDERAL COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT REQUIREMENTS FOR THE STATE MENTAL HEALTH PLANNING COUNCIL**

Section 1914:

The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.

(b) The duties of the Council are:

- (1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;
- (2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and
- (3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

(A) the principle State agencies with respect to:

- (i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and
- (ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;

(B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;

(C) adults with serious mental illnesses who are receiving (or have received) mental health services; and

(D) the families of such adults or families of children with emotional disturbance.

(2) A condition under subsection (a) for a Council is that:

(A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and

(B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

FEDERAL PUBLIC LAW 102-321

Section 1914. State Mental Health Planning Council

71-815 STATE ADVISORY COMMITTEE ON SUBSTANCE ABUSE SERVICES; created; members; duties.

(1) The State Advisory Committee on Substance Abuse Services is created. Members of the committee shall have a demonstrated interest and commitment and specialized knowledge, experience, or expertise relating to the provision of substance abuse services in the State of Nebraska. The committee shall consist of twelve members appointed by the Governor and shall include at least three consumers of substance abuse services.

(2) The committee shall be responsible to the division and shall (a) conduct regular meetings, (b) provide advice and assistance to the division relating to the provision of substance abuse services in the State of Nebraska, (c) promote the interests of consumers and their families, (d) provide reports as requested by the division, and (e) engage in such other activities as directed or authorized by the division.

Source

Laws 2004, LB 1083, § 15; Laws 2005, LB 551, § 5; Laws 2006, LB 994, § 94.

BY-LAWS FOR THE
STATE ADVISORY COMMITTEE ON MENTAL HEALTH SERVICES
Proposed Amendments – February 3, 2011

Article I – Name of Organization

The name of the organization shall be the State Advisory Committee on Mental Health Services.

Article II – Purpose

Section 1

As provided by Nebraska Revised Statutes section 71-814 the purpose of the Committee is to (a) serve as the state's mental health planning council as required by Public Law 102-321, (b) conduct regular meetings, (c) provide advice and assistance to the division relating to the provision of mental health services in the State of Nebraska, including, but not limited to, the development, implementation, provision, and funding of organized peer support services, (d) promote the interests of consumers and their families, including, but not limited to, their inclusion and involvement in all aspects of services design, planning, implementation, provision, education, evaluation, and research, (e) provide reports as requested by the division, and (f) engage in such other activities as directed or authorized by the division.

The Division means the Division of Behavioral Health within the Nebraska Department of Health and Human Services.

Section 2

“Serve as the state's mental health planning council as required by Public Law 102-321 means meeting the requirements for the State Mental Health Planning Council under the Federal Community Mental Health Services Block Grant. Under Section 1914, the State will establish and maintain a State mental health planning council in accordance with the conditions described in this section. (b) The duties of the Council are:

- (1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans [this refers to the Block Grant Application and Implementation Report];
- (2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and
- (3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

Section 3

MISSION STATEMENT

The Mission of Nebraska State Advisory Committee on Mental Health Services is to identify and advocate for an effective and efficient system of accessible, quality mental health services which enable each individual, on their journey of healing and transformation, to achieve their highest potential.

VISION STATEMENT

The Vision of Nebraska State Advisory Committee on Mental Health Services is to advise and assist the Division as it provides information for all Nebraskans, including consumers, families and the public to understand mental health problems, and to provide the knowledge necessary to access and utilize appropriate services in a timely, effective manner.

BY-LAWS FOR THE
STATE ADVISORY COMMITTEE ON MENTAL HEALTH SERVICES
Proposed Amendments – February 3, 2011

Article III – Membership

Section 1

Appointments: The committee shall consist of twenty-three members appointed by the Governor.

Length of Term: The length of term is as appointed by the Governor.

Section 3

Attendance: A member who has two consecutive unexcused absences shall be contacted by the Division regarding his/her intentions for future participation in the Committee. If the person indicates he/she is not able to participate, the Division shall request he/she formally resign from the Committee. Formal resignation shall be in writing and is to be submitted to the Director of the Division of Behavioral Health. The Division staff will maintain attendance sheet and submit to Chairperson periodically or per request.

Article IV - Voting

Section 1

Quorum: A quorum shall consist of one member more than half of the current members of the Committee. Once established, a quorum shall be deemed to continue throughout the meeting. All Committee business shall be conducted by a simple majority vote of members present at a meeting in which a quorum is established.

Section 2

Conflicts of Interest: A conflict of interest is created through the existence of circumstances where the actions of a member may have an effect of direct financial benefit or detriment to the member, a member of his/her family, employer, business associate, or a business in which the member owns a substantial interest. As soon as the member is aware of a potential conflict of interest (or should reasonably be so aware), the member shall complete the Potential Conflict of Interest Statement Form C-2. The Form shall be submitted to the Nebraska Accountability and Disclosure Commission. The member shall follow all directions as prescribed and advised by the Nebraska Accountability and Disclosure Commission. If a dispute arises as to whether a conflict exists, the chairperson shall direct that the member's vote be disregarded on a given issue until such time as the member is in possession of a written opinion from the Nebraska Accountability and Disclosure Commission. Meeting minutes shall record the name of a member(s), who abstains from voting.

Article V – Officers

Section 1

Selection: Officers of the Committee shall be a Chairperson, Vice-Chairperson and Secretary.

Section 2

Duties: The duties of the Officers shall be:

Chairperson – Preside at all Committee and Executive meetings and:

- (1) Attend annual technical assistance meeting on MH Block Grant

BY-LAWS FOR THE
STATE ADVISORY COMMITTEE ON MENTAL HEALTH SERVICES
Proposed Amendments – February 3, 2011

- (2) Represent Nebraska at the MH Block Grant application review
- (3) Write a letter representing the committee's point of view after reviewing the MH block grant application, to be attached and is due September 1.
- (4) Write a letter after reviewing Mental Health block grant implementation report due December 1
- (5) Perform any other duties designated by the Committee.
- (6) Review attendance report and contact members as needed.

Vice-Chairperson - Shall act for the Chairperson in his/her absence. Shall perform other duties as designated by the Chairpersons or Committee

Secretary – Shall act for the Chairperson and Vice-Chairperson in their absence. Shall perform other duties as designated by the Chairpersons or Committee and is designated to review meeting minutes prior to distribution to committee members.

Section 3

At the fall meeting the committee will select officers for one year. The new officers' term are January 1 through December 31. In the event of a vacancy, the Committee will elect a member to serve the unexpired term of office.

Section 4

Executive Committee: The Executive Committee shall consist of the Chairperson, Vice-Chairperson and Secretary. A Chairperson may call the Executive Committee together with the approval of the Division, at his/her discretion.

Article VI – Meetings

Section 1

Frequency: Meetings of the Committee shall be held regularly.

Section 2

Conduct: Meetings shall be held in accordance with the requirements of the Nebraska Public Meetings Law, Neb. Rev. Stat. sections 84-1408 through 84-1414. Business should be conducted according to Roberts Rules of Order.

Section 3

Notice: The time, date and location of the next meeting should be determined prior to adjournment of the preceding meeting. Notification of the time, date and location of the next meeting shall be sent within two weeks to all members absent from the preceding meeting. Within thirty days, but not less than seven days prior to the next meeting, the Division shall mail a written reminder and meeting agenda to each Committee member at his/her last known official address.

Section 4

Duties of the Division: The Division shall provide an orientation to each new Committee member, produce meeting minutes, maintain records to include attendance record of the Committee, and provide support to the Committee.

BY-LAWS FOR THE
STATE ADVISORY COMMITTEE ON MENTAL HEALTH SERVICES
Proposed Amendments – February 3, 2011

Section 5

Expenses: Committee members shall be reimbursed for actual and necessary expenses in the performance of their duties as provided in Neb. Rev. Stat.sections 81-1174 to 81-1177.

Article VII - Committees

With the written approval of the Division, the Chairperson may appoint or otherwise establish ad-hoc task forces comprised of Committee and non-Committee members to accomplish a specific task which is relevant to the purpose of the Committee. Ad-hoc Committee is defined as including Committee and non-committee members.

Article VIII – Amendments

There shall be a review of the Bylaws a minimum of every three years. A two-thirds majority vote of all Committee members will be required to amend the Bylaws. No Bylaws shall be considered for amendment unless notice of the same shall have been established as part of the meeting agenda, and a copy of the proposed changes has been delivered to members within thirty days, but not less than seven days, prior to the meeting at which the vote will take place.

All alterations, amendments, or new by-laws adopted by the Committee are subject to the approval of the Director of the Division of Behavioral Health or the designated representative for the Director.

Bew Ferguson

Committee Chairperson

5/03/11

Date

BY-LAWS FOR THE
STATE ADVISORY COMMITTEE ON MENTAL HEALTH SERVICES
Proposed Amendments – February 3, 2011

71-814. State Advisory Committee on Mental Health Services; created; members; duties.

(1) The State Advisory Committee on Mental Health Services is created. Members of the committee shall have a demonstrated interest and commitment and specialized knowledge, experience, or expertise relating to the provision of mental health services in the State of Nebraska. The committee shall consist of twenty-three members appointed by the Governor as follows: (a) One regional governing board member, (b) one regional administrator, (c) twelve consumers of behavioral health services or their family members, (d) two providers of behavioral health services, (e) two representatives from the State Department of Education, including one representative from the Division of Vocational Rehabilitation of the State Department of Education, (f) three representatives from the Department of Health and Human Services representing mental health, social services, and Medicaid, (g) one representative from the Nebraska Commission on Law Enforcement and Criminal Justice, and (h) one representative from the Housing Office of the Community and Rural Development Division of the Department of Economic Development.

(2) The committee shall be responsible to the division and shall (a) serve as the state's mental health planning council as required by Public Law 102-321, (b) conduct regular meetings, (c) provide advice and assistance to the Division relating to the provision of mental health services in the State of Nebraska, including, but not limited to, the development, implementation, provision, and funding of organized peer support services, (d) promote the interests of consumers and their families, including, but not limited to, their inclusion and involvement in all aspects of services design, planning, implementation, provision, education, evaluation, and research, (e) provide reports as requested by the Division, and (f) engage in such other activities as directed or authorized by the Division.

Source:

Laws 2004, LB 1083, § 14;

Laws 2006, LB 994, § 93;

Laws 2007, LB296, § 460.

BY-LAWS FOR THE
STATE ADVISORY COMMITTEE ON MENTAL HEALTH SERVICES
Proposed Amendments – February 3, 2011

FEDERAL COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

REQUIREMENTS FOR THE STATE MENTAL HEALTH PLANNING COUNCIL

Section 1914:

The State will establish and maintain a State Mental Health Planning Council in accordance with the conditions described in this section.

(b) The duties of the Council are:

- (1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;
- (2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and
- (3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

(A) the principle State agencies with respect to:

- (i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and
- (ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;

(B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;

(C) adults with serious mental illnesses who are receiving (or have received) mental health services; and

(D) the families of such adults or families of children with emotional disturbance.

(2) A condition under subsection (a) for a Council is that:

(A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and

(B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

BY-LAWS
As Amended April 4, 2011

Article I – Name of Organization

The name of the organization shall be the State Advisory Committee on Substance Abuse Services (SACSAS).

Article II – Purpose

As provided in Nebraska Revised Reissued Statutes Section 71-815, the committee shall be responsible to the Division of Behavioral Health and shall (1) conduct regular meetings, (2) provide advice and assistance to the Division relating to the provision of substance abuse services in the State of Nebraska, (3) promote the interests of consumers and their families, (4) provide reports as requested by the Division, and (5) engage in such other activities as directed or authorized by the Division. (71-815-sec 2)

Article III – Membership

Section 1

Appointments: The committee shall consist of twelve members appointed by the Governor. Members of the committee shall have a demonstrated interest and commitment and specialized knowledge, experience, or expertise relating to the provision of substance abuse services in the State of Nebraska. The committee shall consist of twelve members appointed by the Governor and shall include at least three consumers of substance abuse services. (71-815 sec 1)

Section 2

Length of Term: Four of the initial members appointed by the Governor shall serve for three years. Four of the initial members appointed by the Governor shall serve for two years, and four of the initial members for one year. As the terms of the initial members expire, their successors shall be appointed for terms of three years.

Article IV – Voting

Section 1

Quorum: Seven (7) voting members of the Committee present at any called meeting shall constitute a quorum. Once established, a quorum shall be deemed to continue throughout the meeting. All Committee business shall be conducted by a simple majority vote of members present at a meeting in which a quorum is established.

Section 2

Conflicts of Interest: A conflict of interest is created through the existence of circumstances where the actions of a member may have an effect of direct financial benefit or detriment to the member, a member of his/her family, employer, business

associate, or business in which the member owns a substantial interest. A member shall disclose the conflict to the Committee and abstain from voting on issues on which there is a conflict. Meeting minutes shall record the name of a member(s), who abstains from voting.

Article V – Officers

Section 1

Selection: Officers of the Committee shall be a Chairperson, Vice-Chairperson and Secretary. Initial Officers shall be appointed by the Division of Behavioral Health at the first meeting and will be elected by the Committee annually thereafter. In the event of a vacancy, the Committee will elect a member to serve the unexpired term of office.

Section 2: The duties of the Officers shall be:

Chairperson – Preside at all Committee and Executive meetings and perform any other duties designated by the Committee.

Vice-Chairperson – Shall act for the Chairperson in his/her absence.

Second Vice Chairperson – Shall act for the Chairperson and Vice-Chairperson in their absence. Shall perform other duties as designated by the Chairperson or Committee.

Section 3

Term: At any time that a member cannot complete the term of office a new election shall be held to fill the vacancy.

Section 4

Executive Committee: The Executive Committee shall consist of the Chairperson, Vice-Chairperson and Second Vice Chairperson. A Chairperson may call the Executive Committee together with the agreement of the Division at his/her discretion.

Article VI – Meetings

Section 1

Frequency: Meetings of the Committee shall be held regularly.

Section 2

Conduct: Meetings shall be held in accordance with the requirements of the Nebraska Public Meetings Law, Neb. Rev. State. Sections 84-1408 through 84-1414. Business should be conducted according to Roberts Rules of Order.

Section 3

Notice: The time, date and location of the next meeting should be determined prior to adjournment of the preceding meeting. Notification of the time, date and location of the next meeting shall be sent within two weeks to all members absent from the preceding meeting. Within thirty days, but not less than seven days prior to the next meeting, the Division shall mail a written reminder and meeting agenda to each Committee member at his/her last known official address. Public Notice of Committee meetings and agendas shall be made by posting to the State of Nebraska Public Meetings Calendar on the internet.

Section 4

Duties of the Division: The Division of Behavioral Health shall provide an orientation to each new Committee member, produce meeting minutes, maintain records of the Committee, and provide secretarial support to the Committee.

Section 5

Expenses: Committee members shall be reimbursed for actual and necessary expenses in the performance of their duties as provided in Neb. Rev. State. Sections 81-1174 through 81-1177.

Article VII – Committees

With the written agreement of the Division, the Chairperson may appoint or otherwise establish ad-hoc task forces comprised of Committee and non-committee members to accomplish a specific task which is relevant to the purpose of the Committee.

Article VIII – Amendments

There shall be a review of the Bylaws a minimum of every three years. A two-thirds majority vote of all Committee members will be required to amend the Bylaws. No Bylaws shall be considered for amendment unless notice of the same shall have been established as part of the meeting agenda, and a copy of the proposed changes has been mailed to members within thirty days, but not less than seven days, prior to the meeting at which the vote will take place.

All alterations, amendments, or new by-laws adopted by the Committee are subject to the approval of the Director of the Division of Behavioral Health or the designated representative for the Director.



Committee Chairperson

5/3/2011

Date

71-815 State Advisory Committee on Substance Abuse Services; created; members; duties.

(1) The State Advisory Committee on Substance Abuse Services is created. Members of the committee shall have a demonstrated interest and commitment and specialized knowledge, experience, or expertise relating to the provision of substance abuse services in the State of Nebraska. The committee shall consist of twelve members appointed by the Governor and shall include at least three consumers of substance abuse services.

(2) The committee shall be responsible to the division and shall

- (a) conduct regular meetings,
- (b) provide advice and assistance to the division relating to the provision of substance abuse services in the State of Nebraska,
- (c) promote the interests of consumers and their families,
- (d) provide reports as requested by the division, and
- (e) engage in such other activities as directed or authorized by the division.

Source Laws 2004, LB 1083, § 15; Laws 2005, LB 551, § 5; Laws 2006, LB 994, § 94.

STATE ADVISORY COMMITTEE ON MENTAL HEALTH SERVICES

| First Name | Last Name | Representation |
|-------------------|------------------|--|
| Mickey | Adler | Consumer/Region 5 |
| Adria | Bace | Dept. of Education, Special Populations/Region 5 |
| Karla | Bennetts | Family of Consumer/Region 3 |
| Cindy | Buesing | DHHS Admin., Medicaid & Long term Care/Region 5 |
| Sheri | Dawson | DHHS Admin., Div. Behavioral Health/Region 5 |
| Bev | Ferguson | Family of Consumer/Region 4 |
| Kathleen | Hanson | Consumer/Region 5 |
| Brad | Hoefs | Consumer/Region 6 |
| Jette | Hogenmiller | Family of Consumer/Region 6 |
| Lara | Huskey | DHHS Admin., Div. Econ. Dev., Housing/Region 5 |
| Patti | Jurjevich | Regional Program Administrator/Region 6 |
| Linda | Krutz | Nebraska Crime Commission/Region 5 |
| Jerry | McCallum | Regional Governing Board/Region 4 |
| Phyllis | McCaul | Family of Consumer/Region 5 |
| Kasey | Moyer | Family of Consumer & Provider/Region 5 |
| Ashley | Pankonin | Family of Consumer/Region 2 |
| Rachel | Pinkerton | Family of Consumer & Provider/Region 6 |
| Joel | Schneider | Consumer/Region 6 |
| Jill | Schreck | DHHS, Dept. of Children & Family Services/Region 5 |
| Mark | Schultz | State Vocational Rehabilitation/Region 5 |
| Mary | Thunker | Consumer/Region 6 |
| Diana | Waggoner | Family of Consumer/Region 6 |
| Cameron | White | Provider, Dept. of Corrections/Region 5 |

STATE ADVISORY COMMITTEE ON SUBSTANCE ABUSE SERVICES

| First Name | Last Name | Representation |
|-------------------|------------------|--|
| Sheri | Dawson | DHHS Admin., Div. Behavioral Health/Region 5 |
| Ann | Ebsen | Sarpy Co. MH Commitment Board/Region 6 |
| Ingrid | Gansebom | Regional Administrator/Region 4 |
| Paige | Hruza | Consumer/Region 6 |
| Jay | Jackson | Consumer & Provider/Region 4 |
| Janet | Johnson | Provider/Region 5 |
| Dusty | Lord | Provider/Region 5 |
| Kimberley | Mundil | Regional West Medical Center/Region 1 |
| Michael | Phillips | Provider/Region 5 |
| Randy | See | Dept. of Corrections/Region 3 |
| Todd | Stull | Provider/Region 6 |
| Mary | Wernke | Family of Consumer/Region 1 |

**Nebraska Division of Behavioral Health – Joint Meeting
 State Advisory Committee on Mental Health Services (§71-814)
 State Advisory Committee on Substance Abuse Services (§ 71-815)**

May 8, 2014

Country Inn and Suites, 5353 No. 27th Street, Lincoln, NE 68521

- | | | | |
|-------|---|--|--|
| I. | Open Meeting – 9:00 a.m. Welcome Quorum for Committees – Open Meetings Law Attendance – Determination of Quorum of Committees Housekeeping Comments on Meeting Minutes: February 13, 2014 For Mental Health Committee For Substance Abuse Committee | Call to Order Inform Roll Call Inform | Heather Wood Heather Wood Pat Roberts Heather Wood Gen Consent Diana Waggoner, Chairperson Ann Ebsen, Chairperson |
| II. | Public Comment – 9:15 am a. Each person wishing to speak at the meeting needs to sign up on the Public Comment Sign-in Sheet. b. Each person will be called on from the Public Comment Sign-In Sheet. Each person may have five (5) minutes (unless the Chair grants more time) to provide comments. c. Public comments not provided verbally may be sent to the Division of Behavioral Health, Attention: Pat Roberts. | | |
| III. | Legislative Update | | Sheri Dawson |
| IV. | System of Care Update – Status of Planning Grant | | Sheri Dawson |
| | Break | | |
| V. | Prevention Advisory Council | | Heather Wood |
| VI. | PATH Grant | | Nancy Heller |
| | Lunch-Peer Support Survey | | |
| VII. | Block Grant Update | | Karen Harker |
| | <i>Break into MH and SA Committees</i> | | |
| VIII. | SACMHS and SACSAS By-Laws | | Chairs/Moderators |
| | Break | | |
| IX. | Public Comments – 3:15 p.m. | | Chairpersons |
| X. | Adjourn | | Chairpersons |

Nebraska Division of Behavioral Health
Joint Committee Meeting
State Advisory Committee on Mental Health Services (SACMHS)
State Advisory Committee on Substance Abuse Services (SACSAS)

May 8, 2014 / 9:00 am – 4:00 pm
Lincoln, NE – Country Inn & Suites

Meeting Minutes

I. Call to Order and Roll Call

Heather Wood

Heather Wood, Division of Behavioral Health Advisory Committee Facilitator, called the meeting to order and welcomed committee members and others present to the meeting. Roll call was conducted and a quorum was determined for the State Advisory Committee on Mental Health Services and the State Advisory Committee on Substance Abuse Services.

State Advisory Committee on Mental Health Services Attending: Adria Bace; Cynthia Brammeier; Sheri Dawson; Brad Hoefs; Lara Huskey; Linda Krutz; Jerry McCallum; Phyllis McCaul; Rachel Pinkerton; Joel Schneider; Mark Schultz; Diana Waggoner; Cameron White.

State Advisory Committee on Mental Health Services Absent: Karla Bennetts; Bev Ferguson; Kathleen Hanson; Jette Hogenmiller; Patti Jurjevich; Kasey Moyer; Ashley Pankonin; Jill Schreck; Mary Thunker.

State Advisory Committee on Substance Abuse Services Attending: Sheri Dawson; Ann Ebsen; Ingrid Gansebom; Jay Jackson; Delinda Mercer; Kimberley Mundil; Michael Phillips; Jorge Rodriguez-Sierra; Randy See.

State Advisory Committee on Substance Abuse Services Absent: Paige Hruza; Janet Johnson; Dusty Lord.

II. Housekeeping and Summary of Agenda

Heather Wood

(Attachment A)

Heather Wood provided housekeeping/logistics reminders and confirmed the order of the agenda.

III. Approval of Minutes

Heather Wood

Heather Wood asked for comments on, or approval of, the February 13, 2014 minutes of the Joint State Advisory Committee on Mental Health Services and the State Advisory Committee on Substance Abuse Services. No comments/edits were offered each committee approved the respective minutes.

Action: The Mental Health Committee motioned for the minutes to be approved: Adria Bace-Yes; Cynthia Brammeier-Yes; Sheri Dawson-Yes; Brad Hoefs-Yes; Lara Huskey-Yes; Linda Krutz-Yes; Jerry McCallum-Yes; Phyllis McCaul-Yes; Rachel Pinkerton-Yes; Joel Schneider-Yes; Mark Schultz-Yes; Diana Waggoner-Yes; Cameron White-Yes. Motion was approved

The Substance Abuse Committee motioned for the minutes to be approved: Sheri Dawson-Yes; Ann Ebsen-Yes; Ingrid Gansebom-Yes; Jay Jackson-Yes; Delinda Mercer-Yes; Kimberley Mundil-Yes; Michael Phillips-Yes; Jorge Rodriguez-Sierra-Yes; Randy See-Yes. Motioned was approved.

Diana Waggoner, Chairperson of the State Advisory Committee on Mental Health Services, commented that over the last 10 years there are more programs available to serve the community with urgency for early intervention and prevention. A growing concern is the suicide rate of individuals 50 years and older, as well as returning veterans is higher.

Ann Ebsen, Chairperson of the State Advisory Committee on Substance Abuse Services, had no additional information to share at this time.

IV. Public Comment

James Russell with the Returning Veterans Network, commented that there is a veteran that dies every 20 minutes from suicide. He noted the Guard Reserve Troops are more apt to commit suicide than the regular army. Our service members and veterans need access to services. Legalized marijuana in Colorado is going to cause a problem for the state of Nebraska. He recommends the state ask for grants to support the additional cost for the law enforcement and mental health services.

V. Legislative Updates

Sheri Dawson

(Attachment B)

Sheri Dawson, Division of Behavioral Health Deputy Director, provided updates on several Legislative Bills and other topics of interest within the Division of Behavioral Health (DBH). Additional information and bill updates can be found at the following website link: <http://nebraskalegislature.gov/bills/>.

***LB901** (originally this was **LB931**): establish Mental Health First Aid Training. Regions are responsible for conducting the training. The evaluation report is submitted to the Legislature.

- Joel Schneider will be attending the MH First Aid training being offered in Kearney and volunteered to present on his experience at the next Advisory Meeting.

***LB905**: restored the \$10 million that was proposed to be cut.

***LB907**: criminal history background checks.

- criminal history checks will be completed after an applicant is determined to possess the qualifications necessary to become a candidate for the position.

***LB974**: provide duties for divisions of the Department of Health and Human Services related to budgeting and strategic planning.

- DBH will assess its current Strategic Plan and update as necessary, and will focus on priorities for the next biennium.

***LB699**: The NE State Patrol (NSP) is required to report to the Legislature on indicators of success of data transmission to the National Instant Criminal Background Check System (NICS); DBH has reported information to NSP for several years; the NSP gets information for the NICS from several sources.

***LB429**: contracts will be accessible on the Department of Administrative Services website.

***LB260**: indefinitely postponed; provided for cleaning up required language for data reporting.

*The Mental Health and the Substance Abuse block grants both increased; a new requirement includes 5% be set aside in the Mental Health block grant to fund Evidenced Based Practices for young adults and adults with early onset/early Serious Mental Illness.

**Response to Committee questions/comments included:

*The committee was appreciative and felt that it was very informative to receive the Legislative Bills pertaining to Mental Health and Substance Abuse.

Committee member inquired on the status of **LB1027** and **LB1035** Sheri Dawson completed the research

- **LB1027** was indefinitely postponed on April 17, 2014
- **LB1035** was indefinitely postponed on April 17, 2014. However, portions were amended into **LB699** by **AM2234** on April 23, 2014.

***LR535** was passed to complete an interim study of the structure of DHHS.

***LB464** was approved by the governor on April 15 with amended portions **AM2687** added on April 23 from **LB1093**. LB464 eliminated the Truancy Intervention Task Force, replacing it with a newly created Council of Student Attendance.

- Membership is defined on p.27, 79-527.01 as
 - (i) A member of a school board in any class of school district to be appointed by the State Board of Education;

- (ii) Two parents not related to each other who have children attending school in this state to be appointed by the State Board of Education;
- (iii) A superintendent or his or her designee of a school district to be appointed by the State Board of Education;
- (iv) A student attending a public school in this state to be appointed by the State Board of Education;
- (v) A representative of a community or advocacy organization to be appointed by the State Board of Education;
- (vi) A county attorney to be appointed by the State Board of Education;
- (vii) The probation administrator or his or her designee;
- (viii) The Commissioner of Education or his or her designee; and
- (ix) The chief executive officer of the Department of Health and Human Services or his or her designee.

VI. System of Care – Status of Care Update

Sheri Dawson

(Attachment C)

Sheri Dawson, Division of Behavioral Health Deputy Director, stated 200 to 250 individuals participated in the large stakeholder meeting. Sheri invited anyone who would like to attend the System of Care Stakeholder Town Hall Meeting to register at <https://www.surveymonkey.com/s/soctownhall>. Feedback on the strategic plan is welcome until May 30, 2014. Go to http://dhhs.ne.gov/behavioral_health/Pages/beh_systemofcare.aspx.

VII. Prevention Advisory Council

Heather Wood

(Attachment D)

Heather Wood, Quality Improvement and Data Performance Administrator, shared an overview of the first Prevention Advisory Council meeting on behalf of Renee Faber.

Heather introduced David DeVries, Epidemiologist Surveillance Coordinator who has joined the DBH staff.

****Response to Committee questions/comments included:**

- Recommended the concerns of legalized marijuana that were mentioned previously would be discussed at a future Prevention Advisory Council.
- Committee member asked about websites that provide information on the harmful effects of marijuana use. The following suggestions for additional information were presented:
 - Google
 - SAMSHA website
 - National Institute of Drug Abuse
 - NIT – Documentary

Jorge Rodriguez-Sierra recommended, 'Whereas an increase of drugs originating from the State of Colorado has created a social and financial strain to our state; we recommend that DHHS (and other state units) give relief to the communities affected by this emergency'. Randy See seconded the recommendation.

Action: The Substance Abuse Committee voted: Sheri Dawson-Yes; Ann Ebsen-Yes; Ingrid Gansebom-Yes; Jay Jackson-Yes; Delinda Mercer-Yes; Kimberley Mundil-Yes; Michael Phillips-Yes; Jorge Rodriguez-Sierra-Yes; Randy See-Yes. Motion approved.

After further discussion the committee voted to rescind the recommendation so further discussion could be held at the next meeting. Jorge motioned to rescind the recommendation and was seconded by Randy See.

Action: The Substance Abuse Committee motioned for the minutes to be approved: Sheri Dawson-Yes; Ann Ebsen-Yes; Ingrid Gansebom-Yes; Jay Jackson-Yes; Delinda Mercer-Yes; Kimberley Mundil-Yes; Michael Phillips-Yes; Jorge Rodriguez-Sierra-Yes; Randy See-Yes. Motion was approved.

VIII. PATH Grant

Nancy Heller

(Attachment E)

Nancy Heller, DBH Program Specialist, reviewed the Projects for Assistance Through Homelessness (PATH) Grant handout.

** Committee comments included:

* Rural areas struggle with adequate and affordable housing. The total number of vacancies doesn't tell the entire story because vacancies are not always in areas where housing is needed.

*While representing a reduction in the number of homeless individuals, funding is frequently taken from other housing programs to fund public housing projects.

** Response to Committee questions/comments included:

*The Housing First model has proven to be a success.

*Nebraska needs to consider funding homeless prevention activities.

*Licenses are required for each individual entering data into the HMIS, which can use up funding.

*It is possible to track most individuals over time to determine whether or not the individual remained housed or if he/she returned to homelessness, but it requires specific data reports.

*Funding for this Grant is important because mainstream services aren't able to serve this population. The Outreach component is vital for reaching individuals who are homeless.

*The funding assigned to the Regions has evolved over the years, and is dispersed according to the needs across the State.

*Through HMIS, there is not currently a way to track an individual who leaves a PATH service and receives other services from another Provider.

*There is no way to know for certain if an individual relocates to another location, or if they relapsed from services and back into homelessness.

*Outreach workers keep records on individuals contacted, but it is not considered a success unless they are enrolled in services.

IX. Working Lunch – Peer Support Survey

Carol Coussons de Reyes/Maya Chilese

(Attachment F – J)

Maya Chilese, DBH Program Manager presented the data of the Peer Support Survey. The data represents provider information only. More data will be available later.

Carol Coussons de Reyes, Office of Consumer Affairs Administrator reviewed the barriers and challenges of Peer Support Services in Nebraska.

X. Block Grant Update

Karen Harker

(Attachment K)

Karen Harker, DBH Federal & Fiscal Performance Administrator, reviewed the Block Grant Update. Last September Karen provided the committees with FY2014 budget. Since then a new requirement that 5% of the Block Grant be used for youth and young adult Evidence Based Practices (EBP) for early onset/early Serious Mental Illness. The money received in FY2014 will be spent in FY2015.

**Responses to questions/comments included:

*More information on specific guidelines will be available after a webinar scheduled for May 12. There is a concern about ability to meet the requirement given the small amount of funding for the

*The EBP identified for the target population of youth after initial onset of psychosis is Coordinated Specialty Care model, which is similar in many ways to Assertive Community Treatment for adults.

*A plan for implementation is due May 29, 2014.

*Capacity and sustainability is a concern for any service that may be expanded or established as a part of this set aside.

*It may be possible to combine the set aside with other sources such as 4E Waiver.

*The suggested EBP wraps services around a youth to assist them much as ACT wraps services around adults and allowed them to be successful in non-residential based treatment.

XI. Mental Health By-Laws *Sue Adams/Diana Waggoner*

(Attachment L and M)

The Mental Health Committee began at 1:15 p.m. reviewing and discussed potential changes in the by-laws. Separate committee meeting ended at 3:00 p.m., returned to joint committee.

XII. Substance Abuse By-Laws *Heather Woods/Ann Ebsen*

(Attachment L and N)

The Substance Abuse Committee began at 1:15 p.m. reviewing all by-laws and moved to approve by Jorge Rodriguez and seconded by Randy See.

Action: The Substance Abuse Committee voted and approved the changes proposed to the by-laws: Sheri Dawson-Yes; Ann Ebsen-Yes; Ingrid Gansebom-Yes; Jay Jackson-Yes; Delinda Mercer-Yes; Kimberley Mundil-Yes; Michael Phillips-Yes; Jorge Rodriguez-Sierra-Yes; Randy See-Yes.

Separate committee meeting ended at 3:00 p.m., returned to joint committee.

XIII. Public Comment

No public comment was offered.

XIV. Committee Comments and Future Agenda Items *all*

Future Agenda Items include:

- Impact of State resources resulting from legalization of marijuana in neighboring States
- Mental Health First Aid Training

Plus/Delta of today's meeting:

- Plus = Appreciate the great discussions on topics of concerns
- The process of requiring motions needs some work but today it allowed a well-rounded discussion.

XV. Adjournment and next meeting

- The meeting adjourned at 3:58 p.m.
- The next meeting is a Joint Meeting of the State Advisory Committee on Mental Health Services and the State Advisory Committee on Substance Abuse Services and is scheduled for Thursday, August 14, 2014. from 9:00 am to 4:00 pm. The format for the meeting is the Committees will meet jointly in the morning, and meet separately in the afternoon.

Legislative Report
Nebraska Unicameral Actions of Note
May 8, 2014

- LB 905 (Speaker Adams, deficit appropriations bill): Appropriate an additional \$10 million to Behavioral Health Aid.
- LB 999 (Ashford) DBH is required to prepare a program statement for the Hastings Correctional Behavioral Health Treatment Center (HRC) to plan for the long-term needs of mentally ill inmates.
- LB 901 (McGill) DBH is required to establish a mental health first aid training. (Originally this was LB 931-Bolz, it was amended into LB 901). Pass through to Regions. BHECN and DBH referenced with no purpose.
- LB 974 (Mello) DBH is required to develop a strategic plan. DBH has one – 2011-15.
- LB 699 (Larson) DBH and NSP are required biannually information relating to firearms. We do.
- LB907 (Ashford) Ban the box criminal history background checks.
- LB429 (Crawford)(2013) All contracts on DAS website.

Other Issues Holding Legislative Potential

- LB260 dies.
- \$5M reduction in services begins July 1 and will be mitigated.
- Federal block grants both increased; 5% set aside in MHBG.

**NEBRASKA SYSTEM OF CARE
PLANNING PROJECT**
Planning for Transformation through Partnership



STAKEHOLDER TOWN HALL

Featuring Draft Strategic Plan Review

Wednesday May 14, 2014

Country Inn & Suites

**Nebraska Ballroom (South Entrance)
5353 N. 27th Street, Lincoln, NE**

Registration Required!

Go to this link to register:

<https://www.surveymonkey.com/s/soctownhall>

Two identical sessions offered! Plan to attend one!

9:00 AM – Noon CDT, or

1:00 PM – 4:00 PM CDT

Send questions to: dhhs.soc@nebraska.gov

Visit the System of Care web site at: <http://www.dhhs.ne.gov/soc>

**Nebraska Department of Health and Human Services
Divisions of Behavioral Health and Children & Family Services**

Prevention Advisory Council (PAC) kickoff and Partnership for Success (PFS) Orientation
March 27, 2014 ~ Country Inn and Suites, Lincoln, NE

Nikki introduced the purpose of the PAC and objectives of the PFS

- Charter was shared
- 11 Prevention Advisory Council members in attendance.
- Next Steps
 - Invite 2 additional members to join PAC
 - Bring together leadership and partners for workgroups

General Overview of the day:

The PFS grant is based on the premise that changes at the community level will, over time, lead to measurable changes at the state level. By working together at the state, regional and local level to foster change, funded communities of high need can more effectively begin to overcome the challenges underlying their substance abuse prevention priorities and achieve the prioritized goal of preventing underage age drinking among 12-20 year olds.

- Renee discussed expectations of the grant and made clarification on frequently asked questions.
 - The PFS requires the implementation evidence-based programs, practices, and policies (EBPP). **Evidence-based** refers to a set of prevention activities that evaluation research has shown to be effective and one that has been included in one or more of the three categories:
 - Included in Federal registries of evidence-based interventions;
 - Reported (with positive effects on the primary targeted outcome) in peer-reviewed journals; or
 - Documented effectiveness supported by other sources of information and the consensus judgment of informed experts.
 - Unallowable expenses, such as promotional items, and parameters for use of media were reviewed.
 - Reminder: Year 1 ends September 30, 2014.
- Evaluator Mindy Anderson-Knott gave a data presentation to give some context for the work we are embarking on
- Renee spoke about the use of media and the importance of prevention efforts
 - Lane Grindle of Husker Sports Marketing presented the State-level media campaign and gave options for coalition campaigns
 - The logo that will brand our campaign was voted upon and selected.
 - This logo will be featured during the Spring Game and on the drug free pledge cards
- Bob gave an Nebraska Prevention Information Reporting System (NPIRS) demonstration to help make data entry into our prevention data system more accurate and consistent
 - All PFS funded activities must be entered into NPIRS using the designated label of “PFS grant” in the required funding source question.
- Mindy then spoke about the state and local evaluation process.
 - She also discussed how she plans to begin local evaluation planning
- Nikki presented training and TA opportunities and took suggestions for further training
- We have 2 Substance Abuse Prevention Skills Trainings (SAPST) planned
 - April in Omaha
 - October in Kearney

- 44 total attendees representing:
 - 5 of 6 RBHA's
 - Juvenile Probation
 - Dept of Ed
 - Tobacco Free NE
 - DBH
 - UNL
 - UNMC
 - Members of the SEOW

- Coalitions represented were:
 - Box Butte County Family Focus Coalition
 - Monument Prevention Coalition
 - Project Extra Mile
 - Lancaster Prevention Coalition
 - East Central District Health Dept
 - Elkhorn Logan Valley Public Health Dept
 - UNMC – Health Disparities
 - Grand Island Substance Abuse Prevention Coalition
 - Omaha collegiate Consortium
 - Nebraska Urban Indian Health Coalition
 - LiveWise Coalition
 - ASAAP

Joint SACMHS-SACSAS Committee – May 8, 2014

Projects for Assistance in Transition from Homelessness (PATH)

- ❖ PATH was created as part of the Stewart B. McKinney Homeless Assistance Amendments Act of 1990.
- ❖ The PATH program is administered by the Center for Mental Health Services, a component of the Substance Abuse and Mental Health Services Administration (SAMHSA), within the U.S. Department of Health and Human Services.
- ❖ PATH is a formula grant to the 50 states, the District of Columbia, Puerto Rico, and four U.S. Territories. *Nebraska currently receives \$300,000 per year.*
- ❖ PATH services are for people with serious mental illness, including those with co-occurring substance use disorders, who are experiencing homelessness or at imminent risk of becoming homeless. PATH services include street outreach, case management, and screening and referral for appropriate services, such as housing, primary healthcare, job training, education, and other services not supported by mainstream mental health programs. Street Outreach and Case Management are services required by PATH to be provided.
- ❖ Focus of Street Outreach = develop a relationship with an individual to assist him/her move toward readiness for change.
- ❖ Focus of Case Management = access to housing and maintenance services.
- ❖ PATH emphasizes three of SAMHSA's eight Strategic Initiatives: #3-Military Families, #4-Recovery Support, and #6-Health Information Technology.
- ❖ The PATH Program adheres to the Substance Abuse and Mental Health Services Administration's (SAMHSA) Recovery Support Strategic Initiative that delineates four major dimensions that support a life in recovery: Health, Home, Purpose, and Community. The Nebraska PATH Program focuses on connecting individuals experiencing homelessness with the services necessary for recovery support, primarily finding a place to call home and addressing behavioral and medical healthcare needs.

Organizations to Receive Funds for FY2014 (October 1, 2013 – September 30, 2014)

A. Cirrus House

1. Service Area: Western Nebraska – **Region 1**; Scottsbluff; Scotts Bluff County
 2. Primary service(s) provided: Case Management
 3. PATH Funds Received: \$11,333
 4. Required Matching Funds (non-federal/local): \$3,778
 5. Number of Individuals Contacted (FY2013): 36*
 6. Number of Individuals Served/Enrolled (FY2013): 36*
- *All individuals contacted by Cirrus House are enrolled and receive services via PATH funds.

B. Goodwill Industries of Greater Nebraska, Inc.

1. Service Area: Central Nebraska – **Region 3**; Grand Island; Hall County
2. Primary service(s) provided: Street Outreach and Case Management
3. PATH Funds Received: \$11,333
4. Required Matching Funds (non-federal/local): \$3,778
5. Number of Individuals Contacted (FY2013): 21
6. Number of Individuals Served/Enrolled (FY2013): 12

C. CenterPointe, Inc.

1. Service Area: Southeast Nebraska – **Region 5**; Lincoln; Lancaster County
2. Primary service(s) provided: Street Outreach and Case Management
3. PATH Funds Received: \$65,000
4. Required Matching Funds (non-federal/local): \$21,666
5. Number of Individuals Contacted (FY2013): 34
6. Number of Individuals Served/Enrolled (FY2013): 16

D. Community Alliance Rehabilitation Services

1. Service Area: Eastern Nebraska – **Region 6**; Omaha; Douglas County
2. Primary service(s) provided: Street Outreach and Case Management
3. PATH Funds Received: \$200,334
4. Required Matching Funds (non-federal/local): \$66,778
5. Number of Individuals Contacted (FY2013): 180
6. Number of Individuals Served/Enrolled (FY2013): 101

Data Reporting—Homeless Management Information System (HMIS):

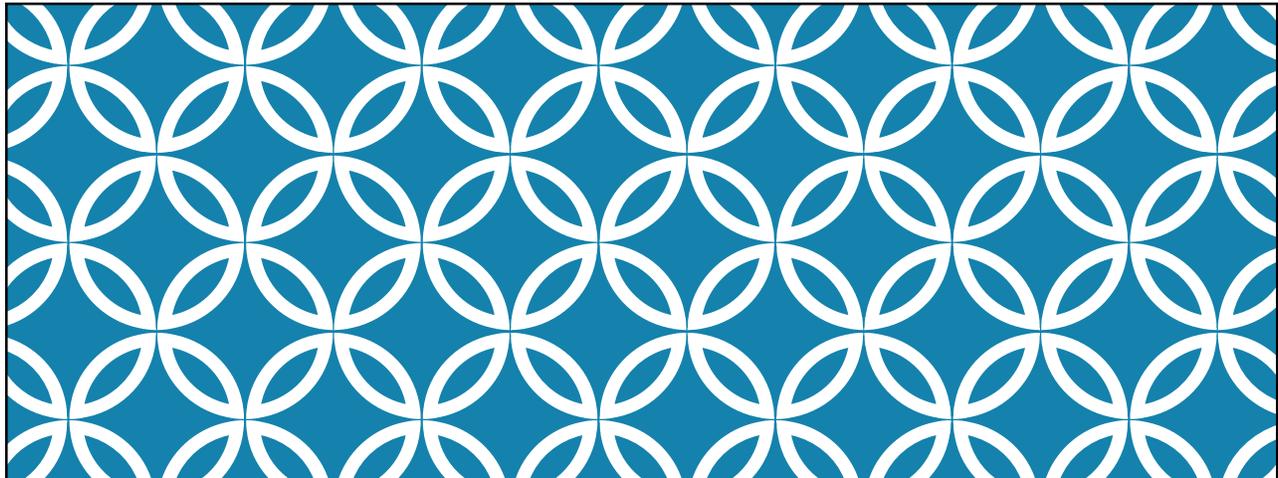
- ❖ Oversight of the HMIS in Nebraska is currently accomplished by the Nebraska Homeless Assistance Program (NHAP) within the DHHS-Division of Children and Family Services.
- ❖ PATH plans to fully implement a HMIS in all States in 2016. All Nebraska providers currently collect housing and homeless related data via ServicePoint.
- ❖ Challenges as we move forward:
 - ✓ *Costs associated with full implementation of a HMIS (i.e., administrative and licensing fees for ServicePoint.*
 - ✓ *HMIS provides only aggregated data and no client-level data.*
 - ✓ *An individual can refuse to give any or all of their personal information—which will skew data and actual numbers of individuals being served.*
 - ✓ *PATH data used to monitor and improve services*
- ❖ PATH Annual Data Reporting—once the HMIS is fully implemented, providers will enter data into the HMIS throughout the year and it will automatically populate the Annual Data Reporting requirements, which is intended to eliminate the need for duplicate data entry.

Moving Forward – SAMHSA’s Focus for PATH services

- ❖ PATH providers involved in homelessness Prevention activities.
- ❖ PATH providers using Evidenced-Based Practices in PATH services.
- ❖ PATH programs collaboration with related resources in the community (are individuals being connected to the services they need, i.e., mental health, co-occurring, housing, healthcare, etc.?)
- ❖ SSI/SSDI Outreach, Access, and Recovery (SOAR) for people who are homeless—connecting PATH and SOAR.

Important considerations for PATH

- ❖ Housing is necessary for Recovery
- ❖ Access to Housing allows access to Healthcare



PEER SUPPORT SERVICES SURVEY

Division of Behavioral Health
April 2014

PEER SUPPORT SURVEY

- As many are aware, the field of 'peer support' is growing nationwide and right here in Nebraska. Peer Support Services are generally described as services and supports provided by individuals with lived experience of behavioral health challenges to other adults and families with children experiencing behavioral health challenges.
- *"Peer support represents one of the strongest and most likely sources of long term recovery for most people and is also underdeveloped in Nebraska."*

– Dr. Scot Adams, DHHS Division of Behavioral Health Director

PEER SUPPORT SURVEY

- ❖ Purpose: To learn more about what Peer Support Services may exist in Nebraska, what opportunities and barriers may exist to providing them and perspectives about the ongoing development and growth of peer support.
- ❖ Method: Survey Monkey online survey tool
- ❖ Distribution: Sent via email invitation and posted to DHHS website
- ❖ Target Audience: Consumers/Stakeholders, Behavioral Health Providers and Peer Support Providers
- ❖ Total Participation:
 - ❖ Consumer/Stakeholder Survey – 25
 - ❖ Behavioral Health Provider/Peer Support Provider - 137

DISCLAIMERS

- ❖ This is a preliminary preview of the survey data, with a more detailed analysis yet to be completed.
- ❖ This presentation includes ONLY Provider response data, not Consumer/Stakeholder response data.
- ❖ Numbers (and Percentages) represent the number of survey respondents, not the number of agencies.
- ❖ Limited understanding of peer support services may have resulted in variance in responses.
- ❖ Most respondents indicated also providing peer support services, which may suggest bias in interest and support.

TOTAL PROVIDER SURVEY RESPONSE RATE = 137

| Region | Peer Agency | BH Agency |
|-------------------|-------------|-----------|
| 1 | 1 | 5 |
| 2 | 3 | 1 |
| 3 | 6 | 13 |
| 4 | 6 | 9 |
| 5 | 25 | 13 |
| 6 | 19 | 36 |
| Sub-Total: | 60 | 77 |
| Total: | 137 | |

PROVIDER (BH AND PEER) DEMOGRAPHICS

| Population Served | Peer Agency* | BH Agency* |
|------------------------|--------------|------------|
| Mental Health | 51 | 63 |
| Substance Abuse | 38 | 50 |
| Co-Occurring Disorders | 48 | 64 |
| Adults (19+) | 49 | 68 |
| Children (0-18) | 22 | 21 |
| Adolescents (19-24) | 24 | 28 |
| Families with Children | 38 | 29 |

* Total number of survey respondents for each response choice

QUESTIONS ABOUT BARRIERS OR INCENTIVES FOR THE CAPACITY TO PROVIDE PEER SUPPORT SERVICES

- Question: Please indicate what barriers or challenges might agencies encounter related to providing peer support services. Please choose all that apply:
- Question: Please indicate what resources or incentives might you suggest as potentially beneficial to increase the capacity of agencies to provide peer support services. Please choose all that apply:

Response options (check all that apply) were broadly defined categories of peer support services.

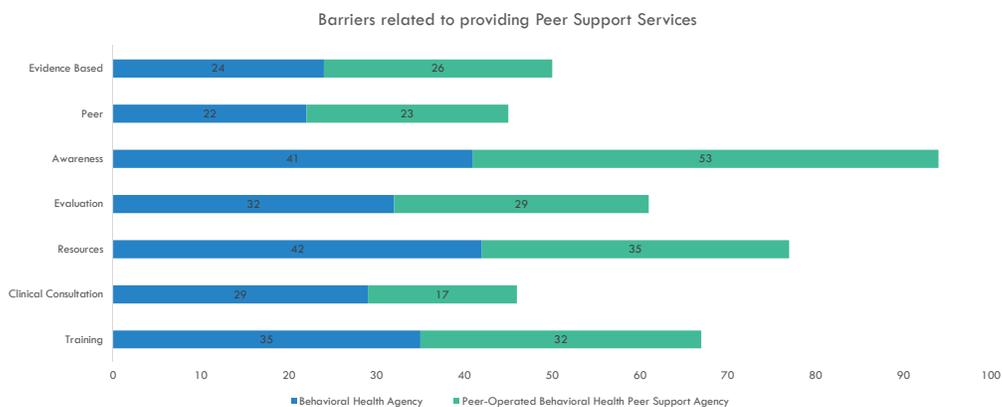
BARRIERS OR CHALLENGES TO PROVIDING PEER SUPPORT SERVICES

| Category | Barrier/Challenge Definition |
|-----------------------|---|
| Evidence-Based | Lack of capacity to implement evidence based peer support programs |
| Peer | Limited availability of certified and/or sufficiently trained peer support specialists |
| Awareness | Lack of awareness among behavioral health providers to integrate peer support services in the behavioral health system |
| Evaluation | Non-availability of resources to ensure program evaluation and quality improvement activities for peer support services |
| Resources | Non-availability of resources to hire qualified peer support specialists |
| Clinical Consultation | Cost of providing clinical consultation for peer support specialists |
| Training | Limited availability of training and ongoing education for peer support specialists |

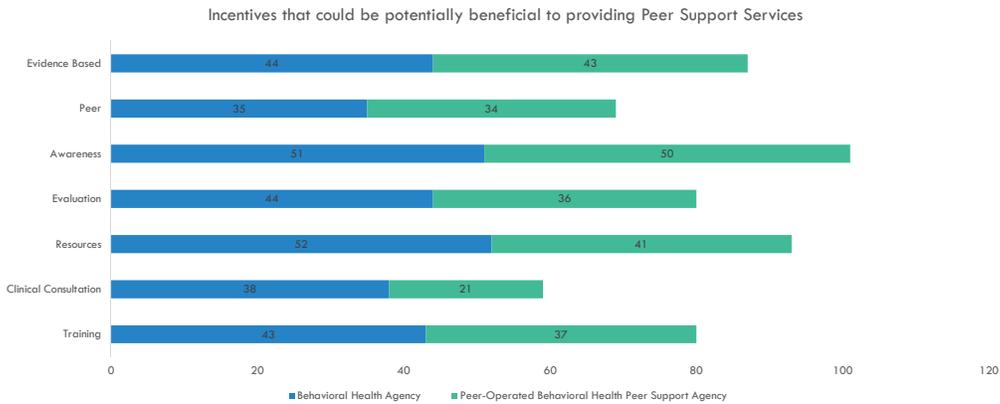
RESOURCES OR INCENTIVES TO PROVIDING PEER SUPPORT SERVICES

| Category | Resources/Incentives Definition |
|-----------------------|---|
| Evidence-Based | Providing resources to implement evidence based peer support programs |
| Peer | Increasing the availability of certified and/or sufficiently trained peer support specialists |
| Awareness | Providing education to behavioral health providers to integrate peer support services in the behavioral health system |
| Evaluation | Providing resources to ensure program evaluation and quality improvement activities for peer support services |
| Resources | Providing resources for employment of qualified peer support specialists |
| Clinical Consultation | Providing resources for clinical consultation for peer support specialists |
| Training | Increase access to training and ongoing education for peer support specialists |

WHAT BARRIERS/CHALLENGES MIGHT AGENCIES ENCOUNTER IN PROVIDING PEER SUPPORT SERVICES?



WHAT RESOURCES OR INCENTIVES MIGHT BENEFIT THE CAPACITY TO PROVIDE PEER SUPPORT SERVICES?



QUESTIONS ABOUT PEER SUPPORT SPECIALIST TRAINING AND CREDENTIALING

Do you believe that Peer Support Specialists should have some type of training prior to providing peer support services?

| | Response # | Percent |
|---------------|------------|-------------|
| Yes | 120 | 97.6% |
| No | 1 | .8% |
| Don't Know | 2 | 1.6% |
| Total: | 123 | 100% |

Do you believe that Peer Support Specialists should earn a certificate through a training entity prior to providing peer support services?

| | Response # | Percent |
|---------------|------------|-------------|
| Yes | 90 | 73.2% |
| No | 22 | 17.9% |
| Don't Know | 11 | 8.9% |
| Total: | 123 | 100% |

QUESTIONS ABOUT PEER SUPPORT SPECIALIST TRAINING AND CREDENTIALING

Do you believe that Peer Support Specialists should be credentialed professionals, recognized and regulated by the State?

| | Response # | Percent |
|---------------|------------|------------|
| Yes | 60 | 48.8% |
| No | 39 | 31.7% |
| Don't Know | 24 | 19.5% |
| Total: | 123 | 100 |

If a formal, regulated credential existed in Nebraska, would you employ a credentialed Peer Support Specialist?

| | Response # | Percent |
|---------------|------------|------------|
| Yes | 81 | 65.9 |
| No | 7 | 5.7 |
| Don't Know | 35 | 28.5 |
| Total: | 123 | 100 |

ADMINISTRATIVE INFORMATION ABOUT PROVIDING PEER SUPPORT SERVICES

Does your agency provide peer support services through a subcontract with an external agency to provide the services directly?

| | Response # | Percent |
|---------------|------------|-------------|
| Yes | 31 | 25.8% |
| No | 89 | 74.2% |
| Total: | 120 | 100% |

Does your agency provide peer support services through paid, employed staff?

| | Response # | Percent |
|---------------|------------|-------------|
| Yes | 107 | 89.2% |
| No | 13 | 10.8% |
| Total: | 120 | 100% |

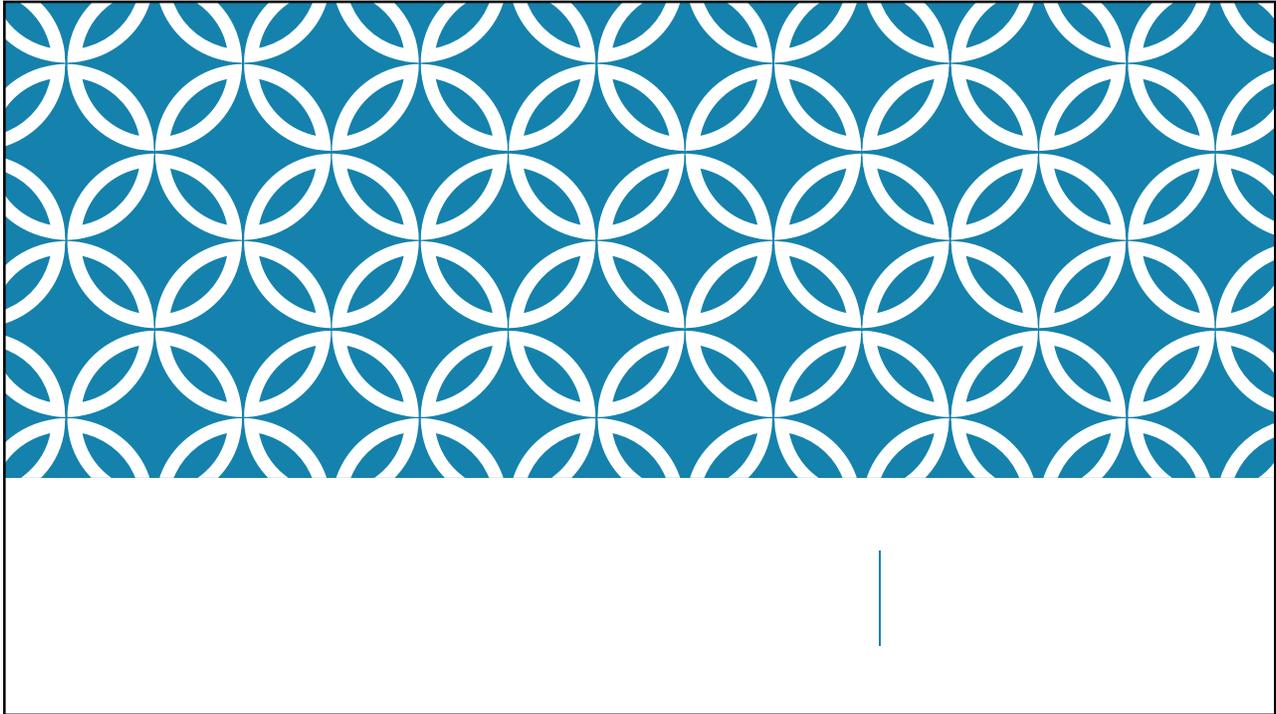
108 RESPONDENTS SAID THEIR AGENCY PROVIDES PEER SUPPORT SERVICES

| Category | Definition |
|--|--|
| Advocacy: | A peer empowering a peer/family to learn self and system advocacy. |
| Mentoring: | A peer to peer/family in a supportive relationship to improve self-help skills. |
| Support Groups: | A group of peers/families in a supportive meeting environment. |
| Crisis Intervention: | A peer providing timely support to a peer/family to help stabilize, reduce risk of system involvement and promote resiliency such as loss teams, family navigators, warmlines, crisis response teams, etc... |
| Recovery Support: | A peer supporting a peer/family to promote resiliency, relapse prevention support plus long term safety and well being; such as Clubhouse, WRAP, respite, transition planning, etc... |
| Supportive Services: | A peer supporting a peer/family to connect to community resources that support recovery and whole health; such as accessing benefits, housing, job training, etc... |
| Health/Behavioral Health Education: | A peer empowering a peer/family with education that supports healthy living; such as parenting courses, smoke-free living, etc... |
| Other Supports: | Aid that benefits peers such as transportation or case management but also provided by a peer. |

TYPES OF PEER SUPPORT SERVICES PROVIDED

| Peer Support Service Category | BH Agency* | Peer Agency* | Category Total*: |
|------------------------------------|------------|--------------|------------------|
| Advocacy | 53 | 51 | 104 |
| Mentoring | 49 | 47 | 96 |
| Support Groups | 40 | 47 | 87 |
| Crisis Intervention | 41 | 39 | 80 |
| Recovery Support | 51 | 45 | 96 |
| Health/Behavioral Health Education | 35 | 37 | 72 |
| Other Supports | 36 | 26 | 62 |

* Total number of survey respondents for each response choice



ADMINISTRATIVE INFORMATION ABOUT PROVIDING PEER SUPPORT SERVICES

Does your agency provide continuing education opportunities for Peer Support Specialist staff?

| | Response # | Percent |
|---------------|------------|-------------|
| Yes | 92 | 76.7% |
| No | 28 | 23.3% |
| Total: | 120 | 100% |

Does your agency provide clinical consultation for Peer Support Specialists to utilize, related to providing peer support services?

| | Response # | Percent |
|---------------|------------|-------------|
| Yes | 67 | 55.8% |
| No | 53 | 44.2% |
| Total: | 120 | 100% |

ADMINISTRATIVE INFORMATION ABOUT PROVIDING PEER SUPPORT SERVICES

Are Peer Support Specialists on staff paid via an hourly rate?

| | Response # | Percent |
|---------------|------------|-------------|
| Yes | 91 | 85% |
| No | 16 | 15% |
| Total: | 120 | 100% |

Are Peer Support Specialists on staff paid an annual salary?

| | Response # | Percent |
|---------------|------------|-------------|
| Yes | 37 | 34.6% |
| No | 70 | 65.4% |
| Total: | 120 | 100% |

ADMINISTRATIVE INFORMATION ABOUT PROVIDING PEER SUPPORT SERVICES

Does your agency provide Peer Support Specialists on staff with the same level of employment fringe benefits as other staff?

| | Response # | Percent |
|---------------|------------|-------------|
| Yes | 96 | 80% |
| No | 24 | 20% |
| Total: | 120 | 100% |

Does your agency utilize volunteers to provide peer support services?

| | Response # | Percent |
|---------------|------------|-------------|
| Yes | 40 | 33.3% |
| No | 80 | 66.7% |
| Total: | 120 | 100% |

A FEW KEY HIGHLIGHTS

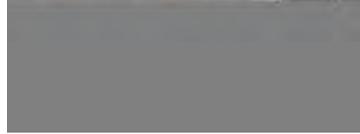
- Top 3 identified barriers to providing peer support services:
 1. Lack of awareness among behavioral health providers to integrate peer support services in the behavioral health system
 2. Non-availability of resources to hire qualified Peer Support Specialists
 3. Limited availability of training and ongoing education for Peer Support Specialists
- Top 3 identified incentives to providing peer support services:
 1. Providing education to behavioral health providers to integrate peer support services in the behavioral health system
 2. Providing resources for employment of Peer Support Specialists
 3. Providing resources to implement evidence based peer support programs

A FEW KEY HIGHLIGHTS

- ❖ Overwhelming agreement that Peer Support Specialists should have some training prior to providing peer support services, and strong support for an earned certification.
- ❖ Mixed response on credentialing but strong support for hiring credentialed Peer Support Specialists.
- ❖ Most respondents indicated providing initial and ongoing training to Peer Support Specialists to equip staff to perform peer support services.

QUESTIONS?

Department of Health & Human Services



Email: DHHS.DBHPeerCert@Nebraska.gov

PEER SUPPORT SERVICES in Nebraska

Percentages of People (at Agencies) that Responded to Questions on Barriers and Resources to Benefit Capacity

Barriers and Challenges for People at Agencies in Providing Peer Support Services

- #1- Lack of Awareness of to Integrate Peer Support Services (69%)
- #2- Non-Availability of Resources to Hire Peer Support Specialists (PSS) (56%)
- #3- Limited Availability of Training and Ongoing Education for PSS (49%)
- #4- Non-Availability of Resources to Ensure Program Evaluation/Quality Improvement Activities for PSS (45%)
- #5- Lack of Capacity to Implement Evidence Based Peer Support Programs (36%)
- #6- Cost of Providing Clinical Consultation for Peer Support Specialists (34%)
- #7- Limited Availability of Certified/Sufficiently Trained Peer Support Specialists (33%)

Incentives or Resource to Benefit Capacity to Provide Peer Support Services

- #1- Awareness- Education on how to Integrate Peer Support Services (74%)
- #2- Resources- To Ensure Employment of PSS (68%)
- #3- Capacity for EBPs- Providing Resources to Implement Evidence Based Peer Support Programs (64%)
- #4- Evaluation- Resources to Ensure Program Evaluation/Quality Improvement Activities for PSS (58%)
 - Training- Increased Access to Training/Ongoing Education for PSS (58%)
- #6- Peer- Increased Availability of Certified/Sufficiently Trained PSS (50%)
- #7- Clinical Consultation – Providing Resources for Clinical Consultation for PSS (43%)

Office of Consumer Affairs: DBH (MAY 2014)



The Director's Award Coin

Do you know someone or a team that embodies the following:

- ◆ Demonstrates wellness, recovery and resiliency
- ◆ Demonstrates dignity, respect, and accountability with individuals utilizing behavioral health services
- ◆ Provides a high level of quality consumer service and teamwork
- ◆ Promotes accessibility, efficiency and quality in the behavioral health system
- ◆ Encourages consumer and family wellness
- ◆ Works for the betterment of all rather than personal gain.

This Award is available through Director Scot Adams. Call or e-mail him to see about qualifying your nomination!

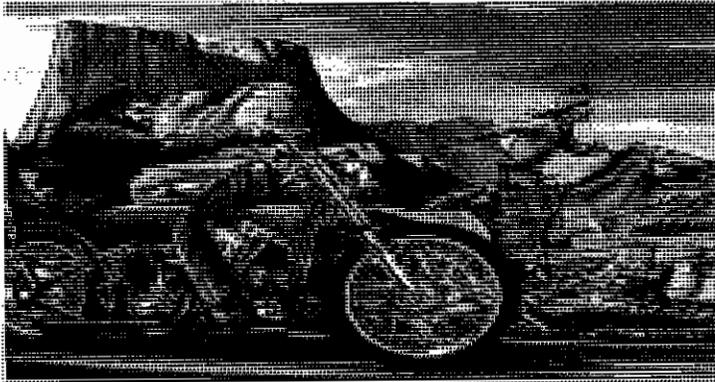
Scot L. Adams, Ph.D

Director of Behavioral Health

Department of Health and Human Services, Nebraska

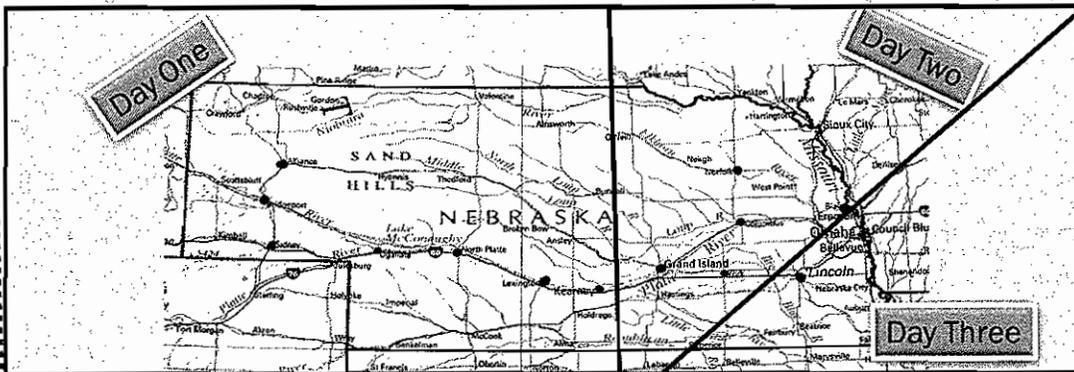
402-471-7853 or scot.adams@nebraska.gov

RIDE ACROSS NEBRASKA-MAY 29TH- 31ST



Nebraskans will be mounting their motorcycles to help bring awareness to children's mental health issues. This statewide awareness and advocacy event places a spotlight on the challenges faced by families with young people whom have behavioral health challenges. The 2014 focus is: *Expanding Perceptions*

The journey begins with the Kick-Off Sparks Festival in Scottsbluff, Nebraska on May 28th, 2014. Motorcyclists will depart from Gering, NE on May 29th, and travel across Nebraska collecting letters that address Nebraska's need to invest in children's mental wellness. The parade will end at the steps of the State Capital in Lincoln on Saturday, May 31st, where the Pony Express Riders will deliver the letters to the hands of the young people to share with Governor Heineman and other Nebraska law makers.



Want to be a "Pony Express" Rider?
Please do, your involvement would be so appreciated!

Contact Sarah @ 308-991-8683 or email at:

info@nefamilies4kids.org

Visit us on Facebook at: www.facebook.com/neffcmh

2014 Pony Express Ride

SMOKE-FREE LIVING TOUR

BE A MOTIVATIONAL CATALYST

JOIN US ON THE FOLLOWING DATES TO BECOME A MOTIVATIONAL CATALYST OF SMOKE-FREE LIVING!

This is open to any and all who want to encourage smoke-free living for people they live or work with! If you are a former smoker, schedule a time to film your story!

- June 11- Lincoln, 1:00pm-3:00pm
- June 12- Omaha, 1:00pm-3:00pm
- June 17- Grand Island, 1:00pm-3:00pm
- June 23- Norfolk, 1:00pm-3:00pm
- June 30- North Platte, 1:00pm-3:00pm
- July 1- Scottsbluff, 9:30am-11:30am

Registration Information to be Released Soon!



Shirley Deethardt

Tobacco Free Nebraska

Division of Public Health

Carol Coussons de Reyes

Nebraska's Office of Consumer Affairs

Division of Behavioral Health

Department of Health & Human Services

DHHS
NEBRASKA

FY2014 & FY2015 Block Grant Application

Updated Financial Information

Estimated Expenditures SFY2015

| Activity | FFY14 SAPTBG | FFY14 MHBG | Medicaid (Federal, State, Local) | Other Federal funds | State funds |
|---|-----------------------------|---------------------|-------------------------------------|------------------------|----------------------|
| SA Prevention & TX | | | | | |
| Preg Women and WDC | \$ 535,401 | | | - | \$ 1,618,261 |
| All other | 4,933,756 | | | - | 23,618,315 |
| Primary Prevention | 1,738,643 | - | | 1,507,564 | 355,311 |
| Turberculosis Services | 0 | | | - | - |
| HIV Early Intevention | 0 | | | - | - |
| State Hospital | | - | | - | - |
| Other 24 hour care | | 277,126 | | - | 13,757,205 |
| Ambulatory/comm non-24 hour care | | 1,659,941 | | - | - |
| EBP Set Aside (NEW) | | 107,615 | | 288,000 | 44,610,233 |
| Admin (excluding program/provider level) | 379,358 | 107,615 | - | - | - |
| Subtotal (Prev, Tx, etc) | \$ 7,207,800 | \$ 2,044,682 | \$ - | \$ 1,795,564 | \$ 83,959,325 |
| subtotal (Admin) | 379,358 | 107,615 | - | - | - |
| Total | \$ 7,587,158 | \$ 2,152,297 | \$ - | \$ 1,795,564 | \$ 83,959,325 |
| | FFY2013 \$ 7,417,381 | \$ 1,964,416 | | | |

Projected SAPTBG Prevention Expenses by Strategy SFY2015

| | | | |
|---------------------------|-------------|-----------|----------------|
| Information Dissemination | Universal | \$ | 67,070 |
| | Selective | \$ | 2,534 |
| | Indicated | \$ | 62 |
| | Unspecified | | |
| Subtotal | | \$ | 69,666 |
| Education | Universal | \$ | 110,844 |
| | Selective | \$ | 93,189 |
| | Indicated | \$ | 11,984 |
| | Unspecified | | |
| Subtotal | | \$ | 216,017 |
| Alternatives | Universal | \$ | 20,800 |
| | Selective | \$ | 9,708 |
| | Indicated | \$ | |
| | Unspecified | | |
| Subtotal | | \$ | 30,508 |
| Problem Identification | Universal | \$ | 34,764 |
| | Selective | \$ | 13,952 |
| | Indicated | \$ | 71,452 |
| | Unspecified | | |
| Subtotal | | \$ | 120,168 |

Projected SAPTBG Prevention Expenses by Strategy SFY2015

| | | | |
|------------------------|------------------------|-----------|------------------|
| Community Based | Universal | \$ | 657,127 |
| | Selective | \$ | 73,281 |
| | Indicated | \$ | 23,377 |
| | Unspecified | | |
| Subtotal | | \$ | 753,785 |
| Environmental | Universal | \$ | 352,468 |
| | Selective | \$ | 98,631 |
| | Indicated | \$ | 21,378 |
| | Unspecified | | |
| Subtotal | | \$ | 472,477 |
| Other | Universal | | |
| | Selective Indicated | | |
| Subtotal | | \$ | - |
| Section 1926 - Tobacco | Universal | \$ | 76,025 |
| | Selective Indicated | | |
| Subtotal | | \$ | 76,025 |
| Total | | \$ | 1,738,646 |

SAPTBG Planned Resource Expenditures SFY2015

| | Prevention SA | Treatment SA |
|--|----------------|-------------------|
| Planning Coordination, and needs assesment | \$ 27,673 | |
| Quality assurance | \$ 27,673 | \$ 27,693 |
| Training (post-employment) | | \$ 87,855 |
| Education (pre-employment) | | \$ 58,571 |
| Program Development | \$ 55,345 | \$ 27,673 |
| Research & Evaluation | | |
| Information Systems | \$ 30,800 | \$ |
| Total \$ | 141,491 | \$ 201,792 |

MHBG Planned Resources Expenditures SFY2015

| | MHBG |
|--------------------------------|-------------------|
| MH Tech Assistance | |
| MH Planning Council Assistance | |
| MH Administration | \$ 98,221 |
| MH Data Collection/Reporting | |
| MH Activities Other than Above | \$ 79,000 |
| Total Non Direct | \$ 177,221 |
| Comments on Data: | |

MHBG New Set Aside

- ▶ 5% of total award (\$107,615)
- ▶ Dedicated to treatment for those “with early serious mental illness,” preferably psychotic disorder but not limited to this
- ▶ Target Population: adolescents and early adulthood

MHBG New Set Aside

- ▶ Not for primary prevention or preventive intervention
- ▶ Must use evidence-based program (EBP)
 - While Congressional language is broad enough to allow use of 5 percent set aside for any EBP, SAMHSA approval is required for any EBP selected
- ▶ Block Grant application must be updated to detail the assessed need and EBP selected by May 29

MHBG New Set Aside

- ▶ Recognition that states may need to dedicate first year to planning, training and/or infrastructure development for implementation in second year
- ▶ Next Steps:
 - Assess needs in Nebraska
 - Determine appropriate EBP to address identified need
 - Develop plan for implementation

Recommendations on MHBG New Set Aside?

- ▶ On targeted illness – early psychotic behavior or other serious mental illness (e.g. major depressive disorder)?
- ▶ Specific EBP?
- ▶ Factors for DBH to keep in mind while developing plan?

Considerations for Advisory Committees reviewing By-Laws

1. By-Law language about quorum, voting and records should accurately reflect adherence to the Open Meetings Act.
 - a. For example: “*Once established, a quorum shall be deemed to continue throughout the meeting*” does not match.
 - b. For example: May want to consider language about workgroups and Executive Committee meetings that would reflect compliance.
2. By-Laws for each Committee should consider similar technical procedures to ensure no conflict of operations during Joint Meetings.
 - a. For example: Things like quorum, voting, records, conflict of interest practices, etc. should be reviewed.
3. By-Laws should reflect expectations for the Committee, but would not include instruction to other entities.
 - a. For example: Expectations of the Division of Behavioral Health should not be included unless in general reference to processes of the Committee.
4. By-Laws should provide guidance for operations but not create burdens that impede purpose or don't reflect actual practice.
 - a. For example: Any requirements about attendance should be reviewed.
 - b. For example: Officer selection and terms should be specified.
 - c. For example: Phrases like “*...a written notice shall be provided...*” or “*...shall mail a reminder...*” should be clarified since use of electronic communication is commonplace.

BY-LAWS FOR THE
STATE ADVISORY COMMITTEE ON MENTAL HEALTH SERVICES
May 3, 2011

Article I – Name of Organization

The name of the organization shall be the State Advisory Committee on Mental Health Services.

Article II – Purpose

Section 1

As provided by Nebraska Revised Statutes section 71-814 the purpose of the Committee is to (a) serve as the state's mental health planning council as required by Public Law 102-321, (b) conduct regular meetings, (c) provide advice and assistance to the division relating to the provision of mental health services in the State of Nebraska, including, but not limited to, the development, implementation, provision, and funding of organized peer support services, (d) promote the interests of consumers and their families, including, but not limited to, their inclusion and involvement in all aspects of services design, planning, implementation, provision, education, evaluation, and research, (e) provide reports as requested by the division, and (f) engage in such other activities as directed or authorized by the division.

The Division means the Division of Behavioral Health within the Nebraska Department of Health and Human Services.

Section 2

“Serve as the state's mental health planning council as required by Public Law 102-321 means meeting the requirements for the State Mental Health Planning Council under the Federal Community Mental Health Services Block Grant. Under Section 1914, the State will establish and maintain a State mental health planning council in accordance with the conditions described in this section. (b) The duties of the Council are:

- (1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans [this refers to the Block Grant Application and Implementation Report];
- (2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and
- (3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

Section 3

MISSION STATEMENT

The Mission of Nebraska State Advisory Committee on Mental Health Services is to identify and advocate for an effective and efficient system of accessible, quality mental health services which enable each individual, on their journey of healing and transformation, to achieve their highest potential.

VISION STATEMENT

The Vision of Nebraska State Advisory Committee on Mental Health Services is to advise and assist the Division as it provides information for all Nebraskans, including consumers, families and the public to understand mental health problems, and to provide the knowledge necessary to access and utilize appropriate services in a timely, effective manner.

BY-LAWS FOR THE
STATE ADVISORY COMMITTEE ON MENTAL HEALTH SERVICES
May 3, 2011

Article III – Membership

Section 1

Appointments: The committee shall consist of twenty-three members appointed by the Governor.

Length of Term: The length of term is as appointed by the Governor.

Section 3

Attendance: A member who has two consecutive unexcused absences shall be contacted by the Division regarding his/her intentions for future participation in the Committee. If the person indicates he/she is not able to participate, the Division shall request he/she formally resign from the Committee. Formal resignation shall be in writing and is to be submitted to the Director of the Division of Behavioral Health. The Division staff will maintain attendance sheet and submit to Chairperson periodically or per request.

Article IV - Voting

Section 1

Quorum: A quorum shall consist of one member more than half of the current members of the Committee. Once established, a quorum shall be deemed to continue throughout the meeting. All Committee business shall be conducted by a simple majority vote of members present at a meeting in which a quorum is established.

Section 2

Conflicts of Interest: A conflict of interest is created through the existence of circumstances where the actions of a member may have an effect of direct financial benefit or detriment to the member, a member of his/her family, employer, business associate, or a business in which the member owns a substantial interest. As soon as the member is aware of a potential conflict of interest (or should reasonably be so aware), the member shall complete the Potential Conflict of Interest Statement Form C-2. The Form shall be submitted to the Nebraska Accountability and Disclosure Commission. The member shall follow all directions as prescribed and advised by the Nebraska Accountability and Disclosure Commission. If a dispute arises as to whether a conflict exists, the chairperson shall direct that the member's vote be disregarded on a given issue until such time as the member is in possession of a written opinion from the Nebraska Accountability and Disclosure Commission. Meeting minutes shall record the name of a member(s), who abstains from voting.

Article V – Officers

Section 1

Selection: Officers of the Committee shall be a Chairperson, Vice-Chairperson and Secretary.

Section 2

Duties: The duties of the Officers shall be:

Chairperson – Preside at all Committee and Executive meetings and:

- (1) Attend annual technical assistance meeting on MH Block Grant

BY-LAWS FOR THE
STATE ADVISORY COMMITTEE ON MENTAL HEALTH SERVICES
May 3, 2011

- (2) Represent Nebraska at the MH Block Grant application review
- (3) Write a letter representing the committee's point of view after reviewing the MH block grant application, to be attached and is due September 1.
- (4) Write a letter after reviewing Mental Health block grant implementation report due December 1
- (5) Perform any other duties designated by the Committee.
- (6) Review attendance report and contact members as needed.

Vice-Chairperson - Shall act for the Chairperson in his/her absence. Shall perform other duties as designated by the Chairpersons or Committee

Secretary – Shall act for the Chairperson and Vice-Chairperson in their absence. Shall perform other duties as designated by the Chairpersons or Committee and is designated to review meeting minutes prior to distribution to committee members.

Section 3

At the fall meeting the committee will select officers for one year. The new officers' term are January 1 through December 31. In the event of a vacancy, the Committee will elect a member to serve the unexpired term of office.

Section 4

Executive Committee: The Executive Committee shall consist of the Chairperson, Vice-Chairperson and Secretary. A Chairperson may call the Executive Committee together with the approval of the Division, at his/her discretion.

Article VI – Meetings

Section 1

Frequency: Meetings of the Committee shall be held regularly.

Section 2

Conduct: Meetings shall be held in accordance with the requirements of the Nebraska Public Meetings Law, Neb. Rev. Stat. sections 84-1408 through 84-1414. Business should be conducted according to Roberts Rules of Order.

Section 3

Notice: The time, date and location of the next meeting should be determined prior to adjournment of the preceding meeting. Notification of the time, date and location of the next meeting shall be sent within two weeks to all members absent from the preceding meeting. Within thirty days, but not less than seven days prior to the next meeting, the Division shall mail a written reminder and meeting agenda to each Committee member at his/her last known official address.

Section 4

Duties of the Division: The Division shall provide an orientation to each new Committee member, produce meeting minutes, maintain records to include attendance record of the Committee, and provide support to the Committee.

BY-LAWS FOR THE
STATE ADVISORY COMMITTEE ON MENTAL HEALTH SERVICES
February 3, 2011

Section 5

Expenses: Committee members shall be reimbursed for actual and necessary expenses in the performance of their duties as provided in Neb. Rev. Stat. sections 81-1174 to 81-1177.

Article VII - Committees

With the written approval of the Division, the Chairperson may appoint or otherwise establish ad-hoc task forces comprised of Committee and non-Committee members to accomplish a specific task which is relevant to the purpose of the Committee. Ad-hoc Committee is defined as including Committee and non-committee members.

Article VIII – Amendments

There shall be a review of the Bylaws a minimum of every three years. A two-thirds majority vote of all Committee members will be required to amend the Bylaws. No Bylaws shall be considered for amendment unless notice of the same shall have been established as part of the meeting agenda, and a copy of the proposed changes has been delivered to members within thirty days, but not less than seven days, prior to the meeting at which the vote will take place.

All alterations, amendments, or new by-laws adopted by the Committee are subject to the approval of the Director of the Division of Behavioral Health or the designated representative for the Director.

Bert Ferguson

Committee Chairperson

5/03/11

Date

BY-LAWS FOR THE
STATE ADVISORY COMMITTEE ON MENTAL HEALTH SERVICES
May 3, 2011

71-814. State Advisory Committee on Mental Health Services; created; members; duties.

(1) The State Advisory Committee on Mental Health Services is created. Members of the committee shall have a demonstrated interest and commitment and specialized knowledge, experience, or expertise relating to the provision of mental health services in the State of Nebraska. The committee shall consist of twenty-three members appointed by the Governor as follows: (a) One regional governing board member, (b) one regional administrator, (c) twelve consumers of behavioral health services or their family members, (d) two providers of behavioral health services, (e) two representatives from the State Department of Education, including one representative from the Division of Vocational Rehabilitation of the State Department of Education, (f) three representatives from the Department of Health and Human Services representing mental health, social services, and Medicaid, (g) one representative from the Nebraska Commission on Law Enforcement and Criminal Justice, and (h) one representative from the Housing Office of the Community and Rural Development Division of the Department of Economic Development.

(2) The committee shall be responsible to the division and shall (a) serve as the state's mental health planning council as required by Public Law 102-321, (b) conduct regular meetings, (c) provide advice and assistance to the Division relating to the provision of mental health services in the State of Nebraska, including, but not limited to, the development, implementation, provision, and funding of organized peer support services, (d) promote the interests of consumers and their families, including, but not limited to, their inclusion and involvement in all aspects of services design, planning, implementation, provision, education, evaluation, and research, (e) provide reports as requested by the Division, and (f) engage in such other activities as directed or authorized by the Division.

Source:

Laws 2004, LB 1083, § 14;

Laws 2006, LB 994, § 93;

Laws 2007, LB296, § 460.

BY-LAWS
As Amended April 4, 2011

Article I – Name of Organization

The name of the organization shall be the State Advisory Committee on Substance Abuse Services (SACSAS).

Article II – Purpose

As provided in Nebraska Revised Reissued Statutes Section 71-815, the committee shall be responsible to the Division of Behavioral Health and shall (1) conduct regular meetings, (2) provide advice and assistance to the Division relating to the provision of substance abuse services in the State of Nebraska, (3) promote the interests of consumers and their families, (4) provide reports as requested by the Division, and (5) engage in such other activities as directed or authorized by the Division. (71-815-sec 2)

Article III – Membership

Section 1

Appointments: The committee shall consist of twelve members appointed by the Governor. Members of the committee shall have a demonstrated interest and commitment and specialized knowledge, experience, or expertise relating to the provision of substance abuse services in the State of Nebraska. The committee shall consist of twelve members appointed by the Governor and shall include at least three consumers of substance abuse services. (71-815 sec 1)

Section 2

Length of Term: Four of the initial members appointed by the Governor shall serve for three years. Four of the initial members appointed by the Governor shall serve for two years, and four of the initial members for one year. As the terms of the initial members expire, their successors shall be appointed for terms of three years.

Article IV – Voting

Section 1

Quorum: Seven (7) voting members of the Committee present at any called meeting shall constitute a quorum. Once established, a quorum shall be deemed to continue throughout the meeting. All Committee business shall be conducted by a simple majority vote of members present at a meeting in which a quorum is established.

Section 2

Conflicts of Interest: A conflict of interest is created through the existence of circumstances where the actions of a member may have an effect of direct financial benefit or detriment to the member, a member of his/her family, employer, business

associate, or business in which the member owns a substantial interest. A member shall disclose the conflict to the Committee and abstain from voting on issues on which there is a conflict. Meeting minutes shall record the name of a member(s), who abstains from voting.

Article V – Officers

Section 1

Selection: Officers of the Committee shall be a Chairperson, Vice-Chairperson and Second Vice Chairperson. Initial Officers shall be appointed by the Division of Behavioral Health at the first meeting and will be elected by the Committee annually thereafter. In the event of a vacancy, the Committee will elect a member to serve the unexpired term of office.

Section 2: The duties of the Officers shall be:

Chairperson – Preside at all Committee and Executive meetings and perform any other duties designated by the Committee.

Vice-Chairperson – Shall act for the Chairperson in his/her absence.

Second Vice Chairperson – Shall act for the Chairperson and Vice-Chairperson in their absence. Shall perform other duties as designated by the Chairperson or Committee.

Section 3

Term: At any time that a member cannot complete the term of office a new election shall be held to fill the vacancy.

Section 4

Executive Committee: The Executive Committee shall consist of the Chairperson, Vice-Chairperson and Second Vice Chairperson. A Chairperson may call the Executive Committee together with the agreement of the Division at his/her discretion.

Article VI – Meetings

Section 1

Frequency: Meetings of the Committee shall be held regularly.

Section 2

Conduct: Meetings shall be held in accordance with the requirements of the Nebraska Public Meetings Law, Neb. Rev. State. Sections 84-1408 through 84-1414. Business should be conducted according to Roberts Rules of Order.

Section 3

Notice: The time, date and location of the next meeting should be determined prior to adjournment of the preceding meeting. Notification of the time, date and location of the next meeting shall be sent within two weeks to all members absent from the preceding meeting. Within thirty days, but not less than seven days prior to the next meeting, the Division shall mail a written reminder and meeting agenda to each Committee member at his/her last known official address. Public Notice of Committee meetings and agendas shall be made by posting to the State of Nebraska Public Meetings Calendar on the internet.

Section 4

Duties of the Division: The Division of Behavioral Health shall provide an orientation to each new Committee member, produce meeting minutes, maintain records of the Committee, and provide secretarial support to the Committee.

Section 5

Expenses: Committee members shall be reimbursed for actual and necessary expenses in the performance of their duties as provided in Neb. Rev. State. Sections 81-1174 through 81-1177.

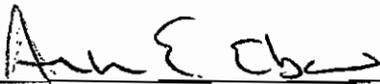
Article VII -- Committees

With the written agreement of the Division, the Chairperson may appoint or otherwise establish ad-hoc task forces comprised of Committee and non-committee members to accomplish a specific task which is relevant to the purpose of the Committee.

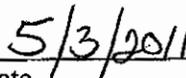
Article VIII -- Amendments

There shall be a review of the Bylaws a minimum of every three years. A two-thirds majority vote of all Committee members will be required to amend the Bylaws. No Bylaws shall be considered for amendment unless notice of the same shall have been established as part of the meeting agenda, and a copy of the proposed changes has been mailed to members within thirty days, but not less than seven days, prior to the meeting at which the vote will take place.

All alterations, amendments, or new by-laws adopted by the Committee are subject to the approval of the Director of the Division of Behavioral Health or the designated representative for the Director.



Committee Chairperson



Date

71-815 State Advisory Committee on Substance Abuse Services; created; members; duties.

(1) The State Advisory Committee on Substance Abuse Services is created. Members of the committee shall have a demonstrated interest and commitment and specialized knowledge, experience, or expertise relating to the provision of substance abuse services in the State of Nebraska. The committee shall consist of twelve members appointed by the Governor and shall include at least three consumers of substance abuse services.

(2) The committee shall be responsible to the division and shall

- (a) conduct regular meetings,
- (b) provide advice and assistance to the division relating to the provision of substance abuse services in the State of Nebraska,
- (c) promote the interests of consumers and their families,
- (d) provide reports as requested by the division, and
- (e) engage in such other activities as directed or authorized by the division.

Source Laws 2004, LB 1083, § 15; Laws 2005, LB 551, § 5; Laws 2006, LB 994, § 94.

Expense Reimbursement Guidelines for Committee Members

Personal information needed for the expense vouched;

Name – Address – City – Vehicle License Number (AB#-HHS will assign)

MEALS:

Meals will not be reimbursed for 1 day travel – (must be over night)

- **Except if you departed your home at 6:30 am or earlier – Breakfast can be reimbursed**
- **Except if you returned to your home after 7 pm- dinner can be reimbursed (the time it takes to dine cannot be used to determine eligibility)**
- **Lunch is reimbursed for overnight travel only**
- **Receipts MUST be submitted for meal reimbursement for overnight travel .**
- **The receipt must include the following information: date, place, item purchased & cost per item and time if possible. (State recommended meal guidelines are: Breakfast \$7.00 Lunch \$11.00 and Dinner \$20.00).**
- **Receipts are required (note credit card receipt alone is not acceptable)**
- **Tips are limited to 20%.**

Meals will not be reimbursed within 20 miles of home.

MILEAGE:

Personal vehicle used for state business such as driving from home to the advisory meeting and returning home will be reimbursed. The mileage is restricted only to miles necessary to reach the meeting and return home.

Current mileage rate as of January 1, 2014 is \$.56

LODGING

Eligibility for Lodging:

Must reside 60 miles or more from the meeting location.

Exception: Medical conditions or weather conditions(exceptions must be clearly stated on the expenditure document.)

Committee members must contact HHS staff to have lodging arrangements, to ensure a government rate and direct billing to the state agency.

HHSS Support staff will prepare Expense Reimbursement Document for the Committee member's signature. Example is attached.

Other expenses:

Parking – receipt needed.

STATE OF NEBRASKA SUBSTITUTE FORM W-9 & ACH ENROLLMENT FORM

Return Form to the Requester.
(Rev. October 2013)

Requester Information:

| | | | |
|----------|--|---------|--|
| Agency: | | Phone: | |
| Name: | | Fax: | |
| Address: | | E-mail: | |

Substitute Form W-9: (IRS Rev August 2013)

Name (as shown on your income tax return):

Business name/disregarded entity name, if different from above:

Check appropriate box for federal tax classification:

- Individual
 Sole proprietor
 C Corporation
 S Corporation
 Partnership
 Trust/estate
 Non-Profit Entity
 Government (Local, State or Federal)
 Limited Liability Company. Enter the tax classification (C = C Corporation, S = S Corporation, P = Partnership) _____
 Other (see instructions) _____

Exemptions (see instructions): Exempt payee code (if any) _____ Exemption from FATCA reporting code (if any) _____

Address: _____ Remit Address (if different): _____

City, state, and ZIP code _____ City, state, and ZIP code _____

Taxpayer Identification Number (TIN):

Social Security Number (SSN): _____ OR Employer Identification Number (EIN): _____

Certification:

Under penalties of perjury, I certify that:

- The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
 - I am not subject to backup withholding due to failure to report interest and dividend income, and
 - I am a U.S. citizen or other U.S. person (defined in the instructions), and
 - The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct
- For additional instructions please refer to <http://www.irs.gov/pub/irs-pdf/fw9.pdf> to obtain a copy of the IRS Form W-9 General Instructions.

Signature of US Person: _____ Date: _____

Printed Name: _____ Contact Phone: _____

Comments or Business/Entity Notes:

ACH Enrollment: (Rev. October 2013) Initial Setup Change

This information is REQUIRED to process payments. Without this information, your payment may be delayed.

| | | |
|-----------------------------|--|--|
| Financial Institution Name: | Nine Digit Routing Number: | <input type="checkbox"/> Check here if the bank is outside of the United States. |
| Address: | Depositor Account Number: | <input type="checkbox"/> Check here if the following must be discussed with your entity: There are new processing requirements for electronic vendor payments that are being sent to a financial institution outside of the United States. If our payments to you are being forwarded from a U.S. financial institution to a financial institution in another country, please advise (Identify who within your company). |
| City, state and ZIP code: | Type of Account: <input type="checkbox"/> Checking <input type="checkbox"/> Savings | |

This account will be used for all payments by the State of Nebraska unless specified here: _____

E-mail: _____
(Used for ACH payment notifications.)

| | |
|-------------------|---|
| Vendor Signature: | Attachment Required! (Select and attach one of the following items for verification): <input type="checkbox"/> Blank check (voided) or <input type="checkbox"/> Photocopy of a check <input type="checkbox"/> Letter or statement from your financial institution <input type="checkbox"/> Vendor Invoice or <input type="checkbox"/> Vendor Letter with ACH instructions |
| Printed Name: | |
| Title: | |
| Date | |

Internal Use Only:

BEHAVIORAL HEALTH ACRONYMS | page 1

| | |
|-------|---|
| AAHC | Accreditation Association for Ambulatory Health Care |
| AABD | Aid to the Aged, Blind and Disabled |
| AAMR | American Association on Mental Retardation |
| ACA | Patient Protection and Affordable Care Act |
| ACF | Administration for Children and Families |
| ACL | Administration for Community Living |
| ACO | Accountable Care Organization |
| ACT | Assertive Community Treatment |
| ADA | Americans with Disabilities Act |
| ADC | Aid to Dependent Children |
| AHRQ | Agency for Healthcare Research and Quality |
| AI | American Indian |
| AIDS | Acquired Immune Deficiency Syndrome |
| AMBH | American Managed Behavioral Healthcare Association |
| AN | Alaska Native |
| APA | American Psychiatric Association |
| APRN | Advanced Practice Registered Nurse |
| ASA | Adult Substance Abuse |
| ASAM | American Society of Addiction Medicine |
| ASI | Addictive Severity Index |
| ASO | Administrative Services Organization |
| ATOD | Alcohol, Tobacco, and Other Drug |
| ATTC | Addiction Technology Transfer Center |
| BH | Behavioral Health |
| BHOC | Behavioral Health Oversight Commission |
| BHSIS | Behavioral Health Services Information System |
| BRFSS | Behavioral Risk Factor Surveillance System |
| BSDC | Beatrice State Development Center |
| CADCA | Community Anti-Drug Coalitions of America |
| CAFAS | Child & Adolescent Functional Assessment Scale |
| CAP | Client Assistance Program |
| CAPTs | Centers for the Application of Prevention Technologies |
| CARF | Commission on Accreditation of Rehabilitation Facilities |
| CASI | Comprehensive Adolescent Severity Index |
| CBH | Children's Behavioral Health |
| CBHSQ | Center for Behavioral Health Statistics and Quality (under SAMHSA, HHS) |
| CBT | Cognitive Behavioral Therapy |
| CCGC | Certified Compulsive Gambling Counselor |
| CCP | Crisis Counseling Projects |

BEHAVIORAL HEALTH ACRONYMS | page 2

| | |
|------|--|
| CEU | Continuing Education Unit |
| CFN | Coercion Free Nebraska |
| CFR | Code of Federal Regulations |
| CFS | Child and Family Services |
| CHC | Community Health Center |
| CHIP | Children's Health Insurance Program |
| CIC | Consumer Input Committee |
| CISM | Critical Incident Stress Management |
| CIT | Crisis Intervention Training |
| CLAS | Culturally and Linguistically Appropriate Services |
| CMHC | Community Mental Health Center |
| CMHS | Center for Mental Health Services (under SAMHSA, HHS) |
| CMS | Centers for Medicare & Medicaid Services |
| CMS | Centers for Medicare & Medicaid Services |
| COA | Council on Accreditation of Services for Families & Children |
| CPC | Civil Protective Custody |
| CPG | Clinical Practice Guidelines |
| CPiP | Community Partners in Prevention |
| CPT | Current Procedural Terminology |
| CRC | Community Resource Center |
| CRT | Crisis Response Team |
| CRT | Clinical Review Team |
| CS | Community Support |
| CSAP | Center for Substance Abuse Prevention |
| CSAT | Center for Substance Abuse Treatment |
| CTA | Community Treatment Aid |
| CTP | Community Transitional Program |
| DBH | Division of Behavioral Health |
| DBT | Dialectical Behavior Therapy |
| DDS | Developmental Disabilities System |
| DHHS | Nebraska Department of Health & Human Services |
| DIG | Data Infrastructure Grant (ended September 29, 2013) |
| DMD | Diagnosable Mental Disorder |
| DPI | Department of Public Institutions (ended December 31, 1996) |
| DR | Day Rehabilitation |
| DRG | Diagnosis Related Group |
| DSM | Diagnostic and Statistical Manual of Mental Disorders |
| EA | Economic Assistance |
| EBP | Evidence-Based Practice |
| ECC | Emergency Communications Center |

BEHAVIORAL HEALTH ACRONYMS | page 3

| | |
|--------|---|
| ECS | Emergency Community Support |
| EHB | Essential Health Benefit |
| EHR | Electronic Health Record |
| EMS | Emergency Medical Services |
| EOC | (state) Emergency Operations Center |
| EPC | Emergency Protective Custody |
| EPI | Epidemiological |
| ERD | Expense Reimbursement Document |
| ESU | Educational Services Unit |
| F/PCP | Family/Person Centered Practice |
| FEMA | Federal Emergency Management Agency |
| FFS | Fee For Service |
| FFY | Federal Fiscal Year |
| FLC | Family Life Center |
| FMAP | Federal Medical Assistance Percentage |
| FPL | Federal Poverty Level |
| FQHC | Federally-Qualified Health Center |
| FS | Food Stamps |
| FY | Fiscal Year |
| GAF | Global Assessment of Functioning |
| GAP | Gamblers Assistance Program |
| GFA | Guidance for Applicants |
| GPO | Government Project Officer |
| GPRA | Government Performance & Result Act |
| HCPCS | Healthcare Common Procedure Coding System |
| HHS | U.S. Department of Health and Human Services |
| HHSS | Health and Human Services System (ended June 30, 2007) |
| HIE | Health Information Exchange |
| HIPAA | Health Insurance Portability & Accountability Act |
| HIT | Health Information Technology |
| HIV | Human Immunodeficiency Virus |
| HRA | Housing-Related Assistance |
| HRC | Hastings Regional Center |
| HRSA | Health Resources & Services Administration |
| HRSA | Health Resources and Services Administration |
| HUD | U.S. Dept. of Housing and Urban Development |
| ICCD | International Center for Clubhouse Development |
| ICCU | Integrated Care Coordination Unit |
| ICD-10 | The International Statistical Classification of Diseases and Related Health Problems, 10th Revision |

BEHAVIORAL HEALTH ACRONYMS | page 4

| | |
|--------|---|
| ICM | Intensive Case Management |
| ICS | Incident Command System |
| ICT | Interactive Communication Technology |
| IDU | Intravenous Drug User |
| IFSP | Individual Family Support Plan |
| IMD | Institutions for Mental Diseases |
| IOM | Institute of Medicine |
| IOP | Intensive Outpatient |
| IPP | Individual Program Plans |
| IRP | Individual Rehabilitation Planning |
| IRT | Intermediate Residential Treatment |
| IS | Information System |
| ISS | Intermediate Specialized Services |
| ITP | Individual Treatment Plan |
| JBHC | Justice Behavioral Health Committee |
| JCAHO | The Joint Commission (Joint Commission for Accreditation of Health Care Organizations) |
| LADC | Licensed Alcohol & Drug Counselor |
| LB | Legislative Bill |
| LCRT | Local Crisis Response Team |
| LGBT | Lesbian, Gay, Bisexual, and Transgendered |
| LGBTQ | Lesbian, Gay, Bisexual, Transgendered, and Questioning |
| LMEP | Lincoln Medical Education Partnership |
| LMHP | Licensed Mental Health Practitioner |
| LOA | Letter of Agreement |
| LOC | Level of Care |
| LOS | Length of Stay |
| LPC | Licensed Professional Counselor |
| LR | Legislative Resolution |
| LRC | Lincoln Regional Center |
| M/SUD | Mental and/or Substance Use Disorder |
| MCO | Managed Care Organization |
| MH | Mental Health |
| MHA | Mental Health Association |
| MHAC | State Advisory Committee on Mental Health Services (§71-814) |
| MHB | Mental Health Board |
| MHBG | Mental Health Block Grant |
| MHBG | Community Mental Health Services Block Grant |
| MHPAEA | Mental Health Parity and Addiction Equity Act |
| MIP | Minor in Possession |

BEHAVIORAL HEALTH ACRONYMS | page 5

| | |
|---------|--|
| MIS | Management Information System |
| MOA | Memorandum of Agreement |
| MOE | Maintenance of Effort |
| MOE | Maintenance of Effort |
| MOU | Memorandum of Understanding |
| MRO | Medicaid Rehab Options |
| MSA | Master Settlement Agreement |
| NABHO | Nebraska Association of Behavioral Health Organizations |
| NAC | Nebraska Administrative Code |
| NAMI | National Alliance for the Mentally Ill |
| NASADAD | National Association of State Alcohol & Drug Abuse Directors |
| NASMHPD | National Association of MH Program Directors |
| NBHQF | National Behavioral Health Quality Framework |
| NBHS | Nebraska Behavioral Health System |
| NCADI | National Clearinghouse for Alcohol and Drug Information |
| NDHHS | Nebraska Department of Health & Human Services |
| NEMA | Nebraska Emergency Management Agency |
| NePIP | Nebraska Partners in Prevention |
| NEPSAC | Northeast Panhandle Substance Abuse Center |
| NF | Nursing Facility |
| NFFS | Non-Fee For Service |
| NH | Nursing Home |
| NHAS | National HIV/AIDS Strategy |
| NIAAA | National Institute on Alcoholism and Alcohol Abuse |
| NIDA | National Institute on Drug Abuse |
| NIMH | National Institute on Mental Health |
| NIMS | National Incident Management System |
| NIS | Nebraska Information System |
| NMAP | Nebraska Medical Assistance Program |
| NMES | Nebraska Medicaid Eligibility System |
| NMMCP | Nebraska Medicaid Managed Program |
| NMT | Network Management Team |
| NOFAs | Notice of Funding Availability |
| NOMs | National Outcome Measures |
| NOMS | National Outcome Measures |
| NPN | National Prevention Network |
| NQS | National Quality Strategy |
| NRC | Norfolk Regional Center |
| NREPP | National Registry of Evidence-based Programs and Practices |
| NRPFS | Nebraska Risk and Protective Factor Student Survey |

BEHAVIORAL HEALTH ACRONYMS | page 6

| | |
|---------|--|
| NRRI | Not responsible by reason of insanity |
| NRRS | Nebraska Revised Reissued Statutes |
| NSDUH | National Survey on Drug Use and Health |
| OCA | Office of Consumer Affairs |
| OCR | Office of Civil Rights |
| OIG | Office of Inspector General |
| OMB | Office of Management and Budget |
| OMHSAAS | Office of Mental Health, Substance Abuse, and Addictions Services |
| ONDCP | Office of National Drug Control Policy |
| PASARR | Preadmission Screening and Resident Review |
| PASP | Preadmission screening process |
| PATH | Projects for Assistance in Transition from Homelessness |
| PBHCI | Primary and Behavioral Health Care Integration |
| PBR | Patient Bill of Rights |
| PCP | Primary Care Physician |
| PERMS | The American Managed Behavioral Healthcare Association's Performance Measures for Managed Behavioral Healthcare Programs |
| PH | Public Health |
| PHI | Protected Health Information |
| PHS | Public Health Service |
| PIER | Partners in Empowerment & Recovery |
| PiP | Partners in Prevention |
| PLADAC | Probationary Licensed Alcohol & Drug Counselor |
| POE | Plan of Expenditures |
| PPACA | Patient Protection and Affordable Care Act |
| PPBG | Federal Performance Partnership Block Grant |
| PPC | University of Nebraska Public Policy Center |
| PPP | Professional Partner Program |
| PPRC | (The Lincoln) Professional Provider Review Committee |
| PPS | Prospective Payment System |
| PRO | Peer Review Organization |
| PRR | Psych Res Rehab |
| PSC | Regional Prevention System Coordination of Goals & Budget |
| QA | Quality Assurance |
| QHP | Qualified Health Plan |
| QI | Quality Improvement |
| R & L | Regulation & Licensure (was part of the former HHSS) |
| RA | Regional Administrator |
| RADAR | Regional Alcohol and Drug Awareness Resource Network |
| RAT | Regional Administration Team |

BEHAVIORAL HEALTH ACRONYMS | page 7

| | |
|---------|---|
| RBP | Regional Budget Plan |
| RC | Regional Center |
| RFA | Request for Application (grants) |
| RFP | Reason for Proposal (contracts) |
| RFP | Request for Proposal |
| RGB | Regional Governing Board |
| ROFC | Reach Out Foster Care |
| ROLES | Restriction of Living Environment Scales & Placement Stability Scales |
| RPA | Regional Program Administrator |
| RPC | Regional Prevention Center |
| RPSC | Regional Prevention Service Coordinator |
| RSC | Regional System Coordination |
| SA | Substance Abuse |
| SAAC | State Advisory Committee on Substance Abuse Services (§ 71-815) |
| SABG | Substance Abuse Prevention and Treatment Block Grant |
| SAMHSA | Substance Abuse & Mental Health Services Administration |
| SAPTBG | Substance Abuse Prevention and Treatment Block Grant |
| SAS | Statistical Analysis System |
| SBIRT | Screening, Brief Intervention, Referral and Treatment |
| SE | Supported Employment |
| SED | Youth with Serious Emotional Disturbance |
| SEOW | State Epidemiological Outcome Workgroup |
| SFY | State Fiscal Year |
| SICA | State Incentive Cooperative Agreement |
| SIG | Statewide Infrastructure Grant |
| SMHA | State Mental Health Authority |
| SMI | Adult with Serious Mental Illness |
| SNF | Skilled Nursing Facility |
| SOC | Systems of Care |
| SOCA | Sex Offender Commitment Act |
| SOMMS | State Outcome Measurement & Management System |
| SPA | State Plan Amendment |
| SPF | Strategic Prevention Framework |
| SPF-SIG | Strategic Prevention Framework – State Incentive Grant |
| SPMI | Adult with Severe and Persistent Mental Illness |
| SSA | Single State Authority or State Substance Abuse Authority |
| SSDI | Social Security Disability Income |
| SSI | Supplemental Security Income |
| STR | Short Term Residential |
| SUD | Substance Use Disorder (note: DSM-5 also uses Substance-Related and |

BEHAVIORAL HEALTH ACRONYMS | page 8

| | |
|-------|---|
| | Addictive Disorders as well as Substance-Induced Disorders) |
| SWCAP | Southwest Center for Applied Prevention Technology |
| SYNAR | Synar Amendment – Not Acronym – 1994 Amendment to add tobacco compliance checks offered by Mike Synar, D – Oklahoma |
| TA | Technical Assistance |
| TAD | Turn Around Document |
| TANF | Temporary Assistance for Needy Families |
| TAP | Training Addiction Professionals |
| TASC | Targeted Adult Service Coordination |
| TBI | Traumatic Brain Injury |
| TE | Transitional Employment |
| TEDs | Treatment Episode Data Set |
| TFN | Tobacco Free Nebraska |
| TIN | Trauma Informed Nebraska |
| TIP | Treatment Improvement Protocol |
| TIW | Transitional Issues Worksheet |
| TJ | Therapeutic Jurisprudence |
| TLOA | Tribal Law and Order Act |
| TRF | Treatment Request Form |
| TTA | Training and Technical Assistance |
| UNK | University of Nebraska-Kearney |
| UNL | University of Nebraska-Lincoln |
| UNMC | University of Nebraska Medical Center |
| UNO | University of Nebraska-Omaha |
| URS | Uniform Reporting Systems (under the Federal Community Mental Health Services Block Grant) |
| VA | Veterans Administration |
| VR | Vocational Rehabilitation |
| WFDLT | Workforce Development Leadership Team |
| WRAP | Wellness Recovery Actions Plan |
| YRBS | Youth Risk Behavior Survey |
| YTD | Year to Date |
| YTS | Youth Tobacco Survey |

**NEBRASKA DEPARTMENT OF
HEALTH & HUMAN SERVICES**

**NEBRASKA OPEN
MEETINGS LAW**

**Nebraska Revised Statutes
Sections 84-1407 through 84-1414**

**Richard Mettler
DHHS Staff Development
July 2009**

PREFACE

This training curriculum presents provisions of Nebraska's Open Meetings Act [the Act] (Nebraska Revised Statutes Sections 84-1407 through 84-1414).

The material appearing under the ten headings (see 'Contents & Learning Objectives', p. 2) of the main text organized by numerals ('1', '2', '3',...) is taken directly from Nebraska's Open Meetings Act. Modest cosmetic and other editorial liberties are taken with this text to render the material more accessible to the reader. For example, statutory references are omitted, the order of topics is changed to better accommodate presentation during training, and for ease of expression the terms 'Open Meetings Act', 'the Act', and 'open meetings law' are preferred throughout. In addition, some portions of the Act are irrelevant to DHHS employees who are charged with operating in accordance with the Act, and those portions are deleted (e.g., references to 'city council', 'village board', 'cities', and 'villages'). These editorial liberties are taken with the understanding that a verbatim reference copy of the Act is immediately available to the reader in *Appendix IV*.

Following material drawn directly from the Act is an occasional subheading: 'Advice from the DHHS Legal Services Section'. This material answers questions that have arisen and anticipates questions likely to arise.

In the case of nine of the ten headings appearing in the main text, following the material drawn from the Act *per se*, is an additional subheading: 'Selected Rulings & Opinion in Addition to what Appears in the Open Meetings Act'. This material is organized by letters ('A', 'B', 'C',...) and presents a range of court findings and legal opinion (most notably the Nebraska Attorney General) that places the Act in sharper context.

All of this contextual material is included courtesy of Dale A. Comer, Assistant Nebraska Attorney General. Mr. Comer researched the Act extensively in preparation of an outline on the Open Meetings Act which is available from the Attorney General's Office, and was as generous in sharing the written results of this research as he was in granting permission for selected entries from this research to be used in this training curriculum.

No training curriculum on this subject can anticipate, account for, or suggest correct action for all imaginable circumstances. *This training curriculum does not constitute legal advice.* For all substantive or procedural questions about open meetings law, there is no substitute for competent legal counsel.

CONTENTS & LEARNING OBJECTIVES

| | |
|--|-----------|
| (I) Open Meetings Law Basic Provision & Purpose----- | 3 |
| (II) Public Bodies Subject to Open Meetings Law----- | 4 |
| (III) ‘Meeting’ Defined----- | 7 |
| (IV) Open Meetings Advance Publicized Notice, Agenda, & News Media----- | 9 |
| (V) Open Meetings & Rights of the Public in Attending----- | 12 |
| (VI) Open Meeting Minutes & Voting Procedures----- | 14 |
| (VII) Open Meetings by Videoconferencing & Telephone Conference Call----- | 16 |
| (VIII) Emergency Meetings----- | 18 |
| (IX) Closed Sessions of a Public Body----- | 20 |
| (X) Circumvention of Open Meetings Law, Enforcement Actions, &----- | 24 |
| Criminal Sanctions | |
| <i>Appendix I—Example Publicized Public Meeting Notice-----</i> | 26 |
| <i>Appendix II—Example Public Meeting Agenda-----</i> | 27 |
| <i>Appendix III—Example Public Meeting Minutes-----</i> | 28 |

NEBRASKA OPEN MEETINGS ACT

Nebraska Revised Statutes Sections 84-1407 through 84-1414

**OPEN MEETINGS LAW
BASIC PROVISION & PURPOSE**

- (1) It is hereby declared to be the policy of this state that the formation of public policy is public business and may not be conducted in secret.
- (2) Every meeting of a public body shall be open to the public in order that citizens may exercise their democratic privilege of attending and speaking at meetings of public bodies, except as otherwise provided by the Constitution of Nebraska, federal statutes, and the Open Meetings Act.

Selected Rulings & Opinion in Addition to what Appears in the Open Meetings Act

- (A)—Nebraska open meetings law is a statutory commitment to openness in government.
- (B)—Open meetings law is intended to ensure that all meetings of public bodies are open to the public, except when protection of the public interest clearly calls for a closed session concerning specific matters.
- (C)—Open meetings law should be broadly interpreted and liberally construed to obtain the objective of openness in favor of the public.
- (D)—The Legislature holds the power to decide the scope of citizen access to governmental meetings. As a result, the Legislature has the right to limit access to public meetings and the effect of the Open Meetings Act through later statutory provisions which provide that certain information in the possession of government should remain confidential without exception or limitation.

PUBLIC BODIES SUBJECT TO OPEN MEETINGS LAW

Public Bodies

- (1) For purposes of the Open Meetings Act, unless the context otherwise requires, ‘public body’ means:
- Governing bodies of all political subdivisions of the State of Nebraska;
 - Governing bodies of all agencies, created by the Constitution of Nebraska, statute, or otherwise pursuant to law, of the executive department of the State of Nebraska;
 - All independent boards, commissions, bureaus, committees, councils, subunits, or any other bodies created by the Constitution of Nebraska, statute, or otherwise pursuant to law;
 - Advisory committees of the public bodies listed above;
 - All study or advisory committees of the executive department of the State of Nebraska whether having continuing existence or appointed as special committees with limited existence; and
 - Instrumentalities exercising essentially public functions.

Exceptions

- (2) ‘Public body’ does not include:
- Subcommittees of such public bodies unless a quorum of the public body attends a subcommittee meeting, or unless such subcommittees are holding hearings, making policy, or taking formal action on behalf of their parent body; and
 - Entities conducting judicial proceedings unless a court or other judicial body is exercising rulemaking authority, deliberating, or deciding upon the issuance of

administrative orders.

Advice from the DHHS Legal Services Section

- If a DHHS employee is in doubt about whether a group constitutes a ‘public body’ subject to open meetings law, he or she should consult the DHHS Legal Services Section.

Selected Rulings & Opinion in Addition to what Appears in the Open Meetings Act

(A)—The Nebraska Court of Appeals held that open meetings law applies to the governing bodies of all agencies of the executive branch of government.

(B)—The Attorney General indicated that the Environmental Control Council is a public body subject to open meetings law. On the other hand, the Department of Environmental Control is not. Open meetings law applies to governing bodies of state agencies, and not to the agencies themselves.

(C)—Committees of faculty, administration, and students created by the Board of Regents of the University of Nebraska to advise the Chancellor of the University in his administrative/management function with respect to budget cuts were part of the management structure of the University and not public bodies subject to open meetings law.

(D)—‘Political subdivision’ is not defined in public meetings law. However, the Attorney General indicated that generally the term denotes any subdivision of a state which has as its purpose carrying out the functions of the state which are inherent necessities of government and which have always been regarded as such by the public.

(E)—The Court held that a county agricultural society, organized under Nebraska statutes, was subject to the provisions of open meetings law. The Court noted that, although the society at issue resembled a private corporation in some respects, the fact that it had the right to receive support from the public revenue gave it a public character. The agricultural society apparently was an ‘independent board’ “created by the Constitution of Nebraska, statute, or otherwise pursuant to law.” The Attorney General concluded that county extension services which have the right to receive support from public revenues are subject to open meetings law.

(F)—An employee grievance appeal hearing conducted by a hearing officer is not a meeting of a public body since the word ‘body’ is commonly understood to refer to a group or number of persons, and thus does not include an individual conducting a hearing.

(G)—A county welfare board is subject to open meetings law as an independent board created by statute.

(H)—The Attorney General indicated that the Mayor’s Citizen Review Board, appointed by the Mayor of Omaha to advise the Mayor with respect to alleged misconduct by police officers, was not subject to open meetings law because it did not fall under the definition of ‘public body’, and because the Board was essentially an administrative body which was part of the management structure of the city.

(I)—The Excellence in Education Council created to make recommendations to the Governor regarding selection of projects for Education Innovation Grants is a public body which is subject to open meetings law, and its decisions concerning specific recommendations must be done in open session.

(J)—The Quality Jobs Board created under the Quality Jobs Act is a public body subject to the Open Meetings Act.

(K)—A County Hospital Authority formed under the Hospital Authorities Act is a public body which is subject to the Open Meetings Act.

(L)—The Nebraska State Board of Agriculture (the State Fair Board) is not a public body which is subject to the Open Meetings Act, primarily because it has no statutory right to public revenue, and also because of case law which indicates that it is a private corporation.

(M)—A county clerk, county attorney, and county treasurer acting as a group to make an appointment to fill a vacancy on a county board constitute a public body which is subject to the Open Meetings Act.

(N)—The Attorney General indicated informally that the Nebraska Board of Pardons and the Board of Inquiry and Review created to receive and act upon applications submitted for membership in Nebraska Veterans’ Homes are subject to open meetings law.

‘MEETING’ DEFINED

- (1) ‘Meeting’ means all regular, special, or called meetings, formal or informal, of any public body for the purposes of briefing, discussion of public business, formation of tentative policy, or the taking of any action of the public body.

Advice from the DHHS Legal Services Section

- A ‘quorum’ is defined as ‘a simple majority’ (i.e. 50% plus one), so a quorum of a 20 member public body would be 11, unless ‘quorum’ is expressly set at a different number by a statute that applies to the public body or if the quorum for the public body is set at a different number in the bylaws validly adopted by the public body.

Selected Rulings & Opinion in Addition to what Appears in the Open Meetings Act

(A)—A meeting of a public body occurs when two things happen:

- 1) A quorum of the public body is present; and
- 2) The members of the public body engage in briefing, discussion of public business, formation of tentative policy, or the taking of any action of the public body.

(B)—The legislative history of open meetings law indicates that a ‘meeting’ does not occur absent a quorum. In addition, the Attorney General concluded that the presence of a majority of the members of a public body is necessary for a meeting to occur.

(C)—Meetings of a public body do not include social meetings or meetings which were not called by the public body.

(D)—An ‘informational and educational’ meeting of a public body governing a political subdivision where members generally discuss matters pertaining to their subdivision, hear reports from various department heads of the subdivision as to their duties, and learn the workings of the subdivision is a meeting of the public body for ‘briefing’ purposes, which is subject to open meetings law.

(E)—The Court of Appeals stated that listening and exposing itself to facts, arguments, and statements constitutes a crucial part of a governmental body’s decision making. As a result, receiving information triggers the requirements of the statutes, and open meetings law applies to meetings at which briefing or the formation of tentative policy takes place, as well as to meetings where action is contemplated or taken.

(F)—A workshop held by the Board of Regents of the University of Nebraska with a professional facilitator to discuss communication practices and the roles of the Board and the University President was not subject to the Open Meetings Act, which exempts chance meetings or attendance at or travel to conventions or workshops. The University also asserted that there would be no briefing, discussion of public business, formation of tentative policy, vote, or taking of other action at the workshop.

(G)—The Attorney General indicated informally that a meeting of a public body “for the purpose of receiving training or doing planning (such as a retreat)” should probably be treated as subject to the Open Meetings Act.

OPEN MEETINGS ADVANCE PUBLICIZED NOTICE, AGENDA, & NEWS MEDIA

Advance Notice & Agenda

- (1) There are notice and agenda requirements for every meeting of a public body other than emergency meetings.
- (2) Each public body shall give reasonable advance publicized notice of the time and place of each meeting by a method designated by each public body and recorded in its minutes.
- (3) Such public notice shall be transmitted to all members of the public body and to the public.
- (4) Such notice shall contain an agenda of subjects known at the time of the publicized notice or a statement that the agenda, which shall be kept continually current, shall be readily available for public inspection at the principal office of the public body during normal business hours.
- (5) Agenda items shall be sufficiently descriptive to give the public reasonable notice of the matters to be considered at the meeting.
- (6) Except for items of an emergency nature, the agenda shall not be altered later than 24 hours before the scheduled commencement of the meeting.
- (7) The public body shall have the right to modify the agenda to include items of an emergency nature only at such public meeting.

News Media

- (8) The secretary or other designee of each public body shall maintain a list of the news media requesting notification of meetings and shall make reasonable efforts to provide advance notification to them of the time and place of each meeting and the subjects to be discussed at that meeting.

Advice from the DHHS Legal Services Section

- If multiple teleconference sites are used to conduct a meeting of a public body, it is required to state in the public meeting notice the name and address of each such site.

Selected Rulings & Opinion in Addition to what Appears in the Open Meetings Act

(A)—The purpose of the agenda requirement is to give some meaningful notice of the matters to be considered at the meeting so that persons who are interested will know which matters are under consideration. Posting notice at 10:00 p.m. on March 15 before a meeting at 10:30 a.m. on March 16 does not constitute reasonable notice. Posting notice one week in advance does.

(B)—A notice of a hearing, given by a school board, stating that a hearing would be held, and that an agenda would be available for inspection, once established, is not proper notice. An agenda must be available to the public at the time of the notice.

(C)—The Open Meetings Act requires public bodies to give reasonable advance publicized notice of the time and place of their meetings, in part so that the public may attend and speak at those meetings.

(D)—The Attorney General concluded that ‘advance publicized notice’ means that a separate, specific advance notice must be given for each meeting.

(E)—An agenda may not be used as the minutes of a meeting.

(F)—‘Reasonable notice’ under the law means notice reasonably calculated to give appropriate advance notice to citizens of the time and place of a meeting.

(G)—The Court seemed to suggest that the sufficiency of an agenda item might be measured, at least to some degree, in the context of the other meetings of the public body immediately prior to the public meeting in question.

(H)—A member of the public should not be required to hunt up and read the documents underlying an agenda of a public body to determine what is actually on that agenda.

(I)—If a public body uses or publishes its agenda to give the required notice for a particular meeting, then the notice contained in the agenda must comport with the law for giving notice of what is to be considered at the meeting.

(J)—The prohibition against altering an agenda within 24 hours of a meeting was added in public meetings law to prevent addition of last minute matters to an agenda which did not accurately represent emergencies.

OPEN MEETINGS & RIGHTS OF THE PUBLIC IN ATTENDING

- (1) Subject to the Open Meetings Act, the public has the right to attend and the right to speak at meetings of public bodies, and all or any part of a meeting of a public body, except for proper closed sessions, may be videotaped, televised, photographed, broadcast, or recorded by any person in attendance by means of a tape recorder, camera, video equipment, or any other means of pictorial or sonic reproduction or in writing.
- (2) It shall not be a violation of open meetings law for any public body to make and enforce reasonable rules and regulations regarding the conduct of persons attending, speaking at, videotaping, televising, photographing, broadcasting, or recording its meetings.
- (3) A public body may not be required to allow citizens to speak at each meeting, but it may not forbid public participation at all meetings.
- (4) No public body shall require members of the public to identify themselves as a condition for admission to the meeting. The public body may require any member of the public desiring to address the public body to identify him or herself.
- (5) No public body shall, for the purpose of circumventing the Open Meetings Act, hold a meeting in a place known by the public body to be too small to accommodate the anticipated audience.
- (6) No public body shall be deemed in violation of open meetings law if it holds its meeting in its traditional meeting place which is located in this state.
- (7) No public body shall be deemed in violation of open meetings law if it holds a meeting outside of this state if, but only if:
 - A member entity of the public body is located outside of this state and the meeting is in that member's jurisdiction;
 - All out-of-state locations identified in the public notice are located within public buildings used by members of the entity or at a place which will accommodate the

anticipated audience;

- Reasonable arrangements are made to accommodate the public's right to attend, hear, and speak at the meeting, including making a telephone conference call available at an instate location to members, the public, or the press, if requested 24 hours in advance;
 - No more than 25% of the public body's meetings in a calendar year are held out-of-state;
 - Out-of-state meetings are not used to circumvent any of the public government purposes established in the Open Meetings Act;
 - Reasonable arrangements are made to provide viewing at other instate locations for a videoconference meeting if requested 14 days in advance and if economically and reasonably available in the area; and
 - The public body publishes notice of the out-of-state meeting at least 21 days before the date of the meeting in a legal newspaper of statewide circulation.
- (8) The public body shall, upon request, make a reasonable effort to accommodate the public's right to hear the discussion and testimony presented at the meeting.
- (9) Public bodies shall make available at the meeting or the instate location for a telephone conference call or videoconference, for examination and copying by members of the public, at least one copy of all reproducible written material to be discussed at an open meeting.
- (10) Public bodies shall make available at least one current copy of the Open Meetings Act posted in the meeting room at a location accessible to members of the public. At the beginning of the meeting, the public shall be informed about the location of the posted information.

Selected Rulings & Opinion in Addition to what Appears in the Open Meetings Act

(A)—The language requiring a reasonable effort to allow all parties to hear a public meeting does not involve an absolute requirement that all persons present shall be able to hear.

OPEN MEETING MINUTES & VOTING PROCEDURES

Open Meeting Minutes

- (1) Each public body shall keep minutes of all meetings showing the time, place, members present and absent, and the substance of all matters discussed.
- (2) The minutes of all meetings and evidence and documentation received or disclosed in open session shall be public records and open to public inspection during normal business hours.
- (3) Minutes shall be written and available for inspection within 10 working days or prior to the next convened meeting, whichever occurs earlier.

Voting Procedures

- (4) Any action taken on any question or motion duly moved and seconded shall be by roll call vote of the public body in open session, and the record shall state how each member voted or if the member was absent or not voting.
- (5) The vote to elect leadership within a public body may be taken by secret ballot, but the total number of votes for each candidate shall be recorded in the minutes.

Selected Rulings & Opinion in Addition to what Appears in the Open Meetings Act

(A)—The Attorney General stated that nothing in open meetings law requires approval of the minutes of a public body prior to their publication.

(B)—The Attorney General indicated that detailed minutes of all matters discussed need not be maintained when a public body is meeting in closed or executive session, so long as the requirements pertaining specifically to the minute entries necessary for a closed session are satisfied.

(C)—Open meetings law concerning roll call votes does not require the record to state that the vote was by roll call but only requires that the record show if and how each member voted. Neither does open meetings law set a time limit for recording the results of a vote.

(D)—The statutory requirements concerning voting and minutes are mandatory since the Legislature provided that action taken in violation of this statute is void.

(E)—The legislative history of the original Open Meetings Act indicates that the requirement of a roll call vote was directed at votes on questions that would bind the particular public body. Other procedural questions were not addressed.

OPEN MEETINGS BY VIDEOCONFERENCING & TELEPHONE CONFERENCE CALL

- (1) 'Videoconferencing' means conducting a meeting involving participants at two or more locations through the use of audio-video equipment which allows participants at each location to hear and see each meeting participant at each other location, including public input.
- (2) Interaction between meeting participants shall be possible at all meeting locations.
- (3) A meeting of a state agency, state board, state commission, state council, or state committee, of an advisory committee of any such state entity, of an organization created under the Interlocal Cooperation Act, the Joint Public Agency Act,...may be held by means of videoconferencing...if:
 - Reasonable advance publicized notice is given;
 - Reasonable arrangements are made to accommodate the public's right to attend, hear, and speak at the meeting, including seating, recordation by audio or visual recording devices, and a reasonable opportunity for input such as public comment or questions to at least the same extent as would be provided if videoconferencing or telephone conferencing was not used;
 - At least one copy of all documents being considered is available to the public at each site of the videoconference or telephone conference;
 - At least one member of the state entity, advisory committee, or governing body is present at each site of the videoconference or telephone conference; and
 - No more than one-half of the state entity's, advisory committee's, or governing body's meetings in a calendar year are held by videoconference or telephone conference.
- (4) Videoconferencing, telephone conferencing, or conferencing by other electronic communication shall not be used to circumvent any of the public government purposes established in the Open Meetings Act.

- (5) A meeting of the governing body of an entity formed under the Interlocal Cooperation Act or the Joint Public Agency Act...may be held by telephone conference call if:
- The territory represented by the member public agencies of the entity or pool covers more than one county;
 - Reasonable advance publicized notice is given which identifies each telephone conference location at which a member of the entity's or pool's governing body will be present;
 - All telephone conference meeting sites identified in the notice are located within public buildings used by members of the entity or pool or at a place which will accommodate the anticipated audience;
 - Reasonable arrangements are made to accommodate the public's right to attend, hear, and speak at the meeting, including seating, recordation by audio recording devices, and a reasonable opportunity for input such as public comment or questions to at least the same extent as would be provided if a telephone conference call was not used;
 - At least one copy of all documents being considered is available to the public at each site of the telephone conference call;
 - At least one member of the governing body of the entity or pool is present at each site of the telephone conference call identified in the public notice;
 - The telephone conference call lasts no more than one hour; and
 - No more than one-half of the entity's or pool's meetings in a calendar year are held by telephone conference call.
- (6) Nothing in open meetings law shall prevent the participation of consultants, members of the press, and other nonmembers of the governing body at sites not identified in the public notice.
- (7) Telephone conference calls, emails, faxes, or other electronic communication shall not be used to circumvent any of the public government purposes established in the Open Meetings Act.
- (8) A public body may allow a member of the public or any other witness other than a member of the public body to appear before the public body by means of video or telecommunications equipment.

EMERGENCY MEETINGS

- (1) When it is necessary to hold an emergency meeting without reasonable advance public notice, the nature of the emergency shall be stated in the minutes and any formal action taken in such meeting shall pertain only to the emergency.
- (2) Such emergency meetings may be held by means of electronic or telecommunication equipment.
- (3) The provisions of the Open Meetings Act concerning meeting notice to the media shall be complied with in conducting emergency meetings.
- (4) Complete minutes of such emergency meetings specifying the nature of the emergency and any formal action taken at the meeting shall be made available to the public by no later than the end of the next regular business day.

Selected Rulings & Opinion in Addition to what Appears in the Open Meetings Act

(A)—Public bodies may hold emergency meetings without reasonable advance public notice when two criteria are satisfied:

- 1) The situation before the public body must require immediate action (as in pressing necessity or urgency); and
- 2) The situation generating the emergency must be unforeseen (as in a sudden or unexpected happening).

(B)—The Attorney General indicated that an ‘emergency meeting’ may be conducted by electronic and telecommunications equipment including radio and telephone conferences.

(C)—On the other hand, open meetings law does not authorize the use of telephone conference calls for non-emergency meetings of a public body, and absent members of a public body may not be counted to achieve a quorum through the use of a conference call.

(D)—The Court indicated, in a case involving allegations of a violation of open meetings law, that an emergency is defined as “any event or occasional combination of circumstances which calls for immediate action or remedy; pressing necessity; exigency; a sudden or unexpected happening; an unforeseen occurrence or condition.”

(E)—The Attorney General stated that an item of an emergency nature is one that requires immediate resolution by the public body, and one which has arisen in circumstances impossible to anticipate at a time sufficient to place on the agenda of a regular, called, or special meeting of the public body.

(F)—The Attorney General also indicated that action taken during a meeting of a public body by a telephone conference call which did not comply with the requirements of open meetings law for emergency meetings was void.

CLOSED SESSIONS OF A PUBLIC BODY

- (1) Any public body may hold a closed session by the affirmative vote of a majority of its voting members if a closed session is clearly necessary for the protection of the public interest or for the prevention of needless injury to the reputation of an individual and if such individual has not requested a public meeting.
- (2) The subject matter and the reason necessitating the closed session shall be identified in the motion to close.
- (3) Closed sessions may be held for, but shall not be limited to, such reasons as:
 - Strategy sessions with respect to collective bargaining, real estate purchases, pending litigation, or litigation which is imminent as evidenced by communication of a claim or threat of litigation to or by the public body;
 - Discussion regarding deployment of security personnel or devices;
 - Investigative proceedings regarding allegations of criminal misconduct; or
 - Evaluation of the job performance of a person when necessary to prevent needless injury to the reputation of a person and if such person has not requested a public meeting.
- (4) Nothing in this section shall permit a closed meeting for discussion of the appointment or election of a new member to any public body.
- (5) The vote to hold a closed session shall be taken in open session.
- (6) The entire motion, the vote of each member on the question of holding a closed session, and the time when the closed session commenced and concluded shall be recorded in the minutes.
- (7) If the motion to close passes, then the presiding officer immediately prior to the closed session shall restate on the record the limitation of the subject matter of the closed session.
- (8) The public body holding such a closed session shall restrict its consideration of matters during the closed portions to only those purposes set forth in the motion to

close as the reason for the closed session.

- (9)** The meeting shall be reconvened in open session before any formal action may be taken.
- (10)** For purposes of open meetings law, ‘formal action’ shall mean a collective decision or a collective commitment or promise to make a decision on any question, motion, proposal, resolution, order, or ordinance, or formation of a position or policy, but shall not include negotiating guidance given by members of the public body to legal counsel or other negotiators in closed sessions as authorized in open meetings law.
- (11)** Any member of any public body shall have the right to challenge the continuation of a closed session if the member determines that the session has exceeded the reason stated in the original motion to hold a closed session, or if the member contends that the closed session is neither clearly necessary for:

 - 1) The protection of the public interest; or
 - 2) The prevention of needless injury to the reputation of an individual.
- (12)** Such challenge shall be overruled only by a majority vote of the members of the public body.
- (13)** Such challenge and its disposition shall be recorded in the minutes.
- (14)** Nothing in this section shall be construed to require that any meeting be closed to the public.
- (15)** No person or public body shall fail to invite a portion of its members to a meeting, and no public body shall designate itself a subcommittee of the whole public body for the purpose of circumventing the Open Meetings Act.
- (16)** No closed session, informal meeting, chance meeting, social gathering, email, fax, or other electronic communication shall be used for the purpose of circumventing the requirements of the Open Meetings Act.
- (17)** The Open Meetings Act does not apply to chance meetings or to attendance at or travel to conventions or workshops of members of a public body at which there is no

meeting of the body then intentionally convened, if there is no vote or other action taken regarding any matter over which the public body has supervision, control, jurisdiction, or advisory power.

Selected Rulings & Opinion in Addition to what Appears in the Open Meetings Act

(A)—One of the purposes for the initial Open Meetings Law was to tighten restrictions on closed or executive sessions of public bodies.

(B)—The prohibition against decisions or formal actions in a closed session proscribes crystallization of a secret decision and then ceremonial acceptance in open session.

(C)—There is a guiding principle with respect to closed sessions: *“If a public body is uncertain about the type of session to be conducted, open or closed, bear in mind the policy of openness promoted by the Open Meetings Act, and opt for a meeting in the presence of the public.”*

(D)—The provisions of open meetings law concerning closed sessions, in part, reflect the Legislature’s judgment of the appropriate balance between the public’s interest in open discussion of governmental issues and the rights of individuals, such as state employees, to have their performance as employees considered in private if they so choose.

(E)—If the primary purpose for a closed session of a public body is authorized under open meetings law, then any necessary discussion of incidental matters is also authorized.

(F)—A closed session is not proper simply because matters permitting a closed session might arise. Such a closed session is permitted only when such matters do arise and must be addressed.

(G)—A public body can go into a proper closed session for discussion of personnel matters and then reconvene for a public vote with no lengthy explanation of the rationale underlying the decision.

(H)—The closed session exception for prevention of needless injury to reputation is for the protection of individual employees and not for the protection of governmental officers on the public body as members of the public body.

(I)—The Attorney General indicated that detailed minutes of all matters discussed need not be maintained when a public body is meeting in closed or executive session, so long as the requirements pertaining specifically to the minute entries necessary for a closed session are satisfied.

(J)—It is not entirely clear what vote of the public body is necessary to go into closed session. The statute states “by the affirmative vote of a majority of its [the public body’s] voting members” as necessary for a closed session. This language appears to imply a majority of those members of the public body present and voting. This interpretation is supported later in requiring “a majority vote of the members of the public body” to overrule a challenge to the continuation of the closed session. However, the legislative history of open meetings law makes it quite clear that the legislators intended to make the requirement for a closed session a vote of the majority of the public body rather than a vote of the majority of those members of the public body present and voting. The safer course is to authorize a closed session of the public body by a majority vote of the members of the public body *per se*, rather than by a mere majority vote of those members of the public body present.

(K)—Good faith motivation for a closed session is not a cure for non-compliance with open meetings law.

(L)—The Nebraska Court of Appeals indicated that ‘private quorum conferences’ are an evasion of open meetings law.

(M)—Discussions of legal matters between a county board and a county attorney involving pending litigation or legal consequences of specific action are suitable for a closed session.

(N)—The Attorney General indicated informally that developing testimony for an upcoming legislative hearing is not a proper reason for a state agency to go into closed session.

(O)—On the other hand, the Attorney General also indicated informally that discussion of “sensitive medical and financial information” pertaining to specific individuals who applied for admission to a state home could be conducted in a closed session so long as the actual vote on admission was done in an open meeting.

CIRCUMVENTION OF OPEN MEETINGS LAW, ENFORCEMENT ACTIONS, & CRIMINAL SANCTIONS

- (1) Enforcement options are available to individuals who believe that open meetings law has been violated.
- (2) Any motion, resolution, rule, regulation, ordinance, or formal action of a public body made or taken in violation of the Open Meetings Act shall be declared void by the district court if the suit is commenced within 120 days of the meeting of the public body at which the alleged violation occurred.
- (3) Any motion, resolution, rule, regulation, ordinance, or formal action of a public body made or taken in substantial violation of the Open Meetings Act shall be voidable by the district court if the suit is commenced more than 120 days after but within one year of the meeting of the public body in which the alleged violation occurred.
- (4) A suit to void any final action shall be commenced within one year of the action.
- (5) The Attorney General and the county attorney of the county in which the public body ordinarily meets shall enforce the Open Meetings Act.
- (6) Any citizen of this state may commence a suit in the district court of the county in which the public body ordinarily meets or in which the plaintiff resides for the purpose of requiring compliance with or preventing violations of the Open Meetings Act, for the purpose of declaring an action of a public body void, or for the purpose of determining the applicability of the Act to discussions or decisions of the public body.
- (7) It shall not be a defense that the citizen attended the meeting and failed to object at such time.
- (8) The court may order payment of reasonable attorney's fees and court costs to a successful plaintiff in a suit brought under provisions of open meetings law.
- (9) Any member of a public body who knowingly violates or conspires to violate or who attends or remains at a meeting knowing that the public body is in violation of any provision of the Open Meetings Act shall be guilty of a Class IV misdemeanor for a first offense, and a Class III misdemeanor for a second or subsequent offense.

Selected Rulings & Opinion in Addition to what Appears in the Open Meetings Act

(A)—The Attorney General indicated that intent is a necessary element of the conduct prohibited by the Open Meetings Act, and that members of a public body can communicate

with other members of that body by electronic means, even if that communication is directed to a quorum of the body, so long as there is no course of communication which becomes sufficiently involved so as to evidence an intent or purpose to circumvent the Open Meetings Act.

(B)—The primary concern is with intentional circumvention of open meetings law rather than inadvertent acts.

(C)—Once a meeting has been declared void pursuant to the Open Meetings Act, the members of the public body involved are prohibited from considering any information which they obtained at the illegal meeting.

(D)—A Class IV misdemeanor is punishable by a fine of from \$100 to \$500 and no imprisonment. A Class III misdemeanor is punishable by up to 3 months imprisonment or up to a \$500 fine, or both. A Class III misdemeanor has no minimum penalty.

(E)—The Nebraska Supreme Court indicated that action by a public body which is proper under the Open Meetings Act may cure defects in actions previously taken by the same public body. In such an instance, an action by a public body which previously might have been declared void will be declared proper. On the other hand, under those circumstances, the original improper meeting itself is still void. The effect of an invalid public meeting under open meetings law is the same as if the meeting never occurred.

APPENDIX I:

EXAMPLE PUBLICIZED PUBLIC MEETING NOTICE

NOTICE OF PUBLIC MEETING

Monday, October 15, 2007

The next meeting of the Nebraska WIC Vendor Advisory Committee will be held on Wednesday, October 24, 2007 at the Interstate Holiday Inn, 7838 South U.S. Highway 281 in Grand Island, Nebraska (308) 384-7770. The Meeting will commence at 10:00 a.m. CDT in the North Platte Room and adjourn by 3:00 p.m. A copy of the meeting agenda is available for public inspection by contacting:

Peggy Trouba, WIC Program Manager
Nebraska Department of Health & Human Services, Division of Public Health
301 Centennial Mall South, Third Floor
Lincoln, NE 68509-5026

Telephone: (402) 471-2781

Fax: (402) 471-9570

E-mail: peggy.trouba@dhhs.ne.gov

Telecommunications Number for the Deaf: (402) 471-9570

APPENDIX II:

EXAMPLE PUBLIC MEETING AGENDA

AGENDA

Nebraska WIC Vendor Advisory Committee Meeting

October 24, 2007—10:00 a.m. to 3:00 p.m. CDT

Interstate Holiday Inn, North Platte Room

7838 South U.S. Highway 281

Grand Island, Nebraska

- I. Welcome & introductions
- II. Revised charter
- III. Agenda items requested during the July 18, 2007 meeting of the Committee
 - A. Planning for the new proposed WIC food package changes
 - B. Possibility of putting vendor number stamps on the back of checks
 - C. Avenues of communication with retailers:
 - 1. WIC website
 - 2. Nebraska Grocery Industry Association
 - 3. Wholesalers' network
- IV. New agenda items:
 - A. Prices & tracking
- V. Period for Public Comment
- VI. Next Steps
- VII. Meeting Review
- VIII. Adjourn

APPENDIX III:

EXAMPLE PUBLIC MEETING MINUTES

Nebraska WIC Vendor Advisory Committee Meeting

October 24, 2007—10:00 a.m. to 3:00 p.m. CDT
Interstate Holiday Inn, North Platte Room
7838 South U.S. Highway 281
Grand Island, Nebraska

Welcome & Introductions

- The third meeting of the Nebraska WIC Vendor Advisory Committee was convened at 10:00 a.m. Copies of the agenda were mailed to Committee members prior to meeting. The meeting was advertised in the State Calendar on Monday, October 15, 2007. Roll call was conducted and a quorum was established of Committee members present.
- The following members were present: Bill Huenemann, Retailer; Karen Lopez, Retailer; Colleen Weber, Retailer; Tracy Walter, Retailer; Peggy Ingersoll, Wholesaler; Doug Cunningham, Wholesaler; Kathy Siefken, Executive Director, Nebraska Grocery Industry Association; Judy Schultz, WIC Local Agency Vendor Manager; Marcia Wallen, WIC Local Agency Vendor Manager; Peggy Trouba, State WIC Program Manager; Regina Paschold, State WIC Vendor Management Coordinator.
- Members not attending: Becky Maser, Retailer; Jeff Lemon, Retailer; Dawnell Pafundi, Retailer; Terri Suhr, Retailer; Debbie Schmick, Retailer; Lisa DeVore, WIC Consumer; Julie Starman, WIC Consumer.
- The minutes of the Nebraska WIC Vendor Advisory Committee meeting held July 18, 2007 were approved.

Protocol for the Group

- An update was made to the charter to include Judy Schultz from Community Action Partnership of Mid-Nebraska as a new Committee member. Judy is representing a WIC local agency. Judy replaces Rochelle Kieborz. Judy's membership was approved by Dr. Schaefer, Director, DHHS Division of Public Health & Chief Medical Officer, and who sponsors this advisory committee. An updated Committee membership list was handed out to attach to the Committee charter.

- Also added to the charter and to be included under a new heading, “Operating Agreements,” was the following statement: “After two consecutive absences, members should be contacted to see if they want to continue as a member or voluntarily withdraw. If members who attend regularly cannot attend and need to send a replacement, they may provide an explanation of why they cannot attend and have a suitable informed alternate pre-approved by the State WIC Office to take their place.” The Committee should decide whether a replacement member is necessary.

Agenda Items Requested during the July 18, 2007 Meeting of the Committee

Planning for the new proposed WIC food package changes

- Lynn Goering and Jane DeCamp provided information regarding the August 2006 USDA “Proposed Rule.” The anticipated date of the final rule is December 2007. The driving force behind the rule change was changes in the dietary guidelines. It was asked how the new regulations would affect new vendor contracts. Regina stated that an extension to the current vendor contract could be made until regulations are completed.
- Members were asked to browse potential food items displayed and answer questions on a quiz. Comments were made regarding adding fresh fruits and vegetables at an allowable voucher amount of \$6.00 for children and \$8.00 for women.

The foods discussed included the following:

- Baby foods—packages of different sizes, different textures, different stages, different types of containers (glass or plastic), and organic.
- Fresh, frozen, and canned vegetables (canned vegetables may not have added sugar).
- Juice (to offset costs and introduce more fruits and vegetables, the amount of juice will be reduced).
- Milk (after the age of two, only reduced fat milk is allowed and the amount will be reduced slightly).
- Whole grains (for children 2 lbs. are allowed; for women 1 lb. is allowed). Size and cost of bread loaves could be a problem.

- Other foods and substitutions could be considered, such as canned salmon or sardines, brown rice, bulgur, barley, tofu, beans (option of canned instead of dried beans) corn, and whole wheat tortillas.
- The WIC Program wants the type of items that are within budget and affordable, and would like participants to learn about new fruits and vegetables. We need to consider our diverse population, offer foods that are acceptable to them, and keep in mind that WIC is only a supplement to their diet.
- What's next—wait for the regulations to be published and then we need to evaluate the changes. We are not sure how long we will have to implement the changes. We will need to review regulations, work with participants, partner with vendors, and update changes in our computer system to make it as efficient as possible. Keeping it simple for vendors, participants, and WIC staff is our goal. *Communication is important!*
- Slides from this presentation will be e-mailed to Committee members.
- A question was asked as to whether retailers are going to be involved in the final rule regarding choices. We will have to revise the food review process. Retailers need time to work with manufacturers and suppliers to carry these products. We need to talk about issues such as unavailable products and not being able to carry certain items. Packaging could be a big problem with differences in sizes of, for example, bread. We have to work through food packaging.
- Members would want to have as many meetings as possible to make decisions on food items. We have to consider what's in the marketplace at that time. Fresh foods will be an option. From the wholesalers' standpoint some of those items, in order to include them, are going to have to be private label products.
- Jane asked the wholesalers and retailers about the demographics of buying certain products such as soy milk—there have been many requests for soy milk from those who are lactose intolerant. What percentage of soy products will be sold? We need to go to each individual retailer for sales information to get a percentage of sales for cow's milk. Soy milk comes through the warehouse and they can tell how many soy products are being distributed statewide.
- A question was asked about baby food. There will be an emphasis on fruits and vegetables.

Breastfed infants will get a larger food package—more fruits and vegetables and meat than formula fed babies.

Lunch: 12:00 - 12:45

Possibility of Putting Vendor Number Stamps on Back of Checks

- The possibility was discussed at the July meeting of having stores put an identifying vendor number on the back of the check as a means to decrease the number of checks returned. The stores would still need to continue to stamp the front of the check. State WIC staff were to follow-up with FSMC to see if this would be feasible.
- State WIC staff checked with our fiscal intermediary, FSMC, and it is possible to use an endorsement edit. When the vendor number is missing or unreadable, they can turn the check over and look at the back. They would look at the area where the check is rung through the cash register. If there is identifying information, such as the store name and identifying store number and/or address the check could be reviewed. That information would then be matched with the file from the State WIC Office. If the store can be identified, then the vendor number can be recorded and the check processed. If the store cannot be identified, then the check will be returned. This would require updating our file with identifying information and sending it to FSMC. We need to review the backs of our checks to see how much information stores have there. Other states that have this advise us to monitor the stores closely so it does not get out of hand.
- FSMC charges \$.85 to turn a check over and look at it. Regina talked to other states that have used this edit and it does decrease the number of checks returned.
- The State would have to update the WIC database that is sent to FSMC to include that number. The number of checks being returned has decreased with September being our best month of all during the past fiscal year. Only 319 checks were returned for missing vendor stamps in September.
- The use of sanction points imposed by the State if a vendor has a high number of rejected checks was discussed. If a high number of sanction points are built up, then the vendor could be taken off the program.

Avenues of Communication with Retailers

WIC Website:

- Handouts of Nebraska's website were passed out and discussion followed on what other states' websites had available.
- The Nebraska website has basic information about WIC agencies and the WIC Program in general, geared toward the client. The WIC approved foods list is on the website and can be printed in PDF format.
- We would like to have a vendor home page providing the name, contact person, and address of our retailers. Missouri has a map with counties that can be clicked on and all the WIC approved stores in that county come up.
- The possibility of putting price surveys on the web was noted. The Kansas website was very clear and concise. It had training materials, infant formula manufacturers, the vendor's procedure manual, vendor application packet, WIC vendor contract, cashier training manual, forms, and memos. We will have our contact people pursue similar changes for our website.

Nebraska Grocery Industry Association:

- Best means of communication is fax and e-mail. First choice is e-mail, second choice is fax, and then everyone else is sent a mailing.

Wholesalers' Network:

- Best means of communication is email, fax, mail, or phone call. Have an access system in the stores to communicate with satellite. E-mail to all grocers except Wal-Mart because they are not members of the Nebraska Grocery Industry Association. Fax sometimes is a faster way to get the word out if you really need to, since the fax will go right to the store. Sometimes e-mail won't get read until that night and sometimes the letters that are mailed are not read.

New Agenda Items

Prices & Tracking:

- It was suggested that wholesalers could be alerted when the number of returned checks is too high.

- Retail price increases and decreases are effective immediately; as soon as the price increase or decrease occurs the price goes into the computer. Everything affects price increases—costs of transportation, heating, cooling, and costs of doing business. It is up to the stores to make the changes in their register system scanning that is linked to the barcode on their product. Wholesalers are good at getting retailers that information. As soon as their price change occurs they let retailers know. The individual retailer has to watch their competitors and has the choice of whether to take price increases or not.
- The group discussed how price increases affect prices on the WIC checks.
- Retailers discussed how bar-coding works on labels.

Period for Public Comment

- No public comment was made.

Next Steps

- Update the charter with operating agreements.
- Wholesalers are going to double check and make sure that all of their stores could add that extra WIC number to the endorsement.
- Meeting minutes and a copy of the power point presentation will be e-mailed to all.
- Look at whether vendors can add store numbers to the endorsement to wholesalers.
- Regina will check with FSMC regarding a store number on endorsements.
- Contact Regina about formula price increases. Regina will contact wholesalers as to the timeline regarding price increases.
- Look specifically at individual stores to see what's happening.
- Pilot price checks with committee members.

Preparations for the Next Meeting

- Within 30 – 60 days of the rule coming out, we could arrange a meeting. An implementation meeting is scheduled in March in Washington D.C. It might be better to wait until then when the State will have more information and guidance. Retailers could be sent USDA's preliminary information.
- A question was asked if we could make an allowance for other visitors "private label" people and it was stated that there's nothing to prohibit that as long as they understand their roles. They can be brought in for consultation as a resource. It was agreed that the next meeting is tentatively scheduled for Wednesday, April 2, 2008 in Lincoln.

Meeting Review

- Committee members agreed that this was the most productive meeting with WIC yet. The Committee was thanked for finding solutions to problems of the past.

Adjourn

- The meeting adjourned at 2:35 p.m.

APPENDIX IV:
NEBRASKA OPEN MEETINGS ACT
NEBRASKA REVISED STATUTES
SECTIONS 84-1407 THROUGH 84-1414

**State of Nebraska Statute
Open Meetings Act**

Section 84-1407

Act, how cited.

Sections 84-1407 to 84-1414 shall be known and may be cited as the Open Meetings Act.

Section 84-1408

Declaration of intent; meetings open to public.

It is hereby declared to be the policy of this state that the formation of public policy is public business and may not be conducted in secret.

Every meeting of a public body shall be open to the public in order that citizens may exercise their democratic privilege of attending and speaking at meetings of public bodies, except as otherwise provided by the Constitution of Nebraska, federal statutes, and the Open Meetings Act.

Section 84-1409

Terms, defined.

For purposes of the Open Meetings Act, unless the context otherwise requires:

(1) (a) Public body means (i) governing bodies of all political subdivisions of the State of Nebraska, (ii) governing bodies of all agencies, created by the Constitution of Nebraska, statute, or otherwise pursuant to law, of the executive department of the State of Nebraska, (iii) all independent boards, commissions, bureaus, committees, councils, subunits, or any other bodies created by the Constitution of Nebraska, statute, or otherwise pursuant to law, (iv) all study or advisory committees of the executive department of the State of Nebraska whether having continuing existence or appointed as special committees with limited existence, (v) advisory committees of the bodies referred to in subdivisions (i), (ii), and (iii) of this subdivision, and (vi) instrumentalities exercising essentially public functions.

(b) Public body does not include (i) subcommittees of such bodies unless a quorum of the public body attends a subcommittee meeting or unless such subcommittees are holding hearings, making policy, or taking formal action on behalf of their parent body, (ii) entities

conducting judicial proceedings unless a court or other judicial body is exercising rulemaking authority, deliberating, or deciding upon the issuance of administrative orders, and (iii) the Policy Cabinet created in section 81-3009;

(2) Meeting means all regular, special, or called meetings, formal or informal, of any public body for the purposes of briefing, discussion of public business, formation of tentative policy, or the taking of any action of the public body; and

(3) Videoconferencing means conducting a meeting involving participants at two or more locations through the use of audio-video equipment which allows participants at each location to hear and see each meeting participant at each other location, including public input. Interaction between meeting participants shall be possible at all meeting locations.

Section 84-1410

Closed session; when; purpose; reasons listed; procedure; right to challenge; prohibited acts; chance meetings, conventions, or workshops.

84-1410 (1) Any public body may hold a closed session by the affirmative vote of a majority of its voting members if a closed session is clearly necessary for the protection of the public interest or for the prevention of needless injury to the reputation of an individual and if such individual has not requested a public meeting. The subject matter and the reason necessitating the closed sessions shall be identified in the motion to close. Closed sessions may be held for, but shall not be limited to, such reasons as:

- (a) Strategy sessions with respect to collective bargaining, real estate purchases, pending litigation, or litigation which is imminent as evidenced by communication of a claim or threat of litigation to or by the public body;
- (b) Discussion regarding deployment of security personnel or devices;
- (c) Investigative proceedings regarding allegations of criminal misconduct; or
- (d) Evaluation of the job performance of a person when necessary to prevent needless injury to the reputation of a person and if such person has not requested a public meeting.

Nothing in this section shall permit a closed meeting for discussion of the appointment or election of a new member to any public body.

(2) The vote to hold a closed session shall be taken in open session. The entire motion, the vote of each member on the question of holding a closed session, and the time when the closed session commenced and concluded shall be recorded in the minutes. If the motion to

close passes, then the presiding officer immediately prior to the closed session shall restate on the record the limitation of the subject matter of the closed session. The public body holding such a closed session shall restrict its consideration of matters during the closed portions to only those purposes set forth in the motion to close as the reason for the closed session. The meeting shall be reconvened in open session before any formal action may be taken. For purposes of this section, formal action shall mean a collective decision or a collective commitment or promise to make a decision on any question, motion, proposal, resolution, order, or ordinance or formation of a position or policy but shall not include negotiating guidance given by members of the public body to legal counsel or other negotiators in closed sessions authorized under subdivision (1) (a) of this section.

(3) Any member of any public body shall have the right to challenge the continuation of a closed session if the member determines that the session has exceeded the reason stated in the original motion to hold a closed session or if the member contends that the closed session is neither clearly necessary for (a) the protection of the public interest or (b) the prevention of needless injury to the reputation of an individual. Such challenge shall be overruled only by a majority vote of the members of the public body. Such challenge and its disposition shall be recorded in the minutes.

(4) Nothing in this section shall be construed to require that any meeting be closed to the public. No person or public body shall fail to invite a portion of its members to a meeting, and no public body shall designate itself a subcommittee of the whole body for the purpose of circumventing the Open Meetings Act. No closed session, informal meeting, chance meeting, social gathering, email, fax, or other electronic communication shall be used for the purpose of circumventing the requirements of the act.

(5) The act does not apply to chance meetings or to attendance at or travel to conventions or workshops of members of a public body at which there is no meeting of the body then intentionally convened, if there is no vote or other action taken regarding any matter over which the public body has supervision, control, jurisdiction, or advisory power.

Section 84-1411

Meetings of public body; notice; contents; when available; right to modify; duties concerning notice; videoconferencing or telephone conferencing authorized; emergency meeting without notice; appearance before public body.

84-1411 (1) Each public body shall give reasonable advance publicized notice of the time and place of each meeting by a method designated by each public body and recorded in its minutes. Such notice shall be transmitted to all members of the public body and to the

public. Such notice shall contain an agenda of subjects known at the time of the publicized notice or a statement that the agenda, which shall be kept continually current, shall be readily available for public inspection at the principal office of the public body during normal business hours. Agenda items shall be sufficiently descriptive to give the public reasonable notice of the matters to be considered at the meeting. Except for items of an emergency nature, the agenda shall not be altered later than (a) twenty-four hours before the scheduled commencement of the meeting or (b) forty-eight hours before the scheduled commencement of a meeting of a city council or village board scheduled outside the corporate limits of the municipality. The public body shall have the right to modify the agenda to include items of an emergency nature only at such public meeting.

(2) A meeting of a state agency, state board, state commission, state council, or state committee, of an advisory committee of any such state entity, of an organization created under the Interlocal Cooperation Act, the Joint Public Agency Act, or the Municipal Cooperative Financing Act, of the governing body of a public power district having a chartered territory of more than fifty counties in this state, or of the governing body of a risk management pool or its advisory committees organized in accordance with the Intergovernmental Risk Management Act may be held by means of videoconferencing or, in the case of the Judicial Resources Commission in those cases specified in section 24-1204, by telephone conference, if:

- (a) Reasonable advance publicized notice is given;
- (b) Reasonable arrangements are made to accommodate the public's right to attend, hear, and speak at the meeting, including seating, recordation by audio or visual recording devices, and a reasonable opportunity for input such as public comment or questions to at least the same extent as would be provided if videoconferencing or telephone conferencing was not used;
- (c) At least one copy of all documents being considered is available to the public at each site of the videoconference or telephone conference;
- (d) At least one member of the state entity, advisory committee, or governing body is present at each site of the videoconference or telephone conference; and
- (e) No more than one-half of the state entity's, advisory committee's, or governing body's meetings in a calendar year are held by videoconference or telephone conference.

Videoconferencing, telephone conferencing, or conferencing by other electronic communication shall not be used to circumvent any of the public government purposes established in the Open Meetings Act.

(3) A meeting of the governing body of an entity formed under the Interlocal Cooperation Act or the Joint Public Agency Act or of the governing body of a risk management pool or its advisory committees organized in accordance with the Intergovernmental Risk Management Act may be held by telephone conference call if:

(a) The territory represented by the member public agencies of the entity or pool covers more than one county;

(b) Reasonable advance publicized notice is given which identifies each telephone conference location at which a member of the entity's or pool's governing body will be present;

(c) All telephone conference meeting sites identified in the notice are located within public buildings used by members of the entity or pool or at a place which will accommodate the anticipated audience;

(d) Reasonable arrangements are made to accommodate the public's right to attend, hear, and speak at the meeting, including seating, recordation by audio recording devices, and a reasonable opportunity for input such as public comment or questions to at least the same extent as would be provided if a telephone conference call was not used;

(e) At least one copy of all documents being considered is available to the public at each site of the telephone conference call;

(f) At least one member of the governing body of the entity or pool is present at each site of the telephone conference call identified in the public notice;

(g) The telephone conference call lasts no more than one hour; and

(h) No more than one-half of the entity's or pool's meetings in a calendar year are held by telephone conference call.

Nothing in this subsection shall prevent the participation of consultants, members of the press, and other nonmembers of the governing body at sites not identified in the public notice. Telephone conference calls, emails, faxes, or other electronic communication shall not be used to circumvent any of the public government purposes established in the Open Meetings Act.

(4) The secretary or other designee of each public body shall maintain a list of the news media requesting notification of meetings and shall make reasonable efforts to provide advance notification to them of the time and place of each meeting and the subjects to be discussed at that meeting.

(5) When it is necessary to hold an emergency meeting without reasonable advance public notice, the nature of the emergency shall be stated in the minutes and any formal action taken in such meeting shall pertain only to the emergency. Such emergency meetings

may be held by means of electronic or telecommunication equipment. The provisions of subsection (4) of this section shall be complied with in conducting emergency meetings. Complete minutes of such emergency meetings specifying the nature of the emergency and any formal action taken at the meeting shall be made available to the public by no later than the end of the next regular business day.

(6) A public body may allow a member of the public or any other witness other than a member of the public body to appear before the public body by means of video or telecommunications equipment.

Section 84-1412

Meetings of public body; rights of public; public body; powers and duties.

84-1412 (1) Subject to the Open Meetings Act, the public has the right to attend and the right to speak at meetings of public bodies, and all or any part of a meeting of a public body, except for closed sessions called pursuant to section 84-1410, may be videotaped, televised, photographed, broadcast, or recorded by any person in attendance by means of a tape recorder, camera, video equipment, or any other means of pictorial or sonic reproduction or in writing.

(2) It shall not be a violation of subsection (1) of this section for any public body to make and enforce reasonable rules and regulations regarding the conduct of persons attending, speaking at, videotaping, televising, photographing, broadcasting, or recording its meetings. A body may not be required to allow citizens to speak at each meeting, but it may not forbid public participation at all meetings.

(3) No public body shall require members of the public to identify themselves as a condition for admission to the meeting. The body may require any member of the public desiring to address the body to identify himself or herself.

(4) No public body shall, for the purpose of circumventing the Open Meetings Act, hold a meeting in a place known by the body to be too small to accommodate the anticipated audience.

(5) No public body shall be deemed in violation of this section if it holds its meeting in its traditional meeting place which is located in this state.

(6) No public body shall be deemed in violation of this section if it holds a meeting

outside of this state if, but only if:

(a) A member entity of the public body is located outside of this state and the meeting is in that member's jurisdiction;

(b) All out-of-state locations identified in the notice are located within public buildings used by members of the entity or at a place which will accommodate the anticipated audience;

(c) Reasonable arrangements are made to accommodate the public's right to attend, hear, and speak at the meeting, including making a telephone conference call available at an in-state location to members, the public, or the press, if requested twenty-four hours in advance;

(d) No more than twenty-five percent of the public body's meetings in a calendar year are held out-of-state;

(e) Out-of-state meetings are not used to circumvent any of the public government purposes established in the Open Meetings Act;

(f) Reasonable arrangements are made to provide viewing at other in-state locations for a videoconference meeting if requested fourteen days in advance and if economically and reasonably available in the area; and

(g) The public body publishes notice of the out-of-state meeting at least twenty-one days before the date of the meeting in a legal newspaper of statewide circulation.

(7) The public body shall, upon request, make a reasonable effort to accommodate the public's right to hear the discussion and testimony presented at the meeting.

(8) Public bodies shall make available at the meeting or the in-state location for a telephone conference call or videoconference, for examination and copying by members of the public, at least one copy of all reproducible written material to be discussed at an open meeting. Public bodies shall make available at least one current copy of the Open Meetings Act posted in the meeting room at a location accessible to members of the public. At the beginning of the meeting, the public shall be informed about the location of the posted information.

Section 84-1413

Meetings; minutes; roll call vote; secret ballot; when.

(1) Each public body shall keep minutes of all meetings showing the time, place, members present and absent, and the substance of all matters discussed.

(2) Any action taken on any question or motion duly moved and seconded shall be by roll call vote of the public body in open session, and the record shall state how each member voted or if the member was absent or not voting. The requirements of a roll call or viva voce vote shall be satisfied by a municipality which utilizes an electronic voting device which allows the yeas and nays of each member of the city council or village board to be readily seen by the public.

(3) The vote to elect leadership within a public body may be taken by secret ballot, but the total number of votes for each candidate shall be recorded in the minutes.

(4) The minutes of all meetings and evidence and documentation received or disclosed in open session shall be public records and open to public inspection during normal business hours.

(5) Minutes shall be written and available for inspection within ten working days or prior to the next convened meeting, whichever occurs earlier, except that cities of the second class and villages may have an additional ten working days if the employee responsible for writing the minutes is absent due to a serious illness or emergency.

Section 84-1414

Unlawful action by public body; declared void or voidable by district court; when; duty to enforce open meeting laws; citizen's suit; procedure; violations; penalties.

84-1414 (1) Any motion, resolution, rule, regulation, ordinance, or formal action of a public body made or taken in violation of the Open Meetings Act shall be declared void by the district court if the suit is commenced within one hundred twenty days of the meeting of the public body at which the alleged violation occurred. Any motion, resolution, rule, regulation, ordinance, or formal action of a public body made or taken in substantial violation of the Open Meetings Act shall be voidable by the district court if the suit is commenced more than one hundred twenty days after but within one year of the meeting of the public body in which the alleged violation occurred. A suit to void any final action shall be commenced within one year of the action.

(2) The Attorney General and the county attorney of the county in which the public body ordinarily meets shall enforce the Open Meetings Act.

(3) Any citizen of this state may commence a suit in the district court of the county in which the public body ordinarily meets or in which the plaintiff resides for the purpose of

requiring compliance with or preventing violations of the Open Meetings Act, for the purpose of declaring an action of a public body void, or for the purpose of determining the applicability of the act to discussions or decisions of the public body. It shall not be a defense that the citizen attended the meeting and failed to object at such time. The court may order payment of reasonable attorney's fees and court costs to a successful plaintiff in a suit brought under this section.

(4) Any member of a public body who knowingly violates or conspires to violate or who attends or remains at a meeting knowing that the public body is in violation of any provision of the Open Meetings Act shall be guilty of a Class IV misdemeanor for a first offense and a Class III misdemeanor for a second or subsequent offense.

DBH Advisory Committee Tips for Open Meeting and Roberts Rules

- ✓ Meeting Definition
Under § 84-1409(2), **meetings**, for purposes of the open meetings statutes, are defined as "***all regular, special, or called meetings, formal or informal, of any public body for the purposes of briefing, discussion of public business, formation of tentative policy, or the taking of any action of the public body.***"
- ✓ Notice and Posting:
Section 84-1411 sets out several requirements for the notice which must be given for a public meeting and for the agenda which must be prepared: *(1) the public body must give reasonable advance publicized notice of the time and place of each meeting by a method designated by the body and recorded in its minutes, (2) that notice must be transmitted to all members of the body and to the public, (3) the notice must contain an agenda of subjects known at the time of the publicized notice, or a statement that such an agenda, which must be kept continually current, is readily available for inspection at the principal office of the public body during normal business hours.*
Agenda. Under § 84-1411(1), an agenda maintained at the office of a public body for public inspection must be kept continually current and may not be altered later than 24 hours before the scheduled commencement of the public meeting (or 48 hours before commencement of a meeting of a city council if that meeting is noticed outside the corporate limits of the municipality). A public body may modify an agenda to include items of an emergency nature only at such public meeting.
Specificity of the Agenda. LB 898 from 2006 added language to § 84-1411 (1) which states that agenda items shall be "sufficiently descriptive to give the public reasonable notice of the matters to be considered at the meeting."
- ✓ Minutes
Every public body shall keep minutes of all meetings showing the time, place, members present and absent, and the substance of all matters discussed. The minutes of all meetings and evidence or documentation received or disclosed during open session shall be public records, open to public inspection during normal business hours. Minutes shall be written and available for inspection within 10 working days or prior to the next convened meeting, whichever is earlier. Minutes to committee members may be made available via electronic copy when they receive the agenda. Minutes should state, who made the motion and second, state the motion and how each member voted or if the member was absent or not voting.
- ✓ Open Meeting Notice
Public bodies shall make available at least one current copy of the Open Meetings Act posted in the meeting room at a location accessible to members of the public. At the beginning of any meeting, the public shall be informed about the location of the posted information. The legislative history of LB 898 indicates that "posting" a copy of the Open Meetings Act means putting it up in some fashion, including attaching it to a bulletin board, hanging it by a chain or fastening it to a wall. "Posting" does not include placing the Act on a table as a loose document which can be removed and therefore might not be available throughout the meeting. At least one copy of all documents being considered or reviewed at the meeting must be made available to the public. This would include items such as the minutes of the last meeting and reports. It is handy to have all such documents together in a three ring binder along with the agenda.

✓ Quorum

A quorum should be determined at the beginning of the meeting. This is calculated by (# of total possible members / 2) +1. **If there is not a quorum, then it is a “non-meeting”** and there is no ability to take action. Our type of advisory committee set forth in statute does not create policy. If it did there would be strict adherence to open meeting statutes. The Advisory Committees can continue to meet with less than a quorum understanding that no action items (motions for recommendations) can be made. A quorum should be determined prior to each vote.

Susan is checking on the “ex-officio” and voting status. (Susan’s findings: These committees do not have any ex-officio members.)

Meeting Tips:

- ✓ Call to Order
- ✓ Statement of Open Meeting Posting
- ✓ Quorum for Committees Identified via Roll Call
- ✓ Meeting Minutes
 - Revisions/corrections
 - Motion to approve minutes [as amended if applicable]
 - May use voice vote

[Let’s keep Public Comment in AM and PM as listed on agenda and processes with sign in.]

Individuals that are not members but sitting in the public section, should not speak during the meeting unless acknowledged by the chair (example of answering a question of the committee).

✓ Motion Procedure

Member makes a motion (motion should be stated in the positive, that is, to do something rather than not to do something)

Second (or dies for lack of a second)

Chair (secretary) restates the motion It is moved and seconded.....

Members debate the motion

Member/Chair can call the question to end debate

Members vote –if there is a quorum

Abstain does not count as a yes – **they are figured in with the # of no’s.**

Chair states the results – the motion carries or the motion failed

- ✓ For annual leadership selection, may do voice vote or secret ballot.
 - Secret ballot total votes for a candidate must be reflected in the minutes even though how each member voted is not recorded.
- ✓ For review of reports/presentations
 - Present topic
 - Group discussion
 - Identify recommendations or can move approval of report or amending of report.
 - Move/2nd recommendations
 - Discussion on the motion
 - Vote on recommendations
- ✓ Adjournment
 - Motion, second
 - May use voice vote

Marijuana Use in Nebraska

August 14, 2014

Presented by Renee Faber and David DeVries



What the Research says...



- ▶ Marijuana use has many serious, negative health effects.
- ▶ Marijuana can lead to tolerance to the effects of THC, as well as to addiction.
- ▶ After tobacco and alcohol, marijuana dependence is the most common type of drug dependence in many parts of the world. It is estimated that 9% of people who try marijuana become dependent.
- ▶ Those who begin using the drug in their teens have approximately a one in six risk of developing marijuana dependence.
- ▶ Many marijuana users who try to quit experience withdrawal symptoms that include irritability, anxiety, insomnia, appetite disturbance, and depression.

White Paper on State-Level Proposals to Legalize Marijuana -Adopted by the ASAM Board of Directors July 25, 2012

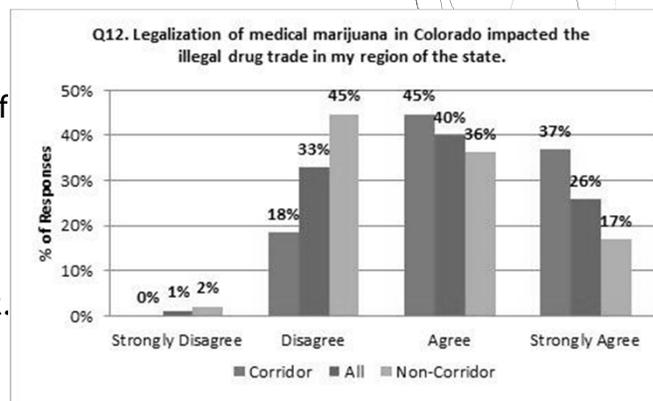
Without A Doubt

- ▶ Preventing marijuana use among young people is one of the greatest challenges for the prevention field.
- ▶ Young people are especially susceptible to marijuana addiction. Research from treatment centers in the U.S. indicates that the earlier marijuana use is initiated, the higher the risk for drug abuse and dependence.
- ▶ The serious health effects of marijuana use adversely affects both users and their families.
- ▶ Beyond the harm to the individual and family, widespread marijuana use can impact the community, the economy, workplace productivity, and healthcare costs etc.



Survey says...

- ▶ An NET News survey of county sheriffs and prosecutors concluded that 66 percent of law enforcement officials surveyed felt legalization of medical marijuana in Colorado impacted the illegal drug trade in their region.
- ▶ For officials serving along the I-80 corridor, the percentage seeing an increased impact rose to 82 percent.
- ▶ *The survey was conducted in cooperation with the Nebraska County Attorneys Association and the Nebraska Sheriffs' Association*



MARIJUANA CROSSROADS:
Nebraska Law Enforcement on Trends in
Drug Trafficking

The impact of Marijuana in Colorado

- ▶ **Colorado Emergency Room - Marijuana Admissions:** From 2005 through 2008 there was an average of 741 visits per year to the emergency room in Colorado for marijuana-related incidents involving youth. That number increased to 800 visits per year between 2009 and 2011.
- ▶ **Colorado Marijuana-Related Exposure Cases:** From 2005 through 2008, the yearly average number of marijuana-related exposures for children ages 0 to 5 years was 4. For 2009 through 2012, that number increased 200 percent to an average of 12 per year.
- ▶ **Diversion of Colorado Marijuana (General):** From 2005 to 2008, compared to 2009 to 2012, interdiction seizures involving Colorado marijuana quadrupled from an average per year of 52 to 242. During the same period, the average number of pounds of Colorado marijuana seized per year increased 77 percent from an average of 2,220 to 3,937 pounds. A total of 7,008 pounds was seized in 2012.

The Legalization of Marijuana in Colorado: The Impact Vol. 1/August 2013

The impact of Marijuana in Colorado

- ▶ **Colorado Driving Fatalities:** From 2006 to 2011, traffic fatalities decreased in Colorado 16 percent, but fatalities involving drivers testing positive for marijuana increased 114 percent.
- ▶ **Colorado Youth Marijuana Use:** In 2011, the national average for youth 12 to 17 years old considered 'current' marijuana users was 7.64 percent which was the highest average since 1981. The Colorado average percent was 10.72.
- ▶ **Colorado Adult Marijuana Use:** In 2011, the national average for young adults ages 18 to 25 considered current marijuana users was at 18.7 percent. The Colorado average was 27.26 percent.

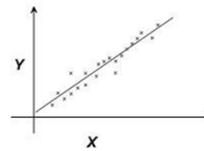
The Legalization of Marijuana in Colorado: The Impact Vol. 1/August 2013

How does Nebraska compare?



Trends in Marijuana Use

David DeVries

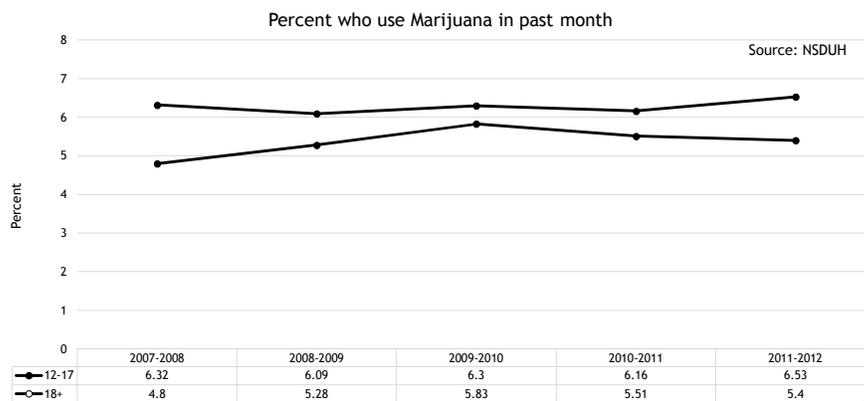


Nebraska's Youth Risk Behavior Survey

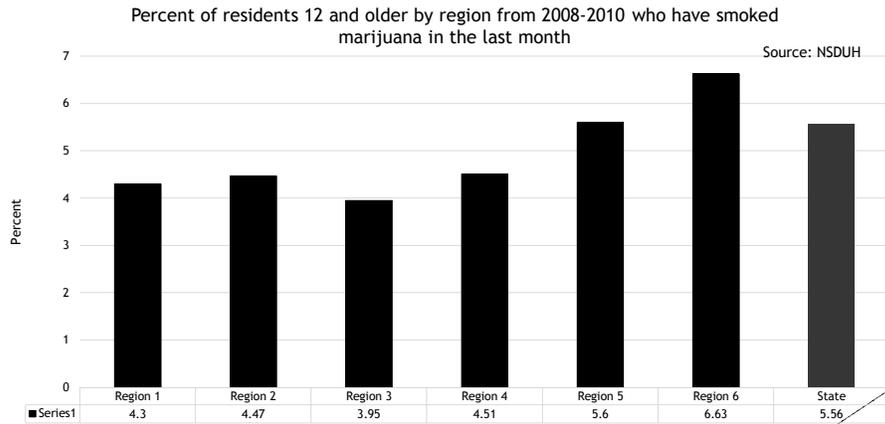
- ▶ In 2013 nearly 1 in 4 (23.6%) of youth have used marijuana at one point.
- ▶ That same year about 1 in 20 (5.5%) reported using marijuana before the age of 13
- ▶ Finally more than 1 in 10 (11.7%) reported currently using marijuana.



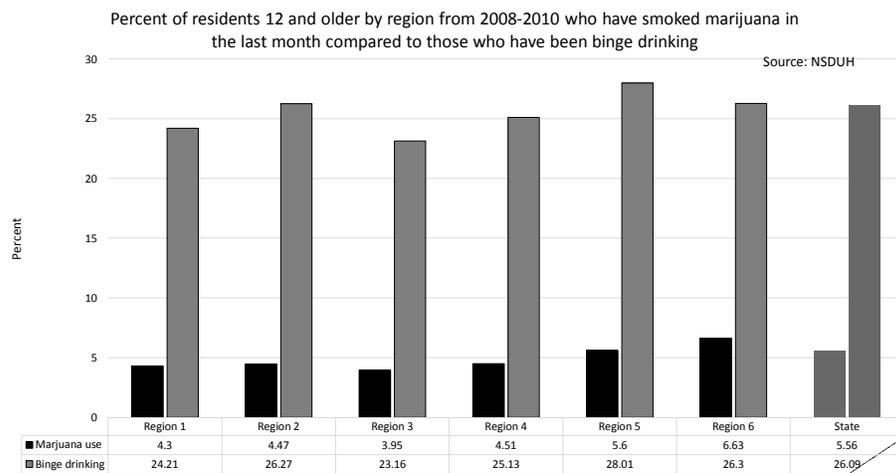
Prevalence of Marijuana Use Youth and Adults



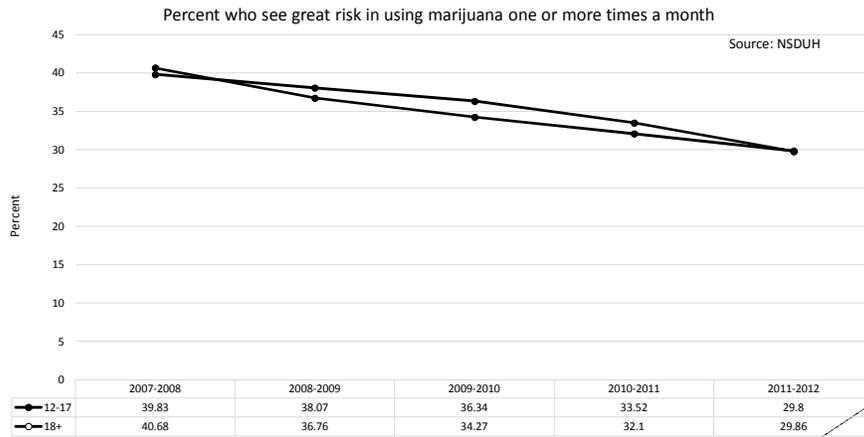
Marijuana use by Region



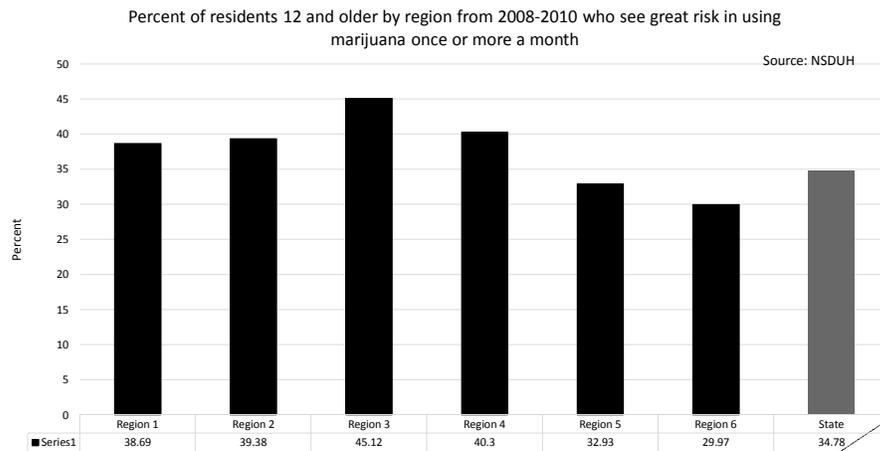
Marijuana vs. Alcohol



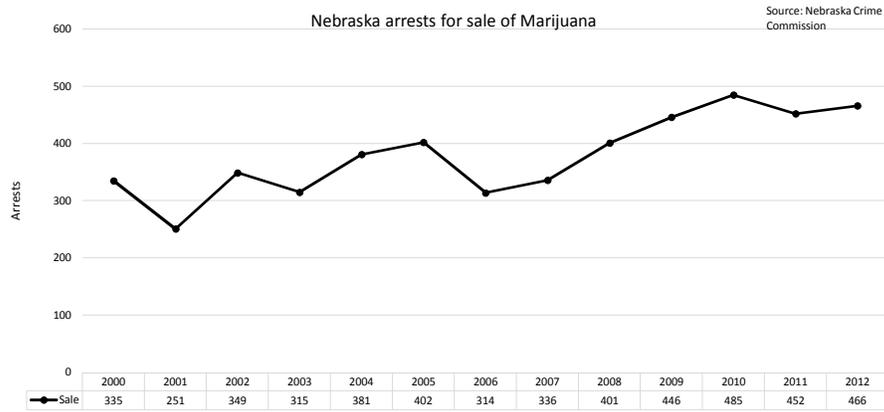
Perceived Risk



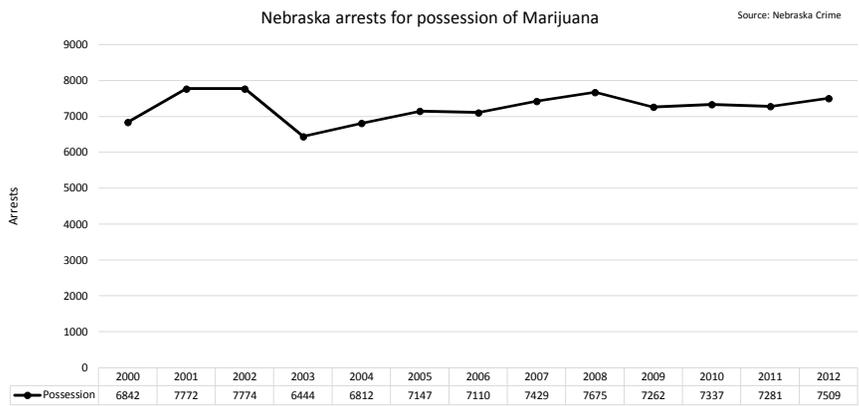
Perceived Risk by Region



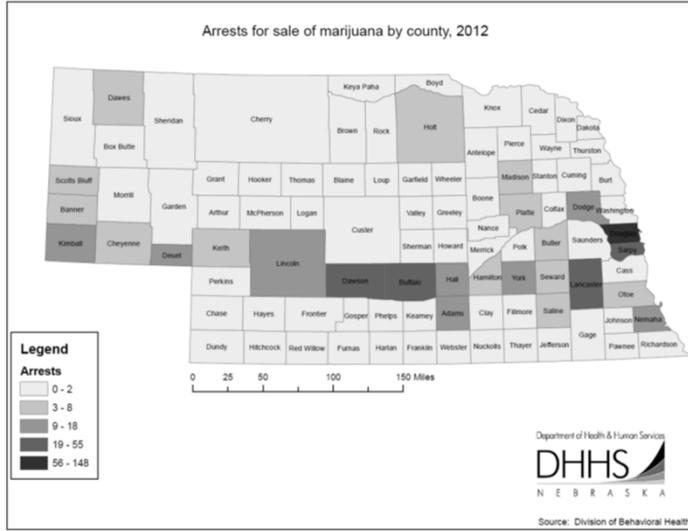
Arrest Data-Marijuana Sales



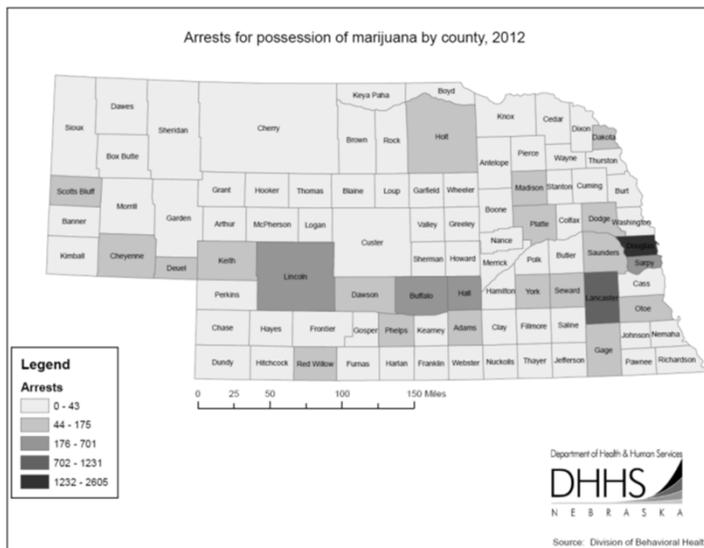
Arrest Data-Possession of Marijuana



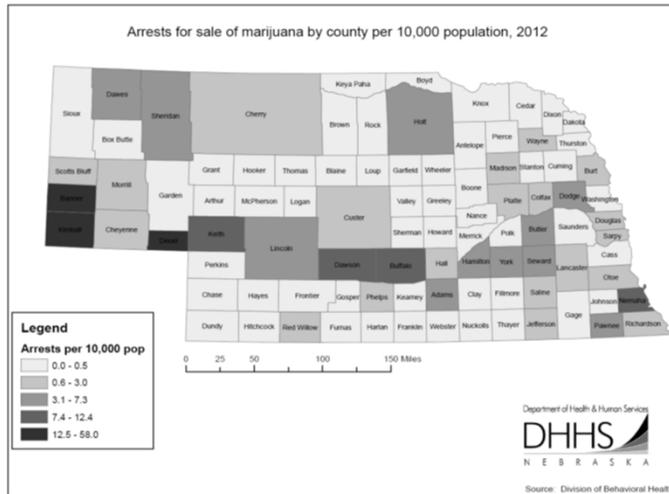
Arrest Data-Sale by County



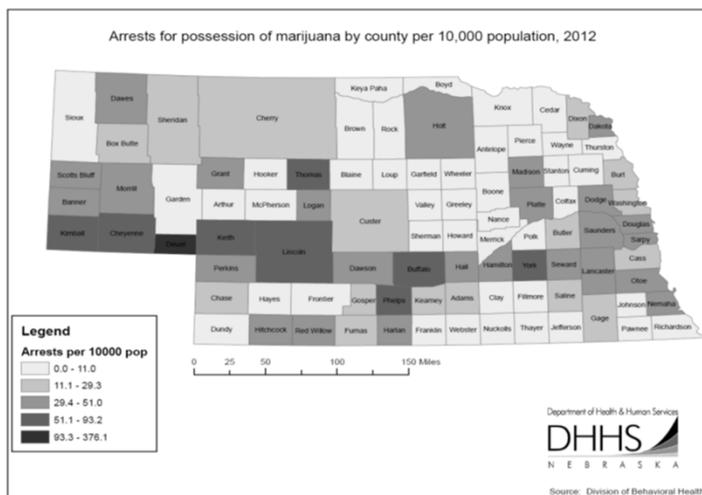
Arrests for Possession by County



Arrest Data- Sale by County Compared to Population



Possession by county compared to population



Drugged Driving

- ▶ Marijuana was the drug impairing drivers in more than half of the DRE evaluations done by trained officers in Nebraska since 2009 (NOHS).
- ▶ Most states, including Nebraska, rely on specially-trained law enforcement officers called drug recognition experts (DRE).
- ▶ Over the past five years it's been a process repeated more than 2,000 times in Nebraska.
- ▶ The specialty is getting added attention as law enforcement anticipates an increase in the number of drivers driving under the influence of marijuana.

- ▶ 'There is no "Marijuana Breathalyzer" So How Can Police Tell if a Driver is High?' by Bill Kelly, Senior Producer, NET News



So what does this mean?

- ▶ Marijuana use has slightly increased over the years.
- ▶ The perception of risk due to marijuana use had declined.
- ▶ Arrests for the possession and sale of marijuana have increased since 2000.
- ▶ Arrests, as compared by county size, are highest in the Panhandle and along the Interstate 80 route.



How can this be Prevented?

Renee Faber



Start with Risk and Protective factors

- ▶ While marijuana use among youth may be a serious concern, the factors that drive the problem in different communities may vary considerably.
- ▶ For example, in one community, high school students may have low perceptions of the risks associated with use. However, this may not be an important risk factor in another community, where easy access to marijuana may be a more salient factor.
- ▶ To be effective, prevention strategies or interventions must be linked to the risk and protective factors that drive the problem in the community.

Evidence-based Programs Effective in Preventing and Reducing Marijuana Use

- ▶ There are a limited number of strategies and interventions available that address the risk and protective factors associated with youth marijuana use in the community, that is supported by sufficient evidence of effectiveness, and that is feasible to implement.
- ▶ The State of Washington has preliminarily identified several programs that have demonstrated research study outcomes specific to preventing or reducing marijuana use in youth (ages 12-17) or young adults (ages 18-20).
 - ▶ LifeSkills Training, Project Northland, Lions Quest Skills for Adolescence (SFA), Project Towards No Drug Abuse, Project Venture, Guiding Good Choices, Keepin' It Real, Caring School Community, Red Cliff Wellness School Curriculum and SPORT.

Using Prevention Research to Guide Prevention Practice

CAPT Decision Support Tools

SAMHSA's Center for the Application of Prevention Technologies (June, 2014)

- ▶ *Prevention Programs that Address Youth Marijuana Use*, detailed descriptions of substance abuse prevention strategies and associated interventions that have been evaluated to determine their effects on marijuana outcomes.
- ▶ *Risk and Protective Factors Associated with Youth Marijuana Use*, summary of research findings on factors associated with marijuana use.
- ▶ *Strategies and Interventions to Prevent Youth Marijuana: An At-a-Glance Resource Tool*, brief summaries of the strategies and associated interventions
- ▶ *Preventing Youth Marijuana Use: An Annotated Bibliography*, abstracts for the articles presented in the support tool.
- ▶ We have at least 2 coalitions implementing the *Strengthening Families* program - which targets enhancement of family protective and resiliency processes and family risk reduction through weekly, two-hour sessions.

Partner efforts - Drug Free Communities

- ▶ This program is unique in that federal support is contingent upon a community demonstrating local commitment and resolve to address its drug problem, before it is eligible to receive any federal funds.
- ▶ Currently, Nebraska has 4 community coalitions are receiving a total of \$523,160 in DFC funding - at least 2 are directly addressing marijuana use.
- ▶ These coalitions are expected to develop strategies for addressing every aspect of a prioritized substance abuse problem - prevention, intervention, treatment, aftercare and law enforcement, but with a particular focus on prevention.



Office of National Drug Control Policy

Key points

- ▶ Prevention of marijuana use is included in the Division's Strategic Plan for Prevention and is among the Prevention priorities for use of federal funds.
- ▶ The Perception of Harm Related to Marijuana Use is on the decline
 - ▶ Education on the harmful effects of marijuana will help address this trend
 - ▶ Universal school improvement programs aimed at promoting prosocial values, increasing academic motivation and achievement, and preventing drug use, are an example of this strategy.
 - ▶ Education on the risks of marijuana-positive driving can also help address this trend
- ▶ Insufficient Data
 - ▶ While we are examining what data is available to track the scale and scope of marijuana use in the state, some data gaps exist in relation to capacity, availability and accessibility.

Questions???

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DHHS Division of Behavioral Health

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Epidemiology Surveillance Coordinator
DHHS Division of Behavioral Health

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Thank you!

Tyler J. Smith was an 18 year old high school student at Bellevue West High school in Bellevue Nebraska. Tyler was a fun loving individual who had a passion for his loved ones, skateboarding, and video games.

Tyler was introduced to Synthetic Marijuana by a friend at school. He was told it was legal and safe to use.

On September 29, 2012 Tyler took his own life.

Since his death Tyler's Story has touched hundreds of lives and has been seen by many more through the media,

In June 2013 Nebraska Legislature passed "Tyler's Law" banning the manufacturing and distribution of synthetic drugs in the state of Nebraska.



The Purple Project Presentation is free to anyone who wants to hear it. If you or anyone you know is in danger you CAN get them help.

Nebraska Poison Control

1-800-222-1222

Nebraska Suicide Hotline

1-800-448-3000

THE TYLER J. SMITH PURPLE PROJECT



402.616.1138

P.O Box 1466 Bellevue NE
tjspurpleproject@gmail.com



THE TYLER J. SMITH PURPLE PROJECT

The Tyler J. Smith Purple Project is a family owned and operated organization dedicated to bringing awareness and education to people everywhere on the dangers of synthetic drugs and teen suicide. We bring a message of hope to people young and old as well as provide a detailed look in to the life of Tyler J. Smith and the world of Synthetic Drugs.



P-romoting hope

U-niting adults and teens

R-aising awareness

P-revention

L-obbying for change in our communities

E-mpowering young people to stay informed

:SCHOOLS

The purple project will come to your school and speak to your class, or assembly with a full presentation on the dangers and side effects of synthetic drug use as well as personal experiences that will leave students well informed and properly educated.



:SMALL GROUPS / ADDICTION CENTERS

The purple project will provide a personal encounter with synthetic drugs and the Tyler Smith story with your group and give them major incite into the dangers of using synthetic drugs and assist them on their path to recovery.



:PARENTS NIGHTS / GENERAL EVENTS

Bring the Purple Project to your next event or parents night we will set up a table with information on the project, synthetic drugs as well as provide support to anyone looking for help.





What is the Purple Project?

P-PROMOTING HOPE

U-NITING ADULTS AND TEENS

R-AISING AWARENESS

P-PREVENTING ONE MORE LIFE FROM BEING LOST

L-OBBYING FOR CHANGE IN OUR COMMUNITIES

E-MPOWERING YOUNG PEOPLE TO STAY INFORMED

- A specialized group formed in October 2012 dedicated to bringing awareness and education to the dangers of Synthetic Drugs.



Synthetic Drugs

What are synthetic Drugs?

- A Drug that is Man Made
- Synthetic Cannabinoids (K2, Spice)
 - Herbal Smoking Blends
- Substituted Cathinones (Bath salts)
 - Effects like amphetamines



What Are Synthetic Drugs?

- A Drug that is MAN MADE
-
- A drug that is designed to attempt to mimic other drugs that have already been made illegal.
- K2
- Bath Salts

A History Of Synthetics

- Dr. John W. Huffman-professor emeritus of organic chemistry at Clemson University discovered Synthetic Cannabinoids in the mid 1990's.

A Short History Of Synthetic Marijuana

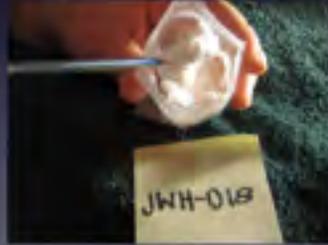


- Dr. John W. Huffman

HERBS



CHEMICALS



What makes up Synthetic Marijuana?

- Herbs
- Chemicals

- All Packages of Synthetic Marijuana Are stamped with the Warning “Not for Consumption”



Side Effects

- Extreme paranoid delusions

- Heart Palpitations

- Prolonged Psychosis

- Aggression

- suicide

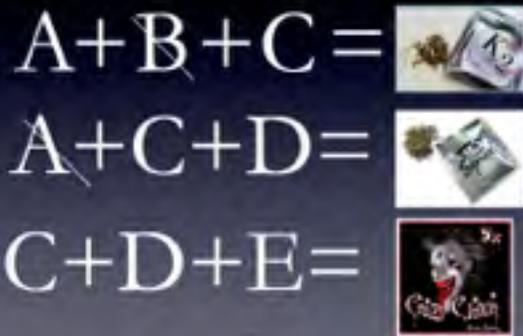
- Withdrawal Symptoms
- heavy sweating
- intense cravings
- inability to sleep
- loss of appetite
- psychotic episodes

• Synthetic Drugs can have intense side effects for regular and recreational users.

• users report the side effects listed are experienced in combination with each other and not generally one or the other.

• Intensity of side effects can depend on amount used

• how are synthetic drugs legal?



• Manufacturers are constantly changing their products to stay outside of local laws.

• There are estimated to be hundreds of different synthetic marijuana brands on the market currently.

- “Tyler’s Law”-(LB 298) Sponsored by Senator Beau McCoy, is 48 pages of chemical names and compounds designed to take action against manufacturers.
- LB 811 Sponsored by Senator Ken Schilz was an update to LB 298 that took action against the current generation of Synthetic Drugs



Tyler J. Smith

To Find more information on the Purple Project please visit us:
on Facebook- The Tyler J. Smith Purple Project

at tjspurpleproject@gmail.com

<http://ladyme01.wix.com/tjs-purple-project>

BY-LAWS
As Amended April 4, 2011

Article I – Name of Organization

The name of the organization shall be the State Advisory Committee on Substance Abuse Services (SACSAS).

Article II – Purpose

As provided in Nebraska Revised Reissued Statutes ~~Section~~ 71-815, the committee shall be responsible to the Division of Behavioral Health and shall (1) conduct regular meetings, (2) provide advice and assistance to the Division relating to the provision of substance abuse services in the State of Nebraska, (3) promote the interests of consumers and their families, (4) provide reports as requested by the Division, and (5) engage in such other activities as directed or authorized by the Division. (71-815-sec 2)

Article III – Membership

Section 1

Appointments: The committee shall consist of twelve members appointed by the Governor. Members of the committee shall have a demonstrated interest and commitment and specialized knowledge, experience, or expertise relating to the provision of substance abuse services in the State of Nebraska. The committee shall consist of twelve members appointed by the Governor and shall include at least three consumers of substance abuse services. (71-815 sec 1)

Section 2

Length of Term: Four of the initial members appointed by the Governor shall serve for three years. Four of the initial members appointed by the Governor shall serve for two years, and four of the initial members for one year. As the terms of the initial members expire, their successors shall be appointed for terms of three years.

Article IV – Voting

Section 1

Quorum: Seven (7) voting members of the Committee present at any called meeting shall constitute a quorum. ~~Once established, a quorum shall be deemed to continue throughout the meeting.~~ The continued presence of a quorum shall be established before taking any vote or stating the question on any motion. All Committee business shall be conducted by a simple majority vote of members present at a meeting in which a quorum is established.

Section 2

Conflicts of Interest: A conflict of interest is created through the existence of circumstances where the actions of a member may have an effect of direct financial benefit or detriment to the member, a member of his/her family, employer, business associate, or business in which the member owns a substantial interest. A member shall disclose ~~the~~ any potential conflict to the Committee and abstain from voting on issues on which there is a conflict. Meeting minutes shall record the name of a member(s), who abstains from voting. As soon as the member is aware of a potential conflict of interest (or should reasonably be so aware), the member shall complete the Potential Conflict of Interest Statement Form C-2. The Form shall be submitted to the Nebraska Accountability and Disclosure Commission. The member shall follow all directions as prescribed and advised by the Nebraska Accountability and Disclosure Commission.

Article V – Officers

Section 1

Selection: Officers of the Committee shall be a Chairperson, Vice-Chairperson and Second Vice Chairperson. Initial Officers shall be appointed by the Division of Behavioral Health at the first meeting and will be elected by the Committee annually thereafter. In the event of a vacancy, the Committee will elect a member to serve the unexpired term of office.

Section 2: The duties of the Officers shall be:

Chairperson – Preside at all Committee and Executive meetings and perform any other duties designated by the Committee.

Vice-Chairperson – Shall act for the Chairperson in his/her absence.

Second Vice Chairperson – Shall act for the Chairperson and Vice-Chairperson in their absence. Shall perform other duties as designated by the Chairperson or Committee.

Section 3

Term: At any time that a member cannot complete the term of office a new election shall be held to fill the vacancy.

Section 4

Executive Committee: The Executive Committee shall consist of the Chairperson, Vice-Chairperson and Second Vice Chairperson. A Chairperson may call the Executive Committee together with the agreement of the Division at his/her discretion. If a meeting of the Executive Committee is held, the full Committee will be notified at the next regularly scheduled meeting. The Executive Committee may not vote or act for the full Committee.

Article VI – Meetings

Section 1

Frequency: Meetings of the Committee shall be held regularly.

Section 2

Conduct: Meetings shall be held in accordance with the requirements of the Nebraska Public Meetings Law, Neb. Rev. State. Sections §§ 84-1408 through 84-1414. Business should be conducted according to Roberts Rules of Order.

Section 3

Notice: The time, date and location of the next meeting should be determined prior to adjournment of the preceding meeting and be documented in the minutes. ~~Notification of the time, date and location of the next meeting shall be sent within two weeks to all members absent from the preceding meeting.~~ Within thirty days, but not less than seven days prior to the next meeting, the Division shall ~~mail~~ send a written reminder and meeting agenda to each Committee member at his/her last known ~~official~~ requested address. Public Notice of Committee meetings and agendas shall be made by posting to the State of Nebraska Public Meetings Calendar on the ~~internet~~ state website.

Section 4

Duties Role of the Division: The Division of Behavioral Health shall provide an orientation to each new Committee member, produce meeting minutes, maintain records of the Committee, and provide secretarial support to the Committee.

Section 5

Expenses: Committee members shall be reimbursed for actual and necessary expenses in the performance of their duties as provided in Neb. Rev. State. Sections §§ 81-1174 through 81-1177.

Article VII – Committees

With the written agreement of the Division, the Chairperson may appoint or otherwise establish ad-hoc task forces or workgroup(s) comprised of Committee and non-committee members to accomplish a specific task which is relevant to the purpose of the Committee.

Article VIII – Amendments

There shall be a review of the Bylaws a minimum of every three years. A two-thirds majority vote of all Committee members will be required to amend the Bylaws. No Bylaws shall be considered for amendment unless notice of the same shall have been established as part of the meeting agenda, and a copy of the proposed changes has been ~~mailed~~ sent to members within thirty days, but not less than seven days, prior to the meeting at which the vote will take place.

All alterations, amendments, or new by-laws adopted by the Committee are subject to the approval of the Director of the Division of Behavioral Health or the designated representative for the Director.

Committee Chairperson

Date

~~71-815 State Advisory Committee on Substance Abuse Services; created; members; duties.~~

~~(1) The State Advisory Committee on Substance Abuse Services is created. Members of the committee shall have a demonstrated interest and commitment and specialized knowledge, experience, or expertise relating to the provision of substance abuse services in the State of Nebraska. The committee shall consist of twelve members appointed by the Governor and shall include at least three consumers of substance abuse services.~~

~~(2) The committee shall be responsible to the division and shall~~

- ~~(a) conduct regular meetings;~~
- ~~(b) provide advice and assistance to the division relating to the provision of substance abuse services in the State of Nebraska;~~
- ~~(c) promote the interests of consumers and their families;~~
- ~~(d) provide reports as requested by the division; and~~
- ~~(e) engage in such other activities as directed or authorized by the division.~~

Source Laws 2004, LB 1083, § 15; Laws 2005, LB 551, § 5; Laws 2006, LB 994, § 94.

BY-LAWS FOR THE
STATE ADVISORY COMMITTEE ON MENTAL HEALTH SERVICES
May 3, 2011

Article I – Name of Organization

The name of the organization shall be the State Advisory Committee on Mental Health Services.

Article II – Purpose

Section 1

As provided by Nebraska Revised Statutes ~~section~~ 71-814 the purpose of the Committee is to (a) serve as the state's mental health planning council as required by Public Law 102-321, (b) conduct regular meetings, (c) provide advice and assistance to the division relating to the provision of mental health services in the State of Nebraska, including, but not limited to, the development, implementation, provision, and funding of organized peer support services, (d) promote the interests of consumers and their families, including, but not limited to, their inclusion and involvement in all aspects of services design, planning, implementation, provision, education, evaluation, and research, (e) provide reports as requested by the division, and (f) engage in such other activities as directed or authorized by the division.

The Division means the Division of Behavioral Health within the Nebraska Department of Health and Human Services.

Section 2

“Serve as the state's mental health planning council as required by Public Law 102-321 means meeting the requirements for the State Mental Health Planning Council under the Federal Community Mental Health Services Block Grant. Under Section 1914, the State will establish and maintain a State mental health planning council in accordance with the conditions described in this section. (b) The duties of the Council are:

- (1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans [this refers to the Block Grant Application and Implementation Report];
- (2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and
- (3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

Section 3

MISSION STATEMENT

The Mission of Nebraska State Advisory Committee on Mental Health Services is to identify and advocate for an effective and efficient system of accessible, quality mental health services which enable each individual, on their journey of healing and transformation, to achieve their highest potential.

VISION STATEMENT

The Vision of Nebraska State Advisory Committee on Mental Health Services is to advise and assist the Division as it provides information for all Nebraskans, including consumers, families and the public to understand mental health problems, and to provide the knowledge necessary to access and utilize appropriate services in a timely, effective manner.

BY-LAWS FOR THE
STATE ADVISORY COMMITTEE ON MENTAL HEALTH SERVICES
May 3, 2011

Article III – Membership

Section 1

Appointments: The committee shall consist of twenty-three members appointed by the Governor.

Section 2

Length of Term: The length of term is as appointed by the Governor.

Section 3

Attendance: A member who has two consecutive unexcused absences shall be contacted by the Division regarding his/her intentions for future participation in the Committee. If the person indicates he/she is not able to participate, the Division shall request he/she formally resign from the Committee. Formal resignation shall be in writing and is to be submitted to the Director of the Division of Behavioral Health. The Division staff will maintain attendance sheet and submit to Chairperson periodically or per request.

Article IV - Voting

Section 1

Quorum: A quorum shall consist of one member more than half of the current members of the Committee ~~Once established, a quorum shall be deemed to continue throughout the meeting. The continued presence of a quorum shall be established before taking any vote or stating the question on any motion.~~ All Committee business shall be conducted by a simple majority vote of members present at a meeting in which a quorum is established.

Section 2

Conflicts of Interest: A conflict of interest is created through the existence of circumstances where the actions of a member may have an effect of direct financial benefit or detriment to the member, a member of his/her family, employer, business associate, or a business in which the member owns a substantial interest. As soon as the member is aware of a potential conflict of interest (or should reasonably be so aware), the member shall complete the Potential Conflict of Interest Statement Form C-2. The Form shall be submitted to the Nebraska Accountability and Disclosure Commission. The member shall follow all directions as prescribed and advised by the Nebraska Accountability and Disclosure Commission. ~~If a dispute arises as to whether a conflict exists, the chairperson shall direct that the member's vote be disregarded on a given issue until such time as the member is in possession of a written opinion from the Nebraska Accountability and Disclosure Commission.~~ A member shall disclose any potential conflict to the Committee and abstain from voting on issues on which there is a conflict. Meeting minutes shall record the name of a member(s), who abstains from voting.

Article V – Officers

Section 1

Selection: Officers of the Committee shall be a Chairperson, Vice-Chairperson and Secretary.

Section 2

Duties: The duties of the Officers shall be:

BY-LAWS FOR THE
STATE ADVISORY COMMITTEE ON MENTAL HEALTH SERVICES
May 3, 2011

Chairperson – Preside at all Committee and Executive meetings and:

- (1) Attend annual technical assistance meeting on MH Block Grant
- (2) Represent Nebraska at the MH Block Grant application review
- (3) Write a letter representing the committee’s point of view after reviewing the MH block grant application, to be attached and is due September 1.
- (4) Write a letter after reviewing Mental Health block grant implementation report due December 1
- (5) Perform any other duties designated by the Committee.
- (6) Review attendance report and contact members as needed.

Vice-Chairperson – Shall act for the Chairperson in his/her absence. Shall perform other duties as designated by the Chairpersons or Committee.

Secretary – Shall act for the Chairperson and Vice-Chairperson in their absence. Shall perform other duties as designated by the Chairpersons or Committee and is designated to review meeting minutes prior to distribution to committee members.

Section 3

At the fall meeting the committee will select officers for one year. The new officers' term are January 1 through December 31. In the event of a vacancy, the Committee will elect a member to serve the unexpired term of office.

Section 4

Executive Committee: The Executive Committee shall consist of the Chairperson, Vice-Chairperson and Secretary. A Chairperson may call the Executive Committee together with the approval of the Division, at his/her discretion. If a meeting of the Executive Committee is held, the full Committee will be notified at the next regularly scheduled meeting. The Executive Committee may not vote or act for the full Committee.

Article VI – Meetings

Section 1

Frequency: Meetings of the Committee shall be held regularly.

Section 2

Conduct: Meetings shall be held in accordance with the requirements of the Nebraska Public Meetings Law, Neb. Rev. Stat. §§ ~~sections~~ 84-1408 through 84-1414. Business should be conducted according to Roberts Rules of Order.

Section 3

Notice: The time, date and location of the next meeting should be determined prior to adjournment of the preceding meeting and documented in the minutes. ~~Notification of the time, date and location of the next meeting shall be sent within two weeks to all members absent from the preceding meeting.~~ Within thirty days, but not less than seven days prior to the next meeting, the Division shall ~~mail~~ send a ~~written~~ reminder and meeting agenda to each Committee member at his/her last known ~~official~~ requested address. Public Notice of Committee meetings and agendas shall be made by posting to the State of Nebraska Public Meetings Calendar on the state website.

BY-LAWS FOR THE
STATE ADVISORY COMMITTEE ON MENTAL HEALTH SERVICES
May 3, 2011

Section 4

Duties- Role of the Division: The Division shall provide an orientation to each new Committee member, produce meeting minutes, maintain records to include attendance record of the Committee, and provide support to the Committee.

Section 5

Expenses: Committee members shall be reimbursed for actual and necessary expenses in the performance of their duties as provided in Neb. Rev. Stat. §§ ~~sections 81-1174 to~~ through 81-1177.

Article VII - Committees

With the written approval of the Division, the Chairperson may appoint or otherwise establish ad-hoc task forces or workgroup(s) comprised of Committee and non-Committee members to accomplish a specific task which is relevant to the purpose of the Committee. Ad-hoc Committee is defined as including Committee and non-committee members.

Article VIII – Amendments

There shall be a review of the Bylaws a minimum of every three years. A two-thirds majority vote of all Committee members will be required to amend the Bylaws. No Bylaws shall be considered for amendment unless notice of the same shall have been established as part of the meeting agenda, and a copy of the proposed changes has been delivered to members within thirty days, but not less than seven days, prior to the meeting at which the vote will take place.

All alterations, amendments, or new by-laws adopted by the Committee are subject to the approval of the Director of the Division of Behavioral Health or the designated representative for the Director.

Committee Chairperson

Date

BY-LAWS FOR THE
STATE ADVISORY COMMITTEE ON MENTAL HEALTH SERVICES
May 3, 2011

~~71-814. State Advisory Committee on Mental Health Services; created; members; duties.~~

~~(1) The State Advisory Committee on Mental Health Services is created. Members of the committee shall have a demonstrated interest and commitment and specialized knowledge, experience, or expertise relating to the provision of mental health services in the State of Nebraska. The committee shall consist of twenty-three members appointed by the Governor as follows: (a) One regional governing board member, (b) one regional administrator, (c) twelve consumers of behavioral health services or their family members, (d) two providers of behavioral health services, (e) two representatives from the State Department of Education, including one representative from the Division of Vocational Rehabilitation of the State Department of Education, (f) three representatives from the Department of Health and Human Services representing mental health, social services, and Medicaid, (g) one representative from the Nebraska Commission on Law Enforcement and Criminal Justice, and (h) one representative from the Housing Office of the Community and Rural Development Division of the Department of Economic Development.~~

~~(2) The committee shall be responsible to the division and shall (a) serve as the state's mental health planning council as required by Public Law 102-321, (b) conduct regular meetings, (c) provide advice and assistance to the Division relating to the provision of mental health services in the State of Nebraska, including, but not limited to, the development, implementation, provision, and funding of organized peer support services, (d) promote the interests of consumers and their families, including, but not limited to, their inclusion and involvement in all aspects of services design, planning, implementation, provision, education, evaluation, and research, (e) provide reports as requested by the Division, and (f) engage in such other activities as directed or authorized by the Division.~~

Source:

~~Laws 2004, LB 1083, § 14;
Laws 2006, LB 994, § 93;
Laws 2007, LB296, § 460.~~

BY-LAWS FOR THE
STATE ADVISORY COMMITTEE ON MENTAL HEALTH SERVICES
May 3, 2011

~~**FEDERAL COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT**~~

~~**REQUIREMENTS FOR THE STATE MENTAL HEALTH PLANNING COUNCIL**~~

~~**Section 1914:**~~

~~The State will establish and maintain a State Mental Health Planning Council in accordance with the conditions described in this section.~~

~~(b) The duties of the Council are:~~

- ~~(1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;~~
- ~~(2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and~~
- ~~(3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.~~

~~(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:~~

~~(A) the principle State agencies with respect to:~~

- ~~(i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and~~
- ~~(ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;~~

~~(B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;~~

~~(C) adults with serious mental illnesses who are receiving (or have received) mental health services; and~~

~~(D) the families of such adults or families of children with emotional disturbance.~~

~~(2) A condition under subsection (a) for a Council is that:~~

~~(A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and~~

~~(B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.~~

State Advisory Committee Survey

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

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

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

YES **NO**

- | | | |
|-----------------------|-----------------------|---|
| <input type="radio"/> | <input type="radio"/> | I have expertise regarding behavioral health services. |
| <input type="radio"/> | <input type="radio"/> | I was specifically asked to consider becoming a committee member. |
| <input type="radio"/> | <input type="radio"/> | It gives me a feeling of accomplishment. |
| <input type="radio"/> | <input type="radio"/> | It supports my personal interests. |
| <input type="radio"/> | <input type="radio"/> | To improve the quality of life for consumers. |
| <input type="radio"/> | <input type="radio"/> | To be a voice for consumers and promote their interests. |
| <input type="radio"/> | <input type="radio"/> | To improve consumer access to services. |
| <input type="radio"/> | <input type="radio"/> | To improve behavioral health services. |
| <input type="radio"/> | <input type="radio"/> | To provide assistance and recommendations to the Division of Behavioral Health. |
| <input type="radio"/> | <input type="radio"/> | To evaluate organized peer support services. |
| <input type="radio"/> | <input type="radio"/> | To promote peer support services. |
| <input type="radio"/> | <input type="radio"/> | It supports my professional development. |
| <input type="radio"/> | <input type="radio"/> | Other: <i>If yes, please specify.</i> |

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

- | | |
|-------------------------|---------------------------|
| Mental <u>Health</u> | Substance <u>Abuse</u> |
| <input type="radio"/> | <input type="radio"/> |

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

- | | | | |
|-----------------------------------|-----------------------|-----------------------|----------------------------------|
| <u>Less than</u> <u>a year</u> | <u>1-2 years</u> | <u>3-4 years</u> | <u>5 years or</u> <u>more</u> |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

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

Please continue to back page   

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

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

Thank you for your participation! We appreciate your help!



STATE OF NEBRASKA | FY 2015-2019 CONSOLIDATED PLAN
COMMUNITY NEEDS SURVEY

COMMUNITY DEVELOPMENT ECONOMIC DEVELOPMENT HOUSING

Make your voice heard— The State of Nebraska is updating the Consolidated Plan for federal funds serving low and moderate income residents. This survey lets you tell the state what your community needs, and your responses are critically important to how State investments will be prioritized over the next five years. Please take just a few moments to share your opinions on the future of your community.

If you would like more information about the Consolidated Plan, please visit:

<http://www.neded.org/community/grants/documentslibrary-a-forms/consolidated-plan>

If you would prefer to complete this survey online, you can do so at:

<http://www.neded.org/community/grants/documentslibrary-a-forms/consolidated-plan>

Spanish language versions of this survey are available online, or by calling Brian Gaskill at 402-471-2280.

1. [OPTIONAL] What is the name of your community (county, city, town or village) that you will address in your responses? If you are offering a statewide perspective, please enter "Nebraska."

COMMUNITY DEVELOPMENT

2. How much need is there for the following improvements in your community ?

| | No need | A little need | Some need | A lot of need |
|---|-----------------------|-----------------------|-----------------------|-----------------------|
| Street improvements | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Water/sewer improvements | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Storm water and drainage improvements | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| ADA accessibility improvements | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Sidewalk improvements | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Street lighting improvements | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Beautification/enhanced public spaces | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Historic preservation | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Improving transit options | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Using sustainable building/construction practices | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Cleanup of public spaces | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Business districts | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Other needed improvements? *(please describe)*:

3. How much need is there for the following facilities and services in your community?

| | No need | A little need | Some need | A lot of need |
|-------------------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Senior centers | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Youth centers | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Child care centers | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Health services | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Mental health services | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Legal services | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Disability services | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Transportation services | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Employment training | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Fire stations | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Police stations | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Educational facilities | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Libraries | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Parks/recreational facilities | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Parking facilities | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Other unmet needs? (please describe):

4. How would you rate the quality of any of the following facilities and services in your community? (If you don't know of any such programs or facilities in your community, please mark "Don't know")

| | Poor quality | Average quality | Good quality | Don't know |
|-----------------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Senior centers | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Youth centers | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Child care centers | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Health services | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Mental health services | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Legal services | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Disability services | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Transportation services | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Employment training | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Fire stations | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Police stations | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Educational facilities | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Libraries | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Parks/recreation facilities | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Parking facilities | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

ECONOMIC DEVELOPMENT

5. How much need is there in your community for the following economic development services or programs?

| | No need | A little need | Some need | A lot of need |
|---|-----------------------|-----------------------|-----------------------|-----------------------|
| Financial assistance for business expansion | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Financial assistance for job creation | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Financial assistance to create small business enterprises | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Public Improvements to commercial/industrial sites | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Other unmet needs? (please describe):

6. How would you rate the quality of any of the following economic development services or programs in your community? (If you don't know of any such services or programs, please mark "Don't know")

| | Poor quality | Average quality | Good quality | Don't know |
|---|-----------------------|-----------------------|-----------------------|-----------------------|
| Financial assistance for business expansion | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Financial assistance for job creation | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Financial assistance to create small business enterprises | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Public improvements to commercial/industrial sites | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

HOUSING

7. How much need is there in your community for the following housing based programs?

| | No need | A little need | Some need | A lot of need |
|---|-----------------------|-----------------------|-----------------------|-----------------------|
| Rental housing rehabilitation assistance | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Homeowner rehabilitation assistance | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Tenant based rental assistance | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Affordable new construction for homebuyers | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Rental housing for the elderly | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Down-payment and/or closing cost assistance | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Affordable new rental homes | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Assistance with home modifications to accommodate disabilities | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Rental housing for the disabled | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Homeless facilities (Transitional housing and emergency shelters) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Housing for persons with HIV/AIDS | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Other housing needs? (please describe): | | | | |
| | | | | |

8. How would you rate the quality of any of the following existing housing resources in your community? (If you don't know of any such resources in your community, please mark "Don't know")

| | Poor quality | About average | Good quality | Don't know |
|---|-----------------------|-----------------------|-----------------------|-----------------------|
| Rental housing rehabilitation assistance | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Homeowner rehabilitation assistance | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Tenant based rental assistance | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Affordable new construction for homebuyers | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Rental housing for the elderly | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Down-payment and/or closing cost assistance | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Affordable new rental homes | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Assistance with home modifications to accommodate disabilities | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Rental housing for the disabled | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Homeless facilities (Transitional housing and emergency shelters) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Housing for persons with HIV/AIDS | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Thank you for taking the time to complete this survey. Please return this survey to Brian Gaskill, Department of Economic Development, 301 Centennial Mall South, Lincoln, NE 68509-4666, fax to 402-471-8405, or email to brian.gaskill@nebraska.gov.

Community Needs Survey Discussion & Focus Group

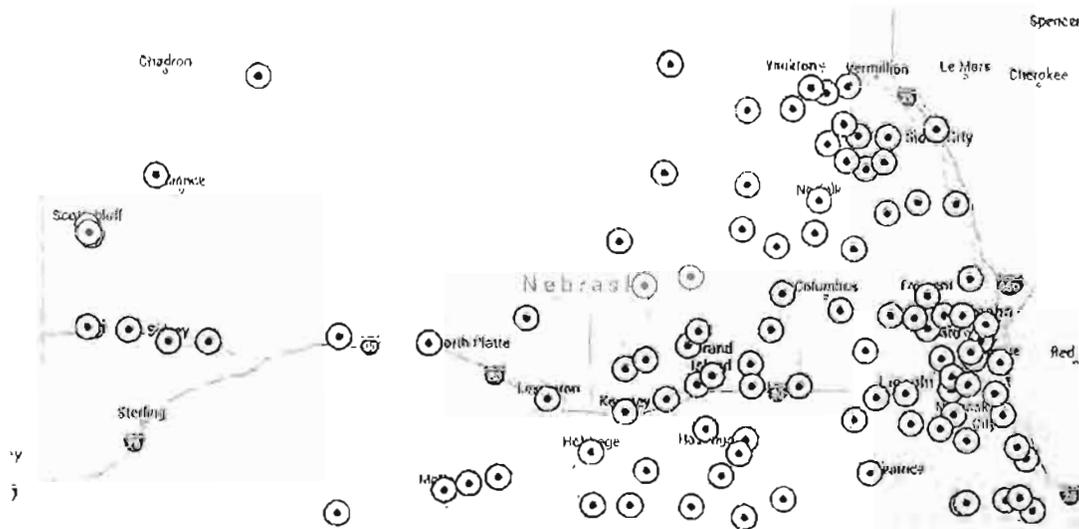
State of Nebraska, Department of Economic Development

for Development of Consolidated Plan 2015-2019

Information for Mental Health & Substance Abuse Advisory Committees

August 14, 2014

Distribution of Surveys Approximately 240 responses



Survey Results

Community Development

- Top 3 needed improvements included: Street Improvements, Sidewalk Improvements, Water/Sewer Improvements
- Community Development Top 3 needed facilities & services included: Youth centers, Child care centers, Employment Training
- Most respondents noted services were average or good quality.

Economic Development

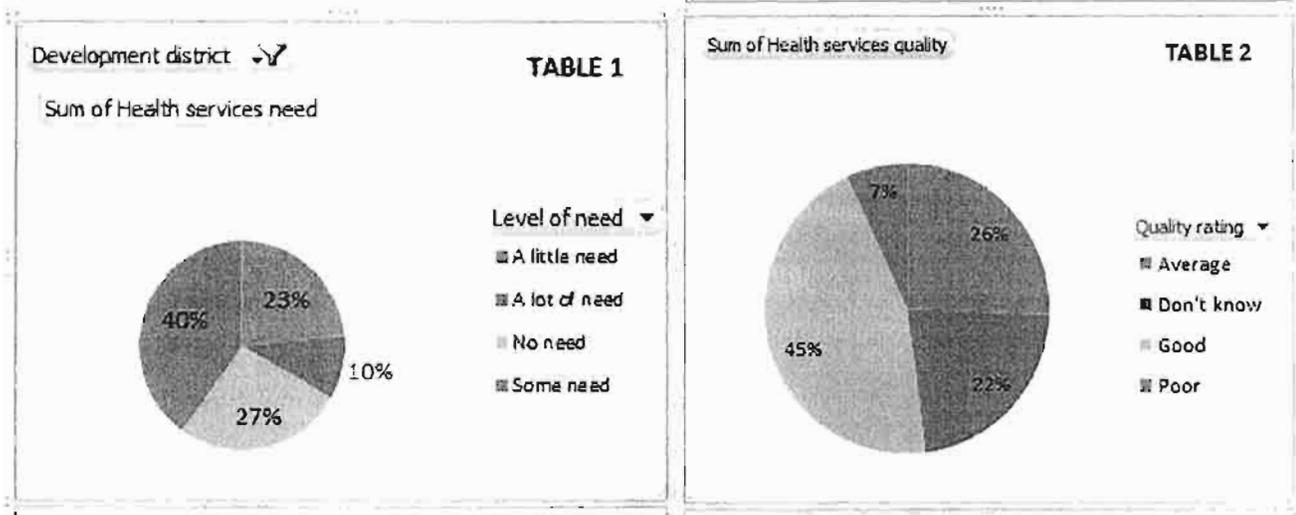
- Top 3 needed services included: Financial Assistance for business expansion, Financial assistance for job creation, and Financial assistance to create small business enterprises
- Most respondents noted services were average or good quality.

Housing

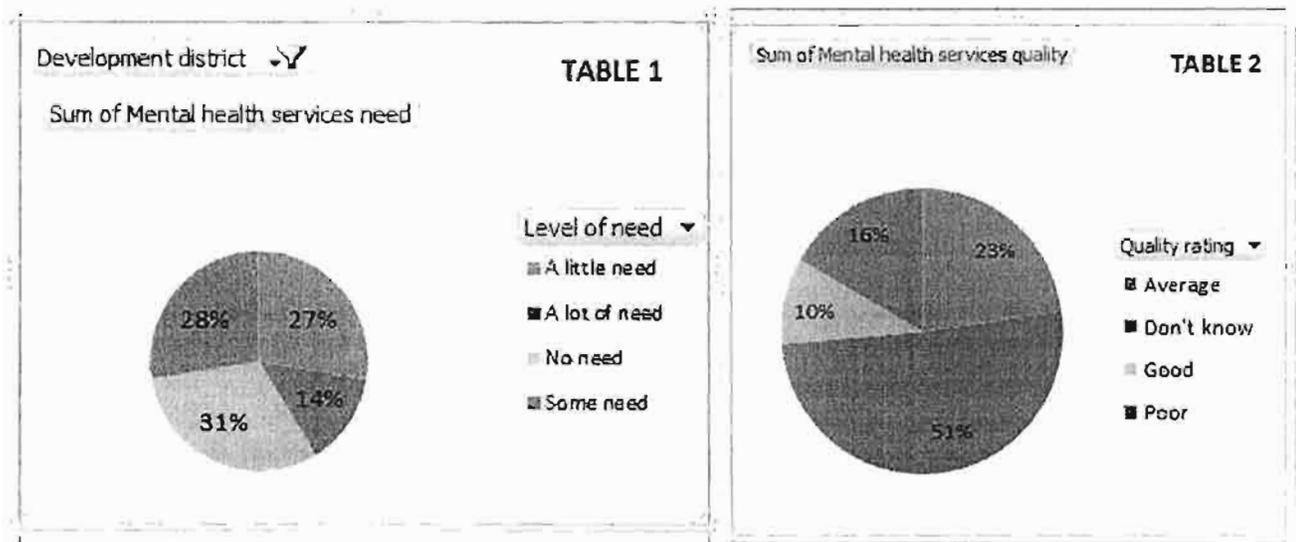
- Top needs included: OOR, New Construction, New Rental Construction, Rental Rehab, Owner Occupied Rehab

Results for Mental Health Services & Substance Abuse Services

Health Services



Mental Health Services



Nebraska Prevention Advisory Council

Quarter 3 meeting - June 26, 2014 - 9:00 a.m. to 12:00 p.m. - Pioneer's Park Nature Center

Meeting Brief

Prepared by: Nikki Roseberry – DHHS Division of Behavioral Health, Prevention Program Specialist

Director Scot Adams appointed the following members to the Prevention Advisory Council.

The co-chairs are delineated with a *:

*Patti Jurjevich – Region 6 Administrator

Fred Zwonechek – Administrator of the Nebraska Office of Highway Safety

Hubert Rupe – Executive Director with the Nebraska Liquor Control Commission

Megan Hopkins – Program Manager with Omaha Collegiate Consortium

Lori Griggs – Chief Probation Officer with Juvenile Probation

*Faith Mills – Region 1 Prevention System Coordinator

Chris Junker – Safe and Healthy Schools Coordinator with the Department of Education

Tricia Kingsley – Program Specialist with the DHHS – Division of Children and Family Services

Judy Martin – Deputy Director with the DHHS - Division of Public Health

Renee Faber – Prevention System Coordinator with the DHHS - Division of Behavioral Health

Terry Krohn – Director of Two Rivers Public Health Department

Dr. Dejun Su – Director of University of Nebraska Medical Center - Center for Reducing Health Disparities

Linda Krutz – Division Chief with the Commission on Law Enforcement and Criminal Justice

Action Planning:

The council members and attendees worked in small groups to consider several planning questions that will help guide the direction of the council in the coming years. Several concepts emerged as being important to the group:

Sustainability – Provide guidance on the development of sustainability plans for prevention programming, plan for the Prevention Advisory Council continuing beyond the 5 years of the Partnership for Success grant

Policy – Educate stakeholders and community members to begin grassroots change efforts, take an active role in advocacy for prevention across the state

Data Awareness – Bring in new data as it is released for discussion, provide data to stakeholders in an easily understandable format

Capacity Growth – Improve workforce capacity through advisement on training and use of funds, bring in new partners to the prevention system

Development of Workgroups: Continuation and growth of Statewide Epidemiological Outcomes Workgroup (SEOW), Begin a policy workgroup and a workforce development workgroup, consider other workgroup options, such as college-aged, rural, marijuana.

The Prevention Advisory Council reported they would like to offer the following operational definition of prevention to the State Advisory Committees on Mental Health Services and Substance Abuse Services:

Prevention

- Prevention is the active process of creating conditions or attributes that promote the wellbeing of people. Prevention activities avert the onset and reduce the progression of alcohol, tobacco, and other drug abuse, symptoms of mental illness, and other problems related to these concerns.
 - A universal prevention intervention targets all people within the general population or a certain subgroup not selected based on individual risk.
 - A selective prevention intervention targets individuals or a subgroup whose risk of developing a condition is higher than average.
 - An indicated prevention intervention targets individuals who are high risk and present minimal, but detectable symptoms of a mental, emotional, or behavioral disorder, but they do not yet have a diagnosis.

As the council moves forward they propose to provide the following updates to the State Advisory Committees on Mental Health Services and Substance Abuse Services:

- Information on the integration of mental health promotion, substance abuse prevention, trauma-informed care, and shared risk and protective factors
- Information on the importance of building capacity in prevention to garner greater investment in prevention work
- Annual report on Nebraska Behavioral Health Prevention Systems
- Recommendations based on our work and data

Nebraska System of Care Strategic Planning Project

Forward

A Family Perspective on the System of Care Planning Process

“As a parent being asked to share my voice as a representative of the voice of so many others families, having spent sleepless nights considering the best path for my child with behavioral health needs, balancing my family’s needs with that of getting my child the help she needed, fearing the unknown and celebrating the successes, my moment of arrival in a room full of professionals was daunting, at best. However, I had been encouraged, prepared, educated and supported to get to that room with years of my own lived experience as a parent coupled with the tools I had gained by listening and learning from other parents in similar situations that had also sought out support from my local family-run organization. As I tiptoed into the conference room, head lowered, hands clasped, I feared judgment and reprisal and felt small and insignificant despite the preparation.

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A Nebraska Parent

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From a philosophical stand point, it was vital for the professional system partners, parent partners and youth partners to come together to identify various perspectives, commonalities

and agreement on priorities. In some situations that union benefited from some very honest, real and often difficult discussions about what it means to truly involve families and youth as opposed to just inviting them to meetings.

System partners identified that launching and sustaining system change requires meaningful participation of families as partners, as much as other public and private child and family serving agencies and other stakeholders. Inclusion, as it was referred to in the planning phases, meant: acknowledging families as experts on their own needs; ensuring an active and meaningful role for family members in a variety of areas; and providing diverse opportunities for family members to participate in shared decision-making.

In the initial planning stages, the core SOC Management Team focused on developing capacity for family inclusion at the family, peer and system level by utilizing the SAMHSA statewide Family Network contract with Nebraska Federation of Families and the affiliate local family-run organizations. This created various opportunities for parent education on SOC, as well as preparation and involvement in various meetings and work groups that allowed parents and youth to share their views in an accepting and open atmosphere focused on cohesion and system improvement.

The parent and youth role in the planning process focused on:

- Leveraging parent's and youth's lived experience in policy, law and financing;
- Continuous reiteration of the values and principles of family-driven care in service delivery, support and processes that directly (and indirectly) impact youth and families;
- Identification of gaps, barriers, theories and wording that is not congruent with parent and youth partnership values in a System of Care model;
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Vast empowerment of parents and youth catapulted the movement to establish further structure around Parent and Youth Leadership programming and a Native American Peer Support project through coordinated efforts with Nebraska Federation of Families for Children's Mental Health and the affiliate family organizations. Though the work was sometimes difficult, it was also a catalyst for hope that the future for families and youth might include necessary changes to improve outcomes.

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NEBRASKA SYSTEM OF CARE
Strategic Planning Project
Planning for Transformation through Partnerships

EXECUTIVE SUMMARY

Nebraska's System of Care Strategic Plan, when implemented, will build on partnerships, include full participation of youth and families, and create a broad, integrated process across all of Nebraska's child-serving systems to achieve positive outcomes for children and youth with serious emotional and behavioral health needs and their families.

Vision: *All Nebraska children, youth and families reach their full potential.*

Mission: *Nebraska will improve the lives of children, youth and families by working within partnerships to transform Nebraska System of Care.*

Return on Investment (ROI):

States and communities that have implemented the system of care approach have reported changes in service utilization patterns. Such changes have resulted in a "return on investment" for the public systems that serve children with serious mental health conditions and their families. Examples include:

- Decreased use of inpatient psychiatric and residential treatment,
- Decreased use of juvenile correction and other out-of-home placements, and
- Decreased use of physical health services and emergency rooms.¹

The following return on investments were realized through the System of Care approach implemented in Nebraska's Behavioral Health Region III serving 22 counties in central Nebraska.

- From 2001 to 2009, the Central Nebraska region successfully returned youth to the community from high levels of care that were provided in restrictive settings outside of the community. These youth were then served with the system of care approach. Savings of \$500,000 in 2001 later grew to \$900,000 which were reinvested to serve additional youth and families.
- The average cost per family served with the system of care approach using wraparound was 60% less than the cost of those served through the child welfare or juvenile justice system.
- In 2012, 90% of youth at risk of entering child welfare or juvenile justice who were served with the system of care approach by six behavioral health authorities remained with their families.²

Capitalizing on initial infrastructure currently in place including the support and involvement of leaders across the state's many child-serving systems, Nebraska can expect to realize similar if not significant return on investment as the System of Care is implemented statewide.

¹ Stroul, Beth A. M.Ed., Pires, Sheila A., M.P.A., *Return on Investment in Systems of Care for Children with Behavioral Health Challenges*, National Technical Assistance Center for Children's Mental Health, April 2014

² Baxter, Beth, 2013; Nebraska Behavioral Health Services, Region III, 2000; Stroul et al., 2009

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A statewide readiness assessment for System of Care, conducted by UNL Public Policy Center, among 1105 families, youth, service providers and other stakeholders, identified clear priority areas to be addressed:

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- Improving access to services and supports.
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Stakeholders across the state were clear in their expectation that state leaders provide the framework, data and resources for local implementation of system of care, including increased opportunities for system level involvement for youth and families.

Planning Structure and Approach:

The planning project involved a comprehensive, highly participatory statewide process featuring more than 260 youth, family members and system representatives. Planning centered around eleven (11) planning groups that were formed and facilitated beginning in December 2013 and extending through April 2014. These groups include ten (10) Core Strategy Teams and an overarching Project Management Team. In addition to system representatives, all teams included youth and family members as an essential element of the planning process.

The Core Strategy Teams (CST) were organized around ten (10) content areas resulting in ten (10) sets of content-specific recommendations for enhancing System of Care. The resulting strategic plan includes goals and culturally and regionally relevant and sustainable strategies organized around the following core areas:

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Positive outcomes associated with System of Care implementation include:

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- 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, increased cross-system collaboration, and improved use of Medicaid and other resources.³

Nebraska’s System of Care, when implemented, will provide meaningful benefits and measureable outcomes to children and youth as experienced in the context of everyday living. A full list of process and functional outcomes can be accessed in the Strategic Plan on pages 18 and 25.

In order to infuse System of Care and the power of partnerships across Nebraska, the strategies as described beginning on page 28 of the Plan should be implemented. Many of these strategies would be low or no-cost thus supporting the “return on Investment” as previously described.

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Nebraska System of Care Planning Project
Planning for Transformation through Partnerships

Table of Contents

Executive Summary 1



Population of Focus..... 4

Context and History of System of Care in Nebraska..... 4

Vision, Mission and Values 10

Nebraska System of Care Planning Process..... 11

 Structure and Approach..... 11

 Training and Technical Assistance..... 13

 Participation in Planning..... 14

 Key Findings from Assessment 14

 Plan Development 15

 Youth Engagement..... 16

 Reviewing and Refining the Plan 17

Logic Model: Transforming Nebraska’s System of Care for Children, Youth and their Families. 18

Strategic Plan..... 26

 Goals..... 26

 Framework 27

 Strategies..... 27

Social Marketing and Communication Plan..... 42

Appendix A: Logic Model and Strategic Plan Development Tool..... 46

Appendix B: Definitions and Acronyms 63

Appendix C: Governance Diagram 70

Acknowledgements..... 71

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Nebraska System of Care Planning Project

July 2013 – July 2014

Population of Focus

The population of focus for Nebraska’s System of Care (SOC) planning efforts is defined, inclusively, as: *Children and youth with serious emotional and behavioral health needs and their families across all of Nebraska’s child-serving systems.*

Context and History of System of Care in Nebraska

The Nebraska Department of Health and Human Services (DHHS) Division of Behavioral Health (DBH) serves as the chief behavioral authority for the State of Nebraska as dictated in Neb. Rev. Stat. §71-806. In relationship to Nebraska’s SOC, DHHS DBH has the authority and responsibility to direct and coordinate the public behavioral health system, including integration and coordination of the system; comprehensive statewide planning for the provision of an appropriate array of community-based behavioral health services and continuum of care; development and management of data and information systems; prioritization and approval of all expenditures of funds received and administered by the division; and promotion of activities in research and education to improve the quality of behavioral health services, recruitment and retention of behavioral health professionals, and access to behavioral health programs and services. DHHS DBH works in partnership with six Regional Behavioral Health Authorities (RBHA) to carry out its charge.

Nebraska organized its mental health system in six regions in 1974. (See Figure 1) In 2004, LB 1083, the Nebraska Behavioral Health Services Act, was passed, establishing the regions as RBHAs. Neb. Rev. Stat. §71-803 outlines that RBHAs ensure: (1) the public safety and the health and safety of persons with behavioral health disorders; (2) statewide access to behavioral health services, including, but not limited to, (a) adequate availability of behavioral health professionals, programs, and facilities, (b) an appropriate array of community-based services and continuum of care, and (c) integration and coordination of behavioral health services with primary health care services; (3) high quality behavioral health services, including, but not limited to, (a) services that are research-based and consumer-focused, (b) services that emphasize beneficial treatment outcomes and recovery, with appropriate treatment planning, case management, community support, and consumer peer support, (c) appropriate regulation of behavioral health professionals, programs, and facilities, and (d) consumer involvement as a priority in all aspects of service planning and delivery; and (4) cost-effective behavioral health services, including, but not limited to, (a) services that are efficiently managed and supported with appropriate planning and information, (b) services that emphasize prevention, early detection, and early intervention, (c) services that are provided in the least restrictive

environment consistent with the consumer's clinical diagnosis and plan of treatment, and (d) funding that is fully integrated and allocated to support the consumer and his or her plan of treatment.

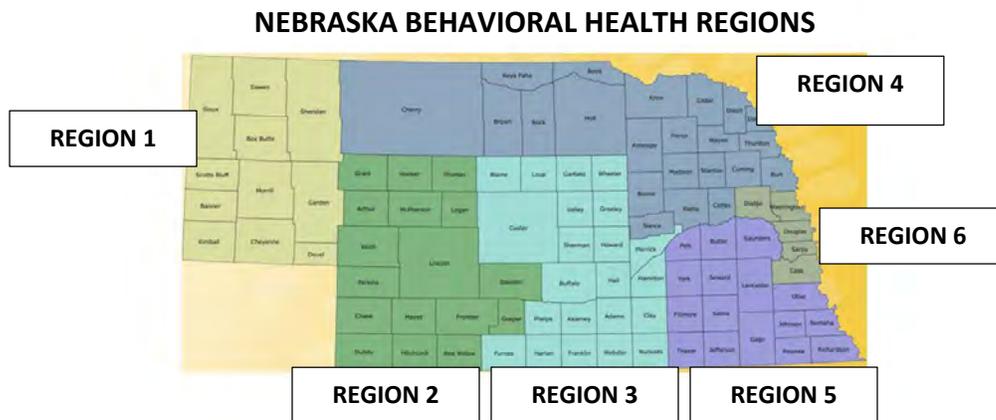


Figure 1

RBHAs develop local systems of care across the state responsive to local needs and building upon the unique strengths and communities of each region, forging partnerships with youth, families, providers, DHHS agencies (inclusive of Division of Behavioral Health (DBH), Children and Family Services (CFS), and Medicaid and Long-Term Care), county leaders (counties provide a 1:3 match for state funding), local system stakeholders, and community leaders and members. RBHA funding is intended to serve individuals who are not Medicaid eligible or do not have insurance coverage. The RBHAs include: Region 1 (11 counties) in western Nebraska with headquarters in Scottsbluff; Region 2 (17 counties) in southwestern Nebraska with headquarters in North Platte; Region 3 (22 counties) in central Nebraska with headquarters in Kearney; Region 4 (22 counties) in northern Nebraska with headquarters in Norfolk; Region 5 (16 counties) in southeastern Nebraska with headquarters in Lincoln; and Region 6 (5 counties) in eastern Nebraska with headquarters in Omaha.

Each RBHA braids funding from state, federal, and local county sources to develop local networks of providers to provide an array of non-traditional supports not covered by Medicaid, ranging from emergency to resiliency-oriented supports to wraparound. System coordination is central to their purpose, coordinating the local behavioral health system in the region through strategic strengths-based/recovery-focused processes that empower individuals and communities to assure that network providers, system partners and the many stakeholders of the behavioral health system work in a coordinated manner that supports individuals across the life span to promote resiliency and achieve recovery. Each RBHA has established multi-stakeholder collaborative structures to coordinate efforts in formal functional areas for Consumers (including youth) and Family Involvement and Inclusion, Network Management, Emergency Services System, Prevention Services System, and Youth System of Care (YSC). Each

RBHA has implemented since 1995 a Professional Partner Program (PPP) using a fidelity-based version of the wraparound care coordination model to support services to families who have children with serious emotional disorders and to ensure that youth and families have a voice and ownership in developing an accessible, comprehensive, individualized family support plan. DBH is currently contracting with TriWest Group to update the wraparound fidelity and outcome evaluation approach of the PPP, as well as its cost methodology. The YSC and PPP infrastructure facilitate the involvement of youth, families, and system partners at the regional (YSC) and individual family (PPP) levels. Over time, specialty PPP has developed within the RBHAs, including transition-age PPP teams and rapid response PPP teams developed as a proactive strategy to reduce the number of individuals and families seeking out-of-home care and services via county attorneys and county/district courts. (See Figure 2). CFS has also identified prevention PPP as part of its Alternative Response strategy to reduce the number of individuals that receive out-of-home care and to decrease the number of youth coming under the custody of the court.

Nebraska Judicial Districts - District Courts

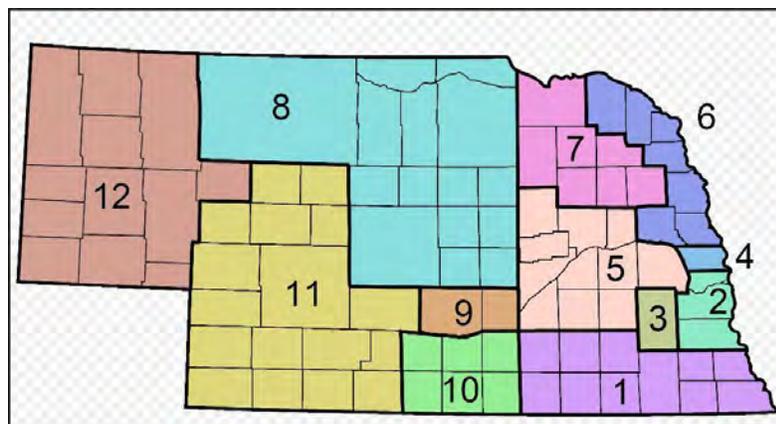


Figure 2

The YSC and PPP structures in each RBHA, alongside parallel structures for child welfare through the CFS’s five Service Areas (SAs) (see Figure 3), are long-standing and provide a key component of the foundation upon which the SOC strategic plan implementation efforts are built. While their geographic boundaries are not fully aligned, there is much overlap and each RBHA works with assigned SAs. This enhanced regional alignment is key to sustainability, as both RBHAs and SAs have established networks among SOC stakeholders in each region.

Nebraska’s past SOC efforts, generated in Behavioral Health Regions 3 and 5, served as the state’s barometer for moving forward with a SOC on a statewide basis. These efforts allowed Nebraska to capitalize on regional successes and incorporate lessons learned in the development of this SOC strategic plan.

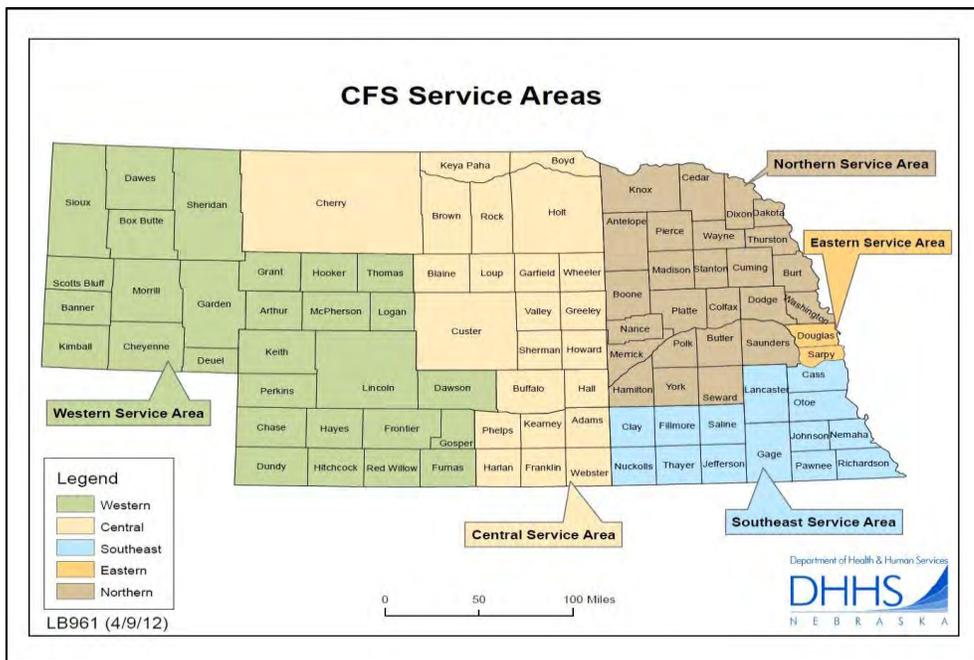


Figure 3

The timing to support System of Care (SOC) development at the state level in Nebraska is in a state of unprecedented readiness. Critical developments in 2011 solidified two directions for the state central to SOC development. First, Legislative Bill (LB) 821 established the Nebraska Children’s Commission (Commission), a 26-member body charged with creating a statewide strategic plan to reform child welfare programs and services, including children’s behavioral health. The Commission is comprised of representatives of the three branches of state government and members of the general public, including: guardians ad litem, prosecuting attorneys, foster and biological parents, children’s services providers, child advocacy organizations, foster care review board members, court-appointed special advocate volunteers, and youth currently or previously in foster care. This Commission serves as a permanent forum for collaboration among state, local community, public and private stakeholders across child-serving programs and services. The intent of the Legislature in creating the Commission was to establish the group as a high-level leadership body with membership from the legislative, executive and judicial branches, along with system stakeholders, to improve the safety and well-being of children and families in Nebraska.

Just as importantly for children with SED, in May 2012 the directors of DBH and CFS issued Administrative Memo #17-2012 defining a process for the two divisions to collaborate in new ways to improve outcomes for every youth involved in the child welfare system with a mental health and/or substance abuse disorder. The Transition Aged Youth Referral and Coordination Process developed through this memo set into motion a renewed spirit of shared responsibility in helping youth with behavioral health challenges access the full array of services and supports

available to them. Then, to set the stage for the recent Title IV-E Waiver application, Administrative Memo #2-2012 in January 2013 identified shared statutory goals for CFS to: 1) increase permanency for all infants, children, and youth by reducing the time in foster placements when possible and promoting a successful transition to adulthood for older youth, 2) increase positive outcomes for infants, children, youth, and families in their homes and communities, including tribal communities, and improve the safety and well-being of infants, children, and youth, and 3) prevent child abuse and neglect and the re-entry of infants, children, and youth into foster care. The memo was promulgated among staff to assure that when a child needs to be removed from their home due to safety concerns, non-custodial parents should be the first person considered for placement, followed by other people the children know and who care about them in order to reduce trauma to the child.

The goals reinforced the need for a Title IV-E Waiver application to develop an Alternative Response Model to reduce Nebraska's exceptionally high rate of foster care placement. With aligned support of DHHS, the Governor and the Legislature to pursue the waiver and carry out the mandate of LB 821, the SOC strategic plan builds on multiple prior initiatives to enable even higher levels of collaboration, including:

- In 2012, Nebraska explored and planned for the launch of an Alternative Response (AR) Model within CFS to allow families an opportunity to address issues prompting the child abuse/neglect reporting without removing children at low risk of harm from their natural environment. An AR stakeholder group has been formed with members including DBH, CFS, RBHAs, CFS's Service Administrators, the Federation of Families, and others. LB 853 allows the statutory change to current investigations and make way for pilots of the AR Model, to begin in State Fiscal Year 2015, in a limited and evaluative manner. AR is an effort to change further the state's culture away from thinking that the safety of a child can only be achieved through removal from the family home. The focus of the pilot is more on enhancing the family's protective factors while maintaining the child's safety. As such, communities enrolled in the pilot are collaborating in ways that inform and strengthen the System of Care.
- Beginning in 2012, DBH and CFS have been working in collaboration on a framework for trauma-informed care (TIC). DBH established Trauma Informed Nebraska in 2005 to guide TIC policy, provide trauma screening and training, gather data, and develop trauma-specific services statewide. All DBH-funded providers must complete a baseline agency assessment using the Harris and Falot TIC tool (Falot & Harris, 2009), and DBH has completed this tool for the state central office. CFS is currently working on a TIC Self-Assessment in order to develop a strategic plan moving forward. DBH and CFS completed training on the use of Results-Based Accountability™ ("RBA") to measure the outcomes achieved through services for children and families. RBA is also incorporated as part of the Title IV-E Waiver demonstration project interventions.

- The 2013 Legislative Session also included numerous bills that impacted the building of services and supports for children. There was legislation introduced to expand Medicaid state plan services to children ages 4-21 with SED who have been diverted or deinstitutionalized (LB270); expand telehealth services for schools (LB556) and juvenile youth (LB605); extend Title IV foster care eligibility until age 21 (LB216); change Foster Care Licensures and Kinship Home/Relative Home provisions to support permanency with kin and relatives (LB265); expand funding for counseling, mental health treatment and supportive services to improve child and caretaker well-being without having to remove children from their homes (LB425); and increase the number of juvenile court judges and specialized courts (LB463). LB 216, 265 and 556 were subsequently passed into law.
- A final, critical opportunity that makes this effort particularly timely involves Medicaid funding. In 2011 and 2012, the Medicaid system addressed multiple issues relating to residential treatment (Psychiatric Residential Treatment Facilities) and reestablishment of the children's mental health benefit within the state plan, as well as a request for proposal process to implement an at-risk behavioral health benefit in September 2013. Health services funding more broadly is also in a state of transition as the health insurance exchange, MHPAEA requirements for Medicaid services, and questions regarding Medicaid expansion will shape the structure of public and private health care in Nebraska that will guide us for years to come.

It is critical that SOC development be a central theme to help structure and influence those decisions, and the SOC Strategic Plan offers the people of Nebraska that opportunity.

Vision, Mission and Values

Partners agreed to a vision, mission and values for developing and implementing a system of Care. The following represents the final products coming from the highly participatory process.

Vision

Nebraska's vision describes our hopes and intentions for system of care for children and youth and their families in the next three to five years – our vision reminds us why this effort is important.

Vision: *Nebraska children, youth and families of all cultures are able to access an integrated system of care that supports them to reach their full potential holistically (health, home, purpose and community), while in school, living in a home and community that supports strong family connections, and in their transition to adulthood.*

Simply Said: *All Nebraska children, youth and families reach their full potential.*

Mission

The Mission of the Nebraska System of Care Partnership guides our efforts by describing (1) what the system of care does; (2) who it serves; and (3) how it functions.

Mission: *Nebraska's child and family serving system of care will improve access to appropriate and timely community-based care that is family-driven and youth-guided; embodies the cultural and linguistic values of the individuals and families being served and improves their clinical, behavioral, social, and educational outcomes; and eliminates fragmented approaches to meeting need. Child and family-serving systems will achieve this change through transparent system collaboration with partnerships and shared ownership involving individuals and families as full partners.*

Simply Said: *Nebraska will improve the lives of children, youth and families by working within partnerships to transform the Nebraska System of Care.*

Values

Our values and principles are the foundation for our system of care; everything we do can be measured against these core values.

Values: *Youth-guided; family-driven; individualized; culturally and linguistically competent; accessible; cost-effective, trusted partnerships.*

Nebraska System of Care Planning Process

Structure and Approach

Planning for Nebraska’s System of Care involved a comprehensive, highly participatory statewide process, featuring youth, family members and system partners. Planning centered around eleven (11) groups that were formed and facilitated beginning in December 2013 and extending through April 2014. These groups include 10 Core Strategy Teams and an overarching Project Management Team. All teams included system, youth and family partners working together. The Core Strategy Teams (CSTs) were organized around content areas and the Project Management Team (PMT) was responsible for project oversight and development of this consolidated statewide plan based on recommendations from each of the other planning groups. While this participatory process was highly intensive in terms of complexity and overall level of effort, this model was chosen in order to promote wide-ranging participation and ownership of identified issues. Our participatory planning process emphasized culturally and regionally relevant and sustainable strategies, and engagement of local experts (including those with lived experience), resources and supports instead of reliance on centralized experts, resources or efforts leading to top-down, generic strategies.

The 10 CSTs were facilitated by planning co-chairs (see the third column in Figure 5 for CST list). The co-chairs for each CST included a system partner and a family partner, who were recruited based on their experience with the topic area systems and stakeholders as well as their willingness to serve as co-facilitator. The CST structure resulted in 10 sets of content-specific recommendations for enhancing System of Care. The Project Management Team then reviewed, analyzed and consolidated these recommendations. This comprehensive statewide plan and logic model is the product of our planning model. Please refer to **figures 4 and 5** for a graphic depiction of the statewide planning process. Note that Phase 4 timelines were compressed to facilitate internal deadlines.

Overview of Timeline and Sequence of Planning Process

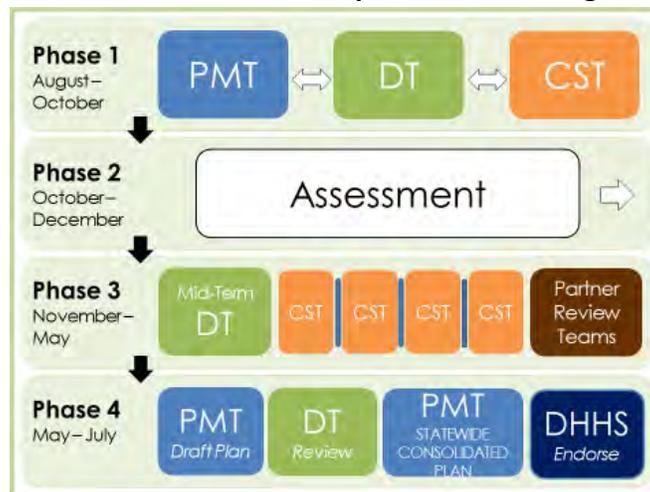


Figure 4

Overview of Planning Group Composition

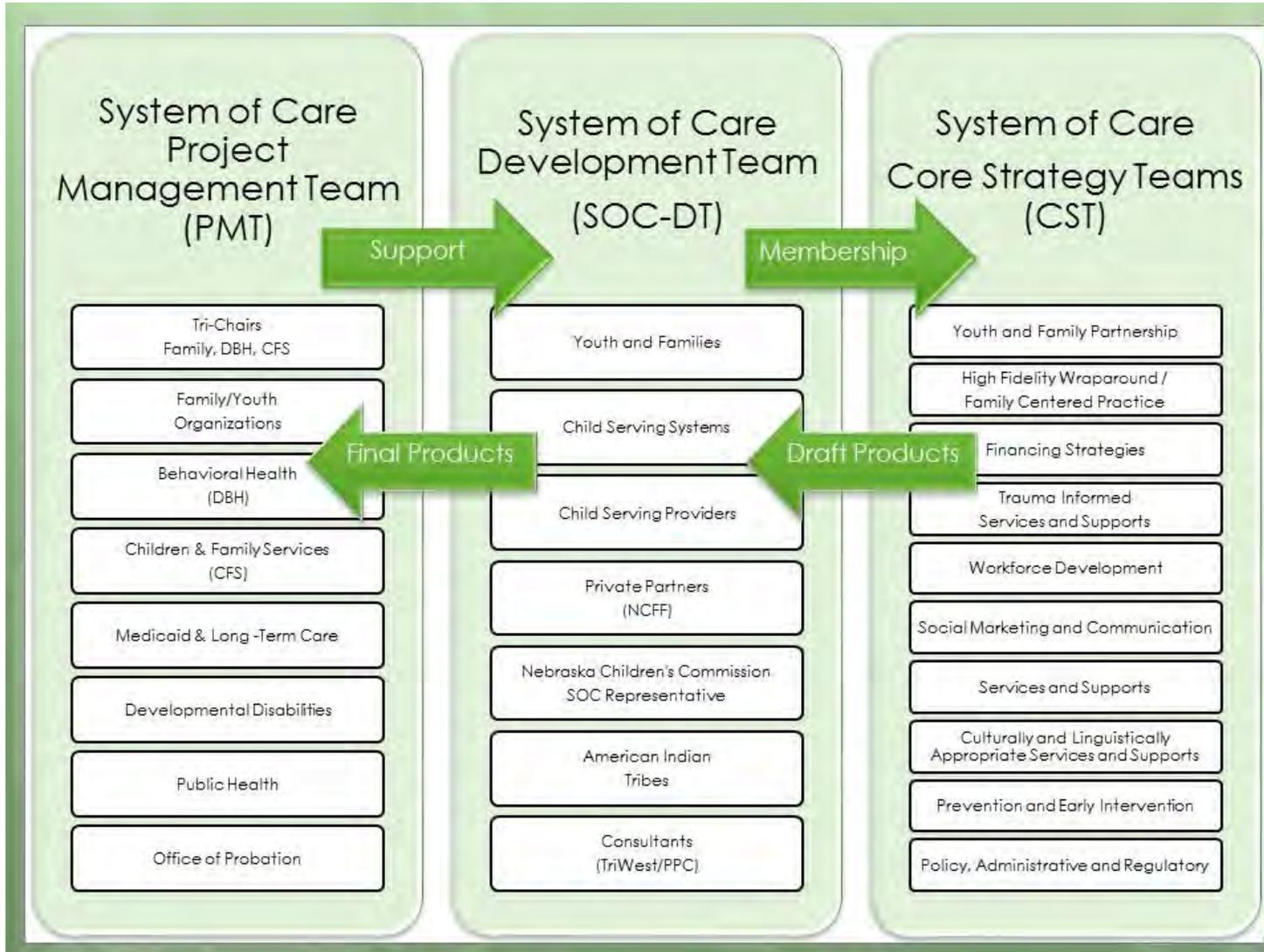


Figure 5

An essential element of our strategic plan planning processes was the involvement of family and youth. Two Nebraska organizations spearheaded the coordination -the Nebraska Federation of Families for Children’s Mental Health (NFF) and Nebraska Children and Family Foundation (NCF). Utilizing grant funding for this critical effort, these organizations assisted throughout the planning by successfully: organizing and gathering the voice of youth and family focus in the readiness assessment and strategic plan review phases; recruiting family and youth for involvement in the CSTs; facilitating CSTs; facilitating family and youth attendance at the kick-off and planning sessions; developing the communication plan; and participating in the final stages of the completion of the strategic plan. Because of these two organizations and their tremendous contribution to the strategic planning process, Nebraska has a strong SOC strategic plan based on an abundance of youth and family engagement.

Training and Technical Assistance

To maximize the intended effectiveness and outcomes of the 10 Core Strategy Teams (CST), two training sessions were provided to all CST co-chairs prior to the initiation of their first CST meeting. Training consisted of an overview of the CST process (review of team charge, logistics, team membership, etc.), and expected outcomes and meeting facilitation tips and techniques. A large portion of the training discussion was focused on how CST chairs could embed and implement the system of care philosophy and principles throughout the planning process as well as growing the understanding and implementation of equal partnership. Continued coaching was provided by the Project Coordinator to CST co-chairs through bi-weekly phone conferenced during the months the CSTs were convened. The phone conferences provided CST co-chairs an opportunity to ask questions and address and resolve issues specific to their individual CST content area and work products.

Central to the success of Nebraska’s SOC Planning Project is adherence to the National Standards for Culturally and Linguistically Appropriate Services (CLAS). A key focus of the planning process was to promulgate and increase commitment to the CLAS standards across all levels of planning and the subsequent strategic plan. To meet this objective one of the 10 Core Strategy Teams was dedicated to identifying and developing strategies to infuse Cultural and Linguistic Competence (CLC) and CLAS principles, practices and standards across all 10 CST content areas. Technical Assistance in the form of an all-day workshop specific to CLC/CLAS was offered to all CST members as well as members of the Project Management Team, project leadership and key staff of system partners. Vivian Jackson, Ph.D., National Center for Cultural Competence, Georgetown University Center for Child and Human Development, presided over the day’s agenda which included topics specific to clarity of concepts and elements of CLC. Application/implementation exercises for CLC and CLAS, adaptable to individual spheres of influence, were offered to participants. We appreciated Dr. Jackson’s time and consultation outside of the workshop to review and improve the plan. Blanca Ramirez-Salazar, Tribal Liaison, DHHS Office of Health Disparities and Health Equity, assisted during final plan

development in reviewing and providing her recommendations for the draft language specific to CLC/CLAS.

Participation in Planning

Statewide Readiness Assessment

The University of Nebraska Public Policy Center conducted a statewide self-assessment of readiness for expanding system of care in Nebraska during November 2013. The self-assessment consisted of a survey of 786 families, youth, service providers and other stakeholders, and 42 discussion forums with 319 participants in all six behavioral health regions. Listed below is participant primary role as reported in the survey and discussion groups.

| Primary Role | Number |
|--|--------|
| Judiciary | 8 |
| Youth | 38 |
| Foster Parent/Guardian | 12 |
| Advocate | 38 |
| Supervisor | 60 |
| Parent/Family Member (past or present) | 171 |
| Teacher | 99 |
| Administrator | 116 |
| Direct Service Provider | 141 |
| Service System | 206 |
| Other* | 216 |

*Other included service providers such as counselors, school counselors, guidance counselors, nurses and school nurses.

Key Findings from Assessment

The statewide readiness assessment indicated a widely held sense that system of care components were lacking both at the state and community level. Clear priority areas from the readiness assessment included: 1) expanding the array of services and support; 2) enhancing the cultural and linguistic appropriateness of services to better match family needs; 3) improving access to services and support; 4) maximizing use of all funding sources, especially federal; 5) inclusion of trauma-informed service options; 6) expanding family and youth involvement and leadership; and 6) systems to monitor quality and outcomes.

Interestingly, stakeholders across the state were clear in their expectation that state leaders provide the framework, data and resources for local implementation of system of care. Participants thought youth and family partnership components were lacking across the state. Families indicated they want to be recognized as equal partners on child and family teams. Increasing opportunities for system level involvement for youth and families, and equipping them with the skills to participate effectively in policy development, appear to be a clear area of need.

Stakeholders noted that workforce development components are lacking in consistency and continuity at the community and state levels. Training the workforce is considered a state and community strength as well as a priority need. There was recognition that Nebraska has a shortage of behavioral health professionals, particularly in rural areas. Survey and focus group participant suggestions include better utilization of other system professionals, such as school social workers; enhancing compensation for behavioral health providers to increase recruitment and retention; and improving the skills of the workforce through training on topics such as trauma-informed care, evidence-based practices, social and emotional development, high-fidelity wraparound, and cultural and linguistic competency.

An essential system partner in the strategic planning process related to workforce development was the University of Nebraska Medical Center (UNMC). By state statute, UNMC's Behavioral Health Education Center of Nebraska's (BHECN) mission is to:

To enhance the behavioral health of the people of Nebraska by improving the numbers, accessibility and competence of the Nebraska Behavioral Health Workforce through the collaboration of academic institutions, providers, governmental agencies and the community.

Along with the Executive Director of a Nebraska Federation of Family organization, BHECN's Associate Director chaired the CST that addressed SOC workforce development, which produced a multitude of strategies to improve Nebraska's behavioral health workforce providing services and supports to children, youth and families. BHECN has pledged to continue to be a central force in the implementation of Nebraska's SOC Strategic Plan.

Plan Development

Core Strategy Teams: Participation = 262

Listed on the next page is SOC partner participation by role on ten core strategy teams. The numbers were compiled from the attendance sheets of the individual CST breakout sessions during two statewide meetings (October 2013 and January 2014) and individual CST meeting in February and March 2014. Numbers listed reflect attendance at one or more (but not necessarily all) CST meetings beginning October 2013 through March 2014. During this period

of time, corresponding to Phase 3 in the planning structure (see Figure 4), CSTs developed the basic content and strategies for the plan.

In spite of recruitment efforts and a moderate level of family and youth participation, Nebraska must pay special attention to building a solid foundation for equal partnership in the SOC.

| CST | System Partners | Family Partners | Youth Partners |
|-------------------------------|-----------------|-----------------|----------------|
| CLAS | 12 | 2 | 3 |
| Finance | 17 | No Volunteers | No Volunteers |
| High Fidelity Wraparound | 18 | 2 | 2 |
| Policy, Administration | 28 | 3 | 1 |
| Prevention/Early Intervention | 29 | 9 | 1 |
| Services and Supports | 38 | 7 | 1 |
| Social Marketing | 4 | 3 | 4 |
| Trauma-Informed Care | 19 | 8 | 2 |
| Workforce Development | 23 | 2 | 1 |
| Youth/Family Partnership | 19 | 2 | 2 |
| TOTAL | 207 | 38 | 17 |

Youth Engagement

Focus Groups: Youth Participation = 143

The voice of youth who were experiencing or had experienced Nebraska’s behavioral health system and other child serving systems was of particular interest in this process. Central to accomplishing the collection of youth voice was the partnership of NCFE and Project Everlast. (See the organization’s link at: <http://www.projecteverlast.org/>.) Through the leadership of NCFE’s Cassy Rockwell, youth voice was included in the planning process by way of a developed plan to conduct youth focus groups with youth organizations around the state. In total, 14 youth-serving organizations hosted youth focus groups across Nebraska (during February and March 2014). NCFE conducted a second round of focus groups in June in order to gather youth input into the developing system of care strategic plan. All groups ranged from one to 17 participants. There was representation from: juvenile justice facilities, child welfare current and former wards, behavioral health, independent living/transitional programs, and Native youth. One hundred forty-three (143) youth participated and 115 provided demographic information.

Of the youth that provided demographic information, 89% reported having received services from a child serving system in Nebraska. Listed below are the types of agencies from which youth had received services.

| System/Agency | Number of Youth |
|----------------------------|-----------------|
| Child Welfare | 32 |
| Developmental Disability | 11 |
| Early Childhood | 13 |
| Education | 27 |
| Health care | 30 |
| Mental Health | 48 |
| Substance Abuse | 31 |
| Vocational Rehabilitation | 23 |
| Juvenile Justice/Probation | 54 |
| Other* | 13 |

*Other: Foster Care (4), Region 3 (2), NYLC (2), Boys Town (1), Project Everlast (1), Team Mates (1), shelters (1) and unspecified (1))

Reviewing and Refining the Plan

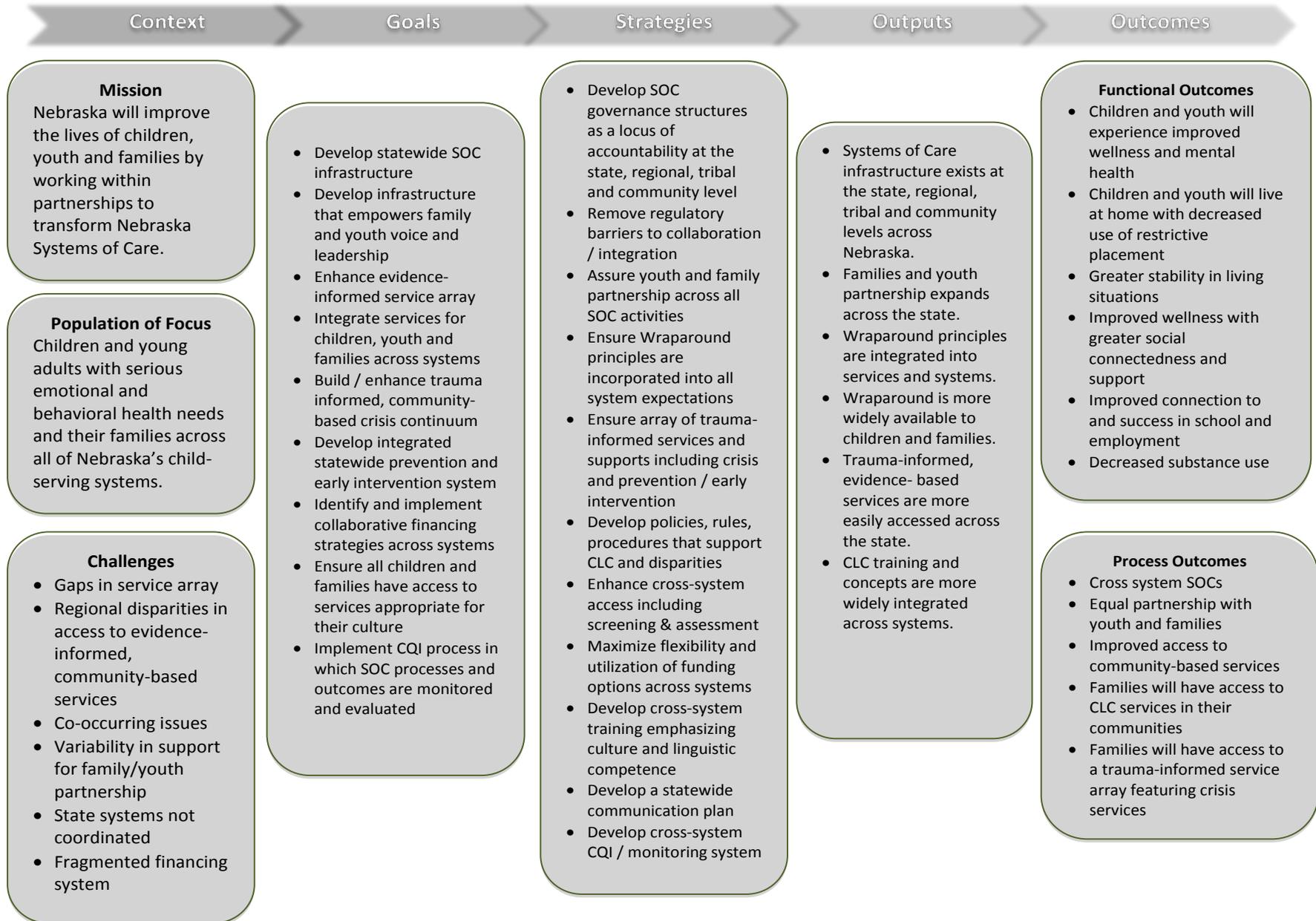
Plan Review and Revision: Participation = 262

The PMT adopted a logic model (page 18). They chose to include an expanded logic model which was an aggregate of the CST work plans. The strategic plan (page 26) was then organized into the nationally recommended format. After the initial logic model and strategic plan were drafted, we conducted a participatory review process during the months of April, May and June. The process included statewide town hall-style meetings as well as a series of youth focus groups, a family survey process and a special effort to ensure feedback from Native Americans in Nebraska. During this period, planning participants were asked to reflect on the priorities, goals and strategies reflected in the plan. The participatory review process resulted in significant revisions to ensure the plan truly reflects the systems and people of Nebraska.

Another activity in the participatory review process was to periodically present the draft plan and core strategies to the Nebraska Commission for Children for their review and support. Going forward, the Commission will use this strategic plan as a foundation for the development of their future priorities for Nebraska’s SOC.

Finally, the PMT and representatives of all Nebraska Family Organizations completed final edits and this document was reviewed and approved by DHHS leadership.

Logic Model: Transforming Nebraska's System of Care for Children, Youth and their Families



Mission

Nebraska will improve the lives of children, youth and families by working within partnerships to transform Nebraska Systems of Care.

Population of Focus

Children and young adults with serious emotional and behavioral health needs and their families across all of Nebraska's child-serving systems.

Challenges

- Gaps in service array
- Regional disparities in access to evidence-informed, community-based services
- Co-occurring issues
- Variability in support for family/youth partnership
- State systems not coordinated
- Fragmented financing system

- Develop statewide SOC infrastructure
- Develop infrastructure that empowers family and youth voice and leadership
- Enhance evidence-informed service array
- Integrate services for children, youth and families across systems
- Build / enhance trauma informed, community-based crisis continuum
- Develop integrated statewide prevention and early intervention system
- Identify and implement collaborative financing strategies across systems
- Ensure all children and families have access to services appropriate for their culture
- Implement CQI process in which SOC processes and outcomes are monitored and evaluated

- Develop SOC governance structures as a locus of accountability at the state, regional, tribal and community level
- Remove regulatory barriers to collaboration / integration
- Assure youth and family partnership across all SOC activities
- Ensure Wraparound principles are incorporated into all system expectations
- Ensure array of trauma-informed services and supports including crisis and prevention / early intervention
- Develop policies, rules, procedures that support CLC and disparities
- Enhance cross-system access including screening & assessment
- Maximize flexibility and utilization of funding options across systems
- Develop cross-system training emphasizing culture and linguistic competence
- Develop a statewide communication plan
- Develop cross-system CQI / monitoring system

- Systems of Care infrastructure exists at the state, regional, tribal and community levels across Nebraska.
- Families and youth partnership expands across the state.
- Wraparound principles are integrated into services and systems.
- Wraparound is more widely available to children and families.
- Trauma-informed, evidence-based services are more easily accessed across the state.
- CLC training and concepts are more widely integrated across systems.

Functional Outcomes

- Children and youth will experience improved wellness and mental health
- Children and youth will live at home with decreased use of restrictive placement
- Greater stability in living situations
- Improved wellness with greater social connectedness and support
- Improved connection to and success in school and employment
- Decreased substance use

Process Outcomes

- Cross system SOC's
- Equal partnership with youth and families
- Improved access to community-based services
- Families will have access to CLC services in their communities
- Families will have access to a trauma-informed service array featuring crisis services

Expanded Logic Model

| |
|---|
| <ul style="list-style-type: none"> • Vision: Nebraska children, youth and families of all cultures are able to access an integrated system of care that supports them to reach their full potential holistically (health, home, purpose and community) while in school, living in a home and community that supports strong family connections, and in their transition to adulthood. • Mission: Nebraska’s child and family serving system of care will improve access to appropriate and timely community-based care that is family-driven and youth-guided; embodies the cultural and linguistic values of the individuals and families being served and improves their clinical, behavioral, social, and educational outcomes; and eliminates fragmented approaches to meeting need. Child and family-serving systems will achieve this change through transparent system collaboration with partnerships and shared ownership involving individuals and families as full partners. |
| <p>Values: Youth-guided; family-driven; individualized; culturally and linguistically competent;; accessible; cost-effective; trusted partnerships.</p> |
| <p>Population of Focus: Children and youth with serious emotional and behavioral health needs and their families across all of Nebraska’s child-serving systems.</p> |

| Strengths & Resources → | Context, Needs, Challenges → | Goals → | Strategies and Sub-Strategies → |
|--|--|---|---|
| <ul style="list-style-type: none"> • Systems (JJ; BH; PH; CFS, Ed.) recognize the importance of, and are beginning to work towards, partnership with family and youth. • Growing understanding that early, community-based care is an effective strategy. • Growing commitment, at the state level, to partnership among youth, family and system partners. | <ul style="list-style-type: none"> • Change is difficult and requires great persistence. Policies and practices inhibit youth and family-centered work and involvement. • Gaps in service array, in some areas of the state, with limited access to evidence-informed, community-based interventions. • Skepticism and limited awareness and/or support for family leadership in some parts of the state. | <ul style="list-style-type: none"> • Develop, implement and sustain System of Care (SOC) infrastructure, inclusive of legislation, policy, regulatory and financing, at regional, tribal and community levels. • Build a sustainable statewide infrastructure to empower children, youth and family voice outreach, education, advocacy and leadership opportunities. | <p>Implementing Policy, Administrative, and Regulatory Changes</p> <ul style="list-style-type: none"> • Develop a SOC governance structure for a locus of accountability at the state level and support the implementation of the strategic plan by the SOC Leadership Team • The SOC Leadership Team will support the formation of regional, tribal and community SOC Leadership Teams that build upon current local strengths, and assume locus of accountability for SOC efforts at the local level. • Identify and review regulations or other barriers that prevent effective collaboration and/or development of a single services plan for youth and families across systems. • Ensure wraparound principles are incorporated into expectations for service provision across systems including contractual language to promote accountability |

| Strengths & Resources → | Context, Needs, Challenges → | Goals → | Strategies and Sub-Strategies → |
|--|---|--|---|
| <ul style="list-style-type: none"> Juvenile justice, child welfare, behavioral health and education systems actively participating in SOC planning. | <ul style="list-style-type: none"> Lack of consistency, common definition of wraparound and family-driven practice. Many of the children and youth with the highest needs are involved in multiple systems. State systems (DBH, CFS, DD, MLTC) are not coordinated in engaging providers, resulting in inefficient use of scarce resources. Regional differences across the state require flexibility and locally tailored strategies for successful implementation. State-funding of fidelity-based wraparound maximizes flexibility, but is limited in terms of funding streams. Fragmented financing system for behavioral health. Need cross-system screening and assessment for trauma. Limited services and supports across the age range (e.g., 0-8 years; TAY). Partnerships with schools vary across the state. Generational, deep-seated BH stigma. | <ul style="list-style-type: none"> Provide a culturally responsive, evidence-based and promising practices service array, featuring wraparound principles/philosophy and peer-to-peer support, to children, youth and families. Integrate children, youth and family services across systems. Build, or enhance a culturally responsive, trauma-informed and community-based crisis continuum across systems. Develop an integrated statewide prevention and early intervention system for children, youth and their families that emphasizes mental health promotion, suicide prevention, resilience, and trauma-informed practices. Utilize collaborative financing strategies across systems that are consistent with SOC values and principles. | <ul style="list-style-type: none"> Assure that youth, family members and system partners will be involved in meaningful partnership in state and regional planning, evaluation, training, social marketing, CLC/CLAS and all other SOC implementation activities. Develop a statewide, cross-system “competency worksheet” for organizations to incorporate into training and evaluation practices. Identify and agree upon a shared screening, assessment and evaluation framework in the context of across system collaboration to support understanding of appropriateness of level of care determinations and service utilization. Identify and establish mechanisms for regional, tribal and community SOC teams to identify and monitor effectiveness of services provided to children and youth involved in multiple systems. Obtain formal commitment across systems to SOC values and principles including contribution of funds for system redesign through a signed Memorandum of Commitment document. Ensure that recruitment, hiring and retention practices result in High Fidelity Wraparound (HFW), regional and state staff that are culturally and linguistically representative of the communities being served. Assure that data regarding outreach, access, outcomes and disparities among culturally and linguistically diverse groups is used in making policy, administrative and regulatory changes. Integrate SOC principles with state and local policy decisions. Develop policies, rules and procedures that support CLC, implement CLAS standards, and address disparities. Coordinate across DBH, CFS, DD and MLTC-funded networks. <p>Developing Services and Supports based on the SOC Approach</p> <ul style="list-style-type: none"> Develop definitions, principles and practices for “no wrong door access” and a single services plan for children, youth and families across systems. Assist regional, tribal and community SOC leadership teams to explore ways to integrate strategies across systems at the local level. |

| Strengths & Resources → | Context, Needs, Challenges → | Goals → | Strategies and Sub-Strategies → |
|-------------------------|---|--|---|
| | <ul style="list-style-type: none"> • Policies, procedures & funding streams are barriers to flexibility in pooling resources or creativity. • Inconsistent family involvement – "expert" mentality; not valuing youth and family input. | <ul style="list-style-type: none"> • All children, youth and families will have access to services that respect and are appropriate for their culture. • Implement a participatory Continuous Quality Improvement (CQI) process in which all SOC intended outcomes are systematically monitored and evaluated. | <ul style="list-style-type: none"> • Promote and support the development of children, youth and family organizations within regions, tribes and communities. • Explore school-based and school-linked services including behavioral health screening, assessment, evaluation and referral protocols at the local level, including behavioral health screening, assessment, evaluation and referral protocols at the local level. • Ensure children and youth have access to wraparound, person-centered and family-driven planning leading to the delivery of evidence-based, promising practices and peer-to-peer services and support. • Identify and agree upon a shared screening, assessment and evaluation framework in the context of across system collaboration to support understanding of appropriateness of level of care determinations and service utilization. • Identify opportunities to promote coordination and eliminate duplication of services and processes across systems. • Facilitate the development and support of an integrated health information exchange (HIE) across systems. • Build a statewide crisis continuum that includes brief out-of-home options for children and youth in crisis such as crisis residential, respite, therapeutic foster care, and emergency shelter options. • Develop an integrated prevention and early intervention system based on primary, secondary and tertiary prevention components and includes efforts to increase parent/caregiver education, resources, integration with primary care, safe out-of-school programs, in-home services, and informal and formal supports. • Provide education/training to youth, family and system partners on accessing and using SOC funding. • Provide support to providers to develop the capacity to deliver services which are evidence-based and or promising practices to children, youth and their families and engage in on-going fidelity monitoring of such services. |

| Strengths & Resources → | Context, Needs, Challenges → | Goals → | Strategies and Sub-Strategies → |
|-------------------------|------------------------------|---------|---|
| | | | <ul style="list-style-type: none"> • Support the development and promotion of resource materials necessary to meet unmet needs of cultural and linguistic populations in Nebraska. • Develop/build on standards to ensure that all service plans developed with children, youth and families are individualized to their unique culture, beliefs and values. • Encourage the development and implementation of monitoring strategies for services and supports. • Explore the implementation of accountability standards for providers and state partners across systems. <p>Creating Financing Mechanisms</p> <ul style="list-style-type: none"> • Explore policy and administrative options to support the development and use of evidence-based and promising practices across funding streams and increase flexibility across funding streams. • Pursue funding mechanisms for youth and family peer support. • Identify funding, incentives and other options for providers to participate in individualized children, youth and family team meetings and activities as related to the individualized service plan. • Identify and develop strategies to increase flexibility within funding streams. • Develop strategies to access flexible service funds designed to support children, youth and their families for items or activities identified in their individualized wraparound service plan or as emergent needs arise. • Develop and implement a pilot project to track the needs of and service provision to children, youth and families who are high-frequency consumers of services across systems and initiate a data-driven management system. • Develop flexible funding options for expenses such as transportation and child care to support youth and family participation and involvement at all levels. • Complete financial scan (financial resource matrix, Children’s Commission Cross System Analysis Report). |

| Strengths & Resources → | Context, Needs, Challenges → | Goals → | Strategies and Sub-Strategies → |
|-------------------------|------------------------------|---------|--|
| | | | <ul style="list-style-type: none"> • Identify options for braided funding approaches to support a culturally responsive, trauma-informed and community-based crisis continuum across systems. • Identify budget allocations to include resources for translation and interpretation services and Culturally and Linguistically Appropriate Services (CLAS) implementation. <p>Providing Training, TA, and Coaching</p> <ul style="list-style-type: none"> • Coordinate efforts of all child serving systems to establish joint curricula and training that supports cross system work and ensure dissemination of that training. • Develop and implement culturally appropriate leadership training for interested youth and families. • Develop state-level family and youth leader position(s) to serve as a liaison between state agencies/systems and the youth and family network(s). • Facilitate the development of statewide training, education and technical assistance for the SOC workforce that utilizes youth and families as trainers. • Develop standards for state best practices for youth-guided and family-driven services. • Develop a competency training/education inventory to be used across systems and inclusive of the following eight domains: trauma informed/capable care; child and adolescent development; cultural and linguistic competence; children and youth with developmental disabilities and behavioral health needs; screening/assessment/evaluation/referral; family and person-centered practice; treatment planning/interventions/service delivery; quality improvement/professionalism and ethics. • Provide education/training for youth, family and system partners in evidence-based and promising practices related to mental health promotion, suicide prevention, resilience, and trauma-informed practices. • Develop a statewide, cross-system “competency worksheet” for organizations to incorporate into training, coaching and evaluation practices. |

| Strengths & Resources → | Context, Needs, Challenges → | Goals → | Strategies and Sub-Strategies → |
|-------------------------|------------------------------|---------|--|
| | | | <ul style="list-style-type: none"> • Develop and/or enhance the formation of local continuous quality improvement (CQI) teams /workgroups and data-informed decision-making. <p>Generating Support/Social Marketing</p> <ul style="list-style-type: none"> • Assure that all children, youth, family and system partners are informed and knowledgeable about the SOC philosophy and HFW. • Inform youth, families and other key stakeholders of the value of youth and family voice and the opportunity for youth and family partnership and leadership at the state, county and individual levels. • Ensure communications plan provides information to the public about how to gain access to a community-based crisis continuum. • Develop and implement a communications plan that increases the awareness of prevention and early intervention resources including a clearinghouse of funded evidence-based and promising practices and availability of services and community resources. • Ensure communications are appropriate across counties with diverse linguistic characteristics, including their primary language, literacy skills and disability status. • Develop CLC component to social marketing and communications plan to include understanding of the cultural issues related to services and include linguistic ability to communicate. • Ensure messaging campaigns consider the cultural communities’ preferred language, medium, messenger and style. |

Outcomes

Functional Outcomes and Indicators

- Children and youth will experience improved wellness and mental health.
- Children and youth will live at home.
 - Decrease utilization of long-term out-of-home placements.
 - Increase use of residential alternatives such as High Fidelity Wraparound, short term crisis, respite, and related supports.
 - Children and youth will experience improved stability in living situation.
- Children, youth and families exhibit well-being.
 - Improved coping skills.
 - Improved social connectedness.
 - Increased ability to overcome behavioral health needs.
- Children and youth will function successfully in the community.
 - Attend school and graduate.
 - Succeed in employment.
 - Engage in pro-social activities.
 - Experience more positive relationships with family, friends and others.
 - Establish effective support networks.
 - Experience decreased substance use.
- Costs for out-of-home care will decrease.

Process Outcomes

- Nebraska child and family serving agencies/systems partner and collaborate.
 - Engage in the implementation of coordinated and integrated system of care.
 - Efficiently and effectively deploy services and supports as determined by wraparound teams.
 - Implement culturally and linguistically appropriate and trauma-informed practice in all phases of interacting with children, youth and families.
 - Create an integrated system with “no wrong door” access.
 - Engage in equal partnership with families and youth in developing improved system of care.
 - Agree to, and implement, a common set of functional outcomes and work toward them together.
 - Have access to flexible funding to ensure individualized service delivery.
 - Be evaluated on implementation of family-centered practice within the agency/system.
- Nebraska children, youth and families
 - Have access to services in their home community.
 - Understand the systems and services they are involved in and know how to access information and get questions answered.
- Policies and funding for behavioral health in Nebraska will place a greater emphasis on prevention and early identification/intervention.

Nebraska System of Care Strategic Plan



Goals

The Project Management Team (PMT) considered all of the input from the planning process described previously and early on identified the following nine (9) goals that will organize our plan to enhance system of care for children, youth and their families across Nebraska:

1. Develop, implement and sustain system of care (SOC) infrastructure, inclusive of legislation, policy, regulatory and financing, at regional, tribal and community levels.
2. Build a sustainable statewide infrastructure to empower children, youth and family voice, outreach, education, advocacy and leadership opportunities.
3. Provide a culturally responsive, evidence-based and promising practices service array, featuring wraparound principles/philosophy and peer-to-peer support, to children, youth and families.
4. Integrate children, youth and family services across systems.
5. Build or enhance a culturally responsive, trauma-informed and community-based crisis continuum across systems.
6. Develop an integrated statewide prevention and early intervention system for children, youth and their families that emphasizes mental health promotion, suicide prevention, resilience, and trauma-informed practices.
7. Utilize collaborative financing strategies across systems that are consistent with SOC values and principles.
8. All children, youth and families will have access to services that respect and are appropriate for their culture.
9. Implement a participatory continuous quality improvement (CQI) process in which all SOC-intended outcomes are systematically monitored and evaluated.

Framework

Nebraska adopted the overarching framework of five core areas of focus identified by Beth Stroul and Robert Friedman (2011)⁴ as a way to organize the system of care strategic plan. They are:

1. Implementing Policy, Administrative, and Regulatory Changes
2. Developing Services and Supports based on the SOC Approach
3. Creating Financing Mechanisms
4. Providing Training, TA, and Coaching
5. Generating Support

Strategies

Nebraska is a diverse and complex state; the strategies that follow on pages 28-41 reflect this diversity as many strategies and activities require state, regional, tribal and local level actions that need to be addressed. Like any strategic plan, these strategies are a work in progress and subject to continuous review and improvement.



⁴ Stroul, B. A., & Friedman, R. M. (2011). Issue brief: Strategies for expanding the system of care approach. Washington, DC: Technical Assistance Partnership for Child and Family Mental Health.

NEBRASKA SYSTEM OF CARE (SOC) STRATEGIC PLAN

| GOALS | Strategies Needed to Complete Goals | | | | |
|--|--|---|---|---|--|
| | (A) Implementing Policy, Administrative, and Regulatory Changes | (B) Developing Services and Supports Based on the SOC Approach | (C) Creating Financing Mechanisms | (D) Providing Training, TA, and Coaching | (E) Generating Support |
| | Strategies | Strategies | Strategies | Strategies | Strategies |
| <p>GOAL # 1</p> <p>Develop, implement and sustain System of Care (SOC) infrastructure, inclusive of legislation, policy, regulatory and financing, at regional, tribal and community levels.</p> | <p>1. A.1. DHHS leadership will develop a SOC governance structure for a locus of accountability at the state level and support the implementation of the strategic plan by the SOC Leadership Team.</p> <p>1. A.2. The SOC Leadership Team, inclusive of equal representation of youth, family, and system partners will be formed and charged with pursuing dissemination and implementation of this strategic plan.</p> | <p>1. B.1. The SOC Leadership Team will develop definitions, principles and practices for “no wrong door access” and a single services plan for children, youth and families across systems.</p> <p>1. B.2. The SOC Leadership Team will assist regional, tribal, community and AR SOC leadership teams to explore ways to integrate strategies across systems at the local level, as identified in the SOC strategic plan.</p> <p>1. B.3 The SOC Leadership Team will identify and implement collaborative opportunities with AR Pilot Communities.</p> | <p>1. C.1. The SOC Leadership Team will develop funding stream options such as braided funding approaches across systems, and private and foundation contributions to develop alternatives to higher levels of care for children and youth.</p> <p>1. C.2. The SOC Leadership Team will develop standards for supporting equal partnership for children, youth and family participation in SOC activities, including financial support needed to fully participate in SOC activities.</p> | <p>1. D.1. The SOC Leadership Team will support the development of SOC principles and practices education/training for the system workforce and identify resources to disseminate education/training throughout the state.</p> | <p>1. E.1. The SOC Leadership Team will develop a communication plan that will inform children, youth, family and system partners about the Nebraska SOC.</p> |

NEBRASKA SYSTEM OF CARE (SOC) STRATEGIC PLAN

| GOALS | Strategies Needed to Complete Goals | | | | |
|--------------------------|---|---|--|---|-------------------------------|
| | (A) Implementing Policy, Administrative, and Regulatory Changes | (B) Developing Services and Supports Based on the SOC Approach | (C) Creating Financing Mechanisms | (D) Providing Training, TA, and Coaching | (E) Generating Support |
| | Strategies | Strategies | Strategies | Strategies | Strategies |
| GOAL #1 Continued | <p>1. A.3. The SOC Leadership Team will support the formation of regional, tribal, community and AR SOC Leadership Teams that build upon current local strengths, and assume locus of accountability for SOC efforts at the local level.</p> <p>1. A.4. The SOC Leadership Team will develop a method to track behavioral health disparities and develop and implement strategies to address accordingly.</p> | | | | |

NEBRASKA SYSTEM OF CARE (SOC) STRATEGIC PLAN

| GOALS | Strategies Needed to Complete Goals | | | | |
|--|--|--|---|--|---|
| | (A) Implementing Policy, Administrative, and Regulatory Changes | (B) Developing Services and Supports Based on the SOC Approach | (C) Creating Financing Mechanisms | (D) Providing Training, TA, and Coaching | (E) Generating Support |
| | Strategies | Strategies | Strategies | Strategies | Strategies |
| <p>GOAL # 2</p> <p>Build a sustainable statewide infrastructure to empower children, youth and family voice, outreach, education, advocacy and leadership opportunities.</p> | <p>2. A.1. (same as 1.A.2.) The SOC Leadership Team, inclusive of equal representation of youth, family, and system partners, will be formed and charged with pursuing dissemination and implementation of this strategic plan.</p> <p>2. A.2. The SOC Leadership Team will identify strategies and resources to fund and sustain children, youth and family equal partnerships.</p> | <p>2. B.1. The SOC Leadership Team will promote and support the development of children, youth and family organizations within regions, tribes and communities.</p> | <p>2. C.1. The SOC Leadership Team will pursue funding mechanisms for youth and family peer support.</p> | <p>2. D.1. The SOC Leadership Team will identify youth and family, culturally appropriate leadership education/training opportunities throughout the state.</p> <p>2. D.2. The SOC Leadership Team will develop state-level family and youth leader position(s) to serve as a liaison between state agencies/systems and the youth and family network(s).</p> <p>2. D.3. The SOC Leadership Team will facilitate the development of statewide training, education and technical assistance for the SOC workforce that utilizes youth and families as trainers.</p> <p>2. D.4. The SOC Leadership Team will develop standards for state best practices for youth-guided and family-driven services.</p> | <p>2. E.1. The SOC Leadership Team will develop and implement a statewide communications plan that incorporates and promotes the value of youth and family partnership and leadership.</p> |

NEBRASKA SYSTEM OF CARE (SOC) STRATEGIC PLAN

| GOALS | Strategies Needed to Complete Goals | | | | |
|--|--|---|---|--|---|
| | (A) Implementing Policy, Administrative, and Regulatory Changes | (B) Developing Services and Supports Based on the SOC Approach | (C) Creating Financing Mechanisms | (D) Providing Training, TA, and Coaching | (E) Generating Support |
| | Strategies | Strategies | Strategies | Strategies | Strategies |
| <p>GOAL # 3</p> <p>Provide a culturally responsive, evidence-based and promising practices service array, featuring wraparound principles, philosophy and peer-to-peer support, to children, youth and families.</p> | <p>3. A.1. (Same as 1.A.3.) The SOC Leadership Team will support the formation of regional, tribal and community SOC Leadership Teams that build upon current local strengths, and assume locus of accountability for SOC efforts at the local level.</p> <p>3. A.2. The SOC Leadership Team will identify regulations, barriers and gaps that prevent effective collaboration and/or development of a single services plan for children, youth and families across systems.</p> | <p>3. B.1. The SOC Leadership Team will support exploration of school-based and school-linked services including behavioral health screening, assessment, evaluation and referral protocols at the local level.</p> <p>3. B.2. The SOC Leadership Team will ensure children and youth have access to wraparound, person-centered and family-driven planning leading to the delivery of evidence based, promising practices and peer-to-peer services and supports.</p> <p>3. B.3 The SOC Leadership Team will identify and address disparities and inequalities in service outcomes.</p> | <p>3. C.1. The SOC Leadership Team will explore policy and administrative options to support the development and use of evidence-based and promising practices across funding streams.</p> <p>3. C.2. The SOC Leadership Team will explore policy and administrative options to increase flexibility across funding streams.</p> <p>3. C.3. (Same as 2.C.1.) The SOC Leadership Team will pursue funding mechanisms for youth and family peer support.</p> | <p>3. D.1. The SOC Leadership Team will develop a competency training/education inventory to be used across systems and inclusive of the following eight domains: trauma-informed/capable care; child and adolescent development; cultural and linguistic competence; children and youth with developmental disabilities and behavioral health needs; screening/assessment/evaluation/referral; family and person-centered practice; treatment planning/interventions/service delivery; quality improvement/professionalism and ethics.</p> | <p>3. E.1. The SOC Leadership Team will develop and implement a communications plan to inform system partners and key stakeholders about SOC; evidence-based and promising practices; peer-to-peer services and supports; and wraparound principles.</p> |

NEBRASKA SYSTEM OF CARE (SOC) STRATEGIC PLAN

| GOALS | Strategies Needed to Complete Goals | | | | |
|------------------------------|--|--|---|---|------------------------|
| | (A) Implementing Policy, Administrative, and Regulatory Changes | (B) Developing Services and Supports Based on the SOC Approach | (C) Creating Financing Mechanisms | (D) Providing Training, TA, and Coaching | (E) Generating Support |
| | Strategies | Strategies | Strategies | Strategies | Strategies |
| GOAL #3 Continued | <p>3. A.3. The SOC Leadership will ensure wraparound principles are incorporated into expectations for service provision across systems including contractual language to promote accountability.</p> <p>3. A.4. The SOC Leadership Team system partners will identify and agree upon a shared screening, assessment and evaluation framework in the context of across system collaboration to support understanding of appropriateness of level of care determinations and service utilization.</p> | <p>3. B.4. The SOC Leadership Team will identify mechanisms to Integrate diverse prevention services in many community-level and family-serving settings such as Early Childhood and evidence-based home visiting programs.</p> | <p>3. C.4. The SOC Leadership Team will identify funding, incentives and other options for providers to participate in individualized children, youth and family team meetings and activities as related to the individualized service plan.</p> | <p>3. D.2. The SOC Leadership Team will ensure the children and youth workforce, across systems, demonstrates proficiency in the eight domains (see 3.D.1.) as well as the wraparound principles and High Fidelity Wraparound.</p> | |

NEBRASKA SYSTEM OF CARE (SOC) STRATEGIC PLAN

| GOALS | Strategies Needed to Complete Goals | | | | |
|--|---|---|---|--|--|
| | (A) Implementing Policy, Administrative, and Regulatory Changes | (B) Developing Services and Supports Based on the SOC Approach | (C) Creating Financing Mechanisms | (D) Providing Training, TA, and Coaching | (E) Generating Support |
| | Strategies | Strategies | Strategies | Strategies | Strategies |
| <p style="text-align: center;">GOAL # 4</p> <p>Integrate children, youth and family services across systems.</p> | <p>4. A.1. The SOC Leadership Team will identify and develop strategies to address requirements regarding confidentiality issues that inhibit collaboration and integration across systems.</p> <p>4. A.2. The SOC Leadership Team will identify and establish mechanisms for regional, tribal and community SOC teams to identify and monitor effectiveness of services provided to children and youth involved in multiple systems.</p> | <p>4. B.1. (Same as 3.A.4.) The SOC Leadership Team system partners will identify and agree upon a shared screening, assessment and evaluation framework in the context of across system collaboration to support understanding of appropriateness of level of care determinations and service utilization.</p> <p>4. B.2. The SOC Leadership Team will identify opportunities to promote coordination and eliminate duplication of services and processes across systems.</p> <p>4. B.3. The SOC Leadership Team will facilitate the development and support of an integrated health information exchange (HIE) across systems.</p> | <p>4. C.1. The SOC Leadership Team will identify and develop strategies to increase flexibility within funding streams.</p> <p>4. C.2. The SOC Leadership Team will develop strategies to access flexible service funds designed to support children, youth and their families for items or activities identified in their individualized wraparound service plan or as emergent needs arise.</p> | <p>4. D.1. The SOC Leadership Team will establish joint curricula based on eight identified domains (see 3.D.1.) and identify opportunities to coordinate education/training activities across systems.</p> <p>4. D.2 The SOC Leadership Team will engage/retain DHHS Division of Behavioral Health to lead and facilitate training and technical assistance across systems.</p> | <p>4. E.1. (Same as 3.E.1.) The SOC Leadership Team will develop and implement a communications plan to inform system partners and key stakeholders about SOC; evidence-based and promising practices; peer-to-peer services and supports; and wraparound principles.</p> |

NEBRASKA SYSTEM OF CARE (SOC) STRATEGIC PLAN

| GOALS | Strategies Needed to Complete Goals | | | | |
|--------------------------|---|--|--|--|------------------------|
| | (A) Implementing Policy, Administrative, and Regulatory Changes | (B) Developing Services and Supports Based on the SOC Approach | (C) Creating Financing Mechanisms | (D) Providing Training, TA, and Coaching | (E) Generating Support |
| | Strategies | Strategies | Strategies | Strategies | Strategies |
| GOAL #4 Continued | | <p>4. B.4. (Same as 1.B.1.) The SOC Leadership Team will develop definitions, principles and practices for “no wrong door access” and a single services plan for children, youth and families across systems.</p> | <p>4. C.3. The SOC Leadership Team will develop and implement a pilot project to track the needs of and service provision to children, youth and families who are high-frequency consumers of services across systems and initiate a data-driven management system.</p> <p>4. C.4. The SOC Leadership Team will develop flexible funding options for expenses such as transportation and child care to support youth and family participation and involvement at all levels.</p> | | |

NEBRASKA SYSTEM OF CARE (SOC) STRATEGIC PLAN

| GOALS | Strategies Needed to Complete Goals | | | | |
|---|--|---|--|--|---|
| | (A) Implementing Policy, Administrative, and Regulatory Changes | (B) Developing Services and Supports Based on the SOC Approach | (C) Creating Financing Mechanisms | (D) Providing Training, TA, and Coaching | (E) Generating Support |
| | Strategies | Strategies | Strategies | Strategies | Strategies |
| GOAL # 5 Build, or enhance a culturally responsive, trauma-informed and community-based crisis continuum across systems. | 5. A.1. The SOC Leadership Team will identify and coordinate regulations, licensing and policy requirements that are relevant to the development of a culturally responsive, trauma-informed and community-based crisis continuum across systems. | 5. B.1. The SOC Leadership Team will explore and identify requirements necessary to build a culturally responsive, trauma-informed and community-based crisis continuum across systems that includes a dedicated on-call team, in-home services and brief out-of-home options for children and youth in crisis, such as crisis residential, respite, therapeutic foster care, and emergency shelter. | 5. C.1. The SOC Leadership Team will identify options for braided funding approaches to support a culturally responsive, trauma-informed and community-based crisis continuum across systems. | | 5 .E.1. The SOC Leadership Team will develop and implement a communications plan that provides information to the public about how to gain access to a community-based crisis continuum. |

NEBRASKA SYSTEM OF CARE (SOC) STRATEGIC PLAN

| NEBRASKA SYSTEM OF CARE (SOC) STRATEGIC PLAN | | | | | |
|---|--|---|--|--|--|
| GOALS | Strategies Needed to Complete Goals | | | | |
| | (A) Implementing Policy, Administrative, and Regulatory Changes | (B) Developing Services and Supports Based on the SOC Approach | (C) Creating Financing Mechanisms | (D) Providing Training, TA, and Coaching | (E) Generating Support |
| | Strategies | Strategies | Strategies | Strategies | Strategies |
| <p style="text-align: center;">GOAL # 6</p> <p>Develop an integrated statewide prevention and early intervention system for children, youth and their families that emphasizes mental health promotion, suicide prevention, resilience, and trauma-informed practices.</p> | <p>6. A.1. The SOC Leadership Team will map current children, youth and family-guided prevention and early intervention efforts, and create shared definitions, processes, performance measures and policies across systems to support community and state partnerships in the development of an integrated statewide prevention and early intervention system.</p> | <p>6. B.1. The SOC Leadership Team will develop an integrated prevention and early intervention system based on universal, selective and indicated prevention components (Behavioral Health) and primary, secondary and tertiary prevention components (Public Health) and includes efforts to increase parent/caregiver education, resources, integration with primary care, safe out-of-school programs, in-home services, and informal and formal supports.</p> <p>6. B.2 The SOC Leadership team will develop and/or align services and supports to address identified risk and protective factors.</p> | <p>6. C.1. The SOC Leadership Team will identify funding for technical assistance and prevention/early intervention education/training for youth, family and system partners and support local prevention and early intervention efforts through partnerships across systems.</p> | <p>6. D.1. The SOC Leadership Team will provide education/training for youth, family and system partners in evidence-based and promising practices related to mental health promotion, suicide prevention, resilience, and trauma-informed practices.</p> <p>6. D.2. The SOC Leadership Team will provide child care providers with professional development opportunities related to early childhood behavioral health.</p> <p>6. D.3. The SOC Leadership Team will provide parent educators with education/training on parenting/care giver curricula that utilizes evidence-based and promising practices.</p> | <p>6. E.1. The SOC Leadership Team will develop and implement a communications plan that increases the awareness of prevention and early intervention resources, including a clearinghouse of funded evidence-based and promising practices and availability of services and community resources.</p> |

NEBRASKA SYSTEM OF CARE (SOC) STRATEGIC PLAN

| NEBRASKA SYSTEM OF CARE (SOC) STRATEGIC PLAN | | | | | |
|---|--|---|---|--|------------------------|
| GOALS | Strategies Needed to Complete Goals | | | | |
| | (A) Implementing Policy, Administrative, and Regulatory Changes | (B) Developing Services and Supports Based on the SOC Approach | (C) Creating Financing Mechanisms | (D) Providing Training, TA, and Coaching | (E) Generating Support |
| | Strategies | Strategies | Strategies | Strategies | Strategies |
| <p style="text-align: center;">GOAL # 7</p> <p>Utilize collaborative financing strategies across systems that are consistent with SOC values and principles.</p> | <p>7. A.1. The SOC Leadership Team will obtain formal commitment across systems to SOC values and principles including contribution of funds for system redesign through a signed Memorandum of Commitment document.</p> <p>7. A.2. The SOC Leadership Team will identify and pursue financial resources to support the implementation of the System of Care strategic plan.</p> <p>7. A.3. The SOC Leadership Team will map current children and youth service and support opportunities, eligibility requirements, funding sources, and relevant policies, practices, and regulations across systems.</p> | <p>7. B.1. The SOC Leadership Team will provide education/training to youth, family and system partners on accessing and using SOC funding.</p> <p>7. B.2. The SOC Leadership Team will provide support to providers to develop the capacity to deliver services which are evidence-based and/or promising practices to children, youth and their families and engage in on-going fidelity monitoring of such services.</p> | <p>7. C.1. The SOC Leadership Team will complete a financial investment blueprint of children and youth services and supports available across systems.</p> <p>7. C.2. (Same as 1.C.1.) The SOC Leadership Team will develop funding stream options such as braided funding approaches across systems, and private and foundation contributions to develop alternatives to higher levels of care for children and youth.</p> <p>7. C.3. (Same as 4.C.4.) The SOC Leadership Team will develop flexible funding options for expenses such as transportation and child care to support youth and family participation and involvement at all levels.</p> | | |

NEBRASKA SYSTEM OF CARE (SOC) STRATEGIC PLAN

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| | (A) Implementing Policy, Administrative, and Regulatory Changes | (B) Developing Services and Supports Based on the SOC Approach | (C) Creating Financing Mechanisms | (D) Providing Training, TA, and Coaching | (E) Generating Support |
| | Strategies | Strategies | Strategies | Strategies | Strategies |
| GOAL #7 Continued | | | <p>7. C.4. The SOC Leadership Team will develop an interactive data system to perform necessary analytics.</p> <p>7. C.5. The SOC Leadership Team will develop budget allocations to include resources for translation and interpretation services and Culturally and Linguistically Appropriate Services (CLAS) implementation.</p> <p>7. C.6. (Same as 4.C.3.) The SOC Leadership Team will develop and implement a pilot project to track the needs of and service provision to children, youth and their families who are high-frequency consumers of services across systems and initiate a data driven management system.</p> | | |

NEBRASKA SYSTEM OF CARE (SOC) STRATEGIC PLAN

| GOALS | Strategies Needed to Complete Goals | | | | |
|--|--|---|--|---|---|
| | (A) Implementing Policy, Administrative, and Regulatory Changes | (B) Developing Services and Supports Based on the SOC Approach | (C) Creating Financing Mechanisms | (D) Providing Training, TA, and Coaching | (E) Generating Support |
| | Strategies | Strategies | Strategies | Strategies | Strategies |
| <p style="text-align: center;">GOAL # 8</p> <p>All children, youth and families will have access to services that respect and are appropriate for their culture.</p> | <p>8. A.1. The SOC Leadership Team will review and make recommendations regarding recruitment, hiring and retention practices to ensure a workforce that is culturally and linguistically representative of the communities and populations being served.</p> <p>8. A.2. The SOC Leadership Team will ensure that data regarding outreach, access, outcomes and disparities among culturally and linguistically diverse groups are used in making policy, administrative and regulatory decisions.</p> | <p>8. B.1. The SOC Leadership Team will review current practice and make recommendations regarding the use of culturally and linguistically relevant outreach materials, services and supports.</p> <p>8. B.2. The SOC Leadership Team will develop/build on standards to ensure that all service plans developed with children, youth and families are individualized to their unique culture, beliefs and values.</p> | <p>8. C.1. The SOC Leadership Team will identify opportunities with each system (local, county, state, tribal, private, and federal partner) for increasing flexibility within funding streams in order to fund and sustain SOC, wraparound, youth and family development, initiatives.</p> <p>8. C.2. (Same as 1.C.1.) The SOC Leadership Team will develop funding stream options such as braided funding approaches across systems, and private and foundation contributions to develop alternatives to higher levels of care for children and youth.</p> | <p>8. D.1. The SOC Leadership Team will develop and implement education/training opportunities for system partners on Cultural and Linguistic Competence (CLC) and Culturally and Linguistically Appropriate Services (CLAS).</p> <p>8. D.2. The SOC Leadership Team will develop communication and training tools to understand challenges based on status as a child, youth, or family member and challenges related to membership in a marginalized cultural group (e.g. race, ethnicity, immigration status, sexual orientation, socioeconomic class, rural/urban).</p> | <p>8. E.1. The SOC Leadership Team will ensure communications to populations with diverse linguistic characteristics are appropriate, including primary languages, literacy skills and disability status.</p> <p>8. E.2. The SOC Leadership Team will develop and implement a Cultural and Linguistic Competence (CLC) and Culturally and Linguistically Appropriate Services (CLAS) component to the communications plan to emphasize understanding of the cultural issues related to services, including the linguistic ability to communicate.</p> <p>8. E.3. The SOC Leadership Team will ensure messaging campaigns consider the cultural communities' preferred language, medium, messenger and style.</p> |

NEBRASKA SYSTEM OF CARE (SOC) STRATEGIC PLAN

| GOALS | Strategies Needed to Complete Goals | | | | |
|--------------------------|--|--|-----------------------------------|--|------------------------|
| | (A) Implementing Policy, Administrative, and Regulatory Changes | (B) Developing Services and Supports Based on the SOC Approach | (C) Creating Financing Mechanisms | (D) Providing Training, TA, and Coaching | (E) Generating Support |
| | Strategies | Strategies | Strategies | Strategies | Strategies |
| GOAL #8 Continued | <p>8. A.3 The SOC Leadership Team will develop policies, rules and procedures that support Cultural and Linguistic Competence (CLC) and implement Culturally and Linguistically Appropriate Services (CLAS) standards, and address disparities.</p> | | | | |

NEBRASKA SYSTEM OF CARE (SOC) STRATEGIC PLAN

| GOALS | Strategies Needed to Complete Goals | | | | |
|---|---|--|--|---|---|
| | (A) Implementing Policy, Administrative, and Regulatory Changes | (B) Developing Services and Supports Based on the SOC Approach | (C) Creating Financing Mechanisms | (D) Providing Training, TA, and Coaching | (E) Generating Support |
| | Strategies | Strategies | Strategies | Strategies | Strategies |
| <p>GOAL # 9</p> <p>Implement a participatory Continuous Quality Improvement (CQI) process in which all SOC intended outcomes are systematically monitored and evaluated.</p> | <p>9. A.1. The SOC Leadership Team will engage regional, tribal and community entities to participate in the development and implementation of monitoring and evaluation activities.</p> <p>9. A.2. The SOC Leadership Team will incorporate measurement and evaluation of SOC outcomes across systems including provider contracts and regional/tribal/community processes, e.g., procurement, training, and implementation of services and supports.</p> <p>9. A.3 The SOC Leadership Team will identify a common Quality Improvement (QI) process that supports monitoring, evaluation and outcome measures and can be used across systems.</p> | <p>9. B.1. The SOC Leadership Team will encourage the development and implementation of monitoring strategies for services and supports.</p> <p>9. B.2. The SOC Leadership Team will explore the implementation of accountability standards for providers and state partners across systems.</p> <p>9. B.3 The SOC Leadership Team will identify and address disparities and inequalities in outcomes among youth and families.</p> | <p>9. C.1. The SOC Leadership Team will identify funding options for fiscally sustaining evaluation activities.</p> | <p>9. D.1. The SOC Leadership Team will develop and/or enhance the formation of local continuous quality improvement (CQI) teams/workgroups and support training and technical assistance as necessary.</p> <p>9. D.2. The SOC Leadership Team will educate/train partners about how data can be effectively used to guide decision-making.</p> | <p>9. E.1. The SOC Leadership Team will utilize data in the communications plan.</p> |

Social Marketing and Communications Plan

The purpose of the Social Marketing and Communications Proposal is to provide a messaging and channel strategy designed to change the behaviors of those involved in the behavioral health system in the state of Nebraska. Whether consumer, parent or provider, referring educator or concerned classmate, virtually any Nebraskan can play a role in how mental health care is accessed and perceived. This breadth of scope comes with serious challenges and remarkable opportunities.

Vision

The social marketing and communication plan moves Nebraska to become a place where children, youth and families of any cultural or ethnic background feel comfortable asking for help, and know where to access high quality behavioral health care without worrying about feeling judged.

In order to bring us closer to reality, the social marketing plan must work to change the perceptions of key audiences that are involved in mental health care – namely:

- Children and youth who need and/or are receiving services;
- Parents striving to get their children and youth the services they need;
- Educators who are working with children and youth every day;
- Behavioral health care providers who are serving consumers; and
- Policymakers and system partners who impact the delivery and availability of services.

Goals

The social marketing plan should achieve the following goals over a four-year implementation period:

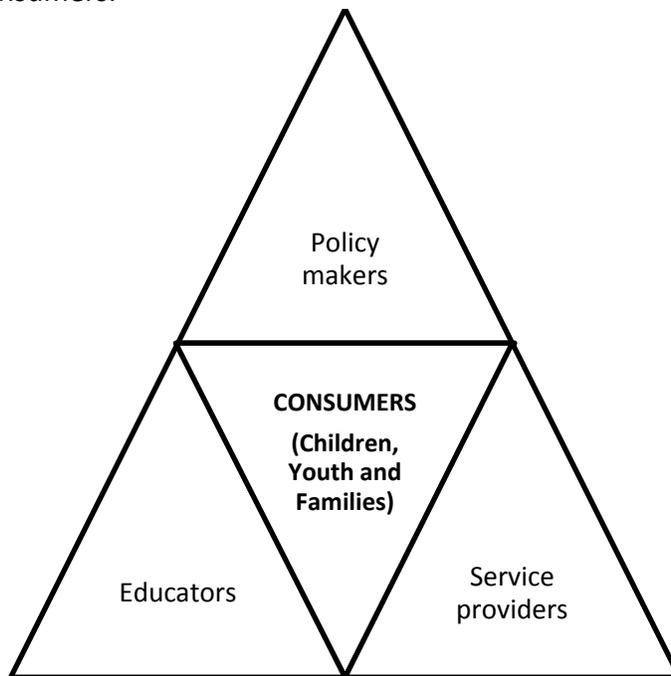
- A general understanding among prospective consumers regarding how to access mental health care;
- A lessening of a feeling of stigmatization or marginalization of children, youth and families who need mental health care services;
- A clearly communicated process and set of best practices for educators to refer students and families into the system of care;
- A more sensitive care-giving environment (with regard to diagnosis, family dynamics and trauma, and linguistic and cultural considerations) within the system of care, where consumers and their families feel supported without judgment;
- A more educated population of policymakers with a complete understanding of the costs associated with poor behavioral health care and the societal benefits associated with the system of care; and
- Prevention and recovery reflected in improved outcomes due to early identification and intervention as a result of expanding awareness.

AUDIENCES

As shown in the audience matrix, the social marketing plan reaches several audiences. The primary audience is the consumers – the children, youth and families who need and/or are receiving services through the system.

Other audiences – educators, service providers, policymakers and system partners – are secondary audiences. It is imperative these audiences receive information, as the most critical roles of these audiences are to understand and work toward the purpose of the grant and to act as a conduit of information to the consumer audiences.

Because the educators and policymakers act as communication channels to our primary consumer audiences, the resulting approach is one that puts the consumer audiences at the core, surrounded by the educators, service providers and policymakers that directly impact services and provide information to consumers.



Primary Audience 1: Families

The families are the action takers when it comes to moving a child who needs services into the system. They are often referred into the system by a physician, other health care provider or educator. Some parents, however, will seek out information on their own. For this audience, making information about the system of care easily accessible and supportive in tone is critical to bringing them into the system poised for a positive experience.

Communicating with families who speak English as a second language will be of critical importance, as this population is susceptible to the social isolation and service unavailability that can cause long-term issues for those needing behavioral health care. The same is true for Nebraska's tribal families.

Teachers and providers will play a critical role in identifying those who need access to the system of

care within these populations, and to help ensure their entry into the system is handled with sensitivity.

Primary Audience 2: Children/youth

Younger children and youth who need to access the system of care will do so via a parent or guardian. While the message of how to access the system will reach young people through parents and secondary audiences, they must also be receiving the message of support, non-judgment and comfort. Older youth may access the system through their own initiative. They too must be receiving a message of support, non-judgment and comfort.

Secondary Audiences: Educators/Service Providers

Working intensively on communicating with educators, health care and behavioral health service providers will focus the messaging on those often responsible for referring families into the system of care and serving families once they're in the system. By nature of the roles they play in the system, these audiences act as powerful word-of-mouth conduits for the messaging of the social marketing plan. Resources spent communicating with these groups will support, bolster and serve as the foundation of communications with the primary audiences. Educators must also carry through the message to all students about treating their peers with behavioral health issues compassionately.

Other Secondary Audiences: Policymakers, System Partners and Internal Teams

The social marketing plan calls for communicating directly with policymakers about the impact a system of care could make on the state's economy and the lives of their constituents. System partners can also bolster their influence as their services intersect. The goal of these communications will be to directly affect policy discussions and swing both legislative and administrative policy in favor of children, youth, and families and a more comprehensive and well-functioning system of care. The decisions made here will directly affect the primary and secondary audiences, so the plan will actively promote feedback mechanisms so that families, youth, educators and service providers can ensure that policymakers are hearing their concerns and experiences.

The Internal audience consists of the other core strategy teams working to build the system of care in Nebraska.

With this audience model in mind, the social marketing and communication plan is created around channels that are focused on reaching the primary audiences, with the intent of simultaneously capturing them through direct message interaction and through the secondary audiences.

Communication Channels

In order to reach all audiences in the most context- and channel-appropriate, cost-efficient and effective way, the social marketing plan uses a variety of strategies. At its center is a new, user-friendly website that will be targeted to serve all audiences. The website will serve as the content foundation and rallying point that all other communication channels reference, promote and reinforce.

In all four years of the social marketing plan, the user-friendly website is an evolving resource for all audiences.

YEAR 1: Year 1 will focus on content and message development based on best practice, results of two or more focus groups, and information gathered through other SOC strategy teams. In addition, stories from families who have children and/or youth with behavioral health challenges and educators/providers who have worked with such children, youth and families will be collected, vetted and edited for use in several communication channels.

Identified needs will drive the development, content and design of a new, user-friendly, interactive website and collateral materials that drive people to the website. Collateral materials will be targeted to specific audiences, to include social media, radio and television PSAs, billboards, printed materials, print advertisements, and other channels. Research will determine the materials to be available in Spanish and specific to Nebraska Tribes.

YEAR 2: The beginning of Year 2 will see the website launched and collateral information distributed. A news release, news conference and pitched stories with press kits will be part of the launch.

This will be a promotional year focused on driving families, educators and service providers across the state to the website. In addition to distributing the collateral materials developed in Year 1, outreach strategies will include meeting with parent groups, professional associations, and attending community events to discuss resources available on the website. Because the website is the focal point of information for key audiences, attention will be given to modifications according to feedback. During this year paid print, TV and radio buys will begin, including in Spanish.

YEAR 3: Development will begin on the creation of short video documentaries based on the stories that have continued to be collected. Documentaries will feature children, youth, families, educators and provider perspectives. When complete, these will be placed on the website and the agency's YouTube channel and will be promoted via a news conference, news release and promotional efforts with system partners. All other social marketing and communication efforts will continue.

During this year, follow-up focus groups will be conducted to identify saturation and understanding of intended messages to primary and secondary audiences. The effectiveness of current efforts will be evaluated to determine what strategies and messages need to be freshened or changed for Year 4 and beyond.

YEAR 4: This year, the website, select collateral materials and outreach strategies will be retooled based on feedback from the focus groups. This will position the social marketing and communications efforts to continue throughout and after Year 4 of the grant.

Appendix A: Logic Model and Strategic Plan Development Tool

The following pages represent a working document organized according to the 10 Core Strategy Teams (CSTs) described earlier. Each section summarizes, in bulleted form, the work of each CST. This content formed the foundation of the logic model and strategic plan.

Logic Model and Strategic Plan Development Tool

Population of Focus: Children and youth with serious emotional and behavioral health needs and their families across all of Nebraska’s child-serving systems.

| Youth and Family Partnership | | | |
|--|--|---|---|
| Vision Statement: Families and youth are partners on all levels within the System of Care. | | | |
| Strengths & Resources ➔ | Context, Needs, Challenges ➔ | Goals ➔ | Strategies and Sub-Strategies ➔ |
| <ul style="list-style-type: none"> • Systems (JJ; BH; CPS) recognize the importance of family/youth voice | <ul style="list-style-type: none"> • Communication/ Awareness – Youth, family and system partners need to know how to give and receive information; speak common language. • Need for training: for professionals, to increase youth and family engagement; for families, to understand systems. • Partnership and engagement – needs to be equal, equitable partnership, needs to be youth and family friendly. • There are policies and practices that prevent /inhibit youth- and family-driven work and involvement. | <ul style="list-style-type: none"> • Ensure a sustainable, well-funded statewide infrastructure for a youth network and family network representative of the population of Nebraska to empower all youth and family voice, outreach, education, advocacy and leadership opportunities. • Ensure that youth and families involved in the behavioral health system of care have opportunities to be meaningfully involved in all levels of planning, policy development, quality improvement and the evaluating/monitoring of programs within Nebraska. | <ul style="list-style-type: none"> • Create a statewide infrastructure for Youth Network and expansion of Family Network in order to build involvement and leadership opportunities. • Identify funding opportunities to support development and maintenance of Youth / Family Networks (YFN) and develop guidelines for reimbursement across agencies. • Provide training to youth and families to serve as trainers and evaluators of systems and providers. • Educational resources for youth and families to understand system(s) and utilize their voice for self-advocacy. • Increase capacity to alleviate transportation as a barrier to utilizing voice. • Increase the number of Family Peer Specialists and establish Youth Peer Specialists through a standardized certification process. • Provide TA and other support utilizing best practices to community coalitions and other interested parties to establish family/peer support organizations. • Develop training and resources for system professionals on how to listen and communicate with youth and families provided by youth and families. • Create state-level family and youth leader position(s) that serves as a liaison between state systems and the youth and family network(s). • Develop training and TA system to support family engagement/involvement that includes youth and families as participants and trainers alongside professionals. • Develop guidelines for best practices for youth involvement, leadership and youth-driven services. |

| Youth and Family Partnership | | | |
|--|------------------------------|---------|---|
| Vision Statement: Families and youth are partners on all levels within the System of Care. | | | |
| Strengths & Resources ➡ | Context, Needs, Challenges ➡ | Goals ➡ | Strategies and Sub-Strategies ➡ |
| | | | <ul style="list-style-type: none"> • Create a formal, standardized approach that utilizes youth and family networks for review of policies, practices and procedures that impact youth and families. |

| High Fidelity Wraparound/Family Centered Practice | | | |
|---|---|--|---|
| Vision Statement: "All children, youth and families consistently experience family-centered practice. Your voice and choice in all decisions." | | | |
| Strengths & Resources ➡ | Context, Needs, Challenges ➡ | Goals ➡ | Strategies and Sub-Strategies ➡ |
| <ul style="list-style-type: none"> • Service providers have training in Family Centered Practice (FCP) models – some have fidelity models • Family organizations are strong statewide/regionally • Legislative Bills LB 464, LB561 and LB216 • Data is routinely collected • Readiness to change • Youth voice is increasing/youth are at the table | <ul style="list-style-type: none"> • Interagency Collaboration /Communication – lack of equal partnership, tendency to blame instead of true collaboration • Fidelity training – lack of consistency, common definition of wraparound and FCP • Developing a FCP culture across all systems – value worker, develop expectations | <ul style="list-style-type: none"> • Promote information and resource sharing and reduce barriers for all families and system partners to include foster families and team members. • Ensuring Fidelity of HFW and FCP models. • Implementation of wraparound/FCP training for all system partners. • Increase funding available for FCP practice models across the state. • FCP culture is infused throughout all child serving systems in Nebraska. | <ul style="list-style-type: none"> • Media coverage to let families know their voice counts and should be heard. • Handbook/brochures in multiple languages. • Support groups. • Communications plan with all agencies involved in the system to roll out plan, address barriers – tag on 1184 meetings (each region could decide best way to accomplish this). • Training for all system partners (training should occur locally). • Look at creating a flexible funding pool across systems for individualized service delivery. • Collect base line – team meeting observation and family voice survey. • Overall Training through core training teams in each region for trainers, workers, youth, foster families, families, tribes, minorities, interpreters. Training teams include youth and families and are culturally diverse. • Gather/develop specific stand-alone training/tools as system partners learn areas that need improvement. • Develop follow-up plan to ensure progress continues. • Select a set of tools to use across all systems. |

| High Fidelity Wraparound/Family Centered Practice | | | |
|--|------------------------------|---------|--|
| Vision Statement: "All children, youth and families consistently experience family-centered practice. Your voice and choice in all decisions." | | | |
| Strengths & Resources ➡ | Context, Needs, Challenges ➡ | Goals ➡ | Strategies and Sub-Strategies ➡ |
| | | | <ul style="list-style-type: none"> • Design system to use data at state-region-local levels. • Explore funding available to provide training (explore cross-system collaborative training hub). • Provide stipends, food, transportation for youth and families. • Look at available national/state/county/foundation funding and funding models for cost efficiency. • Develop regional plans for expanding wraparound facilitation (such as PPP) to expand to populations not currently served. • Identify/recruit system champions. |

| Financing Strategies | | | |
|--|---|--|---|
| Vision Statement: Nebraska's child and family-serving system of care partners will commit to improve youth, family, and system outcomes utilizing coordinated financing strategies that are consistent with system of care values and principles. | | | |
| Strengths & Resources ➡ | Context, Needs, Challenges ➡ | Goals ➡ | Strategies and Sub-Strategies ➡ |
| <p>Available funding for services:</p> <ul style="list-style-type: none"> • Peer-to-peer support (family organization funded) • Housing/advocacy/peers • Juvenile Justice services for pre-adjudication and post-adjudication/predisposition youth. | <p>Limited funding:</p> <ul style="list-style-type: none"> • <i>Everyone</i> is payer of last resort • Funding decisions based on short-term outcomes (need chronic/persistent illness management approach) • Some reimbursement rates inadequate • Affordable Care Act challenges <p>Access and eligibility:</p> <ul style="list-style-type: none"> • Waiting lists • Cross system eligibility | <ul style="list-style-type: none"> • Develop Memorandum of Commitment for all systems to sign as commitment to SOC values and to hold each other accountable during the process of system transformation. | <ul style="list-style-type: none"> • Develop Memorandum of Commitment document. • Memorandum signatories include DBH, CFS, MLTC, PH, probation, education, DD, judicial, county and regional representatives, RBHAs, and private funders. • Identify all financial resources and eligibility requirements. • Develop interactive data system to perform necessary analytics. • Complete financial investment scan (financial resource matrix, Children's Commission Cross System Analysis Report). • Initiate data-driven management system through pilot project of highest service users. |

| Financing Strategies | | | |
|--|--|---|--|
| Vision Statement: Nebraska's child and family-serving system of care partners will commit to improve youth, family, and system outcomes utilizing coordinated financing strategies that are consistent with system of care values and principles. | | | |
| Strengths & Resources ➔ | Context, Needs, Challenges ➔ | Goals ➔ | Strategies and Sub-Strategies ➔ |
| <ul style="list-style-type: none"> • Cost reimbursement / regional system | <ul style="list-style-type: none"> • Must be at “rock bottom” to qualify Limited workforce: <ul style="list-style-type: none"> • Workers at capacity • Providers unwilling to serve difficult-to-serve individuals • Fragmented funding system • No infrastructure to fix this (e.g. data system to show the overlaps) • Rural/urban differences | <ul style="list-style-type: none"> • Ensure data-driven decision-making, including finance, which will result in reduced utilization of intensive, restrictive, and high-end services and promote prevention and earlier intervention. | <ul style="list-style-type: none"> • Prioritize financial needs through pilot project (statewide high-end users payment toward behavioral health services across service systems). • All system partners agree to contribute funds to redesign the system during pilot project. • Explore other financial options to develop alternatives to higher levels of care (1% financing shift [high intensity to prevention], 1915b waiver, wraparound, peer support, etc.). • Assure that appropriations also address and support youth and family participation/involvement at all levels (transportation, child care, etc.). • Ensure that all budget allocations include resources for translation and interpretation and CLAS implementation. |

| Trauma Informed Services and Supports | | | |
|---|---|--|---|
| Vision Statement: A trauma-informed Nebraska is aware that trauma is a lifespan issue that meets this challenge with sensitivity, training, support and follow-up regardless of location. Nebraska strives to be trauma-informed as well as trauma-capable in providing services to all residents. | | | |
| Strengths & Resources ➔ | Context, Needs, Challenges ➔ | Goals ➔ | Strategies and Sub-Strategies ➔ |
| <ul style="list-style-type: none"> • Free training – TF-CBT, Kids for Keeps; online parenting curriculum (available to families through Family Orgs.) Training Academy, Right Turn, workshops, WRAP; foster parents | <ul style="list-style-type: none"> • Better utilization of existing services • Knowledge among providers/consumers of service array • Uniform screening for trauma | <ul style="list-style-type: none"> • Provide training for all systems to become trauma-informed and trauma-capable. • Develop statewide definitions of trauma, trauma-informed care and trauma-informed systems. | <ul style="list-style-type: none"> • Reduce barriers to attend training, including cost and travel time. • Provide basic training and follow-up support to all. • Ensure providers are cross-trained in early intervention and trauma. • Bring more awareness to the topic of vicarious trauma and compassion fatigue to ensure that all members are supported. |

Trauma Informed Services and Supports

Vision Statement: A trauma-informed Nebraska is aware that trauma is a lifespan issue that meets this challenge with sensitivity, training, support and follow-up regardless of location. Nebraska strives to be trauma-informed as well as trauma-capable in providing services to all residents.

| Strengths & Resources ➡ | Context, Needs, Challenges ➡ | Goals ➡ | Strategies and Sub-Strategies ➡ |
|--|--|--|---|
| <ul style="list-style-type: none"> receive specialized training • Common language among partners • Panhandle Partnership • Cedars youth programs • Project Everlast | <ul style="list-style-type: none"> • Intake processes for youth can be traumatizing • Transitions for youth can be traumatizing • Family voice/choice in therapeutic needs • Transportation • TIC training across all systems • Early childhood intervention | <ul style="list-style-type: none"> • Consider the impact of trauma on early childhood and the role of providing early intervention and prevention services. • Explore use of common trauma assessments and screenings. | <ul style="list-style-type: none"> • Resource lists will include whether provider offers trauma-informed services. |

| Workforce Development | | | |
|---|---|---|--|
| Vision Statement: “A behavioral health workforce that is family- and person-centered, competent and supported at all levels”. | | | |
| Strengths & Resources ➡ | Context, Needs, Challenges ➡ | Goals ➡ | Strategies and Sub-Strategies ➡ |
| <ul style="list-style-type: none"> • Commitment by systems to develop a competent workforce. • Different educational backgrounds provide array of well-rounded workforce. • Face-to-face work allowing for detailed explanation and guidance. • Project Everlast provides youth with ability and opportunity to express youth voice. • Training and technical assistance capacity and expertise of the Behavioral Health Education Center of Nebraska and University of Nebraska at Lincoln, Omaha and Kearney as it relates to SOC. | <ul style="list-style-type: none"> • Turnover; burnout is abundant. • Lack of competency among system partners working with youth and family partners. • “Family team” meetings inconsistent and not to fidelity (focused on negatives, some family members aren’t present at meetings, non-compassionate system partners). • Prevention services are not widely available. | <ul style="list-style-type: none"> • The workforce will demonstrate proficiency in the following eight (8) domains: trauma-informed/capable; child and adolescent development; cultural and linguistic competence; child and adolescents with developmental disabilities and behavioral health; screening/assessment/evaluation/referral; family and person-centered practice; treatment planning /interventions/service delivery; quality improvement/professionalism and ethics. • Guidelines to be used for recruitment and retention efforts of a competent and culturally diverse workforce. | <ul style="list-style-type: none"> • Develop a statewide, cross-system “competency worksheet” for organizations to incorporate into training and evaluation practices. • Develop guidelines that assist leadership and organizations with recruitment and retention of the workforce. • Develop guidelines for leaders and organizations that support the workforce, themselves and other agencies. • Address staff turnover issues within the services field. Turnover of staff compromises trust. Encourage retention strategies. Wellness incentives (employer provided “fit bits” to employees, reduced gym memberships, on site wellness programs). |

Social Marketing and Communication

Vision Statement: Nebraskans value preventive behavioral health care so anyone can access help easily and the general public holds no stigma and supports policy changes that create an integrated system of care.

| Strengths & Resources ➡ | Context, Needs, Challenges ➡ | Goals ➡ | Strategies and Sub-Strategies ➡ |
|---|--|--|---|
| <ul style="list-style-type: none"> • Family Partners are facilitating communication. • Nebraska Family Helpline | <ul style="list-style-type: none"> • Generational, deep-seated stigma • Negative experiences with the system • Weakness-based model • Diagnoses as label | <ul style="list-style-type: none"> • Stigma surrounding behavioral health or system involvement will no longer be a barrier to accessing support. • No fear about discussing trauma. • You are an individual, not your case file. • Build public will for improvement. • Prevention is positive: services are available to families before the extremes happen. | <p>Story telling: “de-stigmatize”:</p> <ul style="list-style-type: none"> • Book/video/website: Stories and resources (check out UNL page on mental health) • Panels • Sharing via social media • Directory • Central access referral • Messaging around benefits of prevention • Story sharing website – youth-centered – with linkage to resources • Put the hotline online for youth – make it youth oriented • Training of professionals who interact with families, children & youth • Uniform • Strengths-based • Youth-driven and centered • Frequently updated • Ensure messaging campaigns consider the cultural communities’ preferred language, medium, messenger and style. |

Services and Supports

Vision Statement: In the state of Nebraska, needed services and supports are accessible through inquiry at any and all service delivery agencies and through a common statewide service inquiry access point. Services are available to all persons in need, regardless of income, age, or demographics. Services are consumer-driven, consumer-informed, and consumer-based in delivery and must be provided by qualified, and well-trained staff or peers.

| Strengths & Resources ➔ | Context, Needs, Challenges ➔ | Goals ➔ | Strategies and Sub-Strategies ➔ |
|---|--|--|--|
| <ul style="list-style-type: none"> • Alternative Response Collaborations. • Collaboration among agencies • Greater openness to family/youth partnership • Culture moving away from traditional services • Understanding that community based care is better for youth vs. residential care • Beginning focus on trauma-informed care • Better access to services for juvenile justice clients • Advocacy groups' growth and expansion • High Fidelity Wraparound • Home visitation programs • Programs for youth 4-8 | <ul style="list-style-type: none"> • Accessibility • Providers are walled-in – more interested in preserving turf • Lack of one plan, “no wrong door” • No incentives to improve integration • Limited financing to set up and maintain service delivery structures • Policies, procedures & funding streams are barriers to flexibility in pooling resources or creativity • Waiting lists of programs are long • Limited family voice system/program planning efforts • Little trust among service agencies/systems • Disparities in access across the state | <ul style="list-style-type: none"> • Families are able to access needed service/support. • Families have consistency in their service provision across service systems. • Full service arrays (consisting of quality services) are available to children and families across the state of Nebraska. • All public and private service provision entities understand the importance of collaboration and actively work to improve service provision across service systems. • Expand current efforts of grass roots/community organizations to empower communities to create services/supports. | <ul style="list-style-type: none"> • Use Alternative Response and NCFE's (Nebraska Children and Family Foundation) existing efforts to involve communities in the creation of their own services/supports array. • Nebraska commits to the “no wrong door” model for access. Any point at which a child or family requests/requires services/supports becomes the entry point. Providers work behind the scenes electronically to make the necessary connections to all needed services/supports from that point forward. • Helplines are staffed with skilled, knowledgeable professionals who are able to provide “warm transfers” to other entities. • Creation of Family Review Panels that would make recommendations to Nebraska’s Children Commission and seek approval specific to program content and needed services/supports prior to funding and implementation. • Online access by families and children to their own file information through the use of a confidential access code. Families/children retrieve information but also are able to directly enter their own comments, feedback, requests into case files. • Use existing tele-medicine technology to expand access to services and supports. • Co-location of therapists, psychiatric/psychological providers, medical providers in schools across the state. |

Services and Supports

Vision Statement: In the state of Nebraska, needed services and supports are accessible through inquiry at any and all service delivery agencies and through a common statewide service inquiry access point. Services are available to all persons in need, regardless of income, age, or demographics. Services are consumer-driven, consumer-informed, and consumer-based in delivery and must be provided by qualified, and well-trained staff or peers.

| Strengths & Resources ➔ | Context, Needs, Challenges ➔ | Goals ➔ | Strategies and Sub-Strategies ➔ |
|-------------------------|------------------------------|---------|--|
| | | | <ul style="list-style-type: none"> • Messaging and information are critical to “no wrong door” model. Churches, schools, community centers, neighborhood groups, libraries, newspapers, cultural centers, Twitter, Facebook, etc. need to be involved in the bringing the information to families in need. • Peer-to-peer service provision and supports are funded and integrated into all aspects of service delivery. • Creation of System Navigators that would be assigned at the outset and stay with the family throughout the time the family has service needs. • Recommend that Nebraska fill the gaps of services that exist to children diagnosed on the Autism spectrum. • People who are deaf and hard of hearing have effective/qualified service providers able to communicate but also knowledgeable of the cultural aspects of the hearing impaired community. • Build a crisis continuum including community-based and residential components. • Build a robust para-professional network of service providers. • Explore use of community-based and natural supports accepted by different cultural groups. • Explore school-based and school-linked services. School services typically include 1) screening, assessment, evaluation and referral protocols with local mental health providers; and 2) comprehensive whole school environmental interventions such as the Positive Behavioral Interventions and Supports (PBIS) model. |

Services and Supports

Vision Statement: In the state of Nebraska, needed services and supports are accessible through inquiry at any and all service delivery agencies and through a common statewide service inquiry access point. Services are available to all persons in need, regardless of income, age, or demographics. Services are consumer-driven, consumer-informed, and consumer-based in delivery and must be provided by qualified, and well-trained staff or peers.

| Strengths & Resources ➔ | Context, Needs, Challenges ➔ | Goals ➔ | Strategies and Sub-Strategies ➔ |
|-------------------------|---------------------------------|---------|--|
| | | | <ul style="list-style-type: none"> • Explore flex funding pools of money needed to be created to ensure the creativity we need. Fully funded peer to peer/ service and support delivery created and maintained. • Office of Consumer Protection and Advocacy created and staffed appropriately to address service delivery issues in a formal manner. • Post treatment family survey information reviewed for helpful information in creating services. |

Culturally and Linguistically Appropriate Services and Supports

Vision Statement: In a culturally and linguistically appropriate System of Care the following are available: 1) Culturally and linguistically competent organizations and systems that support a workforce that embodies the cultural and linguistic values of the families being served and have the knowledge and skills to be effective; and 2) A statewide tool that assesses cultural, linguistic socioeconomic information that can be written, telecommunicated or collected appropriately that assists in developing service plans for youth and their families.

| Strengths & Resources ➔ | Context, Needs, Challenges ➔ | Goals ➔ | Strategies and Sub-Strategies ➔ |
|--|--|---|---|
| <ul style="list-style-type: none"> • School-based medical, mental health one-stop shop occurring in some areas <ul style="list-style-type: none"> ○ Medicaid in public schools (billing for services) ○ Interdisciplinary teams • CASA/GAL/Justice = CLAS Navigator PALS • Assessment = Road Map to Wellness = Culture | <ul style="list-style-type: none"> • Treating others the way we want to be treated (Golden Rule) • Training impact – measurement, time • Empower youth who are in the throes – Navigator paired with peer support • Medicaid support – “Family of One” concept • Training (with accountability) <ul style="list-style-type: none"> ○ Hiring practices ○ Qualitative survey of consumer | <ul style="list-style-type: none"> • All children, youth and their families will access services that respect, and are appropriate for, their culture. • All activities involving families and youth are inclusive of the cultural diversity of the families who are eligible for services. • Workforce (providers) in child- and family-serving systems will represent the range of diversity in populations eligible to be served. • Planning and budget allocations across systems will include translation and interpretation, standardized data collection, etc. | <ul style="list-style-type: none"> • Identify all cultural groups that are eligible but may not be accessing services and understand the reasons why they are not accessing these services. • Develop CLC component to social marketing and communication plan to include understanding of the cultural issues related to service and include linguistic ability to communicate. • Develop communication and training tools to understand challenges based on status as a “family member” or “child / youth” AND challenges related to membership in a marginalized cultural group (e.g., race, ethnicity, immigration status, sexual orientation, socioeconomic class, etc.). • Review policies, procedures and training/communication materials to ensure they reflect that implementation of family-driven/youth-guided care will vary across cultural groups. (Note that “family-driven/youth guided” may not be a culturally acceptable framework for all. Culturally, the framework may be for the “professionals” to “drive” the care. In addition, the role and voice of youth may be limited in some cultures. These situations require careful management of the differences between SOC values and the cultural values of the group.) • Design messaging campaigns that match cultural communities’ preferred language, preferred medium, messenger, and style – for example, radio (aural communication) or TV (visual communication). |

Culturally and Linguistically Appropriate Services and Supports

Vision Statement: In a culturally and linguistically appropriate System of Care the following are available: 1) Culturally and linguistically competent organizations and systems that support a workforce that embodies the cultural and linguistic values of the families being served and have the knowledge and skills to be effective; and 2) A statewide tool that assesses cultural, linguistic socioeconomic information that can be written, telecommunicated or collected appropriately that assists in developing service plans for youth and their families.

| Strengths & Resources ➡ | Context, Needs, Challenges ➡ | Goals ➡ | Strategies and Sub-Strategies ➡ |
|-------------------------|------------------------------|---------|--|
| | | | <ul style="list-style-type: none"> • Develop strategies to understand existing protective factors in cultural communities (particularly first generation immigrant communities) and to support/promote them. • Identify and engage culturally affirmed messengers in prevention and early intervention activities – faith leaders, tribal leaders, media personalities, etc. |

Prevention and Early Intervention

Vision Statement: In three years, all children and families are supported by a coordinated continuum of prevention and intervention services. The public is educated and invested in community ownership of the success and well-being of children and their families. Entry at any point of the service gives you access to all appropriate services of the system; no wrong door.

| Strengths & Resources ➔ | Context, Needs, Challenges ➔ | Goals ➔ | Strategies and Sub-Strategies ➔ |
|---|--|---|--|
| <p>Home visitation programs</p> <ul style="list-style-type: none"> • Birth to 3 • Increasing statewide <p>Community/local interest</p> <p>Increased awareness</p> <p>Alternative Response</p> <p>Resources</p> <ul style="list-style-type: none"> • Training, education • Skilled providers • Great services in Metro area | <ul style="list-style-type: none"> • Lack of definition for Community Prevention • Fragmented (“siloed”) systems have limited integration and coordination • Lack of services, programs and personnel for services for all ages <ul style="list-style-type: none"> - Afterschool - 0-8 years - Transitional • Sustainable and limited funding that does not support prevention, collaboration and is competitive | <ul style="list-style-type: none"> • Develop an integrated community prevention system where agencies/systems collaborate on a shared definition, support, training and implementation of services for families. • Establish and maintain connectedness for families through community-based informal and formal supports. • Identify and increase prevention services and supports for all youth across the state. • Realign funding and support to promote sustainable community-owned prevention systems. • Empower families by prioritizing family-centered policies and practices within all systems. | <ul style="list-style-type: none"> • Include Alternative Response and develop a service array according to and aligned with identified protective factors. • Make technical assistance, facilitation, and support available for communities to build a collaborative prevention system (tool kits, definition, processes, functions). • Effectively involve community assets (volunteers, churches) in community prevention systems and in messaging about activities. • Continue to promote trauma-informed practices and training as central to delivery of prevention services. • Provide equitable access to supportive services for all families. • Encourage community ownership of outcomes and success of youth. • Create policies to support community and state partnerships to develop an effective community-based prevention system definition and plan. • Increase awareness of existing resources and connections in places where parents are likely to be. • Build on informal family supports prior to formal services ending/transition by creating a more strategic method. (Family Navigator). • Increase statewide capacity for home-based crisis response. • Increase funding for evidence-based youth development programs. • Utilize new and existing data through a multi-sector approach; identify common goals; and select measures we can influence. • Facilitate the development of an inventory of prevention services that exist and where the gaps are located. |

| Prevention and Early Intervention | | | |
|---|------------------------------|---------|--|
| <p>Vision Statement: In three years, all children and families are supported by a coordinated continuum of prevention and intervention services. The public is educated and invested in community ownership of the success and well-being of children and their families. Entry at any point of the service gives you access to all appropriate services of the system; no wrong door.</p> | | | |
| Strengths & Resources ➡ | Context, Needs, Challenges ➡ | Goals ➡ | Strategies and Sub-Strategies ➡ |
| | | | <ul style="list-style-type: none"> • Integrate behavioral health identification and resources into primary care settings. • Integrate diverse prevention services in many community-level and family-serving settings such as Early Childhood and evidence-based home visiting programs. • Increase out-of-school programs that are safe for youth. • Include parenting programs that stress good connections and relationships with infants and toddlers so that healthy attachments are developed. (Using parenting curriculums like Circle of Security in Home Visitation programs like Sixpence, Healthy Families, EDN, etc). • Provide child care providers with professional development opportunities surrounding early childhood behavioral health. |

| Policy, Administrative and Regulatory | | | |
|--|--|---|---|
| <p>Vision Statement: Nebraska policies support child and family well-being in a System of Care that achieves the Triple Aim: efficiency; overall improved health; improved child and family experience</p> | | | |
| Strengths & Resources ➡ | Context, Needs, Challenges ➡ | Goals ➡ | Strategies and Sub-Strategies ➡ |
| <ul style="list-style-type: none"> • Circle of Security pilots • Implementation of LB561 • Behavioral Health focusing on TIC • BH Regions Contracting with DBH • Prevention Coalitions • Focus on Community-level coordination | <p>Funding</p> <ul style="list-style-type: none"> • Provisionally licensed individuals not eligible for reimbursement with Medicaid/Magellan • Seed/pilot projects not sustainable • Eligibility or access to services not the same between systems • Lack of flexible funding • Lack of transparency in how funds are being spent, why certain people get service and others not | <ul style="list-style-type: none"> • Develop policies that promote flexible funding to maximize all available funding sources and meet accessibility and scheduling needs of youth and families. | <ul style="list-style-type: none"> • Develop policy for best practices for youth involvement, leadership, and youth-driven services. • Develop performance indicators and oversight for family engagement, culturally responsive services and supports, and youth engagement. |

Policy, Administrative and Regulatory

Vision Statement: Nebraska policies support child and family well-being in a System of Care that achieves the Triple Aim: efficiency; overall improved health; improved child and family experience

| Strengths & Resources ➔ | Context, Needs, Challenges ➔ | Goals ➔ | Strategies and Sub-Strategies ➔ |
|--|---|---|---|
| <ul style="list-style-type: none"> • Efforts to include family organizations • LB216 - Bridges to Independence - Senator McGill's Bill • NE Family Help Line • Project Everlast • Caseworkers within the system are very helpful • LB566 - Telehealth in schools • LB1078 – Provider-patient relation; remote health monitoring; insurance health reimbursement | <ul style="list-style-type: none"> • Maximize Medicaid, federal funding, state, county • Lack of funding for former wards <p>Conflicting Policies</p> <ul style="list-style-type: none"> • Multiple services cannot be provided on the same day • Incentivize high quality services • Transparency re: rules and regulations are done • Communication between systems (HIPAA/FRPA) • Cross training across systems • Do the different systems' mandates conflict with each <p>Lack of true family involvement</p> <ul style="list-style-type: none"> • "Expert" mentality; not listening to youth and family input • Meetings are held at times not conducive to families • No clear guidelines on what family involvement should look like • Families may lack skills/support to participate at the "systems level" • Family and youth not paid to participate in meetings • Language and culture barriers • Professional lingo/acronyms • Families fear of being judged | <ul style="list-style-type: none"> • Develop policies that maximize funds through multiple strategies (such as: leveraging, grant development, and blending) to enhance or create programs that will grow and maximize services for youth and families. • Develop policies, procedures and practices that ensure transparency and accountability of all funding streams. • Policy development by cross-system teams that include youth and family that promote parallel eligibility and accessibility standards. Policies will utilize a common language and address risk benefit. | <ul style="list-style-type: none"> • Identify ways to enforce accountability – rules, regulations, contracts, policy, results-based accountability, joint multi-system agreements on policy on system of care. • Develop policy around how trauma-informed care is implemented across systems. • Integrate SOC principles with state and local policy decisions. • Develop policies to support “no wrong door” for accessing service. • Develop policies, rules, procedures that support CLC, implement CLAS standards, and address disparities. Include requirements for Disparities Impact analysis and requires corrective actions. • Develop policies that place prevention/early intervention as part of a continuum within the System of Care |

Outcomes

Functional Outcomes and Indicators

- Children and youth will experience improved wellness and mental health.
- Children and youth will live at home.
 - Decrease utilization of long-term, out-of-home placements.
 - Increase use of residential alternatives such as High Fidelity Wraparound, short-term crisis, respite, and related supports.
 - Children and youth will experience improved stability in living situation.
- Children, youth and families exhibit well-being.
 - Improved coping skills.
 - Improved social connectedness.
 - Increased ability to overcome behavioral health needs.
- Children and youth will function successfully in the community.
 - Attend school and graduate.
 - Succeed in employment.
 - Engage in pro-social activities.
 - Experience more positive relationships with family, friends and others.
 - Effective support networks.
 - Experience decreased substance use.
- Costs for out-of-home care will decrease.

Process Outcomes

- Nebraska child and family serving agencies/systems partner and collaborate.
 - Engage in the implementation of coordinated and integrated system of care.
 - Efficiently and effectively deploy services and supports as determined by wraparound teams.
 - Implement culturally and linguistically appropriate and trauma-informed practice in all phases of interacting with children, youth and families.
 - Create an integrated system with “no wrong door” access.
 - Engage in equal partnership with families and youth in developing improved system of care.
 - Agree to, and implement, a common set of functional outcomes and work toward them together.
 - Have access to flexible funding to ensure individualized service delivery.
 - Be evaluated on implementation of family-centered practice within the agency/system.
- Nebraska children, youth and families
 - Have access to services in 75%-90% of home communities.
 - Understand the systems and services they are involved in and know how to access information and get questions answered.
- Policies and funding for behavioral health in Nebraska will place a greater emphasis on prevention and early identification/intervention.

Appendix B: Definitions and Acronyms

The Definitions document, presented below, is a working document created to help those involved with the Nebraska SOC understand the terms and acronyms used throughout the planning documents.

Nebraska Children and Youth System of Care: Working Definitions

Adverse Childhood Experiences (ACEs): ACEs include verbal, physical, or sexual abuse as well as family dysfunction (an incarcerated, mentally ill, or substance-abusing family member, domestic violence, and absence of a parent due to divorce or separation).

Alternative Response (AR): An approach that allows a response to low-risk reports of child abuse and neglect in a way that is different than a traditional investigation. Family assessments are conducted to determine the family's strengths and needs as well as to assess for child safety and risk. Families will be connected to the supports and services they need in order to enhance the parent's ability to keep their children safe and healthy. Low-risk reports of child abuse and neglect will be assigned to a Children and Family Services Specialist (CFSS) who will begin the assessment process. Research shows that families who receive an assessment rather than an investigation are more likely to be receptive to and engage in services when they are approached in a non-adversarial, non-accusatory manner. Law enforcement agencies will receive all reports assigned for an Alternative Response as they do with traditional responses.

Braided Funding: Braided funding involves multiple funding streams utilized to pay for all of the services needed by a given population, with careful accounting of how every dollar from each stream is spent. The term braiding is used because multiple funding streams are initially separate, brought together to pay for more than any one stream can support, and then carefully pulled back apart to report to funders on how the money was spent.

Child/Youth: For purposes of this document children and youth are collectively defined as the stage from birth to age 24.

Community: In this plan "*community*" is in reference to "*location*" and indicates a large group living in close proximity. Examples range from the local neighborhood, town, city, region, or state. Occasionally it may be in reference to a group of people with a common identity other than location. Examples include a shared identity such as professional, cultural, religious, ethnicity, etc.

Culturally and Linguistically Appropriate Services (CLAS) Standards: The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (the National CLAS Standards) are intended to advance health equity, improve quality, and help eliminate health care

disparities by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services.⁵

Cultural and Linguistic Competence (CLC): Cultural competence is the integration and transformation of knowledge, behaviors, attitudes and policies that enable policy makers, professionals, caregivers, communities, consumers and families to work effectively in cross-cultural situations. Cultural competence is a developmental process that evolves over an extended period of time. Individuals, organizations and systems are at various levels of awareness, knowledge and skills along the cultural competence continuum.⁶

Early Childhood Intervention: Integrating behavioral health services within primary care and early childhood service settings for children from birth to age seven.

Family-driven Care: Family-driven means families have a primary decision-making role in the care of their own children as well as the policies and procedures governing care for all children in their community, state, tribe, territory and nation. This includes: choosing supports, services, and providers; setting goals; designing and implementing programs; monitoring outcomes; and determining the effectiveness of all efforts to promote the mental health of children and youth.⁷

Family Organizations: A family-run organization is a private, nonprofit entity that meets the following criteria: Its explicit purpose is to serve families who have a child, youth, or adolescent with a serious emotional disorder (children, youth, and adolescents who have an emotional, behavioral, or mental disorder, age 0-18; or age 21), if served by an Individual Education Plan (IEP). It is governed by a board of directors comprised of a majority (at least 51%) of individuals who are family members. It gives preference to family members in hiring practices. It is incorporated as a private, nonprofit entity (i.e. 501C3).

Flexible Service Funds: Flexible service funds are a crucial resource in supporting a child/youth and their family. The funds are used to help support individualized wraparound plans that are identified by the family, allowing purchase of services that typically cannot be accessed in any other way. All possible funding options are explored before making available flexible service dollars, including traditional funding streams, entitlements, agency funds and parent/community contributions. Common examples of how flexible service funds are used include: community programs that support a child/youth's interests and strengths (art, sports, music); camp or after-school programs for working families; time-limited job stipend for a youth; respite opportunities for family members to spend

⁵ Accessed from the US Health and Human Services-The Office of Minority Health website on 6/3/14.

<http://gucchdtacenter.georgetown.edu/publications/SOC%20ExpansionStrategies%20Issue%20Brief%20%20FINAL.pdf>

⁶ Accessed from the SAMHSA website on 6/4/14: <http://www.samhsa.gov/children/core-values.asp>

⁷ Accessed from the SAMHSA website on 6/4/14: <http://www.samhsa.gov/children/core-values.asp>

quality time together; bus tickets to support a family's participation in support groups or other activities; and emergency funds to provide help with basic needs, such as food, furniture or clothing.

High Fidelity Wraparound (HFW): High Fidelity Wraparound (HFW) is a youth-guided and family-driven planning process that follows a series of steps to help youth and their families realize their hopes and dreams. It is a process that allows more youth to grow up in their homes and communities. It is a planning process that brings people together (natural supports and providers) from various parts of the youth and family's life. The HFW workforce (HFW Facilitator, and if desired, a HFW Family Support Partner and HFW Youth Support Partner), helps the youth and family achieve the goals that they have identified and prioritized, with assistance from their natural supports and system providers. This is the HFW team. High Fidelity Wraparound is driven by the same HFW Principles, and follows the same HFW Phases and basic HFW activities.⁸

Locus of Accountability: Locus of accountability refers to the continual assessment of practice, organizational, and financial outcomes to determine the effectiveness of system of care in meeting the needs of children and families. Two essential components of an effective accountability strategy in a system of care are:

- The development of an interagency management information system that tracks important indicators of service and system performance, and
- A strong evaluation strategy.

Mental Health Promotion: Mental health promotion is any action taken to maximize mental health and well-being among populations and individuals to enhance the capacity of individuals, families, groups, or communities to strengthen or support positive emotional, cognitive, and related experiences across the lifespan.

No Wrong Door Access: Families and youth will be directed to the appropriate service from whichever provider (healthcare, behavioral health, social service) they initially access.

Prevention: The active process of creating conditions or attributes that promote the wellbeing of people. Prevention activities avert the onset and reduce the progression of disease (public health) or alcohol, tobacco, and other drug abuse and/or symptoms of mental illness (behavioral health), and other problems related to these concerns.

For behavioral health:

- A universal prevention intervention targets all people within the general population or a certain subgroup not selected based on individual risk.
- A selective prevention intervention targets individuals or a subgroup whose risk of developing a condition is higher than average.

⁸ Accessed from the Youth and Family Training website on 6/4/14: <http://antrios.wpic.pitt.edu/pages/definition>

- An indicated prevention intervention targets individuals who are high risk and present minimal, but detectable, symptoms of a mental, emotional, or behavioral disorder, but they do not yet have a diagnosis.

For public health:

- Primary prevention refers to methods used before a person gets a disease. Primary prevention aims to prevent the disease from occurring.
- Secondary prevention is used after the disease has occurred but before the person notices that anything is wrong.
- Tertiary prevention targets the person who already has symptoms of the disease.

Regional Behavioral Health Authorities (Regions): *Regional Behavioral Health Authorities (Regions) are responsible for the development and coordination of publicly funded behavioral health services within their respective geographic region and manage a network of providers for an array of behavioral health services.* The Regions contract with the Department of Health and Human Services, Division of Behavioral Health for federal and state mental health and substance abuse funds. Counties provide local matching funds for the operation of the Regions and for the provision of behavioral health services within their region. The following are the official titles of the six Regions.

- Region 1 Behavioral Health Authority
- Region II Human Services
- Region 3 Behavioral Health Services
- Region 4 Behavioral Health System
- Region V Systems
- Region 6 Behavioral Healthcare

Single Service Plan: The practice by which a service plan is developed through a multi-partner process of all participating agencies providing behavioral services to the child or youth.

SOC Leadership Team: A leadership team with equal representation of youth, family, and system partners charged with pursuing dissemination and implementation of the Nebraska SOC strategic plan.

System of Care (SOC): System of care includes the following characteristics:

1. Family-driven and youth-guided, with the strengths and needs of the child and family determining the types and mix of services and supports provided.
2. Community-based, with the locus of services as well as system management resting within a supportive, adaptive infrastructure of structures, processes, and relationships at the community level.
3. Culturally and linguistically competent, with agencies, programs, and services that reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve to facilitate

access to and utilization of appropriate services and supports and to eliminate disparities in care.⁹

Systems: State agencies included in the SOC are:

- Department of Health and Human Services Divisions: Children and Family Services, Medicaid and Long-Term Care, Behavioral Health, Developmental Disabilities, Public Health;
- Judicial Branch: Juvenile Services Division;
- Department of Education.

Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being. The long-lasting adverse effects on an individual are the result of the individual's experience of the event or circumstance. Trauma is not the event itself, but rather a response to a highly stressful experience in which a person's ability to cope is compromised. It can include:

- The personal experience of interpersonal violence including sexual abuse, physical abuse, severe neglect, loss, and/or the witnessing of violence, terrorism, urban violence, war/combat, motor vehicles accidents and disasters;
- Events that are shocking, terrifying and/or overwhelming to the individual;
- Feelings of horror, fear, helplessness;
- Occurs when an external threat overwhelms a person's internal and external positive coping resources.

Trauma-informed: A trauma-informed approach to the delivery of behavioral health services includes an understanding of trauma and an awareness of the impact it can have across settings, services, and populations. It involves viewing trauma through an ecological and cultural lens and recognizing that context plays a significant role in how individuals perceive and process traumatic events, whether acute or chronic. It involves four key elements of a trauma-informed approach: (1) realizing the prevalence of trauma; (2) recognizing how trauma affects all individuals involved with the program, organization, or system, including its own workforce; (3) responding by putting this knowledge into practice; and (4) resisting re-traumatization.

- *Trauma-informed care (TIC):* TIC is a strengths-based service delivery approach that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment. It is an approach to engage people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges that trauma has played a part in their lives. Being trauma-

⁹ Accessed from the SAMHSA website on 6/4/14: <http://www.samhsa.gov/children/core-values.asp>

informed and trauma-capable includes avoiding re-traumatization and understanding and recognizing the triggers of trauma survivors.

- *Trauma-specific treatment services:* These services are evidence-based and promising practices that facilitate recovery from trauma. The term “trauma-specific services” refers to prevention, intervention, or treatment services that address traumatic stress as well as any co-occurring disorders (including substance use and mental disorders) that developed during or after trauma.¹⁰

Tribes:

- Omaha Tribe of Nebraska
- Ponca Tribe of Nebraska
- Santee Sioux Nation
- Winnebago Tribe of Nebraska

Wraparound Principles: Wraparound is an intensive, holistic method of engaging with children and youth with complex needs so that they can live in their homes and communities and realize their hopes and dreams. Wraparound has been most commonly conceived of as an *intensive, individualized care planning and management process*. Wraparound is not a treatment *per se*. The wraparound *process* aims to achieve positive outcomes by providing a structured, creative and individualized team planning process that, compared to traditional treatment planning, results in plans that are more effective and more relevant to the child/youth and family. The ten Wraparound Principles include: Family Voice & Choice; Team Based; Natural Supports; Collaboration; Community Based; Culturally Competent; Individualized; Strengths Based; Persistence; and Outcome Based.¹¹

Youth-Guided: Youth guided means that youth are engaged as equal partners in creating systems change in policies and procedures at the individual, community, state and national levels. Applicants are required to develop plans for infusing a youth-guided approach throughout the system of care, including plans for training and supporting youth in positions of leadership and system transformation.¹²

Youth Organization: Any structured group of children or youth who gather on a regular basis to develop skills, grow peer-to-peer informal support, and complete other service, awareness or voice activities unique to their group. Groups are typically located within communities and/or youth-

¹⁰ Accessed from the SAMHSA website on 6/4/14:

http://beta.samhsa.gov/samhsaNewsletter/trauma_tip/key_terms.html#.U4-f7Y0U9D8

¹¹ 10 Principles of the Wraparound Process. National Wraparound Initiatives. Accessed from the National Wraparound Initiatives website on 6/4/14. <http://www.nwi.pdx.edu/pdf/TenPrincWAPProcess.pdf>

¹² Accessed from the SAMHSA website on 6/4/14: <http://www.samhsa.gov/children/core-values.asp>

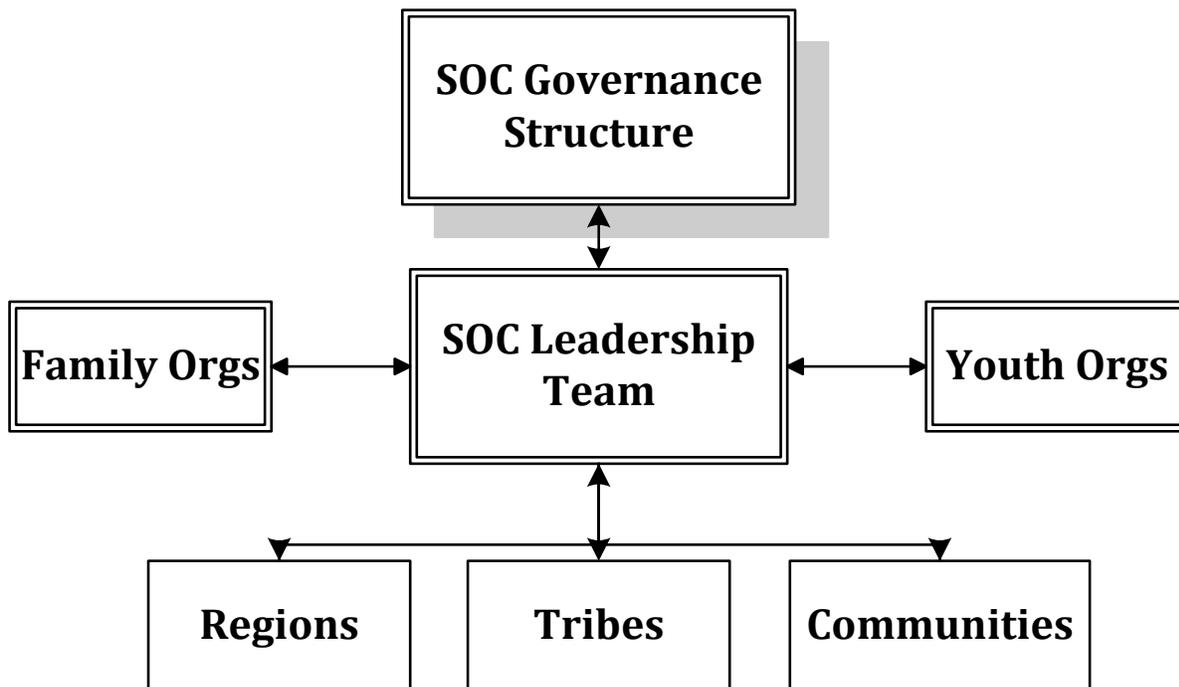
serving entities and supported by agency staff. For the purpose of this plan, they operate as a loose network by which youth voice is gathered.

Strategic Plan Acronyms

AR: Alternative Response Model
BHEC: Behavioral Health Education Center of Nebraska
CFS: Children and Family Services
CLAS: Culturally and Linguistically Appropriate Services
CLC: Cultural and Linguistic Competence
CQI: Continuous Quality Improvement
CST: Core Strategy Team
DD: Developmental Disabilities
DHHS: Nebraska Department of Health and Human Services
DBH: Division of Behavioral Health
ED: Department of Education
HFW: High Fidelity Wraparound
HIE: Health Information Exchange
JJ: Juvenile Justice
LB: Legislative Bill
MHPAEA: Mental Health Parity and Addiction Equity Act
MLTC: Medicaid and Long-Term Care
NCFF: Nebraska Children and Families Foundation
NFF: Nebraska Federation of Families
PMT: Project Management Team
PPP: Professional Partner Program
RBA: Results-Based Accountability
SA: Service Areas - Children and Family Services
SED: Serious and Emotional Disturbance
SOC: System of Care
TIC: Trauma-Informed Care
UNL PPC: University of Nebraska Public Policy Center
UNMC: University of Nebraska Medical Center
YSC: Youth System of Care

Appendix C: Governance Diagram

The following diagram illustrates the proposed governance structure that will oversee implementation of the strategic plan. The SOC Leadership team will have equal representation of youth, family, and system partners. As suggested by family and youth partners, family organizations and youth organizations will also meet separately from the SOC Leadership Team. Regions, tribes and communities will have local SOC implementation teams with representation on the SOC Leadership Team.



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