Nebraska - 2012 Combined Behavioral Health Assessment and Plan

Submitted September 1, 2011

Meeting the requirements from the
U.S. Department of Health and Human Services

Substance Abuse and Mental Health Services Administration

SAMHSA Uniform Block Grant Application FY 2012–2013
(OMB No. 0930–0168)
Community Mental Health Services Block Grant (MHSBG)
Substance Abuse Prevention and Treatment Block Grant (SAPTBG)

Prepared by the

Nebraska Division of Behavioral Health

As the State Mental Health Authority (SMHA) and State Substance Abuse Authority (SSA)

Direct Questions to:
Jim Harvey
Division of Behavioral Health
Nebraska Department of Health and Human Services
301 Centennial Mall South, Third Floor
PO Box 95026, Lincoln, NE 68509
Phone: 402-471-7824
E-mail: Jim.Harvey@nebraska.gov

I: State Information

State Information

Plan Year

Start Year:
2011

End Year:
2013

State DUNS Number

Number
808819957

Extension

I. State Agency to be the Grantee for the Block Grant

Agency Name
Nebraska Department of Health and Human Services

Organizational Unit
Division of Behavioral Health

Mailing Address
301 Centennial Mall South, Third Floor, PO Box 95026

City
Lincoln

Zip Code
68509-5026

II. Contact Person for the Grantee of the Block Grant

First Name
Scot

Last Name
Adams

Agency Name
Nebraska Department of Health and Human Services - Division of Behavioral Health

Mailing Address
301 Centennial Mall South, Third Floor, PO Box 95026

City
Lincoln

Zip Code
68509-5026

Telephone
402-471-8553

Fax
402-471-9449

Email Address
scot.adams@nebraska.gov

III. State Expenditure Period (Most recent State expenditure period that is closed out)

From
7/1/2010

To
6/30/2011

IV. Date Submitted

NOTE: this field will be automatically populated when the application is submitted.

Submission Date

Revision Date

V. Contact Person Responsible for Application Submission

First Name
James

Last Name
Harvey

Telephone
402-471-7824

Fax
402-471-7859

Email Address
Jim.Harvey@nebraska.gov

Footnotes:

Official Identified by Governor as Responsible for Administration of the Grant
Scot L. Adams, Ph.D., Director
NE Division of Behavioral Health

person to Contact with Questions Regarding the Application
James S. Harvey, LCSW

I: State Information

Assurances - Non-Construction Programs

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

Name	Scot L. Adams, Ph.D.
Title	Director
Organization	NE Division of Behavioral Health

Signature: _____ Date: _____

Footnotes:

I: State Information

Certifications

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
b. have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
c. are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
d. have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with subgrantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug -free work-place in accordance with 45 CFR Part 76 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), ?, (d), ?, and (f).

For purposes of paragraph ? regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget

Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. Certifications Regarding Lobbying

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

Name	Scot L. Adams, Ph.D.
Title	Director
Organization	NE Division of Behavioral Health

Signature: _____ Date: _____

Footnotes:

I: State Information

Chief Executive Officer's Funding Agreements/Certifications (Form 3) [SAPT]

FY 2012 Substance Abuse Prevention and Treatment Block Grant Funding Agreements/Certifications as required by Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act

Title XIX, Part B, Subpart II and Subpart III of the PHS Act, as amended, requires the chief executive officer (or an authorized designee) of the applicant organization to certify that the State will comply with the following specific citations as summarized and set forth below, and with any regulations or guidelines issued in conjunction with this Subpart except as exempt by statute.

SAMHSA will accept a signature on this form as certification of agreement to comply with the cited provisions of the PHS Act. If signed by a designee, a copy of the designation must be attached.

I. FORMULA GRANTS TO STATES, SECTION 1921

II. Certain Allocations (Prevention Programs utilizing IOM populations ; Pregnant women and women with dependent children) Section 1922

III. INTRAVENOUS DRUG ABUSE, SECTION 1923

IV. REQUIREMENTS REGARDING TUBERCULOSIS AND HUMAN IMMUNODEFICIENCY VIRUS, SECTION 1924

V. Group Homes for Recovering Substance Abusers, Section 1925

VI. State Law Regarding Sale of Tobacco Products to Individuals Under Age of 18, Section 1926

VII. TREATMENT SERVICES FOR PREGNANT WOMEN, SECTION 1927

VIII. ADDITIONAL AGREEMENTS(IMPROVED REFERRAL PROCESS, CONTINUING EDUCATION, COORDINATION OF ACTIVITIES AND SERVICES), SECTION 1928

IX. IX SUBMISSION TO SECRETARY OF STATEWIDE ASSESSMENT OF NEEDS, SECTION 1929

X. MAINTENANCE OF EFFORT REGARDING STATE EXPENDITURES, SECTION 1930

XI. Restrictions on Expenditure of Grant, Section 1931

XII. APPLICATION FOR GRANT; APPROVAL OF STATE PLAN, SECTION 1932

XIII. Opportunity for Public Comment on State Plans, Section 1941

XIV. Requirement of Reports and Audits by States, Section 1942

XV. ADDITIONAL REQUIREMENTS, SECTION 1943

XVI. Prohibitions Regarding Receipt of Funds, Section 1946

XVII. Nondiscrimination, Section 1947

XVIII. Continuation of Certain Programs, Section 1953

XIX. Services Provided By Nongovernmental Organizations, Section 1955

XX. Services for Individuals with Co-Occurring Disorders, Section 1956

I hereby certify that Nebraska will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, as summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

Name	Scot L. Adams, Ph.D.
Title	Director
Organization	NE Division of Behavioral Health

Signature: _____ Date: _____

Footnotes:

I: State Information

Chief Executive Officer's Funding Agreements/Certifications (Form 3) [CMHS]

Community Mental Health Services Block Grant Funding Agreements
FISCAL YEAR 2012

I hereby certify that Nebraska agrees to comply with the following sections of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

I. Section 1911:

Subject to Section 1916, the State will expend the grant only for the purpose of:
i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved:
ii. Evaluating programs and services carried out under the plan; and
iii. Planning, administration, and educational activities related to providing services under the plan.

II. Section 1912:

(c)(1)&(2) [As a funding agreement for a grant under Section 1911 of this title] The Secretary establishes and disseminates definitions for the terms “adults with a serious mental illness” and “children with a severe emotional disturbance” and the States will utilize such methods [standardized methods, established by the Secretary] in making estimates [of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children].

III. Section 1913:

(a)(1)(C) In the case for a grant for fiscal year 2011, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

[A system of integrated social services, educational services, juvenile services and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which includes services provided under the Individuals with Disabilities Education Act)].

(b)(1) The State will provide services under the plan only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs).

(b)(2) The State agrees that services under the plan will be provided through community mental health centers only if the centers meet the criteria specified in subsection (c).

(C)(1) With respect to mental health services, the centers provide services as follows:

(A) Services principally to individuals residing in a defined geographic area (referred to as a “service area”)
(B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.
(C) 24-hour-a-day emergency care services.
(D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.
(E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

(2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

(3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.

IV. 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.

V. Section 1915:

(a)(1) State will make available to the State mental health planning council for its review under section 1914 the State plan submitted under section 1912(a) with respect to the grant and the report of the State under section 1942(a) concerning the preceding fiscal year.
(2) The State will submit to the Secretary any recommendations received by the State from the Council for modifications to the State plan submitted under section 1912(a) (without regard to whether the State has made the recommended modifications) and comments on the State plan implementation report on the preceding fiscal year under section 1942(a).

(b)(1) The State will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

VI. Section 1916:

(a) The State agrees that it will not expend the grant:

(1) to provide inpatient services;
(2) to make cash payments to intended recipients of health services;
(3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;
(4) to satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds; or
(5) to provide financial assistance to any entity other than a public or nonprofit entity.

(b) The State agrees to expend not more than 5 percent of the grant for administrative expenses with respect to the grant.

VII. Section 1941:

The State will make the plan required in section 1912 as well as the State plan implementation report for the preceding fiscal year required under Section 1942(a) public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

VIII. Section 1942:

(a) The State agrees that it will submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for securing a record and description of:

(1) the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program; and
(2) the recipients of amounts provided in the grant.

(b) The State will, with respect to the grant, comply with Chapter 75 of Title 31, United Stated Code. [Audit Provision]
(c) The State will:
(1) make copies of the reports and audits described in this section available for public inspection within the State; and
(2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

IX. Section 1943:

(1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and
(B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);
(2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and
(3) provide to the Secretary any data required by the Secretary pursuant to section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section

(b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.

Notice: Should the President's FY 2008 Budget be enacted, the following statement applies only to States that received the Mental Health Transformation State Infrastructure Grants:

This Agreement certifies that States that received the Mental Health Transformation State Infrastructure Grants shall not use FY 2008 Mental Health Block Grant transformation funding to supplant activities funded by the Mental Health Transformation Infrastructure Grants.

Name	Scot L. Adams, Ph.D.
Title	Director
Organization	NE Division of Behavioral Health

Signature: _____ Date: _____

Footnotes:

I: State Information

Disclosure of Lobbying Activities (SF-LLL)

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

Standard Form LLL (click here)

Footnotes:

II: Planning Steps

Step 1: Assess the strengths and needs of the service system to address the specific populations

Page 22 of the Application Guidance

Narrative Question:

Provide an overview of the State's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the State, intermediate and local levels differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA and other State agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic and sexual gender minorities as well as youth who are often underserved.

Footnotes:

Step 1: Assess the strengths and needs of the service system to address the specific populations

Provide an overview of the State's behavioral health prevention, early identification, treatment and recovery support systems. Describe how the public behavioral health system is currently organized at the State, intermediate and local levels differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA and other State agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic and sexual gender minorities.

The evolution of Nebraska's public Behavioral Health System is intertwined with rapid changes on both a national and state level. There are initiatives across the nation that will ultimately influence the role of the public behavioral health care system. The Division of Behavioral Health takes seriously its responsibilities to lead and partner with stakeholders to improve and enhance the quality of care available for adults, children and families throughout Nebraska. The recent completion of a strategic plan coupled with national healthcare initiatives provides an exciting environment for behavioral health services.

DIVISION OF BEHAVIORAL HEALTH

On March 15, 2007, Governor Heineman signed LB296 creating the Nebraska Department of Health and Human Services (DHHS). This law combined three state agencies to create one department and established six divisions within that department: (1) the Division of Behavioral Health, (2) the Division of Children and Family Services, (3) the Division of Developmental Disabilities, (4) the Division of Medicaid and Long-Term Care, (5) the Division of Public Health, and (6) the Division of Veterans' Homes.

The Division of Behavioral Health administers, oversees, and coordinates the state's public behavioral health system to address the prevention and treatment of mental health, substance use, and problem gambling disorders. The primary goal is to develop a behavioral health system that is co-occurring capable, trauma-informed, recovery-oriented and person-centered.

By statute, the Division of Behavioral Health is designated as the Chief Behavioral Health Authority for the State of Nebraska. As such the Division of Behavioral Health is a combined State Mental Health Authority (SMHA) and State Substance Abuse Authority (SSA) and is responsible for managing both the Community Mental Health Services Block Grant (MHSBG) and the Substance Abuse Prevention and Treatment Block Grant (SAPTBG).

The Division of Behavioral Health is comprised of three sections: Regional Centers, Community Based Services and Office of Consumer Affairs.

Regional Centers

The Lincoln Regional Center, a 250 bed, Joint Commission accredited state psychiatric hospital, serves people who because of mental illness, require a highly structured treatment setting. The services provided include General Psychiatric, Forensic Psychiatric and Sex Offender. The General Psychiatric unit (72 beds) is reserved for individuals who have been court ordered or committed by a county mental health board to inpatient psychiatric treatment. These individuals demonstrate severe psychosocial dysfunction and pose an actual or potential danger

Step 1: Assess the strengths & needs of service system to address the specific populations / pg 2

to self or others, and therefore cannot be safely served in a community based hospital.

The Norfolk Regional Center is a 120-bed Sex Offender Treatment Center providing Phase I services in the Nebraska Sex Offender Treatment Program. The Nebraska Sex Offender Treatment Program is a three phase treatment program meant to reduce dangerousness and risk of re-offense for patients involved in treatment. Phase I treatment orients patients to the treatment process; begins working with patients to accept full responsibility for their sex offending and sexually deviant behaviors; teaches patients to give and receive feedback and utilize coping skills; and builds motivation for the intensive treatment in Phases II and III which are provided at Lincoln Regional Center.

The Hastings Juvenile Chemical Dependency Program (HJCDP) provides residential substance abuse treatment for young men paroled from the Youth Rehabilitation Treatment Center in Kearney, Nebraska. The program is licensed for 40 beds and has an average length of stay of approximately 4-6 months. The Hastings Regional Center is a Joint Commission accredited facility.

For more information on the Regional Centers, see the DHHS / Division of Behavioral Health web site at http://www.dhhs.ne.gov/beh/rc/rc.htm.

Community Based Services

The Division of Behavioral Health contracts with the six Regional Behavioral Health Authorities for community based mental health and substance abuse services. Originally established in 1974 as mental health regions, the Nebraska Behavioral Health Services Act passed in 2004 incorporated substance abuse services and revised the regional administrative entities into six Regional Behavioral Health Authorities, to mirror designation of the Division as the state's chief behavioral health authority. Each Regional Behavioral Health Authority is governed by a Regional Governing Board consisting of one county board member (locally elected official) from each county in the region. The administrator of the Regional Behavioral Health Authority is appointed by the Regional Governing Board.

Step 1: Assess the strengths & needs of service system to address the specific populations / pg 3

Nebraska Census by Region (Year 2010)

Region	Regional Office	Counties	Population	% of Population
1 (Panhandle)	Scottsbluff	11	87,789	4.8%
2 (West Central)	North Platte	17	101,415	5.6%
3 (South Central)	Kearney	22	226,320	12.4%
4 (Northeast & North Central)	Norfolk	22	207,781	11.4%
5 (Southeast)	Lincoln	16	444,920	24.4%
6 (Eastern)	Omaha	5	758,116	41.5%
Totals		**93**	**1,826,341**	**100%**

Each Regional Behavioral Health Authority is responsible for the development and coordination of publicly funded behavioral health services in the region pursuant to rules and regulations of the DHHS. The Division of Behavioral Health contracts with the Regional Behavioral Health Authority to purchase services using the funds received under both the Community Mental Health Services Block Grant and the Substance Abuse Prevention and Treatment Block Grant.

Each Regional Behavioral Health Authority has an advisory committee consisting of consumers, providers, and other interested parties. In addition, the behavioral health region must secure county and local funding as match against state general funds for the operation of the behavioral health authority and for the provision of behavioral health services in the region.

For more information on the Regional Behavioral Health Authorities, see DHHS / Division of Behavioral Health web site at http://www.dhhs.ne.gov/beh/nebhrgb.htm.

In addition to funding mental health and substance abuse treatment and prevention services through the Regional Behavioral Health Authorities, the Community Based Services section of the Division of Behavioral Health contracts with providers for the treatment of individuals with problem gambling disorders; with family organizations to advocate for families with youth experiencing mental/emotional disorders, support the family voice and offer supportive services such as education, support groups, advocacy and mentoring; and, with the four Federally recognized Native American Tribes in the state for the provision of culturally specific mental health and substance abuse treatment services.

Office of Consumer Affairs

The Office of Consumer Affairs works to build, promote and sustain services which incorporate consumers as integral components of the recovery process throughout the system. Activities include facilitating community forums for consumers to receive feedback on the quality of services being provided and identify gaps in these services, networking with consumer led and advocacy organizations, conducting training and certifying Peer Support and Wellness Specialists, sponsoring an annual conference and other trainings for consumers and providers, disseminating

Step 1: Assess the strengths & needs of service system to address the specific populations / pg 4

information to consumers to promote health and wellness, training mental health boards responsible for the civil commitment of individuals who are mentally ill and dangerous, tracking the number of mental health board committed individuals in the state, implementing classes at the Regional Centers to teach holistic, non-medical coping techniques (e.g., yoga and meditative breathing) and serving as an integral part of the Division of Behavioral administration to ensure the consumer voice is incorporated into decisions at all levels.

For more information about the Office of Consumer Affairs, see DHHS / Division of Behavioral Health web site at http://www.dhhs.ne.gov/beh/mh/mhadvo.htm.

In February 2011, the Division of Behavioral Health finalized the ***Nebraska Division of Behavioral Health Strategic Plan 2011 – 2015***. The construction of this plan was based on a review of many past planning initiative documents, including the work done by the legislatively formed Behavioral Health Oversight Commissions (LB 1083 [2004]; LB 928[2008]) and a public/private consensus group in Omaha. The information acquired throughout the development of the strategic plan was extensively utilized to identify the needs, gaps, and priorities for this block grant application.

The tasks of incorporating consumer viewpoints, reviewing prior planning documents and suggesting key areas of focus were given to a joint strategic planning workgroup made up of representatives from the three Committees guiding the Division of Behavioral Health (Mental Health, Substance Abuse, and Problem Gambling), Regional Behavioral Health Authorities, and the Division of Behavioral Health administration. The work of this group was augmented by consultation with national experts in behavioral health and opportunities for public review and comment. The process was facilitated by the University of Nebraska Public Policy Center.

Hundreds of Nebraskans participated in the development of recommendations in the planning documents and initiatives that were reviewed by the joint strategic planning workgroup. Many of the recommendations evolved from stakeholders with personal experiences in the public behavioral health system.

The plan identified the following vision, mission, and goals for the Division of Behavioral Health.

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).

Step 1: Assess the strengths & needs of service system to address the specific populations / pg 5

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 for realizing the vision, meeting the mission and achieving the Division of Behavioral Health's goals center on Accessibility, Quality, Effectiveness, Cost Efficiency and Accountability. These strategies serve as a way to structure the actions and activities funded or directed by the Division of Behavioral Health.

Each strategy is presented with three parts:
»» The first relates to the role of the Division of Behavioral Health as a *leader* in the public behavioral health system.
»» The second suggests key *partnerships* the Division should focus on as part of the strategy.
»» The third suggests *joint initiatives*.

For more information or to view the complete document, see DHHS / Division of Behavioral Health web site at http://www.dhhs.ne.gov/Behavioral_Health/BHSP-Final-02-17-11.pdf

DHHS Division Partners
Two other Divisions of DHHS that also contribute to the System of Care and provide mental health and substance abuse services for adults and/or children are the Divisions of Medicaid and Long Term Care and the Division of Children and Family Services. The Division of Medicaid and Long-Term Care provides funding for an array of services to address mental health and substance abuse issues of children and adults, including the Medicaid Rehabilitative Option services and 1915(b) Substance Abuse Waiver services. In addition, the Division of Medicaid has worked extensively with the Division of Behavioral Health to standardize service delivery expectations (service definitions) to ensure that Medicaid and non-Medicaid individuals are receiving similar services.

The Division of Children and Family Services is the primary agency responsible for the state's child welfare, juvenile services, and economic assistance problems. Services include child and adult abuse, foster care, adoption, parole and community-based juvenile services, domestic violence, Supplemental Nutrition Assistance Program, Employment First, Aid to Dependent Children, Medicaid eligibility, refugee resettlement, energy assistance, child care subsidy, child support enforcement, resource development, and two Youth Rehabilitation and Treatment Centers in Kearney and Geneva.

The Division of Children and Family Services consists of one Policy Section and five service areas. The Policy Section includes the Child Welfare Unit (CWU), the Office of Juvenile Services (OJS), the Economic Assistance and Child Support Enforcement Unit (EA/CSEU) and the Comprehensive Quality Improvement/Operations area (CQI/O). This Section coordinates the administrative supports to facilitate efficient operation of its programs, policies, and service offering. The CWU and OJS specifically develop policy and provide technical assistance in the areas of child abuse and neglect and juvenile services to service area staff, other division staff, and community partners. The Service Areas provide direct case management services to the children and families involved with child welfare and juvenile services. OJS also operates two secure-care facilities for the detention and

Step 1: Assess the strengths & needs of service system to address the specific populations / pg 6

rehabilitation of serious youth offenders: the Youth Rehabilitation and Treatment Center in Kearney (YRTC-K) for boys, and the Youth Rehabilitation and Treatment Center in Geneva (YRTC-G) for girls. The CWU and OJS serve almost 11,000 children placed in state custody each year. At any point in time, Nebraska averages approximately 6,800 youth in state custody. The CWU serves about 5,200 youth and OJS serves about 1,600 youth. This does not include families being assessed for safety, non-court involved cases, or youth in the process of obtaining an OJS evaluation.

In addition to its focus on service delivery, the Division of Children and Family Services is currently working on a major initiative in Nebraska called Families Matter. Families Matter is a multi-year initiative to reform Nebraska's child welfare and juvenile services. The program operates under the belief that children grow best in their own homes; that children should be reunified or moved to permanency through adoption or guardianship in a timely manner; and, that families should get services earlier and be offered services after they leave DHHS. The goals of Families Matter include: fewer children made state wards; more children served in family settings; and more timely permanency objectives.

Over the past eighteen months, the Division of Behavioral Health, the Division of Medicaid and Long Term Care, and the Division of Children and Family Services have worked collaboratively on an In Depth Technical Review project to improve outcomes for families involved with the Division of Children and Family Services. The goal of the project is to improve access to assessment and treatment related to substance abuse for parents of children in the welfare system and thereby potentially decrease the time families are involved in the system.

The separate Divisions within the DHHS share a common vision for behavioral health services for children: To provide children, adolescents and their families with the right service, in the right amount, at the right location, for the right length of time, at an affordable, sustainable cost.

DIVISION OF BEHAVIORAL HEALTH CHILDREN SERVICES

In 2007, the Nebraska Legislature established the Children's Behavioral Health Task Force and gave it the responsibility for developing a children's behavioral health plan. The task force's membership was broad based and included representation from the Mental Health Advisory Committee, as well as the children and families served by the State's public behavioral health system. The Nebraska's Substance Abuse and Mental Health Services Administration's (SAMHSA) State Infrastructure Grant laid the groundwork for the transformed system of care envisioned in the plan titled *Creating Change and Providing Hope for Nebraska's Children, Adolescents and Their Families.* Since that time, the Division of Behavioral Health has continued to work with mental health system stakeholders including the Nebraska Federation of Families for Children's Mental Health, the Regional Behavioral Health Authorities, as well as other child- and family-serving systems (including child welfare, juvenile justice, and education). Today, Regional Behavioral Health Authorities develop early intervention and treatment services for children based on local needs. Combined, this work has resulted in a more responsive system of integrated social and treatment services for children with Serious Emotional Disturbance (SED) and their families.

Step 1: Assess the strengths & needs of service system to address the specific populations / pg 7

The Nebraska Family Helpline with Family Navigator, and Right Turn Post-Adoption/Post-Guardianship Services, became operational on January 1, 2010, and is the State's single point of contact 24-hours a day, 7 days a week for families of children experiencing a mental health crisis. Family Navigators are trained family members with personal experience as family members of children and adolescents with SED and are responsible for assisting callers in accessing needed crisis services, as well as ongoing behavioral health system services and supports. In addition, preventing adoption and guardianship disruptions and promoting permanency are primary goals of this service.

In addition to these recent developments, the Division of Behavioral Health continues to fund wraparound services for children and youth with Serious Emotion Disturbances, including the Professional Partner Program. The Professional Partner Program is based on the wraparound approach for services and includes the following key components:

- A clear point of access to services 24-hours a day, 7 days a week
- Dedicated, trained staff to assist families in navigating the behavioral health system
- A single, coordinated assessment addressing multiple agency requirements
- Flexible funding designed to address unique concerns of an individual family's situation.

Currently, there is a Professional Partner Program in each of the six behavioral health regions and is the primary children's service provided by the Regional Behavioral Health Authorities. The program embraces a family-centered philosophy and acknowledges families as equal partners. It promotes utilization of the least restrictive, least intrusive, developmentally appropriate interventions in accordance with the youth/young adult and family needs within the most normalized environment. It utilizes specific methods for moving toward an interagency system of care by developing referral sources and collaborative working relationships between families and public and private child serving agencies (i.e., education, social services, probation, courts, law enforcement, medical, mental health and substance abuse services, etc). The mix, intensity, duration and location of services and supports are individually tailored to meet the unique needs of each youth/young adult and his or her family.

In 2009, a variation of the Professional Partner Program was developed to provide assistance for youth who are at risk for becoming state wards. The Rapid Response Professional Partner Program is a time limited (90 day) intensive case management program applying the wraparound approach to address the behavioral health needs of youth and their families who have demonstrated specific high risk behaviors and are at risk of entering the juvenile justice system.

Throughout the 90 day program, parents and youth are involved in all stages of the process and work to create an individualized plan, focused on preventing the youth from becoming a state ward. Youth involved in the program may be transitioned to more traditional Professional Partner Program or other community based services depending on the needs identified during the 90 day program.

Nebraska's transition-age youth have been designated the priority population during the 2011 fiscal year in response to Division of Behavioral Health's recognition of the unique

Step 1: Assess the strengths & needs of service system to address the specific populations / pg 8

needs of youth and younger adults as they move to services designed for older adults. In response to this, each Regional Behavioral Health Authority has established a team dedicated to assisting transition age youth in their area. The team is comprised of members with a variety of strengths, experiences, knowledge and resources. They are intended to provide recommendations for treatment, linkages to beneficial services, and serve as a resource to transition age youth and young adults, their families and the professionals working with them.

The Division of Behavioral Health also uses an Age Waiver for 17- and 18-year-olds to pay for developmentally appropriate vocational, wraparound, and treatment services in programs designed for adults,. Before the older youth may be approved for a service, the provider must demonstrate that an adult service is appropriate for the transition age youth and can provided in a developmentally appropriate manner.

Early identification services for children and youth who may be at risk for substance use disorders or other behavioral health issues is funded through a program called the School Community Intervention Program (SCIP).
SCIP provides a systematic approach for schools and communities to respond to behavioral health issues by establishing school based teams to:

- Identify problem behaviors that affect scholastic performance
- Provide appropriate intervention with the student and family or caregivers
- Make referrals to community drug, alcohol or mental/behavioral health agencies for evaluation and treatment
- Assist in creating a student support system that promotes a healthy lifestyle

SCIP staff understand that when a young person's behavior changes, the people most likely to recognize something unusual are those who interact regularly with them. Therefore, the program is designed to include their parents, guardians, teachers and other school employees. SCIP's role is to make certain that, when school personnel see behaviors out of the ordinary among their students, they understand what is happening and how to respond.

DIVISION OF BEHAVIORAL HEALTH ADULT SERVICES

The Division of Behavioral Health is responsible for ensuring that the community mental health, substance abuse, and gambler assistance services needed by Nebraskans are available and accessible. Funding for mental health and substance abuse treatment and recovery services is primarily funneled through the Regional Behavioral Health Authorities, who subcontract with 144 agencies to provide an array of services to meet the complex and varied needs of individuals in the state. The following is an overview of the types of services available.

- The **General Mental Health Services** array includes specialized mental health treatment services with a primary acute care mission. The main focus of these services is appropriate diagnosis and the amelioration of symptoms through effective treatment. For the most part, mental health services delivered through these service options are short-term and time limited. Examples include Acute and Sub Acute Inpatient treatment, Dual Disorder Residential Treatment, Outpatient, Day Treatment, Outpatient Counseling, Crisis Stabilization, Emergency Community

Step 1: Assess the strengths & needs of service system to address the specific populations / pg 9

Response, Mental Health Respite, Day Support, Assessments, Intensive Case Management, and Medication Management.

- The **Psychiatric Rehabilitation and Support** array is composed of specialized mental health services that have a primary psychiatric rehabilitation and support mission. In this array, the main focus shifts from illness to disability with the goal of providing the support necessary for the individual to live in the least restrictive setting. These services focus on rehabilitative interventions that allow the consumer to overcome or maximally compensate for the deficits produced by mental illness. The Psychiatric Rehabilitation and Support Array, in contrast to the General Mental Health Services array, is composed of long-term services that assume the need for consistent (at least once per week) involvement with one or more of the Rehabilitation and Support services over a long period of time (months or years). Examples of services in this array include Community Support, Psychiatric Residential Rehabilitation, Assertive Community Treatment and Day Rehabilitation.
- **Substance Use Disorder** array of services are accessed through an assessment using the Standardized Model for Substance Abuse Assessment developed in Nebraska. This Assessment mandates the use of the Addiction Severity Index and also the use of the American Society of Addiction Medicine Levels of Care and Patient Placement Criteria. Based on the Assessment, individuals are recommended for the level of treatment which most closely meets their needs. Examples of services include Outpatient Therapy, Community Support, Intensive Outpatient, Partial Hospitalization, Halfway House, Intermediate Residential, Therapeutic Community, Short Term Residential, Dual Disorder Residential, Dual Enhanced Outpatient, Social Detoxification and Opioid Maintenance Therapy.
- In addition to treatment, all individuals can access an array of services intended to promote **Recovery** and **Resilience**. This continuum of services was developed to meet the needs of individuals and their families in a variety of community settings. Examples of these services include Supported Housing, Supported Employment, Peer Recovery Support, Peer Enhanced Services, Supported Living, and Peer Run Hospital Diversion.

The Division of Behavioral Health also directly contracts with trained professionals to screen, assess, and develop prevention and treatment plans for people who have problem gambling issues. Through education and outpatient counseling, the Division of Behavioral Health Gamblers Assistance Program strives to provide support, information, and coping skills to promote recovery, reduce financial pressures, and develop healthy relationships.

It is the responsibility of the Division of Behavioral Health and Regional Behavioral Health Authorities to monitor, review, and perform programmatic, administrative, and fiscal accountability and oversight functions on a regular basis with all subcontractors. Both internal and external measures for oversight of services purchased are utilized to achieve this goal.

External measures include:

1. Fiscal audit as conducted by a certified public accountant, and
2. Accreditation by a nationally recognized accrediting body (as applicable)

Internal measures include:

Step 1: Assess the strengths & needs of service system to address the specific populations / pg 10

1. Services Purchased Verifications (unit/fiscal)
2. Program Fidelity Reviews (programmatic)
3. Systematic quality improvement initiatives

The Division of Behavioral Health also ensures an Independent Peer Review process is conducted each year to assess the quality, appropriateness, and efficacy of services. The Independent Peer Review process requires that at least five percent (5%) of the entities providing services in the State are reviewed by individuals with expertise in behavioral health treatment. The Division of Behavioral Health assures that the entities are representative of the total population of such entities and that the Independent Peer Reviewers are not practitioners/providers or administrative representatives of the programs being reviewed. The Division of Behavioral Health is currently forming a workgroup to evaluate the Peer Review process that is be utilized to identify ways it may be streamlined and improved.

Co-Occurring Services:
In any given year, 5.6 million adults in the nation have co-occurring mental illness and substance use disorders (NSDUH 2006). In 2000, the Center of Substance Abuse Treatment (CSAT) issued a report entitled *Changing the Conversation,* which presented the principle of "No Wrong Door," a belief that to truly care for and treat a person, all professionals should be capable of identifying and addressing the mental health and addiction disorders of the individual seeking service, without requiring them to seek alternative services on their own.

The Division of Behavioral Health is committed to this principle and has used it to guide policy, system and infrastructure development, and quality improvement initiatives. Examples include requiring provider assessments to include mental health, substance abuse, problem gambling and physical health issues; utilizing data systems to identify persons with multiple diagnoses on each axis to assist with data reporting and quality improvement activities for persons served with co-occurring disorders; partnering with the Division of Public Health to review death records of individuals from the state hospitals to identify opportunities to improve health and impact the age of death for many individuals with mental illness; and, incorporate physical health questions in the Division of Behavioral Health's Annual Consumer Survey and utilizing these results with stakeholders to develop plans for improvement.

Only three substance abuse treatment facilities in Nebraska have taken substantial steps closer to the principle of "No Wrong Door" by becoming dual enhanced. Most substance abuse services funded through the Division of Behavioral Health are dual-capable. Recognizing this opportunity, the Statewide Quality Improvement Team (SQIT) in FY2010 developed a quality initiative regarding a co-occurring service delivery system. The desired outcome was to promote recovery of individuals and families by creating a statewide road map to a statewide, integrated co-occurring service delivery system. Stakeholders included a variety of system partners, including Division of Behavioral Health, Nebraska Department of Corrections, University of Nebraska, Magellan Behavioral Health, Division of Medicaid and Long Term Care, providers, Regional Behavioral Health Authorities, Native American Tribal Representatives, and consumers.

Step 1: Assess the strengths & needs of service system to address the specific populations / pg 11

The SQIT Co-Occurring Disorders (COD) Workgroup met for approximately 15 months. They drew upon the work completed by other states who were involved in SAMHSA's initiative as well as the Overview Papers to create a roadmap for integrated COD services for Nebraska. In addition, SAMSHA's Co-Occurring Center for Excellence (COCE) Content Framework was utilized as the basis for the COD Workgroup's roadmap. The Content Framework includes: Definitions, Principles, and Epidemiology; Screening, Assessment, Treatment Planning, and Treatment Services; Workforce Issues; Systems Issues; Prevention and Early Intervention; and Evaluation and Monitoring. Subcommittees were formed to develop action plans corresponding to the Content Framework.

The final workgroup report is in the process of completion and is scheduled to be released in September, 2011. This roadmap will be instrumental in achieving the Division of Behavioral Health's strategic planning goal that 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.

For more information, see http://www.dhhs.ne.gov/Behavioral_Health/BHSP-Final-02-17-11.pdf or http://www.dhhs.ne.gov/beh/gam/GAP2011-2015StrategicPlan-Final.pdf.

In addition to the work completed to date to integrate problem gambling, mental health and substance abuse services, other initiatives have focused on the integration of physical health and behavioral health. The Division of Behavioral Health recently began discussions about partnering with the Division of Medicaid and Long Term Care on health homes, Federally Qualified Health Centers (FQHCs) and other integration entities. The Regional Behavioral Health Authorities have worked with local providers and the FQHC to establish creative pilots to accomplish physical and behavioral health integration by either placing behavioral health staff in medical facilities or medical staff in behavioral health facilities.

Trauma Informed Services:
In Fiscal Year 2011, 37.8% of admissions to Nebraska's community-based behavioral health providers contracting with a Regional Behavioral Health Authority reported a positive trauma history experienced in adulthood, childhood or both. The percentage of individuals receiving mental health or substance abuse services who have experienced trauma is likely higher as the information is currently gathered at admission before a therapeutic rapport has been established with the consumer.

Source: "Trauma History Usage Report (07/01/10-06/30/11)," Behavioral Health Services data as collected by Magellan Behavioral Health

It is not surprising given the substantial number of behavioral health consumers who have experienced trauma that the Division of Behavioral Health is committed to promoting a trauma informed culture of care. Building on key principles of safety, trustworthiness, choice, collaboration and empowerment, trauma informed services continue to develop and grow in Nebraska.

It is the role of Division of Behavioral Health is to identify strengths, guide next steps for making the system trauma informed and encourage the development of trauma specific services. We have created a conceptual framework, implemented statewide data reporting,

Step 1: Assess the strengths & needs of service system to address the specific populations / pg 12

and kept improvement alive and well via Continuous Quality Improvement and technical assistance.

In July 2006, the Nebraska Coalition for Women's Treatment was the recipient of a three-year grant from the Division of Behavioral Health. The grant offered funding for a consumer/survivor leader to facilitate a project named Trauma Informed Nebraska (TIN).

It is the mission of TIN to oversee the development and implementation of a statewide, consumer-driven, recovery-oriented trauma informed system. Key elements include:

- The involvement of consumers/survivors in all aspects of trauma improvements and practices;
- Administrative commitment and capacity to become a trauma-informed system;
- Brief, focused, non-threatening screening for trauma conducted as early as possible;
- Consistent, ongoing trauma assessment as an integral part of the clinical picture and used as a part of the treatment and discharge planning;
- Policies and procedures that incorporate trauma awareness and use the "expectation, not the exception" guidelines in daily treatment practices; and
- Hiring and development of "trauma champions" in behavioral health services.

Since the time of the initial grant, TIN stakeholders developed a mission statement, defined trauma, provided education, developed policy, regulation and contract language, completed trauma informed peer assessments and developed a protocol for agencies to complete peer or self assessments on trauma informed care. The utilization management system has developed data fields to collect trauma history and reports have been incorporated into the Division of Behavioral Health Tuesday Data Call. Quarterly trauma data reports are shared with stakeholders to identify trends, patterns, educational opportunities and improvement possibilities. Pilots were completed in 3 of the 6 regions on peer support models such as 16 Steps for Empowerment and Discovery and Seeking Safety.

As of 2010, the Division of Behavioral Health no longer contracts with a consumer/survivor leader for TIN. Presently, the Chief Medical Officer and Division of Behavioral Health staff lead the initiative at the state level. Stakeholders host the TIN meetings and provide presentations on trauma related topics and DBH develops the agenda and facilitates the meetings. A variety of stakeholders attend the group. The Division of Behavioral Health is fortunate to have many consumer/survivors in the group to share their personal stories and their expertise. Recently the Nebraska Coalition for Women's Treatment combined with TIN. Nebraska and the Division of Behavioral Health are fortunate to have providers and one Regional Behavioral Health Authority involved in the National Trauma Informed Care Learning Collaborative. The change from a contracted leader to the Division of Behavioral Health administration supporting TIN and agency hosts has promoted individual responsibility and accountability for system change.

Nebraska's trauma informed system is evolving and there are many steps remaining before it is complete. For example, the Division of Behavioral Health plans to complete a Trauma Informed Care Review (Harris and Fallot TIC tool) at the system level this year and to continue to develop the concept of trauma care as a universal precaution. In addition, the Division of Behavioral Health needs to engage other DHHS partners to fully integrate trauma care across systems.

Step 1: Assess the strengths & needs of service system to address the specific populations / pg 13

The system has taken many great steps toward becoming trauma informed and trauma specific. The TIN initiative is growing in all of the regional behavioral health systems. Regions are encouraging completion of the TIC tool, sponsoring mini-grants for the development of trauma informed and trauma specific care. Providers are viewing the focus on trauma as integrative and recovery-oriented rather than additive. At a recent statewide quality improvement meeting, providers and regions thanked DBH for keeping trauma informed care as a priority. Together with our partners, consciously and continuously we evolve to promote recovery.

Homeless:
Persons who are homeless and have mental illness in Nebraska have specialized needs that may not be met by more traditional service delivery methods. The Division of Behavioral Health uses Projects for Assistance in Transition from Homelessness (PATH) to support Regional Behavioral Health Authorities with the highest rates of homelessness. These agencies provide the outreach component necessary to engage homeless individuals with mental illness and direct them toward needed services. In addition to PATH funds, the Nebraska Homeless Assistance Program within DHHS supports a network of shelter, supportive housing, and service providers who strategically plan for and provide a balance of emergency, transitional, and permanent housing and service resources to address the needs of people who are homeless so they can make the critical transition from homelessness to jobs, independent living, and permanent housing..

The Division of Behavioral Health also administers specific funding under the Nebraska Housing Related Assistance program to provide Supported Housing for adults with a serious mental illness who are extremely low income. The program is designed to be person-centered, recovery-oriented, and focused on a positive outcome of promoting independent housing and living for individuals in the program. Stable affordable housing is often the biggest barrier for individuals attempting to transition from residential services to independent living. As such, the Division of Behavioral Health continues to seek creative options and funding to provide this necessity for individuals in recovery.

Specialized Services for Pregnant Women and Women with Dependent Children:
The Division of Behavioral Health places a high priority on Women's Services through the Regional Behavioral Health Authorities. Each Regional Behavioral Health Authority closely monitors and adopts the priorities set within the Substance Abuse Prevention & Treatment Block Grant and the Division of Behavioral Health for admission to behavioral health services, including emergency, inpatient, residential, and non-residential services to ensure pregnant women, women who use/abuse injectable drugs, and women with dependent children are placed in services as soon as possible.

In FY2011, nine (9) programs in the state were designated as being Women's Set Aside Qualifying Services programs to meet the unique needs of pregnant women, women who use/abuse injectable drugs, and women with dependent children in need of treatment. In addition, to providing treatment services, these providers must ensure the following are available:

Step 1: Assess the strengths & needs of service system to address the specific populations / pg 14

- Gender-specific substance abuse treatment and other therapeutic interventions for women that may address issues of relationships, sexual and physical abuse, and parenting
- Pre-natal care
- Primary medical care for women who are receiving substance abuse services
- Primary pediatric care including immunizations for children of women receiving substance abuse services
- Therapeutic interventions for children in custody of women in treatment which may, among other things, address their developmental needs, and their issues of sexual and physical abuse and neglect
- Transportation services to ensure that women and children have access to services
- Child care while receiving services
- Sufficient case management to ensure access to services

Workforce Development:
There remains a shortage of qualified Nebraska Behavioral Health Staff for providing treatment, rehabilitation and support services as well as handling administrative functions in the state. This workforce includes psychiatrists, psychologists, mental health practitioners, nurses, substance abuse counselors, and others. In 2010, only three of Nebraska's 93 counties (Douglas, Sarpy and Lancaster) where identified as having an adequate number of qualified behavioral health staff available for the population being served. Eight additional counties are designated has having a partial shortage of staff. The remaining 82 Nebraska counties were designated has having a shortage in the number of qualified individuals to serve the treatment needs of people experiencing behavioral health issues.

Source: Nebraska Department of Health and Human Services Office of Rural Health, http://www.dhhs.ne.gov/orh

To begin to address this shortfall, the Nebraska Legislature created the Nebraska Behavioral Health Education Center. The mission of the Nebraska Behavioral Health Education Center is to create an innovative, recovery-focused education and training center for the purpose of developing a competent, interdisciplinary behavioral health workforce to serve the people of Nebraska. The Center serves to:

- Increase the number of psychiatrists trained in the state
- Develop new coursework to support current providers
- Develop behavioral health training hubs in each region of the state
- Utilize Nebraska's existing telehealth network to provide service to rural areas

The Division of Behavioral Health's Chief Clinical Officer and the Administrator of the Division of Behavioral Health Office of Consumer Affairs are on the advisory board for the Nebraska Behavioral Health Education Center. This provides an opportunity to share data, trends, and emerging issues from the public behavioral health system.

This initiative complements the commitment by Division of Behavioral Health to support training for professionals addressing substance use disorders. Each year, funds are allocated to ensure that education services are available throughout the state. These trainings offer

classes on both basic core competency skills and more advanced continuing education courses on topics such as Gender and Cultural Competence, Evidence-Based Treatment, and Trauma-Informed services.

In addition, Nebraska is working to systematically add Peer Support Specialists to enhance the behavioral health workforce. The Office of Consumer Affairs within the Division of Behavioral Health established a Certified Peer Support and Wellness Specialists (CPSWS) training in 2011. Currently, seventeen (17) individuals have completed the training and have qualified as CPSWS.

Diverse populations:
The Division of Behavioral Health is dedicated to providing excellent behavioral health services that are accessible to all members of the community, including racial/ethnic minorities, Native Americans, refugees, and newly-arrived immigrant groups. The Division of Behavioral Health functions in accordance with the DHHS Office of Minority Health, striving for appropriate cultural and linguistic specificity for all recipients of behavioral health services. All Regional Behavioral Health Authorities and their contractors are required to provide services that are culturally and linguistically appropriate. The Division of Behavioral Health also contracts directly with the four federally recognized tribes of Nebraska (Ponca, Winnebago, Omaha and Santee) for behavioral health services and provides staff assistance to the tribes as needed, and works to promote cultural awareness and diversity in the workforce through leadership, training, and direct funding of continuing education classes for providers.

Information regarding the demographic profile of those served by the public behavioral health system is obtained through a variety of sources, including the Nebraska Department of Economic Development, the Division of Public Health, Nebraska Public Policy Center, the Nebraska State Census Profile and others. Eight hundred and thirteen (813) professionals across the state report serving clients who speak languages other than English. Unfortunately, only eighty-five (85) of professionals in the state report speaking languages other than English fluently. For clients who are not fluent in English, various methods of interpretation are used to communicate including self interpretation, outside interpreter sitting in the session and phone interpreter services. All interpreter services are provided at no cost to the consumer.

Source: UNMC Health Professions Tracking Service – 2010.

PREVENTION SYSTEM:

The Division of Behavioral Health is charged with the development of prevention and treatment services for the State of Nebraska. The Division of Behavioral Health's Prevention System Coordinator serves as the National Prevention Network representative and the Synar Coordinator. The focus of the Prevention Coordinator is to build a comprehensive substance abuse prevention system that reduces incidence and prevalence of problems associated with alcohol, tobacco, and other drugs. Naturally, this work involves the promotion of well-being and supporting healthy lifestyles.

Using a multi pronged approach, the Division of Behavioral Health supports the statewide Nebraska Prevention System through interagency coordination, as well as funding

Step 1: Assess the strengths & needs of service system to address the specific populations / pg 16

prevention activities, directly and through a Regional Prevention Coordination System. The Division of Behavioral Health contracts for technical assistance, training, and database development to support various regions, coalitions and community entities. Direct interagency coordination activities include: Synar committee, partnering with Tobacco Free Nebraska, improving workforce development opportunities for preventionists, participating with the Nebraska Substance Abuse Epidemiological Workgroup (NSAEW), and collaborating with the DHHS Division of Public Health Strategic Prevention Framework State Incentive Grant (SPF-SIG).

The majority of prevention activities purchased by the Division of Behavioral Health are carried out by the Regional Behavioral Health Authorities –the Regional Prevention Coordination system. Funded primarily by the Substance Abuse Prevention and Treatment Block Grant, Regional Prevention Coordination staff utilize coexisting prevention efforts such as SPF-SIG and Drug Free Communities in addition to community partnerships to establish common directives and geographic and target population strategic planning to better utilize training and technical assistance initiatives. Regional Prevention Coordination Systems are designed to operate at the community level embracing local culture while leading the development of sustainable prevention activities for substance abuse, addictive disorders, and related societal problems through the life span. The Regional Prevention Coordination's delivery of such technical assistance contributes greatly to the development of community based prevention coalitions and has proven to be an invaluable asset not only to Division of Behavioral Health Prevention System Coordinator but to the statewide prevention system as well.

Maintaining consistent and frequent communication among the Regional Prevention Coordination staff and with the Division of Behavioral Health is a key factor in the success of our statewide prevention system. In a coordinated approach, the Divisions of Public Health and Behavioral Health are working toward training all communities receiving substance abuse prevention funding to apply the SPF process, whether funded by SAPTBG or the SPF-SIG. In cooperation and partnership with Regional Prevention Coordinators, the two Divisions continue to fund training events throughout the state to introduce, enhance and improve the use of evidence-based, promising and local prevention strategies most appropriate to their local community goals. These local goals have included the reduction of underage drinking, reduction of driving under the influence and reduction of binge drinking. With SPF funding nearing an end, however, a new round of strategic planning is being developed. Ultimately, by requiring all communities to use the SPF model, and by providing effective statewide training and technical assistance in the use of the model, greater progress is being achieved in reducing substance abuse and related health consequences across the state.

Tobacco Cessation and Synar

Nebraska's Synar and tobacco cessation efforts include but are not limited to the control of tobacco products and the enforcement of laws pertaining to tobacco control. The Division of Behavioral Health serves as the lead agency for the Synar workgroup that meets to coordinate and discuss planned activities of each agency represented, to share resources, such as brochures, interpretation of laws and to review potential next steps toward participation in the Federal Drug Administration's tobacco compliance activities. The Division of Behavioral Health is also responsible for ensuring the completion of random, unannounced inspections of any business which manufactures, sells or distributes tobacco

Step 1: Assess the strengths & needs of service system to address the specific populations / pg 17

products to ensure compliance with laws limiting access of tobacco products by any individual under the age of 18. In calendar year 2010, Nebraska's rate was 10.7 percent, compared to the national average of 9.3%.

It is through the Synar workgroup, that a Memorandum of Understanding was developed. This agreement constitutes an ongoing effort to implement a tobacco control policy to reduce under aged tobacco use, provide information exchange on best practices used or funded by the agreeing organizations, and to establish consistent data elements for the measurement of enforcement efforts, surveys or studies either by state agencies or locally funded tobacco coalitions.

With the implementation of the 2008 Nebraska Clean Indoor Air Act, Nebraska has made tremendous progress in reducing exposure to secondhand smoke within the state. The Act eliminates smoking in enclosed indoor workspaces including restaurants, bars, gaming establishments, and other indoor public places. The Division of Public Health - Tobacco Free Nebraska program is the primary lead in the state's smoking cessation efforts and played a vital role in the establishment of the DHHS' toll-free information and quit line. From July to September 2009, nearly one in five callers to the Nebraska Tobacco Quit line said they were influenced to call as a result of the Smoke-Free Air Law.

State Epidemiological Outcomes Workgroup (SEOW)

In Nebraska, the State Epidemiological Outcomes Workgroup (SEOW) is called the Nebraska Substance Abuse Epidemiology Workgroup (NSAEW). This workgroup is comprised of administrators, epidemiologists, and key stakeholders who collaborate to make decisions regarding the collection and reporting of data related to substance use, consequences of substance abuse, and factors that contribute to substance abuse in the state of Nebraska. One of the main functions of the NSAEW is to identify and availability of data, utilization of data and prioritization of substance abuse data gaps, including missing or incomplete data,. In December of 2007, the NSAEW published the *Substance Abuse and Associated Consequences in Nebraska –An Epidemiological Profile*. This work has been an integral component of Nebraska's implementation of the SPF and assisting community coalitions with their prevention activities.

While the NSAEW is a committee supported by the Division of Public Health, the Division of Behavioral Health has been an active participant on the NSAEW since it was formed in March 2007. One of the many contributions from the Division of Behavioral Health is providing data from the community based substance abuse treatment information system to the workgroup on a regular basis.

In promotion of ongoing, in-depth exchange of data and learning among the Nebraska Substance Abuse Epidemiology Workgroup members, state and community leaders committed to prevention of local substance abuse problems are currently reviewing and exploring a possible change in membership of this workgroup. Potential changes could lead to the restructure of sub-committees, as well as posing new topics for discussion. Possible future projects may include a study of the cost of substance abuse to the state, further analysis of existing data on substance abuse and associated consequences, and exploration into prescription drug abuse. Additionally, with respect to the Young Adult Opinion Survey, the NSAEW is considering conducting further analysis of the database to examine the relationship between attitudes and behaviors at the stratified coalition level.

Step 1: Assess the strengths & needs of service system to address the specific populations / pg 18

NePiP

Led by the Division of Public Health and chaired by the Lieutenant Governor, the Nebraska Partners in Prevention (NePiP) is a muti-agency coordinating committee under the Governor's office. The Division of Behavioral Health Director and the Prevention System Coordinator both have active roles in this state advisory council which makes legislative and policy recommendations, provides operational advice and leadership, and reviews other actions most appropriate to advancing the State's agenda for prevention. This 32-member body includes the directors of the major State agencies that administer prevention funding such as the Nebraska Department of Health and Human Services, Nebraska Department of Education, Nebraska Office of Highway Safety, U.S. Attorney's Office, Nebraska Commission Law Enforcement and Criminal Justice, the Nebraska Legislature, the Nebraska Supreme Court, youth, parent and community organizations, Regional Prevention Coordinators, major Nebraska ethnic minority groups and other key stakeholders actively participating in substance abuse prevention.

NePiP was originally convened to provide leadership for the Nebraska SICA and is currently charged with providing leadership and oversight for the Nebraska SPF-SIG. NePiP coordinates with other State efforts and has established specialized workgroups and subcommittees to carry out its work. The NePiP has helped to enhance local community prevention efforts and advance the state data collection activities including a second youth survey of risk and behavioral factors including decision making toward, alcohol, drug, tobacco and gambling activities. Similar to the Nebraska Substance Abuse Epidemiology Workgroup, the NePiP will be exploring potential membership and structure changes as the funding for SPF-SIG ends.

II: Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system

Page 22 of the Application Guidance

Narrative Question:

This step should identify the data sources used to identify the needs and gaps of the populations relevant to each Block Grant within the State's behavioral health care system, especially for those required populations described in this document and other populations identified by the State as a priority.

The State's priorities and goals must be supported by a data driven process. This could include data and information that are available through the State's unique data system (including community level data) as well as SAMHSA's data set including, but not limited to, the National Survey on Drug Use and Health, the Treatment Episode Data Set, and the National Facilities Surveys on Drug Abuse and Mental Health Services. Those States that have a State Epidemiological Outcomes Workgroup (SEOW) must describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with serious mental illness and children with serious emotional disturbances that have been historically reported. States should use the prevalence estimates, epidemiological analyses and profiles to establish substance abuse prevention, mental health promotion, and substance abuse treatment goals at the State level. In addition, States should obtain and include in their data sources information from other State agencies that provide or purchase behavioral health services. This will allow States to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.

In addition to in-state data, SAMHSA has identified several other data sets that are available by State through various Federal agencies such as the Center for Medicaid and Medicare Services or the Agency for Health Research and Quality. States should use these data when developing their needs assessment. If the State needs assistance with data sources or other planning information, please contact planningdata@samhsa.hhs.gov.

Footnotes:

Step 2: Identify the Unmet Service Needs And Critical Gaps Within The Current System / Page | 1

Narrative Question: This step should identify the data sources used to identify the needs and gaps of the populations relevant to each Block Grant within the State's behavioral health care system, especially for those required populations described in this document and other populations identified by the State as a priority. The State's priorities and goals must be supported by a data driven process. Updated September 1, 2011

Contents

Overview of This Document 2
Behavioral Health Strategic Plan 2011-2015 3
Required – Joint Committee Meeting May 3, 2011 6
Required – National Survey on Drug Use and Health (NSDUH) 7
Required – Community Behavioral Health Persons Served 9
Co-Occurring Disorders 13
Required – SAPTBG Priority Populations 13
Required – HIV Services 18
Required – Tuberculosis In Nebraska 18
Required – State Epidemiological Outcomes Workgroup (SEOW) 18
Required – Rural Area Services 19
Required – MHSBG Priority Populations 21
Professional Partner Program (PPP) 23
Transition Age Youth and Young Adult 24
Required – Workforce Issues 27
Consumer Workforce 32
Criminal Justice Involvement 33
Nebraska Prevention Workforce Survey 2011 39
Required – Prevention 40
Required – SYNAR and Tobacco Efforts 42
Trauma Informed Services 43
Underserved Racial & Ethnic Minority Populations 46
Required – SA Treatment – Women's Set Aside Services 47
Required – Homeless 48
Housing 49
Employment 52
Insurance Coverage 54
Projected Covered Services 56
State Priorities 58

Overview of This Document

This Behavioral Health Assessment was prepared to meet the requirements for "Step 2: Identify the unmet service needs and critical gaps within the current system." Many data sources have been used to prepared this document including the Division of Behavioral Health Strategic Plan 2011-2015, Regional Behavioral Health Authorities planning efforts, Behavioral Health Community Services data (as collected by Magellan Behavioral Health), the Annual Consumer Survey [the 2010 Behavioral Health Consumer Survey is online at http://www.dhhs.ne.gov/beh/mh/MHConsumer/Nebraska2010BehavioralHealthConsumerSurvey.pdf and more.

The data sources used are identified within each section. Unless otherwise stated, the following apply to this document.

The FY 2012-2013 SAMHSA Uniform Block Grant Application has sections that are **required** and other sections where additional information is **requested but not required**. The **required** are those sections needed in an application prepared in accordance with the authorizing legislation and implementation regulations. Those sections will be marked as **Required**. Otherwise, the section is included is requested but not required. It is necessary to include both categories to fully identify unmet service needs and critical gaps within the current system.

As this document is reviewed, do note the following (unless otherwise specified):

State of Nebraska Fiscal Year is:

FY2010 (July 1, 2009 to June 30, 2010)
FY2011 (July 1, 2010 to June 30, 2011)

Nebraska 2010 Census Total Population is 1,826,341.

Female:	920,045	50.4%
Male:	906,296	49.6%
Age 0-17:	459,221	25%
Age 18+:	1,367,120	75%

Community Behavioral Health Data

The Division of Behavioral Health does not own a data or claims system. Magellan Behavioral Health, as Administrative Service Organization (ASO) contractor, provides the data and claims information for persons served in community settings. The Division of Behavioral Health contracts with the six Regional Behavioral Health Authorities (RBHA). The RBHAs contract with local providers or, in some cases directly provide the services. At the service provision level, the data are collected and reported to the ASO contractor. Once per month the ASO contractor transfers the data to the Division of Behavioral Health. In this section, the data reports from the ASO are sourced as "Community Behavioral Health Data - NE Division of Behavioral Health". These notes apply to those tables:

1. Data source: data extract from the Magellan Information System.
2. MH ONLY category means person was served in one or more Mental Health (MH) services funded by the Division of Behavioral Health via the six Regional Behavioral Health Authorities.
3. SA ONLY category means person was served in one or more Substance Abuse (SA) services funded by the Division of Behavioral Health via the six Regional Behavioral Health Authorities.

4. Dual ONLY category means person was served in a service where Mental Illness and Substance Use Disorder are both the primary diagnosis. Dual Disorder Residential is at ASAM level III.5 Adult SA program. The service is Dual Diagnosed Enhanced. There are staff present at all times capable of conducting MH and/or SA services and who hold dual credentials.
5. COMBO means the person was served in more than one service category, in some combination of MH, SA and/or Dual.
6. Numbers in the MH only, SA only and Dual only columns indicate that only this type of service was received during the entire time period reported (State Fiscal Year).
7. Unless otherwise specified in this report, Youth means age 0-17; Adult means age 18+.
8. In the State of Nebraska, the age of majority is 19.

Required – Statutory Populations

The SAMHSA Uniform Block Grant application requires the statutory populations (as specified by Block Grants) need to be addressed. Those populations are

Community Mental Health Services Block Grant (MHSBG)

Adults with Serious Mental Illness (SMI)
Children with Severe Emotional Disturbance (SED)

Substance Abuse Prevention and Treatment Block Grant (SAPTBG)

Access to treatment is prioritized giving preference to the following priority populations:
1. Pregnant Injecting Drug Users
2. Pregnant Substance Abusers
3. Injecting Drug Users
4. Women with Dependent Children

The SAPTBG also requires persons with or at risk of contracting communicable diseases
Goal #5: TB Services - tuberculosis services
Goal #6: HIV Services - Nebraska is not a designated State

Other Populations Addressed:
1. Co-occurring (mental and substance use disorders based on service type)
2. Criminal Justice - Individuals with mental and/or substance use disorders who are involved in the criminal or juvenile justice systems
3. Rural Areas - Individuals with mental and/or substance use disorders who live in rural areas.
4. Underserved racial minority populations
5. Underserved ethnic minority populations

Behavioral Health Strategic Plan 2011-2015

The information acquired throughout the development of the Nebraska Division of Behavioral Health Strategic Plan 2011-2015 (February 18, 2011) was extensively utilized to identify the needs, gaps, and priorities for this block grant application. The Strategic Plan final version is posted to the website: http://www.dhhs.ne.gov/Behavioral_Health/BHSP-Final-02-17-11.pdf.

Nebraskans have engaged in a number of past planning and assessment initiatives related to behavioral health, both in the public and private sectors. The DBH Strategic Plan was based on review of many of these documents, including the work done by the legislatively formed Behavioral Health Oversight Commissions (LB 1083 [2004]; LB 928 [2008]), and a public/private consensus group in Omaha (See the DBH Strategic Plan for a complete list of planning documents). The tasks

of incorporating consumer viewpoints, reviewing prior planning documents and suggesting key areas of focus for this planning document were given to a Joint Strategic Planning Workgroup made up of representatives from the three Committees guiding the Division (Mental Health, Substance Abuse, and Problem Gambling), Behavioral Health Regions and the Division of Behavioral Health. A list of people participating in this workgroup is attached in Appendix D in the DBH Strategic Plan. The work of this group was augmented by consultation with national experts in behavioral health and opportunities for public review and comment. The process was facilitated by the University of Nebraska Public Policy Center. Hundreds of Nebraskans participated in the development of recommendations in the planning documents and initiatives that were reviewed by the joint strategic planning workgroup. Many of the recommendations evolved from a great deal of dedication and hard work by stakeholders directly impacted by the public behavioral health system.

Stakeholder Survey Results

The purpose of the non-scientific, web-based survey was to give interested persons an opportunity to weigh in on the areas of concern that could guide priorities of the Strategic Plan. The results were compiled by the University of Nebraska Public Policy Center on behalf of the Nebraska Division of Behavioral Health and the Joint Strategic Planning Group. The survey was publicized in a news release on July 11, 2010. The results were compiled September 7, 2010. A total of 347 people started the survey with 265 respondents completing some or all of the survey. The results include full and partial survey responses. While all of the items listed are important, the ones in **bold with raised letters** were considered in the Block Grant priorities.

Accessibility Survey Question:

The following recommendations related to increasing access to public behavioral health services.

Answer
• Increase behavioral health service capacity
• Expand community based treatment options
• Emphasize early Identification and referral
•Promote standards for timely access to services
• Support Long term Recovery
• Create a uniform definition of system roles, responsibilities, and handoffs
• Formalize system linkages between justice and behavioral health systems
• Expand use of telehealth

total Responses = 265

Quality Survey Question:

The following recommendations related to Quality of Behavioral Health Services have been offered by other planning efforts in Nebraska.

Answer
• Incorporate flexibility and choice of service for consumers and families
• Encourage and expand avenues for consumer / family involvement in the system
• Include consumers in system planning process
• Increase ease of access to information and records for consumers and their providers
• Emphasize culturally responsive and culturally/linguistically competent care in service delivery systems
• Policy, administrative practices and regulatory practices must be subjected to

continuous data-based evaluation

Total Responses = 249

Effectiveness Survey Question:
The following recommendations related to Effectiveness of Behavioral Health Services have been offered by other planning efforts in Nebraska.

Answer
• Increase awareness of behavioral health among all system participants
• Promote best /evidence based practice adoption
• Move to accountability without overburdening consumers and providers of service
• Share assessment information across systems/providers
• Implement a uniform system for collection and analysis of data
• Policy, administrative practices and regulatory practices must support effective collaboration among the consumer and systems
• Balance an emphasis on wellness with State's public safety responsibilities

Total Responses = 236

Cost Effectiveness Survey Question:
The following recommendations related to COST Effectiveness of Behavioral Health Services have been offered by other planning efforts in Nebraska.

Answer
• Focus on prevention and early intervention
• Emphasize supports ie, transportation, stable housing & employment/education
• Promote clear pathways linking service in justice, Medicaid and behavioral health systems
• Maximize information sharing across systems
• Capture Medicaid match dollars
• Promote strategic use of evidence-based practices via policy, reimbursement, monitoring, and training
• Pursue Grants and outside funding
• Create cadre of providers available by telehealth

Total Responses = 245

An overview of the Behavioral Health Strategic Plan 2011-2015 includes recognition that today one can see clear roles for private insurance, Medicaid, and Division of Behavioral Health (DBH) funded services. However, as tomorrow approaches, the funding role for behavioral health treatment will shift. The result is the public behavioral health system must ensure the new system addresses access, quality, effectiveness, efficiency, accountability in relationships, and more. The Division of Behavioral Health will focus on what is realistic given the changinghealthcare environment within the next 3-5 years.

The Division of Behavioral Health Strategic Plan 2011-2015 has the following 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.

This Strategic Plan, gained by consensus, has focused the work of the Division of Behavioral Health on the following needs and gaps.

Required – Joint Committee Meeting May 3, 2011

Required includes Comment on State Plan, a Description of Processes to Involve Individuals and Families, and a State Behavioral Health Advisory Council.

For the purposes of this application, comments started at the May 3, 2011 joint meeting of the three NE Division of Behavioral Health committees:

State Advisory Committee on Mental Health Services (§ 71-814)
State Advisory Committee on Substance Abuse Services (§ 71-815)
State Committee on Problem Gambling (§ 71-816)

Scot Adams, Director of the Division of Behavioral Health (DBH) said his goals for the joint meeting of the three DBH Committees included defining the committees agendas moving forward in light of the Behavioral Health Strategic Plan 2011-2015 and to start a discussion on the SAMHSA Uniform Block Grant. Here are some themes from the May 3, 2011 Joint Committee Meeting discussion:

Prevention

- Prevention – "in-between group" (between young age / don't use and addiction)
  - ✓ Focus on root cause / the source of the problem
  - ✓ "right of passage"
  - ✓ Parenting
  - ✓ Intervention (CJ- MIP / shoplifting)
  - ✓ Random drug testing in high school
- Prevention … for those who aren't eligible for insurance or Medicaid
- Prevention practices are more defined with SA

We believe in RECOVERY

- Funding follows person-centered recovery oriented system of services
- Recovery is long term / life change which requires lifetime maintenance

Peer Support Issues

- "Peer-lead" services
- Importance / value of Peer Support
- SA has established 'Peer' culture which can be replicated
- Informal supports are needed

Workforce Issues:
- Shortages – Increase mid-level practitioners, peers, Nurse Practitioners … burn out support.
- Connecting workforce … effective and efficient across care.
- Provider readiness for Health Care Reform (HCR) … qualification, fear, resistance to serve, capacity issues, access to services
- Lack of knowledge from each system about the other systems – need for cross-training
- In order to reduce reliance on the Lincoln Regional Center for general psychiatric services
  - ✓ Use admission to LRC as a Last resort.
  - ✓ Community Based hospitals must be accessible
  - ✓ Wellness, recovery focus at LRC; not jail-like
- Standardized screening – cross training

Seamless – transitioning from one (1) service to another … no gaps

Access, especially rural levels of care … close to home

Co-Occurring is not only MH and SA.

Important that SA doesn't get lost with funding under the Uniform BG.

Use Keya-like services
- Crisis Diversion … e.g., Keya House, pre-crisis diversion, Independent Living Skills for young adults/youth, accessible and affordable services.
- Utilize Keya House like services … work with Regions to purchase or develop services to prevent LRC dependence

Data Used
- Use prevalence studies / national
- Utilize current waitlist data.

Remember homeless and near homeless persons.

Required – National Survey on Drug Use and Health (NSDUH)

Criterion 2: Mental Health System Data Epidemiology Estimate of Prevalence
SAPTBG Treatment Needs Assessment

The National Survey on Drug Use and Health (NSDUH) provides important data on behavioral health for the general population. The NSDUH is an important source for national prevalence data for both mental health and substance abuse. In the next section, these data are used as the denominator in a performance measure to help determine the percentage of persons with a behavioral health problem in Nebraska are being served in services purchased by the Division of Behavioral Health via the Regional Behavioral Health Authorities.

NSDUH is sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA), an agency of the U.S. Public Health Service in the U.S. Department of Health and Human Services (DHHS). NSDUH is an annual nationwide survey involving interviews with approximately 70,000 randomly selected individuals aged 12 and older. Data from the NSDUH

provide national and state-level estimates on the use of tobacco products, alcohol, illicit drugs (including non-medical use of prescription drugs) and mental health in the United States.

A scientific random sample of households is selected across the United States, and a professional field interviewer makes a personal visit to each selected household. Once a household is chosen, no other household can be substituted for any reason. This practice is to ensure that NSDUH data represent the many different types of people in the United States. As a result, NSDUH data represent the general population.

After answering a few general questions during the in-person visit by the interviewer, one or two residents of the household may be asked to participate in the survey by completing an interview. It is possible that no one will be selected for the interview. If an individual is selected for the interview, their participation is voluntary, but no other person can take their place. Since the survey is based on a random sample, each selected person represents more than 4,500 United States residents. At the end of the completed interview, the selected person receives $30 in cash. For more information on NSDUH see https://nsduhweb.rti.org/.

The NSDUH data below is from Nebraska for the time period 2005-2009.

- 131,000 estimated adults with Serious Psychological Disorders (SPD)* (~10.1% prevalence)
  *NOTE: SPD defined as K-6 scores of 13 or higher
- 133,000 estimated adults with Substance Dependence / Abuse (~10.2% prevalence)
- 28,000 estimated adults have SPD with co-occurring Substance Dependence / Abuse (~2.1% prevalence)

Past Year Serious Psychological Distress and Substance Dependence or Abuse among Persons Aged 18 or Older: Numbers in Thousands and 95% Confidence Intervals, Annual Averages Based on 2005-2009

	Serious Psychological Distress		Substance Dependence/Abuse		Co-Occurring SPD and Substance Dependence/Abuse	
	Numbers in Thousands	95% Confidence Interval	Numbers in Thousands	95% Confidence Interval	Number in Thousands	95% Confidence Interval
Nebraska	131	113 - 151	133	116 - 152	28	20 - 37
Regions 1 & 2	12	7 - 19	14	8 - 23	3	1 - 12
Region 3	13	8 - 22	11	6 - 18	2	1 - 6
Region 4	*	* - *	15	10 - 21	1	0 - 2
Region 5	37	28 - 48	41	34 - 49	11	6 - 18
Region 6	53	44 - 63	53	41 - 68	12	8 - 18

*Low precision; no estimate reported.

NOTE: Serious Psychological Distress (SPD) is defined as having a score of 13 or higher on the K6 scale in the past year. Estimates for 2005, 2006, and 2007 are based on an adjusted SPD variable and may differ from estimates published in prior NSDUH reports.

NOTE: Substance Dependence or Abuse includes illicit drug or alcohol dependence or abuse. Dependence or abuse is based on definitions found in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically, including data from original methamphetamine questions but not including new methamphetamine items added in 2005 and 2006.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2005-2009. Updated July 21, 2011

NOTE: Kessler-6 (K-6) Method to Determine Serious Psychological Distress (SPD)
The NSDUH does measure Serious Psychological Distress (SPD). SPD is defined as having a score of 13 or higher on the K6 scale, which measures symptoms of psychological distress during the one month in the past 12 months when respondents were at their worst emotionally. SPD is measured by scoring a series of six questions from the Behavioral Risk Factor Surveillance System (BRFSS) known as the Kessler-6. The US Department of Health and Human Services - Centers for Disease Control and Prevention (CDC) is responsible for the BRFSS. The BRFSS is the world's largest, on-going telephone health survey system, tracking health conditions and risk behaviors in the United States yearly since 1984.

The K-6 scale asks respondents about six manifestations of psychological distress using the following questions: "Now I am going to ask you some questions about how you have been feeling during the past 30 days. About how often during the past 30 days did you feel: nervous? hopeless? restless or fidgety? so depressed that nothing could cheer you up? that everything was an effort? worthless?"

Respondents could answer,

4 "All of the time,"
3 "Most of the time,"
2 "Some of the time,"
1 "A little of the time"
0 "None of the time"

Scoring for each of these questions ranged between 0 and 4 points, according to the increased frequency of the problem. This method provided an individual score for each question, which could then be summed for a total score ranging from 0 to 24. Consistent with the scoring guidelines provided by the developers, persons with K6 scores $\geq$ 13 were classified as having SPD.

source: Relationships between serious psychological distress and the use of health services in the United States: findings from the Behavioral Risk Factor Surveillance System by William S. Pearson, Satvinder S. Dhingra, Tara W. Strine, Yia Wun Liang, Joyce T. Berry, Ali H. Mokdad; Published Online First 05 April 2009; Pages 24 © Birkhäuser Verlag, Basel, 2009
Int J Public Health 54 (2009) S23–S29 1661-8556/09/010S23-7
http://springerlink.com/content/r1346672q56w3376

Required – Community Behavioral Health Persons Served

Criterion 2: Mental Health System Data Epidemiology Estimate of Prevalence

The Community Mental Health Services Block Grant (MHSBG) requires an estimate of prevalence of persons with serious mental illness. This section also includes data on the number of persons served to help establish a penetration rate (how many of those in need were actually served).

The numerator in the performance measure to help determine the percentage of persons with a behavioral health problem being served comes from the NE Division of Behavioral Health (DBH). Specifically, the Magellan Information System provides the data for persons served by the six Regional Behavioral Health Authorities funded by DBH. The data below provides the FY2010 and FY2011 persons served broken out by type of service (MH ONLY, SA ONLY, Dual ONLY, and COMBO (served in some combination of MH, SA and/or Dual).

Step 2: Identify the Unmet Service Needs And Critical Gaps Within The Current System / Page | 10

Community Based – NE Division of Behavioral Health
Total Number (#) of Persons Served

	MH ONLY		SA ONLY		Dual ONLY		COMBO	
	Youth	Adult	Youth	Adult	Youth	Adult	Youth	Adult
FY2010	2,598	16,826	511	12,757	1	86	100	3,132
FY2011	2,341	17,407	418	11,819	1	84	38	3,279

	TOTAL		TOTAL
	Youth	Adult	#
FY2010	3,210	32,801	36,011
FY2011	2,798	32,589	35,387

Of the persons served by the Community Section of the Division of Behavioral Health, as reported via the Magellan Information System, 8% were youth and 92% were adults; 55.8% received mental health services, 34.6% received substance abuse services, and 9.6% received dual MH/SA or a combination of MH, SA and/or Dual services.

Total Number of Persons Served – State Fiscal Year 2010 & 2011

	MH ONLY		SA ONLY		Dual ONLY		COMBO		TOTAL	
Population	#	%	#	%	#	%	#	%	#	%
FY2010	19,424	53.9%	13,268	36.8%	87	0.2%	3,232	9.0%	36,011	100.0%
FY2011	19,748	55.8%	12,237	34.6%	85	0.2%	3,317	9.4%	35,387	100.0%

Of the persons served by the Community Section of the Division of Behavioral Health, as reported via the Magellan information system, overall, in FY2011, about 56% of the persons served were served in mental health only services.

Persons Served by Gender and Age

	MH ONLY			SA ONLY			TOTAL	
Population	Youth	Adult	Adult %	Youth	Adult	Adult %	#	%
FY2010								
Female	1,072	9,028	53.7%	197	3,726	29.2%	15,468	43.0%
Male	1,526	7,798	46.3%	314	9,031	70.8%	20,543	57.0%
total	2,598	16,826	100.0%	511	12,757	100.0%	36,011	100.0%
FY2011								
Female	966	9,188	52.8%	177	3,574	30.2%	15,365	43.4%
Male	1,375	8,219	47.2%	241	8,245	69.8%	20,022	56.6%
Total	2,341	17,407	100.0%	418	11819	100.0%	35,387	100.0%

Overall, there are more males (57%) served by the Community Section of the Division of Behavioral Health than females (43%). However, it is worth noting that more adult females (53%) are served in the Mental Health Only category. In the Substance Abuse Only, 70% of the persons served are male.

PREVALENCE OF BH ISSUES & NUMBER OF INDIVIDUALS SERVED BY SYSTEM.

Step 2: Identify the Unmet Service Needs And Critical Gaps Within The Current System / Page | 11

For the purposes of this document, behavioral health issues refer to people with Serious Psychological Disorders (SPD), those with Substance Dependence / Abuse as well as adults who have SPD along with co-occurring Substance Dependence / Abuse.

- The prevalence of behavioral health issues in this section is from the NSDUH. The NSDUH provides an estimate of the total number of cases of a disease in a given population at a specific time.
- The penetration rate is the number of individuals with these diseases being served by the public and private sectors in Nebraska. Unfortunately, Nebraska does not have the capacity to determine the penetration rate from all the systems for people served with behavioral health issues. There are a number of systems including DBH funding via the six Regional Behavioral Health Authorities, Medicaid, Office of Protection and Safety, including child welfare and Juvenile Justice, Education, Vocational Rehabilitation, Corrections and Probation, as well as services paid by private insurance or self pay. System integration is not available to gather data from all of these sources to report an unduplicated count of all the persons served.
- The data reported below is on persons served from services funded by the Community Services Section of the Division of Behavioral Health via the six Regional Behavioral Health Authorities reported on the Magellan Behavioral Health Information System.
- Calculation of the penetration rate is number of persons served (numerator) divided number of people with the behavioral health issue as estimated by NSDUH.

The National Survey on Drug Use and Health (NSDUH) provided estimated data on Nebraska for the time period 2005-2009.

Serious Psychological Disorders (SPD)

- 131,000 estimated adults with Serious Psychological Disorders (SPD)* (~10.1% prevalence)
  *NOTE: SPD defined as K-6 scores of 13 or higher

Total Mental Illness – Number of Persons Served –
State Fiscal Year 2011 (July 1, 2010 to June 30, 2011)

MH ONLY	Dual ONLY	COMBO	Total	Estimate of Prevalence Serious Psychological Disorders (SPD)	**Penetration Rate**
19,748	85	3,317	23,150	131,000	17%

NOTES: NSDUH for the SPD. Community Behavioral Health for the persons served.

Substance Dependence / Abuse

The data below is from Nebraska for the time period 2005-2009.

- 133,000 estimated adults with Substance Dependence / Abuse (~10.2% prevalence)

Total Substance Dependence / Abuse – Number of Persons Served –
State Fiscal Year 2011 (July 1, 2010 to June 30, 2011)

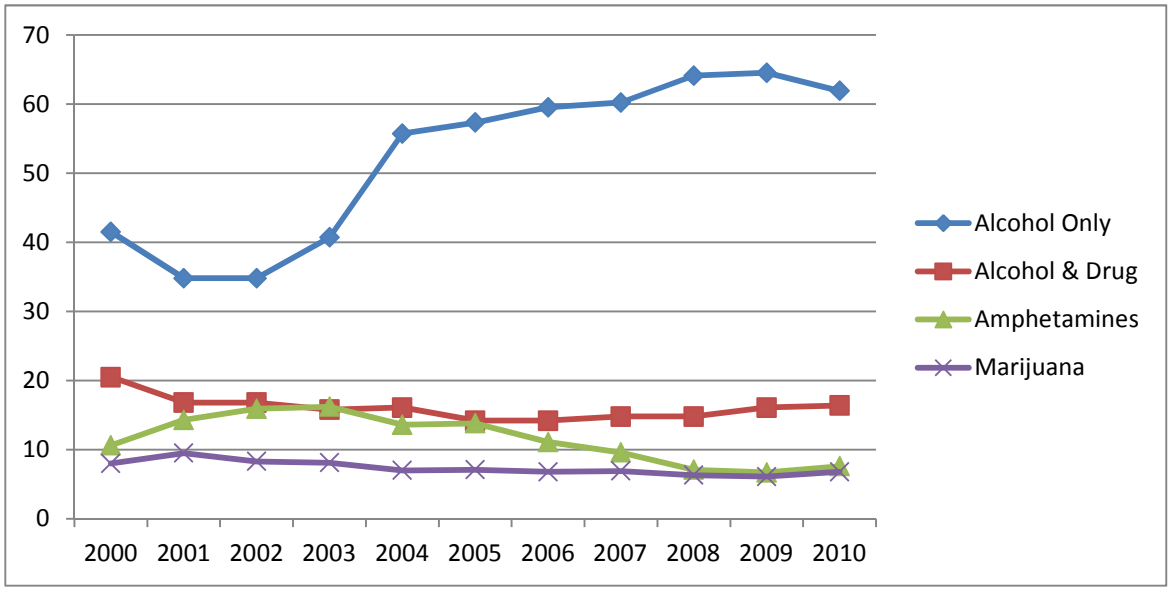
SA ONLY	Dual ONLY	COMBO	Total	Estimate of Prevalence Substance Dependence / Abuse	**Penetration Rate**
12,237	85	3,317	15,639	133,000	11.8%

The following data provide a picture of the primary substance being used as reported by the consumer upon admission to a DBH funded community based service. These data are part of what is reported by DBH to SAMHSA under the Substance Abuse Prevention and Treatment Block Grant requirements. The Table below was prepared by SAMHSA.

Percent of Admissions by Year For Primary Substance

	Alcohol Only	Alcohol and drug Secondary	Amphetamine	Marijuana
2000	41.5	20.5	10.6	8
2001	34.8	16.8	14.3	9.5
2002	34.8	16.8	15.9	8.3
2003	40.7	15.8	16.2	8.1
2004	55.7	16.1	13.6	7
2005	57.3	14.2	13.8	7.1
2006	59.5	14.2	11.1	6.8
2007	60.2	14.8	9.6	6.9
2008	64.1	14.8	7.1	6.3
2009	64.5	16.1	6.7	6.1
2010	61.9	16.4	7.6	6.8

SOURCE: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS)



The graph above shows the trends in Alcohol admissions and in the two top types of substance abuse drugs in Nebraska. Alcohol and a secondary drug is the second most identified problem identified upon admission to the Substance Abuse Treatment System. Amphetamines were identified more than 15 percent of the time in the early 2000's and have since dropped to near 7 percent. Marijuana continues to been mentioned around 7 percent of the time. Overall the percentages indicate a stable primary drug upon admission of Alcohol, Amphetamine and Marijuana. The dramatic increase in alcohol to over 60% of admissions toward 2010 is a result of a high number of unknown reasons for primary drug of choice in the early 2000's owing to error in the instructions in the data system given to those completing the information.

Co-Occurring Disorders

Serious Psychological Disorders (SPD) with Co-occurring Substance Dependence / Abuse

The data below is from Nebraska for the time period 2005-2009.

28,000 estimated adults have SPD with co-occurring Substance Dependence / Abuse (~2.1% prevalence)

State Fiscal Year 2011 (July 1, 2010 to June 30, 2011)

Dual ONLY	COMBO	Total	Estimate of Prevalence SPD with co-occurring Substance Dependence / Abuse	**Penetration Rate**
85	3,317	3,402	28,000	12.2%

The NE Behavioral Health Services Act defines Behavioral health disorder as mental illness or alcoholism, drug abuse, problem gambling, or other addictive disorder [Neb. Rev. Stat. §71-804(1)]. Under the DBH Strategic Planning For Nebraska's Behavioral Health System (Strategic Plan 2011 – 2015), Goal 1 says, "The public behavioral health workforce will be able to deliver effective prevention and treatment in recover y-oriented systems of care for people with co-occurring disorders." The Division of Behavioral Health has a responsibility to meet consumer needs wherever they present in the DBH funded service system to promote recovery in those served. Through a collaborative effort, the Co-Occurring Disorders quality initiative has been working toward ways to improve services to adults with co-occurring mental health and substance abuse disorders and their families. This is important to help promote recovery of individuals and families as well as integrated co-occurring service delivery system.

State Priority 7 Co-Occurring Disorder Services

Required – SAPTBG Priority Populations

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

The National Survey on Drug Use and Health (NSDUH) provides some specific data on the SAPTBG Priority Populations.

	National		Nebraska and Border States[4]	
Substance Use Measures	**Numbers in Thousands**	**Numbers in Thousands**	**95% Confidence Interval**	**95% Confidence Interval**
Past Year Illicit Drug Use[1]	12,807	790	751 - 830	12,579 - 13,039
Past Year Alcohol Use	73,856	3,071	3,027 - 3,115	73,394 - 74,317
Past Year Dependence or Abuse of Illicit Drugs or Alcohol[1,2]	6,770	489	459 - 521	6,609 - 6,934
Lifetime Intravenous Drug Use[3]	1,224	58	47 - 71	1,147 - 1,306
Women with Dependent Children	39,628	170	152 - 189	39,185 - 40,074
Past Year Illicit Drug Use[1]	4,514	26	21 - 34	4,381 - 4,651
Past Year Alcohol Use	27,595	114	100 - 129	27,225 - 27,969

Step 2: Identify the Unmet Service Needs And Critical Gaps Within The Current System / Page | 14

Substance Use Measures	National		Nebraska and Border States[4]	
	Numbers in Thousands	Numbers in Thousands	95% Confidence Interval	95% Confidence Interval
Past Year Dependence or Abuse of Illicit Drugs or Alcohol[1,2]	2,162	15	11 - 21	2,072 - 2,256
Lifetime Intravenous Drug Use[3]	467	3	2 - 6	424 - 514

Substance Use Measures	Nebraska	
	Numbers in Thousands	95% Confidence Interval
Past Year Illicit Drug Use[1]	61	53 - 69
Past Year Alcohol Use	276	266 - 286
Past Year Dependence or Abuse of Illicit Drugs or Alcohol[1,2]	48	42 - 55
Lifetime Intravenous Drug Use[3]	5	3 - 8
Pregnant	15	12 - 19
Past Year Illicit Drug Use[1]	2	1 - 3
Past Year Alcohol Use	12	9 - 15
Dependence or Abuse of Illicit Drugs or Alcohol[1,2]	1	1 - 2
Lifetime Intravenous Drug Use[3]	0	0 - 1

1- Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically, including data from original methamphetamine questions but not including new methamphetamine items added in 2005 and 2006.
2- Dependence or abuse is based on definitions found in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).
3- Refers to lifetime use of a needle to inject a drug that was not prescribed, or that was taken only for the experience or feeling it caused. These estimates are generated from data collected on a "core" module of the NSDUH questionnaire.
4- Nebraska and Border States include Nebraska, Iowa, Kansas, Missouri, South Dakota, Colorado, and Wyoming.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2009.

Needing Treatment for a Substance Use Problem

Needing Treatment for a Substance Use Problem in the Past Year and Seeking Treatment in the Past Year among Persons Aged 12 or Older, Persons Aged 12 or Older with Lifetime Intravenous Drug Use, and Women Aged 18 or Older, by Geographic Category: Numbers in Thousands and 95% Confidence Intervals, Annual Averages Based on 2002-2009

	Total Population in Need			
	Needing Treatment Services		That Would Seek Treatment	
	Numbers in Thousands	95% Confidence Interval	Number in Thousands	95% Confidence Interval
National	23,124	22,803 - 23,448	344	306 - 387
Midwest Region	5,552	5,421 - 5,686	70	57 - 87
West North Central Division	1,737	1,661 - 1,816	20	13 - 29
Nebraska and Border States[1]	1,698	1,624 - 1,775	25	17 - 37
Nebraska	156	141 - 173	3	1 - 6
Regions 1 & 2	15	10 - 22	*	* - *
Region 3	16	12 - 21	0	0 - 2
Region 4	17	13 - 22	0	0 - 1

	Total Population in Need			
	Needing Treatment Services		That Would Seek Treatment	
	Numbers in Thousands	95% Confidence Interval	Number in Thousands	95% Confidence Interval
Region 5	49	41 - 57	1	0 - 3
Region 6	60	50 - 72	2	1 - 5

Lifetime Intravenous Drug Users

Needing Treatment for a Substance Use Problem in the Past Year and Seeking Treatment in the Past Year among Persons Aged 12 or Older, Persons Aged 12 or Older with Lifetime Intravenous Drug Use, by Geographic Category: Numbers in Thousands and 95% Confidence Intervals, Annual Averages Based on 2002-2009 (continued)

	Number of Lifetime Intravenous Drug Users in Need[2]			
	Needing Treatment Services		That Would Seek Treatment	
Geographic Category	Numbers in Thousands	95% Confidence Interval	Numbers in Thousands	95% Confidence Interval
National	1,482	1,395 - 1,575	59	44 - 78
Midwest Region	274	243 - 308	14	9 - 23
West North Central Division	99	82 - 121	2	1 - 6
Nebraska and Border States[1]	118	99 - 141	8	3 - 20
Nebraska	9	6 - 14	1	0 - 3
Regions 1 & 2	3	1 - 8	*	* - *
Region 3	1	0 - 4	*	* - *
Region 4	1	0 - 2	0	0 - 1
Region 5	3	2 - 6	0	0 - 3
Region 6	2	1 - 4	0	0 - 2

Women Aged 18 or Older in Need

Needing Treatment for a Substance Use Problem in the Past Year and Seeking Treatment in the Past Year Women Aged 18 or Older, by Geographic Category:

Numbers in Thousands and 95% Confidence Intervals, Annual Averages Based on 2002-2009 (continued)

	Number of Women Aged 18 or Older in Need			
	Needing Treatment Services		That Would Seek Treatment	
Geographic Category	Numbers in Thousands	95% Confidence Interval	Number in Thousands	95% Confidence Interval
National	7,050	6,883 - 7,221	111	93 - 134
Midwest Region	1,717	1,647 - 1,790	18	13 - 25
West North Central Division	536	496 - 578	6	3 - 11
Nebraska and Border States[1]	547	507 - 590	11	6 - 20
Nebraska	48	41 - 57	1	0 - 5
Regions 1 & 2	4	2 - 10	*	* - *
Region 3	4	3 - 6	*	* - *
Region 4	5	4 - 8	0	0 - 1
Region 5	16	12 - 21	*	* - *
Region 6	19	15 - 25	1	0 - 5

*Low precision; no estimate reported.

NOTE: Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically, including data from original methamphetamine questions but not including new methamphetamine items added in 2005 and 2006.

NOTE: Respondents were classified as needing treatment for an illicit drug or alcohol problem if they met at least one of three criteria during the past year: (1) dependent on illicit drugs or alcohol; (2) abuse of illicit drugs or alcohol; or (3) received treatment for illicit drug or alcohol use at a specialty facility (i.e., drug and alcohol rehabilitation facility [inpatient or outpatient], hospital [inpatient], or mental health center). Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically, based on data from original questions not including methamphetamine use items added in 2005 and 2006.

NOTE: Respondents were classified as seeking treatment for an illicit drug or alcohol problem if they met all three criteria during the past year: (1) needed treatment for illicit drugs or alcohol, but have not received treatment at a specialty facility; (2) felt need to receive treatment; and (3) made an effort to receive treatment.

[1] Nebraska and Border States include Nebraska, Iowa, Kansas, Missouri, South Dakota, Colorado, and Wyoming.

[2] Refers to lifetime use of a needle to inject a drug that was not prescribed, or that was taken only for the experience or feeling it caused. These estimates are generated from data collected on a "core" module of the NSDUH questionnaire.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2002-2009.

The following data are from the Community Section of the Division of Behavioral Health. The persons served count is based on what is reported to the Magellan Information System. Due to how the data are collected, Women with Dependent Children cannot be determined from the Magellan data base. However, Women with Dependent Children are reported on the waiting list data.

Number of person served in FY10 and FY11

	SA ONLY		Dual ONLY	COMBO	Total	
	Youth	Adult	Adult	Adult	#	%
Pregnant Injecting Drug Users						
2010	0	36	0	0	36	0.10%
2011	0	34	0	0	34	0.10%
Pregnant Substance Abusers						
2010	4	230	4	2	240	0.70%
2011	4	207	5	1	217	0.60%
Injecting Drug Users						
2010	13	1347	61	43	1464	4.10%
2011	9	1445	59	46	1559	4.40%
Total # of person served						
2010					36,011	100%
2011					35,387	100%

Summary for the FY11 Annual Substance Abuse Capacity and Waiting List Report

Total Persons Placed on Waiting List by Priority Population				
Statistics	Pregnant/ IV Users	Pregnant Women	IV Users	Women/ Children
Number	3	30	243	282

Mean (Average)	4.3	22.2	18.8	22.5
Initial assessment only				
Number	2	21	189	219
Mean (Average)	2.5	19.8	16	19.4
Transition/discharge				
Number	1	9	54	63
Mean (Average)	8	27.9	28.6	33.2

Average Waiting Days for Substance Abuse Services for FY10, FY11

	FY10	FY11	% Decrease
Pregnant/IV Users	17.5	4.3	75%
Pregnant Women	28.2	22.2	21%
IV Users	22.5	18.8	20%
Women/Children	24.3	22.5	7%

- The average waiting days decreased for all priority populations from FY10 to FY11, ranging from 7% for women with dependent children to 75% for pregnant IV drug users.
- Statewide Average Wait days means the total number of days waiting for admission into an appropriate Substance Abuse Service in all six regions, divided by the number of individuals on the waiting list for that category.
- Number means the total number of individuals within the reported category statewide
- Initial or Transition/Discharge Plan' is referring to whether the service into which the individual is awaiting admission is the ASAM service that was recommended in the initial assessment or a transitional or step-down service from the initial recommended service type (example: as part of individual's discharge plan from the initial recommended service type).

Working from the tables above, the following can be observed.

- For those who are Pregnant Injecting Drug Users 8.8% of the persons served had to wait for admission into a service and the average wait time was 4.3 days.
- For those who are Pregnant Substance Abusers 13.8% of the persons served had to wait for admission into a service and the average wait time was 22.2 days.
- For those who are Injecting Drug Users 15.60% of the persons served had to wait for admission into a service and the average wait time was 18.8 days.

Statewide Substance Abuse Priority Populations State Fiscal Year 2011 (July 1, 2010 – June 30, 2011)

	Number of Person Served in FY11	Number On Waiting List	% of Persons Served Placed on Waiting List	Average Wait Days
Pregnant Injecting Drug Users	34	3	8.8%	4.3
Pregnant Substance Abusers	217	30	13.8%	22.2
Injecting Drug Users	1,559	243	15.6%	18.8

State Priority 4 SA Treatment – Women's Set Aside Services

Pregnant Women and Women with Dependent Children under the Substance Abuse Prevention and Treatment Block Grant [Goal #3: Pregnant Women Services, Goal #9: Pregnant Women Preferences, MOE Table IV]

Required – HIV Services

Goal #6: HIV Services - Nebraska is not a designated State

Required – Tuberculosis In Nebraska

SAPTBG Goal #5: TB Services - tuberculosis services

Tuberculosis (TB) is a disease caused by bacteria called Mycobacterium tuberculosis. The bacteria can attack any part of the body, but it usually attacks the lungs. For more details on the Nebraska DHHS Division of Public Health Tuberculosis (TB) program see:
http://dhhs.ne.gov/cod/Tuberculosis/tbindex.htm

The Tuberculosis Program in the NE Division of Public Health provides the overall coordination for the State of Nebraska in this area. The Tuberculosis Program reports to the Federal Centers for Disease Control (CDC). The available data are reported on a calendar year basis. The most recent available are for Calendar Year 2010. Nebraska has ninety-three (93) counties, nine (9) of which reported cases of Tuberculosis in 2010.

Tuberculosis Cases Reported By Region In Nebraska - 2010

Region	1	2	3	4	5	6	total
Number of cases reported 2010	0	1	1	3	6	16	27

http://dhhs.ne.gov/cod/Tuberculosis/docs/TBchart2010.pdf

		2010
Injected Drug Use Within Past Year	Yes:	0
	No:	27
Non-Injected Drug Use Within Past Year	Yes:	1
	No:	26
Excess Alcohol Use Within Past Year	Yes:	3
	No:	24

Source: Pat Infield, Tuberculosis Program Manager
DHHS - Division of Public Health | July 13, 2011

Based on these data, the Division of Behavioral Health estimates that 15% of DHHS Tuberculosis (TB) expenditures were for consumers with Injected Drug Use, Non-Injected Drug Use, and Excess Alcohol Use in 2010. The percentage reported was based on 4 of the 27 reported to the CDC had Non-Injected Drug Use (1) and Excess Alcohol Use (3).

Accessed on July 13, 2011 from the Nebraska Tuberculosis (TB) Prevention and Control Program Division of Public Health; Nebraska Department of Health & Human Services
http://dhhs.ne.gov/cod/Tuberculosis/tbindex.htm#Data

Required – State Epidemiological Outcomes Workgroup (SEOW)

Step 2: Identify the unmet service needs and critical gaps within the current system
Those States that have a State Epidemiological Outcomes Workgroup (SEOW) must describe its composition and contribution to the process for primary prevention and treatment planning.

In Nebraska, the State Epidemiological Outcomes Workgroup (SEOW) is called the Nebraska Substance Abuse Epidemiology Workgroup (NSAEW). While the NSAEW is a committee supported by the Division of Public Health, the Division of Behavioral Health has been an active participant on the NSAEW since it was formed in March 2007. While several state agencies and entities currently conduct a number of assessment activities and surveillance systems to monitor major health indicators related to substance abuse, there remains a need to improve the state's coordination across systems or disciplines and analyze data at the sub-state (local) level.
For more details on NSAEW see Step 1 Prevention System Overview.

Within Nebraska, the treatment goals component is considered a duty of the State Advisory Committee on Substance Abuse Services (SACSAS), a committee managed by the Division of Behavioral Health, and not of the NSAEW. The SACSAS is authorized under State Statute and is appointed by the Governor. Under State Statute [§71-815(2)(b)] the SACSAS provides advice and assistance to the Division of Behavioral Health on the provision of substance abuse services in the State of Nebraska. By state statute, the SACSAS is a public meeting. The Division of Behavioral Health has used the SACSAS to review the Substance Abuse Prevention and Treatment Block Grant on a regular basis. The SACSAS is specifically used for the public hearing requirement of the Block Grant.

Required – Rural Area Services

Criterion 4: Targeted Services to Rural Populations

According to the U.S. Census Bureau, the Nebraska 2010 population is 1,826,341. Of that population, 59% (1,071,368) live in a Metropolitan Statistical Area. That means 41% (754,973) of the Nebraska population lives in a rural area.

The Division of Behavioral Health contracts with the six Regional Behavioral Health Authorities for community mental health and substance abuse services, including rural services. The Nebraska Behavioral Health Services Act, Neb. Rev. Stat. §§ 71-807 to 71-809 established the regional administration of the Nebraska Behavioral Health System.

Number of Person Served in State

Rural Areas - Individuals with mental and/or substance use disorders who live in rural areas, the non- Metropolitan Statistical Areas.

Number (#) of person served
Rural Areas - Individuals with mental and/or substance use disorders who live in rural areas.

	MH ONLY		SA ONLY		Dual ONLY		COMBO		TOTAL	
	Youth	Adult	Youth	Adult	Youth	Adult	Youth	Adult	Youth	Adult
FY2010	1,175	7,497	209	4,321	1	57	73	1,475	1,458	13,350
FY2011	1,121	7,568	166	3,781	1	54	24	1,546	1,312	12,949

	TOTAL	
	#	%
FY2010	14,808	41.10%
FY2011	14,261	40.30%

A discussion on Rural Areas starts with a review of Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Rural and Frontier Areas. Metropolitan Statistical Area is considered the

urban areas in Nebraska, which means the balance of the state is considered to be rural areas including the Micropolitan Statistical Areas and Frontier Areas.

Each Metropolitan Statistical Area or Micropolitan Statistical Area consists of one or more counties and includes the counties containing the core urban area, as well as any adjacent counties that have a high degree of social and economic integration (as measured by commuting to work) with the urban core.
- A Metropolitan area contains a core urban area of 50,000 or more population
- A Micropolitan area contains an urban core of 10,000 (but less than 50,000) population.

Source: http://www.census.gov/population/www/metroareas/metroarea.html

Metropolitan Statistical Areas (MSA) – population of 50,000 or more
In Nebraska, nine counties are designated as "Metropolitan Statistical Areas" by the U.S. Census Bureau. These counties include:

- Region 6 – Douglas (includes Omaha), Sarpy, Cass, Saunders, and Washington; (Sarpy County includes Offutt Air Force Base in the Omaha, NE—IA MSA)
- Region 5 – Lancaster (includes Lincoln), Seward
- Region 4 – Dakota (includes South Sioux City), Dixon

More than half of Nebraska's population now lives in metropolitan areas. Using the U.S. Census for 2010 shows the following:

Metropolitan Statistical Area: Omaha-Council Bluffs, NE-IA Metro Area		
Douglas County	517,110	
Sarpy County	158,840	
Cass County	25,241	
Washington County	20,234	
Saunders County	20,780	
Total NE part of Omaha-Council Bluffs Metro Area	742,205	41%
Metropolitan Statistical Area: Lincoln, NE Metro Area		
Lancaster County	285,407	
Seward County	16,750	
Total Lincoln, NE Metro Area	302,157	17%
Metropolitan Statistical Area Sioux City, IA-NE-SD Metro Area		
Dakota County	21,006	
Dixon County	6,000	
Total NE part of Sioux City Metro Area	27,006	1%

Nebraska 2010 census	1,826,341	
Total NE Population in Metropolitan Statistical Areas	1,071,368	59%
Total NE Population outside Metropolitan Statistical Areas	754,973	41%

Source: U.S. Census Bureau: State and County QuickFacts.
http://quickfacts.census.gov/qfd/states/31000.html
accessed on July 12, 2011

Micropolitan Statistical Areas (population of 10,000 to 49,999) counties in this category include:

1	Scottsbluff, NE	Scotts Bluff County
		Banner County

2	Lexington, NE	Dawson County
		Gosper County
	North Platte, NE	Lincoln County
		Logan County
		McPherson County
3	Grand Island, NE	Hall County
		Howard County
		Merrick County
	Hastings, NE	Adams County
		Clay County
	Kearney, NE	Buffalo County
		Kearney County
4	Columbus, NE	Platte County
	Norfolk, NE	Madison County
	Norfolk, NE	Pierce County
	Norfolk, NE	Stanton County
5	Beatrice, NE	Gage County
6	Fremont, NE	Dodge County

http://en.wikipedia.org/wiki/Table_of_United_States_Micropolitan_Statistical_Areas

Required – MHSBG Priority Populations

Criterion 2: Mental Health System Data Epidemiology Estimate of Prevalence

- Adults with Serious Mental Illness (SMI)
- Children with Severe Emotional Disturbance (SED)

For the purposes of the MHSBG, this is the Operational Definition for SMI and SED. The method is used for preparing the Uniform Reporting System (URS) Table 14A. (Profile of Persons with SMI/SED served by Age, Gender and Race/Ethnicity). The estimates of prevalence of Adults with Serious Mental Illness (SMI) and Children with Severe Emotional Disturbance (SED) in Nebraska were prepared by the State Data Infrastructure Coordinating Center; NASMHPD Research Institute, Inc. (NRI), National Association of State Mental Health Program Directors (NASMHPD), under contract with the Center for Mental Health Services (CMHS), contract no. 280-99-0504. July 06, 2010. http://www.nri-inc.org/projects/SDICC/urs_forms.cfm
Accessed on July 13, 2010

NE State SMI Definition (Adults):

1. An Axis diagnosis codes between 295-298.9 **AND**
2. Functional impairment:

→ GAF score= 1-59 **OR**

→ SSI/SSDI eligible **OR**

→ were admitted to a Community Mental Health Rehabilitation Based Services: Community Support, Assertive Community Treatment, Psychiatric Residential Rehabilitation, Day Treatment, Day Rehabilitation, Day Support, Vocational Support, or related psychiatric rehabilitation services

Step 2: Identify the Unmet Service Needs And Critical Gaps Within The Current System / Page | 22

Federal Center for Mental Health Services (CMHS) Used for Uniform Reporting System (URS)
URS Table 1: Number of Persons with Serious Mental Illness, age 18 and older, by State, 2009

	Civilian Population	Civilian Population	Lower Limit	Upper Limit
State	Age 18+ Population 2009	with SMI (5.4%)	of estimate (3.7%)	of estimate (7.1%)
Nebraska	1,338,132	**72,259**	49,511	95,007

For Adults, the Adult SMI rate was defined by CMHS/SAMHSA as 5.4% of the adult civilian population of each state. The spreadsheet uses the latest (2009) Civilian Population data.

Adults with Serious Mental Illness (SMI)

	MH ONLY	Dual ONLY	COMBO	SMI TOTAL	Estimate of Prevalence	Penetration Rate (SMI Total)
FY2010	13,134	89	301	13,524	**72,259**	19%
FY2011	13,878	103	327	14,308	**72,259**	20%

1. data source: Community Behavioral Health (Magellan data extract), NE Division of Behavioral Health
2. COMBO contains the following combinations of services: a) MH & SA; b) MH & DUAL; c) SA & DUAL; d) SA & MH & DUAL
3. #s in the MH only, SA only and Dual only columns indicate that only this type of services received during the entire FY10.
3. Youth = 0-17; Adult = 18+
4. methods used to pull SMI and SED population are the same as for FY2010 URS table 14

Children with Severe Emotional Disturbance (SED)

1. Age 3-17 **AND**
2. One of the following Axis diagnosis codes 314.00, 314.01, 314.9, 295.xx, 295.4, 295.7, 297.1, 297.3, 298.8, 298.9,296.0x, 296.4x, 296.5x, 296.6x, 296.7, 296.80, 296.89, 296.90, 301.13, 296.2x, 296.3x, 300.01, 300.21, 300.30, 307.1, 307.51, 309.81, 312.34, 307.23 **AND**
3. Functional Impairment:

→ SSI/SSDI eligible **OR**

→ were admitted to one of the following programs: Professional Partner Services, Special Education Services, Day Treatment MH, Intensive OP – MH, Therapeutic Consultation/School Wrap, Respite Care – MH

URS Table 1: Number of Children with Serious Emotional Distrubances, age 9 to 17, by State, 2009
Estimates using 2008 Federal Poverty Rates

State	2009 Population of Youth Aged 9 to 17 [1]	Age 5 - 17 Percent in Poverty [2]	State Tier for % in Poverty	Level of Functioning Score=50		Level of Functioning Score=60	
				Lower Limit	Upper Limit	Lower Limit	Upper Limit
Nebraska.....	215,800	13.40%	Low	10,790	15,106	19,422	23,738
				12,948		**21,580**	

The Children's SED rate uses two data sets from the Census Bureau (Civilian Population and the Percent of Children Living In Poverty). The latest Census Bureau data on percent of children in poverty shows an increase in the number of children living in poverty due to the economic downturn—as a result there are more changes in state estimates of the prevalence in children with SED than the adult estimates.

Children with Severe Emotional Disturbance (SED)

FY2010	Community BH Data MH ONLY	Estimate of Prevalence	**Penetration Rate**
AGE 9-17	1,311	21,580	6.1%
AGE 3-17	1,654		
FY2011			
AGE 9-17	1,364	21,580	6.3%
AGE 3-17	1,651		

Professional Partner Program (PPP)

As noted under Step 1: Assess the strengths & needs of service system, the Professional Partner Program (PPP) is based on the wraparound approach for services and has been recognized as a key component in access to systems of care for Nebraska children with mental health disorders and their families. There is a PPP in each of the six Regional Behavioral Health Authorities. The program embraces a family-centered philosophy and acknowledges families as equal partners. Here's the PPP unduplicated number of person served in FY2011 by Region.

Professional Partner Program (PPP) / Persons Services FY2011

Region	# of person served
1	90
2	70
3	247
4	152
5	182
6	327
Total	1,068

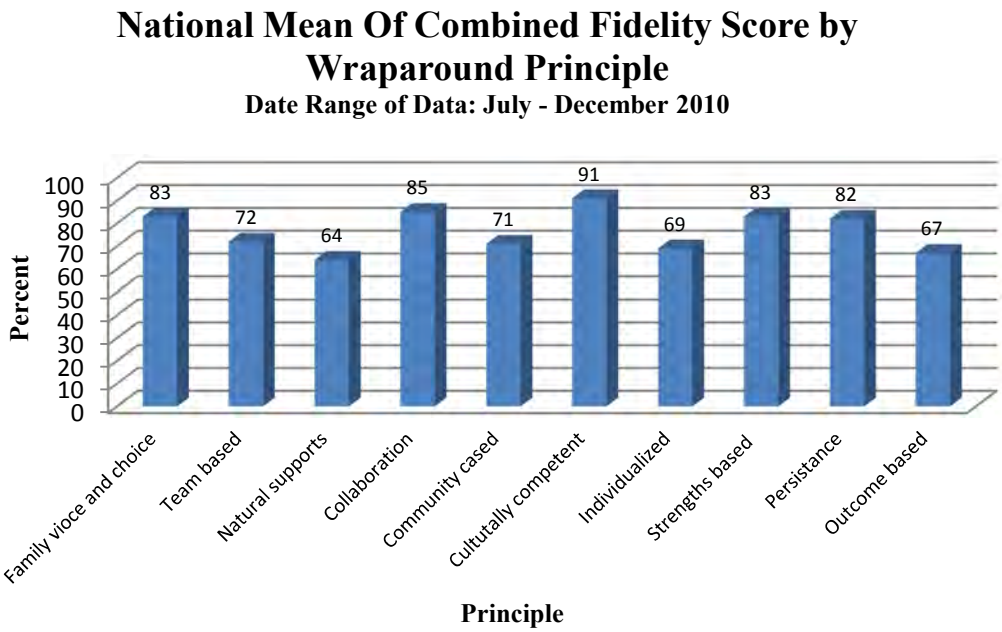
Source: Magellan July 2011 data extract

GAP: Valid and Reliable Evaluation of the Professional Partner Program: As the majority of funding for Children's Mental Health Services is targeted to the Professional Partner Program, attempts to evaluate the effectiveness of the program in achieving positive outcomes for children and families have been attempted. Each program submits data to the Division on a regular basis: the Child and Adolescent Functional Assessment Scale, Ohio Scales, Graduation Checklist, Wraparound Fidelity instrument as well as other standardized tools. In 2010, an analysis of the data had been attempted using funding from the State Infrastructure Grant for Children's Mental Health (Source: The Infrastructure of Evaluation in Children's Behavioral Health, Submitted by: Kenneth W. Gallagher, Research Coordinator, Center for At-risk Children's Services University of Nebraska—Lincoln). However, the evaluator identified several challenges in his report, and concluded there was insufficient data infrastructure in which to evaluate the program:

- Data was not submitted/Incomplete data submitted
- Data was submitted as paper records/text documents
- Aggregate data report submitted
- Data submitted as (separate) spreadsheets
- Data bases/spreadsheets submitted with incompatible formats

Wraparound is a family-driven, youth guided, team-based process for planning and implementing services and supports. Through the wraparound process, teams create plans that are geared toward meeting the unique and holistic needs of children and youth with complex needs and their families. The wraparound team members (e.g., the identified youth, his or her parents/caregivers, other family members and community members, mental health professionals, educators, and others) meet regularly to implement and monitor the plan to ensure its success.

The Wraparound Fidelity Assessment System (WFAS) is a multi-method approach to assessing the quality of individualized care planning and management for children and youth with complex needs and their families. WFAS instruments include interviews with multiple stakeholders, a team observation measure, a document review form, and an instrument to assess the level of system support for wraparound. The Regions collect the Wraparound Fidelity Instrument (WFI) version 4 via Access database.



State Priority 6 - Professional Partners Program

Transition Age Youth and Young Adult

Some youth need assistance as they transition from the youth service system of care into adult services. Specific initiatives are useful to ensure continuity of care for youth who are Ages 16-24.

The target populations are youth who are significantly impaired by serious mental illness and/or substance use disorders. These individuals experience functional impairments, disruption or

limitations in social skills, vocational/educational skills, and activities of daily living and need ongoing behavioral health services to live safely in a community setting and reduce the risks associated with transitioning to the adult behavioral health system. The goal is to facilitate coordination and referral to adult behavioral health supports and services.

The vocational part is also discussed under the Employment section. The Transition Age Supported Employment is designed to assist young people who experience a mental health disorder find and keep competitive employment within their communities. The program serves youth who are within two years of completing high school (ages 16-19). This is a service in Region 3. It is a partnership between Goodwill Industries, Vocational Rehabilitation and the Grand Island Public Schools.

The following is the funding levels from FY2011 in this area.

	Budgeted FY11	Billed FY11
Region 1		
Community Support - Youth Transition Program - WCHR	$39,211.00	$24,682.00
Community Support - Youth Transition Program - Cirrus	$39,210.00	$25,800.00
Region 3		
ERCS Transitions Youth	$105,759.00	$111,149.27
Professional Partners - Transition	$96,493.00	$100,513.75
Transition Age Supported Employment	$37,727.00	$37,727.00
Region 5		
Transition Age Professional Partner	$196,365.00	$202,430.16
Regional Totals FY2011	**$514,765.00**	**$502,302.18**

Transition Age Youth and Young Adults (Ages 16-24)

Person Served In FY2010	**MH ONLY**		**SA ONLY**		**Dual ONLY**		**COMBO**	
AGE 16-18	**Youth**	**Adult**	**Youth**	**Adult**	**Youth**	**Adult**	**Youth**	**Adult**
Female	182	136	126	158	0	1	18	16
Male	233	149	228	291	0	0	38	27
Total	415	285	354	449	0	1	56	43
AGE 19-24								
Female		1,221		1,042		4		227
Male		1,193		2,652		6		291
Total		2,414		3,694		10		518
Total Combined Age 16-24	415	2,699	354	4,143	0	11	56	561
Total # of person served	2,598	16,826	511	12,757	1	86	100	3,132

Person Served in FY2011	**MH ONLY**		**SA ONLY**		**Dual ONLY**		**COMBO**	
AGE 16-18	**Youth**	**Adult**	**Youth**	**Adult**	**Youth**	**Adult**	**Youth**	**Adult**
Female	211	118	115	123	0	0	4	17
Male	211	161	162	209	0	0	18	20
Total	422	279	277	332	0	0	22	37

AGE 19-24								
Female		1,184		963		3		202
Male		1,177		2,296		3		282
Total		2,361		3,259		6		484
Total Combined Age 16-24	422	2,640	277	3,591	0	6	22	521
Total # of person served	2,341	17,407	418	11,819	1	84	38	3,279

Transition Age Youth and Young Adults (Age 16-24) / Number of Persons Served.
Persons Served in FY2010 & 2011

Population	**TOTAL 2010**		**TOTAL 2011**		
AGE 16-18	**#**	**%**	**#**	**%**	
Female	637		588		
Male	966		781		
Total	1,603	4.45%	1,369	3.87%	percent of total persons served
AGE 19-24					
Female	2,494		2,352		
Male	4,142		3,758		
Total	6,636	18.43%	6,110	17.27%	percent of total persons served
Combined Age 16-24					
Female	3,131	38%	2,940	39%	% of total transition age youth / yg adults
Male	5,108	62%	4,539	61%	% of total transition age youth / yg adults
Total	8,239	22.88%	7,479	21.13%	percent of total persons served
Total # of person served	36,011		35,387		

State Priority 5 Transition Age Youth and Young Adult

Youth (age 16 - 18) … Young Adult (age 19 - 24)

Although there are a large number of gaps and needs in this area, we have identified the following priority:

Lack of developmentally appropriate services
Regions identified a lack of developmentally appropriate programs for young adults within the adult service systems. Youth who do qualify for adult services are often put into programs that are geared toward older adults. The youth that attend these programs generally find them unappealing. As one interviewee commented "they're [adult programs] used to serving a population that's 35 to 55 and you've got these 19 and 20 and 21 year olds in there, and they want to listen to music and play video games. They're totally different, and they're bouncing and bouncing instead of sleeping in the chairs. They [adult programs] don't know what to do with them." One interviewee suggested that some of the adult programs just need to be "tweaked" so that they match the needs of younger adults: "It's a matter of, your service programs and day programs just changing your programming a little bit; changing your vocabulary a little bit. Those aren't things that cost a lot more money. Just redirecting what you've already got so that you have some that is maybe geared toward the older adults and some that is geared toward the young adults." Other suggestions included having specific groups, classes, AA/NA meetings, etc, that are just for young adults.

Source: Statewide Review: Regional Behavioral Health Transition Teams DRAFT October 2008

Required – Workforce Issues

- Criterion 5: Management Systems - Describe staffing for mental health services providers necessary for the plan
- SAPTBG - Goal #11: Continuing Education

Behavioral Health workforce issues are very complex. In order to have a quality behavioral health services in Nebraska, there needs to be an adequate supply of workers. Those qualified workers need to be reasonably distributed across the rural and urban communities in the State.

Behavioral Health Education Center of Nebraska (BHECN) at the University of Nebraska Medical Center is to support the recruitment, retention and competency of the Nebraska behavioral health workforce by providing education and training in evidence-based practice, interprofessional collaboration, and use of behavioral telehealth services to expand outreach and serve the people of Nebraska. For more information on BHECN see http://www.unmc.edu/bhecn/.

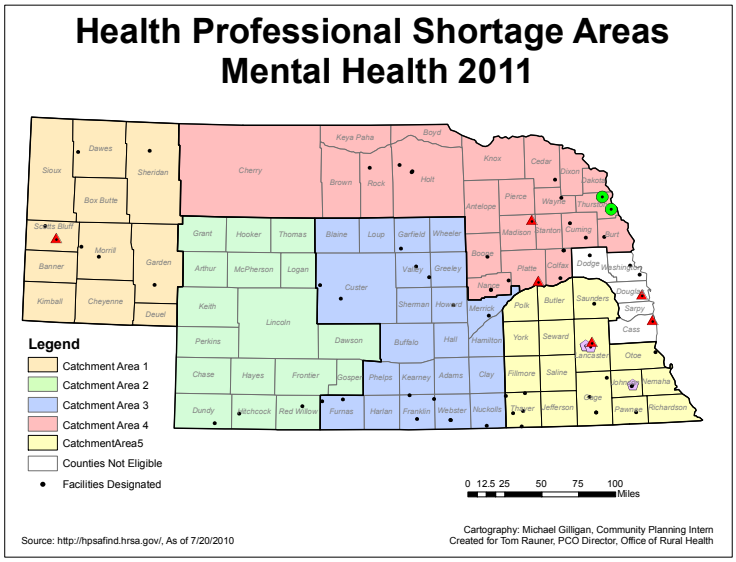
NE Division of Behavioral Health - Strategic Planning For Nebraska's Behavioral Health System - Final (2011 – 2015)

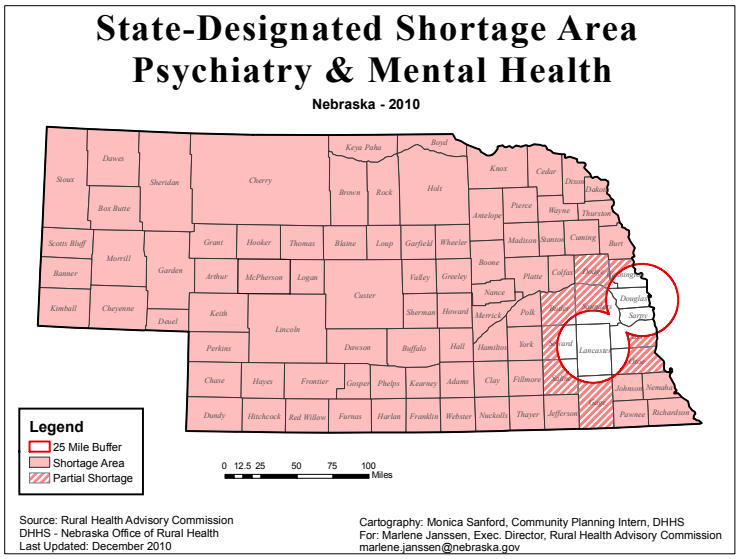
Goal # 1. The public behavioral health workforce will be able to deliver effective prevention and treatment in recovery-oriented systems of care for people with co-occurring disorders.

Mental Health Professional Shortage Areas

Below is the *Health Professional Shortage Areas Mental Health 2011* map and the *State-Designated Mental Health Shortage Area – Psychiatry and Mental Health - Nebraska 2010* map. Three complete counties (Douglas, Sarpy and Lancaster) are not designated shortage areas. Eight counties are designated partial shortage areas. The remaining 82 Nebraska counties are designated shortage areas.

Source: Nebraska Department of Health and Human Services Office of Rural Health, http://www.dhhs.ne.gov/orh





For more information on these Health Professional Shortage Areas contact:
Thomas Rauner, Primary Care Office (PCO) Director
NDHHS Division of Public Health - Office of Rural Health, Lincoln, NE
Phone: (402) 471-0148 email: thomas.rauner@nebraska.gov

Source: Nebraska Department of Health and Human Services Office of Rural Health, http://www.dhhs.ne.gov/orh
Updated July 13, 2011

Nebraska Behavioral Healthcare Professionals by Region
Following is a summary of the supply of Nebraska behavioral health professionals by Region (including Psychiatrists, Advanced Practice Registered Nurses and Physician Assistants). This table was prepared by the Health Professions Tracking Service - University of Nebraska Medical Center, Omaha, NE.

Actively Practicing Licensed Behavioral Health Professionals, by Primary Practice

	Regions						
Professions	**One**	**Two**	**Three**	**Four**	**Five**	**Six**	**Total**
Psychiatrist	2	3	9	6	30	97	147
Advanced Practice Registered Nurse	4	0	11	5	13	33	66
Physician Assistant	0	0	2	2	3	3	10
Alcohol & Drug Counselor	11	4	18	13	37	47	130
Mental Health Practitioner	28	29	121	70	227	429	904
Independent Mental Health Practitioner	9	26	51	19	137	215	457
Psychologist	9	6	21	17	113	132	298
Certified Compulsive Gambling Counselor	0	0	0	0	6	0	6
Single License Subtotal	**63**	**68**	**233**	**132**	**566**	**956**	**2,018**
Dual License Subtotal*	**8**	**12**	**40**	**23**	**56**	**105**	**244**
Multiple License Subtotal*	**0**	**0**	**0**	**2**	**1**	**0**	**3**
Total	**71**	**80**	**273**	**157**	**623**	**1,061**	**2,265**
Percent by Region	*3%*	*4%*	*12%*	*7%*	*27%*	*47%*	

* Dual and Multiple License holders include combinations of Advanced Practice Registered Nurse, Mental Health Practitioner, Independent Mental Health Practitioner, Alcohol & Drug Counselor, Psychologist and Certified Compulsive Gambling Counselor.
Source: Health Professions Tracking Service - University of Nebraska Medical Center, Omaha, NE – July 2010

Languages Spoken and Served

Languages Spoken
All the Behavioral Health professionals report speaking English. In addition, 85 professionals report speaking languages other than English fluently. The following chart identifies the languages and counts of professionals who indicate fluency in each language. (11)

Non-English Language Fluency

Non-English Language Fluency	Physicians, Advanced Practice Registered Nurses and Physician Assistants	All Other Behavioral Health Professionals	Total
Spanish	5	31	36
Sign Language	0	15	15
French	1	7	8
German	2	5	7
Hindi	6	0	6
Chinese	2	2	4
Arabic	2	1	3
Panjabi (India)	4	0	4
Polish	1	2	3
Urdu (India)	3	0	3
Korean	1	1	2
Russian	0	2	2
Farsi	0	1	1
Filipino	1	0	1
Greek	0	1	1
Hebrew	0	1	1
Italian	1	0	1
Japanese	0	1	1
Portuguese	0	1	1
Telugu	1	0	1

Source: UNMC Health Professions Tracking Service – 2010

Languages Offered through Interpreter

Eight hundred and fourteen (814) professionals report serving clients who speak languages other than English. Various methods of interpretation are used to communicate with clients; self interpretation, outside interpreter sitting in the session and phone interpreter services. The following charts indicate the counts of professionals who report access to each method and the languages offered.

Interpretation Services	Physicians, Advanced Practice Registered Nurses and Physician Assistants	All Other Behavioral Health Professionals	Total
Serves people who speak languages other than English	75	739	814
Self Interpreter	6	62	68
Qualified outside interpreter sitting in the session	63	605	668
Phone interpreter service	22	115	137

Languages Served	Physicians, Advanced Practice Registered Nurses and Physician Assistants	All Other Behavioral Health Professionals	Total
Spanish	37	404	441
Sign (ASL, etc.)	10	127	137
Arabic	3	26	29
Vietnamese	1	22	23
French	1	8	9
German	1	7	8
Nuer	0	8	8
Sudanese	1	7	8
Farsi	0	7	7
Kurdish	0	6	6
Dinka	0	5	5
Russian	0	5	5
African Dialects	0	2	2
Chinese	1	1	2
Hindi	2	0	2
Korean	1	1	2
Native American	0	2	2
Swahili	1	1	2
Thai	0	2	2
Afrikaans	0	1	1
Asian	0	1	1
Belarusian	0	1	1
Bosnian	0	1	1
Dakota	0	1	1
Dutch	0	1	1
Georgian (Kartuli)	0	1	1
Greek	0	1	1
Hebrew	0	1	1
Japanese	0	1	1
Karudi	0	1	1
Lakota Sioux	0	1	1
Laos	0	1	1
Mandari	0	1	1
Nepali	0	1	1
Polish	0	1	1
Portuguese	0	1	1
Somalia-Nor	0	1	1
Somlian	0	1	1
Street Slang	0	1	1
Various	6	42	48

Source: UNMC Health Professions Tracking Service – 2010

The Nebraska Behavioral Health Services Act defines Behavioral health disorder as mental illness or alcoholism, drug abuse, problem gambling, or other addictive disorder [Neb. Rev. Stat. §71-804(1)]. To provide problem gambling services, a qualified workforce is required. The table below shows the Compulsive Gambling Counselors by Region, as reported by the UNMC Health Professions Tracking Service.

Actively Practicing Certified Compulsive Gambling Counselor, by Primary Practice Region

Profession: Certified Compulsive Gambling Counselor	One	Two	Three	Four	Five	Six	Total
Single License: Certified Compulsive Gambling Counselor	0	0	0	0	6	0	6
Dual License / Multiple License							
Alcohol & Drug Counselor, Certified Compulsive Gambling Counselor	0	0	0	0	1	0	1
Mental Health Practitioner, Certified Compulsive Gambling Counselor	0	0	0	1	0	3	4
Independent Mental Health Practitioner, Certified Compulsive Gambling Counselor	0	1	0	0	1	1	3
Psychologist, Certified Compulsive Gambling Counselor	0	0	0	0	1	0	1
Alcohol & Drug Counselor, Mental Health Practitioner, Certified Compulsive Gambling Counselor	0	0	0	1	0	0	1
Alcohol & Drug Counselor, Independent Mental Health Practitioner, Certified Compulsive Gambling Counselor	0	0	0	1	1	0	2
Totals	0	1	0	3	10	4	18

Source: Health Professions Tracking Service - University of Nebraska Medical Center, Omaha, NE – July 2010

Plans to Increase the Number of Individuals with Basic Competencies in BH Service Delivery

The Behavioral Health Education Center of Nebraska (BHECN) was established in July of 2009 in response to a directive handed down from the Nebraska Legislature to reform the state's behavioral health educational system. The Behavioral Health Education Center of Nebraska was given the urgent charge of developing the education and training of the state-wide behavioral health care workforce to meet the needs of all Nebraskans through a new, inter-disciplinary behavioral healthcare educational model. The Behavioral Health Education Center of Nebraska is an evolving, collaborative effort that spans professions and partners, linking institutions and traversing distance across a continuum of services. The Behavioral Health Education Center of Nebraska is collaborating with the six Behavioral Health Regions.

The Behavioral Health Education Center of Nebraska is a consortium of partners, including the members of academic institutions, behavioral health professionals, community-based providers, peer support providers, consumers and their family members. The Behavioral Health Education Center of Nebraska is creating new curricula, upgrading the competency of the behavioral health workforce and providing training in an interdisciplinary manner. This collegial, collaborative approach will provide dynamic learning modules that allow current practitioners to quickly receive up-to-date information on evidence-based practices, which will enable and assist them in providing the best behavioral health care possible for patients/consumers throughout Nebraska. The Division of Behavioral Health is in active collaboration with the Behavioral Health Education Center of Nebraska. The Behavioral Health Education Center of Nebraska is appropriated 1.5 million dollars.

Nebraska uses Peer Support for the Behavioral Health System. At this time, the Office of Consumer Affairs within the Division of Behavioral Health reports 85 peers are employed as part of the workforce within the Nebraska Behavioral Health System. Adding in the contracted family peer

supports that represent the parents/caregivers of youth with behavior disorders, this number climbs to over 100.

SAPTBG Goal #11: Continuing Education: The Division of Behavioral Health contracts with the Lincoln Medical Education Partnership (LMEP) "Training for Addiction Professionals (TAP)" program for $175,000 to provide Core and Continuing Education courses that meet the educational requirements for Licensed Alcohol and Drug Counselors (LADCs).

There are more videoconferencing systems available today than ever before. The challenge is how to develop strategies to effectively use this capacity. Telemedicine Practice in Psychiatry and Behavioral Health is currently underutilized. Strategies to address the billing issues, ways for psychiatrists and other providers to collaborate and provide quality care for people in shortage areas, and related issues would be very useful. In addition, standard screening and referral practices, co-occurring treatment, a jointly trained workforce, and accessible technology will be critical components of a holistic health care approach.

SAPTBG - Goal #11: Continuing Education
State Priority 2 Consumer Workforce

Consumer Workforce

As noted above, most of Nebraska is officially designated as a Mental Health Professional Shortage Area. Only three counties (Douglas, Sarpy and Lancaster) are not designated shortage areas.

Peer Support is an intentional learning relationship from which both parties learn and grow. Peer support is a movement toward community relationship building and expanding an individual's world view. It is based on strengths and positive risk taking to create new healthy relationships. As trust in a peer support relationship builds, both people are able to respectfully challenge each other. The peer utilizing the services is able to develop new relationships with others in the community as a result.

The Office of Consumer Affairs has developed standards for Peer Support and Wellness Specialist training, certification, co-supervision, and continuing education standards. The training is currently funded by the Olmstead grant. As of July 28, 2011 the Office of Consumer Affairs has certified 17 Peer Support and Wellness Specialists. One class has been tested with a 74% pass rate.

Consumer Run Organizations have a 51% consumer run board and non-clinical management. The Mental Health Association of Nebraska manages a peer run hospital diversion program called Keya House. The Keya House offers a safe, supportive respite --up to five days -- for people who need to deal with escalating symptoms of their mental health illness. The program started in December 2009. After one year of operation, there were 116 people (unduplicated count) who used 1,313 guest days. After one year, the respite cost per day was $186. That compares to $600 per day at the Region V Crisis Center and $1,200 per day at the local hospital.

Regional Consumer Specialist
In addition, the State of Nebraska funds six (6) Consumer Specialist positions in the six (6) Regional Behavioral Health Authority offices across the state. The Regional offices administer the behavioral health services in their respective Regions. At the Regional level, the Consumer

Specialist participation is expected in the following areas of responsibility: Policy and Regulation Development; Program Planning, including Needs Assessment, Development and Delivery; Training and Technical Support; Financial Planning; Complaints and Grievances; Trauma-Informed and Recovery-Oriented Services; Connect with consumers to address specific needs through information and linkage to support systems; Individual and system advocacy; and Gather feedback regarding the service delivery system—supports and challenges; Participate at provider and/or other stakeholder meetings to raise awareness of the levels of consumer involvement.

The Division sponsors trainings for consumers/providers highlighting the recovery concept. For example, the Nebraska Statewide Conference, 'Success, Hopes & Dreams for the Future' occurred on May 25 and 26, 2011 at the Cornhusker Hotel, Lincoln NE. The Division of Behavioral Health Office of Consumer Affairs and the conference host, the Mental Health Association of Nebraska, the Region V Consumer Family Coalition and other Regional representatives sponsored the conference. The purpose of the conference was to look at and promote recovery as well as networking opportunities. Over 300 people attended the conference. Conference speakers included H. Westley Clark (Director, Center for Substance Abuse Treatment), Chris Hansen (from New Zealand on peer support and advocacy initiatives), Dr. Mary Pipher (therapist, writer and speaker), Amy Anderson (LADC and Director of Lighted Path Recovery Services in Seward, NE); and John McAndrew (Singer/songwriter and piano player) plus many breakout sessions.

There is no real baseline data available but the NE Division of Behavioral Health committees, stakeholders, and Strategic Plan address the need for growth. DBH is excited about the opportunity to improve its data collection on this important issue.

The Nebraska Legislature made this a priority for the State Advisory Committee on Mental Health Services under §71-814(2)(c) which states, "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."

At the May 3, 2011 joint meeting of the three NE Division of Behavioral Health committees commented on Peer Support Issues including having "Peer-lead" services, Importance / value of Peer Support, SA has established 'Peer' culture which can be replicated, and how Informal supports are needed.

State Priority 2 Consumer Workforce
State Priority 3 Peer Run Recovery Supports

Criminal Justice Involvement

SAMHSA's Strategic Initiatives
2. Trauma and Justice—Reducing the pervasive, harmful, and costly health impact of violence and trauma by integrating trauma-informed approaches throughout health, behavioral health, and related systems and addressing the behavioral health needs of people involved or at risk of involvement in the criminal and juvenile justice systems.
SAMHSA Uniform Block Grant FY 2012–2013 Block Grant Application – page 10

One of the SAMHSA National Outcome Measures (NOMs) involves Criminal Justice.

Outcome:	Decrease Criminal Justice Involvement
Mental Health Treatment:	Profile of Client Involvement in Criminal and Juvenile justice systems

Substance Abuse Treatment:	Change in percentage of clients with criminal justice involvement at discharge compared to the percentage at admission.
Substance Abuse Prevention:	Reduction in drug-related crime

The Division of Behavioral Health has view this Criminal Justice Involvement NOM as very important. For example, the Regional Budget Plan Guidelines (issued on January 14, 2011) included the following priority for FY 2012 and 2013:

#10. Collaborate with the Justice System to Improve Access to Behavioral Health Services

Nebraska Crime Commission / Arrest Data

Offense	**2006**	**2007**	**2008**	**2009**	**2010**	**Total**	Percent
Driving Under the Influence	13,528	13,532	13,989	13,662	12,614	67,325	14.93%
Liquor Laws	12,831	12,472	12,986	11,698	10,636	60,623	13.45%
Drug Abuse Violations	10,588	10,508	10,588	10,132	10,202	52,018	11.54%

Source: Information Services Division, Nebraska Commission on Law Enforcement and Criminal Justice (Nebraska Crime Commission) via "Arrest Data Query" web site.
http://www.ncc.ne.gov/statistics/data_search/arrest/arrest_crosstab.html
Data analysis by the NE Division of Behavioral Health
July 20, 2011

When the arrest categories of Driving Under the Influence, Liquor Laws, and Drug Abuse Violations are combined, they represent 39.9% of all arrests in Nebraska for the five year time period 2006 to 2010. "Liquor Laws" could be anything other than Driving Under the Influence (DUI) so it could range from manufacturing to procuring for a minor. It is a general category but the Nebraska Crime Commission does not have any other breakdowns.

Behavioral Health Inmates in the State Correctional System

One challenge in the State Behavioral Health System is offenders discharging from prison who need access to community based behavioral health services including psychiatric, mental health, substance abuse, and dual diagnosis treatment to address their needs.

A growing body of literature indicates that a significant percentage of inmates in state prison are mentally ill. A commonly cited estimate is that about 16 percent of inmates in state prisons have a mental illness. The rate of mental illness among female prisoners has been estimated to be much higher. A recent study found that the prevalence of adults with serious mental illness in jails to be three to six times that of that of the general population (NCJA citation).

Source: Justice Center at the Council of State Governments; June 1, 2009 - New Study Documents High Prevalence of Serious Mental Illnesses among Nation's Jail Populations; accessed on July 20, 2010
http://ncja.informz.net/admin31/content/template.asp?sid=15214&brandid=3027&uid=751049109&mi=537980&ptid=55

Table 1 shows the rates of mental illness diagnosed at Nebraska state correctional intake facilities for the last seven fiscal years. The rate of mental illness in the Nebraska state prison system is somewhat higher than the national trend, even when the fact that the numbers represent intake figures only (i.e., new admissions) as opposed to being based on the total number incarcerated in the correctional system.

Please note that the state prison system is different from the county jail system. Many people are arrested and are sent to county jail facilities during the course of any given year, however only a

very small percentage of this group go on to state prison. The general criteria for state prison is commission of a felony and having a sentence of a year or longer.

Table 1: Rate of Diagnosed Mental Illness at Intake Made By NE Dept of Correctional Services

	FY2005		FY2006		FY2007		FY2008	
Number of inmates with mental illness	341	16%	645	25%	768	31%	949	40%
Total Intakes	2,121		2583		2,447		2,379	
	FY2009		FY2010		FY 2011			
Number of inmates with mental illness	656	29%	843	35%	824	32%		
Total Intakes	2,289		2,418		2573			

Note: Total is for all Axis I diagnoses exclusive of sole substance-related diagnoses. Includes data for adult males, adult females, and youthful offenders. Total number of intakes includes county safe keepers and ninety day evaluators.

Another indicator of the high rate of persons with mental illness in the state prison system is the number of inmates who are prescribed psychiatric medication. On June 30, 2011, 1191 inmates were on psychiatric medication which is about 26.5 percent of the inmate population. This rate represents a increase compared to the last fiscal year and may be due to variability in prescribers.

Table 2: Nebraska Department of Correctional Services Inmate Population With Prescribed Psychiatric Medications on One Day (Point in Time)

On June 30, 2005		Of June 30, 2006		on June 30, 2007		On June 30, 2008	
854	20.2%	871	19.4%	858	19.7%	817	18.7%

On June 30, 2009		On June 30, 2010		On July 30, 2011			
1,080	24.1%	907	20%	1191	26.5%		

The rate of individuals diagnosed with substance-related disorders at intake in the state prison system is significant and has remained fairly stable, but is slightly lower for the most recent fiscal year (see Table 3 below).

Table 3: Substance Related Diagnosis Made By Nebraska Department of Correctional Services Substance Abuse Staff at Intake

	FY2005		FY2006		FY2007		FY2008	
Inmate population with a substance abuse or dependence diagnosis	1,743	82%	1,372	89%	1,782	86%	1,741	89%
Number of inmates screened	2,121		1,538		2,081		1,967	

	FY2009		FY2010		FY 2011	
Inmate population with a substance	1,496	78.6%	1,477	76%	1,666	77%

abuse or dependence diagnosis						
Number of inmates screened	1,903		1,955		2,175	

A large number of inmates who were incarcerated for committing sexual offenses are discharged from NDCS each year. For example, during fiscal year 2011, 248 inmates who had committed a sexual offense were released. Of that number, 21, or about 8.5% were recommended by DCS staff for post incarceration mental health board hearings for possible civil commitment. The chart below summarizes the number of offenders who came from each of the State Behavioral Health Regions (i.e. they were sentenced in a county in that region) and the number who were recommended for possible civil commitment.

Table 4: Number of Sex Offenders Released and Recommended for Civil Commitment FY2011

Region	**I**	**II**	**III**	**IV**	**V**	**VI**	**Totals**
# Released	15	12	24	28	64	105	248
#Recommended	1	2	4	1	6	7	21

Finally, it is worth noting that the Nebraska Department of Correctional Services Behavioral Health consists of about 130 professionals including psychiatrists, mid-level psychiatric providers, psychologists, mental health practitioners, social workers, nurses, and drug and alcohol abuse counselors. The focus is to provide clinical treatment services to the priority populations including those with severe mental illness, violent offenders, substance dependent offenders, and sex offenders.

Source: Cameron S. White, Ph.D.; Behavioral Health Administrator, Nebraska Department of Correctional Services - Central Office, Lincoln, NE (7-18-11).

Based on the information above, it is worth noting that:

- According to NE Crime Commission data, basically 40% of the arrests between 2006 and 2010 were due to Driving Under the Influence, Liquor Laws, and Drug Abuse Violations combined.
- At time of admission in 2011, 77% of the State Prisons Inmate population had a substance abuse or dependence diagnosis.
- At time of admission in 2011, 32% of the State Prisons Inmate population were diagnosed with a Mental Illness at Intake
- On June 30, 2011, 26.5% of the State Prisons Inmate population was prescribed psychiatric medications.

The Nebraska Department of Health and Human Services (DHHS) Division of Behavioral Health (DBH), the Nebraska Commission on Law Enforcement and Criminal Justice (Crime Commission) and the Nebraska Department of Correctional Services (NDCS) worked with the Department of Epidemiology / College of Public Health at the University of Nebraska Medical Center (UNMC) on people with behavioral health problems that also come into contact with the criminal justice system. This joint project formally began in 2009 when the DHHS signed agreements with the Crime Commission and NDCS to use data from respective systems for analysis and

reporting. Planning and implementation of project activities were guided by representatives from these organizations and researchers from UNMC who provided technical assistance in data management, analysis, and report development.

Using data from a five year time period (January 2005 to December 2009), the characteristics of these individuals were examined and people were identified who were served by both behavioral health and criminal justice systems. The purpose of the preliminary report was is to provide information on a cohort of individuals who have been served by Nebraska's DHHS Division of Behavioral Health. A summary of the study can be found on the Web at http://www.dhhs.ne.gov/Behavioral_Health/. A Press Release titled "Study Shows Overlap of Behavioral Health and Criminal Justice Systems" was posted on April 21, 2011 http://www.dhhs.ne.gov/newsroom/newsreleases/2011/Apr/beh.htm. The project was funded through a grant from the Federal Center for Mental Health Services, State Mental Health Data Infrastructure Grants for Quality Improvement, awarded to the Nebraska Department of Health and Human Services, Division of Behavioral Health.

Nebraska Behavioral Health & Criminal Justice Joint Statistics Brief: April 2011
5-year (January 1, 2005-December 31, 2009) data. During this study time period:

Crime Commission - Jail Admission (persons served unduplicated count)	144,479	
Community Behavioral Health (persons served unduplicated count)	68,558	
Overlap Jail Admission and CBH	32,955	48%
Community Behavioral Health Consumers with No Jail Admissions	35,603	52%

NDCS State Prisons (persons served unduplicated count)	11,209	
DBH Community Behavioral Health (CBH) (persons served unduplicated count)	68,558	
Overlap State Prisons and CBH	3,682	5%
Community Behavioral Health Consumers with No Prison Admission	64,876	95%

The Division of Behavioral Health is challenged by finding suitable ways to report the SAMHSA National Outcome Measures (NOM) for Criminal Justice Involvement. The current approach uses a report on Criminal Activity (number of arrests in past 30 days) at time of admission, discharge or for the annual update (reported as two digits or unknown). There is confusion on what is to be reported by both the consumer and the provider asking the question. The data question requires additional clarification and change is needed to accurately address the National Outcome Measure (NOM).

Below is an example of the problems. Jail Admission Only (Yes), Corrections Admission Only (Yes), Jail & Corrections Admission (Yes) are data from the Crime Commission or State Corrections. Community Mental Health Data are from the Division of Behavioral Health (Magellan). The table below is preliminary analysis. What is worth noting is the 14% conflict rate. Out of the 15,515 persons in this study, 2,139 (14%) answered the question about criminal justice contact in conflict with what the actual data shows. Sometime the person reported a criminal justice contact when no admission data to jail or prison shows such contact. There are also cases where a jail or prison admission did occur however person did not report it. More study is needed on how best to report this.

Step 2: Identify the Unmet Service Needs And Critical Gaps Within The Current System / Page | 38

Unduplicated individuals within the Community Mental Health portion using URS Table 2A methods by self-reported status of Arrest Within The Past 30 Days (Yes) compared to Jail / Corrections Admission (Yes) data (Fiscal Year 2010 only).

	Community Mental Health Data					
	Yes		No		Total	
Criminal Justice Data	#	%	#	%	#	%
Jail Admission Only (Yes)	471	3%	1,276	8%	1,747	11%
Corrections Admission Only (Yes)	28	0%	88	1%	116	1%
Jail & Corrections Admission (Yes)	39	0%	69	0%	108	1%
No Jail or Corrections Admissions	706	5%	12,838	83%	13,544	87%
Total	1,244	8%	14,271	92%	15,515	100%

Conflicts with the question	2,139	14%

Source: Nebraska Division of Behavioral Health
Epidemiology Department, College of Public Health, University of Nebraska Medical Center June 27, 2011

There are Jail Diversion programs in Lancaster County, Douglas County and Buffalo County. These programs also are doing discharge planning for selected populations.

Under the Regional Budget Plan Guidelines for FY12 and FY13, there is a priority to have the Regional Behavioral Health Authority Collaborate with the Justice System to Improve Access to Behavioral Health Services.

These data support a number of the Priorities including: SA Prevention – underage drinking alcohol, SA Prevention – Driving Under the Influence, MH Child – Transition Age Youth (age 16 - 18) into adult services as well as MH Adult – Young Adult (age 19 - 24) services, Improve the Permanent Supportive Housing services available, Improve Supported Employment Evidence-Based Practices .

Nebraska Prevention Workforce Survey 2011

StatewideTotals n=65

1. Do you work on a volunteer or paid basis in Prevention?		
	Volunteer	36%
	Paid	61%
	Missing	3%
2. Do you work full-time or part-time in Prevention?		
	Part-time	74%
	Full-time	23%
	Missing	3%
3. How many hours per month do you work in Prevention?		
	Average Hours per month	49.57
	Missing	4
4. How many Years have you worked in Prevention?		
Average Number of years		7.8
6a. Do you work with a Prevention coalition? (YES)		88%
7a. Do you work for a Prevention provider? (YES)		27%
8. what is the highest level of education you have completed?		
	Less than high school	4%
	High school diploma or G.E.D.	4%
	Some college	24%
	Bachelor's degree	31%
	More than a Bachelors degree	36%
9. In 2010, approximately how many hours of Prevention training did you completed?		
	Average hours of training	30.52

Source: Nebraska Prevention Workforce Survey – 2011; Department of Health and Human Services, Division of Behavioral Health, Lincoln NE 2011

Sixty five individuals completed the Nebraska prevention Workforce Survey. The Table above provides the statewide totals of the responses to 9 of the 16 survey questions. Other questions dealt with the perception of the status of the Regional Prevention Networks, the training and technical assistance provided by those entities. Of the 65 respondents, 57% (37) reported being a parent, and 73% (47) indicated they were coalition members (question 5). The professional work force in prevention is composed of the DHHS Division of Behavioral Health prevention staff; the DHHS Division of Public Health Strategic Prevention Framework-State Incentive Grant (SPF-SIG) program staff; the Regional Behavioral Health Authorities Prevention Coordinators (most of whom are devoted 80% or greater of their time to prevention activities) and their staffs; prevention orientated agencies (including local health departments): Mothers Against Drunk Driving (MADD) chapter and other specialized service orientated entities; and Community Coalitions. In 2005 the Division of Behavioral Health began directly defunding specialized prevention organizations and began funding community coalitions. This change in funding was brought about as a result of an analysis of the effectiveness of prevention programming and a move by the federal government to fund community based and environmental strategies through evidence based programming. Since that initial move the Division has continued to strengthen the position of the Regional Behavioral Health Authorities through continued funding and staff training. The survey was provided to community coalitions funded by the Regional Behavioral Health Authorities.

Sixty one percent of the respondents report they are paid (questions 1), but most of the staff at the community level is part time (question 2). Many of the 32 community coalitions have volunteer boards. Various funding sources exist for prevention including Drug Free Communities (12 coalitions), SPF-SIG funded entities (16 coalitions) and through the community dollars provided by the Regional Behavioral Health Authorities (32 coalitions). In most cases a coalition has more than one funding source, with the largest community coalitions having funding from many of the source identified, as well as community funding and having a paid professional staff of at least a community coordinator/educator. There is a great need for additional community, multi community and multi county prevention efforts and staffing (either volunteer or paid) to foster additional emphasis toward the institutionalization of the substance abuse prevention effort. Of the 93 counties and 525 communities in the state of Nebraska, and among the various sub communities within those municipal and county locations there are many that have yet to benefit by funds from any of the sources identified.

Required – Prevention

Perception of "Great Risk" in Substance Abuse

Table 13 Percentage of Nebraska and Monitoring the Future Respondents Who Perceive that Using the Five Categories of Substances Places People at "Great Risk"

Question	Nebraska 6th Grade			Nebraska 8th Grade			8th Grade MTF	Nebraska 10th Grade			10th Grade MTF	Nebraska 12th Grade			12th Grade MTF
	2003	2005	2007	2003	2005	2007	2007	2003	2005	2007	2007	2003	2005	2007	2007
Smoke one or more packs of cigarettes per day	70.2	65.3	67.9	71.0	64.1	70.4	61.1	68.9	62.2	69.2	69.2	66.8	62.2	65.0	77.3
Try marijuana once or twice	48.0	43.4	45.8	42.7	39.4	44.0	32.8	30.2	24.9	29.0	22.2	22.8	17.8	20.8	18.6
Smoke marijuana regularly	82.3	78.6	78.9	81.7	78.0	79.9	74.3	88.1	84.3	88.5	84.5	58.9	53.7	52.8	54.8
Drink one or two alcoholic beverages nearly every day	45.5	41.2	42.8	40.2	36.7	38.0	32.6	32.7	29.1	33.5	33.3	30.0	27.1	28.4	25.1
Used Methamphetamines	83.6	82.0	79.9	88.6	86.6	87.5	—	91.0	88.5	89.1	—	92.5	91.4	89.8	—
Take prescription drugs without a doctor's permission	—	—	60.4	—	—	62.5	—	—	—	58.8	—	—	—	55.5	—
Use inhalants once or twice	—	—	52.7	—	—	56.8	35.9	—	—	56.8	43.0	—	—	58.8	—
Use other drugs not listed above	—	—	72.0	—	—	72.9	—	—	—	69.3	—	—	—	68.1	—

** Cells containing the — symbol indicate an area where data is not available because the question wasn't asked in the 2003 or 2005 survey, or where the MTF Data was not comparable.

Source: Nebraska Risk and Protective Factor Student Survey (NRPFSS) 2007; Bach Harrison, L.L.C., July 2008, Nebraska Department of Health and Human Services.

The Nebraska Risk and Protective Factor Student Survey that was conducted in the fall of 2010 will provide excellent data for monitoring underage drinking and other youth substance abuse issues however data has not yet been released. While alcohol misuse is a cause for concern among people of all ages, it's particularly concerning for young adults who tend to be the most likely age group to misuse alcohol and suffer the consequences. Previous surveys conducted in 2003, 2005 and 2007 student attitudes toward use of Tobacco, Marijuana, Drinking, Methamphetamines, Prescription

Drugs, inhalants, and other drugs suggests that younger students perceive a greater risk than do older students. This may be due to a number of factors including the fact that as young people get older they have occasion to befriend people with differing attitudes toward substance use and abuse. Overall, the drug of choice of adolescents is alcohol.

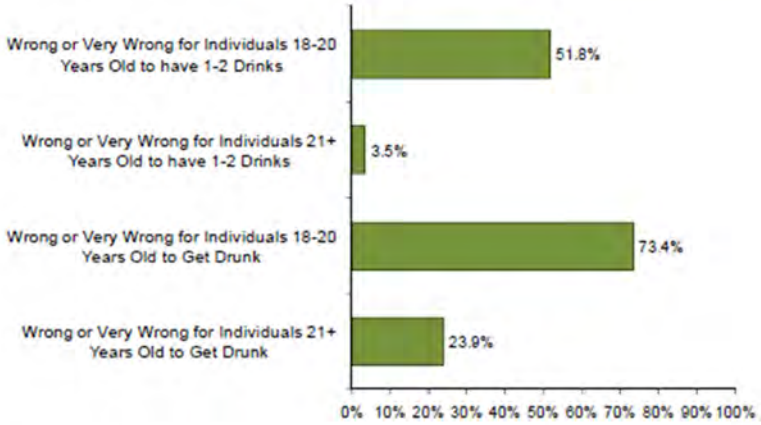
According to the Behavioral Risk Factor Surveillance System, binge drinking among Nebraska adults aged 18 and older has remained relatively stable over the past 20 years and consistently higher than national estimates. In 2009-2010 Nebraska conducted a Young Adult Alcohol Opinion Survey. Young adults for this survey included a sample of 18-25 year olds. The survey asked opinions on alcohol use including the attitudes and perceptions relate to alcohol among 19-25 year olds in Nebraska. Results indicated that alcohol is the substance with the highest rate of abuse or dependence among both adolescents and young adults (4.6 and 16%, respectively).

Among past month alcohol users, nearly two-thirds (64.8%) reported binge drinking during the past month, indicating that the majority of 19-25 year old drinkers in Nebraska binge drink. More than 7 in every 10 young adults (71.7%) who perceived no risk from binge drinking once or twice a week reported past month binge drinking compared to less than one-fourth (22.3%) who perceived great risk from this behavior. And while 73.4% of the respondents reported it is wrong or very wrong for individuals' aged 18-20 years old to get drunk, compared to 1 in every 4 (23.9%) who felt that the same behavior was wrong or very wrong for persons 21 and older. This suggests that among 19-25 year olds, underage drinking is less acceptable than alcohol use among persons 21 and older; although, half (48.2%) still condoned drinking among 18-20 year olds (by indicating that it is only a little wrong or not at all wrong for 18-20 year olds to have one or two drinks).

Attitudes and Perceptions Related to Alcohol among 19-25 year olds in Nebraska

- Nearly all (96.4%) perceived some risk from binge drinking once or twice a week though only one-third (32.1%) saw great risk from this behavior.
- Both moderate alcohol use (having one or two drinks) and getting drunk were seen as much more wrong for persons just under the legal drinking age (18-20 year olds) compared to those at or above the legal drinking age (21 and older) (Figure 2). These results suggest that, among young adults, underage drinking is seen as far less acceptable than legal age drinking; however, half (48.2%) still condoned drinking among 18-20 years olds (by indicating that it is only a little wrong or not at all wrong for 18-20 year olds to have one or two drinks).

Figure 2: Social Norms Related to Underage and Legal Age Drinking Behaviors* among 19-25 year olds in Nebraska



*Percentage reporting how wrong they think different drinking behaviors are based the following scale: *Very Wrong, Wrong, A Little Wrong, Not at all Wrong.*

- The vast majority (80.3%) reported that it is wrong or very wrong for someone 21 and older to provide alcohol to minors under 21 years old.

Source: Nebraska Young Adult Alcohol Opinion Survey – Summary Report, Nebraska Department of Health and Human Services, Lincoln, NE October 2010.
http://www.dhhs.ne.gov/puh/oph/docs/NYAAOS_Final_Report.pdf

This survey, along with other recent studies, further highlight that alcohol use among young adults in Nebraska is very common and continues to be acceptable among a large number of the state's population. The perception among the respondents could be projected toward attitudes of the other substances of the Student Survey and suggests that continued efforts are necessary to change community norms throughout the state. On a positive note, while the data suggest that there is a need to improve attitudes related to alcohol, the majority of young adults appear to be supportive of responsible alcohol service and alcohol enforcement, unsupportive of adults 21 and older providing alcohol to persons 18-20 years old, and they see underage drinking among 18-20 year olds as far less acceptable than legal age drinking.

Driving under the influence and underage drinking of alcohol and are also discussed under the Criminal Justice section.

Required – SYNAR and Tobacco Efforts

SAPTBG Goal #8: Tobacco Products - (status of the Synar report)

Summary of Troop Area Non Compliance Rates for Nebraska 2006 to 2010								
Troop Area	Headquarters	Troop A		Troop B	Troop C	Troop D	Troop E	**Statewide**
		Omaha	Non Omaha					
2010	10.6	7.3	6.8	8.5	13.8	20.0	10.3	**10.7**
2009	15.6	6.1	20.3	13.5	11.7	19.3	15.4	**13.5**
2008	8.7	5.1	8.5	10.8	22.1	25.3	10.0	**12.2**
2007	13.6	3.0	8.1	5.8	14.5	25.2	16.1	**11.5**
2006	18.7	7.6	20.9	4.7	13.9	31.7	12.7	**14.7**

Source: Nebraska Department of Health and Human Services, Division of Behavioral Health, SYNAR report for the Calendar Years listed.

Each spring and early summer the Division of Behavioral Health contracts with the local law enforcement to conduct random unannounced compliance checks on known tobacco retailers across the state. The table above identifies the last 5 years of information from those compliance checks by State Patrol Troop Areas. In each of the last 5 years one or more of the Patrol areas has approached or exceeded 20 percent non-compliance rate. Troop Area "D" (North Platte Region 2) is the most consistently above 20 percent followed by Troop Area C (Grand Island Region 3.) The lowest percentage of non-compliance is consistently the Omaha city area of Troop Area A. There are a number of variables that come into play when reviewing these data including, but not limited to the age, gender and experience of the cooperating individual (youth participant under 18 years of age), alertness of the merchants representative when reviewing youth's documentation, and the community perception of the importance of tobacco compliance.

The state entity most devoted to tobacco compliance and enforcement is the Tobacco Free Nebraska (TFN) section of the Division of Public Health within the Nebraska Department of Health and Human Services. Tobacco Free Nebraska funds local community coalitions who work in communities and counties to inform the public of the hazards of smoking and to reduce youth access and provide smoking cessation. TFN's stated objectives include: Help people quit, Eliminate

exposure to secondhand smoke, Keep youth from starting, Reach underserved populations. To do so the TFN funds 9 community coalitions around the state.

In 2009 the Tobacco use rate approached 20% for adults with youth prevalence rate around 22% as measured by the Youth Behavioral Risk Survey and Tobacco Use Survey. These rates were less than the 21.2% adult prevalence observed in 2000 and the higher 30.5% rate among youth. Progress has been made in reducing youth and adult tobacco use that can be attributed to increased awareness, training and collaborating on cessation efforts including the Nebraska Quit Line, tobacco free work place (including bars), and second hand smoking education.

It is the national goal of the Substance Abuse and Mental Health Services Administration to reduce state tobacco non-compliance, retailer violation rates (RVR) to less than 10%. Nebraska's RVR of 10.7% in the CY 2010 compliance check approaches this national goal, but because of funding cuts to TFN this rate is anticipated to vary over the next few years, and may creep upwards as public education, training and local law enforcement efforts are impacted by decreased budgets. Additionally, Nebraska's amount of Synar checks performed have been reduced almost by half in the last 3 years due to a number of factors, but largely contributed to lack of available workforce. The State of Nebraska is exploring additional resources of the Federal Food and Drug Administration (FDA) through the Family Smoking and Tobacco Control Act of 2009. The provisions of the FDA authority include control on product placement, product additives, merchant education and enforcement. The State is most interested in the merchant education and enforcement possibilities as they compliment the Synar compliance checks and local tobacco coalition efforts.

Conducted in 2010 within the service population of the Division of Behavioral Health, the annual consumer survey included some questions from the BRFSS. One of the questions focused on cigarette smoking. The survey found that 67.2% of those with a substance abuse problem and 49.2% of the individuals receiving mental health services smoked every day or some days. This compares to the general population's rate of 19.2% every day some day rate.

TABLE Differences on BRFSS Questions Between Persons Receiving Mental Health versus Substance Abuse Services and the General Adult Population in Nebraska

Cigarette Smoking:	Mental Health	Substance Abuse	General pop
Every Day	41.6%	58.6%	14.0%
Some Days	7.6%	8.6%	5.2%
Does Not Smoke	50.8%	32.7%	80.8%

Source: Nebraska 2010 Behavioral Health Consumer Survey Results, page 10
http://www.dhhs.ne.gov/beh/mh/MHConsumer/Nebraska2010BehavioralHealthConsumerSurvey.pdf

All of these elements leads to the priority involving tobacco.

State Priority 1 Substance Abuse Prevention

Trauma Informed Services

SAMHSA's Strategic Initiatives

2. Trauma and Justice—Reducing the pervasive, harmful, and costly health impact of violence and trauma by integrating trauma-informed approaches throughout health, behavioral health, and related systems and addressing the behavioral health needs of people involved or at risk of involvement in the criminal and juvenile justice systems.

FY 2012–2013 SAMHSA Uniform Block Grant Application, page 10

The Adverse Childhood Experience (ACE) Study and SAMHSA's national statistics highlight the critical importance of developing a system that is trauma informed and utilizes trauma specific services.

Below is a DBH Trauma History Usage Report [Period: 07/01/2010 - 06/30/2011], which captures positive responses for trauma screened upon admission. In FY2011, 37.8% of admissions to community behavioral health providers contracting with the Regional Behavioral Health Authorities reported a positive trauma history experienced either in adulthood, childhood or both. The first chart shows both genders. The Reason for Admission was 51.1% for mental health services, 29.8% for substance abuse services or 16.6% for Dual/Combo (MH/SA) services. The report is unduplicated at the case level within provider so each client is counted only once per provider. The data reported are from the client's most recent admission with the provider.

All Regions	**Both Genders**			
	Adult	Child	Both	Neither
Emotional Abuse	1,745	2,878	1,902	3,878
Life Threatening Medical Issues	1,171	251	142	8,835
Natural Disasters	313	251	89	9,744
Neglect	247	2,042	283	7,827
Physical Abuse	1,741	2,802	1,215	4,640
Physical Assault	1,734	574	693	7,399
Prostitution/Sex Trafficking	205	45	39	10,108
Sanctuary Trauma	430	107	72	9,788
Serious Accident/Injury	1,662	585	277	7,877
Sexual Abuse	625	2,691	651	6,438
Sexual Assault/Rape	931	977	395	8,099
Traumatic Loss of a Loved One	2,740	1,062	810	5,789
Victim of a Terrorist Act	156	49	18	10,173
War/Political Violence/Torture	153	56	25	10,163
Witness to Community Violence	901	443	447	8,605
Witness to Domestic Abuse	786	2,024	631	6,959
Total Admissions	27,557			
Total w/Trauma History = Yes Total with at least 1 Trauma selected	10,425	37.8%		
Reason for Admission	**Both**			
Primary Mental Health	5,330	51.1%		
Prim.Mental Hlth/Secondary S/A	650	6.2%		
Primary Substance Abuse	3,104	29.8%		
Prim.S/A/Secondary Mental Hlth	323	3.1%		
Dual Diag/Prim.MenHlth/Pri.S/A	759	7.3%		
Prim.Mental Retardation	7	0.1%		
Prim.Sex Offender	26	0.2%		
Unknown	226	2.2%		
Total	10,425	100.0%		

The next tables separate these admissions by gender (male / female). The females reported a Trauma History (at least 1 Trauma selected) at admission 48.7% of the time. The males reported a Trauma History at admission 30.1% of the time.

All Regions	Male		Female	
Total Admissions	16,100		11,457	
Total with Trauma History = Yes / at least 1 Trauma selected	4,847	30.1%	5,578	48.7%

As children, both males and females the top reported trauma history areas were Sexual Abuse, Emotional Abuse, Physical Abuse, Neglect, and Witness to Domestic Abuse. As adults, the top reported trauma history areas for females were Physical Abuse, Traumatic Loss of a Loved One, Emotional Abuse, Physical Assault, and Sexual Assault/Rape. The top reported trauma history areas for males included Traumatic Loss of a Loved One, Physical Assault, Serious Accident/Injury, Life Threatening Medical Issues and Witness to Community Violence as top reported trauma history areas.

Male		Female	
Adult		Adult	
Traumatic Loss of a Loved One	22.8%	Physical Abuse	14.8%
Serious Accident/Injury	16.8%	Traumatic Loss of a Loved One	14.8%
Physical Assault	11.4%	Emotional Abuse	13.8%
Life Threatening Medical Issues	10.6%	Physical Assault	11.0%
Witness to Community Violence	8.4%	Sexual Assault/Rape	8.5%
Child		Child	
Emotional Abuse	19.8%	Sexual Abuse	21.1%
Physical Abuse	19.6%	Emotional Abuse	14.4%
Witness to Domestic Abuse	12.6%	Physical Abuse	13.7%
Neglect	11.0%	Neglect	13.3%
Sexual Abuse	10.9%	Witness to Domestic Abuse	11.4%

A gap exists in the data. DBH recognizes individuals may not have developed therapeutic rapport with the service providers at the time of admission. Thus, since these data are only reported at admission, the trauma experienced may be under reported. To address this, DBH has prioritized a data report change to include the trauma data be collected at discharge as well. DBH can more accurately capture information on individuals experiencing trauma which will drive change and improve trauma care.

Additional gaps include, only 33 DBH funded organization from a total of 77 have completed a trauma informed assessment and developed plans for improvement. A variety of trauma specific services are available but there is not a current repository to evaluate and improve access and distribution across the state. DBH is currently aggregating the 2011 survey information which will be analyzed.

Consumers and families are not consistently aware of providers that might specialize in trauma or implement trauma specific services. DBH needs to increase awareness and publication of this important information to be responsive to our consumers/families.

State Priority 8 Trauma informed care is part of all Behavioral Health Services

Underserved Racial & Ethnic Minority Populations

Culture may be defined as the totality of socially transmitted behavior patterns, arts, beliefs, institutions, and all other products of human work and thought. Culture is learned and shared within social groups and is transmitted by nongenetic means. (source: The American Heritage® Science Dictionary. Retrieved July 26, 2011, from Dictionary.com website: http://dictionary.reference.com/browse/culture).

DBH Strategic Plan 2011 – 2015 | **Strategy 1: Insist on Accessibility** – Access to publicly funded behavioral health services is influenced in Nebraska by geography, workforce limits, culture and language barriers, organizational, technology and information barriers and cost. Accessibility is more than offering a service – it is creating an environment that allows people to make a choice to move into and out of the effective services that are close to home.

Cultural competence requires that organizations:

- Have a defined set of values and principles, and demonstrate behaviors, attitudes, policies and structures that enable them to work effectively cross-culturally.
- Have the capacity to (1) value diversity, (2) conduct self-assessment, (3) manage the dynamics of difference, (4) acquire and institutionalize cultural knowledge and (5) adapt to diversity and the cultural contexts of the communities they serve.
- Incorporate the above in all aspects of policy making, administration, practice, service delivery and involve systematically consumers, key stakeholders and communities.

Cultural competence is a developmental process that evolves over an extended period. Both individuals and organizations are at various levels of awareness, knowledge and skills along the cultural competence continuum. [source: National Center for Cultural Competence (NCCC)Retrieved July 26, 2011 / http://nccc.georgetown.edu/foundations/frameworks.html].

For 2010, the US Census Bureau reported the following for Nebraska.

	Nebraska Census Data 2010					
	Youth		**Adult**		**Total**	
Race	**#**	**%**	**#**	**%**	#	**%**
Asian	8,639	1.9%	23,654	1.7%	32,293	1.8%
Black/African American	26,861	5.8%	56,024	4.1%	82,885	4.5%
Multiracial	22,481	4.9%	17,029	1.2%	39,510	2.2%
Native American/Alaska Native	6,896	1.5%	11,531	0.8%	18,427	1.0%
Native Hawaiian/Other Pacific	398	0.1%	881	0.1%	1,279	0.1%
White	362,760	79.0%	1,210,078	88.5%	1,572,838	86.1%
Other race	31,186	6.8%	47,923	3.5%	79,109	4.3%
Total	459,221	100.0%	1,367,120	100.0%	1,826,341	100.0%

2010 Census Ethnic Populations For Nebraska

	Youth		**Adult**		**Total**	
Ethnicity	**#**	**%**	**#**	**%**	**#**	**%**
Hispanic	69,184	8.3%	98,221	4.5%	167,405	9.2%
Not of Hispanic Origin	390,037	91.7%	1,268,899	95.5%	1,658,936	90.8%
Total	459,221	100.0%	1,367,120	100.0%	1,826,341	100.0%

Source: U.S. Census Bureau

Step 2: Identify the Unmet Service Needs And Critical Gaps Within The Current System / Page | 47

FY2011 Totals	Youth		Adult		TOTAL		Census %
Race	#	%	#	%	#	%	
Asian	21	0.8%	258	0.8%	279	0.8%	1.8%
Black/African American	218	7.8%	2,940	9.0%	3,158	8.9%	4.5%
Multiracial	111	4.0%	152	0.5%	263	0.7%	2.2%
Native American/Alaska Native	76	2.7%	1,077	3.3%	1,153	3.3%	1.0%
Native Hawaiian/Other Pacific	39	1.4%	543	1.7%	582	1.6%	0.1%
White	2,307	82.5%	27,015	82.9%	29,322	82.9%	86.1%
Race not available	26	0.9%	604	1.9%	630	1.8%	
Total	2,798	100%	32,589	100%	35,387	100%	

A summary of the US Census Data 2010 by Race in Nebraska would be Asian (1.8%), Black/African American (4.5%), Multiracial (2.2%), Native American/Alaska Native (1.0%), Native Hawaiian/Other Pacific (0.1%), White (86.1%) and Other race (4.3%). Comparing this percentage to the persons served reported, it suggests that people of Asian race, people of Multiracial as well as White may be underserved.

Persons Served by Ethnic minority populations by service type in FY2011

	Totals						
	Youth		Adult		Total		
Ethnicity	#	%	#	%	#	%	Census Data %
Hispanic	374	11.7%	2,186	6.7%	2,560	7.1%	9.2%
Not of Hispanic Origin	2,208	68.8%	29,581	90.2%	31,789	88.3%	90.8%
Unknown	216	6.7%	822	2.5%	1,038	2.9%	
Total	2,798	87.2%	32,589	99.4%	35,387	98.3%	100%

At first view, it appears the Hispanic population may be underserved when comparing the persons served data to the census data. However, there is a large enough unknown group to challenge that observation.

Required – SA Treatment – Women's Set Aside Services

SAPTBG Goal #3: Pregnant Women Services

SAPTBG Goal #9: Pregnant Women Preferences (includes waiting list / capacity management)

The following table indicates the number of persons served in each Women's Set Aside Service for FY10 and FY11.

Number of Persons Served by Women's Set Aside Services for FY10 and FY11

Region	Provider	Services	FY10	FY11
1	Human Services	Short Term Residential-SA	42	36
	Human Services	Intensive Outpatient-SA	8	13
2	Arm-in-Arm	Community Support-SA	46	49
3	South Central Behavioral Services	Outpatient	274	270
	St. Francis ADTC	Outpatient	226	220
4	Women's Empowering Life Line	Dual Residential	1	7
5	St. Monica's	Community Support-SA	1+	1+
	St. Monica's	Therapeutic Community-SA	77	76

	LMEP	Assessments-SA	4	17
6	Heartland Family Services	Therapeutic Community-SA	33	33

NOTE:
Data source: Magellan July 2011 data extract; reports from Regional Behavioral Health Authorities
+ Magellan has problems with community support service data for many years. Thus, these data are questionable.

In November 2007, the Department of Health and Human Services-Division of Behavioral Health contracted with the Nebraska Coalition of Women's Treatment (NCWT) to create Trauma Informed Nebraska (TIN), a statewide, consumer-driven, recovery-oriented project that focused on wellness and recovery for trauma survivors, their families, and treatment providers. The Nebraska Coalition for Women's Treatment began through St. Monica's, a women's substance abuse provider in Lincoln, NE, began in 1999 by receiving funding from a Maternal Child Health Block Grant. The goal of this organization is to create an infrastructure of women's substance abuse programs and advocate for gender competent treatment. After nearly four years of beneficial accomplishments as separate organizations, the two groups made the decision in June 2011 to merge their resources. The new organization will continue to be guided in part by two statements attributed to Dr. Scot Adams, Director of the DHHS-Division of Behavioral Health. "Providers need to be sensitive to the effects that trauma has on clients. Services should be provided in a way that avoids retraumatization and helps consumers. For example, just watching someone being physically restrained can retraumatize a person, even years later". And "We understand the toll that violence takes in people's lives. Trauma-informed services factor in the impact past traumas continue to have on someone's life as mental health and addiction treatment is provided."

State Priority 4 SA Treatment – Women's Set Aside Services

Required – Homeless

Criterion 4: Targeted Services to Homeless Populations

Nebraska Homeless Assistance Program (NHAP)

Nebraska's outreach to and services for individuals who are homeless or at imminent risk of homelessness is implemented across the state by a network of shelter, supportive housing, and service providers who belong to one of seven regional continua of care. The seven Continuums serve all 93 counties in Nebraska. The Continuum system is supported by the State's Department of Health and Human Services (DHHS) - Division of Children & Family Services - Nebraska Homeless Assistance Program (NHAP).

Garnering and analyzing quality quantitative and qualitative data is at the heart of effective policy and program development. NHAP's transition from manual reporting to electronic reporting via ServicePoint and a domestic violence data collection system has resulted in greater data integrity from NHAP-funded agencies. For the 2009-2010 grant cycle (July 1, 2009-June 30, 2010) 43 agencies reported via ServicePoint. Of agencies reporting on ServicePoint, alcohol abuse, drug abuse, dual diagnosis and/or mental illness was present in approximately 75 percent of the overall or statewide homeless population. This supports the identified need by emergency shelter staff that consistent case management use of a screening instrument could enable staff to more readily identify and make appropriate referrals for a significant portion of individuals assisted by the agencies.

Nebraska Homeless Assistance Program (NHAP) Regional Comparisons FY 2009 & 2010

Annual Figures / **Homeless** Total (Unduplicated)

NHAP Regions	2008-2009	2009-2010	Percentage +/-
Region: 1 – Panhandle	830	754	-9.10%
Region: 2 - North Central	1,684	2,190	-7.90%
Region: 3 - Southwest	1,448	1,534	5.90%
Region: 4 - Southeast	1,971	2,241	-15.90%
Region: 5 - Northeast	994	967	-2.70%
Totals Regions 1-5	6,927	7,686	-7.60%
Region: 6 - Lincoln	4,809	4,373	-9.10%
Total Regions 1-6	11,736	12,059	-8.10%
Region: 7 – Omaha HSATF only+	6,433	6,500	n/a

Annual Figures **Near Homeless** Totals (Unduplicated)

NHAP Regions	2008-2009	2009-2010	Percent +/-
Region: 1 - Panhandle	5,360	5,042	-5.8%
Region: 2 - North Central	4,739	4,428	-6.5%
Region: 3 - Southwest	8,411	6,584	-21.7%
Region: 4 - Southeast	7,296	6,705	-8.1%
Region: 5 - Northeast	4,170	5,260	+26.1%
Totals Regions 1-5	29,976	28,019	-6.5%
Region: 6 - Lincoln	11,894	11,050	-7.1%
Total Regions 1-6	41,870	39,069	-6.6%
Region: 7 – Omaha HSATF only+	1,159	2,194	n/a

+Note: Omaha is reported on a separate line because the state funds Omaha agencies with HSATF only. As an entitlement city, Omaha disburses HUD's Emergency Services Grant funds through a separate grant process. The Omaha data reported here should not be considered a total picture of homelessness and near homelessness in that area. There also are agencies that serve the homeless and near homeless population in Nebraska that are not funded by the NHAP.

For more information contact Charles W. Coley, DHHS - Division of Children & and Family Services, (402) 471-9200, charles.coley@nebraska.gov or visit the DHHS web site. http://www.dhhs.ne.gov/fia/nhap/nhapindex.htm (updated Aug 5, 2010)

Housing

One of the SAMHSA National Outcome Measures (NOMs) involves Housing.

Outcome:	Increased Stability in Family and Living Conditions
Mental Health Treatment:	Profile of Client's change in living situation (including homeless status)
Substance Abuse Treatment:	Percentage of clients in stable living situations at discharge compared to the number/proportion at admission (i.e., housing)
Substance Abuse Prevention:	Increase in parent participation in prevention activities.

Community Behavioral Health data reported by Person Served By Living Situation. The records selected for the report were from the most recent information available based on admission, annual update or discharge.

Step 2: Identify the Unmet Service Needs And Critical Gaps Within The Current System / Page | 50

FY2010	MH ONLY		SA ONLY		Dual ONLY		COMBO	
Population	**Youth**	**Adult**	**Youth**	**Adult**	**Youth**	**Adult**	**Youth**	**Adult**
Jail/Correctional Facility	10	187	14	215	0	3	4	53
Homeless/Shelter	4	658	3	935	0	7	0	343
Private Residence	2,421	13,167	465	10,583	1	56	67	2,103
All Other	163	2,814	29	1,024	0	20	29	633
Total	2,598	16,826	511	12,757	1	86	100	3,132

FY2011	MH ONLY		SA ONLY		Dual ONLY		COMBO	
Population	**Youth**	**Adult**	**Youth**	**Adult**	**Youth**	**Adult**	**Youth**	**Adult**
Jail/Correctional Facility	8	166	4	206	0	5	0	66
Homeless/Shelter	2	782	5	1,008	0	7	0	426
Private Residence	2,203	13,189	380	9,627	1	54	30	2,179
All Other	128	3,270	29	978	0	18	8	608
FY2011 Total	2,341	17,407	418	11,819	1	84	38	3,279

Person Served By Living Situation

	TOTAL 2010		TOTAL 2011	
Population	#	%	#	%
Jail/Correctional Facility	486	1.3%	455	1.3%
Homeless/Shelter	1,950	5.4%	2,230	6.3%
Private Residence	28,863	80.2%	27,663	78.2%
All Other	4,712	13.1%	5,039	14.2%
Total	36,011	100.0%	35,387	100.0%

NOTE: records selected based on the latest admission, annual update or discharge.

Most persons served live in a private residence. However, there are some who report living in a homeless shelter and a few who report living in jail/correctional facility.

Oxford House

Recovery Homes for Substance Abusers … Under the SAPTBG - GOAL # 7 encourages the development of group homes for recovering substance abusers through the operation of a revolving loan fund. This is the "Oxford House" model. The Oxford House is a self supporting, self run Recovery Homes for substance abusers. The houses are a residential location for individuals in recovery. No treatment or prevention services are offered in the house. Houses hold meetings, and all residents of the house are considered "in recovery."

As of July 2010, Nebraska Oxford House International, Inc. operated 23 homes in Omaha (167 beds), 1 home in Lincoln (7 beds) (a new home is scheduled to open on September 15, 2010), two homes in Grand Island (12 beds), and one in Kearney (9 beds).
Source: GOAL # 7: Progress – Development of Group Homes / September 24, 2010

Housing Related Assistance

A State funded program under the Nebraska Behavioral Health Services Act is the Housing Related Assistance program. DBH contracts with the six Regions to provide this service. Below is an unduplicated count of persons served each state fiscal year since the start of the program.

Step 2: Identify the Unmet Service Needs And Critical Gaps Within The Current System / Page | 51

Unduplicated Total Number of Served By Region by State Fiscal Year

	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011
Region 1	19	40	42	70	61	43
Region 2	9	33	77	60	69	43
Region 3	23	85	101	154	136	151
Region 4	7	57	88	117	92	106
Region 5	35	196	209	235	263	242
Region 6	34	146	200	187	224	233
Totals	127	557	717	823	845	818

The eligibility criteria includes but is not limited to (1) people who are adults with serious mental illness, (2) who are receiving Nebraska DHHS funded Behavioral Health Services, (3) person has in Individual Service Plan (ISP) with a goal of independent living, plus income standards and priority standards.

Income Standard for Housing Related Assistance

The program uses the Housing Cost Burden standards as HUD defines it:

- Moderate Cost Burden (Cost Burden > 30%) = Housing costs (including utilities) are between 31 and 50 percent of reported income.
- Severe Cost Burden (Cost Burden >50%) = Housing costs (including utilities) are exceeding 50 percent of reported income.

Priority Standard for Housing Related Assistance

The consumer meets either Priority One or Priority Two criteria as listed below. No one under Priority Three is served in Housing Related Assistance.

a) Priority One – either:
   i) A person with Extremely Low Income (as defined below) who is discharged from an inpatient mental health commitment, OR
   ii) A person with Extremely Low Income who is eligible to move from a residential level of care to independent living to make room for a person being discharged from an inpatient mental health commitment.
b) Priority Two – A consumer with Extreme Low Income who is "at risk" of an inpatient mental health commitment which would be at least in part due to a lack of affordable, independent housing. For the purposes of this section, "at risk" means the individual meets at least one of the following criteria:
   (1) a history of inpatient mental health board commitments within the last five years
   (2) was subject to an emergency protective custody (EPC) within the last five years
   (3) the housing assistance will clearly prevent a psychiatric hospitalization
   (4) the person is currently homeless
   (5) the person has no income and appears eligible for SSI
   (6) the consumer is living in independent housing that is not safe, decent, or affordable
   (7) housing assistance prevents a consumer from moving into a higher level of care
   (8) is currently committed to outpatient services by a mental health board.
c) Priority Three – A behavioral health services consumer with Very Low Income (as defined below) who does not meet either Priority One or Two.

Housing Related Assistance – FY2011 total as reported as of June 30, 2011

II. Enter the total number of consumers with approved applications in each month. Of that number, enter the total number that were priority one and priority two (UNDUPLICATED Count). Also, enter the number of consumers on the waiting list. (This is a sub-number of Column 1).				
	1	2	3	4
	Total # of Consumers with Approved Applications (A)	# Approved as Priority One	# Approved as Priority Two	# of Consumers on Waiting List
Region 1	43	21	22	0
Region 2	79	48	31	8
Region 3	42	10	30	4
Region 4	86	9	77	37
Region 5	230	99	131	21
Region 6	168	116	52	102
Totals	648	303	343	172

Approved as Priority One = 47% | # Approved as Priority Two = 53%

At the time of this report (June 30, 2011), there were 172 individuals found eligible for Housing Related Assistance, but needed to be placed on a waiting list.

State Priority 9 Improve the Permanent Supportive Housing services available

Employment

One of the SAMHSA National Outcome Measures (NOMs) involves Employment

Outcome:	Increased/Retained Employment
Mental Health Treatment:	Profile of adults clients by employment status
Substance Abuse Treatment:	Change in percentage of clients employed at discharge compared to the percentage at admission
Substance Abuse Prevention:	Decrease in drug-related workplace injuries.

When people feel good about having a job, they often see themselves in a more positive way. Work gives people structure and routines. Having an income gives them more choices about what to buy and where to live. Thus, employment is an important component to a person's improvement and needs to be part of a recovery oriented system of services.

The Nebraska Division of Behavioral Health has a long established working relationship with Nebraska Vocational Rehabilitation Services (VR). The Division of Behavioral Health and Vocational Rehabilitation have a Memorandum of Understanding to increase employment opportunities for individuals who experience behavioral health concerns. The Division of Behavioral Health implemented Supported Employment during FY2008 as part of Behavioral Health Reform in Nebraska.

	FY2009	FY2010	FY2011
BH	$683,931	$776,533	$818,143
VR	$1,075,000	$1,320,000	$1,204,000
total	$1,758,931	$2,096,533	$2,022,143

NE Division of Behavioral Health - Supported Employment Funding via Regions

Region	Provider	total FY2009	total FY2010	total FY2011
1	Cirrus House	$16,050	$16,291	$16,372
2	Goodwill Industries-NP	$43,418	$44,069	$44,290
3	Goodwill Industries-GI/K/H	$115,392	$138,565	$139,258
	LB603-SE Transitional+			$37,727
4	Liberty Centre	$75,641	$76,776	$77,160
4	Rainbow Center	$47,067	$47,773	$48,012
5	Mental Health Association	$202,517	$266,455	$267,787
6	Community Alliance	$183,846	$186,604	$187,537
	TOTALS	$683,931	$776,533	$818,143

\+ **Transition Age Supported Employment** is designed to assist young people who experience a mental health disorder find and keep competitive employment within their communities. The supported employment program is staffed by employment specialists who participate in a team-based process with the youth, his/her family, other formal service providers and informal support resources necessary to assist the youth in meeting his/her goals. The program serves youth who are within two years of completing high school (ages 16-19). This is a new service under development in Region 3. It is a partnership between Goodwill Industries, Vocational Rehabilitation and the Grand Island Public Schools.

Source: Regional Behavioral Health Authorities Contracts FY09, FY10, FY11 updated August 3, 2010

Data on the employment status of persons served by the Community Based Section of the Division of Behavioral Health is reported below. The data are reported in four categories:

- Employed: Competitively Employed Full or Part Time (includes Supported Employment)
- Unemployed: Not having work, seeking employment
- Not In Labor Force: Retired, Sheltered Employment, Sheltered Workshops, Other (homemaker, student, volunteer, disabled, etc.)
- Not Available

Number of Person Served By Employment Status FY2010

FY2010	MH ONLY		SA ONLY		Dual ONLY		COMBO	
Population	Youth	Adult	Youth	Adult	Youth	Adult	Youth	Adult
Employed	72	4,849	116	6,585	1	25	7	875
Unemployed	170	7,035	135	5,242	0	36	10	1,849
Not In Labor Force	2,356	4,882	259	918	0	24	83	399
Unknown	0	60	1	12	0	1	0	9
Total	2,598	16,826	511	12,757	1	86	100	3,132
Youth & Adult	19,424	54%	13,268	37%	87	0%	3,232	9%

Number of Person Served By Employment Status in FY2011

FY2011	MH ONLY		SA ONLY		Dual ONLY		COMBO	
Population	Youth	Adult	Youth	Adult	Youth	Adult	Youth	Adult
Employed	49	4,855	97	5,943	1	19	3	910
Unemployed	146	7,674	105	4,969	0	40	6	1,943
Not In Labor Force	2,146	4,817	215	896	0	22	29	418

Unknown	0	61	1	11	0	3	0	8
Total	2,341	17,407	418	11,819	1	84	38	3,279
Youth & Adult	19,748	56%	12,237	35%	85	0.2%	3,317	9%

	TOTAL 2010		TOTAL 2011	
Population	**#**	**%**	**#**	**%**
Employed	12,530	34.9%	11,877	33.6%
Unemployed	14,477	40.3%	14,883	42.1%
Not In Labor Force	8,921	24.8%	8,543	24.1%
Unknown	82	0.2%	84	0.2%
Total	36,011	100.2%	35,387	100.0%

NOTE: records selected based on the latest admission, annual update or discharge.

Only one third (33%) of the persons served in Division of Behavioral Health funded programs were employed in FY2011; 42% were unemployed and 24% were not in the Labor Force. Given that employment is an important component to a person's recovery, there needs to be a focus on this area.

State Priority 10 Improve Supported Employment Evidence-Based Practices

Insurance Coverage

States should begin planning now for individuals with low-incomes who currently are uninsured but will be covered by Medicaid or private insurance in FY 2014 and will present new opportunities for public behavioral health systems to expand access and capacity.
FY 2012–2013 - SAMHSA Uniform Block Grant Application, page 21

There is a need to review the insurance coverage for the persons served within the community behavioral health. This discussion needs to start with the 2011 US Department of Health and Human Services (HHS) Poverty Guidelines. These guidelines are one standard for Federal Poverty Level (FPL), and guide Federal Poverty Measure used below. Below is the chart that applies to Nebraska. See http://aspe.hhs.gov/poverty/11poverty.shtml for more details.

2011 HHS Poverty Guidelines	
Persons in Family	**48 Contiguous States and D.C.**
1	$10,890
2	14,710
3	18,530
4	22,350

SOURCE: *Federal Register*, Vol. 76, No. 13, January 20, 2011, pp. 3637-3638

A source of information to identify those who will not be covered after FY 2014, as well as whose coverage is insufficient comes from a report received by NE DHHS Division of Medicaid and Long-Term Care in August 2010. Milliman, Inc. reported to the Nebraska Department of Health and Human Services - Division of Medicaid and Long-Term Care. Within that report was an estimated Medicaid Enrollment Impact chart. The projected increase in Medicaid enrollment

reflecting a 138% Federal Poverty Level (FPL) limit. The 138% FPL limit reflects the 133% FPL indicated in the Affordable Care Act with the 5% income disregard allowance.

Milliman: Estimated Medicaid Enrollment Impact

Population	FPL Range	Enrollment Full Participation Scenario	Mid-Range Participation Assumption	Enrollment Mid-Range Participation Scenario
Uninsured Adults	0%-138%	36,779	80%	29,423
Newly Eligible Parents	50%-138%	20,510	85%	17,433
Woodwork Parents	<50%	4,623	70%	3,236
Woodwork Children	<138%	23,119	80%	18,496
Insured Switchers - Adults	0%-138%	23,916	50%	11,958
Insured Switchers - Parents	0%-138%	21,429	75%	16,071
Insured Switchers - Children	0%-138%	14,538	75%	10,903
State Disability (1)	0%-138%	154	DHHS 133% FPL Assumption +5%	154
Medically Needy (2)	43%-138%	229	DHHS 133% FPL Assumption +5%	229
Sub-total		145,297		107,903

→ (1) State Disability currently covered with state funds to 100% FPL. Enrollment reflects shift to Medicaid and FPL expansion estimated as of 2014.

→ (2) Enrollment reflects FPL expansion estimated as of 2014.

→ Children defined as ages 0 through 19.

→ Adult and Parent populations defined as ages 20 through 64.

source: Milliman, Inc. report to the Nebraska Department of Health and Human Services - Division of Medicaid and Long-Term Care. August 16, 2010

The table below shows Division of Behavioral Health Community Services ALL ADMISSIONS for FY2011 (mental health, substance abuse, and dual) for FY2011.

	Less than 100% PL		**Between 100% & 138**		**More than 138% PL**	
Health Insurance	**Youth**	**Adult**	**Youth**	**Adult**	**Youth**	**Adult**
No Insurance	573	48,976	112	3,500	111	2,465
Medicaid	1,534	8,911	194	201	143	106
Other Insurance	283	4,111	99	603	247	1,205
Medicare	25	4,450	5	354	3	158
HMO	85	1,027	17	205	42	412
Priv.Self Paid	149	1,037	16	87	36	125
PPO	75	345	20	86	51	236
Veterans Admin	2	142	0	15	0	46
Indian Hlth Svc	4	183	0	5	0	3
Unknown	0	45	0	51	0	0
Othr Direct Fed	0	14	0	2	0	2
Othr Direct Sta	1	4	0	0	0	3

	Less than 100% PL		Between 100% & 138		More than 138% PL	
Child Welfare	3	4	0	0	0	0
Total	2,734	69,249	463	5,109	633	4,761

Health Insurance	Youth	Adult	Total Sum	%
No Insurance	796	54,941	55,737	67.2%
Medicaid	1,871	9,218	11,089	13.4%
Other Insurance	629	5,919	6,548	7.9%
Medicare	33	4,962	4,995	6.0%
HMO	144	1,644	1,788	2.2%
Priv.Self Paid	201	1,249	1,450	1.7%
PPO	146	667	813	1.0%
Veterans Admin	2	203	205	0.2%
Indian Hlth Svc	4	191	195	0.2%
Unknown	0	96	96	0.1%
Othr Direct Fed	0	18	18	0.0%
Othr Direct Sta	1	7	8	0.0%
Child Welfare	3	4	7	0.0%
Total	3,830	79,119	82,949	100%

In FY2011, many of the individuals currently served by the Community Section of the Division of Behavioral Health are not covered by health insurance (67.2%). There were some on Medicaid &/or Medicare (19.4%). Others reported HMO, PPO or Other Insurance (11.1%); a few managed to privately Self Pay (1.7%); some had other Government payments sources such as Veterans Administration, Indian Health Service, related Federal/State direct payment sources, or Child Welfare (0.4%). There were 0.1% whose insurance coverage is Unknown.

Projected Covered Services

Modern Service System: SAMHSA released a document titled, "Description of a Modern Addictions and Mental Health Service System" (Draft – October 9, 2010) to help States prepare an Addendum to Block Grant (December 2010). In that document, SAMHSA made several important points including:

- A good and modern mental health and substance use system should be designed and implemented using a set of principles that emphasizes behavioral health as an essential part of overall health in which prevention works, treatment is effective and people recover. These principles should apply to the provision of mental health and addiction services and cross the lifespan of individuals who need and use these services.
- The elements described in this document should serve as a starting place for discussion among the various policy-makers and stakeholders concerned about services, reimbursement and infrastructure. There will always be differences of what should be included in a modern mental health and addiction system. However, these differences need to be mediated immediately with an understanding that what is modern in 2011 will change in five, ten or twenty years.

At the end of that document was a chart showing SAMHSA's ideas on where current behavioral health services would fit with a Modern Addictions and Mental Health Service System. Those

services included categories such as Healthcare Home/Physical Health; Prevention and Wellness; Engagement Services; Outpatient and Medication Services; Community and Recovery Support (Rehabilitative); Other Supports (Habilitative); Intensive Support Services; and Out-of-Home Residential Services.

It is very difficult at this point in time to know for certain the Division of Behavioral Health role in a "Modern Service System". In order to start the discussion, the following chart was prepared outlining what may or may not be covered as part of a behavioral health service system where many more consumers are covered with health insurance. The table below shows items that may be covered within health insurance (including Medicaid) or may not be covered. This includes the possibility that Medicaid at risk managed care could be introduced in the future as well.

Table of Projected Covered Services by Name

May be Covered	**May be Not Covered by Medicaid/ Insurance**
Acute Inpatient	CH- Prof Partner
EPC/Acute/Subacute	CH- Respite
Assertive Community Tx	CH- Short Term Wraparound
Assertive Community Tx - APRN	Crisis Stabilization/TX
Assess/Eval ONLY - Justice	Day Support
Assess/Eval ONLY - MH	Emergency Comm Supp
Assess/Eval ONLY - SA	Family Navigator
CH - Day Treatment	Hospital Diversion (e.g. Keya House)
CH - Halfway House	Housing Related Assistance
CH - Home Based MST	Intensive Case Management - MH
CH - IOP SA	Intensive Case Management - SA
CH - Med Management	Intensive Commity Service - MH
CH - OP MH	Intensive Commity Service - SA
CH - OP SA	Mental Health Respite
CH- Partial	Opiod Replacement - Methadone/Buprenorphine
CH- Therapeutic Comm	Population-based Prevention Strategies
CH- Youth Assess ONLY - MH	Peer Support
CH- Youth Assess ONLY - SA	Recovery Support
Community Support - MH	Supported Employment
Community Support - SA	Supported Living
Crisis Assess/Eval - LADC/SA	
Crisis Assess/Eval - MH	
Crisis IP - Youth	
Day Rehabilitation	
Day Treatment - MH	
Detox/CPC	
Dual Disorder Res Tx	
Emergency Psych Observation 23:59	
Halfway House - SA	
Intensive Outpatient - SA	
Intermediate Res - SA	
Medication Management	
OP - Dual Dx	
OP - MH	

May be Covered	May be Not Covered by Medicaid/ Insurance
OP - SA	
Partial Care - SA	
Psych Residential Rehabilitation	
Psychological Testing	
Selected and Indicated Prevention	
Secure Residential	
Short Term Res Tx - SA	
Sub-Acute Inpatient	
Therapeutic Comm - SA	

State Priorities

Based on this review of the available data and the material highlighted in this section, the following list identifies Unmet Service Needs And Critical Gaps Within The Current System:

1. Substance Abuse Prevention
2. Consumer Workforce
3. Peer Run Recovery Supports
4. SA Treatment – Women's Set Aside Services
5. Transition Age Youth and Young Adult
6. Professional Partners Program
7. Co-Occurring Disorder Services
8. Trauma informed care is part of all Behavioral Health services.
9. Improve the Permanent Supportive Housing services available
10. Improve Supported Employment Evidence-Based Practices

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 92 of 187

II: Planning Steps

Table 2 Step 3: Prioritize State Planning Activities

Page 23 of the Application Guidance

Start Year:

End Year:

Number	State Priority Title	State Priority Detailed Description
1	Substance Abuse Prevention	Substance abuse prevention and wellness promotion efforts are essential to helping people live better, healthier lives. Through a strategic planning initiative, DBH will strengthen its existing infrastructure to deliver a unified and effective prevention system. The plan will guide DBH in developing a comprehensive prevention approach which focuses on strategies to reduce underage drinking and the occurrence of excessive drinking among adults, and the elimination of tobacco sales to youth as well as others such as the reduction of tobacco use among persons with behavioral health disorders.
2	Consumer Workforce	The DBH Strategic Plan prioritizes four goals. One goal specifies the utilization of funding for innovative service, technology and delivery structures. Peers are an essential component of recovery oriented systems and services. The Office of Consumer Affairs will facilitate training opportunities and certification of Peer Support and Wellness Specialists.
3	Peer Run Recovery Supports	The DBH Strategic Plan prioritizes four goals. One goal specifies the utilization of funding for innovative service, technology and delivery structures. Peers are an essential component of recovery oriented systems and services. The Office of Consumer Affairs will lead the development and implementation of consumer and family driven and consumer run services and supports.
4	SA Treatment – Women's Set Aside Services	The DBH Strategic Plan calls for effectiveness in services and specifies the use of QI processes for services funded and focused on gender, trauma and recovery among other factors. DBH in concert with our system partners must continue to impact the health of Nebraska's families to promote safety, permanency and well-being.
5	Transition Age Youth and Young Adult	Youth/Young Adults need access to developmentally appropriate services, tailored to meet their needs. By developing such services, DBH will be proactive in ensuring this population's needs are met and preventing hospitalization or incarceration. DBH will work in partnerhip with the DHHS Division of Children and Family Services and others.

6	Professional Partners Program	DBH in concert with our system partners must continue to impact the health of Nebraska's families to promote safety, permanency and well-being. We must also strive to improve the fidelity to the wrap-around model to increase the integrity and effectiveness of the Professional Partners Program.
7	Co-Occurring Disorder Services	The Division of Behavioral Health Strategic Plan Goal 1 states, "The public behavioral health workforce will be able to deliver effective prevention and treatment in recovery-oriented systems of care for people with co-occurring disorders." The Statewide Quality Improvement Team (SQIT) Co-Occurring Disorders Workgroup completed a road map to co-occurring service delivery system. Nebraska must develop the no wrong door approach to serving consumers.
8	Trauma Informed Care	Trauma informed care cuts across all identified behavioral health, adult and child treatment service populations. Trauma impacts children and family outcomes. The DBH Strategic Plan requires effectiveness and specifies a continuous QI process for services funded by the DBH, focusing on a number of factors including trauma.
9	Permanent Supportive Housing services	Recovery is challenged when individuals are not in stable housing. Recovery oriented systems of care address the basic needs of the individuals served. A focus on improving the quality and quantity of permanent housing individuals includes addressing the fidelity to Permanent Supportive Housing model, improving the data collected on the NE Housing Related Assistance Program, and housing data in general. The DBH Strategic Plan specifies implementation of processes to ensure fidelity to empirically supported approaches which includes supported housing.
10	Supported Employment	Recovery is challenged when individuals that desire work have limited employment options. Recovery oriented systems of care attempt to meet vocational and school needs of individuals served. The DBH Strategic Plan specifies implementation of processes to ensure fidelity to empirically supported approaches which includes supported employment.

Footnotes:

NOTE: The State Planning Activities listed are not in priority order.

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 94 of 187

II: Planning Steps

Table 3 Step 4: Develop Objectives, Strategies and Performance Indicators

Page 23 of the Application Guidance

Start Year:
2011

End Year:
2013

Priority	Goal	Strategy	Performance Indicator	Description of Collecting and Measuring Changes in Performance Indicator
Substance Abuse Prevention	Nebraska will complete a Strategic Plan for Prevention.	DBH will engage in Strategic Planning for Prevention work.	Strategic Plan for Prevention is completed by target date.	Completion is at the time the Director of DBH approves a Strategic Plan for Prevention.
Substance Abuse Prevention	Nebraska will increase prevention activities designed to reduce underage drinking and excessive drinking by adults	Participate in a statewide campaign with a unified message; Identify survey respondents attitudes toward perception of risk; Regions will increase the number of environmental strategies directed toward reducing underage drinking and excessive drinking by adults.	Total number of environmental strategies/activities funded by the Division related to underage drinking and excessive drinking by adults performed annually.	Nebraska Prevention Information Reporting System (NPIRS) will be used to identify how many environmental strategies/activities have been conducted on an annual basis.
		Increase the number of SYNAR compliance checks performed in Nebraska. Increase		Regional Behavioral Health Authorities will be

Substance Abuse Prevention	Nebraska will reduce the sale of tobacco to youth.	the workforce available to complete these SYNAR compliance checks. DBH will provide SYNAR compliance check training for the Regions or their designees.	Total sales to minors as reported through SYNAR.	trained to complete the SYNAR compliance checks in coordination with local law enforcement using the approved protocol. RBHAs will report the data on compliance checks using the standardize format for SYNAR Reporting to the Divsion.
Consumer Workforce	Nebraska will enhance opportunites for Continuing Education for its Behavioral Health Workforce	Complete the planning and work needed to organize and fund a conference for continuing education. Hold annual conference for continuing education for Peer Support and Wellness Specialists, peers interested in work, consumers, family members, providers, community leaders, and other interested parties.	Number of persons, by BH workforce category receiving continuing education through annual conference.	Conference attendee data will be reviewed, categorized and counted and compared to the previous year data.
Consumer Workforce	Nebraska will increase the peer support workforce.	Evaluate, improve and implement the Peer Support and Wellness Specialist Certification.	Number of trained Peer Support and Wellness Specialists	Number of Peer Support and Wellness Specialists

Peer Run Recovery Supports	Nebraska will increase the capacity for peer run recovery supports.	Partner with the Regional Consumer Specialists and the consumer run non-profit organizations to develop and implement more peer run recovery support services.	Total number of peer run recovery supports statewide.	At the August 18, 2011 Joint MH and SA Advisory Committee meeting, there was much discussion on the multiple approaches to peer run recovery supports (such as veterans groups, family organizations in the six Regions as well as Keya House in Lincoln). The Division of Behavioral Health will: * define what a peer run recovery support service is and * work with the six regions to identify the number of peer run recovery supports there are. Office of Consumer Affairs will report the number annually.
SA Treatment – Women's Set Aside Services	Nebraska will ensure services for Pregnant Women and Women with Dependent Children are trauma informed and trauma specific.	* Work with RBHA and WSA providers to complete TIC tool. * Provide TA for providers in analyzing assessment results and developing plan for becoming trauma informed and trauma specific. * Work to improve the data quality regarding Women's Set Aside Qualifying Services.	Percent of WSA providers who have completed TIC tool. Total number of Persons Served for Pregnant Women and Women with Dependent Children in WSA funded providers.	Collect data via the annual Trauma Informed Care and Trauma Specific services survey completed by TIN.
Transition Age Youth and Young Adult	Nebraska Behavioral Health System will increase access to services for young adults/youth transitioning to adulthood.	* Partner with stakeholders to develop statewide plan for services. * Provide or seek out TA for development of services/supports. * Nebraska will identify funding in services and supports to meet the needs of young adults/youth in transition to adulthood.	Total number of persons served in services specifically designed for youth/young adults transitioing to adulthood.	DBH Community Services information system captures persons served report data.

Professional Partners Program	Nebraska will implement Wrap Around in the Professional Partners Program with integrity.	1. Create reliable data infrastructure. 2. Measure the Effectiveness of the Professional Partners Program. 3. Partner and provide TA on data, QI and fidelity. 4. Implement plans to improve Fidelity to the Wraparound Model.	WFI measures at 80%.	The evaluation of the program will be two-fold: * using the data, the Divsion of Behavioral Health (DBH) will make a determination on how well the Professional Partners Program is implementing the wraparound approach. * DBH will also determine if significant positive outcomes are being achieved for children enrolled in the Program. Upon determination of wraparound indicator fidelity scores, strategies for training and technical assistance to improve scores on indicators found lacking will be developed.
Co-Occurring Disorder Services	Nebraska will increase the capacity of the public behavioral health workforce to be able to deliver effective prevention and treatment in recovery-oriented systems of care for people with co-occurring disorders.	* Nebraska will develop a co-occurring disorder system of care which is consumer driven and consumer centered. * Nebraska will develop strong partnerships across all systems to ensure an expanded continuum of care. * DBH will utilize the roadmap developed by SQIT to implement the strategic plan.	Total number of behavioral health providers that are dual capable and dual enhanced.	Count the number of behavioral health providers who are (1) dual capable or (2) dual enhanced.
		* Increase trauma awareness by using the “expectation, not the exception” guidelines in daily behavioral health service practices. * Improve access to trauma informed care by encouraging providers to		

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 98 of 187

Trauma Informed Care	Nebraska will develop a service system that understands the effects of trauma and avoids re-traumatizing those who seek services (trauma-informed).	complete a trauma informed services self or peer assessment tool and then develop plans for improvement. * Develop a list of trauma specific services available to consumers in Nebraska utilizing the Network of Care website. * Increase the number of DBH funded providers who provide trauma specific services. * Develop stratagies to assist providers in implementing trauma specific services.	Total number of providers completing TIC tool. Total number of trauma specific services. Total number of individuals with a positive screen that have treatment plans related to trauma.	* Review monthly reports and annual summary on trauma screen upon admission via DBH Community Service data (Magellan Information System). * TIN annual survey count of providers completing TIC tool and providing trauma specific services. * RBHA will monitor treatment planning related to positive screens annually.
Permanent Supportive Housing services	Nebraska will increase the quality and quantity of Permanent Supportive Housing services.	* Enhance the implementation of the Permanent Supportive Housing Evidence-Based Practice in Nebraska. * Develop sustainable methods to complete Permanent Supportive Housing Evidence-Based Practice fidelity monitoring. Fidelity monitoring completed in all six Regions. * Improve upon the data	* Number of adult consumers living in a private residence at the time of admission * Total number of Permanent Housing services available * Increased fidelity scores by provider.	Utilize DBH/Magellan and housing database to determine consumers living in private residences and number of permanent Supportive Housing options available. DBH will aggregate and analyze fidelity data and prepare reports for review.

		system used to monitor the Housing Related Assistance program. * Define Permanent Supportive Housing.		
Supported Employment	Nebraska will increase the quantity and quality of Supported Employment services available.	* Partner with Voc Rehab to improve the data quality for the Supported Employment services. * Develop sustainable strategies for monitoring fidelity to the Supported Employment Evidence- Based Practice. * Develop strategies to assist providers with employment related services.	* Number of clients by employment status * Total persons served in Supported Employment.	Utilizing DBH/Magellan employment data and Voc Rehab data, determine number of Supported Employment providers, number of persons in employment statuses.

Footnotes:

NOTE: The State Planning Activities listed are not in priority order.

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 99 of 187

III: Use of Block Grant Dollars for Block Grant Activities

Table 4 CMHS - Services Purchased Using Reimbursement Strategy

Page 29 of the Application Guidance

Start Year:

End Year:

Reimbursement Strategy	Services Purchased Using the Strategy
Encounter based reimbursement	Day Rehabilitation, Dual Residential; Psychological Residential Rehabilitation; Day Treatment; Medication Management
Grant/contract reimbursement	Outpatient, Intensive Outpatient; Day Support, Supported Employment, Therapuetic Consultation; Childrens Day Treatment, Childrens Muli Systemic Therapy, Prevention; Provider Training
Risk based reimbursement	Community Support, Professional Partner; Professional Partner Wraparound
Innovative Financing Strategy	none
Other reimbursement strategy (please describe)	None

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 4 SAPT - Services Purchased Using Reimbursement Strategy

Page 29 of the Application Guidance

Start Year:
2011

End Year:
2013

Reimbursement Strategy	Services Purchased Using the Strategy
Encounter based reimbursement	Intensive Outpatient, Short Term Residential, Therapuetic Community, Halfway House, Intermediate Residential, Dual Residential
Grant/contract reimbursement	Children's Intensive Outpatient, Social Detox, Assessment, Outpatient, Methadone Maintenance, Prevention, Childrens Therapuetic Community, Tobacco Compliance, Provider Training
Risk based reimbursement	Community Support
Innovative Financing Strategy	none
Other reimbursement strategy (please describe)	None

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 5 CMHS - Projected Expenditures for Treatment and Recovery Supports

Page 30 of the Application Guidance

Start Year: 2011

End Year: 2013

Category	Service/Activity Example	Estimated Percent of Funds Distributed
Healthcare Home/Physical Health	• General and specialized outpatient medical services • Acute Primary Care • General Health Screens, Tests and Immunization • Comprehensive Care Management • Care coordination and health promotion • Comprehensive transitional care • Individual and Family Support • Referral to Community Services	N/A 6
Engagement Services	• Assessment • Specialized Evaluation (Psychological and neurological) • Services planning (includes crisis planning) • Consumer/Family Education • Outreach	N/A 6
Outpatient Services	• Individual evidence-based therapies • Group therapy • Family therapy • Multi-family therapy • Consultation to Caregivers	10-25% 6
Medication Services	• Medication management • Pharmacotherapy (including MAT) • Laboratory services	<10% 6
Community Support (Rehabilitative)	• Parent/Caregiver Support • Skill building (social, daily living, cognitive) • Case management • Behavior management • Supported employment • Permanent supported housing • Recovery housing • Therapeutic mentoring • Traditional healing services	10-25% 6
Recovery Supports	• Peer Support • Recovery Support Coaching • Recovery Support Center Services • Supports for Self Directed Care	N/A 6
Other Supports (Habilitative)	• Personal care • Homemaker • Respite • Supported Education • Transportation • Assisted living services	N/A 6

	• Recreational services • Interactive Communication Technology Devices • Trained behavioral health interpreters	
Intensive Support Services	• Substance abuse intensive outpatient services • Partial hospitalization • Assertive community treatment • Intensive home based treatment • Multi-systemic therapy • Intensive case management	26-50% 6
Out-of-Home Residential Services	• Crisis residential/stabilization • Clinically Managed 24-Hour Care • Clinically Managed Medium Intensity Care • Adult Mental Health Residential • Adult Substance Abuse Residential • Children's Mental Health Residential Services • Youth Substance Abuse Residential Services • Therapeutic Foster Care	10-25% 6
Acute Intensive Services	• Mobile crisis services • Medically Monitored Intensive Inpatient • Peer based crisis services • Urgent care services • 23 hour crisis stabilization services • 24/7 crisis hotline services	N/A 6
Prevention (Including Promotion)	• Screening, Brief Intervention and Referral to Treatment • Brief Motivational Interviews • Screening and Brief Intervention for Tobacco Cessation • Parent Training • Facilitated Referrals • Relapse Prevention /Wellness Recovery Support • Warm line	<10% 6
System improvement activities		<10% 6
Other		<10% 6

Footnotes:

CMHS FY12

III: Use of Block Grant Dollars for Block Grant Activities

Table 5 SAPT - Projected Expenditures for Treatment and Recovery Supports

Page 30 of the Application Guidance

Start Year:

End Year:

Category	Service/Activity Example	Estimated Percent of Funds Distributed
Healthcare Home/Physical Health	• General and specialized outpatient medical services • Acute Primary Care • General Health Screens, Tests and Immunization • Comprehensive Care Management • Care coordination and health promotion • Comprehensive transitional care • Individual and Family Support • Referral to Community Services	N/A
Engagement Services	• Assessment • Specialized Evaluation (Psychological and neurological) • Services planning (includes crisis planning) • Consumer/Family Education • Outreach	<10%
Outpatient Services	• Individual evidence-based therapies • Group therapy • Family therapy • Multi-family therapy • Consultation to Caregivers	10-25%
Medication Services	• Medication management • Pharmacotherapy (including MAT) • Laboratory services	10-25%
Community Support (Rehabilitative)	• Parent/Caregiver Support • Skill building (social, daily living, cognitive) • Case management • Behavior management • Supported employment • Permanent supported housing • Recovery housing • Therapeutic mentoring • Traditional healing services	<10%
Recovery Supports	• Peer Support • Recovery Support Coaching • Recovery Support Center Services • Supports for Self Directed Care	N/A
Other Supports (Habilitative)	• Personal care • Homemaker • Respite • Supported Education • Transportation • Assisted living services	N/A

	• Recreational services • Interactive Communication Technology Devices • Trained behavioral health interpreters	
Intensive Support Services	• Substance abuse intensive outpatient services • Partial hospitalization • Assertive community treatment • Intensive home based treatment • Multi-systemic therapy • Intensive case management	10-25% 6
Out-of-Home Residential Services	• Crisis residential/stabilization • Clinically Managed 24-Hour Care • Clinically Managed Medium Intensity Care • Adult Mental Health Residential • Adult Substance Abuse Residential • Children's Mental Health Residential Services • Youth Substance Abuse Residential Services • Therapeutic Foster Care	10-25% 6
Acute Intensive Services	• Mobile crisis services • Medically Monitored Intensive Inpatient • Peer based crisis services • Urgent care services • 23 hour crisis stabilization services • 24/7 crisis hotline services	N/A 6
Prevention (Including Promotion)	• Screening, Brief Intervention and Referral to Treatment • Brief Motivational Interviews • Screening and Brief Intervention for Tobacco Cessation • Parent Training • Facilitated Referrals • Relapse Prevention /Wellness Recovery Support • Warm line	10-25% 6
System improvement activities		<10% 6
Other		<10% 6

Footnotes:

SAPTBG FY12

III: Use of Block Grant Dollars for Block Grant Activities

Table 6 CMHS - Primary Prevention Planned Expenditures Checklist

Page 34 of the Application Guidance

Start Year: 2011

End Year: 2013

Strategy	IOM Target	Block Grant FY 2012	Other Federal	State	Local	Other
Information Dissemination	Universal	$	$	$	$	$
Information Dissemination	Selective	$	$	$	$	$
Information Dissemination	Indicated	$	$	$	$	$
Information Dissemination	Unspecified	$	$	$	$	$
Information Dissemination	Total	$	$	$	$	$
Education	Universal	$	$	$	$	$
Education	Selective	$	$	$	$	$
Education	Indicated	$	$	$	$	$
Education	Unspecified	$	$	$	$	$
Education	Total	$	$	$	$	$
Alternatives	Universal	$	$	$	$	$
Alternatives	Selective	$	$	$	$	$
Alternatives	Indicated	$	$	$	$	$
Alternatives	Unspecified	$	$	$	$	$
Alternatives	Total	$	$	$	$	$
Problem Identification and Referral	Universal	$	$	$	$	$
Problem Identification and Referral	Selective	$	$	$	$	$
Problem Identification and Referral	Indicated	$	$	$	$	$
Problem Identification and Referral	Unspecified	$	$	$	$	$
Problem Identification and Referral	Total	$	$	$	$	$

Community-Based Process	Universal	$	$	$	$	$
Community-Based Process	Selective	$	$	$	$	$
Community-Based Process	Indicated	$	$	$	$	$
Community-Based Process	Unspecified	$	$	$	$	$
Community-Based Process	Total	$	$	$	$	$
Environmental	Universal	$	$	$	$	$
Environmental	Selective	$	$	$	$	$
Environmental	Indicated	$	$	$	$	$
Environmental	Unspecified	$	$	$	$	$
Environmental	Total	$	$	$	$	$
Section 1926 Tobacco	Universal	$	$	$	$	$
Section 1926 Tobacco	Selective	$	$	$	$	$
Section 1926 Tobacco	Indicated	$	$	$	$	$
Section 1926 Tobacco	Unspecified	$	$	$	$	$
Section 1926 Tobacco	Total	$	$	$	$	$
Other	Universal	$	$	$	$	$
Other	Selective	$	$	$	$	$
Other	Indicated	$	$	$	$	$
Other	Unspecified	$	$	$	$	$
Other	Total	$	$	$	$	$

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 6 SAPT - Primary Prevention Planned Expenditures Checklist

Page 36 of the Application Guidance

Start Year: 2011

End Year: 2013

Strategy	IOM Target	Block Grant FY 2012	Other Federal	State	Local	Other
Information Dissemination	Universal	$156,016	$	$7,768	$	$
Information Dissemination	Selective	$64,242	$	$864	$	$
Information Dissemination	Indicated	$36,094	$	$	$	$
Information Dissemination	Unspecified	$	$	$10,224	$	$
Information Dissemination	Total	$256,352	$	$18,856	$	$
Education	Universal	$221,752	$	$	$	$
Education	Selective	$131,931	$	$	$	$
Education	Indicated	$93,573	$	$	$	$
Education	Unspecified	$	$	$10,224	$	$
Education	Total	$447,256	$	$10,224	$	$
Alternatives	Universal	$56,203	$	$	$	$
Alternatives	Selective	$44,070	$	$	$	$
Alternatives	Indicated	$34,054	$	$	$	$
Alternatives	Unspecified	$	$	$10,222	$	$
Alternatives	Total	$134,327	$	$10,222	$	$
Problem Identification and Referral	Universal	$18,882	$	$	$	$
Problem Identification and Referral	Selective	$254,770	$	$	$	$
Problem Identification and Referral	Indicated	$48,608	$	$7,040	$	$
Problem Identification and Referral	Unspecified	$	$	$10,222	$	$
Problem Identification and Referral	Total	$322,260	$	$17,262	$	$

Community-Based Process	Universal	$809,684	$	$186,280	$	$
Community-Based Process	Selective	$294,520	$	$18,844	$	$
Community-Based Process	Indicated	$79,609	$	$50,468	$	$
Community-Based Process	Unspecified	$14,749	$	$	$	$
Community-Based Process	Total	$1,198,562	$	$255,592	$	$
Environmental	Universal	$698,296	$	$44,548	$	$
Environmental	Selective	$257,105	$	$	$	$
Environmental	Indicated	$55,039	$	$	$	$
Environmental	Unspecified	$	$	$	$	$
Environmental	Total	$1,010,440	$	$44,548	$	$
Section 1926 Tobacco	Universal	$108,792	$	$	$	$
Section 1926 Tobacco	Selective	$	$	$	$	$
Section 1926 Tobacco	Indicated	$	$	$	$	$
Section 1926 Tobacco	Unspecified	$	$	$	$	$
Section 1926 Tobacco	Total	$108,792	$	$	$	$
Other	Universal	$189,060	$	$	$	$
Other	Selective	$	$	$	$	$
Other	Indicated	$	$	$	$	$
Other	Unspecified	$	$	$	$	$
Other	Total	$189,060	$	$	$	$

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 7 CMHS - Projected State Agency Expenditure Report

Page 38 of the Application Guidance

Start Year: 2011

End Year: 2013

Date of State Expenditure Period From: 10/01/2011 Date of State Expenditure Period To: 09/30/2013

Activity	A. Block Grant	B. Medicaid (Federal, State, and Local)	C. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	D. State Funds	E. Local Funds (excluding local Medicaid)	F. Other
1. Substance Abuse Prevention and Treatment	$	$	$	$	$	$
2. Primary Prevention	$	$	$	$	$	$
3. Tuberculosis Services	$	$	$	$	$	$
4. HIV Early Intervention Services	$	$	$	$	$	$
5. State Hospital		$	$	$	$	$
6. Other 24 Hour Care	$ 406,111	$ 5,826,856	$	$ 16,209,116	$	$
7. Ambulatory/Community Non-24 Hour Care	$ 3,246,017	$ 14,983,343	$ 576,000	$ 109,659,572	$	$
8. Administration (Excluding Program and Provider Level)	$ 192,218	$	$	$	$	$
9. Subtotal (Rows 1, 2, 3, 4, and 8)	$192,218	$	$	$	$	$
10. Subtotal (Rows 5, 6, 7, and 8)	$3,844,346	$20,810,199	$576,000	$125,868,688	$	$
11. Total	$3,844,346	$20,810,199	$576,000	$125,868,688	$	$

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 7 SAPT - Projected State Agency Expenditure Report

Page 38 of the Application Guidance

Start Year: 2011

End Year: 2013

Date of State Expenditure Period From: 10/01/2011 Date of State Expenditure Period To: 09/30/2013

Activity	A. Block Grant	B. Medicaid (Federal, State, and Local)	C. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	D. State Funds	E. Local Funds (excluding local Medicaid)	F. Other
1. Substance Abuse Prevention and Treatment	$11,307,391	$4,251,009	$	$49,536,718	$	$
2. Primary Prevention	$3,667,049	$	$	$356,704	$	$
3. Tuberculosis Services	$	$	$	$	$	$
4. HIV Early Intervention Services	$	$	$	$	$	$
5. State Hospital		$	$	$	$	$
6. Other 24 Hour Care	$	$	$	$	$	$
7. Ambulatory/Community Non-24 Hour Care	$	$	$	$	$	$
8. Administration (Excluding Program and Provider Level)	$725,448	$	$	$	$	$
9. Subtotal (Rows 1, 2, 3, 4, and 8)	$15,699,888	$4,251,009	$	$49,893,422	$	$
10. Subtotal (Rows 5, 6, 7, and 8)	$725,448	$	$	$	$	$
11. Total	$15,699,888	$4,251,009	$	$49,893,422	$	$

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 8 Resource Development Planned Expenditure Checklist

Page 40 of the Application Guidance

Start Year: 2011

End Year: 2013

Activity	A. Prevention-MH	B. Prevention-SA	C. Treatment-MH	D. Treatment-SA	E. Combined	F. Total
1. Planning, Coordination and Needs Assessment	$	$ 174,818	$	$		$174,818
2. Quality Assurance	$	$ 174,818	$	$		$174,818
3. Training (Post-Employment)	$	$	$	$ 214,737		$214,737
4. Education (Pre-Employment)	$	$	$	$ 126,115		$126,115
5. Program Development	$	$	$	$	$	$
6. Research and Evaluation	$	$	$	$	$	$
7. Information Systems	$	$ 97,000	$	$		$97,000
8. Total	$	$446,636	$	$340,852	$	$787,488

Footnotes:

IV: Narrative Plan

D. Activities that Support Individuals in Directing the Services

Page 41 of the Application Guidance

Narrative Question:

SAMHSA firmly believes in the importance of individuals with mental and substance use disorders participating in choosing the services and supports they receive. To achieve this goal, individuals and their support systems must be able to access and direct their services and supports. Participant direction, often referred to as consumer direction or self direction, is a delivery mode through which a range of services and supports are planned, budgeted and directly controlled by an individual (with the help of representatives, if desired) based on the individual's needs and preferences that maximize independence and the ability to live in the setting of his/her choice. Participant-directed services should include a wide range of high-quality, culturally competent services based on acuity, disability, engagement levels and individual preferences. The range of services must be designed to incorporate the concepts of community integration and social inclusion. People with mental and substance use disorders should have ready access to information regarding available services, including the quality of the programs that offer these services. An individual and their supports must be afforded the choice to receive services and should have sufficient opportunities to select the individuals and agencies from which they receive these services. Person centered planning is the foundation of self-direction and must be made available to everyone. The principles of person centered planning are included at www.samhsa.gov/blockgrantapplication. Individuals must have opportunities for control over a flexible individual budget and authority to directly employ support workers, or to direct the worker through a shared employment model through an agency. People must have the supports necessary to be successful in self direction including financial management services and supports brokerage. In addition, individuals and families must have a primary decision-making role in planning and service delivery decisions. Caregivers can play an important role in the planning, monitoring and delivery of services and should be supported in these roles. In the section below, please address the following:

- Either summarize your State's policies on participant-directed services or attach a copy to the Block Grant application(s).
- What services for individuals and their support systems are self-directed?
- What participant-directed options do you have in your State?
- What percentage of individuals funded through the SMHA or SSA self direct their care?
- What supports does your State offer to assist individuals to self direct their care?

Footnotes:

D. Activities that Support Individuals in Directing the Services | page 1

Narrative Question:
SAMHSA firmly believes in the importance of individuals with mental and substance use disorders participating in choosing the services and supports they receive. To achieve this goal, individuals and their support systems must be able to access and direct their services and supports. Participant direction, often referred to as consumer direction or self direction, is a delivery mode through which a range of services and supports are planned, budgeted and directly controlled by an individual (with the help of representatives, if desired) based on the individual's needs and preferences that maximize independence and the ability to live in the setting of his/her choice. Participant-directed services should include a wide range of high-quality, culturally competent services based on acuity, disability, engagement levels and individual preferences.
August 31, 2011

The Division of Behavioral Health (DBH) knows how important it is for individuals with mental and substance use disorders to participate in choosing the services and supports they receive. DBH has and continues to be purchasing services that support individuals in directing their own services based on the individual's needs and preferences. One long established expectation is each person served has an individual service plan for all services provided including an assessment, service goals and related documentation. This individual service plan needs to be signed by the consumer to document his/her participation and agreement to work in that direction. As reported in the 2010 URS Tables, 80.4% of adults reported positively about their participation in treatment planning. Family members for children services report 82.5% positive responses to participation. While this is good, clearly there is room for improvement.

Table 11: Summary Profile of Client Evaluation of Care (Year Survey was Conducted: 2010)

Adult Consumer Survey Results:	**Number of Positive Responses**	**Responses**	
4. Adults Reporting on Participation In Treatment Planning.	848	1,055	80.4%
Child/Adolescent Consumer Survey Results:	**Number of Positive Responses**	**Responses**	
4. Family Members Reporting on Participation In Treatment Planning for their Children	188	228	82.5%

Nebraska's proposed regulations, 206 NAC 6, speak to consumer choice and self determination, as proposed in the following language regarding rights, complaints and grievances:

"The following rights apply to consumers receiving behavioral health services through Nebraska's public behavioral health system. All consumers have the right to:

1. Be treated respectfully, impartially, and with dignity;
2. Communicate freely with individuals of their choice including, but not limited to, family, friends, legal counsel, and his/her private physician, and to
3. Have clinical records made available to themselves and these individuals of their choice by his/her written request;
4. Actively and directly Participate in decisions which incorporate independence, individuality, privacy, and dignity and to make decisions regarding care and treatment;
5. Refuse treatment or therapy, unless treatment or therapy was authorized by the consumer's legal guardian or was ordered by a mental health board or court;

6. Have privacy and confidentiality related to all aspects of care;
7. Be protected from neglect; physical, emotional or verbal abuse; and exploitation of any kind;
8. Actively and directly participate in developing an individual treatment, rehabilitation, and recovery plan and decision-making regarding his/her behavioral health care;
9. Receive care from providers who adhere to a strict policy of non-discrimination in the provision of services;
10. Be free of sexual exploitation, or harassment, or re-traumatization;
11. Voice complaints and file grievances without discrimination or reprisal and to have those complaints and grievances addressed in a timely manner(see 206 NAC 6-003); and
12. Receive behavioral health services in the most integrated setting appropriate for each consumer's needs based on an individualized and person-centered assessment.

Consumers must be able to freely voice complaints and recommend changes without being subject to coercion, discrimination, reprisal, or unreasonable interruption of care, treatment, and services.

Each provider must establish a written consumer grievance policy with the following components:

1. Consumers and as applicable their legal representative(s), and family of their choosing must be informed of and given a copy of written procedures for addressing and resolving grievances established by each provider (see consumer rights in 206 NAC 6-001);
2. Consumers, families, staff, and others must have access to the provider's grievance process;
3. The consumer's grievance must be responded to by the provider in a timely manner and the provider must document its response to the consumer;
4. If the consumer's grievance is not addressed satisfactorily through the provider's complaint process, the provider must give adequate information, including telephone numbers and addresses, to the consumer to enable the consumer to contact the Division of Behavioral Health, Office of Consumer Affairs; the Division of Public Health, Facility Complaint Intake and the Investigations Section, the designated Protection and Advocacy organization for Nebraska; and/or the Consumer Specialist of the Regional Behavioral Health Authority (RBHA),; and the office of the Ombudsman; the Department's System Advocate, and the vendor who is contracted for system management. This information must also be readily available to consumers, families, staff, and others."

DBH has also been working to implement more participant directed services. The Peer Support & Wellness Specialist Code of Ethics of the Nebraska Office of Consumer Affairs: Division of Behavioral Health helps to move this forward:

> Peer Support Staff facilitate self-determination for peers utilizing peer support services. They encourage and nurture peers to find their own voice. They will advocate for the right of all people to make their own decisions in all matters when dealing with other professionals, promoting concepts of shared-decision making.

This theme continues with Division of Behavioral Health programs like Housing Related Assistance, Supported Employment, Recovery Support, Peer Support, WRAP training and Hospital Diversion.

Housing Related Assistance – This is a State of Nebraska funded program following the Tenant-Based Rental Assistance Model, the money follows the consumer. This means that the funds are designed to help individual households afford housing costs. The eligible participant receives

assistance to cover Housing Related costs (such as rent, utility costs, security deposits, and/or utility deposits). The service participant chooses his/her own housing unit. The housing unit must meet Housing Quality Standards (HQS). If the service participant decides to move, the assistance is moved to the new housing unit; the funding follows the service participant. The Program also follows the Permanent Supportive Housing program model and is developed to be consistent with recovery values of service participant self-determination and choice.

Supported Employment – This is a well-defined approach to helping people with mental illnesses find and keep competitive employment within their communities. Supported employment programs are staffed by employment specialists who have frequent meetings with treatment providers to integrate supported employment with mental health services. The core principles of this program include:

- Eligibility Is Based on Consumer Choice - All consumers who want to work are eligible for Supported Employment (Consumers are not excluded because of severity of symptoms, substance use, diagnosis or recent hospitalizations)
- The program ...
  - helps people find and keep meaningful jobs in the community
  - The jobs
    - exist in the open labor market,
    - pay at least minimum wage, and
    - are in work settings that include people who are not disabled

Supported employment is available throughout all six of Nebraska's Behavioral Health Regions.

Recovery Support - a new service is Recovery Support which is most often, though not always, provided by a peer. Recovery Support services promote successful independent community living by supporting a consumer in achieving his/her behavioral health goals and ability to manage an independent community living situation. Recovery Support is designed to advocate for consumers to access community resources and foster advocacy and self-advocacy in others through the use of wellness and crisis prevention tools. Crisis relapse prevention, case management, and referral to other independent living and behavioral health services are provided to assist the consumer in maintaining self sufficiency. The Service should assist consumers to:

- Develop a mutual set of expectations regarding the roles of the consumer and the Recovery Support Worker
- Develop and implement crisis relapse prevention plan.
- Foster advocacy and self-advocacy.
- Support in rehabilitation and treatment goal achievement and referral to other community resources as needed.

Peer Support services are growing in strength and popularity across Nebraska. Created as an opportunity for consumers who have significantly recovered from their illness to assist others in their recovery process, peer support specialists are employed in each of Nebraska's six behavioral health regions. Serving in various roles and capacities, peer support specialists are employed in health care facilities, job training sites, regional offices, as well as other organizations throughout the state.

Mental Health America supports peer support services stating they teach one another the skills necessary to lead meaningful lives in the community, have demonstrated effective outcomes such as reduced isolation and increased empathic responses, and that research has shown that outcomes improve when consumers serve as peer specialists on case management teams.

D. Activities that Support Individuals in Directing the Services | page 4

The Nebraska Peer Specialist Association serves as an avenue for individuals to learn more about the peer specialist movement and keep up to date on happenings related to peer support services in Nebraska. For more information please visit their website at http://nps-web.org.

WRAP –WRAP training is taught by highly trained consumer facilitators who follow Mary Ellen Copeland's nationally recognized recovery curriculum. In developing a WRAP, an individual will identify the wellness tools that will most benefit them and will then learn how to use these tools when needed, every day or when particular feelings or experiences arise. WRAP helps monitor and relieve uncomfortable and distressing feelings and behaviors and identifies an individual's best course of action. WRAP planning also includes Crisis Planning (an Advance Directive) that lets others know how to respond when a person cannot make decisions, take care of themselves, or keep themselves safe, and a Post Crisis plan to guide the individual through the often difficult time when they are healing from a crisis.
Key elements of WRAP include:

- Wellness Toolbox
- Daily Maintenance Plan
- Identifying Triggers and an Action Plan
- Identifying Early Warning Signs and an Action Plan
- Crisis Planning
- Post Crisis Planning

WRAP is designed and managed by the individual and is designed to:

- decrease and prevent intrusive or troubling feelings and behaviors
- increase personal empowerment
- improve quality of life
- assist in achieving life goals and dreams

Hospital Diversion – Nebraska currently has one peer run hospital diversion program. Keya House is for adults with a behavioral health diagnosis and who live in the Region V Systems service area. You must have transportation to and from the house. Keya House is for Peers helping peers with crisis aversion as well as diverting from psychiatric distress that may lead to hospitalization. It is provided in comfortable, clean, and furnished four-bedroom house in a quiet and safe neighborhood. Keya House includes self help and proactive recovery tools to regain and maintain wellness as well as trained peer companions who are compassionate, understanding, and empowering. This program is strictly voluntary and free of charge. You can self refer or be referred by a health professional or a family member. There is a registration process to ensure the appropriateness of the program for each individual as well as for the comfort of other guests.

Keya House offers:

- Peers helping peers with crisis prevention and diversion from psychiatric distress that may lead to hospitalization.
- A comfortable, clean, and furnished four-bedroom house in a quiet and safe neighborhood.
- Self help and proactive recovery tools to regain and maintain wellness.
- Trained peer companions who are compassionate, understanding, empowering, and available twenty-four hours a day.

This program is strictly voluntary and free of charge. The individual can self- refer or be referred by a health professional or a family member. There is a registration process to ensure the appropriateness of the program for each individual as well as for the comfort of other guests. The

person may stay for up to five days. Peer companions staff the house twenty four hours a day and can maintain contact and support at the individual's request after the stay is finished.
Guidelines – the individual must:

- Be 19 years or older.
- Not be in crisis or severe emotional distress.
- Not have any known physical illness (fever, flu symptoms, intestinal distress, etc.)
- Be able to maintain acceptable personal hygiene.
- Be responsible for preparing own meals and cleaning up after oneself.
- Understand and sign a safety and responsibility contract.
- Have permanent housing after your stay.
- Must follow the house rules which are explained when you enter the house.

The six Family Organizations in Nebraska, under the umbrella of the Nebraska Federation for Families, provide children with behavioral health needs and their families with options for services and supports, as described below:

Nebraska Family Helpline and Family Navigators: The Nebraska Family Helpline provides a single point of access to children's behavioral health services through the operation of a 24-hour, year-round Helpline for the State of Nebraska. The Family Navigator service offers even more assistance to families needing guidance through the mental and behavioral health systems. The Helpline and Family Navigator services support the Children and Family Behavioral Health Support Act(LB603), appropriated by the Legislature in 2009. Under Nebraska's former Safe Haven law 36 children were abandoned by parents and guardians; 29 of those children were from Nebraska. The Helpline and Family Navigator services were formed to give information and assistance to parents, guardians, children others in need. On January 1, 2010, the Helpline and Family Navigator services became operational. The programs' first full fiscal year was 2011.

Boys Town and its partner, Nebraska Federation for Families, also assist families through the Family Navigator service. Family Navigators own children were consumers who have been a part of the mental and behavioral health systems, enabling Navigators to help guide other families and to provide a family voice to support this program. Family Navigators rely on real life experiences and system familiarities to assist other families. The Helpline and Family Navigators serve the six behavioral health regions across Nebraska.

Longer Term Mentoring: In addition, the Federation for Families can provide longer term mentoring and support to families with children in the Behavioral Health system referred through the Behavioral Health Regions.

Right Turn: Lutheran Family Services of Nebraska and Nebraska Children´s Home Society, two human care agencies in Nebraska, have joined together to create Right Turn, a new collaborative program to provide help to families who have adopted or entered into a guardianship. Right Turn was established in response to some of the post adoption/guardianship issues that arose from Nebraska´s original Safe Haven law. Safe Haven made it clear that many adoptive and guardianship families were struggling and frustrated and did not know where to turn for help. Right Turn is the first call you need to make as a single point of access to best help families. Right turn staff assists families to develop individualized success plans and connect families to respite care, mentoring, counseling and other services.

IV: Narrative Plan

E. Data and Information Technology

Page 41 of the Application Guidance

Narrative Question:

Regardless of financing or reimbursement strategy used, unique client-level encounter data should be collected and reported for specific services that are purchased with Block Grant funds. Such service tracking and reporting is required by SAMHSA to be reported in the aggregate. Universal prevention and other non-service-based activities (e.g. education/training) must be able to be reported describing the numbers and types of individuals impacted by the described activities. States should to complete the service utilization Table 5 in the Reporting Section of the Application. States should provide information on the number of unduplicated individuals by each service purchased with Block Grant Funds rather than to provide information on specific individuals served with Block Grant funds. In addition, States should provide expenditures for each service identified in the matrix. If the State is currently unable to provide unique client-level data for any part of its behavioral health system, SAMHSA is requesting the State to describe in the space below its plan, process, resources needed and timeline for developing such capacity. States should respond to the following:

- List and briefly describe all unique IT systems maintained and/or utilized by the State agency that provide information on one or more of the following:
  - Provider characteristics
  - Client enrollment, demographics, and characteristics
  - Admission, assessment, and discharge
  - Services provided, including type, amount, and individual service provider
  - Prescription drug utilization
- As applicable, for each of these systems, please answer the following:
  - For provider information, are providers required to obtain national provider identifiers, and does the system collect and record these identifiers?
  - Does the system employ any other method of unique provider identification that provides the ability to aggregate service or other information by provider?
  - Does the system use a unique client identifier that allows for unduplicated counts of clients and the ability to aggregate services by client?
  - Are client-level data in the form of encounters or claims that include information on individual date of service, type of service, service quantity, and identity of individual provider?
  - Does the system comply with Federal data standards in the following areas (use of ICD-10 or CPT/HCPCS codes)?
- As applicable, please answer the following:
  - Do provider and client identifiers in the behavioral health IT system allow for linkage with Medicaid provider identifiers that provides the ability to aggregate Medicaid and non-Medicaid provider information?
  - Are Medicaid data or linked Medicaid-behavioral health data used to routinely produce reports?
  - Does your State's IT division participate in regular meetings with Medicaid and other agencies to address mutual issues concerning system interoperability, electronic health records, Federal IT requirements or similar issues?
  - Does your State have a grant to create a statewide health information exchange and does your agency participate in the development of the exchange and in issues concerning MH/SA data?
  - Is your State Medicaid agency engaging in or planning to improve its IT system? If so, is your agency included in such efforts for the purposes of addressing issues related to data interoperability, behavioral health IT system reform, and meeting Federal IT data standards?

In addition to the questions above, please provide any information regarding your State's current efforts to assist providers with developing and using Electronic Health Records.

Footnotes:

E. Description of the Use of Technology— Interactive Communication Technologies (ICTs) / pg 1

September 1, 2011

SAMHSA Requirements: FY 2012–2013 Block Grant Application

E. Data and Information Technology

Narrative Question:
Regardless of financing or reimbursement strategy used, unique client-level encounter data should be collected and reported for specific services that are purchased with Block Grant funds. Such service tracking and reporting is required by SAMHSA to be reported in the aggregate. Universal prevention and other non-service-based activities (e.g. education/training) must be able to be reported describing the numbers and types of individuals impacted by the described activities. States should to complete the service utilization Table 5 (see notes below) in the Reporting Section of the Application. States should provide information on the number of unduplicated individuals by each service purchased with Block Grant Funds rather than to provide information on specific individuals served with Block Grant funds. In addition, States should provide expenditures for each service identified in the matrix. If the State is currently unable to provide unique client-level data for any part of its behavioral health system, SAMHSA is requesting the State to describe in the space below its plan, process, resources needed and timeline for developing such capacity. States should respond to the following:

•List and briefly describe all unique IT systems maintained and/or utilized by the State agency that provide information on one or more of the following:
- ◦Provider characteristics
- ◦Client enrollment, demographics, and characteristics
- ◦Admission, assessment, and discharge
- ◦Services provided, including type, amount, and individual service provider
- ◦Prescription drug utilization

Response: NE Division of Behavioral Health data sources used for unique client-level data for any part of its behavioral health treatment system.

Data Sources	Description
DBH-CS	Division of Behavioral Health (DBH) – Community Services (CS) data system. The Nebraska Division of Behavioral Health contracts with Magellan Behavioral Health for data collection and management of data relating to DBH-funded community behavioral health treatment programs including Mental Health and Substance Abuse .
Avatar	State Psychiatric Hospital data is collected using software called Avatar. Lincoln Regional Center (LRC) – January 2006; Hastings Regional Center (HRC) and Norfolk Regional Center (NRC) – June 2007.
NPIRS	Division of Behavioral Health (DBH) - Nebraska Prevention Information Reporting System. – Community coalitions report prevention activities funded by a variety of sources including Block Grant, Strategic Prevention Framework, Department of Education, Department of Roads, Tobacco Free fund distributions.

Characteristics	AVATAR System (State Psychiatric Hospitals)	Magellan Data System (Community Based Programs)
◦Provider characteristics	YES	Magellan (Provider Enrollment)

E. Description of the Use of Technology— Interactive Communication Technologies (ICTs) / pg 2

◦Client enrollment, demographics, and characteristics	YES	YES
◦Admission, assessment, and discharge	Avatar	Magellan (managed care)
◦Services provided, including type, amount, and individual service provider	Avatar	Magellan Turn Around Documents
◦Prescription drug utilization	Avatar	None – but a part of concurrent review – free form text.
Unique Client ID	Yes	Yes

For a basic orientation on the DBH CS data, see web page Magellan Partnership Quality Improvement Team (MQIT) http://www.dhhs.ne.gov/beh/MQIT.htm
April 2011 Training on NBHS Data System by Don Reding, Operations Manager, Magellan Health Services (Power Point Presentation)
http://www.dhhs.ne.gov/beh/MQIT/Mag_Train_April_2011_Data_sys.pdf

The Division of Behavioral Health also maintains an internal Microsoft Share Point site allowing the Division to collaborate on Budget Planning and Tracking (including funding to the Regions), Contract Monitoring and a repository of forms and formats.

The Division of Behavioral Health released a Request for Information in August 2011.
The purpose of the RFI is to solicit ideas from vendors regarding the services and functionality that may be included in a new centralized, enterprise wide behavioral health information system. The Department is seeking input from the vendor community on best practices and state-of the art solutions. The Department is seeking vendor community insight and information prior to finalizing functional and technical requirements that might be included in a Request for Proposal (RFP). The objectives are to identify new technology, best practices and business functions to be considered in the planning process; collect information to facilitate construction of RFP requirements; collect information to aid the Division in understanding the vendor perspective on design, development and operation of a Behavioral Health data system; and insure the Department has technology investment which insures flexibility and functionality that will support the new federal Health Care reform initiatives. No changes to the current operations of the AVATAR or Magellan data systems are anticipated until at least July 2013.

◦For provider information, are providers required to obtain national provider identifiers, and does the system collect and record these identifiers?
No, the Division of Behavioral Health does not utilize the National Provider Identifiers (NPI) in the data system. Magellan Behavioral Health System collects national provider numbers but utilizes other indicators of agency relationship.
Both the Division of Behavioral Health and Magellan have access to the Nebraska MMIS (Medicaid Management Information System) which will implement NPI January 2012.

E. Description of the Use of Technology— Interactive Communication Technologies (ICTs) / pg 3

AVATAR data system utilizes NPI to bill on behalf of the Regional Centers and Beatrice State Developmental Center.
NPIRS – does not utilize NPI.

◦Does the system employ any other method of unique provider identification that provides the ability to aggregate service or other information by provider?
Each umbrella agency has a unique agency identifier. In some cases satellite offices have unique numbers. The Division has explored with Magellan the use of unique identifiers for each agency location, but because of costs involved has not pursued this option. Currently reports are prepared at the parent level for agencies operating several satellite offices (many of which are itinerant offices open limited hours per week).
AVATAR system utilizes unique identifies for each of the regional centers wards.
NPIRS – Uniquely identifies each community coalition reporting to the system.

◦Does the system use a unique client identifier that allows for unduplicated counts of clients and the ability to aggregate services by client?
Each client is provided a unique identifier by the Magellan Behavioral Health Data System. The Magellan system maintains a central client file that in turn can identify the individuals progression through the continuum of treatment services.
AVATAR uses a process to identify each person uniquely within the regional centers including such key indicators as Name, (First, Middle, Surname), Gender, Race, ethnicity, and date of birth together with Social Security Number.
NPIRS – No client identifier are used in NPIRS. Activities reported through NPIRS are generally non-service based, however the number and demographic characteristics of participants in these services is gathered for reporting purposes.

◦Are client-level data in the form of encounters or claims that include information on individual date of service, type of service, service quantity, and identity of individual provider?
The Magellan data system provides for a monthly count of encounters that include the number of service units, by service type, by provider. This system is used to request reimbursement for services by providers to Regions and the Division. Client counts can be generated for unique individuals at all levels of care, at agencies, at services within agencies and for the state as a whole.
AVATAR uses a system of clinical notes and related facts to determine the extent of use of Regional Center Services.
NPIRS – Data is collected by the many community coalitions on prevention activities. The system cannot identify individuals participating in such activities, but does collect the number of participants by demographic characteristics and the specific activity being reported on by the community coalitions.

◦Does the system comply with Federal data standards in the following areas (use of ICD-10 or CPT/HCPCS codes)?
Magellan system does attempt to capture data using the ICD codes, and CPT/HCPCS codes. The Division does not model its service system using ICD-10 nor CPT/HCPCS codes exclusively. It is often necessary to combine several Nebraska services into a single national code.
AVATAR data system uses ICD-9 (currently) and the CPT/HCPCS codes.
NPIRS does not use any national codes for reporting of prevention activities.

E. Description of the Use of Technology— Interactive Communication Technologies (ICTs) / pg 4

•As applicable, please answer the following:

◦Do provider and client identifiers in the behavioral health IT system allow for linkage with Medicaid provider identifiers that provides the ability to aggregate Medicaid and non-Medicaid provider information?
Not in an automated interface, but Division of Behavioral Health staff and approved Magellan staff have access to common client information the MMIS.

◦Are Medicaid data or linked Medicaid-behavioral health data used to routinely produce reports?
Upon request, the Division of Behavioral Health can request special reports comparing and or merging MMIS data with DBH Community Services data.

◦Does your State's IT division participate in regular meetings with Medicaid and other agencies to address mutual issues concerning system interoperability, electronic health records, Federal IT requirements or similar issues
Yes, Nebraska's MMIS is State owned and operated by the DHHS and OCIO (Office of the Chief Operating Officer) Department of Administrative Services. See answers below on Nebraska Information Technology Commission (NITC) and the Nebraska HIT.

◦Does your State have a grant to create a statewide health information exchange and does your agency participate in the development of the exchange and in issues concerning MH/SA data?
Yes. Through the NITC the Nebraska Health Information Initiative (NeHII) is chaired by the Lieutenant Governor Rick Sheehy. DHHS currently is submitting Immunization data records to Health Information Technology (HIT).

◦Is your State Medicaid agency engaging in or planning to improve its IT system? If so, is your agency included in such efforts for the purposes of addressing issues related to data interoperability, behavioral health IT system reform, and meeting Federal IT data standards?
Yes, the Nebraska Department of Health and Human Services (DHHS) Medicaid Management Information System (MMIS) has an Advanced Planning Document (source of approval for Federal Financial Participation in information technology projects – needed to qualify for a 90/10 match rate) for Planning/Preparation for MMIS replacement. This MMIS replacement will meet HIPAA 5010 (Health Insurance Portability and Accountability Act of 1996 – 5010 – federal transaction and code sets), MDS (Minimum Data Set Version 3.0), Resource Utilization Groups (classification system to explain non-therapy ancillary costs), NCCI (National Correct Coding Initiative), Affordable Care Act (previously Patient Protection and Affordable Care Act), state Medicaid Health Information Technology (HIT) plan, and ICD- 10 (International Statistical Classification of Diseases and Related Health Problems, 10th Revision).
Source: Margo Gamet (Application Services Manager, Information Systems & Technology)

In addition to the questions above, please provide any information regarding your State's current efforts to assist providers with developing and using Electronic Health Records.

Providers in Nebraska are encouraged to join health exchanges that may develop in their areas. The Division of Behavioral Health (DBH) is an integrated Division which includes mental health and substance abuse. Currently, DBH does not have its own data or claims system. DBH does not

have direct participation in newly emerging health information systems owing to its contractual relationship with Magellan Behavioral Health.

Magellan Behavioral Health Services, Inc., operates as an Administrative Service Organization (ASO) for the Division of Medicaid and Long Term Care Behavioral Health carve out, and the Division of Behavioral Health. The Division of Behavioral Health's community data system is operated entirely by Magellan Behavioral Health. DBH receives a data extract each month. These are the data used for the Federal reporting under the two block grants such as the National Outcome Measures. Under the current contract, the Division has insisted on is the Magellan develop the capacity to accommodate single data entry on the part of the behavioral health network providers with a file transfer for reporting to Magellan and the State.

Region 5 Behavioral Health Authority and it's network providers have developed the Electronic Behavioral Health Information Network (eBHIN). As of July 2011, eBHIN providers have begun electronic data exchanges between Magellan and eBHIN for all data elements contained in the Magellan data system, thus by-passing the need for repeated data entry into agency practice management systems, Magellan web application and other insurance entities to obtain reimbursement for services by agencies. The eBHIN system also is capable of registering and initiating authorizations for services in accord with the standards set up by the Division of Behavioral Health and Division of Medicaid and Long Term Care. It is anticipated, that other Regional Behavioral Health Authorities will invite providers to join eBHIN in the coming year.

In the larger context the Information Technology staff of the Department of Health and Human Services is participating in the Nebraska Information Technology Commission, the state coordinating body for health information technology. The administrator of the Division of Medicaid and Long Term Care, Administrator of the Information Technology team of the Department of Health and Human Services both sit on the Nebraska Information Technology Commission. The Nebraska Information Technology Commission has created a plan "Digital Nebraska: Envisioning Our Future" that addresses Health Information Technology initiatives, including electronic health records, electronic medical records, personal health records, electronic prescribing, clinical decision support, computerized provider order entry, health information exchange, and telehealth. The Commission meets quarterly or more frequently as conditions demand.

Over the next few years behavioral health care providers will need to be increasingly linked to the Health Information Technology (HIT) system being led by the HHS Office of the National Coordinator. Nebraska's Statewide Technology Plan (2008) "Digital Nebraska: Envisioning Our Future" has Health Information Technology initiatives, including electronic health records, electronic medical records, personal health records, electronic prescribing, clinical decision support, computerized provider order entry, health information exchange, and telehealth.

Revised strategic and operational eHealth plans were submitted to the Office of the National Coordinator for Health Information Technology on September 7 and October 21, 2010. The operational and strategic plans will guide the implementation of Nebraska's State Health Information Exchange Cooperative Agreement. The plans will be revised annually. Provisions pertinent to the Nebraska Department of Health and Human Services – Division of Behavioral Health are contained therein.

E. Description of the Use of Technology— Interactive Communication Technologies (ICTs) / pg 6

Nebraska Information Technology Commission
(www.nitc.nebraska.gov) June 10, 2011
http://www.nitc.nebraska.gov/eHc/plan/NebStrategiceHealthPlanV51Feb32011.pdf

Nebraska Strategic eHealth Plan (as of February 3, 2011) lays out the state's vision, goals, and objectives, and strategies for implementing statewide health information exchange and supporting the meaningful use of health information technology. The plan focuses on the domains of adoption, governance, finance, technical infrastructure, business and technical operations. Key considerations and recommendations are also included. As the eHealth Council continues to address the development of health information exchange and the adoption of health IT, the plan will be updated. Frequent revisions are anticipated due the quickly changing health IT environment. Please check the Nebraska Information Technology Commission's website (www.nitc.nebraska.gov) for the most recent edition.

Appendix - Health Information Exchanges (120 - 128)

→ NeHII is the state's largest health information exchange. As the statewide integrator, NeHII will assume the primary responsibility for implementing the State Health Information Exchange Cooperative Agreement program in Nebraska.

→ The Southeast Nebraska Health Information Exchange (SENHIE) was formed as a result of Thayer County Health Services (TCHS) receiving a Critical Access Hospital-HIT grant enabling them to create an electronic health information exchange across the continuum of care for the patients of TCHS.

→ The Electronic Behavioral Health Information Network (eBHIN) will connect behavioral health providers in Southeast Nebraska. eBHIN is a tax exempt 501(c)3 private, non-profit corporation that serves as a Regional Health Information Organization (RHIO) for providers of Behavioral Health services in southeast Nebraska. eBHIN Network Members are Blue Valley Behavioral Health Center, CenterPointe, Child Guidance Center, Community Mental Health Center of Lancaster County, Cornhusker Place, Houses of Hope, Lincoln Council on Alcoholism and Drugs, Lincoln Medical Education Partnership, Lutheran Family Services, Mental Health Association, Region V Systems, and St. Monica's.

→ The Western Nebraska Health Information Exchange (WNHIE) built health IT capacity in the Panhandle and developed plans to create a regional health information exchange. The Western Nebraska Health Information Exchange (WNHIE) is a collaborative effort of the major healthcare providers in the Panhandle. Partners who have developed the Exchange have been working together since 2004.

IV: Narrative Plan

F. Quality Improvement Reporting

Page 43 of the Application Guidance

Narrative Question:

SAMHSA expects States to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures that will describe the health of the mental health and addiction systems. These measures should be based on valid and reliable data. The CQI processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, reflect their evidence of effectiveness. The State's CQI process should also track programmatic improvements; and garner and use stakeholder input, including individuals in recovery and their families. In addition, the CQI plan should include a description of the process for responding to critical incidents, complaints and grievances. In an attachment, please submit your State's current CQI plan.

Footnotes:

Continuous Quality Improvement Program / August 31, 2011 / page 1

F. Quality Improvement Reporting
Narrative Question: SAMHSA expects States to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures that will describe the health of the mental health and addiction systems. These measures should be based on valid and reliable data. The CQI processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, reflect their evidence of effectiveness. The State's CQI process should also track programmatic improvements; and garner and use stakeholder input, including individuals in recovery and their families. In addition, the CQI plan should include a description of the process for responding to critical incidents, complaints and grievances. In an attachment, please submit your State's current CQI plan.

The DBH Continuous Quality Improvement (CQI) Program establishes accountability for continually improving DBH as an organization and the services provided to consumers and families in the state of Nebraska.

In July 2008, the Community Services Administrator of the Division of Behavioral Health initiated a Quality Improvement (QI) Program. A QI Manager was hired to develop and implement the Continuous Quality Improvement (CQI) Program Plan. Stakeholders have embraced CQI and a fundamental foundation has been established.

The DBH's approach to quality improvement is based on the following core principles:

- ***Customers Focus***. Understanding and respecting needs and requirements of all customers and striving to exceed expectations.

- **Strength Based.** Effective growth and change build on the consumer/family and system's strengths.

- **Recovery Oriented.** Services are characterized by a commitment to promoting and preserving wellness and choice. This approach promotes maximum flexibility to meet individually defined goals in a consumer's recovery journey.

- **Representative Participation and Involvement**. Effective programs involve a diverse representation of stakeholders. The stakeholders are provided the resources, education and opportunity to make improvements required and influence decision making.

- **Data Informed Practice**. Successful QI processes create feedback loops, using data to inform practice and measure results. There is a commitment to seek IT structures, staff, skills and other resources in the provision of data.

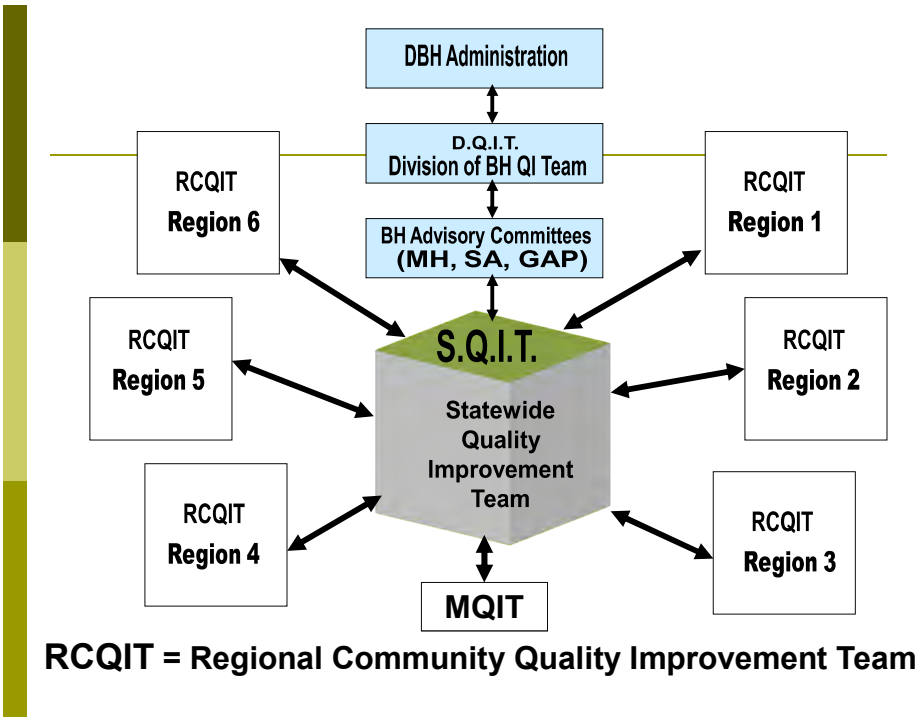
- **Statistical Tools**. For continuous improvement of services, tools and methods are needed that foster knowledge and understanding. CQI organizations use a defined set of analytic tools such as run charts, cause and effect diagrams, flowcharts, Pareto charts, histograms, and control charts to turn data into information.

- **Continuous Quality Improvement Activities**. Quality improvement activities emerge from a systematic and organized framework for improvement. This framework, adopted by the

Division of Behavioral Health, is understood, accepted and utilized throughout the service delivery system, as a result of continuous education and involvement of stakeholders at all levels in performance improvement.

Leaders, through a planned and shared communication approach, ensure all stakeholders have knowledge of and participation in ongoing QI activities as a means of continually improving performance. Communication methods include but are not limited to posting QI information on the DHHS-DBH public website. DBH has established a weekly data call where QI and data related information is communicated and improvement plans developed with DBH staff and regional behavioral health authority and RQIT members. RQIT is then in a position to request additional drill down information from DBH, and work through the Plan, Do, Check, Act at the community level.

CQI stakeholders include Consumers and Families, DBH Administration and Staff Consultants, Regional Staff, Service Providers, Advocacy Groups and Office of Consumer Affairs Participants, Managed Care Staff, and DHHS Partners. Working Relationships are pictured and described below.



- ***Division of Behavioral Health (DBH)Administration*** – The DBH Director and Administrator establish and communicate priorities for the annual plan and review feedback from stakeholders in the reporting structure.
- ***Division Quality Improvement Team (D.Q.I.T.)*** - Provides ongoing operational guidance for continuous quality improvement activities. Meetings are held at least twice monthly.
- ***Behavioral Health Advisory Committees (MH, SA and GAP) - Contributes*** to the development and implementation of the Annual CQI Plan and activities. The committees

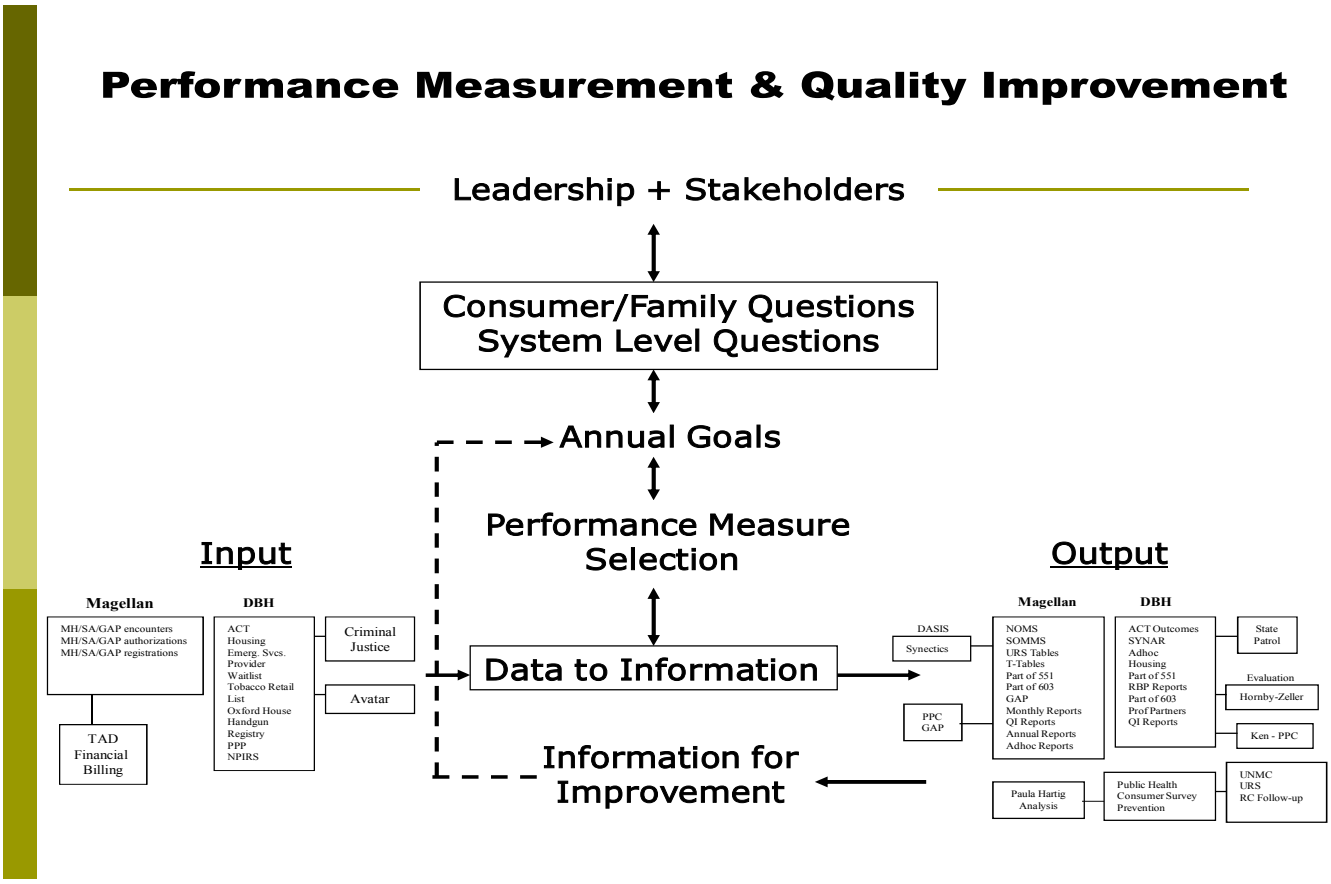
meet quarterly.

- ***Regional Administrator Meetings - Ensure*** that quality improvement processes are operationalized and prioritized at the community team level. Regional Administrators meet regularly with DBH Administration and the R.C.Q.I.T.
- ***Statewide Quality Improvement Team (S.Q.I.T.)*** - primarily responsible for the identification and prioritization of opportunities for improvement and development of the base plan. Ensures the development and implementation of policies and procedures needed to ensure ongoing improvement and change. Meetings are at least quarterly. The SQIT is comprised of consumers (50%), Regional Behavioral Health Authority staff, providers, the ASO, and representative from DHHS Division of Medicaid and Long-Term Care. For more information on SQIT see http://www.dhhs.ne.gov/beh/SQIT/SQIT.htm
- ***Regional Community Quality Improvement Teams (R.C.Q.I.T.)*** **-** Contributes to the development and implementation of local QI activities as it relates to local needs and the DBH CQI Program Plan. Meetings are held on a regular basis.
- ***Magellan Quality Improvement Team (M.Q.I.T.)*** - Primary responsibilities include:
  - Developing an understanding of the work flows, systems and processes related to data and making recommendations for improvement
  - Establishing a mechanism for the identification, review and resolution of data integrity issues with providers, regions, Magellan
  - Meetings are held monthly

  For more information on MQIT see http://www.dhhs.ne.gov/beh/MQIT.htm

The following diagram illustrates the process for identifying performance measurements on an annual basis and establishing data inputs and outputs for improvement.

Continuous Quality Improvement Program / August 31, 2011 / page 4



On an annual basis, stakeholders identify performance measurements. Measurements Utilized in FY10-11 included:

1. 75% of consumers report services received improved their quality of life.
   This measure is based on the annual consumer survey data. Results indicate this measure's threshold was met this year. Stakeholders elected to continue the measure for FY11-12 but have raised the benchmark to 85%.

2. Utilize NOMS performance measurement
   NOMS reports were developed by Magellan and are shared on a quarterly basis via the weekly data call. The data is reported at the statewide, region, provide and service level. Each RQIT developes action plans for results in their regional network. Statewide findings include the need for additional work on the data element utilized to report the criminal justice NOM. The question asks consumers about their arrest record in the last 30 days. The definition of arrest needs to be clarified to improve accurate reporting of the NOM.

3. Annual DBH Consumer Survey results for outcomes and social connectedness domains are targeted. Outcomes and social connectedness domains are the lowest scores from the survey. SQIT is in the process of working with stakeholders on additional analysis and developing action planning.

Critical incident, complaints and grievance processes are being discussed as a result of regulation and policy reviews. DBH is working with stakeholders to finalize the processes at the statewide level and then will be incorporated into the annual QI plan for monitoring and improvement.

Continuous Quality Improvement Program / August 31, 2011 / page 5

Each year the SQIT reviews criteria for initiating or continuing quality initiatives.
An initiative workgroup may be established when:

- A long lasting solution is needed
- The problem is complex and seemingly unsolvable
- The impact of the problem is great
- The problem causes distress and pain for organizations and consumers/families

The two initiatives selected include:

1. Consumer Survey Work Group http://www.dhhs.ne.gov/beh/Cons-Svy/
2. Co-Occurring Work Group For Mental Health and Substance Abuse Treatment Improvement http://www.dhhs.ne.gov/beh/Co-Occur/

For additional information on the FY11-12 plan which is pending approval by the SQIT in September of 2011, please review the attached annual plan.

DHHS-Division of Behavioral Health
Continuous Quality Improvement Program Plan
FY11/12

This is a draft pending approval at Statewide Quality Improvement Team meeting on Sept 27, 2011.

Section 1 Introduction

Vision:
The vision of the Division of Behavioral Health (DBH) and its Quality Improvement Program to promote wellness, recovery, resilience and self-determination in a coordinated, accessible consumer and family-delivery system.

Mission:
The Division of Behavioral Health leads Nebraska in the improvement of systems of care that promote and facilitate resilience and recovery.

Commitment:
DBH is committed to creating a culture that fosters quality improvement and sets clear direction through an annual plan.

Purpose:
The DBH Continuous Quality Improvement (CQI) Program establishes accountability for continually improving DBH as an organization and the service provided to consumers and families in the state of Nebraska.

The Division of Behavioral Health CQI program will ensure:

- Services are appropriate to each consumer's needs and accessible when needed;
- Consumers and families participate in all process of the CQI program and their views and perspectives are valued;
- The services provided incorporate best practice, evidence based practice, and effective practices;
- Services are of high quality and provided in a cost-effective manner.

Definition:
CQI is an ongoing process of using data to plan, identifying opportunities for improvement, implementing changes, studying and analyzing results and celebrating improvements.

The CQI Program is based on the following assumptions:

- Working together creates a system of coordinated services to better meet the needs of consumers and families;
- Stakeholders want to improve consumer and family outcomes;
- Stakeholders participate in monitoring activities, data reporting and information

sharing.

Core Principles

The DBH's approach to quality improvement is based on the following core principles:

- ***Customers Focused***. Understanding and respecting needs and requirements of all customers and striving to exceed expectations.

- **Strength Based.** Effective growth and change build on the consumer/family and system's strengths.

- **Recovery Oriented.** Services are characterized by a commitment to promoting and preserving wellness and choice. This approach promotes maximum flexibility to meet individually defined goals in a consumer's recovery journey.

- **Representative Participation and Active Involvement**. Effective programs involve a diverse representation of stakeholders. The stakeholders are provided the resources, education and opportunity to make improvements required and influence decision making.

- **Data Informed Practice**. Successful QI processes create feedback loops, using data to inform practice and measure results. There is a commitment to seek IT structures, staff, skills and other resources in the provision of data.

- **Use of Statistical Tools**. For continuous improvement of services, tools and methods are needed that foster knowledge and understanding. CQI organizations use a defined set of analytic tools such as run charts, cause and effect diagrams, flowcharts, Pareto charts, histograms, and control charts to turn data into information.

- **Continuous Quality Improvement Activities**. Quality improvement activities emerge from a systematic and organized framework for improvement. This framework, adopted by the Division of Behavioral Health, is understood, accepted and utilized throughout the service delivery system, as a result of continuous education and involvement of stakeholders at all levels in performance improvement.

Plan-Do-Check-Act (PDCA) Model

The recommended model for problem solving and improvement is PDCA. It should be utilized:

- When starting a new improvement project;
- When developing a new or improved design of a process or service;
- When planning data collection and analysis in order to verify and prioritize; and
- When implementing any change.

Plan – Plan for a specific improvement activity

- Recognize opportunity for improvement
- What are the issues?
- Plan a change – who, what, when
- Determine how change will be measured

Do - Do carry out the plan for improvement

- Gain approval and support of the selected improvement solution.
- Implement the improvement solution.
- May use a trial or pilot implementation
- Document observations and data

Check - Check the data again

- Data is analyzed to compare the results of the new process with those of the previous one
- Check for improvement and results
- What was learned?

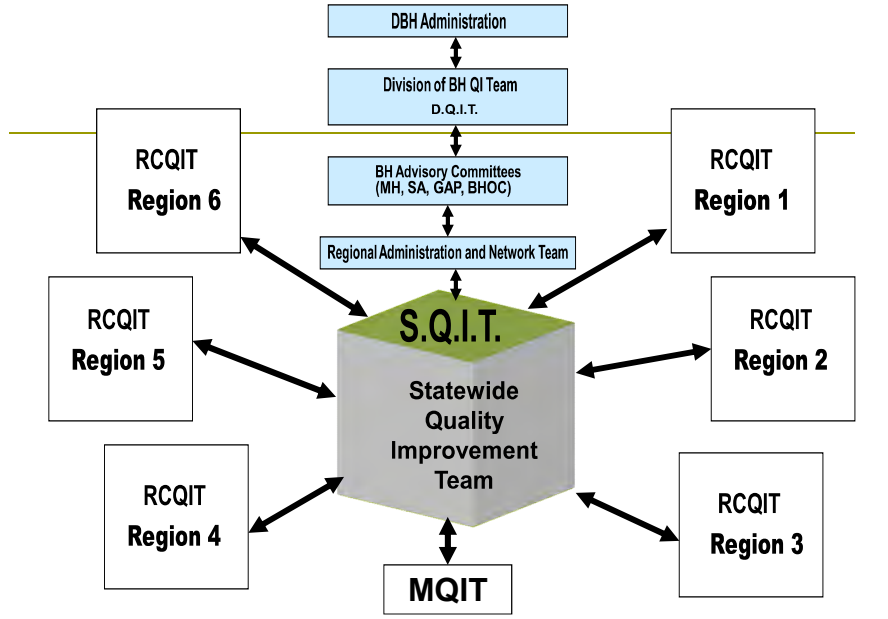
Act – Action for full implementation or reject and try again

- Take action based on what was learned
- Adopt the solution formally as needed, develop policy, etc.
- If there is no improvement refine/revise the solution
- If successful, take action to ensure ongoing improvement

Section 2 Leadership and Organization

Leadership and Stakeholders.
Leaders, through a planned and shared communication approach, ensure all stakeholders have knowledge of and participation in ongoing QI activities as a means of continually improving performance. Planned communication methods include posting QI information on the DHHS-DBH public website.

The CQI process must be stakeholder driven. Stakeholders include Consumers and Families, DBH Administration and Staff, Consultants, Regional Staff, Service Providers, Advocacy Groups and Office of Consumer Affairs Participants, Managed Care Staff, DHHS Partners, etc. Working Relationships are pictured and described below.



RCQIT = Regional Community Quality Improvement Team

<u>Division of Behavioral Health Administration</u> **–** The DBH Director and Community

Services Section Administrator establish and communicate priorities for the annual plan and review feedback from stakeholders in the reporting structure.

Division Quality Improvement Team (D.Q.I.T.) - Provides ongoing operational guidance for continuous quality improvement activities. Meetings are held at least bi-monthly.

Membership includes the following individuals:

- Office of Consumer Affairs Administrator
- Division Administrator – Community Services Section
- Division Chief Clinical Officer
- Prevention, Treatment & Supportive Services Administrator
- Federal and Fiscal Performance Administrator
- Data Team
- Network Operations Team
- GAP Manager
- Team Leader – Quality & Data Performance Measurement Administrator

The responsibilities of D.Q.I.T. include:

- Communicating with and reporting to DBH Administration
- Listening to stakeholder feedback in carrying out other responsibilities
- Developing a draft Quality Improvement Plan to be presented to stakeholders
- Drafting measurable goals based upon priorities and stakeholder feedback
- Proposing performance measures for review by S.Q.I.T
- Reviewing data and reports and making recommendations for action and system planning
- Suggesting quality improvement initiatives and needs to S.Q.I.T.
- Establishing and supporting specific quality improvement initiatives and study workgroups
- Providing technical assistance to Community Q.I Teams
- Recommending specific approaches/models for QI
- Ensuring budget planning includes CQI

Behavioral Health Advisory Committees (MH, SA and GAP) - Contributes to the development and implementation of the Annual CQI Plan and activities. The committees meet quarterly.

Membership includes but is not limited to:

- Consumers and Families
- Providers
- Regional Staff
- Justice/Law Enforcement
- DHHS Partners

- Community Stakeholders

The responsibilities include:

- Receiving information from DBH Administration, D.Q.I.T
- Advising DBH and S.Q.I.T. on the development of the CQI Plan and activities
- Providing input into the creation of quality improvement initiatives
- Assisting in the development of education and communication processes
- Serving as Consultants to DBH representing various viewpoints and concerns
- Reviewing CQI reports and making recommendations
- Assessing Consumer and Family satisfaction survey and other results

Regional Administrator and Network Management Team Meetings - Ensure that quality improvement processes are operationalized and prioritized at the community team level. Regional Administrators meet regularly with DBH Administration and the NMT is held quarterly.

Membership includes:

- Regional Administrators
- DBH Team
- Network Team

The responsibilities include:

- Reviewing information from DBH Administration, D.Q.I.T., Advisory Committees
- Providing leadership to the C.Q.I.T.
- Assessing recommendations received from C.Q.I.T and S.Q.I.T and proposing action
- Reviewing reports, making recommendations for change and ensuring action with C.Q.I.T. as needed
- Providing technical assistance to the C.Q.I.T. regarding DBH quality initiatives

Statewide Quality Improvement Team (S.Q.I.T.) - primarily responsible for the identification and prioritization of opportunities for regional/community improvement, implementation of quality initiatives and development of the annual plan. 50% of voting membership should have a disclosed lived behavioral health experiences.

Membership includes:
Office of Consumer Affairs Representatives
Regional Staff
Consumer Specialists and other Consumer / Family Members
Providers

Consultants include:
Magellan Staff
DHHS Partners (Medicaid and CFS)
DBH Staff
Regional Center Staff

Voting Membership will include Office of Consumer Affairs Representatives, Consumer Representatives. Regional and provider representation is limited to 2 per region and 1 for

the GAP provider.

Responsibilities of SQIT in CQI include:

- Revising the Annual QI Program Plan
- Evaluating the effectiveness of the QI Program each year [Annual Report due in August]
- Monitoring quality improvement activities of the C.Q.I.T. and subcommittees as specified in the Annual Plan
- Monitoring findings and implementation of system-wide corrective actions for improvement
- Offering recommendations on policies, procedures, service definitions, data quality
- Analyzing results of Consumer, Family and other satisfaction surveys or studies
- Ensuring adequate training exists to support the QI Program
- Ensuring communication of S.Q.I.T. activities to the agency/organizations/individuals the member represents

Community Quality Improvement Teams (C.Q.I.T.) **-** Contributes to the development and implementation of local QI activities as it relates to local needs and the DBH CQI Program Plan. Meetings are held on a regular basis.

Membership includes:

- Consumers
- Regional Staff
- Providers
- Other Community Stakeholders

Responsibilities of C.Q.I.T. include:

- Bringing community stakeholders together to participate in quality improvement activities
- Developing, implementing and monitoring the community QI Program
- Ensuring data collection and information are used to manage and improve service delivery at the local level
- Providing ongoing information about performance and improvements to persons served
- Supports accreditation processes and compliance with contracts and DBH regulations
- Audits and reviews findings of service providers on an annual basis
- Improves utilization and data management processes through representation on MQIT

Magellan Quality Improvement Team (M.Q.I.T.) - Primary responsibilities include improvement of data quality utilized in QI processes and activities:

- Improving communication and coordination between the Division, Regions, Providers and Magellan
- Developing an understanding of the work flows, systems and processes related to data and making recommendations for improvement
- Establishing a mechanism for the identification, review and resolution of issues
- Reviewing reports and recommending content and format improvements to ensure the presentation of meaningful data
- Meetings are held monthly

Membership of MQIT shall include:

- Regional Representatives
- Hospital Provider
- MH Provider
- SA Provider
- GAP Provider
- Children's Services Provider
- Federation of Families Representative
- DBH – Office of Consumer's Affair Representative
- ASO Staff
- DBH Staff (Team Leader/Facilitator)

Section 3 Annual Goals

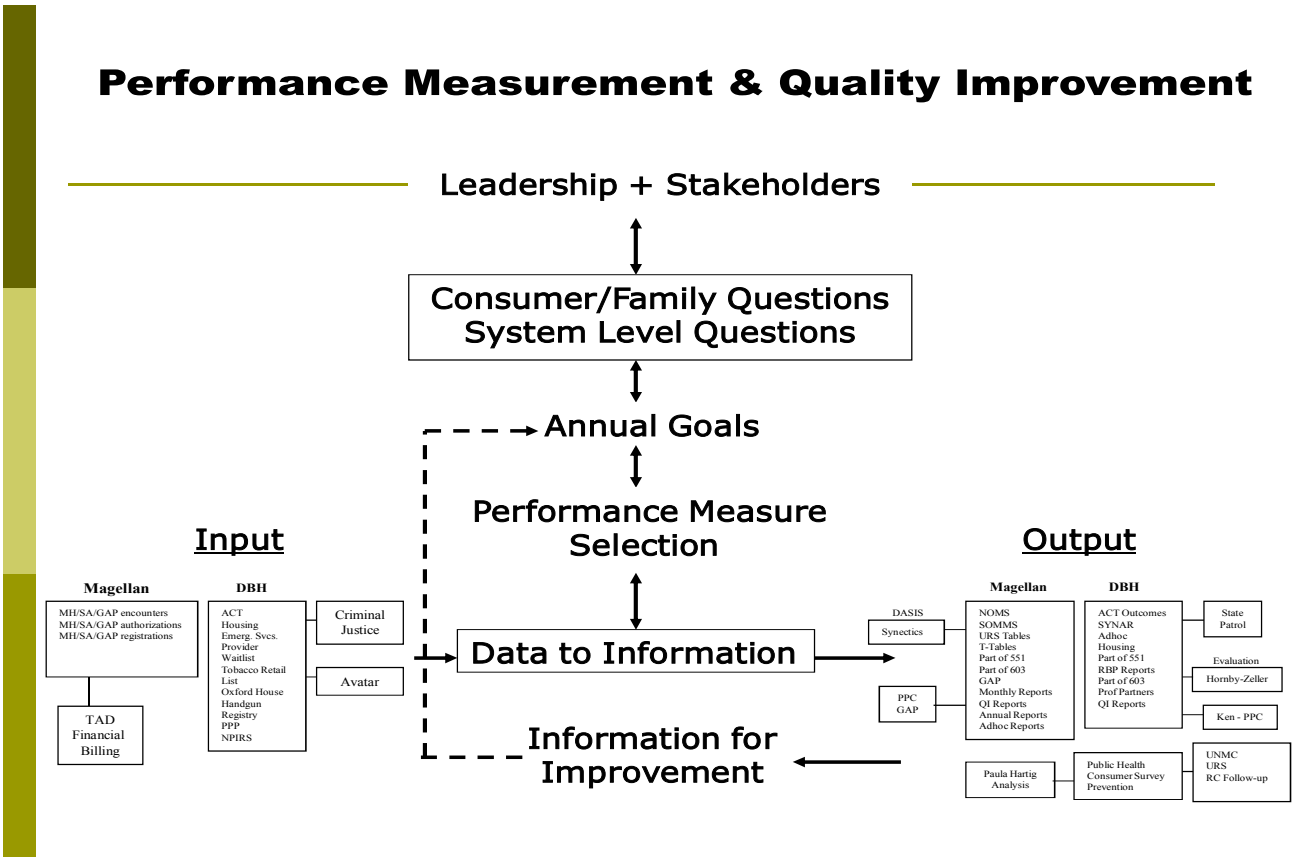
QI Program Goals for FY11/12 include:

1. Implement data education activities that will ensure the understanding of existing data and the utilization of information in system planning and QI improvement activities.

2. Complete the Consumer/Family Survey Quality Initiative and identify implementation strategies based on the workgroup recommendations related to sampling and youth surveys.

3. Ensure stakeholders are involved and informed of QI elements of the Strategic Plan.

The following diagram illustrates the process for identifying performance measurements and utilizing data for improvement.



Section 4 Performance Measurement

1. Accessiblity Measures

   [Will establish at September 2011 SQIT meeting]

2. Quality Measures
   - DBH Annual Consumer Survey [MHSIP outcome and social connectedness domains]
   - 85% of consumers report services received improved their quality of life

3. Effectiveness Measures

   [Will establish at September 2011 SQIT meeting]

4. Cost Effectiveness Measures

   [Will establish at September 2011 SQIT meeting]

Section 5 Quality Improvement Initiatives

Quality Initiatives

A workgroup may be established when:

- A long lasting solution is needed
- The problem is complex and seemingly unsolvable
- The impact of the problem is great
- The problem causes distress and pain for organizations and consumers/families

1. Complete recommendations for FY12 Consumer/Family Survey
2. Co-Occurring Service Delivery Roadmap Integration into the Strategic Plan
3. Evidence Based Practice & Fidelity Monitoring Project via MHBG DIG grant

IV: Narrative Plan

G. Consultation With Tribes

Page 43 of the Application Guidance

Narrative Question:

SAMHSA is required by the 2009 Memorandum on Tribal Consultation to submit plans on how it is to engage in regular and meaningful consultation and collaboration with tribal officials in the development of Federal policies that have Tribal implications.

Consultation is an enhanced form of communication, which emphasizes trust, respect and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process, which results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues. For the context of the Block Grants, SAMHSA views consultation as a government to government interaction and should be distinguished from input provided by individual Tribal members or services provided for Tribal members whether on or off Tribal lands. Therefore, the interaction should include elected officials of the Tribe or their designee. SAMHSA is requesting that States provide a description of how they consulted with Tribes in their State. This description should indicate how concerns of the Tribes were addressed in the State Block Grant plan(s). States shall not require any Tribe to waive its sovereign immunity in order to receive funds or in order for services to be provided for Tribal members on Tribal lands.

Footnotes:

G. Consultation With Tribes / August 25, 2011 / page 1

Consultation with Tribes - States provide a description of how they consulted with Tribes (show evidence of tribal consultation) in their State. How concerns of the Tribes were addressed in the State Block Grant plan(s). Tribal governments shall not be required to waive sovereign immunity as a condition of receiving Block Grant funds or services.

The State of Nebraska recognizes that the four federally recognized tribes headquartered in Nebraska have a unique status that sets them apart from other groups and interests in Nebraska. The Division of Behavioral Health provides funding directly to those four tribes – the Omaha Tribe of Nebraska, the Ponca Tribe of Nebraska, the Santee Sioux Nation, and the Winnebago Tribe of Nebraska.

- How Tribes are currently included in the planning process?

The four federally recognized tribes with whom the Division of Behavioral Health contracts for a total of $1.4 million in state general funds, are invited to participate in advisory committees, local and statewide meetings regarding services, trainings on behavioral health topics, and other state activities.

When appropriate, the Division of Behavioral Health Director and/or other designees work with the Nebraska Commission on Indian Affairs to address behavioral health needs for American Indians residing in Nebraska.

- How are the needs of the tribes assessed and addressed in last year's plan?

The tribes conduct their own needs assessment and work plans and communicate these to the Division of Behavioral Health.

- How is specific information on Tribes collected and reported?

The tribes utilize some combination of the federal Resource and Patient Management System (RPMS) and other private patient information management systems to collect information on the individuals served. The Division of Behavioral Health requires the tribes to report information on persons annually and with contract billings.

- What are your State's plans to consult with each Tribe in your State to ensure their involvement in the needs assessment, planning and service delivery process?

The Division of Behavioral Health will continue its efforts to engage tribal representatives in statewide and regional planning teams and will contract with each of the four tribes for needs assessment and provision of services to their tribal members.

Commission on Indian Affairs

http://www.indianaffairs.state.ne.us/

The Commission on Indian Affairs was established in 1971 and consists of 14 Indian commissioners appointed by the Governor. Additionally, the commission has one "ex-officio" member representing the Pawnee tribe. The commission's statutory mission is "to do all things which it may determine to enhance the cause of Indian rights and to develop solutions to problems common to all Nebraska Indians." It is the state liaison between the four headquarter tribes of the Omaha, Ponca, Santee Sioux and Winnebago Tribes of Nebraska. It helps ensure the sovereignty of both tribal and state governments are recognized and acted upon in a true government-to-government relationship. The commission serves off-reservation Indian communities by helping assure they are afforded the right to equitable opportunities in the areas of housing, employment,

G. Consultation With Tribes / August 25, 2011 / page 2

education, health care, economic development and human/civil rights within Nebraska. All goals of the commission are accomplished through advocacy, education and promotion of legislation.

Contact the Commission:

Nebraska Commission on Indian Affairs
State Capitol, 6th Floor, East
P.O. Box 94981
Lincoln, NE 68509-4981
402.471.3475

Statutory Authority:
The Nebraska Commission on Indian Affairs (NCIA) was created by LB 904 of the 82nd session of the Nebraska Legislature on May 22, 1971. The Indian Commission statutes are outlined in sections 81-2504 R.R.S.

Vision:
Sovereignty of both Tribal and State governments are recognized and acted upon by both in a true government-to-government relationship. Each of the Nebraska's Indian citizens and their families be afforded the right to enjoy equitable opportunities, as do their non-Indian counterparts, in the areas of housing, employment, education, health care, economic development, and human/civil rights. To educate and sensitize the general public, educators, school-age youth, and legislators to the unique status of Tribes and Indian citizens; and the issues that effect them.

Mission and Principles:
Mission:
"The purpose of the Commission shall be to join representatives of all Indians in Nebraska to do all things which it may determine to enhance the case of Indian Rights and to develop solutions to the problems common to all Nebraska Indians."

Principles:
Respect for the Sovereignty of Tribal and State government has an active role to play in the education of Nebraskans to the unique status of Tribes and Indian citizens; the many and varied ways Indian people have and continue to contribute to Nebraska history; to the issues that impact Nebraska's Indian citizens in significant and often devastating ways; to identify and address cultural barriers that impact Indians in Nebraska.

Goals:
Actively promote state and federal legislation beneficial to Tribes and Indian citizens in Nebraska, and monitor and assess their impact. Assist in development and implementation of state and federal programs that provide equitable services and opportunities for Nebraska's Indian families in the areas of housing, employment, economic development, health, human sevices, law and order, tribal sovereignty, and civil/human rights. Educate legislators, educators, school-age youth and the general public on the issues and legislation that impacts Indian country in Nebraska; especially government and private resources to improve the lives of Nebraska's Indian citizens.

IV: Narrative Plan

H. Service Management Strategies

Page 44 of the Application Guidance

Narrative Question:

SAMHSA, similar to other public and private payers of behavioral health services, seeks to ensure that services purchased under the Block Grants are provided to individuals in the right scope, amount and duration. These payers have employed a variety of methods to assure appropriate utilization of services. These strategies include using data to identify trends in over and underutilization that would benefit from service management strategies. These strategies also include using empirically based clinical criteria and staff for admission, continuing stay and discharge decisions for certain services. While some Block Grant funded services and activities are not amenable (e.g. prevention activities or crisis services), many direct services are managed by other purchasers.

In the space below, please describe:

1. The processes that your State will employ over the next planning period to identify trends in over/underutilization of SABG or MHBG funded services
2. The strategies that your State will deploy to address these utilization issues
3. The intended results of your State's utilization management strategies
4. The resources needed to implement utilization management strategies
5. The proposed timeframes for implementing these strategies

Footnotes:

H. Service Management Strategies / August 30, 2011 / page 1

Narrative Question: SAMHSA, similar to other public and private payers of behavioral health services, seeks to ensure that services purchased under the Block Grants are provided to individuals in the right scope, amount and duration. These payers have employed a variety of methods to assure appropriate utilization of services. These strategies include using data to identify trends in over and underutilization that would benefit from service management strategies. These strategies also include using empirically based clinical criteria and staff for admission, continuing stay and discharge decisions for certain services. While some Block Grant funded services and activities are not amenable (e.g. prevention activities or crisis services), many direct services are managed by other purchasers.

The Division of Behavioral Health has established processes to ensure that services are provided to consumers at the right time and in the right amount. The processes are critical to ensure funding matches state and federal priorities, consumer needs, utilization, capacity and waiting. There are three core processes established. The first process includes the system regional budget planning done formally on an annual basis. The second process addresses service utilization via managed care. The third process includes data analysis and reporting performed on a scheduled and ongoing basis.

Annually, Division of Behavioral Health's Prevention, Treatment and Supportive Services Team members meet with the Regional Behavioral Health Authorities to discuss planned initiatives, priorities and funding. The Quality and Data Performance Team prepares a variety of data reports utilized to facilitate the discussion. Utilization, capacity and waiting data and consumer survey reports are the focus. Trends in service utilization are identified and recommendations are provided to the Regional Behavioral Health Authorities (RBHA) and other stakeholders in the budget planning process. The regions in turn, share the data and determine whether change in utilization should be made with individual service providers via Provider Network meetings and/or the Regional Quality Improvement Teams.

Magellan Behavioral Health, the Division of Behavioral Health's Administrative Service Organization, utilizes service definitions and utilization guidelines established by DHHS Division of Medicaid and Long Term Care and the Division of Behavioral Health. The service definitions establish a standard of care and service expectations, i.e. describes what is being purchased. The utilization guidelines establish admission, continued stay and discharge criteria. The service definitions and utilization guidelines are published and posted on the website. Additionally, the service definitions are in the process of being incorporated into the Division of Behavioral Health's Title 206 Regulations. Magellan care managers provide utilization reviews for all authorized services. Authorized services are higher intensity and higher cost. Providers enter data on registered services into the data system. Registered services are lower intensity, recovery oriented and developed to meet state and regional needs and are not generally included in the Medicaid service array. Based on the authorization and registrations, Magellan provides utilization data reports which are sent to the Regional Behavioral Health Authorities on a monthly basis as well as posted on the Magellan reports website for easy access.

H. Service Management Strategies / August 30, 2011 / page 2

Division of Behavioral Health Quality and Data Performance Team facilitate and host a weekly Tuesday Data Call (TDC). The TDC participants include DBH staff, RBHA staff and QI team members. This weekly forum is held via webinar technology. The DBH team schedules data topics for the call. Topics include utilization reports, average length of stay, admission, discharge summaries, National Outcome Measures (NOMS), capacity and waiting list and a variety of other reports. RBHA staff then takes the data analysis and reports and share with the contracted providers in the network meetings or via the regional quality improvement teams. Minutes of the network meeting and Quality Improvement (QI) meetings are sent to DBH for review and action if necessary to ensure funding supports the trends.

Strategies that the Division of Behavioral Health employs to address utilization issues include regional budget planning initiatives and changes in allocations, change in service definitions and utilization guidelines, changes to the managed care contract, establishing policy or procedures to address consumer service needs, collecting consumer perceptions on service delivery and needs, and conducting strategic and budget planning on an ongoing basis.

The intended result of these management strategies is implementing a service system that addresses access to consumers in need in the most efficient and cost effective way possible. The utilization monitoring should also assist DHHS Behavioral Health System in preparing for healthcare reform.

DBH contracts for a data system through Magellan Behavioral Health. Magellan provides a team of individuals to assist with data management and utilization activities including the Operations Director, Clinical Care Manager Supervisor, QI Administrator and others. DBH Data Team includes a program specialist, analyst and administrator along with students and temporary analysts as needed. The fiscal and federal performance team also provides a coordinator and administrator as needed for review and analysis. As mentioned previously, DBH continues to take steps to acquire its own data and claims system which will make processes more efficient.

Strategies are in place and implemented on a monthly, annual and ongoing basis. The Division of Behavioral Health acknowledges data system needs but works diligently to address service management strategies by utilizing every piece of data available, monitoring and communicating trends and patterns with its stakeholders and by making changes necessary to meet consumer service needs.

IV: Narrative Plan

I. State Dashboards (Table 10)

Page 45 of the Application Guidance

Narrative Question:

An important change to the administration of the MHBG and SABG is the creation of State dashboards on key performance indicators. SAMHSA is considering developing an incentive program for States/Territories based on a set of state-specific and national dashboard indicators. National dashboard indicators will be based on outcome and performance measures that will be developed by SAMHSA in FY 2011. For FY 2012, States should identify a set of state-specific performance measures for this incentive program. These state-specific performance indicators proposed by a State for their dashboard must be from the planning section on page 26. These performance indicators were developed by the State to determine if the goals for each priority area. For instance, a state may propose to increase the number of youth that receive addiction treatment in 2013 by X%. The state could use this indicator for their dashboard.

In addition, SAMHSA will identify several national indicators to supplement the state specific measures for the incentive program. The State, in consultation with SAMHSA, will establish a baseline in the first year of the planning cycle and identify the thresholds for performance in the subsequent year. The State will also propose the instrument used to measure the change in performance for the subsequent year. The State dashboards will be used to determine if States receive an incentive based on performance. SAMHSA is considering a variety of incentive options for this dashboard program.

Plan Year: 2012

Priority	Performance Indicator	Selected
Substance Abuse Prevention	Total number of environmental strategies/activities funded by the Division related to underage drinking and excessive drinking by adults performed annually.	b
Substance Abuse Prevention	Total sales to minors as reported through SYNAR.	e
Substance Abuse Prevention	Strategic Plan for Prevention is completed by target date.	e
Consumer Workforce	Training Peer Support and Wellness Specialists - Percent of individuals taking class and completing certification (threshold 60%).	e
Consumer Workforce	Number of persons, by BH workforce category receiving continuing education through annual conference.	e
Peer Run Recovery Supports	Total number of peer run recovery supports statewide.	e
SA Treatment – Women's Set Aside Services	Percent of WSA providers who have completed TIC tool. Total number of Persons Served for Pregnant Women and Women with Dependent Children in WSA funded providers.	e
Transition Age Youth and Young Adult	Total number of persons served in services specifically designed for youth/young adults transitioing to adulthood.	e
Professional Partners Program	WFI measures at 80%.	e
Co-Occurring Disorder Services	Total number of behavioral health providers that are dual capable and dual enhanced.	e
Trauma Informed Care	Total number of providers completing TIC tool. Total number of trauma specific services. Total number of individuals with a positive screen that have treatment plans related to trauma.	b
Permanent Supportive Housing services	* Number of adult consumers living in a private residence at the time of admission * Total number of Permanent Housing services available * Increased fidelity scores by provider.	b
Supported Employment	* Number of clients by employment status * Total persons served in Supported Employment.	b

Footnotes:

The NE Divsion of Behavioral Health is a combined State Mental Health Authority (SMHA) and State Substance Abuse Authority (SSA). Thus three (#2, #3, #4) of these State Dashboard key performance indicators selected apply to both the Community Mental Health Services Block Grant (MHSBG) and Substance Abuse Prevention and Treatment Block Grant (SAPTBG). The Substance Abuse Prevention applies to SAPTBG.

1. Substance Abuse Prevention - Nebraska will increase prevention activities designed to reduce underage drinking and excessive drinking by adults. This will be measured by the total number of environmental strategies/activities funded by the Division related to underage drinking and excessive drinking by adults performed annually.

2. Trauma informed care is part of all Behavioral Health services. Total number of providers completing Trauma Informed Care (TIC) tool. Total number of trauma specific services. Total number of individuals with a positive screen that have treatment plans related to trauma.

3. Improve the Permanent Supportive Housing services available * Number of adult consumers living in a private residence at the time of admission * Total number of Permanent Housing services available * Increased fidelity scores by provider.

4. Improve Supported Employment Evidence-Based Practices * Number of clients by employment status * Total persons served in Supported Employment.

IV: Narrative Plan

J. Suicide Prevention

Page 46 of the Application Guidance

Narrative Question:

In September of 2010, U.S. Health and Human Services Secretary Kathleen Sebelius and Defense Secretary Robert Gates launched the National Action Alliance for Suicide Prevention. Among the initial priority considerations for the newly formed Action Alliance is updating and advancing the National Strategy for Suicide Prevention, developing approaches to constructively engage and educate the public, and examining ways to target high-risk populations. SAMHSA is encouraged by the number of States that have developed and implemented plans and strategies that address suicide. However, many States have either not developed this plan or have not updated their plan to reflect populations that may be most at risk of suicide including America's service men and women -- Active Duty, National Guard, Reserve, Veterans -- and their families. As an attachment to the Block Grant application(s), please provide the most recent copy of your State's suicide prevention plan. If your State does not have a suicide prevention plan or if it has not been updated in the past three years please describe when your State will create or update your plan.

Footnotes:

2011-2015 Nebraska State Suicide Prevention Goals

Nebraska's State Suicide Prevention Goals are drawn from multiple sources including a statewide summit and a strategic planning process led by the Nebraska State Suicide Prevention Coalition (NSSPC). The NSSPC is an all-volunteer coalition with an open membership policy that is recognized as the group with primary responsibility for development of recommendations related to suicide prevention for the Nebraska Department of Health and Human Services. The NSSPC works throughout the year to promote suicide prevention activities statewide via local coalitions and other grassroots initiatives. More information about the NSSPC can be found on its website at http://www.suicideprevention.nebraska.edu.

Vision

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

Decreasing the rates of suicide in Nebraska will signal success for the state's suicide prevention efforts

Three goals are identified for suicide prevention in Nebraska during 2011-2015:

Goal 1:
Nebraskans will view suicide as a preventable public health problem

Goal 2:
Empirically supported suicide prevention programs are implemented across Nebraska.

Goal 3:
Data is collected and reported across systems to evaluate effectiveness and cost efficiency of suicide prevention efforts in Nebraska.

These goals are augmented by specific objectives for the period of 2011-2012. The objectives are intended to guide and inform NSSPC activities; youth suicide prevention work associated with implementation of a federal youth suicide prevention grant award directed by the Division of Behavioral Health (http://www.youthsuicideprevention.nebraska.edu); and surveillance activities directed by the Division of Public Health. The objectives are reviewed and updated annually or as they are achieved.

Goal 1:
Nebraskans will view suicide as a preventable public health problem

Objective	Outcome Measure
By 2012 Public health districts will incorporate suicide awareness benchmarks in regular reports	# Health Depts reporting awareness measures
By 2012 Suicide awareness materials will be distributed to all primary care settings in Nebraska	# and location of material distribution
By 2012 Means Restriction information will be available in all Emergency Departments in Nebraska	# Emergency Rooms incorporating material
By 2012 a public awareness campaign will be completed	# materials distributed; market estimates for media outlets; website statistics

Goal 2:
Empirically supported suicide prevention programs are implemented across Nebraska.

Objective	Outcome Measure
By 2012 25% of Licensed Behavioral Health Clinicians will receive training in assessment and management of suicide	# of Clinicians trained
By 2012 25% of schools in Nebraska will include some form of empirically supported suicide prevention activity	# schools and type of program
By 2012 600 gatekeepers will receive empirically supported gatekeeper training	# Gatekeepers trained
By 2012 3 LOSS postvention programs will be functioning in Nebraska	# and location of LOSS programs

Goal 3:
Data is used to evaluate effectiveness of suicide prevention in Nebraska.

Objective	Outcome Measure
By 2011 a group will be convened to identify cross system measures related to suicide prevention	Slate of measures
By 2012 a report on suicide prevention measures will be issued by the Department of Health and Human Services	Report issued

Attachment A

Nebraska State Suicide Prevention Coalition
Activity Plan 2011-2012

The Statewide Suicide Prevention Coalition is a group of interested citizens, government and private representatives who work together to promote suicide prevention in Nebraska. The Statewide Coalition will work together to implement these activities and build a work plan to support each one. More information about the Coalition and its activities is available on its website: http://www.suicideprevention.nebraska.edu/index.htm. A list of abbreviations and acronyms is available at the end of this document.

The following activities have been identified by the Nebraska State Suicide Prevention Coalition in support of the State Suicide Prevention Plan (2011-2012):

Nebraskans will view suicide as a preventable public health problem

	Activities	Resources
Public Awareness	Disseminate suicide prevention information and resources to faith based groups; service clubs; non-profit groups; and corporations	Website NSSPC Brochure LOSS Conference NSSPC speakers
	Suicide awareness materials will be distributed to all primary care settings in Nebraska	Primary care toolkit SPRC
	Disseminate educational materials on suicide risk, depression and suicide prevention to Nebraskans in the 55+ age range via groups that serve them	Website Educational material Local Coalitions
	Promote suicide prevention during suicide prevention month	PSA's Press Releases Brochure distribution
	Promote Regional programs and community events related to suicide prevention	Website Email lists Newsletter
	Engage youth by having at least one youth organization present at each NSSPC meeting	Website Email lists NSSPC members
	Promote access to treatment resources statewide	Website Partner websites Depression screening Primary care brochure
	Promote awareness of military efforts to prevent suicide	Website Partner websites Military rep on NSSPC
	Engage post secondary education representatives in NSPCC activities	Partner with GLS grant Brochure
	Distribute Public Ad Council's campaign on suicide prevention during mental illness awareness week, suicide prevention month and mental health month	PSA's
	Support the Law Enforcement Training Academy, CIT training and BETA (Behavioral Health Threat Assessment) by providing resources pertinent to suicide prevention and law enforcement	Brochures Educational material Means Restriction material
	Provide means restriction material to emergency rooms for distribution to networks of support for people with self inflicted injuries	Means Restriction material Partner Websites Website

Empirically supported suicide prevention programs are implemented across Nebraska.

Attachment A

Nebraska State Suicide Prevention Coalition
Activity Plan 2011-2012

	Activities	Resources
Intervention	Promote QPR to local coalitions as a gatekeeper training model	Partner with GLS grant QPR trainers
	Promote 1-800-273-TALK hotline	Website & Brochures
	Partner with national groups to incorporate empirically supported means restriction activities in protocols promoted by emergency response entities across the state	Website Means Restriction material SPRC resources National Org material
	Encourage schools to adopt empirically supported suicide prevention practices (e.g., SOS, school prevention specialist training, etc)	SPRC website AAS website Kim Foundation GLS grant
	Enhance clinical competencies through promotion of AMSR training (assessing and managing suicide risk) or similar empirically supported education (primary care training)	GLS grant SPRC material AAS & AFSP material AMSR trainers
	Provide resources to the LOSS development group to assist in establishing 2 additional LOSS teams in Nebraska (total of 3)	LOSS website GLS grant LOSS conference & training
	Encourage AAS certification of crisis centers in Nebraska	AAS material Partner with BH Regions & DHHS
	Promote depression screening in primary care settings with an emphasis on youth and veterans	Screening tools Website Partner with medical community
	Convene a group to explore development of a suicide specialist certification	National certifications SPRC AAS & AFSP DHHS University partners

Data is used to evaluate effectiveness of suicide prevention in Nebraska.

	Activities	Resources
Methodology	Convene a group to identify cross system measures related to suicide prevention	Coalition partners DHHS Strategic Plans
	Support data collection and evaluation of QPR training	GLS grant QPR trainers Local coalitions
	Support data collection and evaluation of AMSR training	GLS grant AMSR trainers DHHS partners
	Track the number of schools in Nebraska that include some form of empirically supported suicide prevention activity	Dept of Ed partner GLS grant
	Collect evaluation data from grantees funded via the NSSPC	Grantees Kim Foundation University Partners Website
	Promote evaluation of promising practices such as the YRTC Greenline program	University Partners GLS grant Kim Foundation SPRC

Attachment A

Nebraska State Suicide Prevention Coalition
Activity Plan 2011-2012

Abbreviations and Acronyms used in this Document	
AAS	American Association of Suicidology
AFSP	American Foundation for Suicide Prevention
AMSR	Assessing and Managing Suicide Risk (Training tool from SPRC)
BH	Behavioral Health
DHHS	Department of Health and Human Services
GLS	Garrett Lee Smith (Grant Act Title)
LOSS	Local Outreach to Suicide Survivors (Outreach Teams)
NSSPC	Nebraska State Suicide Prevention Coalition
PSA	Public Service Announcement
QPR	Question, Persuade, Refer (Suicide Prevention Training Tool)
SPRC	Suicide Prevention Resource Center (National)
YRTC	Youth Rehabilitation and Treatment Center (Kearney, NE)

IV: Narrative Plan

K. Technical Assistance Needs

Page 46 of the Application Guidance

Narrative Question:

Please describe the data and technical assistance needs identified by the State during the process of developing this plan that will be needed or helpful to implement the proposed plan. The technical assistance needs identified may include the needs of State, providers, other systems, persons receiving services, persons in recovery, or their families. The State should indicate what efforts have been or are being undertaken to address or find resources to address these needs, and what data or technical assistance needs will remain unaddressed without additional action steps or resources.

Footnotes:

K. Technical Assistance Needs | August 24, 2011

Narrative Question:

1. Describe the data and technical assistance needs identified by the State during the process of developing this plan that will be needed or helpful to implement the proposed plan.
2. The technical assistance needs identified may include the needs of State, providers, other systems, persons receiving services, persons in recovery, or their families.
3. The State should indicate what efforts have been or are being undertaken to address or find resources to address these needs, and what data or technical assistance needs will remain unaddressed without additional action steps or resources.

During the process of developing the SAMHSA Uniform Block Grant application, the Division of Behavioral Health identified the following as needed or helpful to implement the proposed plan.

1. Determining the best ways to move forward with an integrated, recovery oriented, community-based system of care and identifying options for best practice models.

2. Identifying what other systems use for a data systems (including persons served, financial, and other data) as well as how to improve integration with other intermediaries and partners.

3. What is the proper role of the Division of Behavioral Health in serving children and families given the roles of the NE DHHS Divisions of Children & Family Services, Developmental Disabilities, Medicaid & Long-Term Care, Public Health as well as the State Department of Education including Vocational Rehabilitation (see State Priorities on Transition Age Youth and Young Adult plus Professional Partners Program).

4. Peer Support – The Division of Behavioral Health knows how important it is for individuals with mental and substance use disorders to participate in choosing the services and supports they receive. To that end, DBH has been developing various services such as Housing Related Assistance, Supported Employment, Recovery Support, Peer Support, WRAP training and Hospital Diversion. A challenge involves how to improve the linkages between these services and the infrastructure that is needed for effective implementation to move toward a more effective recovery oriented system of care.

IV: Narrative Plan

L. Involvement of Individuals and Families

Page 46 of the Application Guidance

Narrative Question:

The State must support and help strengthen existing consumer and family networks, recovery organizations and community peer advocacy organizations in expanding self advocacy, self-help programs, support networks, and recovery-oriented services. There are many activities that State SMHAs and SSAs can undertake to engage these individuals and families. In the space below, States should describe their efforts to actively engage individuals and families in developing, implementing and monitoring the State mental health and substance abuse treatment system. In completing this response, State should consider the following questions:

- •How are individuals in recovery and family members utilized in the development and implementation of recovery oriented services (including therapeutic mentors, recovery coachers and or peer specialists)?
- •Does the State conduct ongoing training and technical assistance for child, adult and family mentors; ensure that curricula are culturally competent and sensitive to the needs of individuals in recovery and their families; and help develop the skills necessary to match goals with services and to advocate for individual and family needs?
- •Does the State sponsor meetings that specifically identify individual and family members? issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?
- •How are individuals and family members presented with opportunities to proactively engage and participate in treatment planning, shared decision making, and the behavioral health service delivery system?
- • How does the State support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

Footnotes:

L. Involvement of Individuals and Families | August 30, 2011 | page 1

The State must support and help strengthen existing consumer and family networks, recovery organizations and community peer advocacy organizations in expanding self advocacy, self-help programs, support networks, and recovery-oriented services. There are many activities that State SMHAs and SSAs can undertake to engage these individuals and families. In the space below, States should describe their efforts to actively engage individuals and families in developing, implementing and monitoring the State mental health and substance abuse treatment system.

Office of Consumer Affairs

Under Neb. Rev. Stat. 71-805(1) the Office of Consumer Affairs (OCA) within the Division was established. Carol Coussons de Reyes is the Administrator for OCA. The OCA Administrator has experience as a consumer or former consumer of mental health, substance abuse or gambling addiction services and must have specialized knowledge, experience or expertise relating to consumer-directed behavioral health services, delivery systems and advocacy on behalf of consumers and their families. The Administrator of the Office of Consumer Affairs is a member of Division of Behavioral Health senior management and acts as a systems change agent in partnership with consumers and families at open forums with Regional Consumer Specialists, statewide consumer organizations, and a circle of peer training facilitators.

OCA is very active in working with people in recovery and the development and implementation of recovery oriented services. OCA organizes meetings to specifically identify consumer issues and needs regarding the behavioral health service system. Consumers are provided with opportunities to proactively engage and participate in a variety of ways within the Nebraska behavioral health service delivery system. For more details see the OCA website http://www.dhhs.ne.gov/beh/mh/mhadvo.htm.

Regional Consumer Specialist

In addition, the State of Nebraska funds Consumer Specialist positions in the Regional Behavioral Health Authority offices across the state. At the Regional level, the Consumer Specialist participation is expected to work in a wide variety of areas such as Policy Development (e.g., needs assessment, program planning, training, technical support, financial planning, trauma-informed services, gather feedback regarding the service delivery system, participate meetings to raise awareness of the levels of consumer involvement, and recovery-oriented services) as well as connecting with consumers in a wide variety of areas (such as handling grievances, linking to services, and advocacy).

Family Organizations

Nebraska is home to the Nebraska Federation of Families for Children's Mental Health (herein referred to as the Federation), a chapter of the National Federation. Within each of the six Behavioral Health Regions, is an affiliate Family Organization whose role is to advocate for families with youth experiencing mental/emotional disorders, support the family voice and offer supportive services such as education, support groups, advocacy and mentoring. In addition, the Nebraska chapter of National Alliance on Mental Illness (NAMI) branch also provides some support services to youth and families. In 2011, the Division of Behavioral Health established a contract thru the competitive bidding process, to the Federation to provide Family Navigator Service (a time limited family peer service designed to assist families navigating the behavioral health system) and the Family Peer Support Service (an array of family supportive services as described earlier). These services are available statewide at no cost to the families, contribute to the family's stability and the youth's recovery, and play a vital role in preventing unnecessary family involvement with the Child Welfare System.

State Advisory Committees

Within Nebraska, the State Advisory Committee on Mental Health Services (§ 71-814), the State Advisory Committee on Substance Abuse Services (§ 71-815), and the State Committee on Problem Gambling (§71-816) advise the Division of Behavioral Health. These Committees are authorized under State Statute and are appointed by the Governor. These Committees are to provide advice and assistance to the Division of Behavioral Health on the provision of behavioral health services in the State of Nebraska. By state statute, these Committees hold public meetings.

The State Advisory Committee on Mental Health Services members need to 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 membership includes twelve consumers of behavioral health services or their family members. This committee serves as the state's mental health planning council as required by Public Law 102-321.

The State Advisory Committee on Substance Abuse Services members includes at least three consumers of substance abuse services. The committee members need to have demonstrated interest and commitment and specialized knowledge, experience, or expertise relating to the provision of substance abuse services in the State of Nebraska.

The State Committee on Problem Gambling members includes at least three consumers of problem gambling services. The committee members need to have a demonstrated interest and commitment and specialized knowledge, experience, or expertise relating to problem gambling in the State of Nebraska.

IV: Narrative Plan

M. Use of Technology

Page 47 of the Application Guidance

Narrative Question:

Interactive Communication Technologies (ICTs) are being more frequently used to deliver various health care services. ICTs are also being used by individuals to report health information and outcomes. ICT include but are not limited to: text messaging, etherapy, remote monitoring of location, outreach, recovery tools, emotional support, prompts, case manager support and guidance, telemedicine. In the space below, please describe:

a. What strategies has the State deployed to support recovery in ways that leverage Interactive Communication Technology?
b. What specific applications of ICTs does the State plan to promote over the next two years?
c. What incentives is the State planning to put in place to encourage their use?
d. What support systems does the State plan to provide to encourage their use?
e. Are there barriers to implementing these strategies? Are there barriers to wide-scale adoption of these technologies and how does the State plan to address them?
f. How does the State plan to work with organizations such as FQHCs, hospitals, community-based organizations and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine?
g. Will the State use ICTs for collecting data for program evaluation at both the client and provider levels?
h. What measures and data collection will the State promote for promoting and judging use and effectiveness of such ICTs?

Footnotes:

M. Use of Technology August 30, 2011 page 1

Narrative Question:
Interactive Communication Technologies (ICTs) are being more frequently used to deliver various health care services. ICTs are also being used by individuals to report health information and outcomes. ICT include but are not limited to: text messaging, etherapy, remote monitoring of location, outreach, recovery tools, emotional support, prompts, case manager support and guidance, telemedicine.

Here are some things Nebraska is doing to increase the use Interactive Communication Technology.

The NE Division of Behavioral Health Strategic Plan 2011 – 2015 discusses the further development of communication technology.

- DBH Strategic Plan Goal 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).
- Strategy 1: Insist on Accessibility – Access to publicly funded behavioral health services is influenced in Nebraska by geography, workforce limits, culture and language barriers, organizational, technology and information barriers and cost. Accessibility is more than offering a service – it is creating an environment that allows people to make a choice to move into and out of the effective services that are close to home.
  [see http://www.dhhs.ne.gov/Behavioral_Health/BHSP-Final-02-17-11.pdf]

Nebraska Telehealth Act (§71-8501 to 71-8508) notes the important advantages of this technology such as improve access to health care practitioners in medically underserved areas [see http://dhhs.ne.gov/crl/statutes/telehlthstat.pdf].

NE Medicaid Program has Telehealth Regulations [see http://dhhs.ne.gov/med/telehealth.htm]. These regulations provide specific direction on coverage criteria and reimbursement of telehealth services (Nebraska Administrative Code 471 NAC 1-006). Each service covered as a Medicaid telehealth service must otherwise be covered as a face-to-face service, and all other Medicaid policies and regulations in addition to 471 NAC 1-006 apply to telehealth services.

University of Nebraska Medical Center Department of Psychiatry

- Telepsychiatry - To greater serve the mental health care needs of rural Nebraskans, the University of Nebraska Medical Center's Department of Psychiatry recently initiated a Telepsychiatry Consultation Service. As one of the most effective ways to increase access to psychiatric care for individuals living in underserved areas, the service began in Nebraska Behavioral Region 4 (Columbus, Wayne, and Norfolk) and currently serves 19 rural Nebraska locations. Telepsychiatry provides opportunities for consultative services and second opinions between psychiatrists, primary care physicians and other healthcare providers, particularly for healthcare professionals from rural nursing homes. UNMC expects to continue extending critically needed psychiatric care to other areas of Nebraska in the very near future. For further information, please contact:
  Carl Greiner, MD Professor Telephone: 402 552-6027 email: cgreiner@unmc.edu
- The Behavioral Health Education Center of Nebraska (BHECN) was established in July of 2009 in response to a directive handed down from the Nebraska Legislature to reform the state's behavioral health educational system. BHECN was given the urgent charge of developing the education and training of the state-wide behavioral health care workforce to meet the needs of all Nebraskans through a new, inter-disciplinary behavioral healthcare educational model. Today, the BHECN organization is an evolving, collaborative effort that spans professions and partners, linking institutions and traversing distance across a

continuum of services. Health information technology is a vital part of the solution to workforce shortage in rural areas. New curricula need to be developed to educate the workforce about best practices, quality improvement and adoption of a recovery philosophy in the care system.

— Breaking the Barriers to Behavioral Health Technology - Second Annual Behavioral Health Information Technology Summit (October 29, 2010). The 2010 Behavioral Health Information technology (BHIT) summit focused on further refining the barriers and examining various solutions to effective use of any form of telecommunications for behavioral health care workforce shortages. The 2010 BHIT Summit workgroups addressed the four major issues of (1) developing clinical supervision/education models, (2) designing a model for state wide infrastructure of BHIT, (3) Implementing plans for BHIT service delivery and (4) addressing regulatory issues that would hamper the growth of telecommunications solutions for behavioral health care. The four workgroups demonstrated a convergence of opinions on the development of future telecommunications efforts for BHIT across Nebraska. The work groups advocated for an approach that utilized multiple levels of telecommunications technologies available through a one site internet source which then broke out into a variety of secure technologies dependent on the self determined level of need. The group also advocated for the development of task forces to address the issues of reimbursement and regulatory issues that hampered the implementation of BHIT for the state of Nebraska. A copy of the report from this summit can be found at: http://www.unmc.edu/bhecn/images/10_BHIT_Final_Report.pdf.

Division of Public Health (DPH)

— Office of Rural Health - Telehealth: The Office continues to work with stakeholders to facilitate, create, support and enhance telehealth opportunities in Nebraska. Focus this year is on the utilization of a telehealth backbone, education in telecommunication models, and integration of health services through this technology, especially with *behavioral health providers*. http://www.dhhs.ne.gov/hew/orh/Tech.htm

— The Health Alert Network (HAN) is a nationwide system for coordinating and distributing important information about public health events. It helps DPH strengthen the emergency preparedness at the local, state and federal levels. In Nebraska the HAN is used to distribute health alerts, prevention guidelines and other information. DPH can notify health care providers, hospitals, and local health departments immediately by e-mail and fax. DPH also has a voice notification system to reach the state public health employees and health departments immediately. DPH can also share information with the Nebraska Emergency Management Agency, laboratories, pharmacies, veterinarians and other health agencies. The HAN can also be used for distance learning, national disease surveillance, and electronic laboratory reporting. The federal Center for Disease Control and Prevention (CDC) funds the HAN with grant money. For more information see: http://www.dhhs.ne.gov/han/hanindex.htm

The Nebraska Statewide Telehealth Network (NSTN) is a collaboration of over 110 sites, including hospitals, health departments, mental health centers, physician offices and rural health clinics, with a common purpose of using video technology to extend health care resources to those in need. This includes clinical consultations, support groups, education and training, connectivity for administrative meetings among professionals and compassionate calls that bring families together during a time when connecting can help heal.

M. Use of Technology August 30, 2011 page 3

Additionally, the network is designed to bring together invaluable resources to improve the readiness of the State to deal with terrorist acts and threats, naturally-occurring disasters and issues of public health concern by allowing instant communication between the Lt. Governor, the Chief Medical Officer and physicians, hospitals, public health departments and public health laboratories across the state.
http://www.netelehealth.net/

Division of Behavioral Health REGIONAL BUDGET PLAN GUIDELINES covering State FY2012 and FY2013 (issued January 14, 2011) included a priority on the utilization of information technology to improve access and create system efficiencies such as:

- Develop or increase the utilization of Telehealth to improve access to care
- Develop or enhance opportunities that promote the utilization of electronic health records, health information exchanges
- Target underserved geographic areas and/or rural-frontier areas of the state

Region 1 Behavioral Health Authority – In September 2009, Panhandle Mental Health Center (PMHC) in Scottsbluff, NE launched services by video conference at offices in Alliance and Sidney. More flexible hours and less travel brought very positive responses from clients, and PMHC is now the 3rd largest provider of behavioral health telehealth services in the state.
http://www.pmhc.net/FY10AnnualReport.pdf

IV: Narrative Plan

N. Support of State Partners

Page 48 of the Application Guidance

Narrative Question:

The success of a State's MHBG and SABG will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, education and other State and local governmental entities. States should identify these partners in the space below and describe the roles they will play in assisting the State to implement the priorities identified in the plan. In addition, the State should provide a letter of support indicating agreement with the description of their role and collaboration with the SSA and/or SMHA, including the State education authority(ies); the State Medicaid agency; the State entity(ies) responsible for health insurance and health information exchanges (if applicable); the State adult and juvenile correctional authority(ies); the State public health authority, (including the maternal and child health agency); and the State child welfare agency. SAMHSA will provide technical assistance and support for SMHAs and SSAs in their efforts to obtain this collaboration. These letters should provide specific activities that the partner will undertake to assist the SMHA or SSA with implanting its plan. This could include, but is not limited to:

- The State Medicaid Agency agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to the expanded Medicaid population.
- The State Department of Justice that will work with the State and local judicial system to develop policies and programs that address the needs of individuals with mental and substance use disorders that come into contact with the criminal and juvenile justice systems; promote strategies for appropriate diversion and alternatives to incarceration; provide screening and treatment; and implement transition services for those individuals reentering the community.
- The State Education Agency examining current regulations, policies, programs, and key data-points in local school districts to ensure that children are safe; supported in their social-emotional development; exposed to initiatives that target risk and protective actors for mental and substance use disorders; and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements.
- The State Child Welfare/Human Services Department, in response to State Child and Family Services Reviews, working with local child welfare agencies to address the trauma, and mental and substance use disorders in these families that often put their children at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system.

Footnotes:

The NE Divsion of Behavioral Health is a combined State Mental Health Authority (SMHA) and State Substance Abuse Authority (SSA), responsible for both the Community Mental Health Services Block Grant (MHSBG) and Substance Abuse Prevention and Treatment Block Grant (SAPTBG).

DBH knows the importance of strategic partnerships with other health, social services, education and other State and local governmental entities. DBH knows who these partners are and has a working relationship with many of them.

The statutes of State of NE as well as the DBH Strategic Plan 2011-2015 drive DBH policy. That is carefully considered as DBH is working to successfully implement what is in this SAMHSA Block Grant application as well as other related initiatives. Given all that is involved, balance needs to be in place so make sure there is no promising things and then failing to meet expectations.

With that said, DBH understands this is a requested item. DBH is choosing to defer addressing this requirement to 2012.

IV: Narrative Plan

O. State Behavioral Health Advisory Council

Page 49 of the Application Guidance

Narrative Question:

Each State is required to establish and maintain a State advisory council for services for individuals with a mental disorder. SAMHSA strongly encourages States to expand and use the same council to advise and consult regarding issues and services for persons with or at risk of substance abuse and substance use disorders as well. In addition to the duties specified under the MHBG, a primary duty of this newly formed behavioral health advisory council would be to advise, consult with and make recommendations to SMHAs and SSAs regarding their activities. The council must participate in the development of the Mental Health Block Grant State plan and is encouraged to participate in monitoring, reviewing and evaluating the adequacy of services for individuals with substance abuse disorders as well as individuals with mental disorders within the State.

Please complete the following forms regarding the membership of your State's advisory council. The first form is a list of the Advisory Council for your State. The second form is a description of each member of the behavioral health advisory council.

Footnotes:

O. State Behavioral Health Advisory Council

Narrative Question: Each State is required to establish and maintain a State advisory council for services for individuals with a mental disorder. SAMHSA strongly encourages States to expand and use the same council to advise and consult regarding issues and services for persons with or at risk of substance abuse and substance use disorders as well. In addition to the duties specified under the MHSBG, a primary duty of this newly formed behavioral health advisory council would be to advise, consult with and make recommendations to SMHAs and SSAs regarding their activities. The council must participate in the development of the Mental Health Block Grant State plan and is encouraged to participate in monitoring, reviewing and evaluating the adequacy of services for individuals with substance abuse disorders as well as individuals with mental disorders within the State.

Nebraska has established and maintained State advisory committees for services for individuals with a mental disorder as well as for issues and services for persons with or at risk of substance abuse and substance use disorders. These behavioral health advisory committees make recommendations to the Division of Behavioral Health as the State Mental Health Authority (SMHA) and the State Substance Abuse Authority (SSA). These committees participate in the development of both the Community Mental Health Services Block Grant (MHSBG) and the Substance Abuse Prevention and Treatment Block Grant (SAPTBG). These committees participate in monitoring, reviewing and evaluating the adequacy of services for individuals with behavioral health disorders within the State.

The Nebraska Behavioral Health Services Act (Neb. Rev. Stat. §§ 71-801 to 71-830) authorizes two advisory committees

71-814 **STATE ADVISORY COMMITTEE ON MENTAL HEALTH SERVICES** (MH Committee)

- The State Advisory Committee on Mental Health Services serves as the State Mental Health Planning Council as required for the MHSBG.
- Details on the State Advisory Committee on Mental Health Services including Membership, Meeting Agendas and Minutes can be found at: http://www.dhhs.ne.gov/beh/mh/sacmhs.htm
- The specific statutory language authorizing the MH Committee is:

  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.

71-815 **STATE ADVISORY COMMITTEE ON SUBSTANCE ABUSE SERVICES** (SA Committee)

— Details on the State Advisory Committee on Substance Abuse Services including Membership, Meeting Agendas and Minutes can be found at: http://www.dhhs.ne.gov/hew/sua/SACSA.htm

— The specific statutory language authorizing the SA Committee is:

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.

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 173 of 187

IV: Narrative Plan

Table 11 List of Advisory Council Members

Page 51 of the Application Guidance

Start Year:

End Year:

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
Adria Bace	State Employees	Education	PO Box 94987 Lincoln, NE 68509 PH: 402-471- 4312 FAX: 402-471-5022	adria.bace@nebraska.gov
Beth Baxter	Providers	Region 3- Regional Administrator	4009 6th Avenue, Suite 65 Kearney, NE 68848 PH: 308-237- 5113 FAX: 308-236-7669	bbaxter@region3.net
Cameron White	State Employees	Dept of Correctional Services	PO Box 94661 Lincoln, NE 68509	cameron.white@nebraska.gov
Mark Schultz	State Employees	Vocational Rehabilitation	301 Centenniall Mall South Lincoln, NE 68508 PH: 402-471-1202	mark.schultz@nebraska.gov
Jerry McCallum	Others (Not State employees or providers)	Region 4 - Governing Board Member	55717831 Road Madison, NE 68748 PH: 402-454-3735	jejamc@telebeep.com
Roxie Cillessen	State Employees	Department of Health and Human Services	Div. of Medicaid & Long Term Care, 302 Centennial Mall So. Lincoln, NE 68508 PH: 402-471-9224	roxie.cillessen@nebraska.gov
			South Sioux City Police	

Scot Ford	Others (Not State employees or providers)	NE Crime Commission	Dept, 701 W. 29th Street South Sioux City, NE 68776 PH: 402-494-7512	sford@southsiouxcity.org
Pat Compton	State Employees	Housing	4735 Avenue E Kearney, NE 68847 PH: 308-865-6511	pat.compton@nebraska.gov
Ed Matney	State Employees	Social Services	301 Centenniall Mall South Lincoln, NE 68508 PH: 402-471-8404	ed.matney@nebraska.gov
Dave Lund	Providers		302 Dixie Avenue North Platte, NE 69101 PH: 308-532-0587	dlund@lfsneb.org
Robert Donlan	Individuals in Recovery (from Mental Illness and Addictions)		1013 So. 35th Avenue Omaha, NE 68105 PH: 402-714-3222	donlanrobert@yahoo.com
Kasey Moyer	Individuals in Recovery (from Mental Illness and Addictions)		Mental Health Assoication, 1645 N Street, #A Lincon, NE 68508 PH: 402-441-7371	kmoyer@mha-ne.org
Joel Schnieder	Individuals in Recovery (from Mental Illness and Addictions)		17110 Palisades Drive Omaha, NE 68136 PH: 402-681-5439	velvethammer1@cox.net
Joyce Sasse	Individuals in Recovery (from Mental Illness and Addictions)		3627 California Street Omaha, NE 68131 PH: 402-932-7124	joyesse1@cox.net
Colleen Manthei	Family Members of Individuals in Recovery (from Mental Illness and Addictions)		5625 So. 31st Street, Apt 7 Lincoln, NE 68516	cmanthei09@yahoo.com
Beverly Ferguson	Family Members of Individuals in Recovery (from Mental Illness and Addictions)		3405 Portia Place Norfolk, NE 68701 PH: 402-371-2745	bfergy04@cableone.net

Melanie Lantis	Family Members of Individuals in Recovery (from Mental Illness and Addictions)	132 No. Minden Avenue, Apt 2 Minden, NE 68959 PH: 308-830-3120	lantism@yahoo.com
Sharon Dalrymple	Family Members of Individuals in Recovery (from Mental Illness and Addictions)	Families Inspiring Families, 1645 N Street, #A Lincoln, NE 68508 PH: 402-441-4369	sdalrymple@familiesinspiringfamilies.org
Jette Hogenmiller	Family Members of Individuals in Recovery (from Mental Illness and Addictions)	8687 Tranquility Loop Fort Calhoun, NE 68023 PH: 402-426-5645	jetteh@huntel.net
Kathy Boroff	Family Members of Individuals in Recovery (from Mental Illness and Addictions)	2504 West 8th Street Grand Island, NE 68803 PH: 308-381-7206	klewis@kdsi.net
Diana Waggoner	Family Members of Individuals in Recovery (from Mental Illness and Addictions)	13609 California, #210 Omaha, NE 68154 PH: 402-891-6960	dwaggoner@thekimfoundation.org
Jorge Rodriguez-Sierra (SA)	Family Members of Individuals in Recovery (from Mental Illness and Addictions)	2706 No. 99th Street Omaha, NE 68198 PH: 402-399-8937	
Janet Johnson (SA)	Providers	Choices Treatment Center, 127 So. 37th Street, #B Lincoln, NE 68510 PH: 402-476-2300	janet.johnson@gmail.com
Corey Brockway (SA)	Individuals in Recovery (from Mental Illness and Addictions)	711 1/2 West 2nd McCook, NE 69001 PH: 308-340-2406	coreybrockway@r2hrs.com
Ann Ebsen (SA)	Providers	103 Highland Street Papillion, NE 68046 PH: 402-331-8830	aebsen@aol.com
Jay Jackson (SA)	Individuals in Recovery (from Mental Illness and Addictions)	Jackson Services, 30612 205th Ave Columbus, NE 68601 PH: 402-562-3755	jayjackson@jackson-services.com
		301 Centenniall Mall	

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 175 of 187

Linda Krutz (SA)	State Employees	South, Community Corrections-5th Floor Lincoln, NE 68508 PH: 402-471-4327	linda.krutz@nebraska.gov
DeLinda Mercer (SA)	Providers	Regional West Med Center, 4021 Avenue B Scottsbluff, NE 69361 PH: 308-630-1275	mercerd@rwmc.net
Brenda Miner (SA)	Providers	1430 North Road Grand Island, NE 68803 PH: 308-398-5435	bminer@sfmc-gi.org
Laura Richards (SA)	Providers	Region 1 Behavioral Health Authority, 4110 Avenue D Scottsbluff, NE 69361 PH: 308-635-3171	lrichards@pmhc.net
Randy See (SA)	State Employees	529 Hermitage Court Grand Island, NE 68801 PH: 308-381-8721	randy.see@nebraska.gov
Debra Shoemaker (SA)	Others (Not State employees or providers)	731 Noth 58th Street Lincoln, NE 68505 PH: 402-416-6117	debs@phclincoln.org
Kathleen Hanson	Individuals in Recovery (from Mental Illness and Addictions)	1330 Lincoln Mall, apartment A404 Lincoln, NE 68508 PH: 402-261-3756	Khanson1757@msn.com

Footnotes:

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 176 of 187

IV: Narrative Plan

Table 12 Behavioral Health Advisory Council Composition by Type of Member

Page 52 of the Application Guidance

Start Year:

End Year:

Type of Membership	Number	Percentage
Total Membership	35	
Individuals in Recovery (from Mental Illness and Addictions)	7	
Family Members of Individuals in Recovery (from Mental Illness and Addictions)	8	
Vacancies (Individuals and Family Members)	0	
Others (Not State employees or providers)	3	
Total Individuals in Recovery, Family Members & Others	18	51.43%
State Employees	8	
Providers	7	
Leading State Experts	0	
Federally Recognized Tribe Representatives	0	
Vacancies	2	
Total State Employees & Providers	17	48.57%

Footnotes:

There is one vacancy on the State Advisory Committee on Mental Health Services and one vacancy on the State Advisory Committee on Substance Abuse Services.

IV: Narrative Plan

P. Comment On The State Plan

Page 50 of the Application Guidance

Narrative Question:

SAMHSA statute requires that, as a condition of the funding agreement for the grant, States will provide opportunity for the public to comment on the State plan. States should make the plan public in such a manner as to facilitate comment from any person (including Federal or other public agencies) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary. In the section below, States should describe their efforts and procedures to obtain public comment on the plan in this section.

Footnotes:

HEARTLAND family Service
Good works.

August 8, 2011

Scot Adams, Ph.D.
Director, Division of Behavioral Health
Nebraska Health and Human Services System
P.O. Box 95026
Lincoln, Nebraska 68509-5026

Dear Scot,

The OPEN MINDS newsletter recently posted an article about SAMHSA's requests for states to submit plans by September 1st for how block grant funds will be used to meet the needs of people who lack insurance coverage and to address the needs of priority populations. I thought it was important to take the opportunity to share with you our needs and suggestions in hopes that they will be included in the Nebraska plan.

Family Works

As you know, our Family Works program is serving 3 of the 4 priority substance abuse populations—pregnant injecting users, other pregnant users and women with dependent children. Sixty percent of the families at Family Works have children involved in the child welfare system. Though not on the official list of priorities in our contract, these families' circumstances place them in a priority position for our community and state. The following is our future need related to Family Works:

- An additional allocation of $75,000 per year for Therapeutic Community beginning in State fiscal year 2014. We are launching a capital campaign this fall and plan to have a new facility ready to serve 16 families by early 2014. Region 6 has increased our allocation to $124,000 per year which is sufficient to cover the 10 family capacity we currently serve. This additional (relatively small) allocation is needed to cover the increase in women who have not yet completed the Medicaid eligibility process. This process includes a 1-2 month wait for eligibility to be established followed by a 1 month wait for the Medicaid waiver to begin once they roll over to Magellan's ASO contract.

  I realize that there will most likely be changes between now and 2014 to Medicaid, both in eligibility and possible coverage via at-risk managed care. However, I thought it was important for you to know that this is our plan for continuing to serve these priority populations so it can be incorporated in the State's plan.

- I also ask that the Division plan for a differential (higher) rate for Therapeutic Community when it includes children in the treatment program. The cost for this programming greatly exceeds the cost of treatment for a single adult, yet this is the reimbursement that is currently being provided. I recommend at

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least a 30% increase in the rate.

Expansion of Family Based Treatment—'Better Together'

We are currently working with the 'Through the Eyes of the Child' initiative, the National Center on Substance Abuse and Child Welfare, KVC, NFC and St. Monica's on an expansion of family based treatment—'Better Together'—which will serve child welfare families where substance abuse is the issue that has brought the family into the child welfare system.

'Better Together' will combine intensive addictions treatment with a safe, supportive living environment enabling child welfare parents struggling with addiction to work toward recovery while parenting their children and strengthening their family bonds. This model allows entire families to live in contiguous apartments and receive on-site daily intensive outpatient substance abuse/mental health treatment, 24 hour peer support for their recovery, parenting education and support, and help to overcome any other barriers to achieving self-sufficiency. The comprehensive treatment model is a replication of programming successfully implemented in other states and recommended by Nebraska's In-Depth Technical Assistance (IDTA) project and 'Through the Eyes of the Child'. Vicki Maca and the Families Matters team have recently been brought into the planning process.

As a result of this initiative to expand family based treatment services, I am recommending that additional funding for intensive outpatient treatment be included in the Nebraska plan to facilitate the development of this program across the state. Lincoln and Omaha are committed to the development and it makes sense to use this innovation statewide. This is also an opportunity to request funding for the essential support services that are needed for a sustained recovery for these families—case management/education/support related to parenting, employment and housing.

Outpatient Services

A review of our agency's data for outpatient services shows the following averages per month:

- Mental health
  - 57 new clients admitted per month
  - 26 clients per month unable to serve due to no capacity
  - 35 clients per month unable to serve—seeking psychiatric service only
- Substance abuse
  - 93 new clients admitted per month
  - 44 clients per month unable to serve due to no capacity

It is evident that the Omaha community needs an expanded capacity for low income persons seeking services on a sliding fee basis. I hope that that the Affordable Care Act will result in more persons becoming eligible for Medicaid and expand the provider panel available to these persons. However, Medicaid rates at the current level have resulted in many providers, HFS included, limiting the number of Medicaid clients that we can serve. This will be a significant systems issue to be addressed particularly if Nebraska Medicaid continues the policy of 'Excess Income' resulting in paying a 'share of cost'. The eligibility standards are currently so low that these clients end up having Medicaid coverage 'in name only' as they cannot afford the 'share of cost'.

I am recommending that Nebraska's plan include strategies for developing sufficient capacity to meet the needs of low income persons. I don't believe we can rely on expanded Medicaid coverage alone to address this as there will be a gap for the working poor who fall outside of the new federal poverty level set for Medicaid eligibility who cannot afford to purchase their own plans. There is also the question of whether Nebraska Medicaid will expand the population served beyond families with children and those individuals with a disability. If not, a gap will exist for single adults and couples with no children.

Community Based Services

An expansion of Community Support and Peer Support Specialists will greatly benefit consumers. Each agency providing a mental health or substance abuse service should have funding for these special community- based positions. This will greatly facilitate access, treatment planning, service coordination and aftercare.

Our experience with the Crisis Response Team in Sarpy and Cass counties has identified that there is a service gap for persons under Board of Mental Health commitment that could be better closed if Community Support and Peer Support Specialists were a part of each Crisis Response Team. This would provide the ability for an intensive level of support to persons under Board of Mental Health commitment. The Specialists and the BOMH would have access to the Crisis Response Therapists who could respond immediately in the home/community to complete a mental status evaluation and provide timelier crisis intervention services.

Innovation Incentives

There are new evidenced-based practices and FDA approved interventions that could be more quickly brought to the practice field if funding was available to invest in the materials, train staff, and support the implementation. Technology applications used to support treatment and aftercare, like HeartMath and Virtual and Alternate Reality Treatment tools, have been demonstrated to be effective, but require an investment that organizations like HFS must postpone implementing due to the start-up costs. New neurotherapies, like Vagus Nerve Stimulation and Transcranial Magnetic Stimulation, also show promising results, but are not part of the current treatment system.

I hope this information and these recommendations will be helpful. I'd be happy to answer any questions or provide additional information that can help with your planning process.

Sincerely,

Carolyn Thiele

Carolyn Thiele
Vice President Nebraska Professional Services

Cc: Patti Jurjevic
Taren Petersen

P. Comment On The State Plan
Section 1941 of the Block Grant legislation stipulates that as a condition of the funding agreement for the grant, States will provide opportunity for the public to comment on the State Plan. States will make the mental health plan public in such a manner to facilitate comment from any person (including Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

States should describe their efforts and procedures to obtain public comment on the plan on the plan in this section.

Within Nebraska, the State Advisory Committee on Mental Health Services (§ 71-814) and the State Advisory Committee on Substance Abuse Services (§ 71-815) advise the Division of Behavioral Health. Both of these Committees are authorized under State Statute and are appointed by the Governor. These Committees are to provide advice and assistance to the Division of Behavioral Health on the provision of behavioral health services in the State of Nebraska. By state statute, these Committees hold public meetings. The Division of Behavioral Health used the State Advisory Committee on Mental Health Services to review the Community Mental Health Services Block Grant (MHSBG). The State Advisory Committee on Substance Abuse Services was used to review the Substance Abuse Prevention and Treatment Block Grant (SAPTBG). Their joint meetings on August 18, 2011 and November 3, 2011 are specifically to meet the public hearing requirement of the SAMHSA Uniform Block Grant.

The DHHS Communications and Legislative Services section issued a News Release on August 12, 2011 titled, "Comments Wanted on Federal Block Grant for Mental Health and Substance Abuse Services". http://www.dhhs.ne.gov/newsroom/newsreleases/2011/Aug/blockgrant.htm

In addition, the following content was posted on the Nebraska Department of Health and Human Services – Division of Behavioral Health website on August 5, 2011.

SAMHSA Uniform Block Grant
NE State Application FY 2012 - Public Comments on State Plan

- The Federal Substance Abuse Mental Health Services Administration (SAMHSA) has now combined the previously separate Community Mental Health Services Block Grant (MHSBG) and the Substance Abuse Prevention and Treatment Block Grant (SAPTBG) into one grant.

- Public Comments are welcomed on NE State Application for SAMHSA Uniform Block Grant FY 2012. The Block Grant Application will be due September 1, 2011. The Implementation Reports for the MHSBG and the SAPTBG will be due December 1, 2011.

- There are several approaches one may use to comment on these documents:

  1) The applications from previous years are posted on the Division of Behavioral Health Web site. These documents have already been approved by the SAMHSA. They provide examples of the types of issues addressed within the Application and the Implementation Report.

  2) Two weeks before the joint meetings scheduled with the Mental Health and Substance Abuse Advisory Committees (August 18, 2011 and November 3, 2011), the preliminary draft will be posted.

The NE Draft Application for SAMHSA Uniform Block Grant FY 2012 was posted on the Division of Behavioral Health website on August 5, 2011.

3) Attend the Joint State Advisory Committee on Mental Health and State Advisory Committee Substance Abuse Services.

- For the application, the review meeting is on **August 18, 2011 from 9:00 a.m. to 4:00 p.m**. at the Country Inn and Suites, 5353 No 27th Street, Lincoln, NE. Please check the Public Meeting Calendar - http://www.nebraska.gov/calendar/ for the latest Meeting Agenda information.
- For the implementation report, the **Review Meeting is on November 3, 2011**. Specific meeting arrangements are yet to be determined.
- The comments will be accepted at the designated time. To make public comments at this meeting, please note:
  - Each person wishing to comment on the NE State Application for FY 2012 Federal SAMHSA Uniform Block Grant at the meeting needs to sign up on the Public Comment Sign-in List.
  - Each person will be called on from the Public Comment Sign-in List in order of sign-in. **Each person may have 5 minutes** (unless the chair grants more time) to provide comments.
  - Public comments not provided verbally at the meeting may be mailed to the above address - Attention: Jim Harvey.

4) Comments will be accepted up to five (5) working days prior to the due dates noted above for the Application (September 1, 2011) or the Implementation Reports (December 1, 2011). Please send written comments by US Mail or e-mail to the Nebraska Department of Health and Human Services, Division of Behavioral Health:

Jim Harvey – Federal Resources Manager
Jim.Harvey@nebraska.gov
Nebraska Department of Health and Human Services
Division of Behavioral Health
301 Centennial Mall South, 3rd Floor
PO Box 95026
Lincoln, NE 68509-5026

Comments received during the SAMHSA Uniform Block Grant Application Review / page 1

Division of Behavioral Health
State Advisory Committees on Mental Health and Substance Abuse Services
August 18, 2011 – 9:00 a.m. to 4:00 p.m.
Country Inn & Suites – 5353 No. 27th St. Lincoln, NE

Mental Health Committee Members Present:
Adria Bace, Roxie Cillessen, Pat Compton, Sharon Dalrymple ,Robert Donlan, Bev Ferguson, Scot Ford, Ed Matney, Jerry McCallum, Joyce Sasse, Mark Schultz, Joel Schneider, Diana Waggoner, Cameron White

Mental Health Committee Members Absent:
Beth Baxter, Jette Hogenmiller, Kathy Lewis, Melanie Lantis, Dave Lund, Colleen Manthei, Kasey Moyer

Substance Abuse Committee Members Present: Corey Brockway, Jay Jackson, Brenda Miner, Jorge Rodriguez-Sierra, Linda Krutz

Substance Abuse Committee Members Absent: Ann Ebson, Janet Johnson, Dr. Delinda Mercer, Laura Richards, Randy See, Debra Shoemaker

Comments received during the SAMHSA Uniform Block Grant Application Review

Public Comment

Jonah Deppe from the National Alliance on Mental Illness (NAMI), the largest Consumer and Family grassroots organization, operates with volunteers who are in recovery or who may still be experiencing episodes. The organization receives State General funds, and no Block Grant funding. NAMI functions statewide to connect individuals with recovery support groups, conduct volunteer training, hold various open groups, provide family-to-family and peer-to-peer support. A Peer Specialist works in the office and offers a "warm-line" for people to call in and talk through their issues. NAMI sees a great need for more younger children and family support.

Committee Comments Related to the Block Grant Application

- SA Committee—how adequate services would be provided in a Peer-Run Respite House with only 3 beds available? How does the State foresee the model to apply to more people?

- SA Committee—why the peer-run respite houses need to be funded—why can't they be run by volunteers?

- SA Committee—how Peer Specialists are different that professional clinicians?
- SA Committee—why tobacco is separated from other substances?

- SA Committee—data shows that in Nebraska alcohol continues to be the number one abused substance, and the problem is that the public attitude thinks it is OK; methamphetamine is declining, and marijuana is increasing.
- SA Committee—we need to take a proactive versus reactive approach, education is important is to "plant the seed" for future outcomes.

- SA Committee—suggested a program such as the Groups for Adolescents Providing Support (GAPS) in Region 4 be duplicated across the State.

- SA Committee—has knowledge that in the Region 3 area of the State, the attitude of drinking alcohol is acceptable—that drugs are bad, but alcohol is OK.

Comments received during the SAMHSA Uniform Block Grant Application Review / page 2

- SA Committee—Emphasis on Table 3 – Substance Related Diagnosis Made By Nebraska DCS SA Staff at Intake on page 53 of the Block Grant Application that an 11% decrease occurred between 2006 and 2011. Reasons may be due to the following: in 2006 Evidence Based Practice assessments and Specialized SA Services (SASS) for treatment were started, intake diagnostics are more refined with more professional staff available, as well as the inmate population has changed.

- SA Committee—Also need to look at better methods of Prevention, Treatment, and Law Enforcement, and emphasize Criminogenic Risk Factors.

- MH Committee—how have the Family Organizations been included in information gathering for peer run services?

- MH Committee—expressed concern that a Keya-type House focuses on adults only and does not include families; recommends the Family Organizations be included in the decision to open more Peer-Run Respite Houses.

- MH Committee—understands the importance of peer-run houses, but also recommends that a medical professional be attached for medication checks and medical oversight.

- MH Committee—most health issues can be treated by a Nurse Practitioner, and recommended Nebraska look into developing more NP professionals that are certified in mental health and/or substance abuse treatment.

- MH Committee—some studies track childhood trauma and its correlation with adult MH and SA issues, and recommends that more focus on childhood trauma needs to be done.

- MH Committee—trauma-informed care is one area where the peer services role can be expanded, so an individual has someone they can talk with during the assessment/admission process when answering questions on intake/application paperwork.

- MH Committee—there is not much for youth to do in rural areas, therefore most activities involve alcohol; there is a need to educate parents about the immediate and future affects.

- MH Committee—regulations need to be reviewed, such as limiting the hours youth can be allowed to in businesses that sell alcohol.

- MH Committee—the effects and treatment of all substances cannot be grouped together because tobacco has physical affects, while alcohol also has physical affects as well as public affects (such as drinking and driving).

- MH Committee—ages 16 – 24 is a wide age range to address because when children are younger their parents are usually involved, but when a youth gets older and on their own, they stop taking their medications, which creates more problems; suggests that case workers are educated to begin case management services sooner to provide a “safety net” of services to follow the individual.

- MH Committee—we also need to coordinate with youth and families who are not “in the system” because many don’t know where to turn for services.

Comments received during the SAMHSA Uniform Block Grant Application Review / page 3

- MH Committee—who is included in the population considered as Transition Age Youth? Do they include State Wards, children in foster care without a behavioral health diagnosis? Many youth lack independent living skills and don't have the resources to pay living expenses.

- MH Committee—is there buy-in from the Regions on the Professional Partner Program?

- MH Committee—are family organizations not employed by the Regions organizing the data? Need an outside review.

- MH Committee—Section L. Involvement of Individuals and Families on page 98 of the Block Grant Application includes the roles of the Office of Consumer Affairs, Regional Consumer Specialists, and the State Advisory Committees, but there is little discussion on the involvement of peer advocacy and the family organizations. Also, more focus needed on children services to avoid problems for the adults of tomorrow. We don't want to create a system with no individual choices. Family involvement is the avenue to tomorrow.

- MH Committee—Prevention work in services to parents will result in less traumatization and more benefits to children.

- MH Committee—There is nothing in the Block Grant about using the full range of psychotropic medications rather than the use of generic brands, which don't always work and are not an acceptable replacement.

- MH Committee—Encourage more emphasis on trauma-informed in all services, the collection of data, and the experiences of trauma survivors in Block Grant services.

- MH Committee—Concern about children—many have multiple foster care placements which affects their ability to have a normal life—not many people understand the impact on children now and into adulthood.

- MH Committee—Individuals in prison receive some treatment, but there is a need for continuity of services to recognize the on-going needs of inmates after release from prison.

- MH Committee—There are individuals in the general population who are not in clinical crisis, but their crisis is causing problems for the rest of society, particularly for law enforcement agencies. All components of services must work together—Prevention, Treatment, and Law Enforcement—need focus efforts where the need is the greatest.

- MH Committee—77% of inmates in the correctional system experience the affects of substance abuse; substance abuse costs money and ruins families; there is a need for more education.

- MH Committee—Does the Children and Family Services Division have a mental health component? (DHHS is working on developing better partnerships between divisions).

- MH Committee—Court Judges are ordering services, but who pays for those services? The mental health issues of parents are not recognized until the children have problems; there is a need to provide help sooner to save costs later.

From:????????????????????????????????????? Kit M. Boesch [KBoesch@lancaster.ne.gov]
Sent:??? Friday, August 26, 2011 6:01 PM
To:??? Harvey, Jim
Cc:??? 'Patte Newman'
Subject:????????????????????????????????????? Block Grant

OK - Its after 5Pm but there wasn't a time given just the 26th :).

As coordinator for the Substance Abuse Action Coalition in Lincoln, NE I am very interested in the goals and distribution of potential Block Grant monies for Mental Health and Substance Abuse services. For the past 9 years we have had the privilege of receiving $100,000 to dome of the following work:

a. collect community data on the use of alcohol, tobacco and other illegal drugs
b. develop community coalitions around these topics (we have I believe 9 now)
c. to involve schools, churches, and other agencies in the effort
d. to begin marketing the message (there are billboards all over Lincoln in both English/Spanish
e. We have examined school policies and discussed with coaches and principals strengthening them so they send an immediate and important message to athletes
f. We have reached the rural areas of Lancaster County as well and have begun Best Practice Programs
g. We are examining an immediate response to the new Bar closing times in Lancaster County.

the list goes on and on?????..

In collaboration with that grant we have had the SPF-SIG dollars looking at alcohol/tobacco and illegal drug activity with young adults ages 17-20.. The Lancaster Alcohol Abuse Prevention Partnership involves not only the surrounding colleges and universities but also close work with campus and city police departments. Their strategies have focused on things like game day drinking; enhanced enforcement; Responsible Beverage Server Training; Establishment incentives; Media campaigns targeting ages I8-20 year oldest. It too has been dollars well spent.

Not knowing what is happening in Washington DC is frightening. But the word is that this block grant will replace these other funding sources. If this is the case we implore the state to consider allocating dollars to continue the efforts that have been slowly- consistently and effectively taking hold in our communities. We have made a great deal of progress but need continued support to ensure our successes continue and our efforts don?t come to a halt. Thank you. Have a great weekend. Kit Boesch - SAAC - Lincoln/Lancaster County. NE.

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