Nebraska

UNIFORM APPLICATION
FY 2010 - STATE PLAN

COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT

OMB - Approved 08/06/2008 - Expires 08/31/2011

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Center for Mental Health Services
Division of State and Community Systems Development

Introduction:

The CMHS Block Grant application format provides the means for States to comply with the reporting provisions of the Public Health Service Act (42 USC 300x-21-64), as implemented by the Interim Final Rule and the Tobacco Regulation for the SAPT Block Grant (45 CFR Part 96, parts XI and IV, respectively).

Public reporting burden for this collection of information is estimated to average 563 hours per response for sections I-III, 50 hours per response for Section IV-A and 42 hours per response for Section IV-B, including the 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 this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (0930-0080); Room 16-105, Parklawn Building; 5600 Fishers Lane, Rockville, MD 20857.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0168.

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Nebraska

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FACE SHEET

FISCAL YEAR/S COVERED BY THE PLAN

_X_FY2010 ___FY 2010-2011

STATE NAME: Nebraska

DUNS #: 808819957

I. AGENCY TO RECEIVE GRANT

AGENCY: Nebraska Department of Health and Human Services

ORGANIZATIONAL UNIT: Division of Behavioral Health Services

STREET ADDRESS: P.O. Box 98925

CITY: Lincoln STATE: NE ZIP: 68509-8925

TELEPHONE: 402-471-7824 FAX: 402-471-7859

II. OFFICIAL IDENTIFIED BY GOVERNOR AS RESPONSIBLE FOR ADMINISTRATION OF THE GRANT

NAME: Scot Adams, Ph.D. TITLE: Director

AGENCY: Nebraska Department of Health and Human Services

ORGANIZATIONAL UNIT: Division of Behavioral Health

STREET ADDRESS: P.O. Box 98925

CITY: Lincoln STATE: NE ZIP CODE: 68509-8925

TELEPHONE: (402)471-8553 FAX: (402)471-9449

III. STATE FISCAL YEAR

FROM: 07/01/2009 TO: 06/30/2010

IV. PERSON TO CONTACT WITH QUESTIONS REGARDING THE APPLICATION

NAME: James S. Harvey, LCSW TITLE: Federal Resources Manager

AGENCY: Nebraska Department of Health and Human Services

ORGANIZATIONAL UNIT: Division of Behavioral Health

STREET ADDRESS: P.O. Box 98925

CITY: Lincoln STATE: NE ZIP: 68509-8925

TELEPHONE: 402-471-7824 FAX: 402-471-7859 EMAIL: jim.harvey@nebraska.gov

Nebraska

Executive Summary

Please respond by writing an Executive Summary of your current year's application.

Executive Summary (August 28, 2009)

The Division of Behavioral Health acts as the behavioral health authority for the State of Nebraska and directs the administration and coordination of the public behavioral health system.

The Division operates three Regional Center hospitals. The end-of-year census on June 30, 1955 for the Regional Center inpatient units total was 4,746. Today the Lincoln Regional Center (LRC) has 245 beds used to provide treatment to those who are ordered by the court, sex offenders and general psychiatric services for those committed by a Board of Mental Health, who cannot be served in a community setting. The number of individuals waiting to receive mental health services at the Lincoln Regional Center continues to decrease, as more and more individuals are provided services in their home community. The Norfolk Regional Center (NRC) has 120 beds to provide treatment to sex offenders. The Hastings Regional Center (HRC) provides chemical dependency/addiction treatment to male youth who have been paroled from the Youth Development Center in Kearney, NE. HRC does not provide psychiatric inpatient services.

The Division of Behavioral Health Community Services contracted a total of $72 million in State Fiscal Year 2009 in funding to the six Regional Behavioral Health Authorities who contract with community-based programs to provide mental health and substance abuse services. Behavioral Health Reform concluded with the final reallocation of Regional Center operational funds for community-based services. Closing this chapter of reforming the Nebraska behavioral health care system was marked with a variety of significant achievements which include a statewide increased capacity to serve those with a mental illness in their home community, enhancements to existing services, an increase in peer-delivered services, and far less community dependence on the regional centers for general psychiatric treatment.

The Behavioral Health Oversight Commission operated from July 2008 to June 2009. Their strategic vision will form the basis for a more developed strategic plan, outlining the future for Nebraska's Behavioral Health system.

In May 2009, Nebraska legislature passed LB603, authorizing the creation of a Children's Behavioral Health Help Line and Family Navigator Services. In 2010, the Help Line and Family Navigator services will become a resource to families of youth experiencing an urgent behavioral health situation.

The Office of Consumer Affairs is experiencing revitalization under the new Administrator. Peer Support is receiving new focus with the Transformation Transfer Initiative Grant (TTI) and the Administrator's vision. Town hall meetings on peer support are being held across the state.

Criminal Justice Behavioral Health issues are a priority for the Division of Behavioral Health. The Director addressed the Nebraska Jail Standards Conference saying places like homeless shelters, local jails, and state prisons must not become the replacement locations for people formerly served by the Regional Centers. In order to address these concerns, the Division of Behavioral Health is meeting with the Nebraska Department of Correctional Services (DCS) and the Nebraska Commission on Law Enforcement and Criminal Justice (Crime Commission) on a regular basis. This includes Data Transfer Interagency Agreements for the purpose of analysis, compilation and reporting on persons served in behavioral health also found in the criminal justice system.

Attachment A. COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT FUNDING AGREEMENTS

FISCAL YEAR 2010

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.]

Section 1911:

Subject to Section 1916, the State[1] 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.

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].

Section 1913:

(a)(1)(C) In the case for a grant for fiscal year 2010, 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:

[21]. The term State shall hereafter be understood to include Territories.

(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.

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.

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.

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.

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.

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).

Section 1943:

(a) The State will:
(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.

_____ _____

Governor Date
Scot Adams, Director, Division of Behavioral Health
XXXXXXX

OMB Approval No. 0920-0428

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, In eligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub- grantees 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 workplace 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 workplace 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), (c), (d), (e), and (f).

For purposes of paragraph (e) 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. CERTIFICATION 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, day care, 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 an mental health of the American people.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE Director, Division of Behavioral Health
APPLICANT ORGANIZATION Nebraska Department of Health and Human Services	DATE SUBMITTED

DISCLOSURE OF LOBBYING ACTIVITIES

Approved by OMB
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure.)

1. Type of Federal Action: ☐ a. contract b. grant c. cooperative agreement d. loan e. loan guarantee f. loan insurance	**2. Status of Federal Action** ☐ a. bid/offer/application b. initial award c. post-award	**3. Report Type:** ☐ a. initial filing b. material change **For Material Change Only:** Year _____ Quarter _____ date of last report _____
4. Name and Address of Reporting Entity: Prime Subawardee Tier _____ , *if known:* **Congressional District**, *if known:*	**5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:** **Congressional District,** *if known:*	
6. Federal Department/Agency:	**7. Federal Program Name/Description:** **CFDA Number**, *if applicable:* _____	
8. Federal Action Number, *if known:*	**9. Award Amount,** *if known:* **$**	
10. a. Name and Address of Lobbying Entity *(if individual, last name, first name, MI):*	**b. Individuals Performing Services** *(including address if different from No. 10a.)* *(last name, first name, MI):*	
11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.	**Signature:** _____ **Print Name:** _____ **Title:** _____ **Telephone No.:** _____ **Date:** _____	
Federal Use Only:		Authorized for Local Reproduction Standard Form - LLL (Rev. 7-97)

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity 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 a covered Federal action. Use the SF-LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.

2. Identify the status of the covered Federal action.

3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.

4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.

5. If the organization filing the report in item 4 checks "subawardee", then enter the full name, address, city, state and zip code of the prime Federal recipient. Include Congressional District, if known.

6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.

7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 [e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency]. Include prefixes, e.g., ‘‘RFP-DE-90-001.’’

9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.

10. (a) Enter the full name, address, city, state and zip code of the lobbying entity engaged by the reporting entity identified in item 4 to influence the covered Federal action.

    (b) Enter the full names of the individual(s) performing services, and include full address if different from 10(a). Enter Last Name, First Name, and Middle Initial (MI).

11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (item 4) to the lobbying entity (item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

According to the Paperwork Reduction Act, as amended, no persons are required to respond to a collection of information unless it displays a valid OMB Control Number. The valid OMB control number for this information collection is OMB No.0348-0046. Public reporting burden for this collection of information is estimated to average 10 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 (0348-0046), Washington, DC 20503.

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, re- gulations and policies governing this program.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE Director, Division of Behavioral Health
APPLICANT ORGANIZATION Nebraska Department of Health and Human Services	DATE SUBMITTED

SF-424B (Rev. 7-97) Back

Nebraska

Public Comments on 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.

Narrative Question:

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.

Public Comments are welcomed on NE State Application for FY 2010 Federal Community Mental Health Services Block Grant Application (due September 1, 2009) and Implementation Report (due December 1, 2009).

There are several approaches one may use to comment on these documents.

1) The applications from FY2008 and FY2009 are posted on the Division of Behavioral Health Web site. These documents have already been approved by the Federal Center for Mental Health Services. They provide examples of the types of issues addressed within the Application and the Implementation Report. To see these documents, go to:

http://www.dhhs.ne.gov/beh/mh/mh.htm

Grants and Reports:

Grants and Reports:

Mental Health Block Grant Fiscal Year 2009 Application 4,118 kb

Mental Health Block Grant Implementation Report FY 2008 1,412 kb
NE Final FY 2008 URS Tables (Part E of MH Block Grant) - Dec, 2008 147 kb
Mental Health Block Grant Fiscal Year 2008 Application 4,603 kb

Mental Health Block Grant Implementation Report FY 2007 726 kb
NE Final FY 2007 URS Tables (Part E of MH Block Grant) - **REVISED - Dec, 2008** 120 kb
NE Final FY 2007 URS Tables (Part E of MH Block Grant) - Dec, 2007 167 kb
Mental Health Block Grant Implementation Report FY 2006 1,258 kb

2) WebBGAS

The person interested in commenting may do so via the Web Block Grant Application System (WebBGAS). The NE FY2010 application is now being prepared. As sections are drafted, they will be posted on WebBGAS. Thus, the interested person may comment

on the draft as it is being prepared. Follow the instructions on WebBGAS to submit the comments. Here is the information needed to log onto WebBGAS:

Go to ... https://bgas.samhsa.gov/cmhs2010/

Nebraska Citizen log-on
Username: NE_citizen
Password: Lincoln#835559

This Citizen log-on was on the Division of Behavioral Health web site on July 14, 2009.

3) Send an email to the Division of Behavioral Health with your comments.

   Send the email to:
   Jim Harvey
   Division of Behavioral Health
   Nebraska Department of Health and Human Services
   e-mail address ==> jim.harvey@nebraska.gov

   Mail comments to:
   Jim Harvey
   Nebraska Department of Health and Human Services
   Division of Behavioral Health
   301 Centennial Mall South, Third Floor
   PO Box 98925
   Lincoln, NE 68509

4) Attend the State Advisory Committee On Mental Health Services.

   For the application, the review meeting is on August 13, 2009 from 9:00 a.m. to 4:00 p.m. at the Country Inn and Suites, 5353 No 27th Street, Lincoln, NE.

   For the implementation report, the review meeting is on November 5, 2009. Specific meeting arrangements are 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 2010 Federal Community Mental Health Services 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 Division of Behavioral Health Services,
     Attention: Jim Harvey.

II. SET-ASIDE FOR CHILDREN'S MENTAL HEALTH SERVICES REPORT

States are required to provide systems of integrated services for children with serious emotional disturbances(SED). Each year the State shall expend not less than the calculated amount for FY 1994.

Data Reported by:

State FY ___X___ **Federal FY _____**

State Expenditures for Mental Health Services

Calculated FY 1994	Actual FY 2008	Estimate/Actual FY 2009
$620,801	$4,120,066	$4,473,352

Waiver of Children's Mental Health Services

If there is a shortfall in children's mental health services, the state may request a waiver. A waiver may be granted if the Secretary determines that the State is providing an adequate level of comprehensive community mental health services for children with serious emotional disturbance as indicated by a comparison of the number of such children for which such services are sought with the availability of services within the State. The Secretary shall approve or deny the request for a waiver not later than 120 days after the request is made. A waiver granted by the Secretary shall be applicable only for the fiscal year in question.

III. MAINTENANCE OF EFFORT(MOE) REPORT

States are required to submit sufficient information for the Secretary to make a determination of compliance with the statutory MOE requirements. MOE information is necessary to document that the State has maintained 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.

MOE Exclusion

The Secretary may exclude from the aggregate amount any State funds appropriated to the principle agency for authorized activities of a non-recurring nature and for a specific purpose. States must consider the following in order to request an exclusion from the MOE requirements:

1. The State shall request the exclusion separately from the application;
2. The request shall be signed by the State's Chief Executive Officer or by an individual authorized to apply for CMHS Block Grant on behalf of the Chief Executive Officer;
3. The State shall provide documentation that supports its position that the funds were appropriated by the State legislature for authorized activities which are of a non-recurring nature and for a specific purpose; indicates the length of time the project is expected to last in years and months; and affirms that these expenditures would be in addition to funds needed to otherwise meet the State's maintenance of effort requirement for the year for which it is applying for exclusion.

The State may not exclude funds from the MOE calculation until such time as the Administrator of SAMHSA has approved in writing the State's request for exclusion.

States are required to submit State expenditures in the following format:

MOE information reported by:

State FY ___X___ **Federal FY _____**

State Expenditures for Mental Health Services

Actual FY 2007	Actual FY 2008	Actual/Estimate FY 2009
$48,888,467	**$64,518,621**	**$54,560,767**

MOE Shortfalls

States are expected to meet the MOE requirement. If they do not meet the MOE requirement, the legislation permits relief, based on the recognition that extenuating circumstances may explain the shortfall. These conditions are described below.

(1). Waiver for Extraordinary Economic Conditions

A State may request a waiver to the MOE requirement if it can be demonstrated that the MOE deficiency was the result of extraordinary economic conditions that occurred during the SFY in question. An extraordinary economic condition is defined as a financial crisis in which the total tax revenues declined at least one and one-half percent, and either the unemployment increases by at least one percentage point, or employment declines by at least one and one-half percent. In order to demonstrate that such conditions existed, the State must provide data and reports generated by the State's management information system and/or the State's accounting system.

(2). Material Compliance

If the State is unable to meet the requirements for a waiver under extraordinary economic conditions, the authorizing legislation does permit the Secretary, under certain circumstances, to make a finding that even though there was a shortfall on the MOE, the State maintained material compliance with the MOE requirement for the fiscal year in question. Therefore, the State is given an opportunity to submit information that might lead to a finding of material compliance. The relevant factors that SAMHSA considers in making a recommendation to the Secretary include: 1) whether the State maintained service levels, 2) the State's mental health expenditure history, and 3) the State's future commitment to funding mental health services.

TABLE 1. List of Planning Council Members

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Bace, Adria	State Employees	Education	PO Box 94987 Lincoln,NE 68509 PH:402 471-4312 FAX:	abria.bace@nebraska.gov
Baxter, Beth	Providers	Region 3-Regional Administrator	4009 6th Avenue, Suite 65 Kearney,NE 68848 PH:308 237-5113 ext 222 FAX:	bbaxter@region3.net
Byers, Leslie	Family Members of adults with SMI		5931 No. 108th Circle Omaha,NE 68164 PH:402 934-2037 FAX:	leslieby@cox.net
Chesen, Dr. Chelsea	Providers	UNMC - Department of Psychaitry	10324 Brookside Lane Omaha,NE 68124 PH:402 483-1116 FAX:	cchesen@cox.net
Cillessen, Roxie	State Employees	Medicaid	301 Centenniall Mall South Third Flood Lincoln,NE 68508 PH:402 471-9224 FAX:	roxie.cillessen@nebraska.gov
Compton, Pat	State Employees	Housing	4735 Avenue E Kearney,NE 68847 PH:308 865-6511 FAX:	pat.compton@nebraska.gov

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Crouse, Cheryl	Consumers/Survivors/Ex-patients(C/S/X)		2726 West 8th Street Hastiings,NE 68901 PH:402 261-3686 FAX:	psalm912@chapter.net
Dalrymple, Sharon	Family Members of adults with SMI		1645 N Street, #A Lincoln,NE 68508 PH:402 441-4369 FAX:	unknown
Ferguson, Beverly	Family Members of Children with SED		3405 Portia Place Norfolk,NE 68701 PH:402 371-2745 FAX:	bfergy04@cableone.net
Ford, Scot	Others(not state employees or providers)	NE Crime Commission	South Sioux City Police Department 701 W. 29th Street South Sioux City,NE 68776 PH:402 494-7512 FAX:	
Fowler, Dwain	Family Members of Children with SED		PO Box 180 Beaver City,NE 68926 PH:308 268-5821 FAX:	dmfowler@frontiernet.net
Hanus, Chris	State Employees	Social Services	301 Centennial Mall South Lincoln,NE 68509 PH:402 471-9308 FAX:	chris.hanus@nebraska.gov

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Hawkins, Clint	Family Members of Children with SED		PO Box 722 Woodlake,NE 69221 PH:402 967 3012 FAX:	windmill@cpcom.net
Lewis, Kathy	Family Members of adults with SMI		1316 W. Koenig Street Grand Island,NE 68801 PH:308 381-7206 FAX:	klewis@kdsi.net
Lloyd, Frank	State Employees	Vocational Rehabilitation	301 Centennial Mall So. Lincoln,NE 68509 PH:402 471-3649 FAX:	frank.lloyd@nebraska.gov
Lund, Dave	Providers		302 Dixie Avenue North Platte,NE 69101 PH:308 532-0587 FAX:	dlund@lfsneb.org
Maca, Vicki	State Employees	Mental Health	PO Box 95926 Lincoln,NE 68509 PH:402 471-7727 FAX:	vicki.maca@nebraska.gov
Manthei, Colleen	Family Members of Children with SED		5625 So. 31st , #7 Lincoln,NE 68516 PH:402 601-4162 FAX:	iamme012003@yahoo.com

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
McCallum, Jerry	Others(not state employees or providers)	Region 4 - Governing Board Member	55717831 Road Madison,NE 68748 PH:402 454-3735 FAX:	jejamc@telebeep.com
Moyer, Kasey	Consumers/Survivors/Ex-patients(C/S/X)		1645 N Street, #A Lincoln,NE 68508 PH:402 441-4371 FAX:	kmoyer@mha-ne.org
Talbott, Pat	Consumers/Survivors/Ex-patients(C/S/X)		4000 Huntington, #111 Lincoln,NE 68504 PH:402 540-0576 FAX:	pattalbott@aol.com
Waggoner, Diana	Family Members of adults with SMI		13606 California Omaha,NE 68154 PH:402 891-6960 FAX:	dwaggoner@thekimfoundation.org

TABLE 2. Planning Council Composition by Type of Member

Type of Membership	Number	Percentage of Total Membership
TOTAL MEMBERSHIP	22	
Consumers/Survivors/Ex-patients(C/S/X)	3	
Family Members of Children with SED	4	
Family Members of adults with SMI	4	
Vacancies(C/S/X and Family Members)	1	
Others(not state employees or providers)	2	
TOTAL C/S/X, Family Members and Others	13	59.09%
State Employees	6	
Providers	3	
Vacancies	0	
TOTAL State Employees and Providers	9	40.91%

Note: 1) The ratio of parents of children with SED to other members of the Council must be sufficient to provide adequate representation of such children in the deliberations of the Council, 2) State Employee and Provider members shall not exceed 50% of the total members of the Planning Council, and 3) Other representatives may include public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services. 4) Totals and Percentages do not include vacancies.

Nebraska

Planning Council Charge, Role and Activities

State Mental Health Planning Councils are required to perform certain duties. If available, a charter or a narrative summarizing the duties of the Planning Council should be included. This section should also specify the policies and procedures for the selection of council members, their terms, the conduct of meetings, and a report of the Planning Council's efforts and related duties as mandated by law:

reviewing plans and submitting to the State any recommendations for modification
serving as an advocate for adults with serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems,
monitoring, reviewing, and evaluating, not less than once each year, the allocation and adequacy of mental health services within the State.
the role of the Planning Council in improving mental health services within the State.
<STRONG>In addition to the duties mandated by law, States should include a brief description of the role of the Planning Council in the State's transformation activities that are described in Part C, Section II and Section III. </STRONG>

Planning Council Charge, Role and Activities
Narrative Question:
State Mental Health Planning Councils are required to perform certain duties. If available, a charter or a narrative summarizing the duties of the Planning Council should be included. This section should also specify the policies and procedures for the selection of council members, their terms, the conduct of meetings, and a report of the Planning Council's efforts and related duties as mandated by law:

- Reviewing plans and submitting to the State any recommendations for modification
- Serving as an advocate for adults with serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems,
- Monitoring, reviewing, and evaluating, not less than once each year, the allocation and adequacy of mental health services within the State.
- The role of the Planning Council in improving mental health services within the State.

In addition to the duties mandated by law, States should include a brief description of the role of the Planning Council in the State's transformation activities that are described in Part C, Section II and Section III.

Planning Council Charge

The duties of the Planning Council are in Neb. Rev. Stat. §71-814. The group is officially titled, "State Advisory Committee on Mental Health Services". Here is what the statute says:

(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.
Operative date July 1, 2007 ~Revised Statutes Supplement, 2007

Selection of council members, their terms

Neb. Rev. Stat. §71-814(1) says

- The committee members are appointed by the Governor.
- The Governor appoints members to a three year term on the Committee.

The conduct of meetings

Meetings are held on a quarterly basis. The membership, meeting agendas and the minutes for the State Advisory Committee on Mental Health Services are posted on the web at http://www.hhs.state.ne.us/beh/mh/sacmhs.htm

A Report Of The Planning Council's Efforts And Related Duties

State Advisory Committee on Mental Health Services met on the following dates since the last application:

November 4, 2008
February 5, 2009
May 7, 2009
August 13, 2009

Here is a summary of the work completed at these meetings.

The November 4, 2008 meeting included a report on Nebraska findings from the Patient Health Questionnaire 8 (PHQ-8) in the Behavioral Risk Factor Surveillance System (BRFSS), presentation on the State Public Counsel (Ombudsman's Office) and LB467 by Marshall Lux and Carl Eskridge, Report on the Behavioral Health Oversight Commission, a report on the development of the Magellan Quality Improvement Team (MQIT), a report on the Regional Center Wait list and the Emergency System, a report on the Office of Consumer Affairs Report, the official committee review of the Mental Health Block Grant Implementation Report and URS Tables, a report on the Criminal Justice Mental Health Grant, a presentation by Sharon Wohler, Region 1 Administrator regarding Region 1 Behavioral Health Authority, discussion on Committee Recommendations for Letter by Chair for the Mental Health Block Grant Implementation report, formal review of the Proposal on Transformation Transfer Initiative, discussion on Mental Health Awareness Week, and other related topics.

Based on the minutes of the meeting from August 12, 2008, the following Committee questions and comments were identified. The Division of Behavioral Health responses were reviewed at the State Advisory Committee on Mental Health Services on November 4, 2008.

The Committee Asked

Recommend to the Division to have a breakdown of the population serviced to help determine the Professional services dealing with children and not just adults.

Division of Behavioral Health Response

This is an issue addressed under GAP #4: SHORTAGE OF BEHAVIORAL HEALTH WORKFORCE within the Federal Community Mental Health Services Block Grant. The

Health Professionals Tracking Center (HPTC) at the University of Nebraska Medical Center prepares the information reported under GAP #4. Since 1995 HPTC has effectively developed and maintained a centralized, state of-the-art repository of information regarding Nebraska's health care resources. In general, HPTC reports there remains a critical shortage of qualified Nebraska behavioral health staff for providing treatment, rehabilitation and support services as well as handling administrative functions. The shortage of credential staff includes psychiatrists, psychologists, mental health practitioners, nurses, as well as alcohol and drug counselors.

On August 12, 2008, the NE FY2009 draft application for the Mental Health Block Grant was formally reviewed by State Advisory Committee on Mental Health Services. Members of the Committee asked to have the Health Professions Tracking Center to report on the populations served by behavioral health professionals such as only children, only adults or both to help document the lack of pediatric mental health professionals.

On August 25, 2008, the Health Professions Tracking Center responded with a preliminary analysis based on what could be completed within the time available. The data used in the report below is restricted to the following five age categories: Child: 0 - 12 years; Adolescent: 12 - 18 years; Young Adult: 19 - 25 years; Adult: 26 - 64 years; and Geriatric: 65 +. The data are reported under "Behavioral Healthcare Professional – Patient Age Details by Region" (as of August 22, 2008) on pages 99 to 101 in the FY2009 Nebraska application for the Federal Community Mental Health Services Block Grant. This FY2009 application is posted on the Division of Behavioral Health web site under Mental Health Services, Grants and Reports: Mental Health Block Grant Fiscal Year 2009 Application
http://www.dhhs.ne.gov/beh/mh/mh.htm

For more information on Health Professional Shortage Areas contact Thomas Rauner in the Nebraska Department of Health and Human Services (DHHS), Office of Rural Health and Primary Care (402-471-0148).

The Committee Asked

Recommend the Division to do away with the over medication of children and use more therapy.

Division of Behavioral Health Response

This is a nationwide issue. The Division of Behavioral Health does provide funding for medication (FY2009 Regional contracts for Medication Management total is $1,008,400; the LB95" Psychiatric Medications Indigent Drug Reimbursement in FY2008 was $2,135,203.72). However, most of the DHHS funding for behavioral health drugs is from Medicaid.

Nebraska Medicaid Behavioral Health Drug Expenditures

	Age 0 through 17	Age 18 and older	Total
FY2008	$25,186,739.28	$37,353,287.64	$62,540,026.92

The medications are dispensed by both behavioral health providers and other authorized medical professionals in Nebraska.

We recognize the concerns in the field from families whose children's are recipients of over medication. Medicaid has a drug education program. Dr. Blaine Shaffer, Chief Clinical Officer for the Division of Behavioral Health, serves on this committee. More recently, several brochures were published in collaboration with State Infrastructure Grant (SIG) and the

Nebraska Federation of Families for Children's Mental Health to address the use of psychotropic medicines, what to ask, what to know. SIG is a Federal grant to develop a statewide Children's Mental Health and Substance Abuse delivery system. This issue has also been addressed within SIG in the form of researching and encouraging the use of evidence based therapeutic practices and workforce development. This also includes education to the medical field as we know that many prescriptions are distributed via family care physicians, especially in rural areas where there is a shortage of psychiatrists. This Division can specifically address the practitioners we fund for services and are working in collaboration with the Divisions of Medicaid/Long Term Care and Children/Family Services to address appropriate service application. Much consideration is given to the recommendation of the Committee as to continue the planning of this domain for future implementation.

In October 2004, Nebraska Department of Health and Human Services was awarded a U.S. Department of Health & Human Services - Substance Abuse & Mental Health Services Administration (SAMHSA) State Infrastructure Grant to develop a statewide Children's Mental Health and Substance Abuse delivery system. This is a five year grant at $750,000 per year. This upcoming federal cycle impacting 2009 will be the fifth and last year of this grant project. This funding has been utilized for infrastructure capacity building and system development. This State Infrastructure Grant (SIG) has addressed many challenges to the system.

The Committee Asked

Recommend the Division to inform the committee member on what is the hiring process for the Officer of Consumer Affairs and will there be a National search of applicants.

Division of Behavioral Health Response

Diana Waggoner of the Kim Foundation is chairing the search committee. Dan Powers contacted the three Consumer Technical Assistance centers(National Empowerment Center, CONTAC and National Self-help Clearinghouse) and asked them to post job announcement on their website. In addition Dan sent the announcement out to National Association of Consumer/Survivor Mental Health Administrators listserve. He also contacted Mindfreedom a national consumer organization and they sent job announcement out to membership.

To date, 28 applications have been received. The review team consists of consumers outside the Division of Behavioral Health, Dr. Blaine Shaffer, and representatives from the DHHS Human Resources & Development.

Here is the job announcement.

Administrator - Consumer Affairs #255-28029; NSOB-3rd Floor-Lincoln; Salary: Negotiable based on experience. Full-time, M-F, 8-5.

Under administrative supervision of the Director of the Division of Behavioral Health Manage the Office of Consumer Affairs, develop plans and processes for working in close collaboration with consumers of substance abuse, mental health and gambling services and their families. Advocate for consumer views and achieve the meaningful involvement and participation of consumers as a priority in the state funded behavioral health system; provide comments on proposed regulations and rule changes, develop with Ombudsman and others a fair and equitable consumer grievance system; track complaints and write reports; collect and analyze complaint data. Actively support, expand and develop a plan for consumer participation. Manage federal and other grant projects. Provide supervision and direct the

work activities of assigned staff. Train or manage training consumers to take meaningful roles throughout the behavioral health system. Monitor, encourage and develop regional consumer specialists. Encourage relevant and useful consumer participation in behavioral health emergency system. REQUIREMENTS: Bachelors degree with progressively responsible experience that involve consumer related issues. Must be current or former consumer of behavioral health services and have specialized knowledge, experience or expertise in substance abuse, mental health or gambling services with recovery and willing to disclose this publicly. Supervisory experience required. Experience with grant projects. Excellent communication skills. Ability to analyze, help resolve problems, interpret laws, regulations and procedures.

CLOSING DATE: OPEN UNTIL FILLED.

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The February 5, 2009 meeting included presentation on the Nebraska Association on Aging (June Pedersen, Chair), Discussion on Quality Improvement Framework/Performance Contracting, Discussion on Suicide Prevention Initiative in 2010, a presentation by Beth Baxter Region 3 Administrator regarding Region 3 Behavioral Health Authority, report on the Legislative Bills, Update on Children's Behavioral Health, update on Children's Behavioral Health Task Force, report on the Office of Consumer Affairs, discussion on the Federal Grant - Project for Assistance on Transition from Homelessness(PATH), review of State Advisory Committee on Mental Health Services By-Laws, review of the State Advisory Committee on Mental Health Services Appointment Terms, updated on the Transformation Transfer Initiative (TTI) Grant, report on the Criminal Justice Mental Health grant, report on the Consumer Survey from 2008, and other related topics.

Based on the minutes of the meeting from November 4, 2008 the following Committee questions and comments were identified. The Division of Behavioral Health responses were reviewed at the State Advisory Committee on Mental Health Services on February 5, 2009.

The Committee Asked: Request the Division to check on the Arbor Program process and if there is an assessment/screening to help the individual.

- Division of Behavioral Health Response – There was discussion about the State's federally mandated 'welfare to work' program for those receiving economic assistance at the last meeting. During this discussion, several questions about the process for participants were raised specifically regarding a screening for BH issues. Employment First has indicated that they do brief screening as it relates to potential barriers and allow opportunity for discussion and disclosure during face to face interview. At that time an individual can discuss family circumstances that may create barriers to work but is also responsible for providing documentation of such issues. There are several exemptions for required work participation such as: pregnancy and post partum, incapacitated due to physical or mental impairment, parent needed at home to care for disabled family member/child, and more. Their brief assessment tool includes questions about safety, mental health, emotional stability and substance abuse, in an attempt to identify potential barriers to work. The original screening tool was created using SAMHSA guidelines. Referral to treatment is made as appropriate. Arbor has more extensive assessment documents as well.

The Committee Asked: Recommend the Division to do a comparison of the Consumer Survey Youth Data to the Professional Partner's Satisfaction Survey.

- Division of Behavioral Health Response – The Consumer Survey is designed to measure a number of things for Federal reporting purposes such as access, general satisfaction, participation in treatment and cultural sensitivity. The Professional Partner program utilizes the Wraparound Fidelity Index that evaluates eleven measures for fidelity. These results for PP are quite high across the state. However, they can not be compared to the Consumer Survey because they measure different elements. The most recent Annual Report for PP is 2007. Currently the Division is performing a closer analysis and evaluation of the PP program and will be able to provide a more comprehensive evaluation report of it after the end of this fiscal cycle.

The Committee Asked: Recommends the Division to investigate a payment process regarding a RentWise Trainer.

- Division of Behavioral Health Response – The Division did investigate the situation. It was found the person did successfully complete the RentWise Train the Trainer program and, afterwards, provided the RentWise training for five persons in August 2008. At the person's request, the Division of Behavioral Health entered into a contract with the Mental Health Association on December 3, 2008 in order to pay the $500. The Division received an invoice on December 23, 2008 which was processed that same day. The $500 payment was paid on January 22, 2009.

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The May 7, 2009 meeting included a presentation on a proposal for a Statewide Rent Wise Coordination function, Arbor Program presentation, Legislative Update, Office of Consumer Affairs Administrator announcement by Scot Adams, report on Hastings Regional Center Youth Family Involvement, Community Mental Health Funding and Region Budget Planning for FY2010, report on the Service Definitions update project, report on progress regarding updating Regulations, a presentation by C. J. Johnson Region 5 Administrator regarding Region 5 Behavioral Health Authority and the Region 5 Harvest Project Program, a "Network of Care" Demonstration, Regional Centers Update and the LRC Waiting List, report on the Transformation Transfer Initiative (TTI), Criminal Justice Mental Health grant report, briefing and discussion on the Suicide Prevention Grant, MH Committee By-Laws Review of updated draft, and other related topics.

Based on the minutes of the meeting from May 7, 2009 the following Committee questions and comments were identified. The Division of Behavioral Health responses were reviewed at the State Advisory Committee on Mental Health Services on August 13, 2009.

Based on the minutes of the meeting from May 7, 2009 the following Committee questions and comments were identified. The Division of Behavioral Health responses were reviewed at the State Advisory Committee on Mental Health Services on August 13, 2009.

The Committee Asked
As part of the Community Mental Health Funding and Region Budget Planning for FY2010 discussion, there were questions on "service enhancement category". Is this a new category of funding? How is it determined how much funding each region receives and is it a substantial amount?

Division of Behavioral Health Response
The category of Service Enhancement is a new category of funding for the Division contracts with the Regions.

Service enhancement category allows the Regions to set aside funds to pay for additional components (mainly staff) for an existing service. They can "wrap" an additional component onto an existing service when the traditional service definition does not include that position in its staffing. For example, some Regions are adding a nurse to day rehab or short term residential. Nurses are not a required component of those services, but providers feel that having a nurse consultant will be proactive in keeping people healthy, taking medication, and staying out of the hospital. Service enhancement funds pay for the salary of the nurse. Another common service enhancement is peer support. Funds may pay for a peer to be at the hospital, etc., although peers are not required to be part of the EPC or inpatient hospital services by definition.

Regions decide how much of their given allocation may be used on service enhancement, what services need to be enhanced, etc.

The Committee Asked

Issues connected to the implementation of Crisis Intervention Team (CIT) under goal one of the Criminal Justice Mental Health grant. CIT is an innovative police based first responder program that has become nationally known as the "Memphis Model" of pre-arrest jail diversion for those in a mental illness crisis. Omaha implemented CIT several years. Under the grant, work is being done to move CIT type interventions into the rural areas. There are disagreements on if this can be done, and if it can, how to do that.

Division of Behavioral Health Response

Here is a synopsis of the information and activities related to CIT and law enforcement training in mental health issues for rural areas.

1. CIT includes a 40 hour training program that has been termed the Memphis Model because it originated in Memphis TN. There is an emerging body of research supporting its use as a way to increase law enforcement comfort and competency in working with persons who have mental health problems. The model has been adapted for use in Omaha and is used widely in other areas of the country as well. It is a promising program, not entirely evidenced based at this time. The limitations of current research on CIT includes the lack of studies with CIT in rural areas or CIT within departments using a 'generalist' rather than 'specialist' model of policing.

2. Nebraska recognizes the value of CIT, not only as a training tool but also as a way to systematically link elements of the justice system with the behavioral health system and with consumers. One way to forge links of understanding is to create opportunities for system participants and consumers to interact in forums like joint training. The reality of Nebraska law enforcement in rural areas of the state includes recognition that 40 hours of continuous training is not feasible for many departments. A Nebraska model of law enforcement training has been produced that is consistent with CIT principles, the Federal Bureau of Justice Assistance and the input from Nebraska Stakeholders gathered over the course of the current justice grant. This model uses modularized training that can be customized locally.

3. Regional behavioral health authorities may implement the CIT model or the Nebraska model or both. The choice is presented to allow regions flexibility in their approach while standardizing much of the material. The following objectives were revised in the Justice mental health workplan to reflect the need to disseminate both models:

Goal 1: Provide consistent statewide training for Nebraska Law Enforcement Officers to improve responses to people with mental illnesses

1.1 Expose Regional Behavioral Health Authority representatives to the Omaha CIT model
1.2 Build a modularized law enforcement training guide for use in rural areas that is based on Bureau of Justice Assistance recommendations for improving responses to people with mental illnesses that is appropriate for delivery in rural/frontier areas.
1.3 Pilot and evaluate modularized training guide
1.4 Sustain statewide training for law enforcement

Comments on August 13, 2009 from the State Advisory Comm on Mental Health Services meeting.

Public Comments:
Allen Green remarks included the following:

- What is the definition of Evidence Based Practices in Nebraska?
- He then passed out copies of a document titled: "Nebraska's Consumer Voice: Leading a Change in Mental Health Services" by Melissa Doncheske (April 2009). This document coincides with the MH block grant and could be useful tool as strategic planning.
- lacking any mention of peer support – still considered as GAP.
- pg 167 – unhealthy behaviors, consumer survey is random, concern with mention of obese vs. meds. There is no mention of alcohol use.
- EBP – Supported Employment, Mental Health Association (in Lincoln) is the only one to use EBP

J Rock Johnson remarks included the following:

- appreciates the public comments before and after
- She feels that in condensing comments that her comments were not reflected. She asked she be provided with the materials used to generate the minutes.
- questions that this meeting meets the open public meeting law.
- Renewed her request that all meeting materials sent to committee members be post for public access before meeting.
- feels the deadline of mailing out the MH Block 2 weeks before this meeting to committee members was not met.++
- Block grant info needs to get to committee in time to be reviewed
- appreciates having hard copies of the MH Grant available for the public.
- the committee be aware of how the public is informed of the block grant web page and password.

++ NOTE: The draft FY2010 Community Mental Health Services Block Grant application was place in the mail on the afternoon of July 30, 2009 to Committee members. The review meeting occurred as scheduled on August 13, 2009. The public has access via the Division of Behavioral Health web site under Mental Health Block Grant: NE State Application FY 2010 Page - Public Comments on State Plan
http://www.dhhs.ne.gov/beh/mh/MH_BlockGrant.htm

Comments on August 13, 2009 from the Members of the Committee

- The language in the Block Grant regarding peer support work force and definition of peer support was not mentioned in the steering committee. There needs to be a stronger effort of

inclusion of public voices in the RFP. Consumers need to be involved at an earlier stage of the planning.

- add more Recovery, consumer controlled content in the application.
- Services based on the recovery model – listen more carefully to consumers
- Regarding the Behavioral Health Oversight Commission – need for Vision, BH System does not have a vision – stop all the process around new regulations, service definitions and at risk managed care.
- is there consumer involvement in the strategic planning or is this a internal workgroup?
- Address 2 issues – 1. Co-Occurring disorders (MH-DD) and 2. Nursing home challenges.
- Include the recognition of Dan Powers on national cemetery memorial for psychiatric patients.
- How does TTI grant Peer Support training intermingle with family training under LB603? The hope is for theLB603 RFP bidder to include Family training.
- What is the Peer Support Work Force Model.
- Page 128 does not refer to the Alternative conference
- Page 130 – does this involve family members?
- to have the peer support specialist to be valid, acknowledgeable and independent they need to go through training and be certified.
- Is there any information on people with Mental Illness in jail. Has the numbers gone up?
- Invite Melissa Doneschke to do a presentation on "Nebraska's Consumer Voice: Leading a Change in Mental Health Services"
- BH reform funds treats more people with same amount of funds.
- Focus on early intervention and get a greater benefit to people.
- Peer Specialist to continue to be insured. It is important are my meds are covered. Feel Peer specialist need to be certified to be well paid and get full benefits. Peer Specialist need to be in recovery, pay for meds and go to work.
- Consumer goes to work, earns money, income goes up and then not meet the LB95 income guidelines and loses this medication benefit.
- Need good access to affordable health care options and not depend on employers. Motion made for a letter to be sent to Nebraska's Congressional representatives on the issue of accessing affordable mental health care … Roll call vote taken, motion passed.
- Trilogy Resources (Network Core) – What is the cost and usage rate?
- There were a lot of good comments on the behavioral health part of the Jail Standards conference held April 16, 2009 (Kearney NE).
- On the Gap #7 (regarding State Corrections), Why is the numbers of mentally ill women higher?
- Consumers, important to target age categories, also have 18-24 age consumers to be included in giving input to this. One member volunteered to help the Office of Consumer Affairs to recruit consumers ages 18-24.
- How do you have consumers reported (a recovered inmate or in process) and are in Jail?
- BH Workforce Act… Put significant pressure towards rural outreach, "Too Omaha Centered".
- Suicide Prevention, does this include older adults?
- MH consumer should be okay to be an outreach worker at disasters-be included on all aspects.
- Would the Division of Behavioral Health utilize as a foundation/guideline for strategic planning the "Nebraska's Consumer Voice: Leading a Change in Mental Health Services"?

Nebraska

Adult - Overview of State's Mental Health System

Adult - A brief description of how the public mental health system is currently organized at the State and local levels, including the State Mental Health Agency's authority in relation to other State agencies.

Narrative Question:
Adult - A brief description of how the public mental health system is currently organized at the State and local levels, including the State Mental Health Agency's authority in relation to other State agencies.

GOVERNOR
On January 20, 2005, Dave Heineman became Nebraska's 39th governor. On November 7, 2006, Governor Heineman was re-elected to the office.

DHHS
On March 15, 2007, Governor Heineman signed legislation, LB296, creating the Nebraska Department of Health and Human Services (DHHS). This law created one department with the effective date of July 1, 2007.

The Department of Health and Human Services has six divisions (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 Governor appoints the Chief Executive Officer of the Department of Health and Human Services. Kerry Winterer of Omaha serves as the Chief Executive Officer of DHHS. The Governor also appoints the directors of the six divisions.
(1) Division of Behavioral Health – Scot L. Adams, Ph.D., Director
(2) Division of Children and Family Services – Todd Reckling, Director
(3) Division of Developmental Disabilities – Jodi Fenner, Director
(4) Division of Medicaid and Long-Term Care – Vivianne Chaumont, Director
(5) Division of Public Health – Dr. Joann Schaefer, Director and Chief Medical Officer (CMO) for the state
(6) Division of Veterans' Homes - John Hilgert, Director, and the Director of the Nebraska Department of Veterans' Affairs

Administrator Community-Based Services, Chief Clinical Officer, & Office of Consumer Affairs

- Vicki Maca is the Administrator for the Community-Based Services Section in the Division of Behavioral Health.
- The Nebraska Behavioral Health Services Act, Neb. Rev. Stat. 71-805 (1), created the position of Chief Clinical Officer. The statute requires the chief clinical officer to be a board-certified psychiatrist and to serve as the medical director for the division and all facilities and programs operated by the division. On January 13, 2005, Blaine Shaffer, M.D., was appointed to the position of Chief Clinical Officer for the Division of Behavioral Health Services.
- Office of Consumer Affairs – On April 1, 2009, Scot Adams announced the appointment of Carol Coussons de Reyes, CPS, MS, as Administrator for the Office of Consumer Affairs., effective May 18, 2009. Under Neb. Rev. Stat. 71-805(1) the Office of Consumer Affairs within the Division was established. The Administrator for the Office of Consumer Affairs is responsible for the administration and management of the office. The Administrator of the Office must be 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.

NEBRASKA BEHAVIORAL HEALTH SERVICES ACT

The Nebraska Behavioral Health Services Act (Neb. Rev. Stat. §§ 71-801 to 71-818) establishes the framework for the provision of behavioral health services in Nebraska. LB1083 (Laws 2004) was approved by the Governor on April 14, 2004 and represented a major reform of the Nebraska Behavioral Health System. For example, § 71-806 (1) designates the Division of Behavioral Health as the Chief Behavioral Health Authority for the State of Nebraska. § 71-804 (2) defines a "Behavioral Health disorder" as "mental illness or alcoholism, drug abuse, problem gambling, or other addictive disorder".

BEHAVIORAL HEALTH OVERSIGHT COMMISSION

The Behavioral Health Oversight Commission was established by the legislature. It is a 12 member board designed to assist the State in reviewing activities of Behavioral Health Reform and reports to the Director of the Division of Behavioral Health. This commission supersedes the Behavioral Oversight Commission of the Legislature that was organized under Legislative Bill 1083 in 2004 that was sunsetted on June 30, 2008. This Behavioral Health Oversight Commission sunsetted on June 30, 2009. For more information on the Behavioral Health Oversight Commission see http://www.dhhs.ne.gov/Behavioral_Health/BHcommission/

REGIONAL CENTERS

DHHS is a direct service provider of mental health services through State Psychiatric Hospitals – Lincoln Regional Center (LRC), Norfolk Regional Center (NRC) and Hastings Regional Center (HRC). The Lincoln Regional Center services are General Psychiatric Services, Intensive Residential Treatment Program, Sex Offenders Community Residential Program, as well as Secure Intermediate and Transitional Residential Mental Health. The Norfolk Regional Center services are Inpatient Mental Health and Sex Offender Services. The Hastings Regional Center provides chemical dependency/addiction treatment to male youth who have been paroled from the Youth Development Center in Kearney, NE. 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

Regional Center Bed Capacity (as of 7/01/09)

LINCOLN REGIONAL CENTER (LRC)

Ward / Program	Capacity
Building 3 Females	36
Building 10 Males	37
Building 14	0
Building 5 S4	17
Building 5 Forensic Psychiatric Program (PSYC)	46
Forensic Sex Offender Program (SOS)	40
Adolescent SO Tx Grp Home (Whitehall) - Male Only	8
Adolescent SO Res Tx (Whitehall) – Male Only	16
Forensic SO Transition Program-Males (FMHS-SOST)	40
Forensic SO Transition Program-Females (FMHS-SOSF)	5
total	245

NORFOLK REGIONAL CENTER (NRC)

1 West: Secure SPMI - MH	30
2 West: Male Secure - SO	30
3 East : Male Secure - SO	30
2 East: Male Secure - SO	30
total	120

MH means Mental Health beds

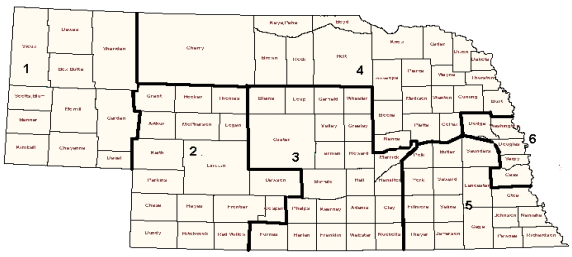
SO means Sex Offender

COMMUNITY MENTAL HEALTH

Under the Nebraska Behavioral Health Services Act the Division of Behavioral Health Services was formed. Under LB296 (2007), the name has been changed to Division of Behavioral Health, one of six Divisions within the Nebraska Department of Health and Human Services (see above). The primary role involves State administration and management of non-Medicaid public behavioral health services through Regional Behavioral Health Authorities and direct service contracts. In that capacity, the Division provides a state leadership role as the Mental Health Authority and State Substance Abuse Authority. For more information on the role of the Nebraska Division of Behavioral Health Services, see “Description of State Agency's Leadership”.

The Division of Behavioral Health contracts with the six Regional Behavioral Health Authorities for community mental health and substance abuse services. The mental health regions were initially established in 1974. The Nebraska Behavioral Health Services Act, Neb. Rev. Stat. §§ 71-807 to 71-809 revised the regional administration of the Nebraska Behavioral Health System. The Act retained the six geographic behavioral health “regions” as started in 1974. §71-807 assigns all 93 counties to one of six Behavioral Health Regions. The Act renames the regional administrative entity as a **Regional Behavioral Health Authority (RBHA)**, to mirror designation of the Division as the state’s chief behavioral health authority. Each RBHA 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 RBHA is appointed by the Regional Governing Board.

Region	Regional Office	Counties	Population (2000)	% of population
1 (Panhandle)	Scottsbluff	11	90,410	5.3%
2 (West Central)	North Platte	17	102,311	6.0%
3 (South Central)	Kearney	22	223,143	13.0%
4 (Northeast & North Central)	Norfolk	22	216,338	12.6%
5 (Southeast)	Lincoln	16	413,557	24.2%
6 (Eastern)	Omaha	5	665,454	38.9%
Totals		93	1,711,213	100.0%



Each county in a behavioral health region provides 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.

The Act prohibits the regions from directly providing services except under very limited circumstances. §71-809 (2) does provide exceptions. One exception is a regional behavioral health authority may continue to directly provide services it operated on July 1, 2004.

Each regional behavioral health authority has a regional advisory committee consisting of consumers, providers, and other interested parties.

The RBHA is responsible for the development and coordination of publicly funded behavioral health services in the region pursuant to rules and regulations of the Department. The Division of Behavioral Health contracts with the RBHA to purchase services using the funds received under the Federal Community Mental Health Services Block Grant.

ASO FOR MH/SA SERVICES

Starting in 1995, there has been a Medicaid managed care contract for mental health and a separate contract for behavioral health.

On February 1, 2008, the State of Nebraska, Administrative Services, Materiel Division, Purchasing Bureau, issued a Request for Proposal, RFP Number #2356Z1 for the purpose of selecting a qualified contractor to provide "Behavioral Health/Children and Family Services/Medicaid and Long-Term Care" Administrative Services Organization (ASO) [Request for Proposal 2356Z1]. The State of Nebraska was seeking a qualified contractor to provide a comprehensive ASO that will automate, manage, maintain, and coordinate the Mental Health and Substance Abuse treatment, Gambling Addictions and Child Welfare and Juvenile Services for the identified populations of the Behavioral Health, Children and Family Services, and Medicaid and Long-Term Care Divisions.

On April 16, 2008, it was announced that Magellan Behavioral Health was selected as the Administrative Service Organization contractor. The contract began on May 1, 2008 and ends on June 30, 2010. There are annual option contract years for State Fiscal Years 2011, 2012 and 2013.

ASO Contract & Data Collection - The data base used for community behavioral health programs was moved to Magellan Behavioral Health during the first contract cycle. Community based data collection by Magellan was implemented on July 1, 1997 and community-based utilization management was initiated in December of 1997 for those services requiring authorization.

The current contract covering Nebraska Behavioral Health System (NBHS) includes the Magellan Behavioral Health data system. Included in this contract are requirements for revisions to improve the State of Nebraska's capacity to report data to meet Federal requirements.

LASTING HOPE RECOVERY CENTER

The Division of Behavioral Health directly contracts with the Lasting Hope Recovery Center (LHRC) in Omaha, NE. The facility, which opened in 2008, offers access to clinical professionals and support staff 24-hours a day. The 64-bed facility provides for the specialized needs of patients. There are 32 beds for people in immediate crisis who need a week or less of treatment, and 32 beds for those who require three to four weeks of inpatient care before they are ready for outpatient programs. Various levels of care are available including a crisis assessment and triage center, acute care and transitional care. Community organizations are co-located at the LHRC including National Alliance on Mental Illness-Nebraska, The Salvation Army and Lutheran Family Services. Having these agencies on site provide clients a more seamless transition into the outpatient setting. LHRC treats patients who experience both mental illness and substance abuse. Evidence-based practices, including Wellness Recovery Action Plan (WRAP) and Peer Support Specialists are important elements of the treatment model. The overall goal is to instill hope, a sense of possibility and to rebuild a positive self-image for patients and help them get back to their daily routine.
At Lasting Hope Recovery Center: Patients experiencing mental illness and co-occurring substance abuse disorders receive high-quality care; Law enforcement has a psychiatric "home-base" for people experiencing a crisis because of their mental illness; Families have access to expertise and support; and Educators and students will train in an enhanced mental health facility.

Nebraska

Adult - New Developments and Issues

Adult - New developments and issues that affect mental health service delivery in the State, including structural changes such as Medicaid waivers, managed care, State Children's Health Insurance Program (SCHIP) and other contracting arrangements.

This section addresses both
Adult - Child - New Developments and Issues
Narrative Question:
New developments and issues that affect mental health service delivery in the State, including structural changes such as Medicaid waivers, managed care, State Children's Health Insurance Program (SCHIP) and other contracting arrangements.
AND
Adult – Child Recent Significant Achievements
Narrative Question:
Adult - A brief summary of recent significant achievements that reflect progress towards the development of a comprehensive community-based mental health system of care.

Safe Haven Law

Nebraska's safe haven law (LB 157) went into effect on July 18, 2008 and ended on November 21, 2008. During this time period the safe haven law applied to children up to age 18. The total number of families using of LB 157 was 27, and the total number of children left at a hospital was 36.

Governor Dave Heineman called a special session of the Legislature to address this issue. He signed LB 1 into law on November 21, 2008. It went into effect at 12:01 a.m. on Saturday, November 22, 2008. The bill amended the law to apply to infants up to 30 days old.
source: HHS news release November 22, 2008
http://www.dhhs.ne.gov/newsroom/newsreleases/2008/Nov/safehaven12.htm

Children and Family Behavioral Health Support Act (71-821 to 71-827) was added to the Nebraska Behavioral Health Services Act under LB603, 2009 (operative date May 23, 2009). This law was designed to address the issues raised by the safe haven law. See Adult – Child Legislative Initiatives and Changes and Child – Plans to Address Unmet Need for more information on this.

Behavioral Oversight Commission

The Behavioral Oversight Commission of the Legislature that was organized under Legislative Bill 1083 in 2004 and sunsetted on June 30, 2008. The Behavioral Health Oversight Commission was established by the Legislature to assist the State in reviewing activities of Behavioral Health Reform from July 2008 to June 30, 2009. See Adult Overview of State Mental Health System, Adult Plans to Address Unmet Needs, and Adult - Unmet Service Needs for more information.

$30.1 Million Transferred from Regional Centers to Community Services

The Division of Behavioral Health moved $30.1 million from the Regional Centers to Community Services. The Division has redirected $30 million in permanent funding to community-based services since July 2004, making it possible to close 232 adult beds and 16 adolescent mental health beds at the Regional Centers. These funds are now being used to purchase community based services through the six Regional Behavioral Health Authorities.

Emergency Systems Benchmarks/Diversion Rates (August 28, 2009)

Starting State Fiscal Year 2009, the Nebraska Psychiatric Emergency Systems Team implemented a new process to measure outcomes and emergency system diversion rates across the state. Representatives from the six Regional Behavioral Health Authorities and the Division of Behavioral Health make up the Nebraska Psychiatric Emergency Systems Team. The team formed benchmarks to be used to measure effectiveness of the emergency system. The preliminary data for this report

was gathered from five of the six regions for the first three quarters of FY2009 (July 1, 2008 through March 31, 2009). At this time, FY2009 data are not available for the Region 6 area (Omaha metro).

The Emergency Protective Custody (EPC) data is gathered by the Regional Emergency Systems Coordinators. It is reported quarterly to the Division of Behavioral Health. All information was collected from law enforcement reports, county attorney reports, provider reports, and through the Magellan Behavioral Health database.

The following is a description of the findings from the first three quarters of FY2009. From the five reporting Regions, there were 1,010 individuals (duplicated count) placed in EPC during the first three quarters of FY2009.

- A major goal of the Emergency System is to provide services in the community to support consumers rather than utilizing the commitment process whenever possible. Data shows that a reported 65.3% of individuals (n=660) had their EPC status dropped prior to receiving a commitment order.
- Another goal of the Emergency System is to reduce the number of individuals ordered into an inpatient commitment. During the first three quarters of FY2009, only approximately individuals placed under EPC were ordered to complete an inpatient commitment.
- The Emergency System has set another goal that consumers who are placed in EPC will receive the support they need to remain in the community of their choice without the need for legal involvement. This is measured by a low number of individuals receiving repeat EPCs. This is another goal being met with only approximately 12% of consumers receiving more than one EPC in a 12-month period.

Please contact Sarah Cox in the Division of Behavioral Health for more information on the EPC diversion rates in Nebraska. [Sarah.Cox@nebraska.gov | 402-471-7645]

Lincoln Regional Center Waiting List

The waiting list for both General Psychiatric and Forensic Mental Health Services has experienced a significant decrease. On December 30, 2008 the Lincoln Regional Center General Psychiatric Waiting List chart was zero (-0-). Using the same 30 week time period (January to July), the General Psychiatric waiting list has gone from an average of 18 in 2007 to 3.2 in 2009. There have been two weeks in 2009 (4/14/09 and 7/7/09) where the waiting list for General Psychiatric Services at the Regional Centers was at zero (-0-). Meanwhile, under Forensic Mental Health Services, the waiting list average for the same 30 week period dropped from an average of 9.1 down to 3.4.

Regional Center Waiting List | 30 Weeks (January to July)

General Psychiatric Waiting List

	maximum on the list	minimum on the list	average
from 1/2/07 to 7/16/07 +	27	10	18
from 1/7/08 to 7/29/08 *	25	7	14
from 1/6/09 to 7/28/09 *	8	0	3.2

+ includes both HRC and LRC
* LRC only

Forensic Mental Health Services Waiting List (LRC Only)

	maximum on the list	minimum on the list	average
from 1/6/08 to 7/27/08	14	4	9.1
from 1/6/09 to 7/28/09	10	0	3.4

Source: NE Division of Behavioral Health

What this means is that Nebraska Behavioral Health System did an incredible job of working together to ensure that those individuals who needed the Regional Center Level of Care receives that service in a timely manner AND that those same individuals were transitioned into community when they are ready for discharge. This achievement needs to take into account that the Lincoln Regional Center is one of the most restrictive and high end levels of care in the system. It shows that individuals move efficiently through this part of the Nebraska system. It reflects the shared vision under Behavioral Health Reform of wanting the consumers to be safe, receive quality services, and move to their community as soon as they were ready.

"LB95" Psychiatric Medications Indigent Drug Reimbursement

The "LB95" Psychiatric Medications Indigent Drug Reimbursement website was updated in October 2008 in order to help improve access to the program. For more details on the program see Adult - Unmet Service Needs under the GAP #5: MEDICATION ACCESS section. The detailed eligibility procedures are on the Nebraska Department of Health and Human Services, Division of Behavioral Health web site under Community-based Services, Psychiatric Medications for the Indigent. http://www.dhhs.ne.gov/beh/LB95/index.htm

Network of Care for Behavioral Health

The Division of Behavioral Health signed a contract with Trilogy Integrated Resources, LLC in August 2008. On March 18, 2009, the new Behavioral Health "Network of Care" Web Site was officially launched. Trilogy Integrated Resources LLC of San Rafael, Calif., created, developed and maintains the Network of Care for Behavioral Health for the Division of Behavioral Health in the Department of Health and Human Services.

The Behavioral Health "Network of Care" Web Site is a easy-to-use Web site is a comprehensive, Internet-based community resource for people with mental illness, their caregivers and service providers. "The Network of Care site is a big step forward in helping people find services and connect and share their stories," said Scot Adams, director of the Division of Behavioral Health. "This one-stop information tool lets you access vital information about treatment resources and diagnoses, insurance, and advocacy and find other pertinent behavioral health Web sites. Consumers can also choose to communicate directly with others and to organize and store personal health records."

Benefits of this Network of Care Web site include:

- Helping people find the right services at the right time. Click anywhere on the Nebraska map on the home page to get a comprehensive Service Directory of providers, organized by Behavioral Health Region.
- Giving consumers the option to use the secure Personal Health Record section to organize and store medical and healthcare-related information.
- Having communication tools like message boards and community calendars to help people connect with each other or share information.
- Facilitating providers who want to share challenges and ideas or use the private message boards. Providers can even build their own free Web sites.

- Accessing the easy-to-search libraries; information about specific behavioral health disorders, pending legislation and advocacy; and daily news articles and the latest research about mental health and substance abuse issues from around the world.
- Having a site that is fully ADA-compliant and that offers a text-only version.

The Network of Care for Behavioral Health is on the NE Division of Behavioral Health Web site. http://www.dhhs.ne.gov/networkofcare/. This web site is a resource for individuals, families and agencies concerned with behavioral health. It provides information about behavioral health services, laws, and related news, as well as communication tools and other features. The user of this web resource starts by either selecting a county on the map provided or by viewing a text listing of counties.

Regardless of where you begin your search for assistance with behavioral health issues, the Network of Care helps you find what you need - it helps ensure that there is "No Wrong Door" for those who need services. This Web site can greatly assist in our efforts to protect our greatest human asset - our beautiful minds.

The web site can be displayed in 14 different languages.

It offers a Service Directory. It can help direct you to a number of different service categories including Addiction Recovery, Advocacy and Assistance, Caregiver & Respite Services, Case/Care Management, Children and Families, Crisis and Emergency Services, Developmental Disabilities, Disabilty Issues/Assistance, Education, Employment, Health Care, Housing and Shelter, Information & Referral, Insurance & Benefits, Legal Services, Mental Health Services & Facilities, Military/Veterans' Services, Problem Gambling Services, Residential/Inpatient Care, Self-Help and Support Groups, and Senior Services. The web site includes COMMUNITY ANNOUNCEMENTS (such as the Alternatives Consumer Conference being held in Omaha October 28 to November 1, 2009), Free Online Consumer Trainings For People Working on Their Recovery, and other resources.

Carol Coussons de Reyes is Director of the Behavioral Health Office of Consumer Affairs

On April 1, 2009, Scot Adams, announced he is appointing Carol Coussons de Reyes, CPS, MS, as administrator for the Office of Consumer Affairs, effective May 18, 2009.

> "Carol's personal experience, professional education and unique leadership history make her particularly suited to this position," said Adams. "She will be a valuable addition, and her lived experience with mental illness, wellness, and recovery will add great value to her role. I look forward to benefiting from her experiences and background with advocacy for consumers."

Coussons de Reyes has served as director of the Consumer Relations and Recovery Section in the Georgia Department of Human Services since 2006. Her background includes serving as a Certified Peer Specialist, research coordinator for the Georgia Department of Veterans Affairs Medical Center, research specialist at Emory University, counselor for South Carolina Vocational Rehabilitation, and psychology technician for the Medical College of Georgia.

> "When I think of the Midwest, I see wide-open spaces and freedom. This is what initially attracted me to life in Nebraska," Coussons de Reyes said. "Part of my journey of recovery has been to dream big dreams. Such dreaming is how I became the Director of Consumer Affairs in Georgia and amassed great knowledge of peer support and consumer-driven mental health and addictive disease services."

Coussons de Reyes received a Masters of Psychology at Augusta State University, Augusta, Georgia and a Bachelor's degree in Psychology from Georgia State University

Coussons de Reyes said,

> "Our family is absolutely thrilled to be moving to Nebraska, where I see that the Office of Consumer Affairs can lead the state in assisting individuals to understand the journey of recovery that their loved ones walk. I know the importance of including individuals who receive mental health, addictive disease, and gambling services in real decisions that shape services, as well as providing peer services, that assist every individual in attaining the life of their choosing - the life of their dreams. Recovery is a meaningful life in the community, where I am the best mother to my son, daughter, aunt, friend, neighbor, co-worker, artist, and writer that I can be."

The Office of Consumer Affairs was created by the Legislature in 2004. The program administrator of the Office must be a consumer or former consumer of behavioral health services and have specialized knowledge, experience or expertise relating to consumer-directed behavioral health services, delivery systems and advocacy on behalf of consumers and their families.

Lincoln Regional Center Received A Perfect Score On Federal Survey

In a press release on December 23, 2008, it was announced that the Lincoln Regional Center (LRC) received a perfect score on Federal Survey.

http://www.hhs.state.ne.us/newsroom/newsreleases/2008/Dec/lrc.htm

State CMS Surveyors interviewed staff and patients and reviewed all internal investigation reports, all incident/accident reports, all restraint seclusion reports, and 10 patient records. They also reviewed staffing plans for all of Nursing Service and Programming and determined that the plans in place are appropriate.

Part of LRC's success is because of the emphasis on trauma-informed care, which focuses on wellness and recovery for trauma survivors, their families and treatment providers.

The Lincoln Regional Center passed a Centers for Medicare and Medicaid Services (CMS) survey of general psychiatric services with no deficiencies.

- "I'm very proud that the Lincoln Regional Center had 'zero' deficiencies after surveyors looked into complaints regarding patient rights and a safe environment," said Scot Adams, Ph.D., director of the DHHS Division of Behavioral Health. "Surveyors complimented staff on having such a safe environment for patients and staff."
- "I appreciate the new set of eyes that surveyors can bring to the services and environment at the Regional Centers," Adams said. "We all want the people being served to receive quality services."

Justice Grant

The Division of Behavioral Health received a grant from the U.S. Department of Justice – Bureau of Justice Assistance (BJA) Grant - **Justice and Mental Health Collaboration Program** (CDFA #16.745) which is a CATEGORY II: PLANNING AND IMPLEMENTATION grant.

- Award with Project Period: (from: September 1, 2008 / to August 31, 2011)
- Grant maximum: $250,000
- NE Theme: collaborative partnerships to address interagency coordination & communication in order to implement system improvements for persons with MI in the Criminal Justice System.
- Target Population: Young adults 18 to 24 years of age.

Final Product from First Grant:

Nebraska Justice Behavioral Health Initiative / Strategic Plan (October 31, 2008)
Complete report on Division of Behavioral Health web site at:
Division of Behavioral Health: Community-based Services
Recent Reports
http://www.dhhs.ne.gov/beh/NEJusticeMHStrategicPlan-UN_PPCFinalReport-Oct31_2008.pdf

As noted under GAP #7: MENTALLY ILL INMATES IN THE STATE CORRECTIONAL SYSTEM (see Adult - Unmet Service Needs) in a study released by the 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) researchers found that 14.5 percent of the men and 31 percent of the women interviewed in the jail population, suffered from serious mental illness. They accounted for 16.9 percent of the total jail population.

The Division of Behavioral Health is implementing a grant from the US Department of Justice. The Justice and Mental Health Collaboration Program will increase public safety by facilitating collaboration among the criminal justice, juvenile justice, and mental health and substance abuse treatment systems to increase access to services for offenders with mental illness.

Goal 1: Provide consistent statewide training for Nebraska Law Enforcement Officers to improve responses to people with mental illnesses
Progress: Regions are currently attending Omaha CIT training and reviewing curriculum to adapt to their regions. Risk assessment training materials completed as resource for regions.

Goal 2: Expand or improve access to crisis response services in Nebraska
Progress: Regional crisis teams working on data collection protocols

Goal 3: Implement standardized mental health and substance abuse screening protocols in the jails that prompt referrals for services
Progress: Work team developed recommendations for jail screening protocols which will be submitted to Jail Standards Board

Goal 4: Increase resources to community mental health to provide diversion services through the use of Forensic Intensive Case Management
Progress: Invitation issued to regions to submit interest in pilot project. Region 3 Behavioral Health was selected based on review. Justice grant funds will be used to pilot a rural jail mental health diversion program in Buffalo County. The next step involves technical assistance provided to start up rural diversion program in Buffalo County.

Goal 5: Enhance affordable supportive housing for justice involved youth transitioning to adulthood and young adults
Progress: Corrections housing team meeting to identify offenders with serious mental illness and develop protocols for transition. Independent Living Plan Team meeting to develop protocols for identifying SED youth and transitioning to housing, employment and mental health treatment.

Criminal Justice Electronic Data Transfer Interagency Agreement

In June 2009, the Nebraska Department of Health and Human Services - Division Of Behavioral Health (DHHS), the Nebraska Department of Correctional Services (DCS) and the Nebraska Commission on Law Enforcement and Criminal Justice (Crime Commission) signed Electronic Data Transfer Interagency Agreements. The final agreements were officially approved on June 9, 2009. These agreements have these three state agencies transferring their data to the Division of Epidemiology, College of Public Health at the University of Nebraska Medical Center in Omaha, NE for the purpose of analysis, compilation and reporting for the mutual benefit of the parties. The initial data covers the time period from January 1, 2005 to December 31, 2008. Before public release, the Report(s) produced under these agreements must be acceptable to the DHHS, DCS and the Crime Commission. The Report(s) remain in draft status until these three code level agencies approve the document. This requirement is due to the sensitive nature of the content of the report(s) using these data.

Administrative Services Organization (ASO) contract

This Magellan Behavioral Health contract for Administrative Services Organization (ASO) covering the three DHHS Division of Behavioral Health, Division of Children & Family Services and Division of Medicaid & Long Term Care continues to be significant achievement. There is increased the level of coordination between these three Divisions.

As reported last year, on April 16, 2008, it was announced that Magellan Behavioral Health was selected as the Administrative Service Organization contractor for the Division of Behavioral Health, Division of Children & Family Services and the Division of Medicaid & Long Term Care. This contract ends on June 30, 2010. There are annual options for contract renewal for State Fiscal Years 2011, 2012 and 2013.

The current contract structure has improved collaboration with the three DHHS Divisions. There is a formalized meeting structure to address a variety of issues.

- Monthly meeting with three divisions to discuss the contract and service delivery plans and issues;
- Monthly meeting with three divisions plus Magellan to discuss the contract and service delivery implications;
- Quarterly meeting with DHHS Division Directors and DHHS Magellan Contract Liaisons to discuss service and contract issues; and
- Network Development meeting with the three divisions and Magellan to identify current projects, address service gaps, contact deliverables and related areas.
- Medicaid and Long Term Care and DBH have held multiple meeting regarding service definitions and regulations.

Transformation Transfer Initiative Grant (TTI)

On November 4, 2008, the State Advisory Committee on Mental Health Services, which serves as the State Mental Health Planning Council under the Federal Community Mental Health Services Block Grant reviewed this proposal. This Committee made the following recommendation:

> "This Committee recommends support for this proposal. This includes Peer Support for both consumers and the family members. It is timely in the state's transformation."

The Division of Behavioral Health submitted the grant application on November 6, 2008. The Division of Behavioral Health was notified by National Association of State Mental Health Program Directors (NASMHPD) on December 8, 2008 of the grant award. Due to the nature of the grant, a

contract needed to be developed between NASMHPD and the Division. That contract was signed on March 26, 2009. The contract included the following Scope of Work:

- Prepare a Request for Proposal (RFP) in order to select a qualified trainer(s) for Peer Support Training. In preparing the RFP, Regional Consumer Specialists, consumer organizations and other stakeholders will be fully involved.
- Administer a competitive bid process to select a qualified contract(s) to provide Peer Support Training in Nebraska. Regional Consumer Specialists, consumer organizations and other stakeholders will be fully involved in this process.
- Complete an evaluation of the Peer Support Training including but not limited to the development and administration of a strategy involving a pre-test, and post-test of consumers attending the training, data analysis and reporting of results.
- Complete an analysis on what other states are doing in the Peer Support area.
- Schedule to hold between three and six Peer Support Training sessions across the state.
- Schedule to hold one Train the Trainer session with consumers who can teach the curriculum.
- Schedule to hold one statewide meeting on Peer Support.

The State Advisory Committee on Mental Health Services wanted both consumers and the family members to be addressed under the TTI grant. The initial work on the TTI grant addressed both. However, as LB603 moved forward, including the § 71-823 Family Navigator Program, the decision was made to drop the family members from the TTI grant. This was because LB603 expects a peer support type of service, called Family Navigator Program be established no later than January 1, 2010. The program shall be administered by the division and consist of individuals trained and compensated by the department. Children and Family Behavioral Health Support Act (71-821 to 71-827) was added to the Nebraska Behavioral Health Services Act under LB603, 2009 (operative date May 23, 2009). This law was designed to address the issues raised by the safe haven law. See Adult – Child Legislative Initiatives for more information on this.

The overall goal of this TTI grant is to develop and implement a Peer Support Workforce model. The core discussion involved how to convert the draft Service Definition of Peer Support into something that could be used for a Peer Support Workforce Model. The decision point for this will be in the Request for Proposal (RFP). The RFP for the qualified trainer(s) for Peer Support Training needs to reflect Peer Support Core Competencies required to be part of the Nebraska Behavioral Health System workforce. The RFP will be prepared by the University of Nebraska Public Policy Center in consultation with the six Regional Consumer Specialists, the Regional Administrators (or their designee), consumer organizations (National Alliance for the Mentally Ill – Nebraska, Mental Health Association of Nebraska, Partners in Recovery, and the Nebraska Federation of Families) and other stakeholders.

Carol Coussons de Reyes started work as the Administrator for the Division of Behavioral Health Office of Consumer Affairs on May 18, 2009. She is now the Project Manager for the TTI Grant.

Contract with University of Nebraska
The Division of Behavioral Health contracted with the University of Nebraska Public Policy Center to help assist in the implementation of the TTI grant. The Scope of Work includes Prepare a Request for Proposal (RFP), Administer a Competitive Bid Process, Complete an Evaluation, prepare a report on What Other States Are Doing, and related tasks.

During the August 13, 2009 review by the State Advisory Committee on Mental Health Services, the committee member indicated she had never heard of anyone talking about a Peer Support Workforce model. Here is the reply to this question:

> The Office of Consumer Affairs had the first TTI Steering Committee meeting on July 27, 2009 to determine what model of peer support training. For the TTI Steering Committee, UNPPC tried to keep the Committee focused on competencies for peer support specialists that would be applicable across service delivery models. This is what UNPPC needed to include in the training and the RFP, so the focus was not on models. The first meeting included a wide range of topics such as funding for peer support services, why consumers weren't part of the initial application, peer support models, whether talking about models even makes sense, whether the Division will accept their recommendations, whether national groups will allow Nebraska to use and modify training curriculums, etc, etc. Having the group focus on competencies has been successful in moving the group forward. The review of what other states are doing will include different service delivery models; however the competencies of peer support specialists should be the same across models.

Unmarked Grave Memorial

Dan Powers, Consumer Liaison with the Office of Consumer Affairs in the Division of Behavioral Health, was recognized for his suggestion of an Unmarked Grave Memorial to be established at St. Elizabeths Hospital in Washington DC. He thought the anonymous people buried in unmarked graves on state hospital grounds across the country should have a national memorial. That was August 2004. He started talking with others, like Larry Fricks, a man with many national connections. The memorial is not built yet, but the steering committee, representing at least seven national organizations, is raising the more than $1 million needed. Dan attended the recent dedication ceremony. The story was documented by Nancy Hicks of the Lincoln Journal Star (Posted: Monday, June 22, 2009).

http://journalstar.com/articles/2009/06/22/news/local/doc4a3eea61111c5272849911.txt

For more information, contact:

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Collaboration between the Behavioral Health and Developmental Disability Systems

Region 6 Behavioral Healthcare (Omaha) was the recipient of a grant from the NE Planning Council of Developmental Disabilities. One year has been completed, with two years to go. This grant was designed to help strength collaboration between the behavioral health and developmental disability systems, in the hope that the two systems could work together to help individuals who are dually diagnosised. The term dual diagnosis applies to the co-existence of the symptoms of both intellectual or developmental disabilities and mental health problems. One goal is to raise awareness of the need for specialty care, behavioral health services for people with developmental disabilities, with a focus on behavioral health. It was designed to address issues such as the dually diagnosed population being caught between the two systems with no one wanting to take

responsibility for serving them. It also looked at the fact that there are a limited number of mental health practitioners with skills and knowledge to serve persons with developmental disabilities and the struggle to come up with appropriate services for what seems to be an increasing number of dually diagnosed individuals.

It is expected that changes in the business practices within the behavioral health and developmental disability systems will be a long term process. It has been the vision that year one of the grant would focus on organizational activities, year two will focus on planning and year 3 would move toward operationalizing the system changes. Several key grant activities include:

Project Steering Committee -

- The purpose of this committee was to develop an increased understanding of both the developmental disability (DD) and the behavioral health (BH) systems to identify challenges and help work on the development of strategies toward integrating the two systems at the local level in Omaha, NE.
- The committee membership consist of representatives from Munroe Meyer Institute, Eastern Service Area - Service Coordination, Alegent Medical Center, University of NE Medical Center, a mix of providers from the developmental disability and behavioral health systems, consumers/family members, state representatives, Eastern NE Community Office of Retardation (ENCOR), NADD, other stakeholders and staff from Region 6 Behavioral Healthcare.

Consultation Services – This is a contract with the National Association for the Dually Diagnosed (NADD). The consultation was provided by Dr. Robert Fletcher, Executive Director of NADD. The service includes personal visits to Omaha, as well as hours of consultation via phone and e-mail.

Case Reviews – A joint system case review for persons with a dual diagnosis. For example, during the first year, individuals reviewed were originally at either the Norfolk Regional Center or the Lincoln Regional Center.

Planning Activities- Two primary needs have surfaced to date:

1. education/training - Education (for individuals working in both systems) was identified as one of the challenges to help improve system collaboration and cooperation. This is education for mental health and developmental disability professionals. Education and training is needed at all levels of both systems. This includes clinical staff, administration and direct care staff.

2. Psychiatric urgent/crisis care - the challenge of psychiatric urgent/crisis care for the developmentally disabled was identified. This would be some type of crisis component to assist staff when an individual is experiencing a psychiatric crisis.

For more information on this project, contact:
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Revising Service Definitions and Regulations

The Division of Behavioral Health, in partnership with the Division of Medicaid and Long Term Care, have implemented a process to collaborate review each of the service definitions for the Mental Health waiver and non-waiver services. The Division of Behavioral Health has produced four (4) drafts to date. The Division is proceeding with the development of the Title 206 Rules and Regulations revision process. To date, there have been a number of drafts produced with input from a variety of stakeholders. The package of service definitions will be moved into the draft Title 206 Regulations. As a result, they will undergo another public review through the regulation review process.

The draft for the Service Definitions and the Regulations can be seen on the NE Department of Health and Human Services web site under the Division of Behavioral Health: Community-based Services section – Quality Improvement Projects

- Adult Behavioral Health Service Definitions
- Draft Regulations

http://www.dhhs.ne.gov/beh/behindex.htm

Nebraska

Adult - Legislative Initiatives and Changes

Adult - Legislative initiatives and changes, if any.

The complete list of legislative bills for 2009 can be found on the Nebraska Department of Health and Human Services Web Site at:
http://www.dhhs.ne.gov/newsroom/legislation/09legsum.pdf

Here are several that impacted the Division of Behavioral Health

LEGISLATIVE BILL 154
Approved by the Governor February 12, 2009
Eliminate boards, commissions, committees, councils, task forces, working groups, and related statutory provisions.

LB 154 eliminated several boards and commissions relating to small business, transit, broadband services and tax policy. Specifically, in the area of health and human services, this bill eliminates the Behavioral Health Oversight Commission, Donor Registry of the Nebraska Advisory Board, Nebraska Veterans Cemetery Advisory Board, Public Health Clinic Formulary Advisory Committee, Special Education Services Task Force, Teen Tobacco Education and Prevention Project Committee and a working group studying sex offender treatment. This bill becomes effective August 30, 2009.

Laws 2009, LB154, § 18 deleted reference to the role of the Behavioral Health Oversight Commission (...shall review such documentation and shall report to the Governor and the Health and Human Services Committee of the Legislature whether, in its opinion, the requirements of subsection (2) of this section have been met with respect to such intended reduction or discontinuation of regional center services and shall enumerate the criteria used by the commission in making such determination) in 71-810(3).

Laws 2009, LB154, § 17
71-801 Sections 71-801 to 71-818 71-817 shall be known and may be cited as the Nebraska Behavioral Health Services Act.

LB 285 (Pirsch) Change Sex Offender Registration Act provisions.
This bill amends the Sex Offender Registration Act to bring Nebraska law into compliance with federal guidelines; specifically the Adam Walsh Act. The Adam Walsh Act establishes the Sex Offender Registration and Notification Act (SORNA). SORNA outlines a comprehensive set of minimum registration and notification standards for sex offenders.

LEGISLATIVE BILL 403
Approved by the Governor April 8, 2009
The bill prohibits illegal immigrants from receiving state and local benefits by requiring state and local governments to verify that any person applying for benefits is in the United States legally. “This bill ensures state and local benefits go to those who truly qualify,” Gov. Heineman said. “I want to thank senators for their leadership and for the time they’ve dedicated to this issue. This is an important step for Nebraska. We still need the federal government to address the problem of illegal immigration in a comprehensive manner.”

LB 403 also requires employers who receive state or local contracts and tax incentives to electronically verify the work status of all new-hired employees. It takes effect Oct. 1.

Sen. Karpisek said, "The basic reasoning behind this bill is to ensure that Nebraska taxpayers' money is not spent on services for people who are not in the state legally."

The bill outlines a process agencies will use to verify eligibility. Those applying for public benefits must first attest that they are either a citizen or an alien able to work in the U.S. Government entities are to verify the immigration status of aliens using the U.S. Department of Homeland Security's (DHS) Systematic Alien Verification for Entitlements (SAVE) program. The web-based program allows government entities to verify whether an individual is in the U.S. lawfully.

In addition, public entities, contractors for public projects, and businesses qualifying for state tax incentive programs will also be required to verify legal status of newly-hired employees using the federal E-Verify system, which is made available to employers by DHS. No fees are charged for accessing the E-Verify database.

LEGISLATIVE BILL 603
Approved by the Governor May 22, 2009

Nebraska Behavioral Health Services Act.
Children and Family Behavioral Health Support Act
Behavioral Health Workforce Act

LB 603 (Health and Human Services Committee) Adopt the Children and Family Behavioral Health Support Act, adopt the Behavioral Health Workforce Act, and change provisions relating to Medicaid and behavioral health services.

The Children and Family Behavioral Health Support Act under LB603 was designed to address the issues raised by the safe haven law.

Nebraska's safe haven law (LB 157) went into effect on July 18, 2008 and ended on November 21, 2008. During this time period the safe haven law applied to children up to age 18. The total number of uses of LB 157 was 27, and the total number of children left at a hospital was 36. Governor Dave Heineman called a special session of the Legislature to address this issue. He signed LB 1 into law on November 21, 2008. It went into effect at 12:01 a.m. on Saturday, November 22, 2008. The bill amended the law to apply to infants up to 30 days old.
source: HHS news release November 22, 2008
http://www.dhhs.ne.gov/newsroom/newsreleases/2008/Nov/safehaven12.htm

CHILDREN AND FAMILY BEHAVIORAL HEALTH SUPPORT ACT
The Children and Family Behavioral Health Support Act is created.
First, no later than January 1, 2010, this new act requires the Department to create a Children and Family Support Hotline. This hotline shall be a single point of access for children's behavioral health triage through the operation of a 24-hour, 7 day per week, telephone line. This hotline shall be administered by the Behavioral Health Division of DHHS and staffed by trained personnel under the direct supervision of a qualified mental health, behavioral health, or social work professional engaged in activities of mental health treatment. In addition, this hotline provides screening and assessment, provides referral to existing community-based resources and

provides an evaluation process. This evaluation shall include, but not be limited to, the county of the caller, the reliability and consistency of the information given, an analysis of services needed or requested, and the degree to which the caller reports satisfaction with the referral service.

Second, this new act requires the department to establish, by January 1, 2010, a Family Navigator Program to respond to children's behavioral health needs. The program shall be administered by the division and consist of individuals trained and compensated by the department. These individuals, at a minimum, shall provide peer support and provide connection to existing services, including the identification of community-based services. This program shall be evaluated. The evaluation shall include, but not be limited to, an assessment of the quality of the interactions with the program and the effectiveness of the program as perceived by the family, whether the family following through with the referral recommendations, the availability and accessibility of services, the waiting time for services and cost and distance factors.

Third, this new act requires the department to provide, by January 1, 2010, post-adoption and post-guardianship care management services for adoptive and guardianship families of former state wards on a voluntary basis. The department shall notify adoptive parents and guardians of the availability of such services and the process to access such services and that such services are provided on a voluntary basis. Notification requirements are provided. These services shall be administered by the Division of Children and Family Services and shall be evaluated. The evaluation shall include, but not be limited to, the number and percentage of persons receiving such services and the degree of problem resolution reported by families receiving such services.

Fourth, this new act provides a reporting requirement for the Department regarding the sections relating to the hotline, Family Navigator Program and voluntary post-adoption and postguardianship case management services.

BEHAVIORAL HEALTH WORKFORCE ACT
LB 603 creates the Behavioral Health Workforce Act.

LB 603 provides findings regarding the shortage of behavioral health professionals and that this shortage leads to inadequate accessibility and response to behavioral health needs of all Nebraskans. The purpose of this act is improve community-based behavioral health services and focus on addressing behavioral health issues before they become a crisis through increasing the number of behavioral health professionals and their training.

LB 603 creates the Behavioral Health Education Center. This center will be created on July 1, 2009 and shall be administered by the University of Nebraska Medical Center. This center is required to provide funds for additional medical residents in a Nebraska-based psychiatry program, provide psychiatric residency training experiences that serve underserved areas, focus on training of behavioral health professionals in telehealth techniques, analyze the geographic and demographic availability of behavioral health professionals, prioritize the need for additional professionals, establish learning collaborative partnerships and develop interdisciplinary behavioral health training sites. Reporting requirements are provided for this center.

Below are the actual changes to the Nebraska Behavioral Health Services Act as a result of LB603.

LB 603 (2009) Sec. 3. states,
Section 71-801, Revised Statutes Cumulative Supplement, 2008, is amended to read:
71-801 Sections 71-801 to 71-818 and sections 5 to 14 of this act shall be known and may be cited as the Nebraska Behavioral Health Services Act.

71-821 Children and Family Behavioral Health Support Act; act, how cited. Sections 71-821 to 71-827 shall be known and may be cited as the Children and Family Behavioral Health Support Act.

Source
Laws 2009, LB603, § 5. Operative Date: May 23, 2009

71-822 Children and Family Support Hotline; establishment. No later than January 1, 2010, the department shall establish a Children and Family Support Hotline which shall:

(1) Be a single point of access for children's behavioral health triage through the operation of a twenty-four-hour-per-day, seven-day-per-week telephone line;

(2) Be administered by the division and staffed by trained personnel under the direct supervision of a qualified mental health, behavioral health, or social work professional engaged in activities of mental health treatment;

(3) Provide screening and assessment;

(4) Provide referral to existing community-based resources; and

(5) Be evaluated. The evaluation shall include, but not be limited to, the county of the caller, the reliability and consistency of the information given, an analysis of services needed or requested, and the degree to which the caller reports satisfaction with the referral service.

Source
Laws 2009, LB603, § 6. Operative Date: May 23, 2009

71-823 Family Navigator Program; establishment; evaluation. (1) No later than January 1, 2010, the department shall establish a Family Navigator Program to respond to children's behavioral health needs. The program shall be administered by the division and consist of individuals trained and compensated by the department who, at a minimum, shall:

(a) Provide peer support; and

(b) Provide connection to existing services, including the identification of community-based services.

(2) The Family Navigator Program shall be evaluated. The evaluation shall include, but not be limited to, an assessment of the quality of the interactions with the program and the effectiveness of the program as perceived by the family, whether the family followed through with the referral recommendations, the availability and accessibility of services, the waiting time for services, and cost and distance factors.

Source
Laws 2009, LB603, § 7. Operative Date: May 23, 2009

71-824 Post-adoption and post-guardianship case management services; notice; administration; evaluation.
No later than January 1, 2010, the department shall provide post-adoption and post-guardianship case management services for adoptive and guardianship families of former state wards on a voluntary basis. The department shall notify adoptive parents and guardians of the availability of such services and the process to access such services and that such services are provided on a voluntary basis. Notification shall be in writing and shall be provided at the time of finalization of the adoption agreement or completion of the guardianship and each six months thereafter until dissolution of the adoption, until termination of the guardianship, or until the former state ward attains nineteen years of age, whichever is earlier. Post-adoption and post-guardianship case management services under this section shall be administered by the Division of Children and Family Services and shall be evaluated. The evaluation shall include, but not be limited to, the number and percentage of persons receiving such services and the degree of problem resolution reported by families receiving such services.

Source
Laws 2009, LB603, § 8. Operative Date: May 23, 2009

71-825 Annual report; contents. The department shall provide an annual report, no later than December 1, to the Governor and the Legislature on the operation of the Children and Family Support Hotline established under section 71-822, the Family Navigator Program established under section 71-823, and the provision of voluntary post-adoption and post-guardianship case management services under section 71-824.

Source
Laws 2009, LB603, § 9. Operative Date: May 23, 2009

71-826 Legislative intent regarding appropriations; allocation.
It is the intent of the Legislature to appropriate from the General Fund five hundred thousand dollars for fiscal year 2009-10 and one million dollars for fiscal year 2010-11 to the Department of Health and Human Services â□" Behavioral Health, Program 38, Behavioral Health Aid, for behavioral health services for children under the Nebraska Behavioral Health Services Act, including, but not limited to, the expansion of the Professional Partner Program and services provided using a sliding-fee schedule. General Funds appropriated pursuant to this section shall

be excluded from the calculation of county matching funds under subsection (3) of section 71-808, shall be allocated to the regional behavioral health authorities, and shall be distributed based on the 2008 allocation formula. For purposes of this section, children means Nebraska residents under nineteen years of age.

Source
Laws 2009, LB603, § 10. Operative Date: May 23, 2009

71-827 Children's Behavioral Health Oversight Committee of the Legislature; created; members; duties; meetings; report.
(1) The Children's Behavioral Health Oversight Committee of the Legislature is created as a special legislative committee. The committee shall consist of nine members of the Legislature appointed by the Executive Board of the Legislative Council as follows: (a) Two members of the Appropriations Committee of the Legislature, (b) two members of the Health and Human Services Committee of the Legislature, (c) two members of the Judiciary Committee of the Legislature, and (d) three members of the Legislature who are not members of such committees. The Children's Behavioral Health Oversight Committee shall elect a chairperson and vice-chairperson from among its members. The executive board shall appoint members of the committee no later than thirty days after May 23, 2009, and within the first six legislative days of the regular legislative session in 2011. The committee and this section terminate on December 31, 2012.

(2) The committee shall monitor the effect of implementation of the Children and Family Behavioral Health Support Act and other child welfare and juvenile justice initiatives by the department related to the provision of behavioral health services to children and their families.

(3) The committee shall meet at least quarterly with representatives of the Division of Behavioral Health and the Division of Children and Family Services of the Department of Health and Human Services and with other interested parties and may meet at other times at the call of the chairperson.

(4) Staff support for the committee shall be provided by existing legislative staff as directed by the executive board. The committee may request the executive board to hire consultants that the committee deems necessary to carry out the purposes of the committee under this section.

(5) The committee shall provide a report to the Governor and the Legislature no later than December 1 of each year. The report shall include, but not be limited to, findings and recommendations relating to the provision of behavioral health services to children and their families.

Source
Laws 2009, LB603, § 11. Operative Date: May 23, 2009

71-828 Behavioral Health Workforce Act; act, how cited. Sections 71-828 to 71-830 shall be known and may be cited as the Behavioral Health Workforce Act.

Source

Laws 2009, LB603, § 12. Operative Date: May 23, 2009

71-829 Legislative findings.

The Legislature finds that there are insufficient behavioral health professionals in the Nebraska behavioral health workforce and further that there are insufficient behavioral health professionals trained in evidence-based practice. This workforce shortage leads to inadequate accessibility and response to the behavioral health needs of Nebraskans of all ages: Children; adolescents; and adults. These shortages have led to well-documented problems of consumers waiting for long periods of time in inappropriate settings because appropriate placement and care is not available. As a result, mentally ill patients end up in hospital emergency rooms which are the most expensive level of care or are incarcerated and do not receive adequate care, if any.

As the state moves from institutional to community-based behavioral health services, the behavioral health services workforce shortage is increasingly felt by the inability to hire and retain behavioral health professionals in Nebraska. In Laws 2004, LB 1083, the Legislature pledged to "promote activities in research and education to improve the quality of behavioral health services, the recruitment and retention of behavioral health professionals, and the availability of behavioral health services". The purpose of the Behavioral Health Workforce Act is to realize the commitment made in LB 1083 to improve community-based behavioral health services for Nebraskans and thus focus on addressing behavioral health issues before they become a crisis through increasing the number of behavioral health professionals and train these professionals in evidence-based practice and alternative delivery methods which will improve the quality of care, including utilizing the existing infrastructure and telehealth services which will expand outreach to more rural areas in Nebraska.

Source

Laws 2009, LB603, § 13. Operative Date: May 23, 2009

71-830 Behavioral Health Education Center; created; administration; duties; report.

(1) The Behavioral Health Education Center is created beginning July 1, 2009, and shall be administered by the University of Nebraska Medical Center.

(2) The center shall:

(a) Provide funds for two additional medical residents in a Nebraska-based psychiatry program each year starting in 2010 until a total of eight additional psychiatry residents are added in 2013. Beginning in 2011 and every year thereafter, the center shall provide psychiatric residency training experiences that serve rural Nebraska and other underserved areas. As part of his or her residency training experiences, each center-funded resident shall participate in the rural training for a minimum of one year. Beginning in 2012, a minimum of two of the eight center-funded residents shall be active in the rural training each year;

(b) Focus on the training of behavioral health professionals in telehealth techniques, including taking advantage of a telehealth network that exists, and other innovative means of care delivery in order to increase access to behavioral health services for all Nebraskans;

(c) Analyze the geographic and demographic availability of Nebraska behavioral health professionals, including psychiatrists, social workers, community rehabilitation workers, psychologists, substance abuse counselors, licensed mental health practitioners, behavioral analysts, peer support providers, primary care physicians, nurses, nurse practitioners, and pharmacists;

(d) Prioritize the need for additional professionals by type and location;

(e) Establish learning collaborative partnerships with other higher education institutions in the state, hospitals, law enforcement, community-based agencies, and consumers and their families in order to develop evidence-based, recovery-focused, interdisciplinary curriculum and training for behavioral health professionals delivering behavioral health services in community-based agencies, hospitals, and law enforcement. Development and dissemination of such curriculum and training shall address the identified priority needs for behavioral health professionals; and

(f) Beginning in 2011, develop two interdisciplinary behavioral health training sites each year until a total of six sites have been developed. Four of the six sites shall be in counties with a population of fewer than fifty thousand inhabitants. Each site shall provide annual interdisciplinary training opportunities for a minimum of three behavioral health professionals.

(3) No later than December 1, 2011, and no later than December 1 of every odd-numbered year thereafter, the center shall prepare a report of its activities under the Behavioral Health Workforce Act. The report shall be filed with the Clerk of the Legislature and shall be provided to any member of the Legislature upon request.

Source
Laws 2009, LB603, § 14. Operative Date: May 23, 2009

Nebraska

Adult - Description of State Agency's Leadership

Adult - A description of how the State mental health agency provides leadership in coordinating mental health services within the broader system.

Narrative Question:
Adult - Child - A description of how the State mental health agency provides leadership in coordinating mental health services within the broader system.

Description of the Division of Behavioral Health as the State Agency's Leadership
(updated July 24, 2009)

COMMUNITY MENTAL HEALTH
Under the Nebraska Behavioral Health Services Act (Neb. Rev. Stat. §§ 71-801 to 71-830) the Division of Behavioral Health Services was formed. On March 15, 2007, Governor Heineman signed legislation, LB296, creating the Nebraska Department of Health and Human Services (DHHS) with the effective date of July 1, 2007. The Division of Behavioral Health is one of six divisions within the Department of Health and Human Services. Under Neb. Rev. Stat. § 71-806(1), the Division is the chief behavioral health authority for the State of Nebraska. The Nebraska Behavioral Health Services Act (§ 71-804) defines the term Behavioral Health Disorder as "mental illness or alcoholism, drug abuse, problem gambling, or other addictive disorder".

The primary role involves State administration and management of non-Medicaid public behavioral health services through Regional and direct service contracts. In that capacity, the Division provides a state leadership role as the Mental Health Authority and State Substance Abuse Authority. Key sections under the statute assigning duties to the Division of Behavioral Health Services are

71-804 Division means the Division of Behavioral Health of the department;
71-805 Division of Behavioral Health Services; chief clinical officer and the office of consumer affairs.
71-806 (1) The Division of Behavioral Health Services shall act as the chief Behavioral Health authority for the State of Nebraska.
71-810 Division; community-based behavioral health services; duties; reduce or discontinue regional center behavioral health services; powers and duties.
71-811 Division; funding; powers and duties.
71-812 Behavioral Health Services Fund; created; use; investment.
71-813 State Behavioral Health Council
71-814 State Advisory Committee on Mental Health Services
71-815 State Advisory Committee on Substance Abuse Services
71-816 State Advisory Committee on Problem Gambling and Addiction Services
71-817 Compulsive Gamblers Assistance Fund; created; use; investment.
71-916 Mental health commitment board training

Children and Family Behavioral Health Support Act (71-821 to 71-827) was added to the Nebraska Behavioral Health Services Act under LB603 (2009) with an operative date of May 23, 2009.

This leadership role involves a number of different areas including but not limited to:
- Funding, contracting, & monitoring community mental health & substance abuse services;
- Behavioral Health System Management and Information Management via Administrative Services Only contract with Magellan Behavioral Health;
- State Behavioral Health Standards (Regulations, Contracts, other related policy);
- Training/Technical Assistance;
- Planning / Define Services / Establish Rates;
- Professional Partner Services (Mental Health Children's Services only);

- Consumer Empowerment Projects including Neb. Rev. Stat. §71-805 (3) to establish an Office of Consumer Affairs;
- Gambling Assistance Program;
- Mental Health and Substance Abuse funding for Native American Tribes;
- Mental Health Commitment Board Training (Neb. Rev. Stat. § 71-916);
- Statewide Behavioral Health Disaster Preparedness & Response / Critical Incident Stress Management;
- Pre-admission Screening / Annual Resident Reviews;
- State Advisory Committee on Mental Health Services (Neb. Rev. Stat.§71-814);
- State Advisory Committee on Substance Abuse Services (Neb. Rev. Stat.§71-815);
- State Advisory Committee on Problem Gambling and Addiction Services (Neb. Rev. Stat.§71-816);
- Housing-related assistance for very low-income adults with serious mental illness [Neb. Rev. Stat. § 71-812(3)];
- Federal Grants Management (such as PATH Homeless Services, SA Needs Treatment Assessment, MH Data Infrastructure Grant).

Nebraska

Child - Overview of State's Mental Health System

Child - A brief description of how the public mental health system is currently organized at the State and local levels, including the State Mental Health Agency's authority in relation to other State agencies.

See Part C, Section 1: Description of State Service System: Adult 1. Overview of the State's Mental Health System

Nebraska

Child - New Developments and Issues

Child - New developments and issues that affect mental health service delivery in the State, including structural changes such as Medicaid waivers, managed care, State Children's Health Insurance Program (SCHIP) and other contracting arrangements.

see Adult - New Developments and Issues

Nebraska

Child - Legislative Initiatives and Changes

Child - Legislative initiatives and changes, if any.

The Child - Legislative initiatives are described under Section I. Description of State Service System - Adult - 3. Legislative Initiatives and Changes.

Nebraska

Child - Description of State Agency's Leadership

Child - A description of how the State mental health agency provides leadership in coordinating mental health services within the broader system.

see Adult - Description of State Agency's Leadership

Nebraska

Adult - Service System's Strengths and Weaknesses

Adult - A discussion of the strengths and weaknesses of the service system.

Narrative Question:
Adult - A discussion of the strengths and weaknesses of the service system.

Strengths of the Service System includes:
Most of this document outlines the strengths of the State of Nebraska Behavioral Health System. Some of the key points include:

- Governor Dave Heineman as well as the Legislative commitment and support for building on past accomplishments under Nebraska's Behavioral Health Reform with the new efforts.
- The integration of mental health and substance abuse into one Division of Behavioral Health. For example, the Nebraska Behavioral Health Services Act defines the term behavioral health disorder as "mental illness or alcoholism, drug abuse, problem gambling, or other addictive disorder" [Neb. Rev. Stat. §71-804 (1)].
- NE Behavioral Health Reform created additional capacity within the community based service system and significantly decreased the reliance on state operated psychiatric hospitals.
- The Nebraska Behavioral Health Services Act authorized creation of the Division of Behavioral Health within the Nebraska Department of Health and Human Services. This act established the Division of Behavioral Health as the source of contact for the Nebraska Behavioral Health System.
- There is an established system of community mental health services dating back to 1974.
- Methodical approach to system design with Behavioral Health Reform
- Involvement of constituents in planning, implementation and evaluation of reform efforts.
- The Office of Consumer Affairs authorized under the Nebraska Behavioral Health Services Act. This places a consumer in an administrative level position in Nebraska's Behavioral Health Division. In addition, there are Regional Consumer Specialists in all six Regional Behavioral Health Authorities.
- Evidence-based practices have been implemented including Assertive Community Treatment (ACT), Supported Housing, and Supported Employment.
- Dedicated, informed, knowledgeable, and experienced behavioral health workforce.
- Division of Behavioral Health has State level partnerships including but not limited to Vocational Rehabilitation, Correctional Services, Economic Develop, Education, Emergency Management Agency, University of Nebraska Medical Center, University of Nebraska Public Policy Center, Family Federation of Nebraska, National Alliance for the Mentally Ill – Nebraska, and Mental Health Association of Nebraska.
- The waiting list for admission to the civil commitment beds in the Lincoln Regional Center continues to decline.
- State Advisory Committee on Mental Health Services (71-814), which serves as the mental health planning council as required by Public Law 102-321, as well as the State Advisory Committee on Substance Abuse Services (71-815) meet consistently. Both advisory committees possess valuable expertise and knowledge making them a valuable resource to the Division of Behavioral Health.
- The Magellan Behavioral Health contract for the Administrative Services Organization (ASO) covers three Divisions within DHHS – Division of Behavioral Health, Division of Children & Family Services and Division of Medicaid & Long Term Care. This should increase the level of coordination between these three Divisions. It does establish the possibility of reporting an unduplicated count of children receiving services across multiple systems funded by DHHS.

Weaknesses In The System include:
As reported under "Unmet Service Needs" for FY2010, there are critical gaps within the current system including the following:

From the BEHAVIORAL HEALTH OVERSIGHT COMMISSION OF THE LEGISLATURE Final Report (June 2008) and reaffirmed by the BEHAVIORAL HEALTH OVERSIGHT COMMISSION (June 2009)

The Commission finds that many of the goals and responsibilities as set out in LB 1083 have not been accomplished. Those with the highest priority include:

- Consumer involvement in all aspects of service planning and delivery
- Development of a consumer focused culture that is driven by the needs of consumers.
- A plan for integrating the administration of behavioral health programs
- A comprehensive statewide plan for behavioral health services
- Development and management of a data and information system.
- A quality improvement plan
- Services that are research based, focus on recovery, and include peer support
- A methodology for measuring consumer, process, and system outcomes
- Development of plans for developing the behavioral health work force
- An integrated rate setting methodology
- Development and implementation of peer support services

Sources:

- Behavioral Health Oversight Commission Of The Legislature Final Report (June 2008)
- The Behavioral Health Oversight Commission Final Report (Approved June 22, 2009) notes the following about this list from the previous Commission report

  5) Utilize the Legislative Behavioral Health Oversight Commission's June 2008 Final report as a guiding document in the strategic planning process. (page 7).

The Division of Behavioral Health analysis of unmet service needs and critical gaps include the following:

GAP #1: CONSUMER INVOLVEMENT
GAP #2: THE PREVALENCE OF MENTAL ILLNESS AND NUMBER OF INDIVIDUALS SERVED BY SYSTEM.
GAP #3: INFORMATION SYSTEM IMPROVEMENT
GAP #4: SHORTAGE OF BEHAVIORAL HEALTH WORKFORCE
GAP #5: MEDICATION ACCESS
GAP #6: CULTURALLY AND LINGUISTICALLY COMPETENT SERVICES
GAP #7: MENTALLY ILL INMATES IN THE STATE CORRECTIONAL SYSTEM

Nebraska

Adult - Unmet Service Needs

Adult - An analysis of the unmet service needs and critical gaps within the current system, and identification of the source of data which was used to identify them.

Section II. Identification and Analysis of the Service System's Strengths Needs and Priorities Adult

2. Unmet Service Needs

Adult - An analysis of the unmet service needs and critical gaps within the current system, and identification of the source of data which was used to identify them.

From the BEHAVIORAL HEALTH OVERSIGHT COMMISSION OF THE LEGISLATURE Final Report (June 2008)

The Commission finds that many of the goals and responsibilities as set out in LB 1083 have not been accomplished. Those with the highest priority include:

- Consumer involvement in all aspects of service planning and delivery
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- A comprehensive statewide plan for behavioral health services
- Development and management of a data and information system.
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- Services that are research based, focus on recovery, and include peer support
- A methodology for measuring consumer, process, and system outcomes
- Development of plans for developing the behavioral health work force
- An integrated rate setting methodology
- Development and implementation of peer support services

Source: Behavioral Health Oversight Commission Of The Legislature Final Report (June 2008)

The Behavioral Health Oversight Commission Final Report (Approved June 22, 2009) notes the following about this list from the previous Commission report

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The Division of Behavioral Health analysis of unmet service needs and critical gaps include the following:

GAP #1: CONSUMER INVOLVEMENT
GAP #2: THE PREVALENCE OF MENTAL ILLNESS AND NUMBER OF INDIVIDUALS SERVED BY SYSTEM.
GAP #3: INFORMATION SYSTEM IMPROVEMENT
GAP #4: SHORTAGE OF BEHAVIORAL HEALTH WORKFORCE
GAP #5: MEDICATION ACCESS
GAP #6: CULTURALLY AND LINGUISTICALLY COMPETENT SERVICES
GAP #7: MENTALLY ILL INMATES IN THE STATE CORRECTIONAL SYSTEM

Here is a review on each of these items.

GAP #1: CONSUMER INVOLVEMENT

This gap is the need for clarification on system integration of consumers and families. The State Advisory Committee on Mental Health recommended this additional "gap" be added as an unmet need during the August 12, 2008 meeting. This is consistent with the findings from Behavioral Health Oversight Commission of the Legislature, the Charter for the Behavioral Health Oversight Commission, and the state statute authorizing the State Advisory Committee on Mental Health.

In the Behavioral Health Oversight Commission of the Legislature Final Report (June 2008), the following recommendation was made:

***Recommendation #1*:**
The Commission recommends that the Department fulfill the mandate of the Act which stipulates "consumer involvement in all aspects of service planning and delivery." Suggested approaches include:

a. Publically take the position that new treatment approaches and attitudes have developed. To transform the mental health system, efforts need to be made to implement these innovative approaches in Nebraska.
b. Fund the increase of leadership development, advocacy skills, and board and committee participation, at multiple levels so that all who wish can be involved, and there is "no wrong door".
c. Identify and incorporate existing "real world" opportunities, and create the additional opportunities for consumer voice that are required for this mandate. No government employed consumer is the voice of consumers, or represents consumers. Their charge is to help consumers develop their own voice, regardless of where they may be in their recovery.
d. Develop meaningful and good faith mechanisms for creating individual recovery plans, self-determined care, shared decision making and other recovery mechanisms as well as service definitions to be included in the Medicaid State Plan.
e. Provide for consumer driven integrated peer support with the cost of these positions included in the rates paid for the service.
f. Continue to measure and demonstrate the increase of consumer advocacy and inclusion at all levels of the system.
g. Provide funding and training necessary to enable consumers to develop meaningful consumer outcomes and measure those in system level research.
h. When individuals have both a mental illness and an addiction, they must have specific "integrated treatment". Comprehensive training in integrated treatment approaches must be provided to all members of treatment teams, including peers.
i. The Office of Consumer Affairs (OCA) needs to be accountable to consumers. Oversight by consumers is needed:
   - To ensure broad based participation by consumers.
   - To ensure regular, consistent, creditable, and comprehensive reports of OCA activities.
   - To demonstrate strategic planning including the development of specific goals and objectives.
   - To develop a budget for consumer projects and demonstrate fiscal accountability.

The Behavioral Health Oversight Commission Charter (Adopted: August 11, 2008) notes the need of the Division of Behavioral Health regarding promotion of:

(i) the interests of consumers and their families;
(ii) both individual and systemic recovery; and,

(iii) consumer involvement in all aspects of implementation of the Nebraska Behavioral Health Services Act.

Under the state statute that authorizes the State Advisory Committee on Mental Health Services [Neb. Rev. Stat. §71-814(2)] it says:

(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,

The Behavioral Health Oversight Commission Final Report (Approved June 22, 2009) reaffirmed this.

Source:

- The State Advisory Committee on Mental Health meeting on August 12, 2008.
- Behavioral Health Oversight Commission Final Report (June 2008)
- Behavioral Health Oversight Commission Charter (Adopted: August 11, 2008)
- The Behavioral Health Oversight Commission Final Report (Approved June 22, 2009)
- Neb. Rev. Stat. §71-814(2)

GAP #2: THE PREVALENCE OF MENTAL ILLNESS AND NUMBER OF INDIVIDUALS SERVED BY SYSTEM.

This gap involves two areas:

1. Nebraska's capacity to determine the prevalence and penetration rate for adults with mental illness.
2. The gap between the actual number of persons in need (prevalence) and the NBHS capacity to meet these needs (penetration rate).

Here is an estimation on the prevalence of mental illness in Nebraska and the number of individuals receiving services funded by the Division of Behavioral Health. This section uses these items in combination to show an estimation of unmet need for both adult and youth services.

- The **prevalence** of mental illness is the estimated 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.

The Nebraska Behavioral Health System (NBHS) is the publicly funded, non-Medicaid program. Calculation of the penetration rate is limited to those served within NBHS and reported on the Magellan Behavioral Health Information System. The data presented below uses the Nebraska Implementation Reports Table 2A data for 2008 for the Federal Uniform Reporting System. The Estimate of Prevalence reported for Table 1 is from the Center for Mental Health Services.

ADULT PENETRATION/UTILIZATION RATES	From URS Table 1	From URS Table 2*	Adult Penetration Rates
Federal Estimated number of adults in Nebraska with Serious Mental Illness	71,351		
Total number of adults served by NBHS in FY 2008		32,862	46%

YOUTH PENETRATION/UTILIZATION RATES	From URS Table 1	From URS Table 2*	Youth Penetration Rates
Federal Estimated number of youth in Nebraska with Serious Emotional Disturbance	24,192		
Total number of youth served by NBHS in FY 2008		4,049	17%

* Table 2A. Profile of Persons Served, All Programs by Age, Gender and Race/Ethnicity

Under the Federal Community Mental Health Services Block Grant, Implementation Report, Uniform Reporting System (URS Tables), Nebraska reported the data on Table 2A (Profile of Persons Served, All Programs by Age, Gender and Race/Ethnicity). This is an unduplicated count of the persons served using data from Magellan Behavioral Health (community based behavioral health services) and Avatar (Regional Centers). The data are reported by state fiscal year. The services are limited to those provided (state hospital) or funded (community services) by the state mental health agency (DHHS Division of Behavioral Health). The Adult data do not include Medicaid or any other publicly funded behavioral health services. The Children data do not include the services provided by the DHHS Division of Children & Family Services nor the Division of Medicaid & Long Term Care.

ESTIMATE OF PREVALENCE

For more information on Estimate of Prevalence see Criterion 2: Mental Health System Data Epidemiology / Estimate of Prevalence.

SOURCE:

- URS Table 2A. Profile of Persons Served, All Programs by Age, Gender and Race/Ethnicity (December 1, 2008)
- Number of Persons with Serious Mental Illness, age18 and older / number of children and adolescents (Age 9 to 17) with Serious Emotional Disturbance (SED) in Nebraska from Prepared by NRI/SDICC for CMHS: June 14, 2008
  State Data Infrastructure Coordinating Center (NRI)
  Under contract with Center for Mental Health Services (CMHS contract no. 280-99-0504). http://www.nri-inc.org/projects/SDICC/urs_forms.cfm

Ted Lutterman, NASMHPD Research Institute, Inc., Alexandria, VA

- State Advisory Committee on Mental Health Services reviewed and discussed on August 4, 2006; August 7, 2007; August 12, 2008 and August 13,2009.

GAP #3: INFORMATION SYSTEM IMPROVEMENT

Nebraska continues to experience challenges in the collection, analysis, and reporting of data. There is a continuing need to work on improving the management information systems used by the Nebraska Division of Behavioral Health. At minimum, there is a need to check for accuracy and provide feedback on data quality. Also, more work needs to be done on reporting the data collected. Federal Medicaid, the Federal Centers for Mental Health Services (CMHS) and Substance Abuse Treatment (CSAT) each have different reporting requirements. Solutions to those problems are left to the states to resolve. Coordination on these data reporting requirements at the Federal level would provide for enormous efficiencies for the state. In general, the data needs to be used to answer questions such as "who are we serving?" "What services are they getting?" and "What results were produced?"

Under the Nebraska Behavioral Health Services Act, §71-806 the duties of the Division of Behavioral Health Services are listed. The duties include (1)(e) "development and management of data and information systems". Meanwhile §71-810 (7) [from Laws 2005, LB 551, § 3] sets legislative requirements for data and information system reporting duties for the Division of Behavioral Health Services.

Behavioral Health Oversight Commission of the Legislature Final Report (June 2008), the Commission found the goal and responsibility on the development and management of a data and information system had not been accomplished. DHSS continues to address the data infrastructure in order to improve the capacity for data collection, analysis and reporting.

ASO for MH/SA Services

On February 1, 2008, the State of Nebraska, Administrative Services, Materiel Division, Purchasing Bureau, issued a Request for Proposal, RFP Number #2356Z1 for the purpose of selecting a qualified contractor to provide "Behavioral Health/Children and Family Services/Medicaid and Long-Term Care" Administrative Services Organization (ASO). On April 16, 2008, it was announced that Magellan Behavioral Health was selected as the Administrative Service Organization contractor for these three DHHS Divisions – Behavioral Health, Children & Family Services and Medicaid & Long Term Care. The Magellan Behavioral Health contract began on May 1, 2008 and ends on June 30, 2010. There are optional annual contract renewals for State Fiscal Years 2011, 2012 and 2013.

The Division of Behavioral Health continues to address the data infrastructure in order to improve the capacity for data collection, analysis and reporting. Nebraska uses two data bases to prepare the Uniform Reporting System tables. These two data bases are merged into one data set used to actually prepare the URS tables.

- Magellan Behavioral Health contract is the source used to collect the client data for reporting under the Federal Community Mental Health Services Block Grant. Magellan collects client data for both community mental health and substance abuse. The data being reported under this application was collected under the Magellan Behavioral Health ASO services contract covering Nebraska Behavioral Health System (NBHS).
- The Division of Behavioral Health is a service provider via the state psychiatric hospitals - Lincoln Regional Center (LRC), Hastings Regional Center (HRC), and Norfolk Regional Center (NRC). These three facilities, as a service provider, collect client level data. They use software called "Avatar". NOTE: As of July 1, 2007, the Hastings Regional Center only provides chemical dependency/addiction treatment to male youth who have been paroled from the Youth Development Center in Kearney, NE.

- DBH data management is challenging for a variety of reasons including:
  - Reliance on and limitations of the ASO data system;
  - Multiple data projects/contractors exist and multiple individuals within DBH manage the data related contracts;
  - Integration and coordination of data and reports with other DHHS partners is currently limited to the ASO;
  - DBH limitations prompted regions and providers to develop their own data bases for Professional Partner Program, Housing, Waiting and Capacity Management Lists, Prevention, and other QI related data projects;
- DBH hired a Managed Care and Quality Improvement Manager in July 2008.
  - Implemented Division level QI team (DQIT) to provide a formal structure for reviewing QI information and data reporting and analysis;
  - Implemented Magellan QI Team (MQIT) to improve data quality;
  - Works with ASO contract partners and Magellan on data reports to assist management of the system;
  - Implementing Statewide QI Team (SQIT) and statewide performance measurements for DBH, RBHA's and providers.
- DBH hired Statistical Analyst, February 2009
  - Much of the data presented in past years was not analyzed for reliability and validity. This position will be of great benefit to the long term strategy of DBH.
  - In cleaning up the Magellan system, clarifying data codes and reviewing report processes, multiple issues have been uncovered, adding time to correct actions and improve processes.
  - Externs are available to assist with specific assigned data projects. The Statistical Analyst is now assigned to monitor the extern tasks daily to determine if additional time is available for data requests/projects.
  - Seeking approval to hire an additional data team member to assist with both QI processes and data analysis.
- Criminal Justice Electronic Data Transfer Interagency Agreement – as reported in Adult - Child - New Developments and Issues, the Nebraska Department of Health and Human Services - Division Of Behavioral Health (DHHS), the Nebraska Department of Correctional Services (DCS) and the Nebraska Commission on Law Enforcement and Criminal Justice (Crime Commission) signed Electronic Data Transfer Interagency Agreements on June 9, 2009. These agreements have these three state agencies transferring their data to the Division of Epidemiology, College of Public Health at the University of Nebraska Medical Center in Omaha, NE for the purpose of analysis, compilation and reporting for the mutual benefit of the parties. The initial data covers the time period from January 1, 2005 to December 31, 2008. Before public release, the Report(s) produced under these agreements must be acceptable to the DHHS, DCS and the Crime Commission. The Report(s) remain in draft status until these three code level agencies approve the document. This requirement is due to the sensitive nature of the content of the report(s) using these data.

Source: Nebraska Division of Behavioral Health, August 31, 2009

GAP #4: SHORTAGE OF BEHAVIORAL HEALTH WORKFORCE
Updated July 23, 2009

There remains a critical shortage of qualified Nebraska Behavioral Health Staff for providing treatment, rehabilitation and support services as well as handling administrative functions. This workforce includes psychiatrists, psychologists, mental health practitioners, nurses, substance abuse counselors, and others. Nebraska is working to systematically add Peer Support Specialists to the behavioral health workforce. For many years, Nebraska has taken steps to improve the supply and distribution of the behavioral health workforce. However, there remains too few qualified behavioral health workers practicing in the state. Further, the available workforce is unevenly distributed with many communities having few if any qualified professionals available to provide services. Thus, Nebraska needs to do more to encourage people to enter the behavioral health profession and to practice in underserved areas.

Behavioral Health Oversight Commission

In the Behavioral Health Oversight Commission Final Report (Approved June 22, 2009), there was a recommendation made regarding the Behavioral Health Workforce Shortage (page 9):

> 2. Behavioral Health Workforce Shortage
> The Commission approved the following outline for "Behavioral Health Workforce Shortage":
>
> > **There is a behavioral health workforce shortage nationally and in the state of Nebraska. There are an inadequate number of psychiatrists and other mental health and substance abuse professionals to provide necessary services to consumers. Education and training are needed to grow the workforce. Collaborate with private, government and academic partners to investigate ways to cultivate a workforce, funding, and incentives for growing the behavioral health workforce.**

Health Professions Tracking Service

Since 1995 the Health Professions Tracking Service (HPTS) has effectively developed and maintained a dynamic customized healthcare tracking system. HPTS maintains a centralized, state-of-the-art repository of information regarding Nebraska's healthcare resources. Included in the repository are physicians, advanced practice registered nurses, physician assistants, dentists, pharmacists, psychologists, behavioral health professionals, practice locations and hospitals. To maintain the most current data possible, surveys are sent to both professionals and facilities throughout the year. Results are input into a relational database, continuously updating both providers and facilities. The repository provides an accurate foundation to assist in workforce forecasting and planning, provide accurate shortage area designations, formulate health policies to support recruitment and retention and support biosecurity preparedness and response.

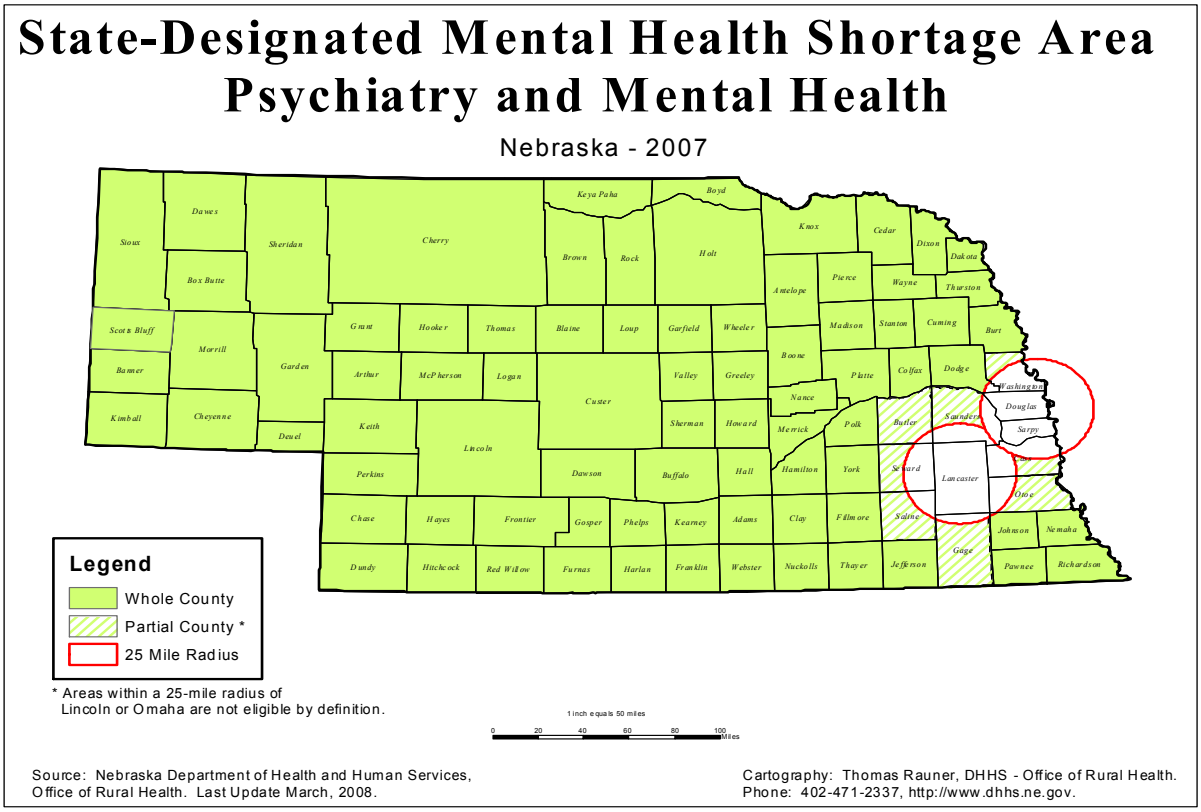
HPTS has addressed a number of issues unique to behavioral health professionals that are vital to the accurate assessment of workforce issues in the state. The issues include, but are not limited to; multiple licenses and certifications, specialties, patient characteristics, languages spoken, interpreter availability and treatment modalities. HPTS developed customized surveys for behavioral health providers to address these issues.

A much more complete and accurate profile of behavioral health in the State of Nebraska can be provided by surveying behavioral health facilities. If critical funding were made available, customized surveys could be developed to obtain complete information including, but not limited

to; additional practicing providers, services offered, contact information, recruitment and openings, demographics, etc.

Mental Health Professional Shortage Areas
Below is the *State-Designated Mental Health Shortage Area – Psychiatry and Mental Health - Nebraska 2007* 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. (1)
Source: Nebraska Department of Health and Human Services Office of Rural Health, http://www.dhhs.ne.gov/orh

For more information on the federal Health Professional Shortage Area status contact Thomas Rauner in the Nebraska DHHS Office of Rural Health and Primary Care (402-471-0148).



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

Psychiatrists – Actively Practicing
Based on 2009 survey results, 150 physicians specialize in psychiatry and actively practice in Nebraska. Of the 150 psychiatrists, 120 practice full time, 9 practice part time (30-39 hours per week) and 21 practice part time (≤ 29 hours per week) with primary practice locations in 11 Nebraska counties. The remaining 82 counties do not have a psychiatrist with a primary practice location. Only 22 psychiatrists; 16 full-time, 2 part time (30-39 hours per week) and 4 part-time (≤ 29 hours per week), have a primary practice location in a State Designated Mental Shortage Area. Seven (7) Psychiatrists with a primary practice in a State Designated Mental Shortage Area are age 61 or greater. (2)

Source: UNMC Health Professions Tracking Service - 2009

Advanced Practice Registered Nurses – Actively Practicing
Based on 2009 survey results, 59 Advanced Practice Registered Nurses (APRNs) specialize in psychiatry and actively practice in Nebraska. Three APRNS are dual licensed as an APRN and Licensed Mental Health Practitioner. One dual licensed professional practices in a State Designated Mental Shortage Area. Forty-nine (49) APRNs practice full time, 4 practice part time (30-39 hours per week) and 6 practice part time (≤ 29 hours per week) with primary practices in 12 Nebraska counties. Nineteen (19) APRNs have a primary practice in a State Designated Mental Shortage Area. Four (4) APRNs with a primary practice in a State Designated Mental Shortage Area are age 61 or greater. (3)
Source: UNMC Health Professions Tracking Service -2009

Physician Assistants – Actively Practicing
Based on 2009 survey results, 9 Physician Assistants (PAs) specialize in psychiatry and actively practice in Nebraska. Six (6) PAs practice full time and 3 practice part time (30-39 hours per week) with primary practices in 5 Nebraska counties. Four (4) PAs have a primary practice in a State Designated Mental Shortage Area. No PAs with a primary practice in a State Designated Mental Shortage Area are age 61 or greater. (4)
Source: UNMC Health Professions Tracking Service - 2009

Psychologists – Actively Practicing
Based on 2009 survey results, 288 Psychologists actively practice in Nebraska. Two Hundred and Sixteen (216) practice full time, 23 practice part time (30-39 hours per week) and 49 practice part time (≤ 29 hours per week) with primary practices in 22 Nebraska counties. Sixty seven (67) have a primary practice in a State Designated Mental Shortage Area. Fourteen (14) Psychologists with a primary practice in a State Designated Mental Shortage Area are age 61 or greater.
Source: UNMC Health Professions Tracking Service - 2009

Behavioral Health Professionals (Mental Health Practitioners, Independent Mental Health Practitioners, Alcohol and Drug Counselors and Certified Compulsive Gambling Counselors)
Based on 2009 survey results, 1565 behavioral health professionals actively practice in Nebraska. One thousand one hundred and twenty one (1121) practice full time, 167 practice part time (30-39 houses per week) and 277 practice part time (≤ 29 hours per week) with primary practices in 55 Nebraska counties. Five hundred and thirty (530) have a primary practice in a State Designated Mental Shortage Area. One hundred and nine (109) behavioral health professionals with a primary practice in a State Designated Mental Shortage Area are age 61 or greater.
Source: UNMC Health Professions Tracking Service – 2009

Licensed Psychologists, Mental Health Practitioners, Independent Mental Health Practitioners, Alcohol and Drug Counselors and Certified Compulsive Gambling Counselors
The following provides the number of licensed behavioral health professionals: Licensed Psychologists, Mental Health Practitioners, Independent Mental Health Practitioners, Alcohol and Drug Counselors and Certified Compulsive Gambling Counselors. Professionals with multiple licenses have been identified and included only once. (5)

Licensed Psychologists and Behavioral Health Professionals

Profession	Actively Licensed

Alcohol & Drug Counselor	205
Mental Health Practitioner	1740
Independent Mental Health Practitioner	461
Psychologist	414
Certified Compulsive Gambling Counselor	7
Single License Subtotal	**2827**
Alcohol & Drug Counselor, Mental Health Practitioner	191
Alcohol & Drug Counselor, Independent Mental Health Practitioner	78
Alcohol & Drug Counselor, Psychologist	3
Mental Health Practitioner, Psychologist	8
Mental Health Practitioner, Certified Compulsive Gambling Counselor	6
Independent Mental Health Practitioner, Certified Compulsive Gambling Counselor	4
Alcohol & Drug Counselor, Certified Compulsive Gambling Counselor	3
Psychologist, Certified Compulsive Gambling Counselor	**1**
Dual License Subtotal	**294**
Mental Health Provider, Alcohol & Drug Counselor, Certified Compulsive Gambling Counselor	2
Multiple License Subtotal	2
Total	3123

Source: Health Professions Tracking Service - 2009

Aging Workforce

According to the Health Professions Tracking Service survey respondents of actively practicing professionals with a primary practice in Nebraska, approximately 9% of mental health practitioners are 66 years of age and older. An additional 30% are between the ages of 56 and 65. Based upon an average retirement age of 65, it is estimated that 39% of the mental health practitioners will retire within 10 years, necessitating the need to recruit more than 1/3 of the current workforce. Only 11% of practitioners report being 35 years or age or younger. (6)

Licensed Behavioral Health Professionals, by Age

	35 & Under	36-45	46-55	56-65	66 & Over	Unknown	Total
Psychiatrists	**7**	**39**	**53**	**38**	**13**		*150*
	5%	*26%*	*35%*	*25%*	*9%*		*100%*
Advanced Practice Registered Nurses	**4**	**7**	**19**	**26**	**3**		*59*
	7%	*13%*	*32%*	*43%*	*5%*		*100%*
Physician Assistants	**0**	**2**	**4**	**3**	**0**		*9*
	0%	*22%*	*44%*	*33%*	*0%*		*100%*
Psychologists	**33**	**48**	**76**	**95**	**35**	**1**	*288*
	12%	*17%*	*26%*	*33%*	*12%*	*0%*	*100%*
Mental Health Practitioners, Independent Mental Health Practitioners, Alcohol & Drug Counselors, Certified Compulsive Gambling Counselors	**177**	**346**	**453**	**450**	**135**	**4**	*1565*
	11%	*22%*	*29%*	*29%*	*9%*	*0%*	*100%*

Licensed Behavioral Health Professionals, by Age

	35 & Under	36-45	46-55	56-65	66 & Over	Unknown	*Total*

All Professions	**221**	**442**	**605**	**612**	**186**	**5**	*2071*
	11%	*21%*	*29%*	*30%*	*9%*	*0%*	*100%*

Source: Health Professions Tracking Service - 2009

The table below indicates a total of 473 (23%) behavioral health professionals are considering retirement in the next ten years. Retirement Plans in the next 10 years by Region are displayed below for Actively Practicing Psychiatrists, Psychologists, Licensed Psychologists, Advanced Practice Registered Nurses, Physician Assistants, Mental Health Practitioners, Independent Mental Health Practitioners, Alcohol and Drug Counselors and Certified Compulsive Gambling Counselors.

Behavioral Health Professionals Considering Retirement, by Region

Region	One	Two	Three	Four	Five	Six	Total
Number	16	16	56	33	133	219	473
Percent of Total Practicing	25%	21%	23%	24%	23%	23%	23%

Lack of Expertise Available To Work with Persons with Dual Disorders

Substance abuse and dependence may go undiagnosed and untreated in adults with serious mental illness and children with serious emotional disturbance. Assessing substance abuse disorders is a key issue here. As the following chart indicates, dual licensed specialists are limited.

Providing for children with serious emotional disturbances is a particularly acute problem. All of the Nebraska Behavioral Health Regions have expressed the need for more qualified staff and professionals; and, more specialized training for all non mental health staff and professionals who work with children diagnosed with a dual disorder (mental health and substance dependence). There is a need to expand services in order to serve more youth in rural and frontier areas. Treatment professionals and educators, as well as parents in Nebraska would benefit from more education and training to assess and refer children for dual disorder treatment and earlier intervention and assessment services. Furthermore, there is a need for more cooperation and communication between the mental health and substance abuse treatment systems, as well as other child-serving systems.

Following are counts of actively practicing licensed behavioral health professionals; Psychologists, Mental Health Practitioners, Independent Mental Health Practitioners, Alcohol and Drug Counselors, and Certified Compulsive Gambling Counselors. Professionals with multiple licenses have been identified and included only once. (7)

Three APRNS are dual-licensed as APRNs and Licensed Mental Health Practitioners. These practitioners have been included in the APRN counts. (8)

Licensed Mental Health Professionals

Profession	Actively Practicing
Alcohol & Drug Counselor	118
Mental Health Practitioner	899
Independent Mental Health Practitioner	342
Psychologist	277

Profession	Actively Practicing
Certified Compulsive Gambling Counselor	6
Single License Subtotal	**1642**
Alcohol & Drug Counselor, Mental Health Practitioner	123
Alcohol & Drug Counselor, Independent Mental Health Practitioner	63
Alcohol & Drug Counselor, Psychologist	3
Mental Health Practitioner, Psychologist	7
Mental Health Practitioner, Certified Compulsive Gambling Counselor	6
Independent Mental Health Practitioner, Certified Compulsive Gambling Counselor	4
Alcohol & Drug Counselor, Certified Compulsive Gambling Counselor	2
Psychologist, Certified Compulsive Gambling Counselor	1
Dual License Subtotal	**209**
Mental Health Practitioner, Alcohol & Drug Counselor, Certified Compulsive Gambling Counselor	2
Multiple License Subtotal	2
Total	**1853**

Source: Health Professions Tracking Service – 2009.

In 2008, 235 Mental Health Practitioners were licensed as Independent Mental Health Practitioners with 34 (14%) identified as dual licensed. In 2009, 409 Independent Mental Health Practitioners are licensed with 67 (17%) dual licensed.

Source: Health Professions Tracking Service – 2009.

LB1083 (2004) sections 103 – 125 amended the Uniform Licensing Law and the Requirements for Certified Alcohol/Drug Abuse Counselors (CADAC). The result was the following levels of certification: Licensed Alcohol/Drug Abuse Counselor (LADAC); Licensed Provisional Alcohol/Drug Abuse Counselor (LPADAC); and Licensed Provisional and Licensed Mental Health Professionals Special Provisions.

Blaine Shaffer, MD (Chief Clinical Officer for the Division of Behavioral Health), commenting on the shortage of psychiatrists in Nebraska, said, "The point is that we need psychiatrists, not others acting as psychiatrists. Physician extenders are very helpful but should not replace psychiatrists. Telepsychiatry could be a way for psychiatrists and other providers to collaborate and provide quality care for people in shortage areas. This modality is also currently underutilized."

Languages Spoken

All the Behavioral and Mental Health professionals report speaking English. In addition, 82 professionals report speaking languages other than English fluently. The following chart identifies the languages and counts of professionals who indicate fluency in each language. (9)

Non-English Language Fluency

Spanish	35	Punjabi	5	Filipino	2	Farsi	1
Sign Language	12	Urdu (India)	4	Italian	2	Greek	1
French	10	Arabic	3	Japanese	2	Korean	1
German	8	Chinese	3	Russian	2	Portuguese	1
Hindi	7	Polish	3				

Source: Health Professions Tracking Service – 2009

Languages Offered through Interpreter

698 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. (10)

Do you serve people who speak languages other than English?	698

Self interpreter	60
Qualified outside interpreter sitting in the session	573
Phone interpreter service	111

Languages Offered:

Spanish	357	Russian	4	Dakota	1	Native American	1
Sign (ASL, etc.)	117	Dinka	3	Dutch	1	Nepali	1
Arabic	22	African Dialects	2	Georgian (Kartuli)	1	Polish	1
Vietnamese	18	Korean	2	Greek	1	Portuguese	1
German	8	Somali	2	Hebrew	1	Street Slang	1
Sudanese	7	Thai	2	Japanese	1	Swahili	1
Farsi	5	Asian Dialects	1	Karudi	1	Various	39
French	5	Belarusian	1	Lakota Sioux	1		
Kurdish	5	Bosnian	1	Laos	1		
Nuer	4	Chinese	1	Mandari	1		

Source: Health Professions Tracking Service – 2009

Nebraska Behavioral Healthcare Professionals by Region

Below is a summary of the supply of Nebraska behavioral health professionals by region (including Psychiatrists, Advanced Practice Registered Nurses and Physician Assistants. (11)

Behavioral Health Professionals, by Region

Region	One	Two	Three	Four	Five	Six	Total
Psychiatrists	4	3	9	5	31	98	150
	3%	*2%*	*6%*	*3%*	*21%*	*66%*	*100%*
Advanced Practice Registered Nurses	3	0	12	4	10	30	59
	5%	*0%*	*20%*	*7%*	*17%*	*52%*	*100%*
Physician Assistants	0	0	1	2	3	3	9
	0%	*0%*	*11%*	*22%*	*33%*	*33%*	*100%*
Psychologists	8	5	20	17	110	128	288
	3%	*2%*	*7%*	*6%*	*38%*	*44%*	*100%*
Mental Health Practitioners, Independent Mental Health Practitioners, Alcohol & Drug Counselors, Certified Compulsive Gambling Counselors	50	69	203	111	423	709	1565
	3%	*4%*	*13%*	*7%*	*27%*	*45%*	*100%*
All Professions	65	77	245	139	577	968	2071
	3%	*4%*	*12%*	*7%*	*28%*	*47%*	*100%*

Source: Health Professions Tracking Service – 2009

Education

Below are charts summarizing the Nebraska behavioral health professionals by profession, highest degree reported, and region. (12)

Psychiatrists

Region	1	2	3	4	5	6	Total
Associate's Degree	0	0	0	0	0	0	**0**
Baccalaureate Degree	0	0	0	0	0	0	**0**
Master's Degree	0	0	0	0	0	0	**0**
Doctorate/Ph.D.	0	0	0	0	0	0	**0**
Medical Degree	4	3	9	5	31	98	**150**
Unknown	0	0	0	0	0	0	**0**
Total	4	3	9	5	31	98	**150**

Advanced Practice Registered Nurses

Region	1	2	3	4	5	6	Total
Associate's Degree	0	0	0	0	0	0	**0**
Baccalaureate Degree	0	0	0	0	0	0	**0**
Master's Degree	3	0	12	4	9	30	**58**
Doctorate/Ph.D.	0	0	0	0	1	0	**1**
Medical Degree	0	0	0	0	0	0	**0**
Unknown	0	0	0	0	0	0	**0**
Total	**3**	**0**	**12**	**4**	**10**	**30**	**59**

Physician Assistants

Region	1	2	3	4	5	6	Total
Associate's Degree	0	0	0	0	0	0	**0**
Baccalaureate Degree	0	0	0	1	2	0	**3**
Master's Degree	0	0	1	1	1	3	**6**
Doctorate/Ph.D.	0	0	0	0	0	0	**0**
Medical Degree	0	0	0	0	0	0	**0**
Unknown	0	0	0	0	0	0	**0**
Total	**0**	**0**	**1**	**2**	**3**	**3**	**9**

Psychologist

Region	1	2	3	4	5	6	Total
Associate's Degree	0	0	0	0	0	0	**0**
Baccalaureate Degree	0	0	0	0	0	0	**0**
Master's Degree	0	0	0	0	0	0	**0**
Doctorate/Ph.D.	8	5	20	17	110	128	**288**
Medical Degree	0	0	0	0	0	0	**0**

Unknown	0	0	0	0	0	0	**0**
Total	**8**	**5**	**20**	**17**	**110**	**128**	**288**

Mental Health Practitioners, Independent Mental Health Practitioners, Alcohol and Drug Counselors, Certified Compulsive Gambling Counselors

Degree / Region	**1**	**2**	**3**	**4**	**5**	**6**	**Total**
Associate's Degree	2	0	3	2	7	11	**25**
Baccalaureate Degree	3	2	5	6	14	22	**52**
Master's Degree	34	61	178	90	350	631	**1344**
Doctorate/Ph.D.	7	2	12	9	32	32	**94**
Medical Degree	0	0	0	0	0	0	**0**
Unknown	4	4	5	4	20	13	**50**
Total	**50**	**69**	**203**	**111**	**423**	**709**	**1565**

Source: Health Professions Tracking Service – 2009

Behavioral Healthcare Professional – Patient Age Details by Region

On August 12, 2008, the NE FY2009 draft application for the Federal Community Mental Health Services Block Grant was formally reviewed by the State Advisory Committee on Mental Health Services. Members of the Committee asked to have the Health Professions Tracking Service report on the populations served by behavioral health professionals such as only children, only adults or both to help document the lack of pediatric mental health professionals.

The Health Professions Tracking Service survey of behavioral health professionals includes a question regarding the age category of clients seen in the practice of the responding professional. The five age categories are listed below:

- Child: 0 - 12 years
- Adolescent: 12 - 18 years
- Young Adult: 19 - 25 years
- Adult: 26 - 64 years
- Geriatric: 65 +

The following data summarizes the count of behavioral health professionals by profession serving each Patient Age Category.

Professionals Serving Each Patient Age Category

Age Category	Child	Adolescent	Young Adult	Adult	Geriatric	All Ages	No Response
Psychiatrists	12	27	60	64	47	17	61
Nurse Practitioners	3	7	26	28	20	15	17
Physician Assistants	0	0	5	5	5	0	4
Psychologists	76	118	128	135	71	57	60

Mental Health Practitioners, Independent Mental Health Practitioners, Alcohol and Drug Counselors, Certified Compulsive Gambling Counselors	362	663	808	904	369	310	208
Total	**453**	**815**	**1027**	**1136**	**512**	**399**	**350**

Note: Professionals may service more than one Age Category; therefore, may be counted more than once.

Supporting data is listed below detailing the count of behavioral health professionals by region serving each combination of Patient Age Category.

Professionals Serving Each Patient Age Category by Region

Psychiatrists:

Region	One	Two	Three	Four	Five	Six	Total	% Total
Child, Adolescent						4	4	2.7%
Child, Adolescent, Young Adult						5	5	3.3%
Child, Adolescent, Young Adult, Adult		1				2	3	2.0%
Adolescent, Young Adult						1	1	0.7%
Adolescent, Young Adult, Adult					2	4	6	4.0%
Adolescent, Young Adult, Adult, Geriatric					3	3	6	4.0%
Adolescent, Young Adult, Geriatric		1	1				2	1.3%
Young Adult, Adult						3	3	2.0%
Young Adult, Adult, Geriatric			3	2	7	22	34	22.7%
Adult					1	2	3	2.0%
Adult, Geriatric						1	1	0.7%
Geriatric						4	4	2.7%
All Ages	3		2	1	6	5	17	11.3%
No Response	1	1	3	2	12	42	61	40.7%
Total	4	3	9	5	31	98	150	100.0%

Nurse Practitioners:

Region	1	2	3	4	5	6	Total	% Total
Child, Adolescent, Young Adult						1	1	1.7%
Child, Adolescent, Young Adult, Adult					1	1	2	3.4%
Adolescent, Young Adult, Adult, Geriatric	1		1		1	1	4	6.8%
Young Adult, Adult					1	3	4	6.8%
Young Adult, Adult, Geriatric			3	2	1	9	15	25.4%
Adult					1		1	1.7%
Adult, Geriatric						1	1	1.7%
All Ages	1		4	2	3	5	15	25.4%

No Response	1		4		2	9	17	27.1%
Total	3	0	12	4	10	30	59	100.0%

Physician Assistants:

Region	**1**	**2**	**3**	**4**	**5**	**6**	Total	% Total
Young Adult, Adult, Geriatric				1	1	3	5	55.6%
No Response			1	1	2		4	44.4%
Total			1	2	3	3	9	100.0%

Psychologists:

Region	**1**	**2**	**3**	**4**	**5**	**6**	Total	% Total
Child			1		4	3	8	2.8%
Child, Adolescent	1			1	11	12	25	8.7%
Child, Adolescent, Young Adult			1		7	8	16	5.6%
Child, Adolescent, Young Adult, Adult			2	2	7	12	23	8.0%
Child, Adolescent, Adult					1	1	2	0.7%
Child, Adolescent, Adult, Geriatric			1				1	0.3%
Child, Adult, Geriatric	1						1	0.3%
Adolescent			1		1		2	0.7%
Adolescent, Young Adult					1		1	0.3%
Adolescent, Young Adult, Adult	1		1		5	5	12	4.2%
Adolescent, Young Adult, Adult, Geriatric	2	1	1	1	19	12	36	12.5%
Young Adult						1	1	0.3%
Young Adult, Adult					6	3	9	3.1%
Young Adult, Adult, Geriatric			1	2	13	14	30	10.4%
Adult						1	1	0.3%
Adult, Geriatric					1	1	2	0.7%
Geriatric						1	1	0.3%
All Ages	2	3	7	9	14	22	57	19.8%
No Response	1	1	4	2	20	32	60	20.8%
Total	8	5	20	17	110	128	288	100.0%

Mental Health Practitioners, Independent Mental Health Practitioners, Alcohol and Drug Counselors, Certified Compulsive Gambling Counselors

Region	**1**	**2**	**3**	**4**	**5**	**6**	Total	% Total
Child	5	1	1	1	6	14	28	1.8%
Child, Adolescent		3	7	2	21	28	61	3.9%
Child, Adolescent, Young Adult		1	3	3	3	12	22	1.4%
Child, Adolescent, Young Adult, Adult	3	15	29	14	49	98	208	13.3%
Child, Adolescent, Young Adult, Geriatric					1		1	0.1%
Child, Adolescent, Adult			2	2	8	11	23	1.5%

Child, Young Adult, Adult			1		2	3	6	0.4%
Child, Young Adult, Adult, Geriatric					1	2	3	0.2%
Child, Adult				1	2	3	6	0.4%
Child, Adult, Geriatric					1		1	0.1%
Child, Adolescent, Adult, Geriatric			1	1	1		3	0.2%
Adolescent, Young Adult, Geriatric						1	1	0.1%
Adolescent		1	7	2	15	19	44	2.8%
Adolescent, Young Adult	1		1	1	2	5	10	0.6%
Adolescent, Young Adult, Adult	4	3	20	6	30	58	121	7.7%
Adolescent, Young Adult, Adult, Geriatric	10	12	21	10	37	68	158	10.1%
Adolescent, Adult				1	2	4	7	0.4%
Adolescent, Adult, Geriatric					1	2	3	0.2%
Adolescent, Geriatric				1			1	0.1%
Young Adult			2	1	2	1	6	0.4%
Young Adult, Adult	2	1	8	10	36	53	110	7.0%
Young Adult, Adult, Geriatric	5	2	12	11	55	77	162	10.4%
Adult		1	2	1	9	13	26	1.7%
Adult, Geriatric		1	6	1	5	14	27	1.7%
Geriatric			1		1	7	9	0.6%
All Ages	17	23	52	29	71	118	310	19.8%
No Response	3	5	27	13	62	98	208	13.3%
Total	50	69	203	111	423	709	1565	100.0%

source: Health Professions Tracking Service – 2009

Comments from Chelsea Chesen, MD

On 07/23/2009, two comments were received from Chelsea Chesen, MD. Dr. Chesen is a member of the State Advisory Committee on Mental Health Services. Dr. Chesen's comments involved the following:

- Telemedicine Practice in Psychiatry and Behavioral Health
- The University of Nebraska Medical Center has a responsibility to the entire state to help the state develop and maintain a highly educated and effective medical workforce.

TELEMEDICINE

Historically, the practice of telemedicine (the use of telecommunications technology to expand the reach of healthcare) got it's start at the University of Nebraska in the Department of Psychiatry in the 1950s. Despite the fact that UNMC was ahead of its time and set the stage for a worldwide shift in medical and behavioral health practices in the last century, at this time, Nebraska remains a state that is grossly underserved medically, especially in behavioral health, with only 3 of 95 counties having adequate access to behavioral health care. There are volumes of published research supporting the use of telemedicine for rural outreach, much of which was generated by the University of Arizona's Telemedicine Program, with which I used to be

affiliated. States such as Arizona have much in common with Nebraska, given the large rural areas, cultural diversity and RHBA system of behavioral health care delivery.

Telemedicine practice in psychiatry and behavioral health is easily accomplished today from a technological standpoint, and available technologies become more and more affordable each day. Nebraska has a few functioning telehealth systems that do provide some behavioral health care at this time, including some care provided to nursing homes by UNMC, a small telehealth network for psychiatric and behavioral health care through the Veteran's Administration Medical Centers to reach rural veterans, and a couple of private groups that provide care in the middle of the state (mostly out of Hastings).

In 2004, I was brought from Arizona by Creighton University's Department of Psychiatry to present a talk on Telepsychiatry to experts in psychiatry in the Omaha area. In addition, I had the opportunity to meet with a multidisciplinary group working on a White Paper for then-Governor Johanns regarding the opportunities for and obstacles against developing telemedicine services further in Nebraska. At that time, the main obstacle to expanding telebehavioral health seemed to be the fragmentation of the behavioral healthcare system since most of the telehealth services provided in outstate Nebraska were by private groups that did not seem motivated to work with the State to form an integrated telehealth network that would make needed technologies more accessible to everyone in terms of affordability, maintenance and administration/training.

In any case, given the real-life practice of telehealth today, there is no reason that every single family practice office in rural Nebraska could not be "hooked into" a telemedicine system that could essentially provide behavioral health consultation on-site via videoconferencing. The other role of telehealth technology (other than providing patient/client care) is to provide education to rural practitioners. This can be in the form of continuing education programming (lectures or workshops) or consultation. For example, when I practiced telepsychiatry in Tucson, AZ, I had regular telemedicine meetings with family practitioners in Payson, AZ who essentially presented patient cases to me for input. Psychiatrists can be "extended" by nonpsychiatrist physicians/PA's as well as other behavioral health practitioners and can provide such extenders "supervision" and consultation via telemedicine.

Videoconferencing systems are available now even on a PC and do not require expensive specialized systems. What IS necessary is good IT support to handle confidentiality issues (firewalls) and connectivity, as well as coordinating administrative staff at both the rural site and the consulting site. Obviously, the other thing that is required is behavioral health practitioners (at the consulting site), so staffing a service is still an issue whether the psychiatrist or other practitioner lives in Omaha or Broken Bow.

ROLE OF UNMC IN TRAINING AND EDUCATING PRACTITIONERS IN UNDERSERVED AREAS

The University of Nebraska Medical Center (including the College of Medicine, College of Nursing, College of Allied Health Providers, etc.) has a responsibility to the entire state to help the state develop and maintain a highly educated and effective medical workforce. This includes behavioral health practitioners (specifically psychiatrists, behavioral-health-friendly primary care doctors, nurse practitioners and nurses, PA-C's etc.). Perhaps the block grant could include a proposal that UNMC (perhaps through the Department on Rural Health) take a leadership role in developing recruiting and training programs for behavioral health practitioners in the State. For example, UNMC could set specific goals (1 year, 5 year, 10 year) for

producing a certain number of psychiatrists, PA's in psychiatry and psychiatric APRN's. Perhaps UNMC could develop incentive training programs that would place trainees in rural areas, where the trainees could receive supervision via telemedicine (from the academic hub). This system has worked beautifully in the areas of Family Medicine, and could easily be implemented in behavioral health. The Department of Psychiatry could provide incentives to resident physicians in psychiatry to do rural rotations (again, with supervision via telemedicine). Continuing medical education and keeping practitioners connected to the wider behavioral health community are important, and UNMC (and Creighton University) could provide this via telemedicine.

Such programs at the University level need funding to support those in leadership positions who can make these things happen. I am sure that the leadership at UNMC would be interested in our goals if we make them better known and can provide support and funding.

SOURCE:

- July 23, 2009 from Chelsea Chesen, MD, as a member of the State Advisory Committee on Mental Health.
- July 23, 2009 from Marlene Deras, Administrator; Health Professions Tracking Service at the College of Public Health, University of Nebraska Medical Center (UNMC); Omaha, NE .
- Thomas Rauner, Office of Rural Health & Primary Care, Nebraska Department of Health & Human Services. This office has the responsibility to review (and submit if appropriate) federal shortage area applications to the Shortage Designation Branch, including the Psychiatric Health Professional Shortage Area.
- Reviewed with the State Advisory Committee on Mental Health Services on 8/19/2004, 5/10/2005, 8/9/2005 and on 8/12/2008 as well as the NE Mental Health Planning and Evaluation Council meetings on August 16, 2001, February 4, 2002, and August 8, 2003.
- Blaine Shaffer, MD, NE Division of Behavioral Health Services

GAP #5: MEDICATION ACCESS

This gap involves a variety of things. Providing access to psychiatric medications for persons with serious mental illness or youth with serious emotional disturbance is a critical element of recovery. Lack of access to medication can lead to an increase in the likelihood of a relapse, resulting in crisis services, emergency room visits, and in-patient hospitalization. One of the SAMHSA Evidence-Based Practices (EBP) is Medication Management involves the consistent use of medications as a part of the treatment for schizophrenia.

Access to medication is a problem. On July 24, 2008, Dr. Blaine Shaffer, Chief Clinical Officer for the Division of Behavioral Health noted the following:

> While Nebraska is doing well serving indigent consumers who have been committed for Mental Health treatment, many consumers who are voluntarily treated have difficulty gaining access to medications in a timely manner. Medications are expensive and those who are non-insured or under-insured often can not afford them. The shortage of trained Behavioral Health providers also impacts the ability to receive quality care including medications.

The overmedication of children was also discussed by State Advisory Committee on Mental Health Services on August 12, 2008 as part of the review of the NE FY2009 draft application for the Federal Community Mental Health Services Block Grant. This discussion needs to include how some children can be overmedicated as a quick fix. When this happens, it can cause some immediate problems as well as set up the youth for problems as an adult. Improved medication management is needed for youth.

- Medication Access was first noted as a problem as a result of comments collected by the "ACCESS TASK FORCE" Forum held on January 20, 2000 in Omaha by the Nebraska Mental Health Planning and Evaluation Council (MHPEC). Those comments included:
  - Many times know someone needs to get into hospital, but are not yet to the crisis level of MI & Dangerous. If not eligible for Medicaid or Medicare, it is real hard to get money for the medications. If you can get the medications you can prevent the need for the hospital bed.
  - substance abuse is self medication ... abuse and violence may come with it.
  - access to insurance company - need 20 phone call to get care ... a barrier to services
  - working poor - person is not eligible for Medicaid because they work but do not earn enough to pay for the medication. With Medicaid you can usually find someone who can take care of the individual ... the working poor need some mechanism to access the care.
  - One person testified he was on 8 different medications in last 15 years.
  - Trouble in rural NE not the same in urban NE … shortage of psychiatrists.

This is from the MHPEC Strategic Planning meeting on April 12, 2002.

- Lack of access to medication is a concern because:
  - there is not a stable reliable source of medications for people with mental illness.
  - no clear cut mandate on who is to pay for what. Everyone wants to be the one who pays last dollar.
- Lack of Access to Medication" Theme: Reducing the barriers to getting the right drug to the right recipient in the right dosage by the right route at the right time to consumers in community mental health settings.

Specific populations impacted by lack of medications include:

1. Consumers, family members
2. County Level Services: Counties, County Attorneys, Mental Health Commitment Boards, Sheriffs (transportation), Veteran Service Center, County Corrections
3. Service Providers: Regional Centers, Community Mental Health providers, Emergency Care Centers, Housing providers; Pharmacies, Physicians, and other health care practitioners, Nebraska Medical Association's mental health task force, Regional Governing Boards, Law enforcement, Corrections ...
4. Payers: Medicaid, Medicare, Managed Care Companies, Private insurance companies, SSI, SSDI, and Nebraska Department of Health and Human Services.
5. Resources: Drug companies, Pharmacies ...
6. Advocates / allies: Nebraska Association of Behavioral Health Organizations (NABHO), National Alliance for the Mentally Ill-Nebraska (NAMI-NE), and Mental Health Associations of Nebraska.

Trish Blakely, Healthy Families (August 11, 2004): "It is also a tremendous problem trying to locate a psychiatrist to prescribe medication. There seems to be a very long waiting period to see a psychiatrist. Families have little selection about whom they see due to the choices available and if there is a crisis situation there is little probability that they will be able to reach a psychiatrist to get

assistance. This happens over and over with families in Healthy Families Project and the Family Resource Center."

Nebraska does fund medications. Examples include:
- Medication Management
- "LB95" Psychiatric Medications Indigent Drug Reimbursement
- Medicaid Behavioral Health Drug* Expenditures

Medication Management
According to the Behavioral Health / Medicaid "yellow book", the Medication Management service definition was approved by the HHSS Policy Cabinet on 12/17/2005. This service is still purchased today. This service definition along with others applied to both the Behavioral Health and Medicaid Divisions. These Service Definitions and Utilization Guidelines, which included Medication Management, were for the Adult Mental Health System. Here is some of what the Medication Management Service Definition said:
- Basic definition: Evaluation, provision and monitoring of psychotropic medication and symptom management
- Services
    - Psychiatrist, Psychiatric APRN+, evaluation of need for psychotropic medication. BH: Include PA+ supervised by psychiatrist.
    - Provision of prescriptions for psychotropic medications
    - Ongoing medication monitoring

- Consumer Need
    - Requires control of symptomology related to psychiatric disorder with need for improved functioning
    - BH: 1+ functional limitations (social, occupational, educational, interpersonal, self care)
    - Determination and initiation of a treatment plan
    - Assessment of re-emerging psychiatric symptoms or medication side effects
    - DSM (current version) (Axes I-V) diagnosis

- Utilization Guidelines / ADMISSION (All are required):
    1. Valid principal DSM (current version) diagnosis in Axis I or II
    2. Need for prescribing and monitoring psychotropic medications
- Utilization Guidelines / DISCHARGE
    1. The individual no longer requires psychotropic medications.
    2. The individual no longer meets Continued Stay Guidelines, or meets Guidelines for a less or more restrictive level of care.

NOTE: Provision of medication management service by APRN and the supervision required.
- Advanced Practice Registered Nurse (**APRN)**
- Nurse Practitioner (NP) is a term for the Advance Practice Registered Nurse

- There is no credentialing for physicians who evaluate or provide psychotropic medications; or who supervise Physician Assistant **(PA)** or Nurse Practitioner (NP) to do so. In other words, any physician under his or her NE license could do either of these things, from a licensure standpoint. The Medicaid "yellow book" requirement as stated below (see above) seems to imply that there is some type of credentialing of physicians who are not

psychiatrists to be able to evaluate and provide psychotropic meds or to supervise PAs and NPs to do so, such is not the case, at least from a licensure standpoint.

- Medicaid program reimburses family practice physicians for all Evaluation and Management (E&M) codes for any diagnosis, whether it is psychiatric or medical. Between July 2007 and May 2008, Medicaid paid approximately 2700 claims with a primary psychiatric diagnosis submitted by family practice doctors. It is not necessary for family practice doctors to be credentialed into the Magellan network of psychiatric providers in order to provide medication management services to psychiatric patients.

The FY2010 (from July 1, 2009 to June 30, 2010) Regional Contract for Behavioral Health and Network Management Services between the DHHS Division of Behavioral Health and the six Regional Governing Boards includes funds for this service.

Medication Management – MH (FY2010 Regional Contracts)

Region	FY2010 Region Total
1	$83,219
2	$302,557
3	$297,212
4	$73,734
5	$192,210
6	$232,495
state total	$1,181,427

NOTE: The Mental Health Services includes both Fee-For-Service (FFS) and Non-Fee-For-Service (NFFS). The names of the services include Medication Management – MH, SE - Medication support, Children's Medication Management – MH, CAG- Medication Management Rural MP, and Urgent Medication Management – MH.

- SE means Service Enhancement
- CAG means Capacity Access Guarantee
- Med Management means paying for the medical personal needed to administer the medication needed

Nebraska Medicaid Behavioral Health Drug* Expenditures by Service date
Nebraska Medicaid Behavioral Health Drug Expenditures July 2009
Claims Paid through June 2009

	Age 0 through 17	Age 18 and Over	Total
FY 2004	$14,258,697.47	$64,381,847.46	$78,640,544.93
FY 2005	$17,328,589.25	$72,310,510.26	$89,639,099.51
FY 2006	$20,264,788.00	$58,157,873.13	$78,422,661.13
FY 2007	$22,565,922.89	$34,944,549.34	$57,510,472.23

FY 2008	$24,928,579.20	$37,720,741.77	$62,649,320.97
FY 2009	$25,150,687.31	$39,157,281.93	$64,307,969.24

Note: Report is for claims paid during each state fiscal year, July-June. Medicare Part D was implemented in January 2006, which lowered state drug costs for ages 18 and older.

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"LB95" Psychiatric Medications Indigent Drug Reimbursement

In 1981, the Nebraska Legislature authorized the indigent outpatient prescription medicine program. Within the Nebraska Behavioral Health System, the program is generally referred to as "LB95 Meds". The state statute that authorizes the program is Nebraska Rev. Stat. § 83-380.01. The "LB95" Psychiatric Medications Indigent Drug Reimbursement website was updated in October 2008 in order to help improve access to the program. As a result, the detailed eligibility procedures are on the Nebraska Department of Health and Human Services, Division of Behavioral Health web site under Community-based Services, Psychiatric Medications for the Indigent.
http://www.dhhs.ne.gov/beh/LB95/index.htm

Nebraska residents who have been committed by a mental health board are eligible to receive some medications to support their recovery. A person must have been committed and in active recovery to receive these benefits. Payment is for extremely low income people. A commitment is made through a Nebraska Mental Health Commitment Board, as described in the Nebraska Mental Health Commitment Act. (N.R.R.S 71-900 et seq.). For more information on the Nebraska Mental Health Commitment Process see http://www.dhhs.ne.gov/beh/Commit/Commit.htm. Medications are only available through the Lincoln Regional Center or the Norfolk Regional center depending on where you live in the state.

NOTE: Beginning July 1, 2006, LB-95 recipients who appear to qualify for Medicare were required to demonstrate that they have applied for enrollment in Medicare Parts A, B and (if found eligible for Part A or B) Part D programs.

The Division of Behavioral Health expends state funds to support this program. Here are the expenditure levels from FY2004 to FY2009.

Indigent Drug Reimbursement	
FY2004	$1,447,566.88
FY2005	$1,785,672.48
FY2006	$1,967,796.62
FY2007	$2,145,076.92
FY2008	$2,135,203.72
FY2009	$2,022,078.12

Source: Lori Dawes, DHHS, Financial Services (07/02/2009)

Here are the number of persons who received LB95 Meds by fiscal year (FY2006 to FY2009).
Note: This is an unduplicated count of persons served.

	HRC	LRC	NRC	TOTAL
FY06	270	291	283	844
FY07	126	246	217	589
FY08	0	340	311	651

FY09*	0	400	174	574

* In FY2009, 30 persons received LB95 Meds from both LRC and NRC. The person served unduplicated count report is based on the facility who last served the individual.

Source: Shirley Baack, Financial Responsibility, DHHS Financial Services – Operations (07/16/2009)

In combining these two data sets, one can show a reimbursement per person.

	Indigent Drug Reimbursement	Number Of Persons	Reimbursement Per Person
FY06	$1,967,796.62	844	$2,331.51
FY07	$2,145,076.92	589	$3,641.90
FY08	$2,135,203.72	651	$3,279.88
FY09	$2,022,078.12	574	$3,522.78

sources:

- The State Advisory Committee on Mental Health meeting on August 12, 2008.
- Nebraska Medicaid Behavioral Health Drug Expenditures by Service Prepared by Heidi Burklund, DHHS, 7-16-2009
- LB95 drug program data from Lori Dawes, DHHS, Financial Services (07/02/2009) and Shirley Baack, Financial Responsibility, DHHS Financial Services – Operations (07/16/2009)
- Dr. Blaine Shaffer, Chief Clinical Officer, Division of Behavioral Health (July 24, 2009)
- "ACCESS TASK FORCE" Forum held on January 20, 2000 in Omaha by the Nebraska Mental Health Planning and Evaluation Council (MHPEC).
- MHPEC Strategic Planning meeting on April 12, 2002

GAP #6: CULTURALLY AND LINGUISTICALLY COMPETENT SERVICES

A service gap in the adult and children's mental health system was identified to be cultural and linguistically competent services. A language barrier was reported in several communities across Nebraska both rural and urban, due to the increase in minority populations living across the state.

The National Center for Cultural Competence defines culture as an integrated pattern of human behavior, which includes but is not limited to thought, communication, languages, beliefs, values, practices, customs, courtesies, rituals, manners of interacting, roles, relationships and expected behaviors of a racial, ethnic, religious, social or political group; the ability to transmit the above to succeeding generations. Cultural competence is a developmental process that evolves over an extended period. Linguistic competence is thus referred to as the capacity of an organization and its personnel to communicate effectively and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with communication disabilities.

This gap in mental health care was first identified nationally in 1999 by the Surgeon General who addressed disparity as lying in the availability, accessibility, and quality of mental health services for racial and ethnic minorities. The Surgeon General made it clear that these disparities result in ethnic and racial minorities bearing a disproportionately high disability burden from mental disorders. The Surgeon General also identified the lack of information regarding the mental health needs of many racial and ethnic minorities as adding to the critical disparity. As part of the

challenge to the nation the Surgeon General released *Healthy People 2010* in early 2000 to address disparities in health care access and outcome.

In December 2000, the Office of Minority Health, U.S. Department of Health and Human Services, published final recommendations on national standards for culturally and linguistically appropriate services in health care. These are meant to be a blueprint for federal and state health agencies, policy makers, and national organizations to build culturally competent health care organizations and workers.

The Culturally and Linguistically Appropriate Services (CLAS) Standards facilitate the closing of this gap. On February 8, 2005 the State Advisory Committee on Mental Health Services first addressed cultural competence goals and objectives. Dr. Maria Prendes-Lintel presented on the fourteen CLAS Standards. These CLAS Standards were identified and members of the committee were asked whether their agencies were in compliance with these standards particularly those that are federally mandated. The lack of resources and complexity in addressing these gaps was discussed as well as the cost and complexity of not addressing these needs. The importance of having competent and trained interpreters was highlighted. The impact of the language barrier was addressed as one of the most critical gaps affecting access, delivery and viable use of mental health services. One way this disparity can begin to be addressed in Nebraska is for the Behavioral Health Council that oversees the Mental Health, Gamblers and Substance Abuse committees to develop a subcommittee to address the cultural competency of those providing services. It is a goal in the future to close this gap and report progress in this area.

Sudanese and Somali Bantu refugees have again been recognized by Tanya D. Cook, Governor's Director of Urban Affairs and Manager, Office of Minority Health. These refugees have unique mental health challenges due to conflicts in their home countries and refugee camps; how issues are handled within family structure and less likely to seek outside help. Stigma associated with life outside the hospital in communities is very strong, and it is different from that of Anglo/Germanic populations. More needs to be understood to help these consumers learn to help themselves.

For these populations, and those of the other 50 racial or linguistic groups who now live by thousands in Nebraska, a common resettlement site for refugees, new realities are being dealt with. For some, they have come to the United States without an older or generation, whose roles are critical in social development, such as for helping to arrange meetings, coordinate relationship and marriages, family counsels and mediation, disputes and collaborations between tribal or political groups. Some have deep feelings of loss and confusion around tradition, spirituality, community building, child rearing practices, new laws and ways that less recent arrivals to America interact. Developing systems which broker relationships between communities and individuals is an art, as much as a science, and is practiced well by a few very helpful individuals, whose time is very limited.

Jackie Miller, Chief Administrator for the Community Health Section in the DHHS Division of Public Health noted the following, “Domestic violence is the norm in Sudanese households. In addition the women are not allowed to speak when interviewed, etc----the men speak for the women. For those women who do break away and get help, the family unit is completely destroyed. The father looses the respect of his children----as he is unable to keep his wife under thumb (especially if she ends up in a shelter). The children also despise the mother in such cases.”

Mary Pipher, Lincoln psychologist and nationally recognized author, notes some of the difficulties other groups face. Of course, the young Sudanese men, who moved here en masse as children,

essentially all male, have few partners to take as wives. Refugees without a social structure which allows them to move into traditional roles of husband, father, religious leader, and other traditional roles. Their role models did not move with them, neither did women of their tribe, race or language. So, once incarcerated for crimes they either did during a mental health or substance abuse episode, they are sometimes misunderstood, and frequently ostracized. Outside, on the street, they may self medicate and thus cut themselves off from support from their only support groups. Among refugees, these who have behavioral helath problems, they are further separated from support.

Among the growing number of middle eastern and eastern populations, even the change in food and daily routines can be enough to cause individuals to despair and decompensate. Their financial expectations/needs/opportunities are limited. Affordable housing is difficult to find. Health providers are largely white, and educated in western medical procedures, so they do not necessarily honor the expectations unlike their own. The consumers have difficulty building trust in the health system, so we rely upon individuals to again break through, sometimes one person at a time.

The State has been using housing vouchers in each Region to help meet the need for housing. State staff have developed mechanisms to work with officers of the law to understand how to work with diverse populations under stress or whose behavioral health is compromised. A promising program which is growing is Region 5's TASC program, which matches a peer consumer and/or social worker with a consumer-in-crisis, for the quickest support possible. Often in 5 minutes, the consumer in crisis can be on the phone with a supporter, and within 45 minutes, a peer and social worker can calmly help alleviate tension which could otherwise arise between a consumer and the law.

The Division of Behavioral Health approaches work on in the area of cultural competence as an opportunity for improvement. The reason is due to the current contract provisions with the six Regions as well as the requirements for National Accreditation means there should be basic compliance. However, there is always room for improvement. Below is a discussion on the current status in this area regarding the Native American Mental Health service expenditures, workforce issues, number of persons served by the NE Behavioral Health System, as well as the role of the Nebraska Office of Minority Health.

Here is an example of how one Regional Behavioral Health Authority, Region V Systems (covering Southeast Nebraska) has worked to address these issues.

CLAS efforts in Region V Systems' Behavioral Health System of Care

In response to the federal Culturally and Linguistically Appropriate Services (CLAS) Standards (2000) and Governor Johanns priority goal to "increase capacity to special populations" (2001), Region V Systems hosted a workshop on CLAS issues in behavioral health care (2002). The event had participation from over 80 behavioral health providers, administrators, and staff.

In 2003 a formal planning process was done with the goal of eliminating barriers to behavioral health treatment. In response to gaps identified in this process Region V Systems created the CLAS Coalition in 2003 and set aside funding to assist in closing those gaps. At the same time Region V Systems created a Bi-Lingual/Bi-Cultural Service Coordinator position. This position was a partnership between Lutheran Family Service and The Hispanic Center (now El Centro de Las Americas).

The CLAS coalition began to meet monthly in late 2003 with participation from Region V Staff, Network Providers, other behavioral health providers, providers of interpretation and translation services, cultural community representatives and others.

The CLAS Coalition focused its resources on the following three target areas in FY03-04 and has continued these efforts since then.

- Developed an annual cycle of CLAS grants to allow agencies to address CLAS issues in behavioral health. The small grants have been used to translate agency documents, provide CLAS training for behavioral health providers, purchase equipment to improve interpretation, provide education for interpreters on working in a behavioral health setting and more.
- Provided a pool of funds for Region V Systems Network Providers to receive reimbursement for interpretation costs incurred while delivering behavioral health services.
- Hosted a Statewide Summit on Quality Assurance in Interpretation. This was followed up by a partnership with the Nebraska Office of Minority Health to host an annual conference on CLAS related issues in health care. The third annual "Missing Links" conference will be held on August 6, 2009.

Additionally, the Region V Systems' CLAS Coalition facilitator, Malcom Miles, has ensured behavioral health representation in other community efforts in Lancaster County including the New Americans Task Force (NATF) and the Medical Translation and Interpretation Leadership Team (MTI).

The New Americans Task Force is a network of public and private organizations and community members, dedicated to supporting New Americans in Lancaster County. NATF strives to welcome all newcomers, assisting them in building the lives they seek through the removal of barriers and the provision of culturally competent support services.

The Medical Translation and Interpretation Leadership Team (MTI) was a three year project (2006-2009) whose goal was to examine and enhance medical translation and interpretation services in Lincoln and Lancaster County through strategic leadership, innovation, collaboration, and advocacy. MTI was sponsored by the Community Health Endowment (CHE) in response to two community reports; *Urgent Matters* a study of Lincoln's healthcare safety net (*2004*, conducted by the Robert Wood Johnson Foundation and George Washington University) and *The Blueprint Project (2002,* conducted by CHE) that identified healthcare issues and solutions in three of Lincoln's census tracts.

Ongoing education, outreach and financial support are necessary for behavioral health agencies to continue to develop culturally and linguistically appropriate services. Interpretation services are a focus of much of the current effort to ensure quality health care. Given that Nebraska has no licensure process for interpreters in health care three main goals have been identified to provide the best possible interpretation services, and thus get positive health outcomes.

- Prohibiting the use of children as interpreters. Region V Systems has created a policy stating that interpreters shall be 19 years of age or older and continues to provide education about the dangers of using children as interpreters but a statewide solution to this problem is needed.

- Pursuing reimbursement strategies for interpretation. Region V Systems' reimbursement funding has established the need for and benefit of providing reimbursement for interpretation services to behavioral health providers. Further funding needs to be pursued.
- Moving Nebraska toward certification or licensure of interpreters in health care. National court interpreter certification provides a model that could be used to ensure that interpreters working in health care provide quality interpretation services, provide risk management for healthcare providers and provide good outcomes consumers.

Under GAP #3: SHORTAGE OF BEHAVIORAL HEALTH WORKFORCE (Updated July 2009) there is a section on "Language Issues". Under this section, it is notes that 698 professionals reported serving clients who speak languages other than English. Various methods of interpretation are used; self interpretation, outside interpreter sitting in the session, and phone interpreter services to communicate with clients. This number includes the NE Behavioral Health Professionals of Psychiatrists, Nurse Practitioners, Physician Assistants, Psychologists, LMHP, LADC, and CCGC.

The Network of Care for Behavioral Health is on the NE Division of Behavioral Health Web site. http://www.dhhs.ne.gov/networkofcare/. The web site can be displayed in 14 different languages. This web site is a resource for individuals, families and agencies concerned with behavioral health. It provides information about behavioral health services, laws, and related news, as well as communication tools and other features. The user of this web resource starts by either selecting a county on the map provided or by viewing a text listing of counties.

The data presented below uses the Nebraska Implementation Report 2008 from the Federal Uniform Reporting System. Here are the numbers of persons served in Division of Behavioral Health funded mental health services as reported under the Federal Community Mental Health Services Block Grant Uniform Reporting System Table 2A (Profile of Persons Served, All Programs by Age, Gender and Race/Ethnicity) and Table 2B (Profile of Persons Served, number of persons who are Hispanic/Latino or not Hispanic/Latino) for FY2008 (July 1, 2007 to June 30, 2008).

2A (Profile of Persons Served, All Programs by Age, Gender and Race/Ethnicity)

2008	American Indian or Alaska Native	Asian	Black or African American	Native Hawaiian or Other Pacific Islander	White	More Than One Race Reported	Race Not Available	Total
	1,079	206	2,903	43	30,687	1,854	139	36,911
	2.9%	0.6%	7.9%	0.1%	83.1%	5.0%	0.4%	100.0%

According to the Nebraska Department of Economic Development web site http://www.neded.org/files/research/statab09.htm

Population, 2007 estimate	American Indian and Alaska Native persons	Asian persons	Black persons	Native Hawaiian and Other Pacific Islander	White persons	Persons reporting two or more races	Total population

	1.0%	1.7%	4.4%	0.1%	91.6%	1.2%	1,774,571

Table 2B (Profile of Persons Served, number of persons who are Hispanic/Latino or not Hispanic/Latino)
2008

Not Hispanic or Latino	Hispanic or Latino	Hispanic or Latino Origin Not Available	Total
34,020	2,510	381	36,911
92.20%	6.80%	1.00%	100%

According to the Nebraska Department of Economic Development web site http://www.neded.org/files/research/statab09.htm

	Persons of Hispanic or Latino origin
percent, 2007	
84.5%	7.5%

The DHHS State Infrastructure Grant (SIG) for Children's Behavioral Health identifies the incorporation of expectations and mechanisms to ensure cultural and linguistic competence across child serving systems as a component of the SIG work plan. As noted above, Nebraska has undergone significant demographic changes in recent years and with that, challenges for the behavioral health system in serving this growing minority and immigrant population. The continued development of a highly trained and competent behavioral health workforce is a critical component of this system of care. Utilizing the resources of SAMHSA, the SIG Steering Committee, and the National Center for Cultural Competence, a strategic plan is being developed to examine the current workforce, identify potential materials to translate and collaborate with the DHHS Office of Minority Health to facilitate curriculum within the NBHS. This effort is an ongoing process that spans both tangible goals as well as systems internal and external culture change. It is the Department's goal to provide compassionate, effective, efficient, culturally and linguistically competent services to children, adolescents and their families.

The Nebraska Department of Health and Human Services / Division of Public Health includes the Office of Minority Health (OMH). This Office works to equalize health outcomes and eliminate health disparities in Nebraska.

Mission of OHA: Equalizing health outcomes and eliminating health disparities

The Nebraska Office of Minority Health is dedicated to improving the health status of racial/ethnic minorities, Native Americans, refugees, and newly-arrived immigrant groups in Nebraska.

Priority Populations:
- Racial/ethnic minorities
- Native Americans
- Refugees
- Newly-arrived immigrants

Priority Issues:
- Improve access to health services for racial/ethnic minorities
- Improve data collection strategies
- Increase racial/ethnic minority representation in science and health professions

- Develop a relevant and comprehensive research agenda
- Expand community-based health promotion and disease prevention outreach efforts.
- Eliminating disparities requires a strong partnership with federal, state, tribal, and local organizations.

The OMH works with
- local and regional health agencies,
- other state agencies,
- faith-based organizations,
- community-based organizations,
- others

OMH develops minority health training materials, and assists / supports minority grantees and organizations working on minority health activities. For more information on the DHHS Office of Minority Health see http://www.dhhs.ne.gov/minorityhealth/

Sources:
- LB 542 (2007) Implementation Report January 4, 2008 titled "Creating Change and Providing Hope for Nebraska's Children, Adolescents and Their Families Pursuant to LB 542" http://www.dhhs.ne.gov/beh/mh/LB542.pdf
- State Advisory Committee on Mental Health Services: Cultural Competence Goals and Objectives. February 8, 2004. Presented by Maria Prendes-Lintel, Ph.D. Licensed Psychologist, Executive Director FIRST Project; and written text 7/22/2005.
- State Advisory Committee on Mental Health Services meeting 5/10/2005 & 8/9/2005.
- Surgeon General's Report, 1999 Mental Health: Culture, Race, Ethnicity. SAMHSA.
- Closing the Gap. A newsletter of the Office of Minority Health, U.S. Department of Health and Human Services. February/March 2001
- Nebraska Community Mental Health Services Block Grant Implementation Report 2004; 2005; 2006; 2007 - Uniform Reporting System (URS).
- Nebraska 2000 State Census Profile; Nebraska Department of Economic Development <http://info.neded.org/neprof00.htm>
- Jose J. Soto, Vice President for AA/Equity/Diversity, Southeast Community College Area, Lincoln, NE; July 2, 2004; email to the six Regional Program Administrators Subject; Unmet Mental Health Needs.
- Source for CLAS efforts in Region V Systems' Behavioral Health System of Care Malcom Miles, Network Specialist with Region V Systems; (402- 441-4359); mmiles@region5systems.net; 07/23/2009

GAP #7: MENTALLY ILL INMATES IN THE STATE CORRECTIONAL SYSTEM

(updated July 23, 2009)

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 continues to be a service gap in Nebraska.

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 16.9 percent of inmates in state prisons have

a mental illness. Researchers found that 14.5 percent of the men and 31 percent of the women interviewed, suffered from serious mental illness.

Please see Table 1 for the rates of mental illness diagnosed at Nebraska state correctional intake facilities for the last five 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.

Table 1: The Rate of Diagnosed Mental Illness at Intake Made By Nebraska Department of Correctional Services

	FY2005		FY2006		FY2007		FY2008		FY2009	
Number of inmates with mental illness	341	16%	645	25%	768	31%	949	40%	656	29%
Total Intakes	2,121		2583		2,447		2,379		2,289	

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, 2009, 1080 inmates were on psychiatric medication which is about 24.1 percent of the inmate population. This rate represents an increase when compared to prior years.

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		On June 30, 2009	
854	20.2%	871	19.4%	858	19.7%	817	18.7%	1,080	24.1%

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		FY2009	
Inmate population with a substance abuse or dependence diagnosis	1,743	82%	1,372	89%	1,782	86%	1,741	89%	1,496	78.6%
Number of inmates screened	2,121		1,538		2,081		1,967		1,903	

Finally, a large number of inmates who were incarcerated for committing sexual offenses are discharged from Nebraska Department of Correctional Services each year. For example, during

fiscal year 2009, 205 inmates who had committed a sexual offense were released. Of that number, 28, or 13.6% were recommended by Nebraska Department of Correctional Services 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 FY2008

Region	**I**	**II**	**III**	**IV**	**V**	**VI**	**Totals**
# Released	13	13	25	20	49	85	205
#Recommended	1	2	4	1	12	8	28

- NOTE for Tables 1 and 3: FY2005 is from July 1, 2004 to June 30, 2005; FY2006 is from July 1, 2005 to June 30, 2006; FY2007 is from July 1, 2006 to June 30, 2007; FY2008 is from July 1, 2007 to June 30, 2008. FY2009 is from July 1, 2008 to June 30, 2009.
- Source for Tables 1, 2, 3, and 4: Nebraska Department of Correctional Services (NDCS)

The Criminal Justice Electronic Data Transfer Interagency Agreement reported on are intended to improve understanding of these issues.

Sources:

- Cameron S. White, Ph.D.; Behavioral Health Administrator, Nebraska Department of Correctional Services - Central Office, Lincoln, NE (July 23, 2009).
- 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
  http://ncja.informz.net/admin31/content/template.asp?sid=15214&brandid=3027&uid=751049109&mi=537980&ptid=55

Nebraska

Adult - Plans to Address Unmet Needs

Adult - A statement of the State's priorities and plans to address unmet needs.

Narrative Question:
Adult - A statement of the State's priorities and plans to address unmet needs.

There are three Adult goals intended to address the State's priorities and plans to address unmet needs.
Adult Goal 1: Statewide Planning (as of August 18, 2009)
Adult Goal 2: Consumer Empowerment (as of August 18, 2009)
Adult Goal 3: Suicide Prevention (as of August 18, 2009)

ADULT GOAL 1: STATEWIDE PLANNING

Under the Nebraska Behavioral Health Services Act § 71-806(1) the Division of Behavioral Health is the **chief behavioral health authority** for the State of Nebraska and shall direct the administration and coordination of the public behavioral health system. One of the duties under the Act as chief behavioral health authority is

> "Comprehensive statewide planning for the provision of an appropriate array of community-based behavioral health services and continuum of care" [see § 71-806(1)(c)].

The Behavioral Health Oversight Commission

The Behavioral Health Oversight Commission was established by the legislature. It is a 12 member board designed to assist the State in reviewing activities of Behavioral Health Reform and reports to the Director of the Division of Behavioral Health. This commission supersedes the Behavioral Oversight Commission of the Legislature that was organized under Legislative Bill 1083 in 2004 that was sunsetted on June 30, 2008. This commission sunsetted on June 30, 2009.

For more details on the Behavioral Health Oversight Commission see:
http://www.dhhs.ne.gov/Behavioral_Health/BHcommission/

The Behavioral Health Oversight Commission approved a Final Report on June 22, 2009. The complete report is on-line at
http://www.dhhs.ne.gov/Behavioral_Health/BHcommission/BHOC-FinalReport-06-25-09.pdf

Below are several excerpts from the Behavioral Health Oversight Commission Final Report

A. Strategic Vision Statement (Page 3)

The Public Behavioral Health System in the State of Nebraska will:

1. Promote wellness, recovery, resilience, and self determination for adults and children and such system will be consumer and family driven;

2. Focus on and create positive outcomes coupled with a performance evaluation process that supports continuous quality improvement for the division as well as the Regional Behavioral Health Authorities, providers and recipients of services;

3. Provide inclusive and transparent planning through genuine partnership and collaboration with a diverse group of stakeholders, including meaningful participation by consumers, to promote a rational, strategic decision-making environment and process;

4. Focus on prevention and early intervention;

5. Share a cooperative and common vision among DHHS divisions regarding recovery, best practice, access to care, and funding;

6. Encourage public/private partnerships;

7. Pursue every opportunity to maximize available revenue sources, including but not limited to Federal grants and maximization and capture of Federal Medicaid match dollars, and these new revenue sources will be reinvested in the behavioral health system;

8. Implement a process that expands the above seven strategic vision statements into specific processes, activities and objectives to be accomplished and provide progress and accomplishment measurements to ensure the above strategic vision statements are effectively implemented.

C. Recommendations (page 7-8)
It is NOT assumed that new money will be available to implement the recommendations in this document. These recommendations assume that in the strategic planning process priorities will be set and an opportunity will exist for discussion on how existing funds may potentially be used differently.

The Commission recommends the following:

2. Suspend the service definition revision process currently underway until the adoption of the strategic plan so that the vision, core values, principles, and definitions of recovery and recovery-based care are be incorporated into new and existing service and support definitions.

3. Suspend the Title 206 Rules and Regulations revision process currently underway until the adoption of the strategic plan so that the vision, core values, principles, and definitions of recovery and recovery-based care can be incorporated into new and existing rules and regulations.

4. Suspend the at-risk managed care planning efforts currently underway until the adoption of the strategic plan so that the vision, core values, principles, and definitions of recovery and recovery-based care can be used to guide discussion, examination, analysis, and decision making around the feasibility of a managed care program in the public behavioral health system.

2. Behavioral Health Workforce Shortage (page 9)
The Commission approved the following outline for "Behavioral Health Workforce Shortage"

There is a behavioral health workforce shortage nationally and in the state of Nebraska. There are an inadequate number of psychiatrists and other mental health and substance abuse professionals to provide necessary services to consumers.

> Education and training are needed to grow the workforce. Collaborate with private, government and academic partners to investigate ways to cultivate a workforce, funding, and incentives for growing the behavioral health workforce.

In the Behavioral Health Oversight Commission Final Report (Approved June 22, 2009), there was a review of LB603 intent to address the Behavioral Health Workforce Shortage (page 10).

LB 603 was signed into law by Governor Heineman on May 26, 2009. LB 603 addresses the behavioral health workforce shortage by establishing a Behavioral Health Education Center. The Center will:

> 1. Provide funding for two additional medical residents in a Nebraska based psychiatry program beginning in 2010 until a total of eight additional psychiatry residents are added in 2013. Each of these residents would participate in rural training for a minimum of one year. Beginning in 2012, a minimum of two of the eight residents would be active in the rural training each year;
>
> 2. Focus on training of behavioral health professionals utilizing the telehealth network that is already established throughout Nebraska. This is particularly helpful to rural areas in Nebraska;
>
> 3. Establish learning collaborative partnerships with other higher education institutions in the state, hospitals, law enforcement, community-based agencies, consumers and their families in order to develop evidence-based, recovery focused, interdisciplinary curriculum and training for behavioral health professionals delivering behavioral health services in community-based agencies and law enforcement;
>
> 4. Beginning in 2011, two interdisciplinary behavioral health training sites would be developed until a total of six sites have been developed. Each of theses sites would provide annual interdisciplinary training opportunities for a minimum of three behavioral health professionals.

A total of $1,385,160 was appropriated from general funds to the University of Nebraska for fiscal year 2009-10 to administer this program.

Recommendation
The BHOC is pleased that LB 603 passed and acknowledges that there is more work required to address the behavioral health workforce shortage, in both rural and urban areas in Nebraska, but this is a great first step.

3. Enhanced Communication and Partnering (Page 11)

The Commission approved the following outline for "Enhanced Communication and Partnering" (page 10-11):

> Foster, encourage and promote creative ways to develop services and supports that consumers want and need while maximizing existing funding, using open communication and developing trusting relationships. We accomplish this by promoting partnerships and multi-dimensional communication among consumers,

the divisions of the Department of Health and Human Services, the Behavioral Health Regions, Regional Centers, Community-Based Agencies, peer providers, law enforcement and Behavioral Health Division advisory committees.

Recommendation (Page 11)

Open communication and development of trusting relationships is an area requiring more development during the strategic planning process. All communication points are either opportunities or missed opportunities depending on how system stakeholders and partners utilize the communication points. Opportunities are designed to enhance communication and partnerships at strategic intersects of the Nebraska Behavioral Health System. Opportunities for communication should be evaluated, refined and improved upon in the strategic planning process. Frequency of such communications should be defined during the planning process.

Nebraska Division of Behavioral Health
2009 Strategic Planning
Overview of the Strategic Planning Process as of 7/20/2009

The Division of Behavioral Health is taking the next steps in Strategic Planning. A strategic plan for the Division of Behavioral health is a dynamic document that charts a course of Division activities based on statutory mandates, statewide priorities and funding requirements.

The benefit of having a strategic plan with flexible, measureable objectives would be to:

- Create a shared understanding of the Division's mission with the public and stakeholders
- Set an example and expectation of accountability and performance
- Encourage thoughtful development of new or innovative behavioral health activities compatible with the vision, mission, values and goals in the plan

The proposed transparent process recommended for developing a strategic plan for the Nebraska Division of Behavioral Health:

- Builds on previous planning efforts
- Incorporates the work of legislative groups like the behavioral health oversight commissions
- Includes stakeholders and the public

The strategic planning process has been underway for some time. It began with behavioral health reform in the adult system, continued through the development of recommendations for children's behavioral health and most recently included visioning work by the Behavioral Health Oversight Commission II. Proposed key milestones in the ongoing strategic planning process include:

- Obtaining input from the public and stakeholders on proposed strategic plan elements (July 2009)
- Drafting a strategic plan document based on previous work and public input (August 2009)
- Obtaining feedback from the public and stakeholders on the draft document (September 2009)
- Creating work groups to craft and monitor objectives and performance measures related to goals and specific populations or initiatives (October 2009)

The resulting strategic planning document will set the course through 2014 but goals and objectives will be continuously reviewed and updated to reflect Nebraska priorities and opportunities.

The timeline for completion of the plan document is ambitious given the level of transparency and public participation anticipated. The University of Nebraska Public Policy Center has been placed under contract to assist with document production and facilitation of the planning process. Division personnel will be integrally involved in the process.

Frequently Asked Questions (FAQ's)

Q. Why is strategic planning happening now?

A. Behavioral health reform efforts made possible by legislative action and reports from Behavioral Health Oversight Commissions have set the stage for strategic planning. It is anticipated that a strategic plan will guide the Division of Behavioral Health by creating measurable objectives as benchmarks to assess the Division's progress toward accomplishing its mission.

Q. Hasn't Nebraska been involved in numerous other planning efforts related to behavioral health?

A. Yes, formal planning efforts have taken place in many areas related to behavioral health. It is important to recognize and value previous planning by building on those recommendations.

Q. Who is involved in strategic planning for the Division of Behavioral Health?

A. The planning process begins by recognizing all the work that has already taken place in previous planning efforts like the children's behavioral health state infrastructure grant project, justice and behavioral health planning, gambling assistance program planning, early childhood mental health, substance abuse planning, behavioral health oversight commission work and the planning that has been part of behavioral health reform. The Division would like to be inclusive and transparent in the planning process. Although some work will be done by the Division, it is imperative that anyone with an interest or stake in the Division's work be involved.

Q. How can I be involved in the process?

A. There are several ways to be involved. Throughout the process there will be opportunities to provide comments or voice your preferences via web-based surveys, in-person meetings with Division personnel and of course comments are always welcome via email or in writing. In the fall of 2009 there will be additional opportunities for involvement in work groups charged with developing measurable objectives for areas whose responsibility overlaps with other State agencies or divisions like suicide prevention, justice and behavioral health, workforce development, children's behavioral health and funding of services.

Q. When is strategic planning going to start?

A. The planning process began with behavioral health reform. The continuation of this planning process will be most evident in July and August 2009 as the Division gathers input from Nebraskans across the state about its mission and proposed goals based on the vision set by the Behavioral Health Oversight Commission II at the end of June 2009.

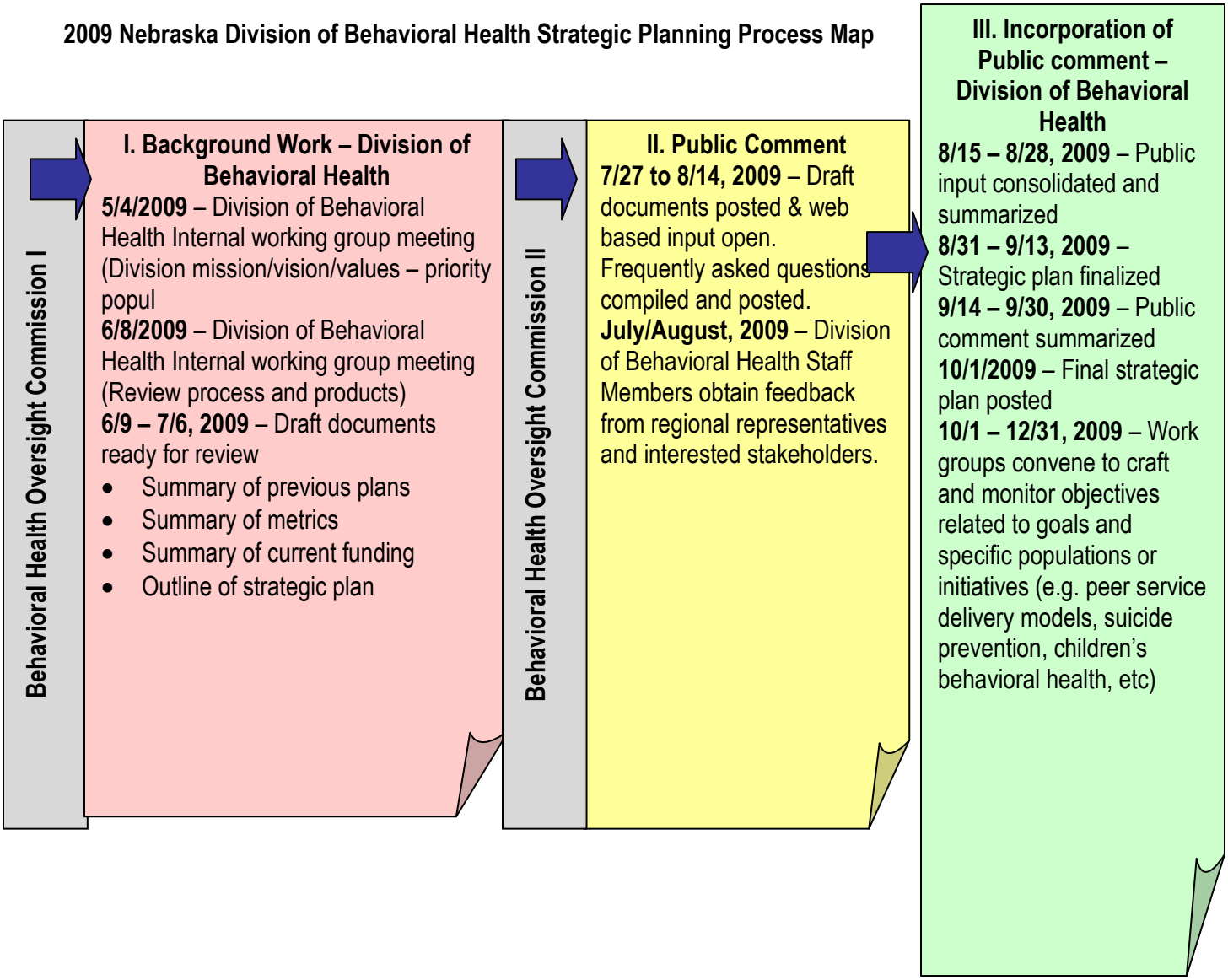
Q. When will a planning document be ready for review?

A. A draft of the plan will be available at the end of August 2009.

Q. Where can I find out more about the Division of Behavioral Health's strategic planning process?

A. Information about the process will be posted on our website http://www.hhs.state.ne.us/Behavioral_Health/

2009 Nebraska Division of Behavioral Health Strategic Planning Process Map



At the State Advisory Committee on Mental Health Services meeting August 13, 2009, there was a considerable discussion on this strategic planning section.

- As documented above, the Division of Behavioral Health has been preparing for a strategic planning effort.
- As a result of a very generous offer from the private sector, the Administration is considering additional options for a statewide strategic planning effort.

At the State Advisory Committee on Mental Health Services meeting August 13, 2009, there were some public comments on the Behavioral Health Oversight Commission recommendations. The Division of Behavioral Health received the recommendations.

- Regarding #2 (Suspend the service definition revision process) - The Division is proceeding with the Service Definition work. There have been four (4) drafts reviewed and published to date. The package of service definitions will be moved into the draft Title 206 Regulations. As a result, they will undergo another public review through the regulation review process.
- Regarding #3 (Suspend the Title 206 Rules and Regulations revision process) - The Division is proceeding with the development of the Title 206 Rules and Regulations revision process. To date, there have been a number of drafts produced with input from a variety of stakeholders.
- Regarding #4 (Suspend the at-risk managed care planning efforts) - the Division of Behavioral Health has put this project on the back burner for now.

Planning on Criminal Justice and Behavioral Health

The Nebraska Division of Behavioral Health is also working in the area of criminal justice and mental health partnerships. The general issue is to decrease criminal justice involvement for people with behavioral health problems in Nebraska.

The NE Department of Health and Human Services applied for a grant from the U.S. Department of Justice - Office of Justice Programs - Bureau of Justice Assistance under the Justice and Mental Health Collaboration Program (CDFA #16.745). The Nebraska grant title is the "Nebraska Justice-Mental Health System Collaboration Planning Project".

Justice and Mental Health Collaboration Program grants are available in one of the following three categories. Each category requires a joint application with a mental health agency and unit of government responsible for criminal and/or juvenile justice activities.

- CATEGORY I: PLANNING – Grant maximum: $50,000. Project period: 12 months. Category I applicants (local or state level) will design a strategic, collaborative plan to initiate systemic change for the identification and treatment of offenders with mental illness.
- CATEGORY II: PLANNING AND IMPLEMENTATION – Grant maximum: $250,000. Project period: 36 months. Category II applicants will complete an already-initiated strategic plan for their mental health collaboration, and then begin implementation of the plan during the project period.

The Nebraska Justice-Mental Health System Collaboration Planning Project seeks to increase public safety through innovative cross-system collaboration for individuals with mental illness who come into contact with the criminal or juvenile justice systems. In August 2007, the Department was notified of the grant award. Specifically, the grant is:

- CATEGORY I: PLANNING ($50,000)
- PROGRAM PERIOD and BUDGET PERIOD: From 11/01/2007 To 10/31/2008.

– GOAL: The Overarching Goal for the Office of Justice Programs grant is to improve the cross-disciplinary system of care for persons with mental illness who encounter the criminal justice system in Nebraska by strengthening early intervention efforts to mitigate recidivism and prevent persons, especially juveniles, from cycling through institutionalized settings throughout their lives.

The Division of Behavioral Health was designated as the administrative unit responsible for this grant. The Division has contracted with the University of Nebraska Public Policy Center (UNPPC) to implement the grant and facilitate the strategic planning process from initiation to conclusion. Dr. Mark DeKraai, UNPPC Project Director, leads this work.

The Division planned and held a strategic planning workshop on December 5 & 6, 2007 for 59 key stakeholders to identify gaps, strengths, priorities and strategies at both the state and local levels based on the sequential intercept model. This meeting was well received and generated tremendous enthusiasm across the state. The report from this workshop was completed. The report can be found at the following address:
http://www.hhs.state.ne.us/beh/NE_CriminalJusticeMHReport&Attachmts-Jan28_2008.pdf

The report outlines the information presented during the two day session, summarizes the strategic planning outputs, and provides 14 recommendations for moving Nebraska forward in addressing the needs of justice involved individuals with mental illness. A Steering Committee was developed from the participating state agencies for this planning project.

Nebraska's Justice Behavioral Health Initiative builds on transformation efforts for adults (LB 1083, 2004) and children/youth (LB 542, 2007) to improve access to high quality, community based mental health and substance abuse services so people can be served closer to their homes and families. Funded initially through a U.S. Department of Justice Planning Grant and currently through a U.S. Department of Justice Planning and Implementation Grant, the purpose of the Nebraska Initiative is to build collaborative partnerships to address interagency coordination and communication in order to implement system improvements for persons with mental illness in contact with Nebraska's criminal justice system. Nebraska envisions a comprehensive approach to screening, assessing, and treating the mental health needs of individuals involved in the juvenile and criminal justice systems. This strategic planning process is designed to focus on priority areas as beginning steps in achieving this vision.

The Justice Behavioral Health Initiative follows the Sequential Intercept Model developed through the GAINS Center. Implementation strategies are intended to provide mental health intervention across the phases of justice involvement – contact with law enforcement, initial detention and court hearing, involvement in with courts and in jail or prison, reentry to the community, and parole/probation.

- Provide statewide mental health intervention training for law enforcement officers and make clear linkages with local crisis response teams
- Expand or improve access to crisis stabilization services with improved coordination with law enforcement officers
- Implement a standardized mental health and substance abuse screening process in the jails that prompt referrals for services
- Increase resources to community mental health to provide diversion services through the use of Forensic Intensive Case Management

- Enhance affordable supportive housing for justice involved adults and youth transitioning to adulthood

The Planning Grant resulted in a Strategic Plan for Justice Behavioral Health in Nebraska can be found at:
http://www.hhs.state.ne.us/beh/NEJusticeMHStrategicPlan-UN_PPCFinalReport-Oct31_2008.pdf

Since completion of this strategic plan, three work teams developed and refined implementation strategies for the five goals. Included here are the final recommendations for action steps for implementation.

The Justice and Mental Health Collaboration Program will increase public safety by facilitating collaboration among the criminal justice, juvenile justice, and mental health and substance abuse treatment systems to increase access to services for offenders with mental illness.

Goal 1: Provide consistent statewide training for Nebraska Law Enforcement Officers to improve responses to people with mental illnesses

1.1 Expose Regional Behavioral Health Authority representatives to the Omaha CIT model
1.2 Build a modularized law enforcement training guide for use in rural areas that is based on Bureau of Justice Assistance recommendations for improving responses to people with mental illnesses that is appropriate for delivery in rural/frontier areas.
1.3 Pilot and evaluate modularized training guide
1.4 Sustain statewide training for law enforcement

Progress: Regions are currently attending Omaha CIT training and reviewing curriculum to adapt to their regions. Risk assessment training materials completed as resource for regions.

Goal 2: Expand or improve access to crisis response services in Nebraska

2.1 Refine crisis response service functions most useful at intercept one (law enforcement encounters)
2.2 Pilot implementation of crisis response service standards in interested Regions
2.5 Implement strategies for sustaining crisis response programs

Progress: Regional crisis teams working on data collection protocols

Goal 3: Implement standardized mental health and substance abuse screening protocols in the jails that prompt referrals for services

3.1 Refine plan for standardized screening and assessment process
3.2 Incorporate processes into Nebraska jail standards
3.3 Develop and provide training and technical assistance for jail personnel
3.4 Evaluate impact of change in standards

Progress: Work team developed recommendations for jail screening protocols which will be submitted to Jail Standards Board

Goal 4: Increase resources to community mental health to provide diversion services through the use of Forensic Intensive Case Management

4.1 Gauge and solicit interest for the planning and implementation of a rural Nebraska post-booking jail diversion program.
4.2 Complete necessary technical assistance and subsequent implementation of pilot rural jail diversion program for transition aged youth in one area of the state in coordination with crisis response teams
4.3 Examine service definitions for community support/case management and examine financing approaches for sustainability
4.4 Study impact of jail diversion pilot

Progress: Invitation issued to regions to submit interest in pilot project. Region 3 selected based on review. Technical assistance provided to start up rural diversion program in Buffalo County.

Goal 5: Enhance affordable supportive housing for justice involved youth transitioning to adulthood and young adults

5.1 Develop housing transition process for persons with mental health challenges being released from Department of Correctional Services including identification, needs assessment, pre-release planning, Rent Wise training, and linkage to community services

5.2 Enhance process for ensuring youth with mental health challenges in the Omaha Youth Independent Living Plan have stable housing and supported employment

5.3 Assist in developing infrastructure for providing Rent Wise training to justice involved transitioning adolescents and young adults with mental health challenges

Progress: Corrections housing team meeting to identify offenders with serious mental illness and develop protocols for transition. Independent Living Plan Team meeting to develop protocols for identifying SED youth and transitioning to housing, employment and mental health treatment.

Jail Diversion Programs as of July 2009

Lancaster County (Lincoln, NE)
The Behavioral Health Jail Diversion Program of Lancaster County (BHJDPLC) began in 2003 through a grant from the Substance Abuse and Mental Health Services Administration (SAMHSA). This 3-year grant provided approximately $300,000 annually in funding. Through August 2009, the BHJDPLC will operate through a combination of funding from the Bureau of Justice Assistance--Department of Justice and the Lancaster County Board of Commissioners. Beginning, September 2009, the Lancaster County Board of Commissioners will provide full sustainability funding for the BHJDPLC.

The Jail Diversion Program seeks to identify potential candidates once they are booked into the Lancaster County Jail. The Program serves persons with a severe and persistent mental illness (SPMI) or co-occurring substance use disorder who have committed non-violent (misdemeanor or felony) offenses. The BHJDPLC has also teamed up with Lancaster County's Community Corrections Agency to work with consumers of the Adult Drug Court and Pre-Trial Services Programs who have severe mental health needs and would otherwise not be able to be served by these programs.

Once a person is diverted from the jail, the Program provides multiple services with two primary goals in mind: (1)-Improve the quality of life for persons served. 2-Eliminate or drastically reduce the “revolving door” in and out of the criminal justice system for persons served. Forensic Intensive Case Managers work with the diverted person to help them meet many basic needs, such as stable housing; obtaining food, medications, dental and medical care; providing transportation to appointments and court appearances; assisting in applications for Medicaid, Medicare, General Assistance, Food Stamps, Patient Assistance Programs for free medications, etc. The Program typically works with individuals for 6 to 12 months. Beyond stabilization services, the Program also ultimately seeks to link diverted individuals into community services where they can receive long-term, less intensive, lower cost, outpatient services.

From November 2, 2003 to July 1, 2009, the program has diverted 235 persons. Collectively, the recidivism rate for this population is approximately 44% over an almost 6 year period. This is compared to a recidivism rate of 87.4% for potentially mentally ill persons incarcerated in the Lancaster County Corrections system who have not received services through the Jail Diversion Program during this same approximate 6 year time period.

Additionally, persons utilizing the Program do not use costly emergency and inpatient services, such as the crisis center, hospital emergency departments, etc. Instead, they are now stabilizing and accessing lower cost, less intensive, long-term outpatient services. Participants also boast improved self-esteem, ability to better deal with crisis situations in their life, and drastically decreased symptomatology.

For more information about the Program, contact Travis Parker, Program Director (402- 441-6610 / <tparker@lancaster.ne.gov>)

Douglas County Jail Diversion Program (Omaha, NE) update June 2009

The Douglas County Mental Health Diversion program is a pretrial diversion program. Individuals most appropriate for participation in the program are those who would most likely not be in contact with the criminal justice system were it not for their mental illness and who exhibit an ability and willingness to seek care and receive assistance from the program. To be eligible, those individuals who respond positively to mental health screening questions and who have a qualifying charge are then screened by staff. To be accepted for services, the following people have to approve: the judge, county attorney and/or city prosecutor, the individual's behavioral health provider, if they have one, and the consumer.

The program started in April 2006. It was funded by Alegent Community Benefit Trust (a local philanthropic organization) through December 2008. Douglas County now funds the program ($150,000 annually) and provides one screener and two case managers as full-time staff. Each case manager serves about 20 consumers. As of May 31, 2009, there have been a total of 127 individuals served, including 65 who have successfully completed the program.

For more information, please contact John Sheehan, Director of the Douglas County Community Mental Health Center (402-444-7608 / John.Sheehan@Douglascounty-ne.gov).

Region 2 Behavioral Health Authority

- In Keith County, Region 2 does an hour of education a week with inmates. Also the jail administers the standardized model assessments on substance use. If an inmate scores high on Drug and Alcohol, a Counselor does an assessment. If the assessment shows that treatment is needed she goes to the jail and does individual treatment.
- In Dawson County Region 2 goes to the jail to teach parenting class for some of the women prisoners. They work with the drug court to provide an education and support group for the female clients.

For more information, please contact Kathy Seacrest, Region 2 Regional Administrator in North Platte [Phone: 308-534-0440 / Email: kathy@r2hs.com].

Region 3 Behavioral Health Authority

Under the Justice Mental Health Grant (Goal 4), a pilot project in Buffalo County for the Jail Diversion will be started in the Fall of 2009.

Trauma-Informed Nebraska (TIN)

The Nebraska Coalition for Women's Treatment was the recipient of a three-year contract from DHHS Division of Behavioral Health. The contract was developed as a proactive response to a consent decree resulting from lawsuits at the Regional Centers. The project has been named Trauma-Informed Nebraska (TIN). The goal of this project is to identify service gaps and modify behavioral health services so the system becomes trauma-informed and moves towards a trauma specific system.

It is the mission of TIN to oversee the development and implementation of a statewide, consumer driven, recovery-oriented trauma project to promote:

- The utilization of consumers/survivors in all aspects of trauma improvements and practices;
- Administrative commitment and capacity to become a trauma-informed system;
- Service provision that is aware of the origins of trauma, effects of trauma on survivors and their loved ones, and the possibility that re-traumatization may occur if safe, effective, sensitive services are not available;
- Brief, focused, non-threatening screening for trauma conducted as early as possible;
- 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;
- Decreasing the stigma surrounding survivors of trauma;
- Policies and procedures that incorporate trauma awareness and use the "expectation, not the exception" guidelines in daily treatment practices; and
- The hiring and development of "trauma champions" in behavioral health services.

TIN membership currently includes individuals and consumers/survivors from the community as well as the Division of Behavioral Health, Regional Centers, Nebraska Advocacy Services and other Consumer Advocacy agencies, Department of Corrections, Behavioral Health Providers, Regional Behavioral Health Systems, Veteran's Administration, Academic Administration and Nebraska Coalition for Women's Treatment. Third year (FY09) activities included the following:

- Implemented Division to Region contract language regarding trauma informed care.

  Contractor will develop and implement strategies to ensure that all behavioral health providers are informed about the effects of psychological trauma, consistently screen for trauma symptoms and history of traumatic events, provide ongoing assessment of trauma symptoms and problems related to that trauma, offer services that are recovery-oriented and trauma-sensitive and understand that re-traumatization may occur if safe, effective, responsive services are not available."
- The Consumer System section of regional budget planning documents, included the following:

  "The Behavioral Health workforce (contracted providers or Regional Behavioral Health Authority providers) will receive training to increase their knowledge level regarding how to deliver services that are trauma-informed."
- Implemented minimum information data elements for inclusion in the provider utilization system. Produced a template for reporting and analysis for numbers of individuals affected by trauma, type of trauma, by gender, by whether the trauma occurred as a child or as an

adult, etc. The collection of the information has encouraged providers to review their process of intake, assessment and treatment planning tools and service interventions.
  - The most frequently reported trauma was traumatic loss of a loved one, followed by physical abuse, emotional abuse and physical assault. Continued review of data will assist the system in identifying training needs, areas to focus on in treatment and implementation of specific best practices.
- Facilitated two state-wide TIN stakeholder meetings.
- Completed four provider trauma informed care reviews. Roger Fallot's trauma assessment model was utilized. Review teams included consumer/survivors, clinicians and TIN members. Team members completed review of policies and processes, interviews with staff and consumers, observations of treatment, and reviewed consumer records. A final written report is given to the provider to assist them with identifying strengths and opportunities to improve the provider's trauma informed care system. The process was so valuable; one region is completing the review process in all contracted providers.
- Collaborated with Regional Administrators and Network Management Team to identify training needs and completed discussion or trainings in all regions.
- A Consumer/Survivor/Recovering Person's Partnership pilot project was initiated. Accomplishments of the project to date include:
  - TIN Project Coordinator provided training on general trauma concepts to consumer/survivor participants.
  - Consumer/Survivors are involved in trauma informed care reviews and received training regarding the review process.
  - Participants attended training on peer support models 16 Steps for Empowerment and Discovery and Seeking Safety. As a result there are peer support groups following these models in the pilot areas as well as other regions.
- Collaborated on an educational film regarding prostitution and sex trafficking as it relates to trauma and treatment and supportive interventions.
- In June 2009, requested consultation from NTAC to build an infrastructure to support a trauma informed and trauma specific system of care in Nebraska.

Coercion Free Nebraska

Coercion Free Nebraska (CFN) is a statewide coalition of public and private members dedicated to reducing the use of restraint and seclusion in Nebraska health systems and facilities. *CFN envisions a future in which all providers throughout the state of Nebraska adopt a trauma informed system of care*. Charged with identifying interventions aimed at preventing and reducing the need for restraint and seclusion, Coercion Free Nebraska looks to early interventions designed to minimize and quickly resolve conflicts that do occur, using the least restrictive method possible.

Evidence indicates that the use of restraint and seclusion presents significant risks, including:
- The potential to be physically dangerous and traumatizing for both individuals and staff; effects of trauma are pervasive on a child's overall well-being.
- Subjecting individuals with a history of trauma to any form of restraint can retraumatize them, significantly rolling back recovery.
- Physical injuries and deaths resulting from the use of restraint and seclusion present significant agency liabilities for both individuals and staff.
- Persons who are subject to restraint and seclusion frequently experience a loss of dignity, further compromising recovery and empowerment.

Restraint and seclusion are not therapeutic interventions but rather *safety* interventions of last resort and should be utilized *only* when there exists an *imminent* risk of danger to the individual or others and *all* other less-intrusive alternative interventions have been exhausted.

Coercion-Free Nebraska is committed to preventing, reducing, and ultimately eliminating the use of physical, mechanical, and chemical restraints and seclusion in out-of-home and residential treatment facilities across Nebraska. Future goals of CFN include continued growth and involvement of public and private agencies, additional opportunities for peer sharing, identification and engagement of key leaders, and a commitment statewide to restraint and seclusion free treatment environments.

For additional information or to learn how you can become involved, please visit www.cfnebraska.org.

Continuous Quality Improvement Program

In July 2008, the Director of the Division initiated a Quality Improvement (QI) Program. A QI Manager was appointed to coordinate the CQI Program Plan. A formal reporting structure to implement the CQI Plan was developed and is outlined below

Leadership and Stakeholders

The Director and Administrator establish priorities and provide direction for the Annual CQI Plan.

The Divisions Quality Improvement Team (DQIT) provides ongoing operational leadership of CQI activities. Staff members of DBH comprise the team. Meetings were initially held on a monthly basis but now meet weekly for one hour.

Behavioral Health Advisory Committees for MH, SA and GAP contribute to the development and implementation of the annual CQI plan and activities. The committees meet quarterly and advise DBH on the CQI Plan and initiatives.

The Stateside Quality Improvement Team (SQIT) is primarily responsible for the identification and prioritization of opportunities for improvement, development and implementation of processes to ensure improvement, selection of performance measures, revisions for the annual CQI plan, reviewing data and recommending quality initiatives and studies. The DBH Office of Consumer Affairs established an application process for consumer and family participation on SQIT. The selected members are in addition to the regional consumer specialists who participate. Consumers and families will comprise approximately 50% of the voting membership. The Office of Consumer Affairs selected 6 members who had lived experience with MH, SA, and Problem Gambling and/or as family members of individuals with lived experience. SQIT membership also includes regional staff and providers, DHHS consultants from DBH, Medicaid, Children and Family Services and staff from the ASO vendor.

Community Quality Improvement Teams (CQIT) contributes to the development and implementation of CQI activities at the local level (provider, regional, organizational). Representatives will provide ongoing information and data exchange between the local level and the SQIT. The DBH QI Manager will coordinate technical assistance and QI study groups to ensure improvements are made at the local level on a timely basis.

Through the formal structure, on an annual basis, leaders and stakeholders will identify priority questions the system should answer to improve service delivery and outcomes for consumers and families. Annual goals will be established, performance measures selected, data will be reviewed and provide information for decision making and improvement.

QI Forums
QI forums were held in all six BH regions to share the Division's CQI plan. Regional staff, providers, consumers and families participated in the forums. The desired outcome of the forums was the identification of suggested performance measures for the FY10 contract. Small group processes were implemented to identify top questions members wanted answered by the DBH. Questions such as, "How long do I have to wait to enter services?" Or "Are the services improving the functioning of individuals served?" The group also identified goals/outcomes for each of the questions and recommended a performance measurement for each question. Participants prioritized their work and selected at least one performance measure to be forwarded to the Statewide Quality Improvement Team (SQIT). The SQIT will select the statewide performance measures to be used in FY10 at their first meeting scheduled on August 7, 2009.

MQIT
The DHHS Divisions of Medicaid and Long Term Care, Children and Family Services and the Division of Behavioral Health (DBH) entered into a 2 year contract with an ASO vendor on July 1, 2008.

The RFP and resulting contract required Division participation in the vendor's Quality Improvement Committee. DBH establish the M-QIT (Magellan Partnership Quality Improvement Team) to improve data entry and data quality related issues.

Goals of the Committee include:

- 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; and
- Reviewing reports and recommending content and format improvements to ensure the presentation of meaningful data.

Stakeholders on MQIT include providers, regions, consumers and staff from the vendor.

The committee meets monthly.

ADULT GOAL #2: EMPOWER CONSUMERS (July 24, 2009)

- The State's Priorities and Plans To Address Unmet Needs.

The Division of Behavioral Health is working on a variety of strategies to empower consumers. The Office of Consumer Affairs is established under the Nebraska Behavioral Health Services Act (§71-805). The Act authorizes the following:

> Section 71-805 (1) The director shall appoint a chief clinical officer and a program administrator for consumer affairs for the division. The chief clinical officer shall be a

board-certified psychiatrist and shall serve as the medical director for the division and all facilities and programs operated by the division. The program administrator for consumer affairs shall be a consumer or former consumer of behavioral health services and shall have specialized knowledge, experience, or expertise relating to consumer-directed behavioral health services, behavioral health delivery systems, and advocacy on behalf of consumers of behavioral health services and their families. The chief clinical officer and the program administrator for consumer affairs shall report to the director. The Governor and the director shall conduct a search for qualified candidates and shall solicit and consider recommendations from interested parties for such positions prior to making such appointments.
(2) The director shall establish and maintain an office of consumer affairs within the division. The program administrator for consumer affairs shall be responsible for the administration and management of the office.

Office of Consumer Affairs – On April 1, 2009, Scot Adams announced the appointment of Carol Coussons de Reyes, CPS, MS, as Administrator for the Office of Consumer Affairs., effective May 18, 2009. The Administrator for the Office of Consumer Affairs is responsible for the administration and management of the office. The Administrator of the Office must be 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.

Dan Powers participated in recruiting applicants for the Administrator for the Office of consumer affairs by advertising the position with nationally known consumer websites, reviewing top applicants' resumes, and making key recommendations in interview candidate selection. He then participated in the interviews of the candidates for the Office and made recommendations on candidate selection.

Phyllis McCall facilitated regular meetings at the Lincoln Regional Center for peers in the Wellness Recovery Action Plan, NAMI Connections, and Rent-Wise. Phyllis and Sandy Omeara co-lead a Women's Group at the Lincoln Regional Center that encourgages women to talk about issues related to trauma and their stay at the hospital.

Phyllis McCall entered data from charts and volunteer surveys for a Trauma Related Care Improvement Initiative and provided coordination for the Consumer Advocacy Team at Lincoln Regional Center.

The Office of Consumer Affairs had a meeting on July 27, 2009 to determine what model of peer support training the State of Nebraska would like to purchase with a Technical Assistance Grant for the National Association of State Mental Health Program Directors. The OCA is also hosting 7 town hall meetings this year to discuss current and future peer support initiatives in Nebraska.

NOTE: for more information on the TTI grant funding the development of Peer Support, see Adult - Child - New Developments and Issues / August 18, 2009.

The State of Nebraska funds seven (7) Consumer Specialists that work in each of the six Regional Behavioral Health Authorities (Region 2 has two half time Consumer Specialists). At the Regional level, consumer participation is expected within the following areas of responsibility:

1. Policy And Regulation Development,
2. Program Planning, Including Needs Assessment, Development And Delivery,
3. Training and Technical Support,
4. Financial Planning,
5. Complaints and Grievances and
6. Trauma-Informed and Recovery-Oriented Services.

Dan and Phyllis coordinated the September 16-18 2008 Consumer Conference held at the Leadership Center in Aurora, NE. There were 75 consumer participants. This conference invitation was exclusively extended to a consumer audience.

The conference featured 4 Keynote Speakers: Steve Harrington of the National Association of Peer Specialists, Ken Timmerman of Region 6, and Dr. Stuart Munro, and Kim Carpenter. The speaker topics included: "Three Roads One Journey; a Story of Recovery by Ken Timmerman,; "Ready, Set, Do It" by Steve Harrington; "Choices in Recovery: What's In It for You" by Dr Stuart Munro and "From Recovery to Uncovery and Discovery by Kim Carpenter. In addition there were ten workshops presented. The conference also had eight conference guides who met with consumers who were divided into four teams.

Steve Harrington received an honorarium of $1000 while the rest of the speakers presented without charge. The Leadership Center in Aurora was paid $14,034.

Dan and Phyllis planned the event with the assistance of a planning committee composed of the following consumer leaders: Jan Baxter, Linda Bleck, John Butler, Joleine Hall, Judie Moorehouse, Cindy Scott, Kenneth Timmerman,Tami Walden, and Chris Dominguez.

Dan Powers represented the state of Nebraska by attending the National Consumer Memorial in Washington, DC at St. Elizabeth's Hosptial Cemetary. This National Memorial is part of Dan Power's vision of how individuals should be remembered that died in State Hospitals across the country. Dan has been interviewed by the media about his participation.

NOTE: for more information on this, see Unmarked Grave Memorial under Adult - Child - New Developments and Issues / August 18, 2009.

FY 2010 CONSUMER INITIATIVES	Total
National Alliance for the Mentally Ill –Nebraska - The Office contracts with the National Alliance for the Mentally Ill -Nebraska contract with this national advocacy organization to provide Family to Family, Peer to Peer, Connections, and Basics support groups and training.	$46,500
League of Human Dignity - This contract is used to fund cash advances and reimbursements to consumers in order to help consumers attend meetings, workgroups and conferences.	$22,500
Mental Health Association of Nebraska - The Office contracts with the Mental Health Association to provide basic WRAP, WRAP for Vets, and Spanish WRAP to consumers that request them from the Association and the Office of Consumer Affairs. The Association will provide needed accommodations to support peers attending Regional Town Hall meetings with consumers on Peer Support in September 2009. Also, MHA will provide $5,000 in scholarships to consumers attending Alternatives, a national consumer conference that will be held in Nebraska.	$18,500

FY 2010 CONSUMER INITIATIVES	Total
Consumer Network Initiative- The State of Nebraska will fund a starter grant for a community partner to ally in providing annual trainings for peer specialists in Nebraska.	$46,500
Partners in Recovery – for substance abuse consumers, networking, creating new opportunities for people in recovery to meet and to help one another in settings that are casual, comfortable, local, fun, and above all, safe because they are among recovering communities.	$46,500
Federal MH Services Block Grant 5% administrative set aside to fund two Consumer Liaisons & Annual Consumer Conference. This year the funds for the Annual Conference are going to support the participation in a national consumer led conference in Nebraska called Alternatives. Approximately 50 individuals will benefit from this opportunity.	$98,695
Regional Consumer Specialists in each Region. The Consumer Specialists will help to assure that Consumers will have input in policy and regulation development, program planning, service delivery, training, technical support, financial planning and the review of complaints and grievances.	$300,000

Alternatives Conferences (October 28, 2009 through November 1, 2009)

The 23rd Annual Alternatives Conference has been scheduled to be held in Omaha, Nebraska. Each Alternatives conference offers in-depth technical assistance on peer-delivered services and self-help/recovery methods. Beyond the exchange of knowledge and networking, Alternatives offers a rich social, artistic, and healing environment. The only national mental health conference organized by and for people with psychiatric labels, the next Alternatives Conference will be held Wednesday, October 28, 2009 through Sunday, November 1, 2009, at the Hilton Omaha.

Each year, DHHS Division of Behavioral Health-Office of Consumer Affairs pays for (with funding from the 5% administrative portion of the Community Mental Health Services Block Grant) and helps organize an annual Consumer Conference which features three days of learning, sharing, and networking. The conference also gets support from national, state and local Mental Health Officials.

This is a great opportunity for Nebraska consumers to attend Alternatives Conference this year. In order to support Nebraska consumers, the Division of Behavioral Health has decided to not hold the annual Nebraska Consumer Conference in 2009. Instead, the funding for this annual Consumer Conference will be used to support consumers attending Alternatives Conference in Omaha. This is just for this year. The Office of Consumer Affairs will continue to have a Nebraska Consumer Conference in future years. It will be changed by what is learned at the Alternatives Conference.

ADULT GOAL 3: SUICIDE PREVENTION (August 18, 2009)

Suicide prevention is a process that is multifaceted effort that addresses the mental health needs of Nebraskan children, adolescents, and adults. Dr. Blaine Shaffer, Chief Clinical Officer for the Division of Behavioral Health, attends the meetings of the Nebraska State Suicide Prevention Committee. The Nebraska State Suicide Prevention Committee has the following proposed goals:

1. Maintain our website dedicated to suicide prevention for use by the community, consumer, and clinician to access Nebraska suicide prevention efforts. This website address is www.suicideprevention.nebraska.edu
2. Update 'Gatekeeper' training for public education (K-12) and college-age youth
3. Update 'Gatekeeper' training for law enforcement, and clergy

4. Develop a two year plan for coordination and implementation of a continuing education program that allows for the improvement of mental health clinician competency in identifying suicide risk
5. Support the Nebraska Suicide Prevention Coalition in becoming a state-wide coalition utilizing telehealth resources
6. Provide state-wide education designed to identify depression symptoms on both the community level and health-care level
7. Work with NAMI, and other community efforts to reduce the stigma of mental illness
8. Develop and provide the LOSS (Local Outreach to Suicide Survivors) team in Lincoln/Lancaster County as a pilot project with a plan to help other communities across Nebraska replicate
9. Develop a Means Awareness public campaign twice a year
10. Encourage local school districts to address suicide prevention by engaging formalized programs such as SOS and Teen Screen
11. Provide adult and youth detention centers resources to address suicide prevention
12. Recommend to the State of Nebraska Department of Education to require teachers in renewing teacher certificates to demonstrate at the minimum a three-hour competency training in recognizing signs and symptoms of suicidal behavior. Accessing free or low-cost on-line training could be an option.
13. Require all out-of-home placements for children and youth to complete a minimum of a two-hour competency training in recognizing signs and symptoms of suicidal behavior. Accessing free or low-cost on-line training could be an option.
14. Coordinate efforts with the Veteran's Administration to develop a system of support that will promote positive mental health in the process of veteran's reintegrating into the community
15. Work with the Native American tribes and other minority groups in developing culturally competent suicide prevention efforts
16. Provide mini-grants with the support of a Nebraska Foundation and oversight by Interchurch Ministries so that communities across Nebraska can have access to funds to help them develop evidenced based suicide prevention programs.

The Division of Behavioral Health applied for the Federal Center for Center for Mental Health Services grant titled "Cooperative Agreements for State-Sponsored Youth Suicide Prevention and Early Intervention" (Short Title: State and Tribal Youth Suicide Prevention Grants) in April 2009. The anticipated award is up to $500,000 per year for up to 3 years. The Division of Behavioral Health expects to hear about this grant award by September 2009. The purpose of this program is to build on the foundation of prior suicide prevention efforts in order to support States and tribes in developing and implementing statewide or tribal youth suicide prevention and early intervention strategies, grounded in public/private collaboration. Such efforts must involve public/private collaboration among youth-serving institutions and agencies and should include schools, educational institutions, juvenile justice systems, foster care systems, substance abuse and mental health programs, and other child and youth supporting organizations.

Suicide Prevention Web Sites

- Nebraska State Suicide Prevention Coalition web site www.suicideprevention.nebraska.edu
- The DHHS Division of Public Health Suicide Prevention web site can be found at: http://www.dhhs.ne.gov/beh/mh/suialert.htm

Nebraska

Adult - Recent Significant Achievements

Adult - A brief summary of recent significant achievements that reflect progress towards the development of a comprehensive community-based mental health system of care.

see Adult - New Developments and Issues for the discussion on recent significant achievements.

Nebraska

Adult - State's Vision for the Future

Adult - A brief description of the comprehensive community-based public mental health system that the State envisions for the future.

Narrative Question:
Adult - A brief description of the comprehensive community-based public mental health system that the State envisions for the future.

The Nebraska Behavioral Health Services Act (Neb. Rev. Stat. §§ 71-801 to 71-830) provides a vision of the mental health system in the future. For example, under Neb. Rev. Stat. § 71-803, the Act states the purposes for the public behavioral health system.

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

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

The Act also includes things such as Children and Family Behavioral Health Support Act (Sections 71-821 to 71-827) and the Behavioral Health Workforce Act (Sections 71-828 to 71-830). See **Adult_Child_Legislative Initiatives and Changes** for more details.

The strategic planning now underway by the Division of Behavioral Health will further clarify this vision statement. See **Adult - Plans to Address Unmet Needs** for more details.

Nebraska

Child - Service System's Strengths and Weaknesses

Child - A discussion of the strengths and weaknesses of the service system.

Child - A discussion of the strengths and weaknesses of the service system.

FY10Children's Portion of the MHBG
Part C. State Plan
Section II. Identification and Analysis of the Service System's Strengths, Needs and Priorities

1. **Service System's Strengths and Weaknesses**

One of the Department of Health and Human Services top ten priorities for the 2007-2008 year was to integrate children's behavioral health services into the Division of Behavioral Health (DBH). The Division of Behavioral Health embraced this mission by hiring a full time Children's Behavioral Health Administrator in the fall of 2007. The DBH welcomed this addition and immediately expanded the system scope by mandating requirements and emphasizing the importance of Children's Behavioral Health (CBH) to the contracted Regional Behavioral Health Authorities. Because of the preceding work by the State Infrastructure Grant, this integration at the State, Regional and local levels continues to be an ongoing systems change. With the addition of a State CBH Manager, we have been able to maximize the value of partnerships with family members, community providers and various child serving organizations to operationalize this value on both governance and treatment levels.

DBH continues to collaborate with the Nebraska Federation of Families for Children's Mental Health, the DHHS Office of Consumer Affairs, the Division of Medicaid and Long Term Care, the Division of Public Health, the Division of Children and Family Services, Division of Developmental Disabilities and the Department of Education and Vocational Rehabilitation. The relationship with these entities has strengthened considerably within the last year and is molding into a more unified systematic approach. As of late, the Department has experienced some firsts in terms of coordinated efforts to achieve collaborative strategic methods of operation, preemptive planning, coordinated legislative action, collective program development and management, system data analysis, and even in direct case management to assist youth in one system transitioning to another. These 'wins' have strengthened the environment of collaborative action and encouraged further interaction resulting in frequent and regular meeting between divisions and departments. The difficulty still lies in the challenge of getting the 'same page' to move the 'same direction' at the 'same time' since each entity often has their own federal, state, legislative or administrative requirements. Sometimes these barriers are philosophical; sometimes they are tangible policies and regulations. Regardless the challenge, the commitment from within the Department is pushing forward a systems of care environment.

Within our six Regional Behavioral Health Authorities (RBHA), there is a Youth Specialist that coordinates services and systems at the regional level. This ensures local communities have a point of contact as well as assists in the management of provider networks and the development of the systems of care partnerships across their area. In addition to this role, the state has contracted with each region to operate a Transition Team to address the target population of youth aging out of one system and accessing

adult behavioral health services. In each region, the membership of this team includes a variety of people/agencies that may address one of the many needs of this age of youth. These teams are designed to allow for community referral into a case review setting in which professionals, youth and family strategize, assess needs, identify strengths and provide resources or referrals for consideration as the youth prepares for this transition. Some challenges in our system today are the sometimes fragmented service delivery system, lack of knowledge of available resources, minimal number of developmentally appropriate providers and the high numbers of youth utilizing residential treatment facilities. In addition, the challenge in providing a variety of services for a youth with significant developmental and behavioral issues, missing or unstable family environments and economic stressors creates a dynamic difficult to address soon to be legal adult where all services become voluntary. The worst case scenario is these youth become homeless, engage in high risk activities and enter into the adult emergency system via emergency protective custody, mental health board commitment or hospitalization. There is a true need to address the transition aged youth population; the strength of our current system is the overwhelming support and dedication to this specific population. Many independent efforts have occurred over time, but this year a specific workgroup is launching to identify best strategies moving forward.

The State also funds six local affiliate Family Organizations, one within each behavioral health region. In addition to their role of consumer advocacy, the Family Organizations support family voice in treatment and offer many support activities such as education and mentoring. These Family Organizations have typically been funded from two sources: a contract directly from DHHS and a contract with the Integrated Care Coordination Unit's (ICCU's). This program was built on the principal of family-centered care, using a family and youth team approach within a case management approach to care, as well as making use of wraparound services. However, the ICCU's have been contracted providers via the Division of Children and Family Services (CFS) to manage family cases with intensive needs including behavioral health with a wraparound approach. Unfortunately, as with many programs, not all ICCU's produced the same results or same fidelity ratings as desired by the state. In addition, the CFS performance review process and additional recommendations produced a shift of governmental oversight and allowed for a fundamental movement into the 'privatization' of these services. This shift in process and philosophy will allow for more community based development and ownership, less government management, potentially more cost effective service provision and interaction with behavioral health as most of the contractors of these new "Out-of-Home" CFS services are also child centered family focused behavioral health providers. Although some are skeptical of these new changes, others see this opportunity as a ripe time for a new direction. The Family Organizations have received significant technical assistance from the DHHS State Infrastructure Grant to help position them as viable organizations and service providers as they are potential partners in this new structure.

Despite the attention to the two core programs serving children and youth with serious emotional disorders, and their families, cultural barriers exist for some children and families, depending on the service provider and the region. At this time the State does not issue any minimal standards for cultural competency beyond the requirements of a

provider's national accrediting agency, and the provider network is monitored by the Regional Behavioral Health Authorities for integrity. However, we recognize room for improvement as a couple of regions are rapidly expanding in cultural diverse populations. With 56 languages spoken in the Lincoln school system and 42 in Omaha schools, the need is clear for more focus on cultural competency for programs serving children and their families. The work of the SIG, combined with the work of the Office of Minority Health, will be important in the coming years to help mental health practitioner become more responsive to the needs of the many ethnic groups across the State. This partnership will result in a statewide series of trainings made available to all practitioners, agencies and organizations serving youth and families. The Office of Minority Health has developed a comprehensive curriculum to be facilitated in modules and will be adapted to the audience needs. SIG is seeking the continuing education credits relevant for behavioral health professionals. In addition, SIG's Cultural/Linguistic Competency workgroup will be addressing the administrative needs of an agency related to providing orientations, consumer rights and privacy materials, translation services, etc. This training series is set to launch beginning early fall of FY10.

Last year, the DBH has mandated that each Regional Behavioral Health Authority begin to address transition aged youth by developing a team to facilitate case reviews in order to ensure a smooth transition of youth with behavioral health disorders that will be merging into adult services. These teams have functioned differently in each region with some receiving few referrals and others collaborating well with community partners. In addition, an increasing number of considerably difficult youth have been identified as needing a transition plan as they age out of the state child welfare system after having a long stay in a residential treatment facility displaying significant mental health symptomology. Thru an aggressive collaborative process between the Division of Children and Family Service and the DBH, a process for transition has been identified, but not without recognizing significantly differing dynamics between these two fields of care. As a result, the Department and the RBHA's have identified this population as a priority to address in this upcoming year.

Despite the growing strength in relationship and collaborative systems planning, Nebraska does not have consistent standards for access to services for children with mental health needs across the three Divisions that provide services to this group of children and their families. The SIG has placed priority on access in strategic planning activities. The reorganization of the DHHS system has made significant strides toward collective action, policy and language enhancement, fiscal management and especially data collection. The DBH has developed a Behavioral Health and Medicaid Service Definition Reference Book on service definitions and utilization guidelines for some adult programs that include guidelines for admission, exclusions, continued stay, and discharge. During the upcoming year, the focus will be to complete the children's section.

In spite of significant progress in many areas, Nebraska experienced an unusual time during the fall of 2008 that sparked controversy about the children's system for families and specifically about children's behavioral health. This event is referred to as 'Safe

Haven' and resulted in 32 children being relinquished into the states care. Although these reasons were complex and varied, the media frenzy highlighted the stories of a few parents who have chosen to relinquish custody of their child in order to access the care he/she needed for the persistent, severe and sometimes dangerous emotional disorder(s). While it has been true for some parents, the Safe Haven experience suggested that all child and family issues were behavioral health issues. This created confusion for the general population to accurately understand true mental health disorders, appropriate levels of care, eligibility criteria for services and access to publicly funded services. However, the spotlight on behavioral health presented a ripe opportunity for education to Nebraska Legislatures during their term and resulted in several bill proposals, significant debates and eventually the passage of (LB603) offering assistance to youth and families. Many suggest this wasn't enough and yet others recognize the magnitude of a bill passing with additional funding during a time of such economic strife when few programs are getting additional funds if not being reduced. Of critical importance will be the establishment of a children's behavioral health help line; an urgent response line targeted to parents with a child/youth experiencing an urgent behavioral health issue. In addition, a family navigator service established for the two primary functions of peer support and system navigation as parents attempt to access existing community based services. This upcoming fiscal year will be a critical time in reviewing the results of the evaluation of these new services.

In summary, our 'youth system' across the state consists of strength in staff, partnerships, collaborative efforts and progressive action in this last year of the State Infrastructure Grant. This collaborative effort greatly improves the state's ability to identify local need, systems weaknesses and appropriate strategies for improvement. The Department is committed to a consistent process plan in order to move children's behavioral health forward and has taken progressive steps to get there.

Nebraska

Child - Unmet Service Needs

Child - An analysis of the unmet service needs and critical gaps within the current system, and identification of the source of data which was used to identify them.

Child - An analysis of the unmet service needs and critical gaps within the current system, and identification of the source of data which was used to identify them.

FY10Children's Portion of the MHBG
Part C. State Plan
Section II. Identification and Analysis of the Service System's Strengths, Needs and Priorities

2. Unmet Service Needs

In attempting to identify the prevalence rates of children and youth with severe emotional disturbances (SED) in Nebraska, we look to the number of cases of youth diagnosed with an SED at a specific time. The penetration rate is the number of children/youth with this diagnosis that have received services through the DHHS system which includes the Division of Behavioral Health, the Division of Child and Family Services including the Juvenile Justice Systems and those receiving service paid thru Medicaid or private insurance. Our current data on this prevalence indicates that 3750 (2008 data) children were served by the Nebraska Division of Behavioral Health. At this time, Nebraska does not have the capacity to determine the penetration rate for all systems for children with severe emotional disturbances because youth often cross systems and gathering an unduplicated count is difficult. However, at the end of this upcoming fiscal year, we expect to be able to identify unduplicated counts between the three Divisions pending the compliance with our Administrative Service Organization. Nonetheless, there is minimal ability to monitor children and youth with SEDs that are not receiving services but would qualify and should be receiving appropriate care. The Department is anticipating that the utilization of the children's behavioral help line may provide some additional indication of needs as evidenced by parents calling for assistance and the tracking of relevant data. In addition, there is a need for a standard outcome measurement system to more accurately identify youth in multiple systems of behavioral health, child welfare, education and juvenile justice. The Department has been working towards this goal. The challenge is the multiple indicators that may be required from the variety of funding streams, review systems or otherwise and oversight bodies.

Services in the public system are targeted to specific groups such as those financially eligible for Medicaid or those in child welfare which includes abuse and neglect, juvenile justice and/or severe behavioral health disordered youth. Unfortunately, this results in a gap in services between the multiple systems which has grown in the current economic conditions of the state and country. An additional difficulty is identifying which target population the Division should serve amidst the challenges of funding limitations, guidelines and priorities. This fall, DHHS will receive the final results of the 'state ward study,' administered in order to better identify the prevalence, precursors and implications of youth entering state custody. This study will identify potential gaps in behavioral health services and identify the occurrence of state ward solely to access behavioral health services. This occurrence combined with other issues, has created a high out of home placement rate within Nebraska. Currently, around 60% of state wards are in out-of-home care, but at a steady decline and reduction in the last year from 70%. This decrease demonstrates a trend in the right direction. Without an increase in funding,

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our challenge is to restructure the delivery of services to promote more preventative and early intervention services in order to reduce the number of out of home placements as well as reduce the need for deep end services. Expanding the service array is imperative as are collaborative partnerships with all systems that directly impact the lives of children, youth and families.

There are several special populations that the Division considers a priority due to service capacity barriers. Most specifically, youth in transition and children ages birth to five. Youth in transition have several barriers that include developmentally appropriate services, payment for services, vocational issues and lack of service providers. There have traditionally been few services that provide the coordinated effort to help youth transition into adulthood besides addressing the more complex needs of mental health disorders. The Division of Behavioral Health has revised the Age Waiver criteria. This waiver addresses youth ages 17-18 that are currently involved in care but will age out and need to transition to adult services. Currently, Nebraska lacks an evidence based practice for this population and is experiencing challenges with identifying appropriate treatment for these youth. Often, these youth are aging out of the child welfare system where placement was secured with treatment in a residential facility. Many adult providers are ill equipped to address the complex needs of this population. Serving these youth effectively will mean more than evidence based treatment, but often habilitating, and the establishment of more informal supports that remained limited while in state care.

It is anticipated that the new services being implemented January 1, 2010 and authorized by LB603 will provide some insight into additional system needs. There will be an evaluation of the Help Line, Family Navigator and Post Adoption/Post Guardianship Services to determine not only service effectiveness but also the implications and system barriers/strengths identified by the use of these services. This component will allow DHHS to further review system needs and strategically plan for service implementation.

Nebraska

Child - Plans to Address Unmet Needs

Child - A statement of the State's priorities and plans to address unmet needs.

Child - A statement of the State's priorities and plans to address unmet needs.

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3. Plans to Address Unmet Needs

In addressing the plans to meet the needs previously identified as special populations, Nebraska has identified several strategies, some of which are related to infrastructure and some related to service provision. Regarding the transition age youth, the Division of Behavioral Health will continue to offer the Age Waiver. The FY10 contracts with the Regional Behavioral Health Authorities include a requirement to integrate children's behavioral health into their service delivery planning with a special emphasis on youth in transition. Each region has developed a transition team focused on reviewing youth needing to access the adult behavioral health system. In addition, the Division is establishing a specific workgroup to address the complicated cases that require more intensive planning. This group is charged with identifying a process for internal regional level case reviews as well as process and policy recommendations for the larger system from which most of the challenging youth are currently being served.

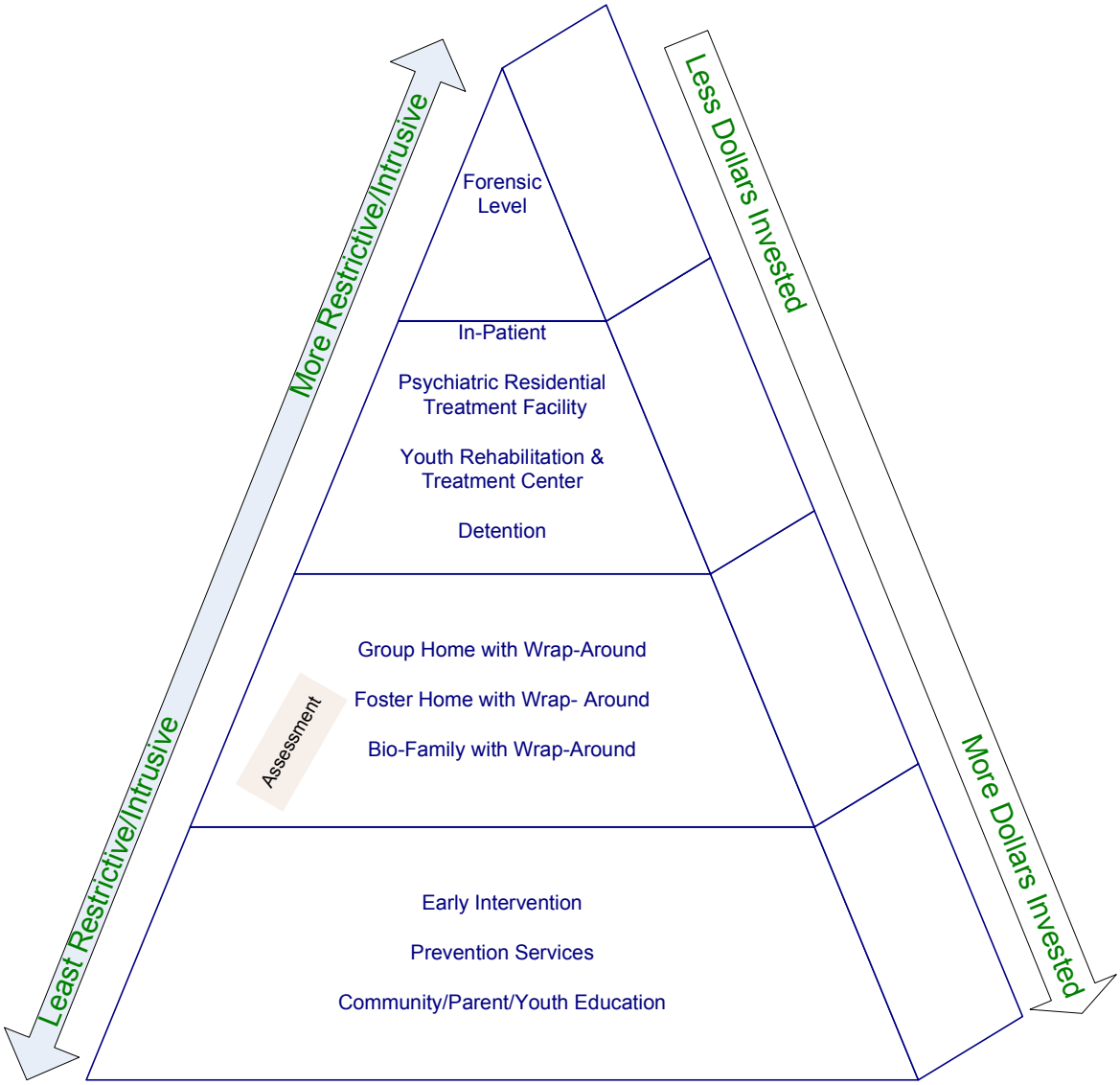
As noted in other sections, the Safe Haven experience in Nebraska resulted in considerable attention to children and youth experiencing behavioral health challenges. The Nebraska Legislature authorized several new services to help meet the needs of these youth and families. Five originally proposed bills became LB603 to offer the following:

- Children's Behavioral Health Help Line – an 24/7/365 urgent care line staffed by trained behavioral health professionals supervised by licensed behavioral health professionals aimed at providing crisis response and service referrals to youth and families in need of behavioral health services aimed at reducing morbidity of immediate crisis, improving access and retention as well as reducing police involvement and/or restrictive levels of care;
- Family Navigator Services – a family peer support service aimed at assisting families in navigating the sometimes complex system of behavioral health services designed to empower, encourage and connect families who have called the Help Line, available within 24-72 hours after the call and increasing access to services, retention, social connection and consumer satisfaction;
- Post Adoption/Post Guardianship Services – services provided to families after adoption or guardianship whom are experiencing difficulty with their child/youth and may benefit from additional services and supports in order to ensure safety, permanency and well-being;
- Increase of S-CHIP eligibility from 185% to 200% of the federal poverty line;
- Psychiatric program to provide education and training for at least eight psychiatric professionals with specific training in tele-health medicine in the rural/frontier areas and children's behavioral health;
- Increase of funding to the Regional Behavioral Health Authorities for the expansion of capacity to serve youth with behavioral health disorders and

particularly the expansion of the Professional Partners Program (a wraparound program);

- Requirement of Medicaid to amend or waiver to the Center for Medicare and Medicaid to provide coverage under the medical assistance program for community based secure residential and sub-acute behavioral health services for all eligible adult recipients for a cost savings to fund other LB603 services.

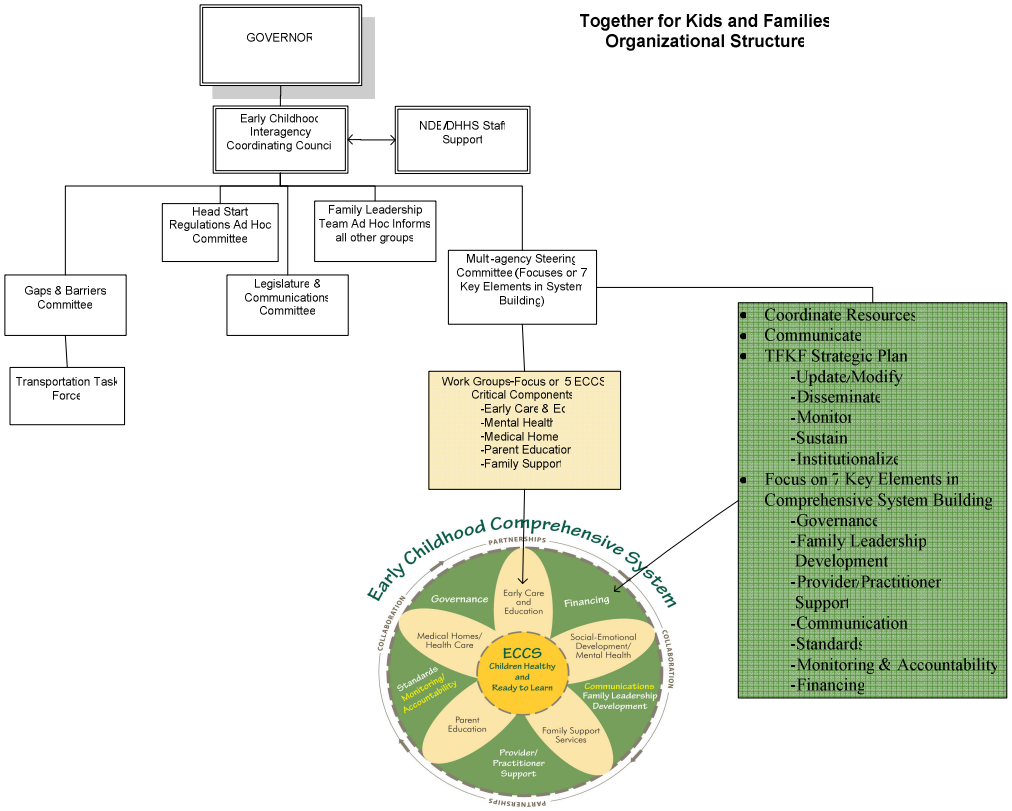
The Help Line, Family Navigator and Post Adopt/Post Guardianship Services are all out for public bid with a required service start date of January 1, 2010. In addition, funding was appropriated for the evaluation of these three services as it is anticipated that the use of them (and adequate data collection and analysis) may provide the Department with information about the current strengths and needs of the system. Regardless, the addition of these new services is a significant addition to the Nebraska service array for youth and families. Particularly the funded family peer support service. A similar service has been funded in part by DHHS and now with the Out of Home Reform contracts managed by the Division of Children and Family Services. These early intervention supports are a step towards the continued efforts of the DHHS "Creating Change and Providing Hope for Nebraska's Children, Adolescents and Families Pursuant to LB542". This document, created in January of 2008 still provides the guidance towards meeting the unmet needs in Nebraska. It states: "We share a common vision: 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. This plan is a step forward to ensure that Nebraska's children, adolescents and their families receive the mental health and substance abuse services they need through a comprehensive system of care. This plan is not intended to be static, but rather a living document, that will change and grow as lessons are learned and as collaborative ideas emerge. The values and principles defined in this plan will guide our reform and will move us forward. Our reform efforts must be progressive, but true system change takes time and will require a significant commitment to collaborate broadly. Our thinking must change and our language must be common among all. Developing an array of services that focuses on assessment and identification of potential problems must also be a system that provides services that are accessible, culturally and linguistically competent, utilizing treatment that is focused and based in evidence to improve symptoms, effectively managed and coordinated, and fiscally responsible. These guiding principles must be more than written words and will be the roadmap to provide clarity for change. This change will seem slow for some and hurried for others, but we will move forward with developing a system of care that meets the needs unique to Nebraska families."


More Restrictive/Intrusive
Least Restrictive/Intrusive
Less Dollars Invested
More Dollars Invested
Forensic Level
In-Patient
Psychiatric Residential Treatment Facility
Youth Rehabilitation & Treatment Center
Detention
Group Home with Wrap-Around
Foster Home with Wrap- Around
Bio-Family with Wrap-Around
Assessment
Early Intervention
Prevention Services
Community/Parent/Youth Education

To further support the 'flip of the pyramid', we must continue to focus on children ages birth to five as they have specific needs and often are difficult to identify due to developmental variations, limited access to population and parental/provider lack of knowledge. This challenge has been addressed thru the Nebraska State Infrastructure Grant (SIG) with the development of a curriculum for screening and early intervention of this population. This is a web based program aimed at health care providers as a point of contact for this population. In addition, SIG is investigating a training opportunity for public and private care givers of this age range. A curriculum was also established targeting the population of 6-9 year old youth and the early adolescent population to offer additional training for professionals.

An additional focus of this plan was to increase the understanding and use of evidence based practices amongst all groups addressing youth and families. The DHHS implementation plan Pursuant to LB542 states:
"Evidence-Based Practices: Determining the types of evidence-based practices should follow a strategic process based on the specific system level needs to be addressed. Some of the critical system level issues in Nebraska include youth sent out of state to access services, too many youth in out-of home care, and youth who have difficulty transitioning to adulthood. The evidence-based practices selected for implementation should be those that will effectively address the needs of the target populations and be reasonably expected to achieve desired system outcomes. Development of evidence-based practices requires a sophisticated infrastructure to ensure appropriate support of service development. For example, an assessment and referral process need to be established to ensure youth appropriate for the service are identified and linked to the service; reimbursement rates must be structured to adequately cover the costs for service delivery as well as program certification, training, fidelity monitoring and program evaluation; essential data must be collected and reported to ensure services are delivered as designed and result in the anticipated outcomes."
To this end, an Evidence Based Practice Consortium was hosted in August, 2009 to begin a collaborative effort between researchers, policy makers, practitioners and stakeholders. This effort will continue to support the efforts within multiple Divisions and Departments in strengthening effective and efficient resources for youth and families.

Additional relationships between child serving entities collaborates thru the 'Together For Kids and Families' initiative under the Governor appointed Early Childhood Interagency Coordinating Council. This effort combines a statewide body of individuals addressing everything that impacts youth and families in order to maximize resources, partnerships, efforts, planning and overall system coordination. The Division of Behavioral Health's Children's Behavioral Health Manager has a Governor appointed seat at this Council.



Finally, a significant focus for the upcoming year is the continued development and strengthening of a true system of care environment. Nebraska has well utilized its State Infrastructure Grant (SIG) and two regions of our state have received a Systems of Care Grant. A third region submitted an application for this progressive grant but was denied funding this year. However, the momentum of change continues to grow and with it presents great opportunity. SIG hosted a Systems of Care training attended by almost 100 persons from across the state, presenting in teams, ready to learn from trainer Sheila Pires and implement systems of care strategies. This event was a part of a three phase plan in supporting continued systems of care movement. Partnered with the Out of Home Reform and revised goals for the youth coordination within the Regional Behavioral Health Authorities, this change should propel the larger system vision a better place.

Nebraska

Child - Recent Significant Achievements

Child - A brief summary of recent significant achievements that reflect progress towards the development of a comprehensive community-based mental health system of care.

Child - A brief summary of recent significant achievements that reflect progress towards the development of a comprehensive community-based mental health system of care.

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4. Recent Significant Achievements

This year marks the end of the five year State Infrastructure Grant (SIG). The recommendations made by the Steering Committee for SIG have supported DHHS development of organizational and financial structures, policy changes, needs assessment and strategic planning for children/youth with severe emotional disturbances. A sampling of several pilot projects include the expansion of a single assessment tool-the Comprehensive Family Assessment, Crisis Response trainings using a CIT model averted for rural youth, Program Evaluations, Evidence Based Practice Consortium, and the strengthening of the family organizations and the Nebraska Federation of Families for Children's Mental Health via technical assistance that enhanced infrastructure allowing agencies to identify sustainable funding.

The Division of Behavioral Health and Division of Child and Family Services participate in the Nebraska "*Through the Eyes of the Child*" project. This Juvenile Justice Initiative creates awareness of a child's journey through the juvenile justice system and increases visibility of a child or adolescent's special mental health needs. There also was further distribution of three brochures throughout the state as a response to the complications families and youth endure while addressing their mental health needs. These three learning tools are: the "Children's Service Initiative", which describes how to access mental health and substance abuse services for Nebraska children; the "Your Child and Psychiatric Medications", which aids parents in addressing and inquiring about the potential meds a young person may be prescribed; the "Adolescents and Psychiatric Medications", which aids youth on their journey to learn and deal with their potentially prescribed meds. These tools have proven very beneficial and are distributed via paper and web.

The new Help Line and Family Navigator Services, administered by the Division of Behavioral Health and in collaboration with the Division of Children and Family Services. It is considered a valiant success for state funding to be appropriated to family/peer support services. The Department believes in the facilitation of family centered practice, early intervention services and youth/family empowerment in decision making for service planning.

- Children's Behavioral Health Help Line – an 24/7/365 urgent care line staffed by trained behavioral health professionals supervised by licensed behavioral health professionals aimed at providing crisis response and service referrals to youth and families in need of behavioral health services aimed at reducing morbidity of immediate crisis, improving access and retention as well as reducing police involvement and/or restrictive levels of care;

- Family Navigator Services – a family peer support service aimed at assisting families in navigating the sometimes complex system of behavioral health services designed to empower, encourage and connect families who have called the Help Line, available within 24-72 hours after the call and increasing access to services, retention, social connection and consumer satisfaction;

These services will begin January 1, 2010 after a competitive bid process during the fall of 2009. The evaluation of these services will result in indicators to measure the success of the services and the strengths and weaknesses of our system as evidenced by consumer experience. LB603 also provided for the limited existence of a Legislative Oversight Commission who will be monitoring the service implementation and evaluation.

In addition to these new services, a significant barrier in data collection has been addressed by SIG. A standardized, statewide information system is crucial for the DHHS Division of Behavioral Health to make informed policy and program decisions regarding children's behavioral health and to evaluate its Professional Partners Program. Such an information system can be thought of as being comprised of three separate processes: data collection, data entry & storage, and data analysis & reporting. Over time, the individual behavioral health regions have developed separate databases and information systems for data entry and storage. Due to data compatibility issues after the submissions, the process of merging the data took the better part of three months. After the recent submissions, the process took less than three days. As a result, the state's efforts over the last six months to merge the existing regional databases have been effective and beneficial. One of the most exciting areas of potential for the state is the capacity to couple the newly merged outcome data with the existing financial data to conduct cost-effectiveness studies using techniques such as data envelopment analysis (DEA). The data collected in the regions represent a very rich source of information regarding the Professional Partners Program and its effect on children's behavioral health in the state. Over the next several months, the state will analyze the data contained in the newly merged statewide database to take advantage of the information that currently exists piecemeal in each individual region. This achievement will result in the ability to utilize the rich data sources collected across the state and perform data driven decision making, fulfilling another goal of the DHHS Implementation Plan Pursuant to LB542.

Nebraska

Child - State's Vision for the Future

Child - A brief description of the comprehensive community-based public mental health system that the State envisions for the future.

see Adult - State's Vision for the Future and Child - Plans to Address Unmet Needs

Nebraska

Adult - Establishment of System of Care

Adult - Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness.

Adult - Establishment of System of Care (August 14, 2009)
Narrative Question:
Adult - Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness.

Organizational Structure for the System of Care:
Nebraska Behavioral Health Services Act (Neb. Rev. Stat. §§ 71-801 to 71-830) establishes the framework for the provision of behavioral health services.

Under § 71-803 the purposes of the Public Behavioral Health System are to ensure:
(1) The public safety and the health and safety of persons with Behavioral Health disorders;
(2) Statewide access to Behavioral Health services
(3) High quality Behavioral Health services
(4) Cost-effective Behavioral Health services

Under § 71-804 (1) Behavioral health disorder means mental illness or alcoholism, drug abuse, problem gambling, or other addictive disorder;

Under § 71-804 (3) Behavioral health services means services, including, but not limited to, consumer-provided services, support services, inpatient and outpatient services, and residential and nonresidential services, provided for the prevention, diagnosis, and treatment of behavioral health disorders and the rehabilitation and recovery of persons with such disorders;

- Under §§ 71-807 to 71-809, the six Regional Behavioral Health Authorities (RBHA) are established.
- 71-806 (1) says the Division shall act as the chief Behavioral Health authority for the State of Nebraska. HHS contracts with the six Regional Behavioral Health Authorities established under §§71-807 to 71-809 to purchase community mental health services. State and federal community mental health funds are allocated to the RBHAs by contract for service delivery at the local level. The RBHAs contract with public and/or private service agencies or individuals to provide services in their regions or assume direct responsibility for the provision of community-based services.

In general, for a consumer to access any of the behavioral health services presented in this section and are funded in whole or in part by the Nebraska Division of Behavioral Health Services, he/she needs to contact the Regional Behavioral Health Authority in the area.

- Region 1 Behavioral Health Authority - 4110 Avenue D; Scottsbluff, NE 69361 (308-635-3171)
- Region 2 Behavioral Health Authority - 110 North Bailey Street; P.O. Box 1208; North Platte, NE 69103; (308-534-0440)
- Region 3 Behavioral Health Authority; 4009 6th Avenue, Suite 65; P.O. Box 2555; Kearney, NE 68848; (308-237-5113)
- Region 4 Behavioral Health Authority; 206 Monroe Avenue; Norfolk, NE 68701; (402-370-3100 x 120)
- Region 5 Behavioral Health Authority; 1645 "N" Street Suite A; Lincoln, NE 68508 (402-441-4343)
- Region 6 Behavioral Health Authority; 3801 Harney Street; Omaha, NE 68131-3811; (402-444-6573)

For more information, see the Nebraska Department of Health & Human Services / Division of Behavioral Health: Community-Based Services web site:
Regional Behavioral Health Authorities
http://www.dhhs.ne.gov/beh/nebhrgb.htm

Nebraska

Adult - Available Services

Adult - Describes available services and resources in a comprehensive system of care, including services for individuals with both mental illness and substance abuse. The description of the services in the comprehensive system of care to be provided with Federal, State, and other public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities shall include:

Health, mental health, and rehabilitation services;
Employment services;
Housing
services;
Educational services;
Substance
abuse services;
Medical and dental services;
Support services;
Services provided by local school
systems under the Individuals with Disabilities Education Act;
Case management services;
Services
for persons with co-occurring (substance abuse/mental health) disorders; and
Other activities
leading to reduction of hospitalization.

-Adult-Available Services

- Describes available services and resources in a comprehensive system of care, provided with Federal, State, and other public and private resources, in order to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities. These shall include:
  - Health, mental health, and rehabilitation services;
  - Employment services;
  - Housing services;
  - Educational services;
  - Substance abuse services;
  - Medical and dental services;
  - Support services;
  - Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA);
  - Case management services;
  - Services for persons with co-occurring (substance abuse/mental health) disorders; and
  - Other activities leading to reduction of hospitalization.

Following is a description of community services that support adults with serious mental illness (SMI) in the areas of health, mental health, rehabilitation services, employment services, housing services, educational services, substance abuse services, medical services, dental services, support services, case management services, services for persons with co-occurring (substance abuse/mental health) disorders, and other activities leading to reduction of hospitalization.

Health, Mental Health, and Rehabilitation Services

The Nebraska Division of Behavioral Health is responsible for ensuring that the community mental health, substance abuse, and gambling assistance services needed by Nebraskans are available and accessible. Following is an overview of the array of services:

- 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.
- 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 also 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).

Health Services (Medical and Dental Services) are made available to individuals with Serious Mental Illness (SMI) via the Community Support services. Individuals with SMI functioning outside of inpatient or residential institutions use the "Community Support" service. There is Emergency Community Support, Community Support Mental Health and Community Support Substance Abuse. These services provide linkages, referrals and coordination of necessary

services and supports as identified in the Individual Service Plan (ISP) to ensure consumer recovery, including, but not limited to **health, mental health, rehabilitation services; employment services; housing services**; **educational services; substance abuse services; medical and dental services; support services; case management services; and other activities to help reduce psychiatric hospitalization.**

Employment 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.

Following is a summary of the funding between the Nebraska Division of Behavioral Health and Vocational Rehabilitation for State Fiscal Year 2009 (July 1, 2008 - June 30, 2009) and State Fiscal Year 2010 (July 1, 2009 – June 30, 2010).

	FY2009	FY2010
BH	$683,931	$776,533
VR	$1,075,000	$1,320,000
total	$1,758,931	$2,096,533

The following table indicates the funds allocated for Supported Employment Services in State Vocational Rehabilitation contracts with local providers, as well as Division of Behavioral Health FY2009 and FY2010 Regional Behavioral Health Contracts.

NE Division of Behavioral Health - Supported Employment

Region	Provider		
		total FY2009	total FY2010
1	Cirrus House	$16,050	$16,291
2	Goodwill Industries-NP	$43,418	$44,069
3	Goodwill Industries-GI/K/H	$115,392	$138,565
4	Liberty Centre	$75,641	$76,776
4	Rainbow Center	$47,067	$47,773
5	Mental Health Association	$202,517	$266,455
6	Community Alliance	$183,846	$186,604
	TOTALS	$683,931	$776,533

Source: Regional Behavioral Health Authorities Contracts
FY09 & FY10 Attachment G Summaries (as of July 23, 2009)

Nebraska Vocational Rehabilitation Services contracts for employment services with local providers. The table below indicates the projected outcomes, outcomes achieved, and consumers served by provider in FY2009. "Outcome" is a Vocational Rehabilitation term meaning the

individual must first be successfully employed for 30 days to establish stability. Then the person needs to be successfully employed 90 days or longer, for a total of 120 days of successful job placement, before Vocational Rehabilitation documents the outcome.

FY2009

Region	Provider	City	Outcomes		Agreement Amount	VR Funds Expended	Consumers Served
			Achieved	Projected			
1	Cirrus House	Scottsbluff	10	10	$50,000	$50,000	38
2	Goodwill Industries	North Platte	14	22	$110,000	$94,000	70
3	Goodwill Industries	GI/H/K	88	87	$435,000	$435,000	307
4	Liberty Centre	Norfolk	13	14	$70,000	$68,000	25
5	Mental Health Assoc	Lincoln	17	20	$100,000	$94,000	146
6	Community Alliance	Omaha	83	62	$310,000	$310,000	200
	totals		225		$1,075,000	$1,051,000	786

FY2010

Region	Provider	City	Outcomes		Agreement Amount
			Achieved	Projected	
1	Cirrus House	Scottsbluff		15	$75,000
2	Goodwill Industries	North Platte		30	$150,000
3	Goodwill Industries	GI/H/K		97	$485,000
4	Liberty Centre	Norfolk		15	$75,000
5	Mental Health Assoc	Lincoln		25	$125,000
6	Community Alliance	Omaha		82	$410,000
	totals				$1,320,000

Source: DHHS-Division of Behavioral Health and Nebraska Vocational Rehabilitation Services (as of August 6, 2009)

Housing Services

Nebraska utilizes facility based housing programs for inpatient services, referred to as Psychiatric Residential Rehabilitation and Dual Disorder Residential Treatment. The Psychiatric Residential Rehabilitation service is designed to provide individualized treatment and recovery inclusive of psychiatric rehabilitation and support for individuals with a severe and persistent mental illness and/or co-occurring disorder who are in need of recovery and rehabilitation activities within a residential setting. Psychiatric Residential Rehabilitation is provided by a treatment/recovery team in a 24-hour staffed residential facility. The intent of the service is to support the individual in the recovery process so that he/she can be successful in a community living setting of his/her choice. The Dual Disorder Residential Treatment service is intended for adults with a primary Axis I diagnosis of substance dependence and a co-occurring severe and persistent mental illness requiring a more restrictive treatment environment to prevent substance use. This service is highly structured, based on acuity, and provides primary, integrated treatment to further stabilize acute symptoms and engage the individual in a program of maintenance, treatment, rehabilitation and recovery.

Housing Related Assistance Program

State law, Neb. Rev. Stat. § 71-812 (LB 40 established in 2005), authorizes the use of state funds to provide Housing Related Assistance for very low-income adults with serious mental illness. Assistance includes rental payments, utility payments, security and utility deposits, as well as other related costs and payments. During the first year of the program in FY2006 (July 1, 2005 to June 30, 2006), the first few months were utilized to develop the program capacity. The program was fully operational statewide in FY2007, FY2008 and FY2009.

The following two tables show the number of persons served since the inception of the Housing Related Assistance Program.

Unduplicated Total Number of Consumers Served By Region by State Fiscal Year

	FY2006	FY2007	FY2008	FY2009
Region 1	19	40	42	70
Region 2	9	33	77	60
Region 3	23	85	101	154
Region 4	7	57	88	117
Region 5	35	196	209	235
Region 6	34	146	200	187
Totals	127	557	717	823

Persons Per Household – Method for calculation

Total Persons Served	One Person	Two People	Three People	Four People	Five or more People	Total
Number Served Times	___ x 1 +	___ x 2 +	___ x 3 +	___ x 4 +	___ x 5 =	estimated total people in household

Persons Per Household	One Person	Two People	Three People	Four People	Five or more People	Total
FY2007 Unduplicated Number Served+	433	71	29	14	10	557
2007 Estimated Total People Impacted	433	142	87	56	50	768
FY2008 Unduplicated Number Served+	551	91	42	18	15	717
2008 Estimated Total People Impacted	551	182	126	72	75	1,006
FY2009 Unduplicated Number Served+	613	99	64	31	16	823
2009 Estimated Total People Impacted	613	198	192	124	80	1,207

+ The Unduplicated Number Served as reported under the Unduplicated Total Number of Served by Region by State Fiscal Year (see above).

Most of the consumers (approximately 74% in FY2009) live alone, while the remainder (approximately 26%) live in households of two or more people. Thus, the number of persons per household provides an indication of how many people were impacted by these services. In FY2007, the number of persons served was 557 and the number of persons per household was 768. In FY2008, the number of persons served was 717 and the number of persons per household was

1,006. In FY2009, the number of persons served was 823 and the number of persons per household was 1,207.

The Housing Quality Standards (HQS) are established by the US Department of Housing and Urban Development (HUD). These standards are specifically used under the HUD Section 8 Tenant Based Assistance - Housing Choice Voucher Program. The HQS offer a guide to what is required for safe, sanitary, and affordable housing. These same standards are used by the Nebraska Housing Related Assistance program to help consumers transition to HUD Section 8 whenever possible.

Housing Quality Standards (HQS) Inspections Completed / Statewide Totals

	# of Passed HQS Inspections	# of Failed HQS Inspections	# of Inconclusive HQS Inspections	Total # of HQS Completed
FY2007	365	52	21	438
Percent 2007	83%	12%	5%	100%
FY2008	414	58	10	482
Percent 2008	86%	12%	2%	100%
FY2009	479	44	7	530
Percent 2009	90%	8%	1%	100%

Statewide, there were officially 372 discharges reported in FY2008 and 462 reported for FY2009. Of this group, the discharges are consistent with the original program goals developed during the Behavioral Health Reform in 2004.

The following consumers discharged from the Housing Related Assistance Program and transitioned to Section 8.

FY2008	92	25%
FY2009	77	17%

The following consumers discharged from the Housing Related Assistance Program and transitioned into Public Housing Units.

FY2008	11	3%
FY2009	22	5%

Also worth noting is the persons served who were discharged due to their income exceeding eligibility requirements for state housing related assistance because the person could now pay self-sustaining rent. This suggests the consumer was hired at a job with sufficient income to pay his/her own rent.

FY2008	31	8%
FY2009	35	8%

On June 30, 2008, there were 504 consumers being served in the Housing Related Assistance Program. As of June 30, 2009, statewide, there were 569 active in the program. As of June 30, 2008, statewide, there were 95 Consumers on the Waiting List for Housing Related Assistance. On June 30, 2009, there were 136 on the Waiting List.

Source: DHHS Division of Behavioral Health Housing Related Assistance Program

Substance Abuse Services

Nebraska State Statute [Neb. Rev. Stat. § 71-804 (2)] defines "Behavioral Health Disorder" as mental illness or alcoholism, drug abuse, problem gambling, or other addictive disorder. The Nebraska Legislature expects the Division of Behavioral Health to fully address the provision of services for Behavioral Health Disorders. The Division of Behavioral Health and Medicaid adopted the American Society of Addiction Medicine (ASAM) Standards for use in the implementation of the 1915B Waiver for Adult Substance Abuse services.

One expectation for Behavioral Health providers in Nebraska is that they have the capability to assess the need for mental health and substance abuse services for clients of their agency. Upon recognition of the need for these services, the provider either refers the client to another provider or conducts an evaluation as part of their program activities. It is required that all primary mental health treatment services screen for substance abuse and seek consultation for further evaluation, and that all of the primary substance abuse treatment services screen for mental illness and seek consultation for further evaluation.

Services Provided by Local School Systems Under the Individuals with Disabilities Education Act (IDEA)

Students diagnosed with a severe emotional disorder qualify for special education services while attending the public school system under the Individuals with Disabilities Education Act (IDEA) program. School districts are required to provide public education and related services to meet the unique needs of all children with verified disabilities from date of diagnosis to age twenty-one (21). Within a community-based system of care environment, these services support the child/adolescent needs in collaboration with other services available.

Case Management Services

In Nebraska, case management services are part of the service referred to as "Community Support", which is a rehabilitative and support service for individuals with primary Axis I diagnosis consistent with a serious and persistent mental illness. Community Support Workers provide direct rehabilitation and support services to the individual in the community with the intention of supporting the individual to maintain stable community living, and prevent exacerbation of mental illness and admission to higher levels of care. The service typically occurs outside the program office, and the roles of the community support provider vary based on consumer need. The contact frequency is individualized and adjusted in accordance with the level of rehabilitation and support needed.

Community Support-Mental Health service expectations include:

- Provision of active rehabilitation and support interventions with focus on activities of daily living, education, budgeting, medication compliance and self-administration (as appropriate and part of the overall treatment/recovery plan), relapse prevention, social skills, and other independent living skills that enable the individual to reside in their community.
- Provision of service coordination and case management activities, including coordination or assistance in accessing medical, psychiatric, psychopharmacological, psychological, social, education, housing, transportation or other appropriate treatment/support services as well as linkage to other community services identified in the treatment/rehabilitation/recovery plan.

- Develop and implement strategies to encourage the individual to become engaged and remain engaged in necessary mental health treatment services as recommended and included in the treatment/rehabilitation/recovery plan.

The intent of the service is to increase independent living skills, enhance quality of life, and decrease the frequency and duration of hospitalization by linking the consumer to appropriate service providers, providing rehabilitative/support services and monitoring service provision of other allied service providers. The referrals and coordination of necessary services and supports, as identified in the treatment/rehabilitation/recovery plan, include, but are not limited to: **health, mental health, rehabilitation services; employment services; housing services**; **educational services; substance abuse services; medical and dental services; support services; case management services; and other activities to help reduce psychiatric hospitalization.** The community support program provides a clear focus of accountability for meeting the consumer's needs within the resources available in the community.

Services for Persons with Co-Occurring (Substance Abuse/Mental Health Disorders

Dual Disorder Residential Treatment is intended for adults with a primary Axis I diagnosis of substance dependence and a co-occurring severe and persistent mental illness requiring a more restrictive treatment environment to prevent substance use. This service is highly structured, based on acuity, and provides primary, integrated treatment to further stabilize acute symptoms and engage the individual in a program of maintenance, treatment, rehabilitation and recovery. This service may be located in a community setting or a specialty unit within a licensed health care facility. Programs are designed to treat persons who have significant social and psychological problems. Such programs are characterized by their reliance on the treatment community as a therapeutic agent, and treatment includes 24-hour crisis management, family education, self-help group and support group orientation. The goals of treatment are to promote abstinence from substance use and antisocial behavior, and to effect a global change in participant's lifestyle, attitudes and values. Individuals placed in this program typically have multiple deficits, which may include substance-related disorders, criminal activity, psychological problems, impaired functioning and disaffiliation from mainstream values. Their mental disorders may involve serious and persistent mental health issues. Other functional deficits include a constellation of criminal history or antisocial behaviors, with a risk of continued criminal behavior, and extensive history of treatment and/or criminal justice involvement, limited education, little or no work history and limited vocational skills, poor social skills, inadequate anger management skills, extreme impulsivity, emotional immaturity, and/or an antisocial value system.

Source: Adult Criteria of the Patient Placement Criteria for the Treatment of Substance-Related Disorders of the American Society of Addiction Medicine, Second Edition Revised (ASAM PPC-2R).

The following table indicates the unduplicated count of persons receiving services funded by the Division of Behavioral Health by category of Mental Health *only*, Substance Abuse *only*, and Co-Occurring (*both* Mental Health and Substance Abuse diagnosis). Three variables were used to distinguish between consumers with *only* mental health needs, consumers with *only* substance abuse needs, and consumers with needs stemming from co-occurring (*both* mental health and substance abuse) issues: 1) the primary reason for admission to services; 2) the type of service to which consumers were admitted; and 3) consumer diagnoses. An example of a consumer who falls into the substance abuse only category is a consumer who was admitted into a substance abuse treatment

service, had a primary substance abuse reason for admission, and/or who has one or more substance abuse diagnoses. An example of a consumer who falls into the co-occurring category is a consumer whose reason for admission was primary substance abuse and secondary mental health (or some other combination of the two), or a consumer with a primary substance abuse reason for admission who received a mental health service or had a mental health diagnoses.

Unduplicated Count of Persons Receiving Services Funded by the Division of Behavioral Health in SFY2009

	All Clients	Mental Health ONLY Clients	Substance Abuse ONLY Clients	Co-occurring Clients
Total Number	37,669	17,720	5,095	14,854
Percentage	100%	47%	14%	39%

Footnote:
(1) In January 2009, the Division of Behavioral Health cleaned its data system by administratively discharging nearly 18,000 records of admission to program prior to November 2003 and of which had no activity in the last year. This reduced the number of active cases in the system.
(2) To obtain the unduplicated count of persons served, the Division used social security numbers and dates of birth to identify unique clients in the data system.

Source: NE Division of Behavioral Health (August 20, 2009)

Following is a listing of mental health and rehabilitation services provided by the Division of Behavioral Health through the six Regional Behavioral Health Authorities. The first list of Adult and Children services are those that are purchased with Community Mental Health Services Block Grant allocations. The second list of mental health services includes services on the first list, as well as services the Division of Behavioral Health purchases with other funding sources. Together these lists of services represent a comprehensive system of consumer services.

Adult

Community Support
Day Rehabilitation
Psych Residential Rehabilitation
Day Treatment
Medication Management
Outpatient Therapy
Day Support
Supported Employment

Children

Therapeutic Consultation (P.L. 100-690) Service
Day Treatment (P.L. 102-321) Service
Children's Multi-Systemic Therapy
Professional Partner
Children's Intensive Outpatient

MENTAL HEALTH SERVICES - FEE FOR SERVICE (FFS)

A. NON-MEDICAID Eligible Residential and Non-Residential MRO SERVICES
1. Community Support - MH
2. Day Rehabilitation - MH
3. Psych Residential Rehab - MH
4. Assertive Community Treatment – MH

B. MH Residential and Non-Residential Services
1. Dual Residential
2. Day Treatment - MH
3. Medication Management – MH

C. Inpatient Services
1. Post Commitment Days Treatment - MH
2. Acute Inpatient for Commitments - MH
3. Subacute Inpatient for Commitments - MH
4. Secure Residential – MH

MENTAL HEALTH SERVICES – NON-FEE FOR SERVICE (NFFS)

A. Emergency Services
1. 24 hour Crisis Phone
2. Crisis Assessment - MH
3. Urgent Assessment - MH
4. Urgent Medication Management - MH
5. Urgent Outpatient - MH
6. Crisis Response Teams
7. Crisis Respite
8. Emergency Community Support
9. Crisis Stabilization/Treatment (Voluntary)
10. EPC Inpatient (Involuntary)
11. Crisis Inpatient - Youth
12. Flex Funds – MH

B. Non-Residential Services
1. Assessment Only - MH
2. Outpatient Therapy - MH (Ind, Grp &/or Fam)
3. Outpatient Therapy - Dual (Ind, Grp, &/or Fam)
4. Intensive Case Mgmt/Community Services
5. Psychological Testing - MH
6. Day Support - MH
7. Recovery Support – MH
8. Supported Employment - MH

C. Inpatient Services
1. Acute Inpatient
2. Subacute Inpatient

- Community Support – MH - Community Support is a rehabilitative and support service for individuals with primary Axis I diagnosis consistent with a severe and persistent mental illness. Skilled paraprofessionals provide direct rehabilitation and support services to the individual in the community, most generally the individual's home, with the intention of supporting the individual to maintain stable community living, and prevent exacerbation of mental illness and admission to higher levels of care.
- Day Rehabilitation – MH - Day Rehabilitation services are designed to provide individualized treatment and recovery, inclusive of psychiatric rehabilitation and support for clients with a severe and persistent mental illness and/or co-occurring disorders who are in need of a program operating during day hours. The intent of this service is to support the individual in the recovery process so that he/she can be successful in a community living setting of his/her choice.
- Psychiatric Residential Rehabilitation – MH - Psychiatric Residential Rehabilitation is designed to provide individualized treatment and recovery inclusive of psychiatric rehabilitation and support for individuals with a severe and persistent mental illness and/or co-occurring disorder who are in need of recovery and rehabilitation activities within a residential setting. This service is provided by a professional recovery team in a 24-hour staffed residential facility. The intent of the service is to support the individual in the recovery process so that he/she can be successful in a community living setting of his/her choice.
- Assertive Community Treatment – MH - The Assertive Community Treatment (ACT) Team provides high intensity services, and is available to provide treatment, rehabilitation, and support activities seven days per week, twenty-four hours per day, 365 days per year. The team has the capacity to provide multiple contacts each day as dictated by client need. The team provides ongoing continuous care for an extended period of time, and clients who are admitted to the service and demonstrate any continued need for treatment, rehabilitation, or support will not be discharged except by mutual agreement between the client and the team.
- Dual Residential – This residential treatment service is intended for adults with a primary Axis I diagnosis of substance dependence and a co-occurring severe and persistent mental illness requiring a more restrictive treatment environment to prevent substance use. This service is highly structured, based on acuity, and provides primary, integrated treatment to further stabilize acute symptoms and engage the individual in a program of maintenance, treatment, rehabilitation and recovery.
- Day Treatment – MH - Day Treatment provides a community based, coordinated set of individualized treatment services for individuals with psychiatric disorders who are not able to function full-time in a normal school, work, and/or home environment and need the additional structured activities of this level of care. This service is less intensive than hospital based day treatment.
- Medication Management – MH - Medication Management is a level of outpatient treatment rendered by a qualified physician that includes evaluation of the individual's need for psychotropic medications, provision of prescriptions, and ongoing medical monitoring of medications. Service expectations include: medical evaluation; medication monitoring; and client education pertaining to the medication and its use.
- Acute Inpatient for Commitments – MH - An Acute Inpatient program is designed to provide medically necessary, intensive assessment, psychiatric treatment and support to individuals with a DSM (current version) diagnosis and/or co-occurring disorder experiencing an acute exacerbation of a psychiatric condition. The Acute Inpatient setting is

equipped to serve patients at high risk of harm to self or others and in need of a safe, secure, lockable setting.

- Subacute Inpatient for Commitments – MH - The purpose of subacute care is to provide further stabilization, engage the individual in comprehensive treatment, rehabilitation and recovery activities, and transition him/her to the least restrictive setting as soon as possible. Secure Residential – MH – The Secure Residential program is designed to provide individualized recovery, psychiatric rehabilitation, and support determined by a strengths-based assessment of consumers with a severe and persistent mental illness and/or co-occurring substance abuse disorder demonstrating a moderate to high risk for harm to self/others, and in need of recovery/rehabilitation/therapeutic activities. Secure Residential is provided by a professional recovery team in a 24-hour staffed residential facility. The intent of the service is to support the consumer in the recovery process so that the consumer's community living setting of choice can be successfully attained.
- The 24-Hour Crisis Phone must be answered by a live voice 24 hours a day and 7 days a week and have the ability to link to a licensed behavioral health professional, law enforcement, and other emergency services. The 24-Hour Crisis Phone is designed to assist consumers in pre-crisis or crisis situations related to a behavioral health problem. The desired outcome is ensuring the safety of the consumer in a time of distress that has the potential to lead to a life-threatening situation.
- Crisis Assessment and Urgent Crisis Assessment are thorough mental health assessments for a consumer experiencing a behavioral health crisis. The assessment must be completed by an appropriate professional. The assessment takes place in a setting such as a Mental Health Center, Hospital, or Substance Abuse Treatment Center. The assessment will determine behavioral health diagnosis, risk of dangerousness to self and/or others, and the recommended behavioral health service level. Based on the assessment, appropriate behavioral health referrals will be provided.
- Urgent Medication Management is the level of outpatient treatment where the sole service rendered by a qualified physician (or APRN, PA, or NP supervised by a physician) is the evaluation of the individual's need for psychotropic medications, and provision of a prescription. Urgent Medication Management is provided within 72 hours of contact and referrals for this service must come from an emergency system provider.
- Urgent Outpatient - intense intervention for individuals presenting in the psychiatric emergency system with an urgent/emergent behavioral health crisis. The purpose of this service is to support the individual in achieving crisis resolution and determining next steps for further treatment, if needed. This service is intended to assure that individuals receive immediate treatment intervention when and where it is needed.
- Crisis Response is designed to use natural supports and resources to build upon a consumer's strengths to help resolve an immediate behavioral health crisis in the least restrictive environment by assisting the consumer to develop a plan to resolve the crisis. The service is provided by licensed behavioral health professionals who complete brief mental health status exams and substance abuse screenings, assess risk, and provide crisis intervention, crisis stabilization, referral linkages, and consultation to hospital emergency room personnel, if necessary. The goal of the service is to avoid an Emergency Protective Custody hold or inpatient psychiatric hospitalization.
- Crisis Respite is designed to provide immediate, short-term, individualized, crisis-oriented supports needed to stabilize acute symptoms of mental illness, alcohol and other drug abuse, and/or emotional distress. Assessment, observation, and intervention is provided to consumers exhibiting a psychiatric and/or substance abuse crisis with a low to moderate risk

for harm to self/others and in need of a short-term, safe, protected, supervised residential environment. Crisis Respite is provided by staff trained in crisis management services in a 24/7 staffed residential facility. The intent of the service is to support the consumer throughout the crisis, provide linkages to needed behavioral health services, and assist in transition back into the personal residential setting of choice. Provide screening for dangerousness to self and others by a mental health professional and a screening for physical health conditions by a medical professional within 24 hours of admission.

- Emergency Community Support – is designed to assist consumers who are can benefit from support due to a behavioral health need and who are either currently residing in a community setting or transitioning from a psychiatric hospital into a community setting. Service Expectations include: case management, behavioral health referrals, assistance with daily living skills, and coordination between consumer and/or consumer support system and behavioral health providers.
- Crisis Stabilization/Treatment (Voluntary) – is a twenty-four (24) hour assessment, observation, and supervision service. Services are provided in locked facilities and include Emergency Protective Custody (EPC) admissions. The emphasis of the service is on crisis intervention, stabilization, and psychiatric triage activities.
- EPC Inpatient (Involuntary) – a 24-hour medical facility that provides emergency care to stabilize a person on an EPC hold who is alleged to be mentally ill and dangerousness and/or chemically dependent and dangerousness. The county attorney decides within 72 hours to request a hearing to involuntarily require an individual to receive appropriate mental health and/or substance abuse services. An EPC hold can be dropped after the evaluation if no mental illness or chemical dependency is found, or if the person agrees to voluntarily seek treatment. A commitment hearing must be held within 7 days of admission.
- Outpatient Therapy (Individual and/or Family) - the treatment of psychiatric disorders through scheduled therapeutic visits between the therapist and the individual, and/or the nuclear and/or extended family. The focus of outpatient individual psychotherapy treatment is to improve or alleviate symptoms that may significantly interfere with functioning in at least one life domain (e.g., familial, social, occupational, educational, etc.). The goals, frequency, and duration of outpatient individual therapy will vary according to individual needs and response to therapy. The focus of family therapy is to alter the family system to increase the functional level of the identified consumer/family through services/interventions on the systems within the family unit.
- Outpatient Therapy (Group) - the treatment of psychiatric disorders through scheduled therapeutic visits between the therapist and the consumer in the context of a group setting of at least three, and no more than twelve, participants with a common goal. The focus of outpatient group psychotherapy is to improve or maintain an individual's ability to function as well as alleviate symptoms that may significantly interfere with their interpersonal functioning in at least one life domain (e.g., familial, social, occupational, educational, etc.). Group therapy must provide active treatment for a primary DSM IV diagnosis. The goals, frequency, and duration of outpatient group treatment will vary according to individual needs and response to treatment. **Groups that are educational or supportive in nature do not meet the definition of outpatient group psychotherapy.**
- Intensive Case Management - is designed to promote community stabilization through frequent case management activities responsive to the intensity of the consumer's needs. This service includes mobile case management addressing illness management, peer support, crisis prevention/intervention, and appropriate utilization of community-based resources and services. This service is provided in the community with most contacts

typically occurring in the consumer's place of residence or other community locations consistent with consumer choice/need.

- Psychological Testing – psychological and diagnostic tests completed by a licensed, clinical psychologist.
- Day Support - is designed to provide minimal social support to individuals who currently receive, or have received, behavioral health services and are succeeding in their recovery process. The intent of the service is to support the individual in the recovery process so he/she can experience continued success in the community living setting of his/her choice.
- Recovery Support - promotes independent community living success through the monitoring of a consumer's adherence to behavioral health goals and ability to manage an independent community living situation. 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.
- Supported Employment – is designed to provide recovery and rehabilitation services and supports in employment-related activities for consumers with a severe and persistent mental illness and/or a co-occurring substance abuse disorder who express a desire to return to work. A supported employment team provides assistance with all aspects of employment development as requested and needed by the consumer. The intent of the service is to support the consumer in the recovery process so the consumer's goals can be successfully obtained.
- Acute Inpatient – is a medically necessary, intensive, psychiatric facility based service, the purpose of which is to stabilize acute psychiatric conditions. Services are provided in a structured treatment environment within locked facilities for persons with high to moderate risk of harm to self and/or others. Treatment modalities include: medical treatment, psychiatric care, and psychopharmacology.
- Subacute Inpatient – provides services for individuals with high to moderate risk for harm to self and/or others, the purpose of which is to provide further stabilization, engage the consumer in treatment, rehabilitation and recovery activities, and transition the consumer to a least restrictive setting as soon as possible.

Nebraska

Adult - Estimate of Prevalence

Adult - An estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children

This is an estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children.

- **Adults**: The estimate on the number of Adults with Serious Mental Illness (SMI) in Nebraska ranges from **71,351** to **80,009**. However, it is more complicated than that. For example, the 71,351 represents 5.4% of the total state civilian population with SMI. The 80,009 represents basically the 5.4% looking at each of the 93 counties in Nebraska. If you apply the available estimates for Serious Psychological Distress (SPD), the range for adults age 18 and older may be 53,432 to 145,672. The SAMHSA News Release (May 19, 2009) reveals that 1 in 13 (7.7%) adults experienced major depressive episode in the past year. The 2006 BRFSS in Nebraska found 6% of adults had current depression in the two weeks prior to the survey, 8% reported "frequent mental distress" (FMD), 16% of adults have been told by a health professional that they have a depressive disorder and 10% reported a lifetime diagnosis of anxiety. Finally, estimates of 3% (42,267) of adults, 18 years of age and older, are annually affected by gambling additions in Nebraska. Increased individuals seeking treatment addressing pathological gambling, DSM-IV category under impulse control disorder, contributes to suicide incidents rates reflecting financial and emotional instability.

- **Children and Adolescents**: The estimate on the number of Children and Adolescents (Age 9 to 17) with Serious Emotional Disturbance (SED) in Nebraska ranges from **24,192** to **32,768**.

Below are the details on this estimate.

Source: 2007 SMI and SED Estimates for Table 1 (Excel file - 155 KB)
http://www.nri-inc.org/projects/SDICC/urs_forms.cfm
Prepared by the State Data Infrastructure Coordinating Center (SDICC), National Association of State Mental Health Program Directors Research Institute (NRI) under contract with the Center for Mental Health Services (CMHS) (contract no. 280-99-0504). June 14, 2008

URS Table 1: Number of Persons with Serious Mental Illness, age 18 and older, by State, 2007
Civilian Population with SMI (5.4%)
Nebraska = 71,351

URS Table 1: Number of Children with Serious Emotional Distrubances, age 9 to 17, by State, 2007
Nebraska has an estimated range from 21,993 to 26,391 (Level of Functioning Score=60 from Lower Limit to Upper Limit). 24,192 is the average of these two numbers.

Source: The University of Texas Medical Branch / Psychiatry and Behavioral Sciences, UTMB
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Estimation of Need for Mental Health Services
http://psy.utmb.edu/estimation/WICHE/wiche_p5/Nebraska/p5wsmi01_ne000.htm

The University of Texas Medical Branch web site on the "Estimation of Need for Mental Health Services". Under "7. Estimates Based on National Comorbidity Study 1990-1994" click on "Earlier WICHE Collaboration for 2000"

Series P5 Estimates of Need for Mental Health Services
Series P5 Estimates of Need for Mental Health Services
For Nebraska for Serious Mental Illness for 2000

Combined Youth and Adult Index

	Total Population (HH.,Inst.& Group)		
Total Pop	Cases	Pop	Percent
All ages	112,777	1,711,263	6.59

Index for Youth age 0-17

– Youth with Serious Emotional Disturbance (SED) in Nebraska can be estimated at **32,768**.

Youth	Cases	Pop	Percent
Youth total	32,768	450,242	7.28

Index for Adults age 18 and older

– Adults with Serious Mental Illness (SMI) in Nebraska can be estimated at **80,009**.

Adult total	Cases	Pop	Percent
Adult total	80,009	1,261,021	6.34

source:
Serious Psychological Distress (SPD)

				Serious Psychological Distress (SPD)	
		2. Total population Census data (estimated 2008)	age 18 and older (Nebraska's 2008 U.S. Census Bureau Estimates)	10.9% Using NSDUH (a)	4% Using BRFSS data (b)
	State Total	1,783,432	1,336,437	145,672	53,457

(a)10.9% Using National Survey on Drug Use and Health (NSDUH)

– In 2007, 10.9 percent of adults aged 18 or older (an estimated 24.3 million persons) experienced serious psychological distress (SPD) in the past year,

– About two fifths of these (44.6 percent) received mental health services in the past year
Sources:
1. "Serious Psychological Distress and Receipt of Mental Health Services", 2007 National Survey on Drug Use and Health (NSDUH) data (December 22, 2008)
The NSDUH Report is published periodically by the Office of Applied Studies, Substance Abuse and Mental Health Services Administration (SAMHSA). All material appearing in this report is in the public domain and may be reproduced or copied without permission from SAMHSA.
2. Table G.37 – Serious Psychological Distress in the Past Year among Persons Aged 18 or Older, by Demographic Characteristics: Percentages, 2004-2007
http://www.oas.samhsa.gov/NSDUH/2k7NSDUH/AppG.htm#TabG-37
80415 (8.35B)

(b) 4% Using BRFSS data
Serious Psychological Distress (SPD).
Table 1. Description of Population by Serious Psychological Distress, N = 199,209

Serious Psychological Distress (SPD).	n =	%
SPD: K6 > 13	7,986	4%
No SPD: K6 < 13	191,223	96%
Table 1. Description of Population by Serious Psychological Distress	199,209	100%

From the sample of 199,209 survey participants (adults aged 18- years-old and older) in this study, a total of 7,986 (4.0%) persons were categorized as having a serious psychological disorder (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
Int J Public Health 54 (2009) S23–S29
1661-8556/09/010S23-7
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http://springerlink.com/content/r1346672q56w3376

Kessler-6 (K-6) Method to Determine Serious Psychological Distress (SPD)
Serious psychological distress (SPD) is defined as having a score of 13 or higher on the K6 scale, which measures symptoms of psychological distress during the 1 month in the past 12 months when respondents were at their worst emotionally.

The main predictor variable used in these analyses was SPD, which was measured by scoring a series of six questions in the BRFSS known as the Kessler-6. This 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" to each of the questions.

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 ≥ 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
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http://springerlink.com/content/r1346672q56w3376

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source: SAMHSA News Release
For Immediate Release Contact: SAMHSA Press Office, (240) 276-2130
May 19, 2009 www.samhsa.gov

Nationwide Report Reveals that 1 in 13 Adults Experienced Major Depressive Episode in the Past Year

An estimated 16.5 million people aged 18 years or older experienced at least one major depressive episode (MDE) in the past year and 64.5 percent of them received treatment, according to a new report released today by the Substance Abuse and Mental Health Services Administration (SAMHSA).
"Depression is a medical condition that should be treated with the same urgency as any other medical condition," said SAMHSA Acting Administrator Eric Broderick, D.D.S., M.P.H. "This study helps us gain better insight into how many people suffer from major depressive episodes, where they seek treatment, and why they don't. This information is critical to help inform health system reform."
Among the findings:

- The rate of past year MDE was lower among persons aged 50 or older (5.8 percent) than among those aged 18 to 25 (8.9 percent) or 26 to 49 (8.5 percent). Overall the rate of past year MDE was 7.5 percent for adults aged 18 or older.
- The rate of MDE was higher for adults who perceived their overall health to be fair or poor (14.2 percent) than for those who described their health as excellent (4.3 percent).

- Among those with past year MDE who received treatment for depression in the past year, 68.8 percent saw or talked to a medical doctor or other health professional about depression and used prescription medication for depression.
- A quarter (24 percent) of those with MDE who received treatment for depression saw or talked to a medical doctor or other health professional but did not use a prescription medication.

According to the report one third of adults experiencing an MDE in the past year did not receive treatment during that period. The most frequently reported reasons for not receiving mental health services among these adults was not being able to afford the cost (43.2 percent), feeling they could handle the problem on their own (29.3 percent), not knowing where to go for services (18.1 percent), not having the time (16.7 percent), having health insurance that did not cover enough treatment (11.3 percent), and concerns about confidentiality (11.1 percent).
The report is drawn from SAMHSA's 2007 National Survey on Drug Use and Health (NSDUH) which collected data from a representative sample of approximately 45,000 civilian, non-institutionalized adults throughout the United States.

MDE is defined as a period of two weeks or longer during which there is either depressed mood or loss of interest or pleasure and at least four other symptoms that reflect a change in functioning, including problems with sleep, eating, energy, concentration, and self-image.
The full report is available on the web at http://oasbeta.samhsa.gov/2k9/149/MDEamongAdults.cfm . Copies may be obtained free of charge by calling SAMHSA's Health Information Network at 1-877-SAMHSA-7 (1-877-726-4727) or at http://ncadistore.samhsa.gov/catalog/productDetails.aspx?ProductID=18120. For related publications and information, visit http://www.samhsa.gov/ .
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SAMHSA is a public health agency within the Department of Health and Human Services. The agency is responsible for improving the accountability, capacity and effectiveness of the nation's substance abuse prevention, addictions treatment, and mental health services delivery system.

Please visit for http://www.samhsa.gov/newsroom/advisories/0905184956.aspx additional details.

Source: 2006 BRFSS in Nebraska
The US Department of Health and Human Services - Centers for Disease Control and Prevention (CDC) is responsible for the Behavioral Risk Factor Surveillance System (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 following content is from the 2006 Nebraska Behavioral Risk Factor Surveillance System. It is a Report of Prevalence of Anxiety and Depression Among Adults in Nebraska in 2006, based on analysis of the PHQ-8 questions from 2006 (September 29, 2008).

For the 2006 BRFSS, telephone surveys with 7,967 randomly selected Nebraska residents aged 18 and older were conducted by the Nebraska Health and Human Services System during 2006. However, 3,990 interviews included the Anxiety/Depression Module. Prevalence estimates are based on weighted data rather than raw numbers of responses to a question. The weights adjust for over- or under-sampling of age/gender groups. Age adjustment was used for most prevalence

estimates in this report as well. In most cases, prevalence estimates are presented along with the 95 percent confidence intervals associated with them. Confidence intervals are a method of measuring sampling error and defining the range where the "true" percentage would be found 95 percent of the time.

Prevalence of Selected Mental Illnesses

Based on responses to the 2006 Nebraska BRFSS Anxiety and Depression Module and related questions:

- Six percent of adults had **current depression** in the two weeks prior to the survey (based on CDC's Severity of Depression scale).
- Eight percent reported **"frequent mental distress" (FMD)**. Respondents who had FMD stated that their "mental health was not good" due to "stress, depression, and problems with emotions" for at least 14 of the last 30 days. This measure may include a wider range of mental health problems than "current depression".
- Sixteen percent of adults had ever been told by a health professional that they had a depressive disorder (a **lifetime diagnosis of depression**).
- Ten percent reported a **lifetime diagnosis of anxiety**.

Prevalence of Frequent Mental Distress (FMD) means
Responses to the following question, "Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?"
- Frequent Mental Distress (FMD): 14 or more days during the past 30 days.
- Infrequent or No Mental Distress: less than 14 days during the past 30 days.

BRFSS respondents who reported current depression, FMD, or a lifetime diagnosis of depression shared some common characteristics. Prevalence rates for these conditions were generally higher for: females, persons with less than a college education, low-income respondents, previously-married respondents, and those who were unemployed or unable to work.

Prevalence of Alcohol Abuse

- A total of 18 percent of Nebraska adults aged 18 and older engaged in **binge drinking** in the past 30 days.
- Three percent of adults participated in **heavy (or chronic) drinking** in the last month.

Binge Drinking means
For Men--Five or more drinks of alcohol (beer, wine, wine coolers, cocktails, or liquor) on an occasion, one or more times during the past 30 days.
For Women—Four or more drinks of alcohol (beer, wine, wine coolers, cocktails, or liquor) on an occasion, one or more times during the past 30 days.

Heavy (Chronic) Drinking means
Responses to the question, "One drink is equivalent to a 12-ounce beer, a 5-ounce glass of wine, or a drink with one shot of liquor. During the past 30 days, on the days when you drank, about how many drinks did you drink on the average?"
For Men—two or more drinks.
For Women—one or more drink.

Co-Occurrence of Mental Illnesses
Results of this study show some co-occurrence of mental illnesses.

- Three percent of all respondents were categorized as having current depression and FMD.
- Three percent also had current depression and a lifetime diagnosis of depression.
- Seven percent of respondents indicated they had ever received a diagnosis of depression and a diagnosis of anxiety, although not necessarily at the same time.

Co-Occurrence of Depression and Alcohol Abuse
Only about one percent of all respondents reported current depression and alcohol abuse. However, 6 percent of adults who were classified as having current depression also reported alcohol abuse.

Among persons with a lifetime diagnosis of depression, 13 percent reported alcohol abuse in the past month. For respondents with a lifetime diagnosis of anxiety, 17 percent also indicated abuse of alcohol in the last 30 days.

Association of Mental Illness with Chronic Diseases
Prevalence rates for some chronic diseases were significantly higher among adults with the mental illnesses addressed in this study than among those who did not have mental illness. Rates of coronary heart disease were significantly higher among persons with current depression, FMD, or lifetime diagnoses of anxiety and/or depression than among those without these conditions.

Prevalence of stroke was significantly higher among persons with current depression, FMD, or a lifetime diagnosis of anxiety.

Compared to respondents without these mental illnesses, significantly higher rates of asthma were found among respondents with a lifetime diagnosis of depression or with current depression/FMD. Diabetes was also significantly more prevalent among persons with current depression/FMD and among persons ever diagnosed with anxiety and depression.

Association of Mental Illness with Unhealthy Behaviors
Cigarette smoking and physical inactivity were both significantly more prevalent among persons with all of the mental illnesses included in this survey.

Obesity was also significantly more prevalent among persons with current depression, current depression/FMD, or lifetime diagnoses of both depression and anxiety.

However, no significant association was found between prevalence of current depression or lifetime diagnoses of anxiety and/or depression and alcohol abuse. That is, rates of alcohol abuse for persons with these mental illnesses were not significantly higher than corresponding rates for persons without these mental illnesses.

Association of Alcohol Abuse with Chronic Diseases and Unhealthy Behaviors
Of the four chronic diseases studied by alcohol abuse, a significant difference in prevalence was noted only for diabetes. Prevalence of diabetes was significantly lower among persons who reported current binge drinking than among those who reported no alcohol abuse. (This result may be due in

part to the fact that diabetes is more prevalent in middle-aged or older adults, while binge drinking rates are highest among young adults).

Prevalence of cigarette smoking was significantly higher among respondents who engaged in binge drinking or in both binge and heavy drinking than it was among those who reported no alcohol abuse in the past 30 days.
To see the complete report "2006 Nebraska BRFSS Anxiety and Depression Module", go to:
http://www.dhhs.ne.gov/beh/mh/Prevalence_of_Anxiety&Depression_in_Nebraska2006.pdf

It is under the Division of Behavioral Health: Community-based Services web site - Recent Reports.

Source: Problem Gambling: United States. National Gambling Impact Study Commission (NGISC). *National Gambling Impact Study Commission Report*. By Kay C. James. Washington DC: National Gambling Impact Study Commission, 1999. (Chapter 4: Problem and Pathological Gambling, page 4-4/5)

ESTIMATING THE PREVALENCE: Pathological Gambling
"One reason for the variation in estimates centers on the timeline used. For example, studies using the DSM-IV may make a distinction between those gamblers who meet the criteria for pathological or problem gambling at sometime during their life ("lifetime") and those who meet the criteria only during the past 12 months ("past year"). Each approach has its defenders and critics. For the purpose of measuring prevalence in the general population, lifetime estimates run the risk of overestimating problem and pathological gambling because these estimates will include people who may recently have gone into recovery and no longer manifest any symptoms. On the other hand, past year measures may understate the problem because this number will not include people who continue to manifest pathological gambling behaviors, but who may not have engaged in such behavior within the past year. Prior to the research undertaken by this Commission, the data on prevalence was scattered at best. Nevertheless, virtually all estimates indicate a serious national problem. For example, Dr. Shaffer's review of the existing literature on the subject concluded that approximately 1.6 percent of the adult population 7 Testimony of Edward Looney before the NGISC, January 22, 1998. National Gambling Impact Study Commission Report Problem and Pathological Gambling Page 4-5 (3.2 million people) are lifetime "Level 3" gamblers (comparable to the DSM-IV's "pathological" gamblers). Another 3.85 percent (7.7 million) are lifetime "Level 2" gamblers (those with problems below the pathological level). A number of state-based and regional studies also have been conducted, with mixed results. A 1997 survey in Oregon indicated that the lifetime prevalence of problem and pathological gambling in that state was 4.9 percent. Recent studies in Mississippi and Louisiana indicated that 7 percent of adults in those states could be classified as "lifetime" problem or pathological gamblers, with approximately 5 percent meeting "past year"criteria. The problems inherent in measuring this disorder are indicated in a study of surveys carried out in 17 states, which reported results ranging from 1.7 to 7.3 percent."

"Background Information on H.R. 2906, the Comprehensive Problem Gambling." National Council on Problem Gambling. Web. 24 July 2009. <www.ncpgambling.org>.

Problem gambling is a growing public health concern, characterized by increasing preoccupation with and loss of control over gambling, restlessness or irritability when attempting to stop gambling, and/or continued gambling despite serious negative consequences. In particular:
• Nationwide, 6 to 9 million people (3-4% of adults) met criteria for a gambling problem.
• The estimated social cost to families and communities from gambling-related bankruptcy, divorce, crime and job loss was almost $7 billion last year.
• Problem gamblers also have high rates of co-occurring substance abuse and mental health disorders, including smoking, alcohol use and abuse, drug use and abuse, depression and suicidal behavior.

FACTS and FIGURES (Problem Gambling)." *National Problem Gambling Awareness Week* -

Problems Related to Gambling				
	Mental Health			
Financial Problems	Depression	Anxiety	Suicide Attempt	Other
19.2%	5.4%	2.2%	1.1%	0.7%
N =1,765 from 1996 to 2007				

Welcome. National Council on Problem Gambling. Web. 24 July 2009. <http://www.npgaw.org>.

- Ten percent of clients enrolled in Oregon 's gambling treatment system considered and formulated plans to commit suicide within six months of enrollment to treatment (Moore , 2003)

- A major depressive disorder is likely to occur in 76 percent of pathological gamblers (Unwin Davis, & Leeuw, 2000)

Ramírez, Juan-Paulo, "Gamblers Assistance Program Annual Reporting Requirements." Gamblers Assistance Program, DBH, DHHS. Magellan Health Services, July-Aug. 2008. Web. 24 July 2009. <http://www.magellanhealth.com/>.

According to Nebraska Division of Behavioral Health records, the table below reports percentage rates among suicide attempts, mental health issues, and financial problems among consumers who received outpatient treatment services related to gambling addictions from 1996 to 2007 in Nebraska. Percentage rates determined within approximately thirty days of intake.

Note: Between years 2004 to 2007 an average of 287 clients have been treated annually. It's estimated that approximately 250 persons were served during fiscal year 2008.

For more information contact Eric Hunsberger at Eric.Hunsberger@nebraska.gov
Gamblers Assistance Program, DBH-NEDHHS
Updated July 24, 2009

Nebraska

Adult - Quantitative Targets

Adult - Quantitative targets to be achieved in the implementation of the system of care described under Criterion 1

Narrative Question: Adult - Child - Quantitative targets to be achieved in the implementation of the system of care described under Criterion 1

(updated on August 20, 2009)

Adult - Quantitative Targets

FY 2007 Actual	FY 2008 Actual (December 2008)	FY 2009 Projected	Estimated FY 2010 Target
30,742	32,862	29,957	29,000

Child - Quantitative Targets

FY 2007 Actual	FY 2008 Actual (December 2008)	FY 2009 Projected	Estimated FY 2010 Target
4,135	4,049	2,617	2,600

The data reported are an unduplicated count. To obtain unduplicated count of persons served, the Division used social security numbers and dates of birth to identify unique clients in the data system.

The numbers are changing for unduplicated count persons served. In January 2009, the Division of Behavioral Health had Magellan Behavioral Health cleaned its data system by administratively discharging nearly 18,000 records of admission to programs prior to November 2003 and of which had no activity in the last year. This reduced the number of active cases in the system. This effort to clean up the data can be seen in the unduplicated count persons served for FY2008 compared to the projected data for FY2009. The Division of Behavioral Health reported 36,911 for URS Table 2A (Profile of Persons Served, All Programs by Age, Gender and Race/Ethnicity) on December 1, 2008. On August 20, 2009, the preliminary analysis (projected) on FY2009 was completed, showing a total of 32,574. This would be a 13% decline.

Given the current economic climate, the level funding, the work to clean-up the Division of Behavioral Health data by Magellan Behavioral Health, the Target setting for FY2010 needs to be limited.

Here are the numbers used for the FY2007 and FY 2008 reports above.

URS Table 2A. Profile of Persons Served, All Programs by Age, Gender and Race/Ethnicity (December 1, 2008)

	Total			
	Female	Male	Not Available	Total
Youth				
0-12 Years	703	1,183	0	1,886
13-17 years	877	1,286	0	2,163
total youth				4,049
Adult				
18-20 years	939	1,309	0	2,248
21-64 years	13,916	15,974	0	29,890
65-74 years	294	233	0	527

Narrative Question: Adult - Child - Quantitative targets to be achieved in the implementation of the system of care described under Criterion 1

75+ years	110	87	0	197
Not Available	0	0	0	0
total adult				32,862
Total Youth and Adult combined	16,839	20,072	0	36,911

URS Table 2A. Profile of Persons Served, All Programs by Age, Gender and Race/Ethnicity
Report Year: 2007 (submitted December 1, 2008)

	Total			
	Female	Male	Not Available	Total
Youth				
0-12 Years	736	1,222	0	1,958
13-17 years	916	1,261	0	2,177
total youth				4,135
Adults				
18-20 years	950	1,283	0	2,233
21-64 years	12,882	14,964	0	27,846
65-74 years	269	209	0	478
75+ years	113	72	0	185
Not Available	0	0	0	0
total adults				30,742
Total	15,866	19,011	0	34,877

Nebraska

Adult - Outreach to Homeless

Adult - Describe State's outreach to and services for individuals who are homeless

-Adult / Child-

- Describes the State's outreach to and services for individuals who are homeless

This section is covered in two parts.

1. Projects for Assistance In Transition from Homelessness (PATH)
2. Nebraska Homeless Assistance Program (NHAP)

Projects for Assistance In Transition from Homelessness (PATH) (July 1, 2009)

The Nebraska Department of Health and Human Services contracts with the Regional Behavioral Health Authorities (§71-809 Neb. Rev. Stat. 1943) for delivery of community mental health services including contracts for the implementation of PATH Grant activities.

The State of Nebraska, consistent with the Stewart B. McKinney Act, defines an individual as homeless if he/she: (1) lacks a fixed, regular, and adequate night-time residence; (2) has a primary night-time residence that is (a) a supervised publicly or privately operated shelter designed to provide temporary living accommodations; (b) an institution that provides a temporary residence for individuals intended to be institutionalized; or (c) a public or private place not designed, or ordinarily used as, regular sleeping accommodations for human beings.

The State of Nebraska is currently using as a provisional definition of persons who are at imminent risk of becoming homeless an adaptation of the US Housing and Urban Development (HUD) definition of such persons. Individuals are considered to be at imminent risk if: (1) they are in the process of being evicted from dwelling units or are being discharged from institutions; (2) no subsequent residences have been identified; and (3) they lack the resource and support networks to obtain access to housing.

Services supported by PATH Funds include: outreach, screening and diagnostic treatment services, case management, referral, temporary housing assistance, and other appropriate services to individuals who experience serious mental illness or both serious mental illness and substance abuse, and are homeless or at imminent risk of becoming homeless.

Number of Persons to be served: The estimated number of persons to be served statewide in FY2010 is 649.

Service Areas: Based on the evidence of need, the two primary geographic areas within Nebraska receiving most of the PATH funds are Lincoln (Region 5) and Omaha (Region 6). This is based on the fact that Lincoln and Omaha have the largest population of individuals who are homeless in Nebraska. PATH funds will also be allocated in two other locations in the State: Scottsbluff (Region 1) and Grand Island (Region 3).

According to the Nebraska Homeless Assistance Program Regional Comparisons, Omaha has 39.2% of the State's homeless population while Lincoln has 21.7%. These two cities receive 92% of the PATH funds and have 60.9% of the homeless population according to

the most recent figures. These two cities have the longest running PATH programs and originally received all of the PATH funds. The point in Time Count reveals Lincoln has 29% and Omaha 30% of the homeless population, which is slightly different than the data from the Nebraska Homeless Assistance Program.

Organizations to Receive Funds and Amounts Allocated (FY2010):

Region 1	Western Nebraska (Scottsbluff)		
	Cirrus House: (Private non-profit)	$11,333	4%
Region 3	Central Nebraska (Grand Island)		
	Central Nebraska Goodwill Industries, Inc. (Private non-profit)	$11,333	4%
Region 5	Southeast Nebraska		
	Lincoln and Lancaster County Community Mental Health Center/Lancaster County (Public/County Government)	$32,500	11%
	CenterPointe, Inc. (Private non-profit)	$32,500	11%
Region 6	Eastern Nebraska Omaha and Douglas County		
	Community Alliance (Private, non-profit)	$200,334	69%
TOTAL		$288,000	100%

The continued implementation of the PATH Formula Grant Program will be coordinated with Nebraska's Comprehensive Mental Health Services Plan under PL 103-321 as follows:

The State of Nebraska's overall plan for mental health services is contained in the Nebraska Mental Health System Plan for Adults. A major emphasis of the plan for mental health services is on the Rehabilitation and Support service array targeted toward persons disabled by severe and persistent mental illness (SPMI). Persons that are homeless and have a mental illness (PHMI) in Nebraska have available to them any of the mental health services available in the Rehabilitation and Support array. The State Plan recognizes that PHMI have more specialized needs and, in conformance with the requirements of PL 102-321, the plan endeavors to provide for the establishment and implementation of a program of outreach to and services for homeless individuals with a serious mental illness. PATH funded agencies are unique in their ability to provide the outreach component necessary to engage PHMI and direct them toward needed services. PATH funded agencies will also provide specialized case management services to keep PHMI engaged, link them with entitlements, and coordinate a service package designed to maximize their potential for transitioning out of homelessness. Thus, the State Plan recognizes the need for, and takes advantage of PATH funded services to provide specialized programs (particularly with regard to outreach and case management) for PHMI, which would not otherwise be available in the Nebraska Community Mental Health System.

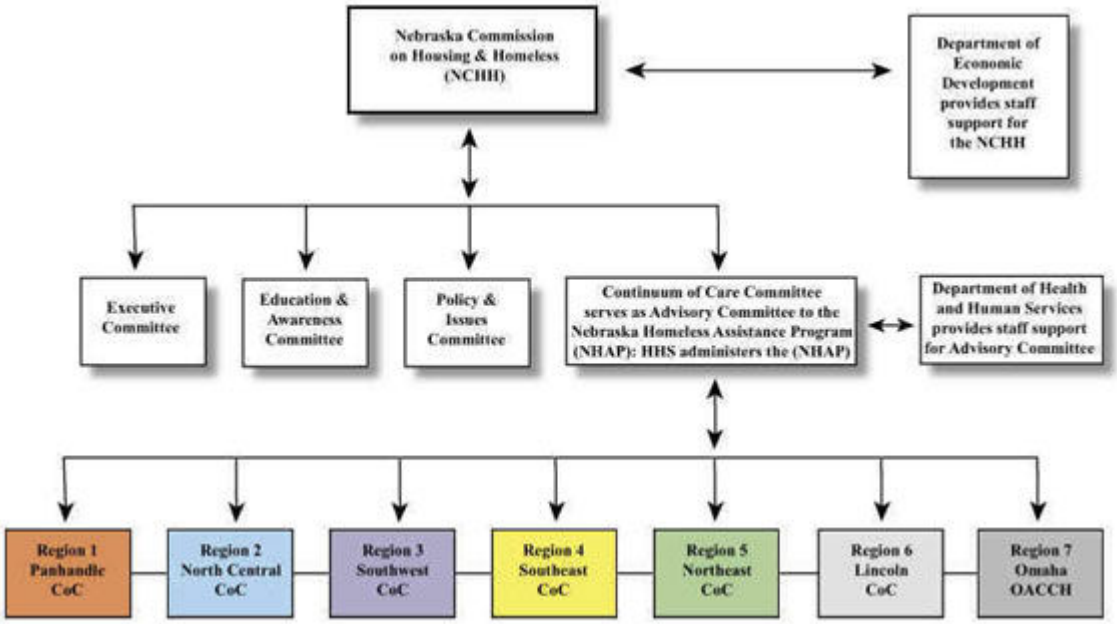
The PATH Grant will be specifically coordinated with the PL 102-321 outreach and service requirements for homeless, seriously mentally ill individuals through the

contractual requirement that Nebraska PATH Grant Programs have an outreach and case management component.

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) - Nebraska Homeless Assistance Program (NHAP).

Regional Continuum chairs are members of the Nebraska Commission on Housing & Homelessness (NCHH), Continuum of Care Committee. Two regional Continuums are currently chaired by Behavioral Health Housing Specialists. The NCHH is composed of 21 Governor-appointed members. The Continuum of Care Committee has both NCHH appointed and at-large members that represent diverse stakeholders from various geographic areas of the state. This committee is the NHAP Advisory Committee, which is required by state statute. The chart below shows the organizational structure of the Nebraska Commission on Housing & Homelessness.



Each regional Continuum of Care includes activity components identified by the Department of Housing and Urban Development (HUD) as integral to a successful Continuum: (1) outreach, intake, and assessment to identify an individual's or family's service and housing needs in order to link them to appropriate housing and/or service resources; (2) emergency shelter and safe, decent alternatives to the streets; (3) transitional housing with supportive services to help people develop the skills necessary

for permanent housing; (4) permanent housing and permanent supportive housing. The focus is on permanent supportive housing, while maintaining or replacing aging emergency shelters and transitional housing.
Funding to agencies is provided through a competitive grant program that consists of two funding sources: the Nebraska Homeless Assistance Trust Fund (HSATF) and the Department of Housing and Urban Development (HUD) Emergency Shelter Grant (ESG). The state trust fund accounts for 77 percent of the funding; ESG funds 23 percent of the NHAP. Applications are reviewed and scored individually. Awards are allocated by a formula that ensures an equitable distribution of funds across Continuums. The formula uses a base of $50,000 per region plus an allocation based on population, poverty and other economic indicators. Approximately, $2.5 million is awarded each year to assist 65 to 70 agencies with homeless outreach and other related activities.

2007-2008 NHAP Awards by Region		
#	**Name**	**Amount**
1	Panhandle	$181,131.00
2	North Central	$285,992.00
3	Southwest	$282,353.00
4	Southeast	$486,844.00
5	Northeast	$377,135.00
6	Lincoln	$395,888.00
7	Omaha	$580,000.00
	Total	$2,578,543.00

(Please Note: this table will be updated when new data is available. New data is expected to be available in mid-August.)

The American Recovery and Reinvestment Act of 2009 (ARRA) also allocated $5,128,578 in Homelessness Prevention and Rapid Re-housing Program (HPRP) funding to the State of Nebraska. The program will be administered by NHAP. HPRP funding will be granted to every Continuum of Care region via a formula allocation based upon the percentage of NHAP funding that each region currently receives. Each Continuum region will select one lead agency to implement HPRP during the funding period (2009-2012). The Lincoln Continuum has selected a Behavioral Health agency, Region V Systems, to receive HPRP funding. Other Behavioral Health agencies statewide are actively involved in HPRP planning and lead agency selection within other Continuum regions.

In 2003/2004 the Ending Chronic Homelessness Committee (Ad Hoc) was added to the NCHH. The chart below depicts the addition of the Ad Hoc Committee to the NCHH.

Organizational Structure for Nebraska Commission on Housing & Homeless (NCHH)

The Ad Hoc Committee is composed of members who attended a federally-sponsored and facilitated Policy Academy on Ending Chronic Homelessness and additional members who were selected for expertise in specific planning areas. The original 10-Year Plan on Ending Chronic Homeless was adopted by the NCHH in 2004. The Behavioral Health Housing Assistance Program was one of many successes of the initial plan. Because many of the initial strategies and action steps had been accomplished, committee members worked with a facilitator in 2007 to re-focus the plan to address strategies and action steps for the next 18 to 24 months. The revised plan was adopted by the NCHH in September 2007, and implementation began in January of 2008. The implementation of the plan will continue through 2009 and the first half of 2010.

Regional Continuum members were involved in the initial 10-year plan and in the revision of the plan. Additionally, an expanded group of representatives from the seven regional Continuums of care were invited to a day-long session to integrate activities from the revised state plan into regional strategic plans. This provided an opportunity for Continuums to address regional impact of state strategies and also to identify and address gaps in shelter and services. One identified gap was early detection of persons with mental health and/or dual diagnosis issues. Homeless shelters and service providers generally do not have staff qualified to diagnose or assist individuals who have serious mental health or drug and/or alcohol abuse issues. The Ad Hoc Committee is working on a policy and procedure that would identify potential mental health issues so an appropriate referral could be made. This effort also is in coordination with a sub-committee working on discharges from institutions. Case management identification of

mental health issues and institutional discharge planning were both topics of Ad Hoc Committee meetings in 2009.

In the revised plan (http://www.dhhs.ne.gov/fia/nhap/nhapplan.htm), two strategies and corresponding action steps specifically address outreach to people who are homeless. The first addresses homelessness prevention and discharge planning; the second addresses access to mainstream services: SSI/SSDI.

The first priority strategy is to analyze data to identify issues related to discharge from institutions and re-entry from correctional facilities. This includes issues related to drug and alcohol abuse, serious mental illness, and race and ethnicity. The data will inform development or improvement of institutional discharge and monitoring procedures at the regional and local level. Institutional (hospitals, jails, correctional facilities) discharge plans that include appropriate permanent housing help ensure that people do not become homeless in the discharge process. Working with institutions prior to discharge also is a proactive outreach activity.

The Sequential Intercepts for Change: Criminal Justice-Mental Health Partnerships model is integral to this strategy and was presented at the 2008 first quarter video conference meeting of the NE Commission on Housing & Homelessness, Continuum of Care Committee. The model was introduced to members to educate them about various interventions that can occur along the incarceration process to help ensure individuals do not become homeless or re-cycle through institutions.

The second priority strategy is to address gaps and barriers to services in a culturally dynamic way. One barrier is access to SSI/SSDI when applications are not submitted with sufficient information. Over the past three years, Nebraska has worked with Policy Research Associates to train case workers in the Stepping Stones to Recovery application process. During five trainings across the state conducted in 2006 and 2007, 230 individuals participated in the training. Based on the interest in and success of the training sessions, the state sent two professional facilitators to be trained so on-going training is available for providers

During one of the two training sessions these trainers facilitated, Social Security and disability representatives indicated that, to date, no application received had the medical summary filled out. This section is vital in the determination of disability. Another reason for denial for individuals who are homeless is the lack of an address at which to receive required paperwork from the Social Security Administration. The solution is for the case worker to become a personal representative so they can receive copies of the paperwork and help the individual follow through when s/he has not received the mailing. Additionally, the Lincoln SSA office received permission from the regional SSA office to flag applications from persons who are homeless. All these activities were done to enhance the initial first-time rate of approval on SSI/SSDI applications.

This training is one component of the SSI/SSDI Outreach, Access, and Recovery (SOAR) process. The process also evaluates the effectiveness of the training. In 2008, the NHAP worked with the Lincoln Continuum of Care to develop a pilot SOAR project to serve as a model for other Continuums. The Lincoln Continuum conducted research that revealed that the annual average cost of keeping one person homeless and on the streets was $25,943. The cost of housing that individual in an efficiency apartment and helping him/her access food stamps for a year was estimated at $7,344. It was determined that access to SSI/SSDI could possibly provide the necessary income to help an individual become housed. Locally funded SOAR initiatives began in both Lincoln and Omaha in late 2008. SOAR updates and best practices techniques are discussed at every State Continuum of Care Committee and Ad Hoc Committee meeting.

Garnering and analyzing quality quantitative and qualitative data is at the heart of effective policy and program development. The NHAP's transition from manual reporting to electronic reporting via ServicePoint and a new domestic violence data collection system is resulting in greater data integrity from NHAP-funded agencies. For the 2008-2009 grant cycle (July 1, 2008 through June 30, 2009) 45 agencies reported via ServicePoint. Twenty domestic violence agencies reported using the coalition's newly implemented system. 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 using a screening instrument at the facilities 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
Fiscal Years (2007-08) (2008-09)

Homeless Figures

NHAP Regions	NHAP 2007-2008 Annual Figures Homeless Totals (Unduplicated)	NHAP 2008-2009 Annual Figures Homeless Totals (Unduplicated)	Percent Increase/Decrease
Region: 1 - Panhandle	1,155	830	- 28.1%
Region: 2 - North Central	2,532	1,684	- 33.5%
Region: 3 - Southwest	1,614	1,448	- 10.3%
Region: 4 - Southeast	2,152	1,971	-8.4%
Region: 5 - Northeast	649	994	+ 53.2%
Totals Regions 1-5	**8,102**	**6,927**	**-14.5%**
Region: 6 - Lincoln	4.521	4,809	+ 6.4%
Total Regions 1-6	**12,623**	**11,736**	**-7.0%**
NHAP Regions	**NHAP 2007-2008 Annual Figures Homeless Totals (Unduplicated)**	**NHAP 200-2009 Annual Figures Homeless Totals (Unduplicated)**	**Percent Increase/Decrease**
Region: 7 – Omaha HSATF only	**8,158**	**6,433**	**n/a**

Nebraska Homeless Assistance Program (NHAP)
Regional Comparisons
Fiscal Years (2007-08) (2008-09)

Near Homeless Figures

NHAP Regions	NHAP 2007-2008 Annual Figures Near Homeless Totals (Unduplicated)	NHAP 2008-2009 Annual Figures Near Homeless Totals (Unduplicated)	Percent Increase/Decrease
Region: 1 - Panhandle	4,960	5,360	+ 8.1%
Region: 2 - North Central	6,294	4,739	- 24.7%
Region: 3 - Southwest	7,419	8,411	+ 13.4%
Region: 4 - Southeast	10,030	7,296	- 27.3%
Region: 5 - Northeast	4,211	4,170	-1.0%
Totals Regions 1-5	**32,914**	**29,976**	**- 8.9%**
Region: 6 - Lincoln	9,390	11,894	+26.7%
Total Regions 1-6	**42,304**	**41,870**	**- 1.0%**
NHAP Regions	**NHAP 2007-2008 Annual Figures Homeless Totals (Unduplicated)**	**NHAP 2008-2009 Annual Figures Homeless Totals (Unduplicated)**	**Percent Increase/Decrease**
Region: 7 – Omaha HSATF only	**1,330**	**1,159**	**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 ESG 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

Homeless Emergency and Rapid Transition to Housing (HEARTH) Act

On May 20, 2009, President Obama signed the Homeless Emergency and Rapid Transition to Housing (HEARTH) Act into law. The HEARTH Act reauthorizes the McKinney-Vento Homeless Assistance Grant Programs with several significant changes, including:

* A consolidation of HUD's competitive grant programs;
* The creation of a Rural Housing Stability Program;
* A change in HUD's definition of homelessness and chronic homelessness;
* A simplified match requirement;
* An increase in prevention resources; and,

* An increase on the emphasis of performance.

The HEARTH Act stipulates that HUD shall promulgate regulations not later than 12 months after the date of enactment that will govern the operation of the programs created under this Act. HUD considers obtaining the input of its stakeholders an important step in the creation of the new regulations.

Homelessness Prevention and Rapid Re-Housing Program (HPRP)

The State of Nebraska's allocation for the Homelessness Prevention and Rapid Re-Housing Program is $5,128,578. The funds under this program are intended to target individuals and families who would be homeless but for this assistance. More information regarding the HPRP can be found at http://www.hudhre.info/documents/HPRP_Notice_3-19-09.pdf.
In addition, an online Question/Answer page is posted via HUD's Homeless Resource Exchange Virtual Help Desk at http://www.hudhre.info/HPRP/

Homelessness Prevention and Rapid Re-housing Program	HPRP Award:	%
Region I (Panhandle): Cirrus House	$341,232	7%
Region II (North Central): Central Nebraska Community Services	$539,077	11%
Region III (Southwest): Community Action Partnership of Mid-Nebraska	$511,470	10%
Region IV (Southeast): Blue Valley Community Action	$917,661	18%
Region V (Northeast): Goldenrod Hills Community Action	$710,854	14%
Region VI (Lincoln): Region V Systems	$746,130	15%
Region VII (Omaha): Heartland Family Service	$1,105,725	22%
Nebraska Management Information System (NMIS) allocation for the HPRP-eligible activity of Data Collection and Evaluation:	$205,000	4%
total	$5,077,149	100%
Retained by DHHS for Admin	$51,429	1%
the State of Nebraska's allocation amount for HPRP	$5,128,578	

July 14, 2009	Official start of HPRP program
July 14, 2011	60% HPRP funds expended | $3,077,146.80
July 14, 2012	HPRP program ends

Source: Nebraska Homeless Assistance Program (NHAP)
Division of Children and Family Services / Department of Health and Human Services

The following article, *Nebraska, Iowa see Homeless Spike*, written by Juan Perez, Jr. World-Herald Staff Writer, was published on Friday, July 10, 2009 in the Omaha World Herald. For more details go to the following website: http://www.omaha.com/article/20090710/NEWS01/707109936

While Nebraska has largely evaded the worst of the national economic downturn, the state last year still had the 12th-highest percentage of homeless residents in the country, according to a federal report released Thursday, July 9, 2009.

The 3,985 people thought to be homeless in Nebraska in 2008 represented 0.22 percent of the state's population, according to data compiled by the U.S. Department of Housing and Urban Development.

Iowa tied for 36th on the list with 0.11 percent of the state's population, 3,346 people listed as homeless. South Dakota and Kansas ranked 48th and 50th, respectively.

Nebraska's total homeless population had increased by 12.9 percent since 2007, the report said. Kansas' had dropped by nearly 18 percent, but Iowa experienced a 22.4 percent spike from 2007.

The overall homeless rate in the United States held steady from 2007 to 2008. Still, some of the Midwest's numbers reflect a 56 percent increase in the number of homeless families from suburban or rural areas.

“The economic crisis is forcing more families who had previously been well-housed into homelessness,” said Shaun Donovan, the department's secretary. Many statistics for this part of the department's study came from measuring a state's sheltered and unsheltered homeless populations on a single night during the last week of January 2008.

Officials said the report shows the first echoes of an economic recession that gripped many sectors of the U.S. economy and spurred a relative freeze in household spending, manufacturing activity and overall growth. Yet, Donovan warned, the picture may dim further in 2009.

“This data, given the timing of it, does not reflect the full brunt of the economic crisis and the housing crisis,” Donovan said.

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Nebraska

Adult - Rural Area Services

Adult - Describes how community-based services will be provided to individuals in rural areas

-Adult / Child-

- Describes how community-based services will be provided to individuals in rural areas

Rural Area Services (last updated August 21, 2009)

The discussion on Rural Area Services will include a review of Metropolitan Statistical Areas (MSA), Micropolitan Statistical Areas, and Rural and Frontier Areas. For the purposes of this document, the MSA 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. This section also discusses a Nebraska service called the Rural Mental Health Hotline and Voucher Program.

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—population of 390,007), Sarpy, Cass, Saunders, and Washington; (Sarpy County includes Offutt Air Force Base in the Omaha, NE—IA MSA)
- Region 5 – Lancaster (includes Lincoln—population of 225,581), Seward
- Region 4 – Dakota (includes South Sioux City—population of 11,925) (connected to Sioux City, Iowa), Dixon

More than half of Nebraska's population now lives in metropolitan areas. As of 2000, the Nebraska portion of the "Omaha, NE—IA MSA" (Cass, Douglas, Sarpy, and Washington Counties) is 629,294 people. The "Lincoln, NE MSA" (Lancaster County) has a population of 250,291. These two MSAs include 879,585 people, accounting for 51.4% of the total state population of 1,711,263.

The Nebraska portion of the "Sioux City, IA—NE MSA" (Dakota County, NE) has a population of 20,253 people. When combined with the other two MSAs in Nebraska, these areas include 899,838 people, accounting for 52.6% of the total population of 1,711,263.

Micropolitan Statistical Areas – population of 10,000 to 49,999

The counties in this category include:

- Region 1 – Scottsbluff County (population of 36,951), includes Scottsbluff (14,732), Gering (7,751), and Terrytown (646)
- Region 2 – Lincoln County (34,632), includes North Platte (23,878); Dawson County (24,365), includes Lexington (10,011)
- Region 3 – Hall County (53,534), includes Grand Island (42,940); Buffalo County (42,259), includes Kearney (27,431); Adams County (31,151), includes Hastings (24,064)
- Region 4 – Madison County (35,226), includes Norfolk (23,516); Platte County (31,662), includes Columbus (20,971)
- Region 5 - Gage (22,993), includes Beatrice (12,496)
- Region 6 – Dodge County (36,160), includes Fremont (25,174)

Rural and Frontier areas

According to the Rural Policy Research Institute at the University of Missouri-Columbia, the term "Frontier Area" is used to describe an area with extremely low population density. Frontier Areas are isolated rural areas characterized by considerable distances from central places, poor access to market areas, and people are relatively isolated from each other in large geographic areas.
The National Rural Institute on Alcohol and Drug Abuse uses the following definitions:

- Rural areas contain 50 or fewer people per square mile
- Frontier areas contain 6 or fewer people per square mile.

Overall, Nebraska has 22.3 Persons per Square Mile.
Applying these standards to Nebraska's "Population Density by County" indicate Nebraska has:

- 52 – Rural counties (areas that contain **50 or fewer** people per square mile) with a population of 604,757, which accounts for 35% of the total population of 1,711,263.
- 33 – Frontier counties (areas that contain **6 or fewer** people per square mile) with a total population of 93,711, which accounts for 5% of the total population of 1,711,263.
- 8 – remaining Nebraska counties (areas with **more than 50** people per square mile) with a total population of 1,012,795, which accounts for 59% of the total population of 1,711,263.

Of the 33 **Frontier Area** counties in Nebraska, 11 counties have **less than 1,000** people:

- Keya Paha (983), Wheeler (886), Banner (819), Hooker (783), Logan (774), Grant (747), Thomas (729), Loup (712), Blaine (583), McPherson (533), and Arthur (444).

The Nebraska Counties with **more than 50** people per square mile include:

- Adams and Hall in Region 3
- Madison and Dakota in Region 4
- Lancaster in Region 5
- Dodge, Sarpy, and Douglas in Region 6.

(Source: Fact Sheet #1—"Definitions of Rural"; National Rural Institute on Alcohol and Drug Abuse; University of Wisconsin-Stout; 140 Vocational Rehabilitation Building; P.O. Box 0790; Menomonie, WI 54751-0790)

The following tables compare the unduplicated count of persons served by age and county of admission for FY2008 and FY2009:

Unduplicated Count of Persons Served by Age and County of Admission

The following table compares the unduplicated count of persons served in SFY2009 in Mental Health Programs funded by the Division of Behavioral Health. The table indicates the count by age in Rural versus Metro counties. (This includes clients who received mental health services only, and clients who received mental health and substance abuse co-occurring services.) (N=32,574)

Rural / Metro Analysis of Mental Health Persons Served (SFY2009)

	Total	Rural	Metro	Out-of-State	Unknown	Not Available
Less Than 18	2,617	1,111	1,506	0	0	0
18 Years +	29,269	11,319	17,893	20	2	35
Not Available	688	374	291	4	0	19
Total	32,574	12,804	19,690	24	2	54

Footnote:

(1) In January 2009, the Division of Behavioral Health cleaned its data system by administratively discharging nearly 18,000 records of admission to program prior to November 2003, and of which had no activity in the last year. This reduced the number of active cases in the system.

(2) To obtain unduplicated count of persons served, the Division used social security numbers and dates of birth to identify unique clients in the data system.
(3) Metropolitan counties per U.S. Census Bureau, November 2007: Cass, Dakota, Dixon, Douglas, Lancaster, Sarpy, Saunders, Seward, Washington. (For the purposes of reporting this measure, the remaining 84 Nebraska Counties are classified as rural.) (Source: NE Division of Behavioral Health - August 20, 2009)

Rural Mental Health Voucher Program and Hotline Services

The Nebraska Department of Health and Human Services-Division of Behavioral Health contracts with Interchurch Ministries of Nebraska to manage a statewide program for the provision of free mental health crisis counseling and hotline services to rural agribusiness residents and/or family members impacted by a farm crisis. The program, known as the Counseling Outreach & Mental Health Therapy (COMHT) Program, was discontinued in the early 1990s due to lack of funding. In the spring of 1999, the declining situation of family farms incited the Division of Behavioral Health to re-establish the "hot line and voucher" program by providing $50,000 in funding. The amount of funding for this program is currently $204,000.00 per fiscal year to support mental health services in rural Nebraska.

The Rural Voucher Program is accessed by calling the Nebraska Rural Response Hotline. An intake is conducted at which time the hotline operator assesses the reason for request and demographic data is recorded for eligibility and reporting purposes. A voucher is subsequently mailed to the hotline caller with a list of psychiatrists or licensed counselors available for the individual to choose from. Those utilizing the Mental Health Voucher can receive up to 6 counseling sessions at no cost. There are 84 active Nebraska service providers currently participating in the program who receive $75 per session. It the responsibility of the program to ensure that enrolled providers only accept funds paid for each voucher, as this is the sole source of reimbursement for providing mental health crisis counseling to eligible persons.

Of the 2,926 vouchers mailed out from July 1, 2008 through June 30, 2009 the number of vouchers returned for payment was 2,696. Essentially, the purpose of these vouchers is to support anyone who suffers direct repercussion from fluctuations in the agricultural economy. The Division recently approved the hotline expanding their target population to include Iraq and Afghanistan war veterans who have recently returned to rural areas. A tracking system was implemented in October of 2007 to capture this additional data, and to date a total of 33 veterans have been served through the program. The growing demand for vouchers can also be attributed in part to the increased knowledge of their existence, the positive outcomes, as well as the significant amount of drought and weather related problems Nebraska experiences throughout the year.

Source: Nebraska Division of Behavioral Health - July 24, 2009

Nebraska

Adult - Older Adults

Adult - Describes how community-based services are provided to older adults

-Adult-

- Describes How Community-Based Services are Provided to Older Adults

Mental illnesses have a significant impact on the health and functioning of older people and are associated with increased health care use and higher costs. According to the report, Community Integration for Older Adults with Mental Illnesses: Overcoming Barriers and Seizing Opportunities, prepared by the National and Statewide Coalitions to Promote Community-Based Care, sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA), the number of older adults in the United States is increasing rapidly, and so are their needs for long-term mental health services and supports. Seven million people age 65 and older in the U.S. (20 percent of the older adult population) have a psychiatric illness, and that number is expected to double to 15 million in the next thirty years. Older adults with serious mental illnesses receive lower quality of care and have higher mortality rates than older adults without a mental disorder. They are also three times more likely to be placed in nursing homes. Frequently, older adults with mental disorders have co-morbid medical conditions that complicate their treatment and long-term stability. Older adults are at risk of developing both depression and alcohol dependence for perhaps the first time in their lives.

Source: http://mentalhealth.samhsa.gov/publications/allpubs/sma05-4018/

Although older adults represent 13 percent of the U.S. population, they receive only 6 percent of community mental health services. Numerous fiscal, service system, clinical, and societal barriers make it difficult for older adults with serious mental illnesses to find long-term, community-based treatment, housing, and supports. Current reimbursement and fiscal policies tend to favor inpatient versus outpatient care; medical versus psychological care; acute versus chronic care; and more restrictive versus less restrictive care. Nebraska has utilized the provisions of the Preadmission Screening and Resident Review (PASRR) through the Nursing Home Reform Act of 1987 to identify people with serious mental illnesses who can be more appropriately treated in the community.

In the Report of the Surgeon General on Mental Health, it notes that millions of older Americans cope constructively with the physical limitations, cognitive changes, and their various losses that frequently are associated with later life. However, a substantial proportion of the population 55 and older—almost 20 percent of this age group—experience specific mental disorders that are not part of "normal" aging. The stigma of mental illnesses and substance use disorders, and the lack of understanding that these problems can be successfully treated in older adults, keep many older Americans from seeking the help they need. Successful programs feature accurate assessment, outreach, interdisciplinary treatment, education, collaboration with other agencies, and home care services. Several promising approaches provide direction for future development of community-based services. These include supported housing, attention to cultural competence in service delivery settings, and a focus on consumer involvement and empowerment. Because no one service system is equipped to meet the multiple and complex needs of older adults with serious mental illnesses, effective services require coordination and collaboration among providers of aging, mental health, health care, substance abuse, and social services.

In Nebraska, collaboration is occurring between the State Unit on Aging, the eight (8) Nebraska Area Agencies on Aging (AAA), assisted living facilities, nursing homes, and other related community aging services. The State Unit on Aging is located within the Nebraska Department of Health and Human Services-Division of Medicaid and Long-Term Care. This Unit provides a number of services and resources designed to provide support to people age 65 or older. These

services include but are not limited to: Information and Assistance, Senior Employment, Long Term Care Ombudsman Program, Nebraska Medicare/Medicaid Fraud & Waste Project, Nutrition Programs, Senior Centers, Care Management Services, Legal Services, Senior Care Options, Caregiver Support, Alzheimer's Demonstration Project, and more.

One of Nebraska's optional Medicaid services is Personal Assistance Services (PAS). Personal assistance services are available for eligible persons with disabilities and chronic conditions of all ages, who are residing in the community, to enable them to accomplish tasks that they would normally do for themselves if they did not have a disability. Personal assistance services are based on individual needs and include assistance with activities of daily living (e.g. bathing, dressing, toileting, assistance with ambulation, meal preparation, assistance with medication); supportive services (e.g. housekeeping, laundry); and specialized procedures – with physician approval (e.g. catheter care, dressing application, injections). Personal assistance services (PAS) are consumer-directed. The consumer hires, trains, schedules and manages his or her own PAS Medicaid-approved provider(s). A presentation was provided for the Behavioral Health Regional Administrators on this service, as a consumer-directed alternative to home health.

Funded by the Older Americans Act, the Nebraska Community Aging Services Act, and the Nebraska Department of Health and Human Services, the State Unit on Aging has broad responsibilities for addressing the concerns of older Nebraskans. The State Unit on Aging grants state and federal funds to the eight (8) Area Agencies on Aging to support local programs and services. With the assistance of local individuals and advisory groups, each Area Agency on Aging determines needs and develops a plan to provide an appropriate array of services for its aging population. In addition to its planning responsibilities, each Area Agency on Aging is a key source for information on available local resources and services. The Nebraska Association of Area Agencies on Aging members are:

- Aging Office of Western NE in Scottsbluff, NE
- Blue Rivers Area Agency on Aging in Beatrice, NE
- Eastern Nebraska Office on Aging in Omaha, NE
- Lincoln Area Agency on Aging in Lincoln, NE
- Midland Area Agency on Aging in Hastings, NE
- Northeast Nebraska Area Agency on Aging in Norfolk, NE
- South Central Nebraska Area Agency on Aging in Kearney, NE
- West Central Nebraska Area Agency on Aging in North Platte, NE.

The FY 2008-11 State Plan, submitted by the State Unit on Aging to the U.S. Administration on Aging, contains the following information regarding current activities and plans to coordinate aging and behavioral health services and address the mental health needs of older adults:

At the State level, in coordination and collaboration with the Nebraska Department of Health and Human Services - Division of Behavioral Health, the State Unit on Aging will continue efforts to increase public awareness of mental illness and its impact on older Nebraskans, remove barriers to mental illness diagnosis and treatment, as well as coordinate mental health services, including screenings. In addition, the State Unit on Aging continues to work in partnership with the Division of Behavioral Health to identify systemic problems and concerns regarding mental illness in older adults, and to identify solutions and preventative strategies. For example, the Unit Manager of the State Unit on Aging serves on the Nebraska All-Disasters Behavioral Health Committee to continue to develop plans for meeting the mental health needs of Nebraskans in the event of a disaster. The

Ombudsman is a member of the Advisory Committee to Nebraska Advocacy Services, the identified state advocacy agency for persons with disabilities. The two programs work together to advocate for, and on behalf of, individuals with disabilities, including mental illnesses, who reside in long-term care facilities, helping to ensure their rights are protected and their needs are met.

The Aging Advisory Committee consists of 12 members appointed by the governor, one from each of the eight (8) Area Agencies on Aging, and the remaining members are from the State at large. The Committee meets as least three (3) times a year to discuss the needs and issues affecting older Nebraskans. In addition, the State of Nebraska has nine (9) Community Action Agencies (CAA) that cover all 93 counties in the state. Some of the Community Action Agencies work in cooperation with the Area Agencies on Aging to serve older adults. Some of the programs available through the CAAs are funded by the Department of Health and Human Services. Some of the services include: Advocacy Services, Community Education, Domestic Violence Program, Nutrition Service, Transportation, and Weatherization.

At the Local level, Nebraska Area Agencies on Aging coordinate services with their Regional Behavioral Health Systems, as well as local behavioral health service providers, working to ensure the mental health needs of older Nebraskans are met and concerns are addressed.

- This includes access to services (e.g. transportation), information, assistance, and outreach.
- On an individual basis, Medicaid Service Coordinators and Care Managers work together with local Behavioral Health providers to provide mental health services for their clientele.

Other examples include:

- the Lincoln Area Agency on Aging operates the Harvest Project which joins the services of a treatment provider, the local Community Mental Health Center, and the local AAA to meet the needs of low-income and homeless older adults with mental health and/or substance abuse problems;
- a new partnership has been developed between the local Community Mental Health Center and the local AAA Senior Companion Program, which matches eligible senior adults with chronic behavioral health clients to provide additional socialization, increased life skills, and assistance with banking, shopping, and other community services.
- Nebraska's Area Agencies on Aging also provide cross-training opportunities, so that AAA staff become familiar with the programs and services offered by the Behavioral Health Regions and mental health providers, and vice versa; and
- the Eastern Nebraska Office on Aging, in cooperation with the Omaha Housing Authority, established a specialized homeless shelter for older adults.

In addition, the Division of Behavioral Health invited the Director of the Lincoln Area Agency on Aging to attend a meeting of the State Advisory Committee on Mental Health Services on February 5, 2009. Following are notes from the report she provided:

> June Pedersen, Director of the Lincoln Area Agency on Aging, explained her agency's concerns with Behavioral Health Services. She spoke of the stigma of the older population being labeled "mentally ill", sporadic access to mental health services, and problems accessing services within the rural areas. She states her agency believes there is a need for Intensive Case Management for mental health and would like it to be available in all of the Behavioral Health Regions. June also reported on the Harvest Project, which is currently funded only in the Lincoln Region, stating the Agencies on Aging across the State would like the project to be expanded throughout the State. The three collaborating components of this project are: The Lincoln Area Agency on Aging, CenterPointe (co-occurring disorder

provider), and the Community Mental Health Program. June reports individuals are involved in the project on a voluntary basis, and are without family and other support. The individuals must have a mental health and/or substance abuse diagnosis for providers to receive reimbursement for services. The Project includes three Intensive Case Managers, each with a case load of 25 individuals. An additional staff person was authorized for FY2010 for the Harvest Project. The need for additional staff is due to a significant increase in the number of individuals needing services, as well as the cases becoming more labor intensive. Each staff position can adequately manage a caseload of twenty-five (25) individuals. Looking into the future, the Director of the Lincoln Area Agency on Aging sees more evidence of un-diagnosed older adults with depression and varying forms of mental illness. The first step in managing this trend is to educate older adults about depression, but once individuals are diagnosed the services must be in place to meet their needs. The Director continues to develop a collaborative relationship with the local Community Mental Health Center to increase and provide for the necessary services.

The Table below indicates the unduplicated count of persons served, age 65 or older, as reported in URS Table 2A for FY2007 and FY2008. The projected count of persons served during FY2009 is provided because the actual Table 2A data have not been compiled as of this date. Across the three year time period, approximately two percent (2%) of the adults served in the Nebraska public, non-Medicaid mental health system were age 65 or older. These tables demonstrate that older adults do receive services within the Nebraska Behavioral Health System (NBHS).

Profile of Persons Served, All Programs by Age, Gender and Race/Ethnicity

Older Adults Served			
	2007 Actual	FY2008 Actual	projected FY2009
65-74 years	493	527	525
75+ years	186	197	127
total	679	724	652
Total Adults	33,068	32,862	32,574
percent served	2.10%	2.20%	2.00%

Source: NE Division of Behavioral Health (August 20, 2009)

Footnote:

(1) In January 2009, the Division of Behavioral Health cleaned its data system by administratively discharging nearly 18,000 records of admission to program prior to November 2003 and of which had no activity in the last year. This reduced the number of active cases in the system.

(2) To obtain the unduplicated count of persons served, the Division used social security numbers and dates of birth to identify unique clients in the data system.

(3) The data includes consumers who received only mental health services or who received both mental health and substance abuse services. The Unduplicated Count of Persons Receiving Services Funded by the Division of Behavioral Health in State Fiscal Year 2009 is: Mental Health ONLY consumers (17,720 / 47%), Co-occurring consumers (14,854 / 39%) and Substance Abuse ONLY consumers (5,095 / 14%) for a total of 37,669.

Nebraska

Adult - Resources for Providers

Adult - Describes financial resources, staffing and training for mental health services providers necessary for the plan;

-Adult-

- Describes financial resources, staffing, and training for mental health services providers necessary for the plan
- Provides for training of providers of emergency health services regarding mental health
- Describes how the State intends to expend this grant for the fiscal years involved

Financial Resources

The following table shows State Expenditures for Mental Health Services by State Fiscal Year (SFY) (July 1 to June 30) in the Nebraska Department of Health and Human Services - Division of Behavioral Health. The data is from the Nebraska Information System (NIS). This is the same data reported under the Maintenance of Effort (MOE) Report requirement.

State Expenditures for Mental Health Services FY09

	Actual FY07	Actual FY08	Estimated FY09
	48,888,467	47,482,195	54,560,767
Rolling 2 year average 2007+2008/2:			48,185,331

Sources: Actual FY07: Nebraska Information System Fiscal Year 2008 Summary of Expenditures, Behavioral Aid Program 038, as of June 30, 2009

Actual FY08: Nebraska Information System Fiscal Year 2008 Summary of Expenditures, Behavioral Aid Program 038, as of June 30, 2009 – as approved by SAMHSA removing one time funding of 17,100,000, approved May 06, 2009.

Estimated FY09: Nebraska Information System Fiscal Year 2008 Summary of Expenditures, Behavioral Aid Program 038, as of June 30, 2009.

The Regional Behavioral Health Authorities agree to provide the following services, funded by the Community Mental Health Services Block Grant, through their subcontracted providers:

- Closely monitor inpatient, residential, and non-residential service subcontractor compliance with the following priorities for admission to behavioral health services
  a. Mental Health Board Commitments;
  b. Persons discharged from a state regional center meet clinical admission criteria;
  c. Persons who meet clinical criteria who would be admitted to a regional center but who can be served in a community service;
  d. All others.
- Provide services as specified by the Division, in accordance with all State standards and regulations and Federal requirements
- Provide network management services for the Nebraska Behavioral Health Services in the Region's geographic area of responsibility
- Facilitate continuity between the State operated Regional Centers and the Region network providers upon the discharge of a consumer from a Regional Center
- Provide Regional System Coordination for the following major service systems in the Region's geographic area of responsibility:
  1. Region Youth Behavioral Health Services System

2. Region Behavioral Health Emergency Services System
3. Region Behavioral Health Prevention Services System
4. Region Behavioral Health Consumer Services

Staffing

Following is a list of the current staff employed in the Division of Behavioral Health.

Scot Adams, Director of the Division of Behavioral Health

Community Services Section

Vicki Maca, Administrator for Community-Based Services
Blaine Shaffer, MD, Chief Clinical Officer
Sue Adams, Network Operations Manager
Sheri Dawson, Data and Continuous Quality Improvement Manager
Maya Chilese, Children's Behavioral Health Manager
Carol Coussons de Reyes, Office of Consumer Affairs Administrator
Jim Harvey, Federal Resources Manager
Eric Hunsberger, Gambler's Assistance Program Manager
Karen Harker, Federal Aid Administrator
Sarah Cox, Renee Faber, Ann Vogel, Network Operations Specialist
Rachel West, Statistical Analyst
Bob Bussard, Data Specialist
Dan Powers, Consumer Liaison
Phyllis McCaul, Consumer Liaison
Nancy Heller, Federal Resources Program Specialist
Mary Andregg, Administrative Assistant
Abigail Anderson, Alexandra Castillo, Iliana Martin, Christine Newell, Staff Assistant

The Division of Behavioral Health does not collect data on staffing of the Regional Behavioral Health Authorities or on local level behavioral health providers.

- **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. For more details, see Adult - Unmet Service Needs GAP #4: SHORTAGE OF BEHAVIORAL HEALTH WORKFORCE.

Behavioral Health Professionals by Region

Region	One	Two	Three	Four	Five	Six	Total
Psychiatrists	4	3	9	5	31	98	150
	3%	*2%*	*6%*	*3%*	*21%*	*66%*	*100%*
Advanced Practice Registered Nurses	3	0	12	4	10	30	59
	5%	*0%*	*20%*	*7%*	*17%*	*52%*	*100%*
Physician Assistants	0	0	1	2	3	3	9
	0%	*0%*	*11%*	*22%*	*33%*	*33%*	*100%*
Psychologists	8	5	20	17	110	128	288
	3%	*2%*	*7%*	*6%*	*38%*	*44%*	*100%*
Mental Health Practitioners, Independent Mental Health Practitioners, Alcohol & Drug Counselors, Certified Compulsive Gambling Counselors	50	69	203	111	423	709	1565
	3%	*4%*	*13%*	*7%*	*27%*	*45%*	*100%*
All Professions	65	77	245	139	577	968	2071
	3%	*4%*	*12%*	*7%*	*28%*	*47%*	*100%*

Source: Health Professions Tracking Service - University of Nebraska Medical Center, Omaha, NE – July 2009

Training

The Division of Behavioral Health provides and/or oversees the following categories of training opportunities across the State:

- Magellan Provider Training – Magellan Behavioral Health continues to provide training with all contract providers on managed care issues in accordance with the renewal of the Administrative Services Option (ASO).

- The Division will continue to sponsor trainings for consumers/providers highlighting the recovery concept. For example, the Division continues to support the Annual Consumer Conference, usually held in September.

- Suicide Prevention Curricula continues to be delivered via a Train the Trainers model. This model develops and maintains local expertise in suicide prevention. The target population for this pilot is adults in Southeast Nebraska with emphasis on reaching those at highest risk for suicide.

FY2010 Allocations to Regions

Adult	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Total
Community Support		$86,624	$18,328	$31,678			$136,630
Day Rehabilitation		29,673				19,159	48,832
Psych Residential Rehabilitation						183,955	183,955
Day Treatment					15,000		15,000
Medication Management	5,789	51,649			20,000		77,438
Outpatient Therapy	20,094		31,085	26,817	144,000	152,941	374,937
Day Support	31,958		34,877				66,835
Supported Employment	1,440	11,251	26,439	39,800			78,930
Total Adult Services	**$59,281**	**$179,197**	**$110,729**	**$98,295**	**$179,000**	**$356,055**	**$982,557**

Children	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Total
Therapeutic Consultation (PL 100-690) Service	$40,850		$10,356		$68,800		$120,006
Day Treatment (P.L. 102-321) Service			32,500		129,689		162,189
Children's Multi-Systemic Therapy			50,131				50,131
Professional Partner	78,000		50,000	160,000		182,613	470,613
Children's Intensive Outpatient					36,219		36,219
Total Children Services	**$118,850**	**$0**	**$142,987**	**$160,000**	**$234,708**	**$182,613**	**$839,158**
Grand Totals	**$178,131**	**$179,197**	**$253,716**	**$258,295**	**$413,708**	**$538,668**	**$1,821,715**

Other designated uses for funds:	
Peer Reviews	5,000
Administrative Portion	96,270
	$1,922,985
Previous Year MHBG	$1,925,411
	-$2,426

Sources:

--SFY2010 Regional Budget Plans/Contracts for Behavioral Health and Network Management Services as of July 24, 2009.

--Division of Behavioral Health SFY2010 Budget Projections as of July 24, 2009, drafted by Karen Harker and being uploaded into the Nebraska Information System (NIS) by Lori Dawes.

Nebraska

Adult - Emergency Service Provider Training

Adult - Provides for training of providers of emergency health services regarding mental health;

-Adult-

- Provides for training of providers of emergency health services regarding mental health

Mental Health Commitment Board Training

In Nebraska, at the core of providing training of providers of emergency health services regarding mental health is Mental Health Commitment Board training. The Department of Health and Human Services (DHHS) is responsible for training of Mental Health Commitment Boards under Neb. Rev. Stat. §71-916 (Source: Laws 2004, LB 1083, § 36). There are approximately twenty-eight mental health boards across the state.

Under §71-916 (1), DHHS shall provide appropriate training to members and alternates of each Mental Health Board. The section says no person shall remain on a Mental Health Board or be eligible for appointment or reappointment as a member or alternate of such board unless he or she has attended and satisfactorily completed such training pursuant to rules and regulations adopted and promulgated by DHHS.

The training provided by the Division of Behavioral Health is posted on the DHHS Web Site for the Division of Behavioral Health: Community-Based Services under "Mental Health Commitment Board Training" (http://www.dhhs.ne.gov/beh/Commit/Commit.htm) The Nebraska Mental Health Commitment Process / Mental Health Board Training Handbook is available at this site.

Mental Health Board Training is the primary training available to the Mental Health Commitment Boards in the State of Nebraska. Persons who have not previously received classroom training are required to review the handbook and submit the Self Study Examination to the Division of Behavioral Health. All Board members are encouraged to review the handbook and submit the Self Study Examination to the Division, who reviews and scores all examinations.

Nebraska Mental Health Commitment Process - The Mental Health Commitment Boards play a key role under the Nebraska Mental Health Commitment Act (Sections 71-901 to 71-962). One of the aspects of the Nebraska Mental Health Commitment Act includes the proceedings of the Mental Health Boards. One of the starting points for the commitment cycle is with an emergency protective custody (EPC). If a Law Enforcement Officer has probable cause to believe that a person is mentally ill and dangerous and the harm is likely to occur before a Mental Health Board proceedings can be arranged, the Officer may take such person into emergency protective custody (EPC). The person shall be admitted to the nearest appropriate and available medical facility and shall not be placed in a jail. The medical facility shall complete an evaluation by a mental health professional of the person no later than thirty-six hours after admission. The person shall be released from the EPC after completion of such evaluation unless the mental health professional determines, in his or her clinical opinion, that such person is mentally ill and dangerous.

The County Attorney receives a copy of the evaluation. If the County Attorney concurs that such person is mentally ill and dangerous and that neither voluntary hospitalization nor other treatment alternatives less restrictive of the person's liberty than inpatient or outpatient treatment ordered by a Mental Health Board is available, he or she shall file a petition. The petition is for a hearing by the Mental Health Board. The hearing needs to be held within seven calendar days after the person has been taken into emergency protective custody.

The hearing is held by the Mental Health Board to determine whether there is clear and convincing proof evidence that the subject is mentally ill and dangerous as alleged in the petition filed by the

County Attorney. Treatment may be ordered by the Mental Health Board. Such services shall represent the appropriate available treatment alternative that imposes the least possible restraint upon the liberty of the person. If the Mental Health Board finds the subject to be mentally ill and dangerous and commits the subject to the custody of the Department of Health and Human Services to receive inpatient treatment, the Department shall secure placement of the subject in an appropriate inpatient treatment facility to receive such treatment.

Disaster Behavioral Health

The Division of Behavioral Health staff participate in the annual Nebraska Disaster Behavioral Health Conference. During the 2009 conference, staff participated in the following activities:

Behavioral Health Tabletop Exercise (July 16, 2009) in Omaha, NE; 47 state and local participants

- Disaster Preparedness involves a cycle of planning, capability development, training, exercising, evaluation, and improvement. Successful exercises lead to an ongoing program of process improvements. This Behavioral Health Tabletop Exercise was funded by the Nebraska Department of Health and Human Services (DHHS) and facilitated by the University of Nebraska-Public Policy Center personnel. The exercise was designed to bring together individuals working for the state DHHS behavioral health division, the six regional behavioral health entities, local pubic health, local emergency management, and volunteer organizations. The goal of the exercise was to provide participants with an opportunity to discuss and critique plans for responding to a major disaster involving a flooded small town in the state.

The Nebraska Disaster Behavioral Health Conference was held on July 17, 2009 at the Embassy Suites Hotel in Omaha, NE. There were officially 180 people who attended.

Following is the information from the brochure for the 2009 Disaster Behavioral Health Conference:

Conference Objectives:
• Introduce the Nebraska Behavioral Health Emergency Response Team (BHERT)
• Learn about offender characteristics of adolescent and adult mass murderers
• List at least three reactions children may experience with parental deployment
• Delineate four primary reasons to evaluate disaster mental health programs
• Prepare disaster behavioral health responders in responding to declared disasters and undeclared incidents that overwhelm local communities

Conference Schedule
9:00-9:15 *Introduction and Opening Remarks* **- Scot Adams, Ph.D.**
9:15-10:15 *Human Factors in Disaster Response: Blending Clinical and Tactical Considerations* **--Steve Crimando, MA, BCETS**
10:30– 12:00 *Adolescent and Adult Mass Murder: Contemporary Findings and Trends* **--J. Reid Meloy, Ph.D.,**
1:15-2:15 *Coping with deployment: Reaching out to military families* **--Robin Gurwitch, Ph.D.**
2:15-3:15 *Improving Disaster Mental Health Practice through Research: Cross-Site Evaluation of the Crisis Counseling Program* **--Fran H. Norris, Ph.D.**

3:30-4:30 *Disaster Behavioral Health: Lessons Learned in the Aftermath of the Trolley Square Shooting*--**Robert Snarr, MPA, LPC, NCC**

Conference Faculty:

Scot Adams, Ph.D., *Director, Division Behavioral Health, Nebraska Dept. of Health and Human Services*
Dr. Adams was appointed to head the Division of Behavioral Health by Governor Dave Heineman in March 2007. He has been instrumental in developing Nebraska's capacity to respond to the psychological and social consequences of disaster. Under his leadership, Nebraska recently added to this capacity with the development of a State Behavioral Health Emergency Response Team. In addition to spurring the team's development, Dr. Adams also serves as a team member.

Steve Crimando, MA, BCETS—*Disaster & Terrorism Branch, New Jersey Div. of Mental Health Services*
Steven M. Crimando is an internationally known consultant and educator specializing in the human factors/behavioral sciences aspects of crisis management, homeland security and disaster recovery. Mr. Crimando is a Board Certified Expert in Traumatic Stress (BCETS), a Diplomate of the National Center for Crisis Management and the American Academy of Experts in Traumatic Stress. He has more than 20-years experience as a frontline disaster responder and consults with government agencies, NGO's and multinational businesses on the importance of using accurate behavioral assumptions to inform disaster related policies, plans and exercises, as well as response activities.

J. Reid Meloy, Ph.D.—*Private Practice, Forensic Psychologist*
Dr. Meloy is a diplomate in forensic psychology of the American Board of Professional Psychology. Formerly Chief of the Forensic Mental Health Division for San Diego County, he now devotes his time to private criminal forensic practice, research, writing, and teaching. He is a sought after psychological expert on various criminal cases throughout the United States and Europe, and is currently a consultant to the counterintelligence division of the FBI. He is also a member of the Fixated Research Group for the United Kingdom's Home Office concerning threats to the Royal Family and British political figures.

Robin H. Gurwitch, Ph.D.—*Program Coordinator for the National Center for School Crisis and Bereavement*
Dr. Gurwitch is a Professor in the Department of Pediatrics at Cincinnati Children's Hospital Medical Center. She co-authored a guidebook for community resilience in the face of disaster with a focus on children and families with the CDC. She has worked with the Department of Defense/Pentagon to develop materials for families and children whose parents are in Iraq and Afghanistan. Dr. Gurwitch was recently asked to Chair the APA Presidential Task Force on the Psychological Needs of US Military Service Members and Their Families.

Fran H. Norris, Ph.D.—*National Center for Post-Traumatic Stress Disorder*
Dr. Norris is a community psychologist and research professor in the Department of Psychiatry at Dartmouth Medical School, where she is affiliated with the National Center for PTSD and the National Consortium for the Study of Terrorism and Responses to Terrorism (START). She is also the Director of the NIMH-funded National Center for Disaster Mental Health Research. Her research interests include posttraumatic stress, post-disaster mobilization of social support, and community resilience.

Robert Snarr, MPA, LPC, NCC—*State Adult Programs Mgr, Utah Div. of Substance Abuse and Mental Health*
Mr. Snarr developed and directs the Utah Behavioral Health Crisis Counseling program, coordinated FEMA trainings for the 2002 Utah Winter Olympics, the All-Hazards Southwestern Regional Training, facilitated a statewide plan for Utah on disaster preparedness, and provided consultation to the U.S. Secret Service. He has provided training for more than 500 crisis counselors, worked with FEMA, SAMHSA and statewide programs to help serve people relocated due to Hurricane Katrina, facilitated crisis counseling services for the Utah Crandall Mine disaster and the Trolley Square Shooting.

For more information on the Nebraska Disaster Behavioral Health go to
http://www.disastermh.nebraska.edu

Nebraska

Adult - Grant Expenditure Manner

Adult - Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal years involved

see Adult - Resources for Providers.

Table C. MHBG Funding for Transformation Activities
State: Nebraska

	Column 1	Column 2	
	Is MHBG funding used to support this goal? If yes, please check	If yes, please provide the *actual* **or** *estimated* amount of MHBG funding that will be used to support this transformation goal in FY2010	
		Actual	**Estimated**
GOAL 1: Americans Understand that Mental Health Is Essential to Overall Health	☐		
GOAL 2: Mental Health Care is Consumer and Family Driven	☒		772,157
GOAL 3: Disparities in Mental Health Services are Eliminated	☒		1,049,558
GOAL 4: Early Mental Health Screening, Assessment, and Referral to Services are Common Practice	☐		
GOAL 5: Excellent Mental Health Care Is Delivered and Programs are Evaluated*	☐		
GOAL 6: Technology Is Used to Access Mental Health Care and Information	☐		
Total MHBG Funds	N/A	0	1,821,715

*Goal 5 of the Final Report of the President's New Freedom Commission on Mental Health states: Excellent Mental Health Care is Delivered and Research is Accelerated. However, Section XX of the MHBG statute provides that research … Therefore, States are asked to report expected MHBG expenditures related to program evaluation, rather than research.

Nebraska

Table C - Description of Transformation Activities

For each mental health transformation goal provided in Table C, breifly describe transformation activities that are supported by the MHBG. You may combine goals in a single description if appropriate. If your State"s transformation activities are described elsewhere in this application, you may simply refer to that section(s).

Table C Description of Transformation Activities July 27 2009

Table C - Description of Transformation Activities

Narrative Question:

For each mental health transformation goal provided in Table C, breifly describe transformation activities that are supported by the MHBG. You may combine goals in a single description if appropriate. If your State's transformation activities are described elsewhere in this application, you may simply refer to that section(s).

July 27, 2009

Table C

GOAL 2: Mental Health Care is Consumer and Family Driven	$772,157
GOAL 3: Disparities in Mental Health Services are Eliminated	$1,049,558
Total Community Mental Health Block Grant Funds Allocated to the Six Regional Behavioral Health Authorities	$1,821,715

The Division of Behavioral Health believes that all of the funds ($1,821,715) allocated to the six Regional Behavioral Health Authorities within the FY2010 contracts are being used for transformation activities. All of these funds improve access to services and promote the least restrictive community based services needed to meet consumer need. This was reviewed with the State Advisory Committee on Mental Health Services on August 13, 2009.

GOAL 2: Mental Health Care is Consumer and Family Driven

Goal 2 - 2.1 Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance.

NOTE: Every consumer needs to have an individualized plan of care in the community based services including but not limited to Medication Management – MH, Outpatient Therapy - MH (Ind, Grp &/or Fam), Outpatient Therapy - Dual (Ind, Grp, &/or Fam), Day Treatment – MH, Day Rehabilitation – MH, Supported Employment, Community Support – MH, Psych Residential Rehab – MH, Prof Partner, Prof Partner/School Wrap, Children's Intensive Outpatient - MH, Multi Systemic Therapy, Therapeutic Consultation (P.L. 100-690) Service, and Day Treatment (P.L. 102-321) Service. This actually applies to all six Regions. However, the numbers for Regions 1 to 4 plus rural Region 5 are already included inside Goal 3.

Goal 2 - 2.2 Involve consumers and families fully in orienting the mental health system toward recovery.

NOTE: Day Support – MH meets this standard.

GOAL 3: Disparities in Mental Health Services are Eliminated

3.2 Improve access to quality care in rural and geographically remote areas.

All funds allocated to Regions 1 to 4 plus the Region 5's rural areas [funds allocated to Blue Valley Behavioral Health (BVBH)].

Some of the services also are under this Goal.

Goal 4: Early Mental Health Screening, Assessment, and Referral to Services Are Common Practice

– Professional Partner/School Wrap services using Federal Community Mental Health Block Grant funds

– Therapeutic Consultation (P.L. 100-690) Service using Federal Community Mental Health Block Grant funds are in Regions 1, 3 and 5.

As reported under Adult/Child - Grant Expenditure Manner here are the allocations of these Federal funds to the six Regions for State Fiscal Year 2010.

FY10 Allocations to Regions

Adult	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Total
Community Support		$86,624	$18,328	$31,678			$136,630
Day Rehabilitation		29,673				19,159	48,832
Psych Residential Rehabilitation						183,955	183,955
Day Treatment					15,000		15,000
Medication Management	5,789	51,649			20,000		77,438
Outpatient Therapy	20,094		31,085	26,817	144,000	152,941	374,937
Day Support	31,958		34,877				66,835
Supported Employment	1,440	11,251	26,439	39,800			78,930
Total Adult Services	**$59,281**	**$179,197**	**$110,729**	**$98,295**	**$179,000**	**$356,055**	**$982,557**

Children	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Total
Therapeutic Consultation (PL 100-690) Service	$40,850		$10,356		$68,800		$120,006
Day Treatment (P.L. 102-321) Service			32,500		129,689		162,189
Children's Multi-Systemic Therapy			50,131				50,131
Professional Partner	78,000		50,000	160,000		182,613	470,613
Children's Intensive Outpatient					36,219		36,219
Total Children Services	**$118,850**	**$0**	**$142,987**	**$160,000**	**$234,708**	**$182,613**	**$839,158**
Grand Totals	**$178,131**	**$179,197**	**$253,716**	**$258,295**	**$413,708**	**$538,668**	**$1,821,715**

Other designated uses for funds:	
Peer Reviews	5,000
Administrative Portion	96,270
	$1,922,985
Previous Year MHBG	$1,925,411
	-$2,426

NOTE: In the FY10 allocations for Region 5, Blue Valley Behavioral Health (BVBH received a total of $180,219. This is 43.5% of Region 5's MHBG allocation. Services to be funded are Outpatient Services ($144,000) and Children's Intensive Outpatient ($36,319). Source: Region 5 FY10 Regional Budget Plan, BH10a, BVBH worksheet, submitted May 22, 2009.

Sources:

- SFY10 Regional Budget Plans/Contracts for Behavioral Health and Network Management Services as of July 24, 2009.
- Division of Behavioral Health SFY10 Budget Projections as of July 24, 2009, by Karen Harker and being uploaded into NIS by Lori Dawes.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Increased Access to Services (Number)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	33,068	32,862	29,957	29,000	N/A
Numerator	N/A	N/A	--	--	--
Denominator	N/A	N/A	--	--	--

Table Descriptors:

Goal: Increased Access to Services

Target: To maintain the number of adults (age 18 or older), unduplicated count

Population: The adults served in mental health services in the Nebraska Behavioral Health System funded by the Nebraska Division of Behavioral Health Services

Criterion: 2:Mental Health System Data Epidemiology
3:Children's Services

Indicator: Number of Persons Served by Age, Gender, and Race/Ethnicity as reported in the Uniform Reporting System (URS) Table 2A

Measure: Total Adults Served as reported on URS Table 2A

Sources of Information: NE Division of Behavioral Health / Community Mental Health and State psychiatric hospitals / unduplicated count

Special Issues: (1) In January 2009, the Division of Behavioral Health cleaned its data system by administratively discharging nearly 18,000 records of admission to program prior to November 2003 and of which had no acitivity in the last year. This reduced the number of active cases in the system.
(2) To obtain unduplicated count of persons served, the Division used social security numbers and dates of birth to identify unique clients in the data system.
(3) The data includes consumers who received only mental health services or who received both mental health and substance abuse services. The Unduplicated Count of Persons Receiving Services Funded by the Division of Behavioral Health in State Fiscal Year 2009 is: Mental Health ONLY consumers (17,720 / 47%), Co-occuring consumers (14,854 / 39%) and Substance Abuse ONLY consumers (5,095 / 14%) for a total of 37,669.

Significance:

Action Plan: Narrative: The data is persons served as reported on Table 2A. These are reporting the Federal Uniform Reporting System using the capacity to report an unduplicated count of persons served between the Regional Centers (State Psychiatric Hospitals) and community mental health using Magellan Data. Summary from Table 2A “Profile of Persons Served, All Programs by Age, Gender and Race/Ethnicity”

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 30 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	3.13	4.71	3	3	N/A
Numerator	15	16	--	--	--
Denominator	480	340	--	--	--

Table Descriptors:

Goal: Reduced 30 day readmission rates - Utilization of Psychiatric Inpatient Beds -

Target: Non-Forensic (Voluntary and Civil-Involuntary) Patients Readmission to Any State Psychiatric Inpatient Hospital Within 30 Days of Discharge

Population: Non-Forensic (Voluntary and Civil-Involuntary) Patients subject to Readmission to Any State Psychiatric Inpatient Hospital

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Percent Readmitted 30 days

Measure: Percent Readmitted 30 days | Numerator (Number of Readmissions to ANY STATE Hospital within 30 days) | Denominator - Total number of Discharges in Year

Sources of Information: FY2007 & FY2008 from URS Table 20A Non-Forensic Patients Readmission to Any State Hospital 30/180 Days of Discharge. The FY2009 data are not available at this time. Revised FY 2007 URS Tables were submitted as of Dec 1, 2008.

Special Issues: FY2009 preliminary data not available at the time this was prepared. As a result, the FY2007 and FY2008 data used to estimate FY2009 Projected and FY2010 target as 3%.

Significance: This is a good indicator on how well the community based systems and State Hospitals are coordinating efforts on discharge planning.

Action Plan:

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 180 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	7.36	8.53	7	7	N/A
Numerator	32	29	--	--	--
Denominator	435	340	--	--	--

Table Descriptors:

Goal: Reduced 180 day readmission rates - Utilization of Psychiatric Inpatient Beds -

Target: Non-Forensic (Voluntary and Civil-Involuntary) Patients Readmission to Any State Psychiatric Inpatient Hospital Within 180 Days of Discharge

Population: Non-Forensic (Voluntary and Civil-Involuntary) Patients subject to Readmission to Any State Psychiatric Inpatient Hospital

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Percent Readmitted 180 days | Numerator (Number of Readmissions to ANY STATE Hospital within 180 days) | Denominator - Total number of Discharges in Year

Measure: Percent Readmitted 180 days

Sources of Information: FY2007 & FY2008 from URS Table 20A Non-Forensic Patients Readmission to Any State Hospital 30/180 Days of Discharge. The FY2009 data are not available at this time. Revised FY 2007 URS Tables were submitted as of Dec 1, 2008.

Special Issues: FY2009 preliminary data not available at the time this was prepared. As a result, the FY2007 and FY2008 data used to estimate FY2009 Projected and FY2010 target as 7%.

Significance: This is a good indicator on how well the community based systems and State Hospitals are coordinating efforts on discharge planning.

Action Plan:

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Evidence Based - Number of Practices (Number)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	6	6	6	6	N/A
Numerator	N/A	N/A	--	--	--
Denominator	N/A	N/A	--	--	--

Table Descriptors:

Goal: Maintain, and expand when possible, the number of Evidence-Based Practices (EBPs) in Nebraska.

Target: Maintain, and expand when possible, the number of Evidence-Based Practices (EBPs) in Nebraska.

Population: Persons served by NE Division of Behavioral Health who may benefit from Evidence-Based Practices (EBPs) in Nebraska.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Count of the number of Evidence-Based Practices (EBPs) implemented by NE Division of Behavioral Health

Measure: Count of the number of EBPs [1. Assertive Community Treatment (ACT); 2. Supported Employment (SE); 3. Supported Housing; 4. Integrated Treatment For Co-Occurring Disorder (Mental Health / Substance Abuse) Dual Diagnosis Treatments; 5. Medication Management; and 6. Multisystemic Therapy (MST)] funded by the Division of Behavioral Health.

Sources of Information: NE Division of Behavioral Health

Special Issues: Nebraska Division of Behavioral Health is implementing the following Evidence-Based Practices (EBPs)
1. Assertive Community Treatment (ACT)
2. Supported Employment (SE)
3. Supported Housing
4. Integrated Treatment For Co-Occurring Disorder (Mental Health / Substance Abuse) Dual Diagnosis Treatments
5. Medication Management
6. Multisystemic Therapy (MST)

Nebraska has implemented or is developing Fidelity Measurement for the following Assertive Community Treatment (ACT), Supported Employment (SE), and Supported Housing.

Significance:

Action Plan: Narrative: At this time, Nebraska has very limited capacity to report on this measure. Nebraska is developing the following evidence-based practices 1. Assertive Community Treatment (ACT); 2. Supported Employment (SE); 3. Supported Housing; 4. Integrated Treatment For Co-Occurring Disorder (Mental Health / Substance Abuse) Dual Diagnosis Treatments; 5. Medication Management; and 6. Multisystemic Therapy (MST). Each one has a different capacity for reporting unduplicated counts of persons served.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Supported Housing (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	557	N/A	823	700	N/A
Numerator	N/A	717	--	--	--
Denominator	N/A	N/A	--	--	--

Table Descriptors:

Goal: Implement Supported Housing using the NE Housing Related Assistance program

Target: To serve 700 eligible consumers in FY2010. The funding was cut by 8% to the six Regional Housing Coordinators. With the reduced level of funding available, one may expect fewer persons served.

Population: Supported Housing is for adults who are extremely low income with a serious mental illness with the goal of independent housing who are eligible under the Nebraska Housing-related assistance program, as authorized under Neb. Rev. Stat. § 71-812.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Number of persons served annually, unduplicated count, by the NE Housing Related Assistance program

Measure: The count of persons served annually, unduplicated count, by the NE Housing Related Assistance program

Sources of Information: Summary of the monthly Housing Related Assistance data reported from the six Regional Behavioral Health Authorities to the Division.

Special Issues: Narrative: The Nebraska Housing-related assistance program, as authorized under Neb. Rev. Stat. § 71-812, is the basis for reporting the number of consumers who are receiving the Evidence Based Practice service of Supported Housing. This is a conservative count. For example, it excludes consumers who are receiving DHHS funded Behavioral Health support services and have HUD section 8. The SAMHSA EBP Toolkit is not published at this time. However, SAMHSA material was used to guide EBP Implementation. Staff have been specifically trained to implement Supported Housing. The capacity to measure fidelity was developed during FY2008. The Division completed the fidelity monitoring in FY2009.

Significance: The NE Housing Related Assistance program was developed under NE Behavioral Health Reform. It is designed to be Person-centered, recovery-oriented, accessible, focused on a positive outcome of promoting independent living, and cost effective.

Action Plan:

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Supported Employment (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	388	400	N/A
Numerator	N/A	453	--	--	--
Denominator	N/A	N/A	--	--	--

Table Descriptors:

Goal: Implement Supported Employment in partnership with Vocational Rehabilitation

Target: 400 persons with behavioral health disorders age 19 and older in FY2010

Population: persons age 19 and older with mental illness, alcoholism, drug abuse, and/or related addictive disorder.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Number of persons served annually, unduplicated count, under the Supported Employment program as reported by Magellan

Measure: The count of persons served annually, unduplicated count, under the Supported Employment program

Sources of Information: Community Mental Health data as reported under Magellan Behavioral Health

Special Issues: The Division of Behavioral Health has a Memorandum of Understanding (MOU) with Nebraska Vocational Rehabilitation to increase employment opportunities for people with behavioral health (BH) problems. However, the data reported for this indicator is limited to what is collected by the Division of Behavioral Health. In January 2009, the Division of Behavioral Health cleaned its data system by administratively discharging nearly 18,000 records of admission to program prior to November 2003 and of which had no acitivity in the last year. This reduced the number of active cases in the system. Supported Employment persons served for FY2007 is 419; for FY2008 is 478 and the preliminary for FY2009 is 388. The webBGAS system did not permit these data to be uploaded in this manner. The reduction in persons served reflects the data clean-up efforts.

Significance: The Supported Employment program was developed under NE Behavioral Health Reform. It is designed to be Person-centered, recovery-oriented, accessible, focused on a positive outcome of promoting employment, and cost effective.

Action Plan: Narrative: Receiving Supported Employment - In FY2007, the Division of Behavioral Health and Vocational Rehabilitation worked together to develop the service definition of Supported Employment. The Supported Employment service definition was approved on January 5, 2007 for implementation in FY2008. The capacity to measure fidelity needs to be developed.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Assertive Community Treatment (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	221	N/A	242	250	N/A
Numerator	N/A	229	--	--	--
Denominator	N/A	N/A	--	--	--

Table Descriptors:

Goal: Report the number of persons served in Assertive Community Treatment (ACT) in Nebraska.

Target: 225 persons served in Assertive Community Treatment (ACT).

Population: the number of persons served in Assertive Community Treatment (ACT)for the three(3) teams (Omaha, Lincoln, and Hastings).

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: The count of the number of persons served in Assertive Community Treatment (ACT)

Measure:

Sources of Information: Community Mental Health data as reported under Magellan Behavioral Health

Special Issues: In January 2009, the Division of Behavioral Health cleaned its data system by administratively discharging nearly 18,000 records of admission to program prior to November 2003 and of which had no acitivity in the last year. This reduced the number of active cases in the system.

Significance:

Action Plan: Nebraska continues to implement the evidence-based practice of Assertive Community Treatment (ACT). A first URS Table 16 for ACT was completed with the FY2005 report. Fidelity is measured annually. The SAMHSA EBP Toolkit was used to guide EBP Implementation. Staff have been specifically trained to implement the EBP. The ACT teams are in Omaha, Lincoln, and Hastings. The count is the total persons served (unduplicated) for the fiscal year reported.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Family Psychoeducation (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--
Denominator	N/A	N/A	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan: Narrative: At this time, Nebraska has no capacity to report on the Number of Persons Receiving Family Psychoeducation measure. Nebraska is developing other evidence-based practices. Receiving Family Psychoeducation is not offered at this time. It will not be reported any time soon.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Integrated Treatment of Co-Occurring Disorders(MISA) (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	2,714	N/A	74	80	N/A
Numerator	N/A	2,970	--	--	--
Denominator	N/A	N/A	--	--	--

Table Descriptors:

Goal: Report the number of Adults with Serious Mental Illnesses Receiving Integrated Treatment for Co-occurring Disorders (MH/SA) During The Year

Target: Adults with Serious Mental Illnesses Receiving Integrated Treatment for Co-occurring Disorders

Population: Adults with Serious Mental Illnesses Receiving Integrated Treatment for Co-occurring Disorders

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Count of the number of Adults with Serious Mental Illnesses Receiving Integrated Treatment for Co-occurring Disorders

Measure: The measure is limited to the Division of Behavioral Health funded Dual Residential. The service is intended for adults with a primary Axis I diagnosis of substance dependence and a co-occurring severe and persistent mental illness requiring a more restrictive treatment environment to prevent substance use.

Sources of Information: Division of Behavioral Health funded Integrated Treatment for Co-occurring Disorders under the "Dual Diagnosis Residential" Treatment

Special Issues: The Division of Behavioral Health is changing this measure. The measure is now restricted to counting only those consumers who received Dual Disorder Residential services. The new measure reports 87 for FY07, 82 for FY08 and 74 for FY09.

In the previous FY07 and FY08 reports, any consumer who was identified as having co-occurring mental health and substance abuse needs (defined by reason for admission, service received, or diagnoses) but who was not necessarily receiving Dual Disorder Residential service was included in the count. The previous report for FY2007 was 2,714 and 2,970 for FY2008.

Using updated methods, the Division of Behavioral Health has new counts on co-occurring mental health and substance abuse. The Unduplicated Count of Persons Receiving mental health and/or substance abuse Services Funded by the Division of Behavioral Health in FY2009 was 37,669. Of that group, Mental Health ONLY Consumers are 17,720 (47%); Substance Abuse ONLY Consumers are 5,095 (14%); Co-occurring Consumers are 14,854 (39%).

The previous method Adults with Serious Mental Illnesses Receiving Integrated Treatment for Co-occurring Disorders (MH/SA) appeared to under count people with these problems. The revised method appears to better represent the number of persons being served in the Nebraska Behavioral Health System but not necessarily receiving Integrated Treatment for Co-occurring Disorders. Thus, the new measure is restricted to only those receiving Dual Disorder Residential services.

Significance:

Action Plan: Narrative: At this time, Nebraska has very limited capacity to report on this measure. This is a count on the number of persons served under "Dual Diagnosis Residential" Treatment. There is no fidelity measurement at this time.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Illness Self-Management (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--
Denominator	N/A	N/A	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan: Narrative: At this time, Nebraska no capacity to report on the Number of Persons Receiving Illness Self-Management. This service is not offered at this time. It will not be reported any time soon.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Evidence Based - Adults with SMI Receiving Medication Management (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	2,360	N/A	4,257	4,200	N/A
Numerator	N/A	3,444	--	--	--
Denominator	N/A	N/A	--	--	--

Table Descriptors:

Goal: To develop the capacity to consistently report on the number of persons Receiving Medication Management

Target: Persons Receiving Medication Management

Population: Persons Receiving Medication Management

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Number of Persons Receiving Medication Management.

Measure:

Sources of Information: From the URS table 17, data for the column labeled Receiving Medication Management represents an extract for the population presented in table 2a of those person who meet the qualifications for "Medication Management -- MH" (cpt_codes 156 or 90862)

Special Issues: FY2008 preliminary data not available at the time this was prepared. Thus, no reasonable basis for estimating. As a result, the FY2007 data was used for FY2008 estimated and FY2009 target.

Significance:

Action Plan: Narrative: Nebraska has a limited capacity to report on this measure. Receiving Medication Management is a service offered across the state. There is no capacity to measure fidelity. The SAMHSA EBP Toolkit was not used to guide EBP Implementation. Staff have not been specifically trained to implement the EBP. First successfully reported in URS for FY2006.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Client Perception of Care (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	72.91	72.04	70	70	N/A
Numerator	802	688	--	--	--
Denominator	1,100	955	--	--	--

Table Descriptors:

Goal: To maintain the number of consumers responding Positively About Outcomes in the annual Nebraska Behavioral Health Consumer Survey

Target: maintain the number of consumers responding Positively About Outcomes in the annual Nebraska Behavioral Health Consumer Survey

Population: All consumers with valid addresses and/or phone numbers within the Magellan Behavioral Health database who do respond to the annual Nebraska Consumer Survey

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Percentage responding positively

Measure: Numerator: Average of positive responses to the MHSIP Consumer Survey: Perceptions of Outcomes questions (21. I deal more effectively with daily problems; 22. I am better able to control my life; 23. I am better ablet o deal with crisis; 24. I am getting along better with my family; 25. I do better in social situations; 26. I do better in school and/or work; 27. My housing situation has improved; 28. My symptoms are not bothering me as much). Denominator: total number of responses

Sources of Information: Numerator and Denominator Data Source: Nebraska annual consumer survey as reported on Uniform Reporting System/Implementation Report-Table 11. Summary Profile of Client Evaluation of Care using the official MHSIP consumer survey posted on www.mhsip.org.

Special Issues: The annual Nebraska Behavioral Health Consumer Survey is funded by the Federal Mental Health Data Infrastructure Grants for Quality Improvement (State DIG). FY2009 consumer survey data not available at the time this was prepared. Thus, no reasonable basis for estimating. As a result, the FY2007 and FY2008 were used for FY2009 Projected FY2010 Target .

Significance:

Action Plan: Estimated Completion Date: Completed NOTE: Nebraska uses Federal Mental Health Data Infrastructure Grant funds to pay for this survey.
To be collected as part of the consumer survey and reported on Tables 9 and 11 under the agreement with NE HHS Div of Public Health Data Management Unit (FY2007, FY2008). That unit is now part of the UNMC College of Public Health. For FY2009 the data are being collected by UNMC.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Adult - Increase/Retained Employment (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--
Denominator	N/A	N/A	--	--	--

Table Descriptors:

Goal: Implement Supported Employment in partnership with Vocational Rehabilitation

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator:

Measure:

Sources of Information: Community Mental Health data as reported under Magellan Behavioral Health

Special Issues: The Division of Behavioral Health has a Memorandum of Understanding (MOU) with Nebraska Vocational Rehabilitation to increase employment opportunities for people with behavioral health (BH) problems. However, the data reported for this indicator is limited to what is collected by the Division of Behavioral Health.

Significance:

Action Plan: -Currently report URS Table 4. Profile of Adult Clients by Employment Status.
-Developing the capacity to reporty Table 16: Profile of Adults with Serious Mental Illnesses...Recieving Evidence-Based Services-Supported Employment.
- At this time, Magellan collects the data for employment at time of admission and time of discharge. However, for consumers who are in the system for an extended period of time, there is no capacity to update key data fields such as employment. Thus, at this time, Nebraska does not have the capacity to address the "Increase/Retained Employment (Percentage)" aspect of this measure.
- Under the new Magellan ASO Contract, there will be an annual update of the data including living situation. As a result, over time NE should develop the capacity to report this measure.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Adult - Decreased Criminal Justice Involvement (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--
Denominator	N/A	N/A	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan: Possible to develop this capacity with the UNMC contract. NE is working on developing this capacity using administrative data from Criminal Justice (Jail Admission Data), NE Department of Correctional Services and Division of Behavioral Health. MOU needed to authorize the data extract transfer from Corrections and Criminal Justice to UNMC was signed in June 2009. The Division of Behavioral Health continues to work with the NE Dept of Correctional Services, The NE Crime Commission, the Community Corrections Council, and other Justice stakeholders. The goal includes developing an administrative data base to report this measure. No consumer survey data will be used to report on this measure.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Adult - Increased Stability in Housing (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--
Denominator	N/A	N/A	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan: -Currently report URS Table 15. Profile of Persons Served by Living Situation and Table 16: Profile of Adults with Serious Mental Illnesses...Recieving Evidence-Based Services-Supported Housing.
- At this time, under the new Magellan ASO Contract, there is an annual update of the data including living situation. As a result, over time NE should develop the capacity to report this measure.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Adult - Increased Social Supports/Social Connectedness (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	74.46	76.27	75	75	N/A
Numerator	869	720	--	--	--
Denominator	1,167	944	--	--	--

Table Descriptors:

Goal: Adult - Increased Social Supports/Social Connectedness

Target: Adult - Increased Social Supports/Social Connectedness

Population: Adults who received mental health services and responded to the consumer survey.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Number of Positive Responses divided by Responses

Measure:

Sources of Information: Table 9: SAMHSA NOMs: SOCIAL CONNECTEDNESS AND IMPROVED FUNCTIONING

Special Issues: The annual Nebraska Behavioral Health Consumer Survey is funded by the Federal Mental Health Data Infrastructure Grants for Quality Improvement (State DIG). FY2009 consumer survey data not available at the time this was prepared. Thus, no reasonable basis for estimating. As a result, the FY2007 and 2008 data were used for FY2009 estimated and FY2010 target.

Significance:

Action Plan: Nebraska uses Federal Mental Health Data Infrastructure Grant funds to pay for this survey. To be collected as part of the consumer survey and reported on Tables 9 and 11 under the agreement with NE HHS Div of Public Health Data Management Unit (FY2007, FY2008). That unit is now part of the UNMC College of Public Health. For FY2009 the data are being collected by UNMC.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Adult - Improved Level of Functioning (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	77.38	80.42	78	78	N/A
Numerator	903	809	--	--	--
Denominator	1,167	1,006	--	--	--

Table Descriptors:

Goal: Adult - Improved Level of Functioning (Percentage)

Target: Adult - Improved Level of Functioning (Percentage)

Population: Adults served in Nebraska mental health system who completed the consumer survey.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services
4:Targeted Services to Rural and Homeless Populations

Indicator: Number of Positive Responses divided by the total Responses

Measure:

Sources of Information: Table 9: SAMHSA NOMs: SOCIAL CONNECTEDNESS AND IMPROVED FUNCTIONING

Special Issues: The annual Nebraska Behavioral Health Consumer Survey is funded by the Federal Mental Health Data Infrastructure Grants for Quality Improvement (State DIG). FY2009 consumer survey data not available at the time this was prepared. Thus, no reasonable basis for estimating. As a result, the FY2007 and 2008 data were used for FY2009 estimated and FY2010 target.

Significance:

Action Plan: Nebraska uses Federal Mental Health Data Infrastructure Grant funds to pay for this survey. To be collected as part of the consumer survey and reported on Tables 9 and 11 under the agreement with NE HHS Div of Public Health Data Management Unit (FY2007, FY2008). That unit is now part of the UNMC College of Public Health. For FY2009 the data are being collected by UNMC.

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Maintain Comprehensive Community-Based Mental Health Service Systems

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	557	717	823	700	N/A
Numerator	N/A	N/A	--	--	--
Denominator	N/A	N/A	--	--	--

Table Descriptors:

Goal: To maintain the capacity of Supported Housing Services.

Target: Provide Supported Housing for adults who are extremely low income with a serious mental illness with the goal of independent housing who are eligible under the Nebraska Housing-related assistance program, as authorized under Neb. Rev. Stat. § 71-812 (3).

Population: Supported Housing is for adults who are extremely low income with a serious mental illness with the goal of independent housing who are eligible under the Nebraska Housing-related assistance program, as authorized under Neb. Rev. Stat. § 71-812.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: Number persons served in Nebraska Housing Related Assistance program

Measure: Number of persons with SMI who are receiving Support Housing services.

Sources of Information: Summary of the monthly Housing Related Assistance data reported from the six Regional Behavioral Health Authorities to the Division.

Special Issues: The Nebraska Housing-related assistance program, as authorized under Neb. Rev. Stat. § 71-812, is the basis for reporting the number of consumers who are receiving the Evidence Based Practice service of Supported Housing. This is a conservative count. For example, it excludes consumers who are receiving DHHS funded Behavioral Health support services and have HUD section 8. The SAMHSA EBP Toolkit is not published at this time. However, SAMHSA material was used to guide EBP Implementation. Staff have been specifically trained to implement Supported Housing. The capacity to measure fidelity was developed during FY2008. The Division completed the fidelity monitoring in FY2009.

Significance: The NE Housing Related Assistance program was developed under NE Behavioral Health Reform. It is designed to be Person-centered, recovery-oriented, accessible, focused on a positive outcome of promoting independent living, and cost effective.

Action Plan:

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Maintain if not increase the number of people receiving Mental Health Services

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	33,068	32,862	29,957	29,000	N/A
Numerator	N/A	N/A	--	--	--
Denominator	N/A	N/A	--	--	--

Table Descriptors:

Goal: Maintain the number of people receiving Mental Health Services.

Target: To maintain the number of persons age 18 or older (unduplicated count)

Population: Adults receiving mental health services within the Nebraska Behavioral Health System (NBHS).

Criterion: 2:Mental Health System Data Epidemiology

Indicator: count the Number of adults receiving Mental Health Services as reported on URS Table 2A.

Measure: Number of adults receiving Mental Health Services as reported on URS Table 2A.

Sources of Information: Nebraska Division of Behavioral Health Services Federal Uniform Reporting System/NE Implementation Report

Special Issues: (1) In January 2009, the Division of Behavioral Health cleaned its data system by administratively discharging nearly 18,000 records of admission to program prior to November 2003 and of which had no acitivity in the last year. This reduced the number of active cases in the system.
(2) To obtain unduplicated count of persons served, the Division used social security numbers and dates of birth to identify unique clients in the data system.
(3) The data includes consumers who received only mental health services or who received both mental health and substance abuse services. The Unduplicated Count of Persons Receiving Services Funded by the Division of Behavioral Health in State Fiscal Year 2009 is: Mental Health ONLY consumers (17,720 / 47%), Co-occuring consumers (14,854 / 39%) and Substance Abuse ONLY consumers (5,095 / 14%) for a total of 37,669.

Significance:

Action Plan:

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Maintain per Capita State Expenditures for Community Mental Health Services

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	28.57	27.75	31.88	30	N/A
Numerator	48,888,467	47,482,195	--	--	--
Denominator	1,711,263	1,711,263	--	--	--

Table Descriptors:

Goal: At least maintain per Capita State Expenditures for Community Mental Health Services.

Target: By June 30, 2009, the per capita state expenditures for community mental health services will be maintained at over $37.00.

Population: Total Population

Criterion: 5:Management Systems

Indicator:

Measure: Performance Indicator: per Capita State Expenditures for Community Mental Health Services
Numerator: "actual" Mental Health State Expenditures (as reported for the Maintenance of Effort section of the Block Grant Application)
Denominator: Total State population

Sources of Information: Numerator Data source: Division of Behavioral Health Services | Denominator Data source: Nebraska Databook, Last Updated on 5/20/01 based on data from the U.S. Bureau of the Census Web site (www.census.gov) 2001

Special Issues: Section III. Maintenance of Effort (MOE) DATA REPORTED BY: State Fiscal Year (July 1 to June 30). Actual FY 2007 was $48,888,467. The Nebraska revised MOE for FY2008 is $47,482,195. This change was approved by Barbara Orlando (Grants Management Officer at the Center for Mental Health Services) on May 6, 2009. As of August 21, 2009, the NE MOE was still listed as Actual FY 2008 = $64,518,621 on webBGAS. Actual/Estimate FY 2009 is $54,560,767

Significance:

Action Plan:

ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Targeted Services to Rural Populations with the Rural Mental Health Program

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	16,296	15,514	11,693	11,000	N/A
Numerator	N/A	N/A	--	--	--
Denominator	N/A	N/A	--	--	--

Table Descriptors:

Goal: To maintain services to adults with in non-Metropolitan areas.

Target: The number of adults in non-Metropolitan areas receiving services.

Population: Adult Persons Served (Unduplicated Count) from the NE Counties classified as Non-Metropolitan

Criterion: 4:Targeted Services to Rural and Homeless Populations

Indicator: Number of non-Metropolitan adults receiving services

Measure: Number of non-Metropolitan adults receiving services

Sources of Information: Magellan Behavioral Health Information System, as under contract with NE DHHS Division of Behavioral Health.

Special Issues: There are 93 Counties in Nebraska. For the FY2010 application, the November 2007 Metropolitan counties per U.S. Census Bureau were used: Cass, Dakota, Dixon, Douglas, Lancaster, Sarpy, Saunders, Seward, Washington. For the purposes of reporting this measure, the remaining 84 Nebraska Counties are classified as rural. In prior fiscal years only six counties were counted as Metropolitan counties (Douglas, Sarpy, Cass, Washington, Lancaster, and Dakota county).

Significance:

Action Plan:

Nebraska

Child - Establishment of System of Care

Child - Provides for the establishment and implementation of
an organized community-based system of care for individuals with mental illness.

Child - Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness.

FY10 Children's Portion of the MHBG

Part C. State Plan
Section III. Performance Goals and Action Plans to Improve the Service System
****(See Adult Criterion 1: Establishment of System of Care)*

1. **Current Activities:**
   Criterion 1: Comprehensive community-based mental health services
   Establishment of System of Care

In October, 2004 Nebraska's Department of Health and Human Services (DHHS) received funding to develop a statewide Children's Mental Health and Substance Abuse delivery system. This Child-Adolescent State Infrastructure Grant (SIG) was a five year grant from the Substance Abuse Mental Health Service Administration, funding $750,000 annually. Nebraska DHHS is now completing it's fifth and final year of this venture. The SIG Steering Committee had set priorities, identified focus areas, established subcommittees, coordinated and maintained oversight of the progress towards the goals set forth in order to strengthen the statewide service delivery system for children and adolescents.

Each subcommittee consisted of members from a broad array of professional backgrounds as well as family and youth to ensure appropriate representation from the multitude of systems that impact the care of young people. These subcommittees were charged with identifying strengths and barriers in the service delivery system, financial mapping and utilization patterns as well as preparing recommendations to the Project Management Team. After reviewing the data and proposals, the work group developed an annual plan of action, noting to ensure the integrity of the core values and guiding principles of the nationally recommended Systems of Care process. This work continued to progress with some barriers but great success and has largely impacted the infrastructure of Nebraska's DHHS.

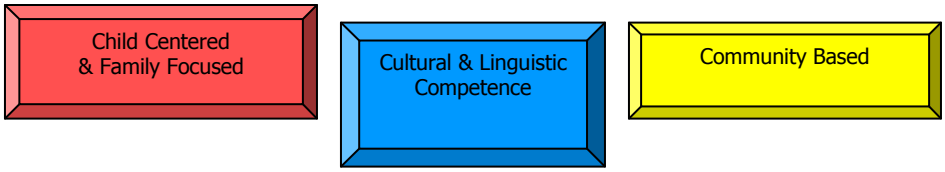
In addition, LB 542, passed by the Nebraska Legislature in 2007, created the Children's Behavioral Health Task Force and mandated that it provided a set of recommendations to the Department. The Task Force produced a report of 16 recommendations for the behavioral health system for children and adolescents which focused on both specific initiatives as well as system issues addressing both adjudicated and non-adjudicated juveniles. . This report required the Department to develop an Implementation Plan in response to there recommendations. This report, knows as "Creating Change and Providing Hope for Nebraska's Children, Adolescents and Their Families Pursuant to LB 542 (2007)" is available at: http://www.dhhs.ne.gov/beh/mh/LB542.pdf .

The initiation of this priority within DHHS increased the integration of children's services into the overall identity of mental health service delivery as well as increasing the partnerships between the Division of Child and Family Services and the Division of Medicaid and Long Term Care. These system successes are not only represented at the

state level, but also within the regional systems with the facilitation of the Youth Systems Coordinator and Family Organizations. These entities will continue to work in tandem to establish a system of care for children in Nebraska.

With another year of this charge underway, we focused on providing opportunities to grow, strengthen and support systems of care values for teams across the state. In partnership with SIG, we offered statewide training for six teams and state leaders, for a two day intensive event facilitated by Sheila Pires and her team. This venue was the beginning of a systemic change for several communities and for others, represented a recommitment to systems of care. Over 100 people from various child/youth serving entities attended and continue to meet within their own region as a part of a systems of care team. Each team was to develop a plan of action for their respective part of the state, proposing methods to strengthen the child/adolescent behavioral health system in partnership with multiple agencies, organizations and entities. The Department, with SIG, will continue to provide technical assistance for these teams and also funded additional learning via web-based training from University of South Florida on a variety of topics. In addition, we are addressing sustainability for ongoing systems of care efforts by funding graduate coursework in systems of care for six people to ensure availability of future trainings. The Department and its stakeholders are still identifying additional opportunities for true systems of care advancement. An initial commitment is the expression of the DHHS Core Values and Guiding Principles :

Core Values



Guiding Principles

- **Assessment**
- **Balanced array of services**
- **Utilize best practices**
- **Effective care coordination, management and evaluation**
- **Data driven decision making**
- **Access for children, adolescents and families**
- **Coordinated funding structures**

Nebraska

Child - Available Services

Child - Describes available services and resources in a comprehensive system of care, including services for individuals with both mental illness and substance abuse. The description of the services in the comprehensive system of care to be provided with Federal, State, and other public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities shall include:

Health, mental health, and rehabilitation services;
Employment services;
Housing
services;
Educational services;
Substance
abuse services;
Medical and dental services;
Support services;
Services provided by local school
systems under the Individuals with Disabilities Education Act;
Case management services;
Services
for persons with co-occurring (substance abuse/mental health) disorders; and
Other activities
leading to reduction of hospitalization.

Child - Describes available services and resources in a comprehensive system of care, including services for individuals with both mental illness and substance abuse. The description of the services in the comprehensive system of care to be provided with Federal, State, and other public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Part C. State Plan

Section III. Performance Goals and Action Plans to Improve the Service System

1. **Current Activities**

Criterion 1: Comprehensive community-based mental health services

Available Services

Children and adolescents with severe emotional disturbances may receive services through a variety of methods. The Department of Health and Human Services (DHHS) has several Divisions that include mechanisms for behavioral health service provision based upon clinical and financial eligibility. Regardless of the payment mechanism, any services provided to children and youth with behavioral health disorders fall under Department regulation and procedures to ensure an environment of family centered practice occurs.

Within DHHS, The Division of Behavioral Health (DBH), Division of Medicaid and Long Term Care (MLT) and the Division of Children and Family Services (CFS) all provide funding for certain services with attempts to address a comprehensive service array of both mental health and substance abuse services. In addition, the Division of Public Health provides funding for special programming addressing preventative services to the general population. However, persons must meet certain eligibility requirements to utilize services funded by the varying Divisions. For example, CFS operates within a safety model, and youth and families are only involved in their service system due to an identified issue of safety risk, from self or others. This could mean a youth with significant behavioral health risks of extreme self injurious behavior or needs beyond what the family is able to manage or provide for, or cases of abuse and/or neglect. This also includes youth involved with the Juvenile Justice system under state care. On the contrary, youth may only receive services funded by MLT that are financially eligible for this state insurance program and are deemed clinically eligible for such medically defined services. DBH is designed to meet the needs of those youth and families that are not experiencing a safety issue and are not Medicaid eligible; hence the service delivery mechanism via our Regional Behavioral Health Authorities. Since children and youth interact with multiple systems simultaneously, DBH provides funding for 'Youth System Coordination' at the regional level in order help youth and families identify multiple opportunities, increase system collaboration and ensure smooth service delivery.

CFS system provides management and funding for a variety of services for children, youth and families involved in their system such as: adoption support, agency based foster care, child care, day reporting, detention, emergency shelter foster care, emergency shelter centers, family group centers, family supportive

services, foster care, group homes, intensive family preservation, parent education, respite, transitional living programs, visitation supervision, and other non-therapeutic services such as educational supports, interpreters, legal as well as other personal needs. CFS is undergoing a system privatization transformation and new providers will begin to provide and/or manage the needs of the families, providing any services to meet the expected outcomes of safety, permanency and well-being.

Medicaid continues to provide funding for medically defined clinical services such as child/adolescent assessments, comprehensive family assessments, day treatment, enhanced treatment group home, family/group/individual therapy, acute inpatient, intensive outpatient, medication management, residential treatment care, treatment foster care and treatment group homes. Medicaid, along with the other Divisions, has been reviewing the service definitions for such services and exploring additional possible services in order to ensure quality delivery, system management, efficient practices and effective outcomes. It is the desire of the DHHS Divisions to promote the community based and least restrictive levels of care are utilized for children, youth and families.

DBH continues to provide mental health and substance abuse services with the majority of our funding utilized in a wraparound program with flexible funding demonstrating the best results for the greatest majority of children and adolescents with severe emotional disorders. Additional therapeutic services offered are: outpatient, intensive outpatient, crisis inpatient, day treatment, home based therapy, medication management, therapeutic consultation, assessments, community support, transition team case reviews, substance abuse prevention programs and Professional Partners Program (wraparound).

In addition to this system structure, there are a variety of state and regional programs addressing a specific initiative or target population. For example, certain medical services may be provided through funds in the Maternal and Child Health Block Grant Statutory Authority: Chapter 21, Article 22, R.R.S., 1943. The DDHS is the administering agency and under Title V of the Social Security Act of 1935 as amended, Nebraska receives federal funding to address the health needs of all mothers and children, with particular attention to low-income individuals or other populations with limited access to care. With the 2009 passage of LB603, the eligibility for certain services has increased from 185% of the Federal Poverty Line to 200% to increase access to such services. Here are an example of services provided thru projects targeting children and adolescent health:

- Health history, physical examinations, nutrition counseling
- Dental Health and education services
- Immunizations
- Access to Health Check services
- Teen pregnancy prevention and education
- Preventative and simple intervention dental care

- Acute and chronic care
- Mental Health services including early screening, infant and toddler mental health programming

Some Dental services may be provided by the Dental Health Program, which provides comprehensive dental services for children who would not otherwise receive care. This program has been funded by the Maternal and Child Health Block Grant. This program serves as an entry point into the dental health delivery system for eligible youth and to improve the quality of all services necessary to prevent disease and restore oral health. These programs serve approximately 300+ per year in Nebraska.

Services for children with a severe emotional disorder are also provided through the public school system and especially for those requiring transition services. In the public education system, the term 'transition services' means a coordinated set of activities for a student with a disability that is designed within an outcome oriented process to promote movement from school to post school activities. These services may include post secondary, education, vocational training, integrated employment, continuing education, independent living and more based upon student need.

With the recent attention from the Nebraska Legislature on children's mental health, there is an opportunity to review current service provision, mechanisms for identifying system needs, system organization and child serving system coordination. These peaked interests have provided for an arena in which all child serving agencies are able to demonstrate both successes and barriers with an audience and opportunity to address potential areas for growth.

Nebraska

Child - Estimate of Prevalence

Child - An estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children

See Adult - Estimate of Prevalence.

Nebraska

Child - Quantitative Targets

Child - Quantitative targets to be achieved in the implementation of the system of care described under Criterion 1

see adult Quantitative targets

Nebraska

Child - System of Integrated Services

Child - Provides for a system of integrated services appropriate for the multiple needs of children without expending the grant under Section 1911 for the fiscal year involved for any services under such system other than comprehensive community mental health services. Examples of integrated services include:

Social services;
Educational services, including services provided under the Individuals with Disabilities Education Act;
Juvenile justice services;
Substance abuse services; and

Health and mental health services.

Child - Provides for a system of integrated services appropriate for the multiple needs of children without expending the grant under Section 1911 for the fiscal year involved for any services under such system other than comprehensive community mental health services. Examples of integrated services include: social services, educational services, juvenile justice, substance abuse, health and mental health services.

FY10Children's Portion of the MHBG
Part C. State Plan
Section III. Performance Goals and Action Plans to Improve the Service System

1. **Current Activities**

Criterion 3: Children's Services
System of Integrated Services

The Department of Health and Human Services is comprised of six Divisions, several of which fund services and programs for children and adolescents, in a variety of ways. The Division of Behavioral Health, Division of Medicaid and Long Term Care, Division of Children and Family Services and the Division of Developmental Disabilities are four (4D's) of the six Divisions that often overlap. Although each Division has its own target population, eligibility requirements, desired outcomes and goals, the merged system of a singular Department has significantly increased the ability for these previously independent Divisions to utilize a singular data system, enhance policy coordination, strengthen infrastructure development and have a more efficient financial structure. This allows for service integration and efficiency in strategic planning while addressing the needs of children, youth and families. To this end, there are multiple layers of administrative workgroups designed to address operations, fiscal and service array mapping, policy reviews, service definitions, staff and workforce training, reporting and parameters for care.

In addition to the inter department collaboration, there are partnerships with external department and agencies that also address children and youth. A true systems of care environment includes all possible members at the table, including the powerful voices of youth and families. DHHS and especially DBH, have a working relationship with the Nebraska Federation of Families for Children's Mental Health to ensure family voice is a partner in the development of policy, programs and planning. DBH collaborates with the Federation in the leadership of the Youth Systems Team, a group whose membership includes providers, system coordinators, families and other stakeholders to provide opportunity for system planning.

Another such concerted effort is a transition aged workgroup between DBH, Department of Education and Vocational Rehabilitation. Significant efforts over the years has lead to improved data collection and service coordination, and a recent commitment by multiple partners to address the needs of transition aged youth is enhanced by these long standing relationships. Multiple systems are coming together to identify strategies to ensure the smooth transition of youth experiencing behavioral health disorders into the adult behavioral health system. Often these adolescents are experiencing multiple barriers such as finding developmentally appropriate behavioral health services, connecting to viable employment opportunities, securing residency and defining or redefining peer and family

environments. Sometimes, the greatest barrier is that participation in any services at all is purely voluntary once a youth becomes a legal adult.

However, students diagnosed with a severe emotional disorder does qualify for special education services while attending the public school system under the Individual with Disabilities Education Act (IDEA) and Nebraska's 92 NAC 51. School districts are required to provide public education and related services to meet the unique needs of all children with verified disabilities from date of diagnosis to age 21. And within a community based system of care environment, these services should support the child/adolescent needs in collaboration with other services.

An example of this collaborative effort is our Professional Partner Program. This wraparound program embodies the meaning of integrated services with its family centered approach, flexible funding and team approach. A family with a youth experiencing a severe emotional disorder will create a plan of care with their Professional Partner who will assist them in identifying both informal and formal supports. This partner in their plan may accompany the family to important meetings, partner with school supports, fund tutoring, mentoring, therapy or other supportive services. DBH utilizes the majority of its funding for this program in order to maximize the collaborative partnerships of other integrated system leaders. This approach leverages early childhood initiatives, supports the Department of Education's Positive Behavioral Health schools, partners with child welfare providers and most importantly preserves the family voice.

Nebraska

Child - Geographic Area Definition

Child - Establishes defined geographic area for the provision of the services of such system.

Division of Behavioral Health
Behavioral Health Network Managers Mental Health and Substance Abuse Regional Behavioral Health Authorities (Map of Behavioral Health Regions)
http://www.dhhs.ne.gov/beh/nebhrgb.htm

See NE Division of Children & Family Services - DHHS Offices and Service Areas
http://www.dhhs.ne.gov/SvcAreaMap.pdf

Nebraska

Child - Outreach to Homeless

Child - Describe State's outreach to and services for individuals who are homeless

see Adult - Describe State's outreach to and services for individuals who are homeless

Nebraska

Child - Rural Area Services

Child - Describes how community-based services will be provided to individuals in rural areas

see Adult - Describes how community-based services will be provided to individuals in rural areas

Nebraska

Child - Resources for Providers

Child - Describes financial resources, staffing and training for mental health services providers necessary for the plan;

See Section III. Performance Goals and Action Plans to Improve the Service System: Adult Plan - Criterion 5, Resources for Providers.

In addition to the information provided in the Adult Plan, several special initiatives occured this year to increase the proficiency of child serving providers. In partnership with the Department's SAMHSA Child-Adolescent State Infrastructure Grant (SIG), several training events occured to increase and strengthen provider utilization of evidence based practices. Over 100 mental health clinians received such training and continued proficiency testing to ensure integrity of service delivery. Another such opportunity was provided to the staff of our Professional Partner Program as well as the Family Organizations statewide. This event reached almost 100 people who gathered for a three day intensive training on Wraparound and Family Centered Practice. This target audience was critical to reach as they serve the majority of children and adolescents funded from the mental health block grant as well as families often involved in multiple systems; but more importantly, in support of the Department's committment to Family Centered Practice.

Nebraska

Child - Emergency Service Provider Training

Child - Provides for training of providers of emergency health services regarding mental health;

See Section III. Performance Goals and Action Plans to Improve the Service System: Adult Plan Criterion 5, Emergency Service Provider Training

In addition to the information provided in the Adult Plan, a specific initiative to pilot the CIT crisis response model in rural areas and with specific training on addressing adolescents. This pilot project is occuring in partnership with the Department's Child-Adolescent State Infrastructure Grant.

Nebraska

Child - Grant Expenditure Manner

Child - Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal years involved

See Part C, Section III: Performance Goals and Action Plans to Improve Service Systems - Adult Plan, Criterion 5: Grant Expenditure Manner.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☑

Name of Performance Indicator: Increased Access to Services (Number)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	4,095	4,049	2,617	2,600	N/A
Numerator	N/A	N/A	--	--	--
Denominator	N/A	N/A	--	--	--

Table Descriptors:

Goal: To increase access to services

Target: To maintain the number of Children (age 0-17) served

Population: The persons served in mental health services in the Nebraska Behavioral Health System funded by the Nebraska Division of Behavioral Health Services

Criterion: 2:Mental Health System Data Epidemiology
3:Children's Services

Indicator: Access to Services

Measure: Total persons served as reported on the URS Table 2 Table 2A. Profile of Persons Served, All Programs by Age, Gender and Race/Ethnicity Youth URS Table 2A

Sources of Information: Division of Behavioral Health Services / Community Mental Health and State psychiatric hospitals - unduplicated count

Special Issues: 1) In January 2009, the Division of Behavioral Health cleaned its data system by administratively discharging nearly 18,000 records of admission to program prior to November 2003 and of which had no acitivity in the last year. This reduced the number of active cases in the system.
(2) To obtain unduplicated count of persons served, the Division used social security numbers and dates of birth to identify unique clients in the data system.
(3) The data includes consumers who received only mental health services or who received both mental health and substance abuse services. The Unduplicated Count of Persons Receiving Services Funded by the Division of Behavioral Health in State Fiscal Year 2009 is: Mental Health ONLY consumers (17,720 / 47%), Co-occuring consumers (14,854 / 39%) and Substance Abuse ONLY consumers (5,095 / 14%) for a total of 37,669. For the persons served age 17 Years & Under in State Fiscal Year 2009 is: Mental Health ONLY consumers (2,256), Co-occuring consumers (133) and Substance Abuse ONLY consumers (361) for a total of 2,750.

Significance:

Action Plan: Narrative: The data are as reported on URS Table 2A. These are reporting the Federal Uniform Reporting System using the capacity to report an unduplicated count of persons served between the Regional Centers (State Psychiatric Hospitals) data and community mental health using Magellan Data. Summary from 2A “Profile of Persons Served, All Programs by Age, Gender and Race/Ethnicity” Estimated Completion Date: Completed

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 30 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	3.64	.88	.75	.75	N/A
Numerator	2	1	--	--	--
Denominator	55	113	--	--	--

Table Descriptors:

Goal: Reduced 30 day readmission rate for youth into Psychiatric Inpatient Beds

Target: youth served in Psychiatric Inpatient Beds

Population: youth served in Psychiatric Inpatient

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Numerator: For youth age 0-17, the Number of Readmissions to ANY STATE Hospital within 30 days | Denominator: Total number of Discharges in Year for For youth age 0-17 to ANY STATE Hospital

Measure: 30 day readmission rate for youth into Psychiatric Inpatient Beds

Sources of Information: Division of Behavioral Heatlh

Special Issues: FY2009 preliminary data not available at the time this was prepared. Thus, no reasonable basis for estimating. As a result, the FY2007 and FY2008 data were used for the projected FY2009 and FY2010 target.

Significance:

Action Plan: The Division has contracted with the University of Nebraska Medical Center (UNMC) College of Public Health to prepare the URS Tables. UNMC prepared the URS Tables 20A for FY2007 and FY2008. The URS Table 20A will not be available until Fall 2009.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Reduced Utilization of Psychiatric Inpatient Beds - 180 days (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	5.45	2.65	2.50	2.50	N/A
Numerator	3	3	--	--	--
Denominator	55	113	--	--	--

Table Descriptors:

Goal: Reduced 180 day readmission rate for youth into Psychiatric Inpatient Beds

Target: youth served in Psychiatric Inpatient

Population: youth served in Psychiatric Inpatient

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Numerator: For youth age 0-17, the Number of Readmissions to ANY STATE Hospital within 180 days | Denominator: Total number of Discharges in Year for For youth age 0-17 to ANY STATE Hospital

Measure: 180 day readmission rate for youth into Psychiatric Inpatient Beds

Sources of Information: Division of Behavioral Health

Special Issues: FY2009 preliminary data not available at the time this was prepared. Thus, no reasonable basis for estimating. As a result, the FY2007 and FY2008 data were used for the projected FY2009 and FY2010 target.

Significance:

Action Plan: The Division has contracted with the University of Nebraska Medical Center (UNMC) College of Public Health to prepare the URS Tables. UNMC prepared the URS Tables 20A for FY2007 and FY2008. The URS Table 20A will not be available until Fall 2009.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Evidence Based - Number of Practices (Number)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--
Denominator	N/A	N/A	--	--	--

Table Descriptors:

Goal: Maintain, and expand when possible, the number of Evidence-Based Practices (EBPs) in Nebraska.

Target: Maintain, and expand when possible, the number of Evidence-Based Practices (EBPs) in Nebraska.

Population: Persons served by NE Division of Behavioral Health who may benefit from Evidence-Based Practices (EBPs).

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Count of the number of Evidence-Based Practices (EBPs) implemented in Nebraska.

Measure: Count the number of Evidence-Based Practices (EBPs) in Nebraska [1. Assertive Community Treatment (ACT); 2. Supported Employment (SE); 3. Supported Housing; 4. Integrated Treatment For Co-Occurring Disorder (Mental Health / Substance Abuse) Dual Diagnosis Treatments; 5. Medication Management; and 6. Multisystemic Therapy (MST)] funded by the Division of Behavioral Health.

Sources of Information: NE Division of Behavioral Health

Special Issues: Nebraska Division of Behavioral Health is implementing the following Evidence-Based Practices (EBPs)
1. Assertive Community Treatment (ACT)
2. Supported Employment (SE)
3. Supported Housing
4. Integrated Treatment For Co-Occurring Disorder (Mental Health / Substance Abuse) Dual Diagnosis Treatments
5. Medication Management
6. Multisystemic Therapy (MST)

Nebraska has implemented or is developing Fidelity Measurement for the following Assertive Community Treatment (ACT), Supported Employment (SE), and Supported Housing.

Significance:

Action Plan: Narrative: At this time, Nebraska has very limited capacity to report on this measure. Nebraska is developing the following evidence-based practices 1. Assertive Community Treatment (ACT); 2. Supported Employment (SE); 3. Supported Housing; 4. Integrated Treatment For Co-Occurring Disorder (Mental Health / Substance Abuse) Dual Diagnosis Treatments; 5. Medication Management; and 6. Multisystemic Therapy (MST). Each one has a different capacity for reporting unduplicated counts of persons served.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Evidence Based - Children with SED Receiving Therapeutic Foster Care (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--
Denominator	N/A	N/A	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan: Narrative: At this time, Nebraska has very limited capacity to report on this measure. Nebraska is developing evidence-based practices. Each one has a different capacity for reporting. Receiving Therapeutic Foster Care – This service is offered in a few areas. The capacity to report the data is poor. No capacity to measure fidelity. The SAMHSA EBP Toolkit was not used to guide EBP Implementation. Staff have not been specifically trained to implement the EBP. Difficult to estimate a completion date.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Evidence Based - Children with SED Receiving Multi-Systemic Therapy (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	38	N/A	9	9	N/A
Numerator	N/A	35	--	--	--
Denominator	N/A	N/A	--	--	--

Table Descriptors:

Goal: To mainrtain the number of Children with SED Receiving Multi-Systemic Therapy services

Target: serve 9 Children with SED in Multi-Systemic Therapy

Population: Children with SED Receiving Multi-Systemic Therapy

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: count of persons served in Multi-Systemic Therapy services.

Measure: number of Children with SED Receiving Multi-Systemic Therapy served in Region 3 - Mid Plains Center in Grand Island

Sources of Information: Mid Plains Center in Grand Island is the only provider of this service.

Special Issues: Mid Plains Center in Grand Island is the only provider of this service. The Division believes there was an over count of persons served in this program. The previous reports were 38 served in FY2007 and 35 in FY2008. Based on reports directly from Region 3, the actual number of persons served in FY2009 was 9. This count has been consistent over the last few years. This was not a registered service under the Magellan contract. Starting in July 2009, Mid Plains Center started reporting these data on Magellan.

Significance:

Action Plan: Narrative: At this time, Nebraska has very limited capacity to report on this measure. Nebraska is developing evidence-based practices. Each one has a different capacity for reporting. Receiving Multi-Systemic Therapy – This service is offered in one place only. The capacity to report the data is poor. No capacity to measure fidelity. The SAMHSA EBP Toolkit was not used to guide EBP Implementation. Staff have not been specifically trained to implement the EBP. Difficult to estimate a completion date.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Evidence Based - Children with SED Receiving Family Functional Therapy (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--
Denominator	N/A	N/A	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan: Narrative: At this time, Nebraska has no capacity to report on this measure. Nebraska is developing evidence-based practices. Each one has a different capacity for reporting. Receiving Family Functional Therapy – This service is not offered at this time. It will not be reported any time soon.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Client Perception of Care (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	52.59	58.40	55.50	55.50	N/A
Numerator	132	73	--	--	--
Denominator	251	125	--	--	--

Table Descriptors:

Goal: To maintain the number of clients reporting positively about outcomes.

Target: maintain the number of consumers responding Positively About Outcomes in the annual Nebraska Behavioral Health Consumer Survey

Population: All consumers with valid addresses and/or phone numbers within the Magellan Behavioral Health data base who do respond to the annual Nebraska Consumer Survey

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Number of Positive Responses on the consumer survey for Outcomes for Children

Measure: Numerator: average of positive responses to the MHSIP Consumer Survey: Perceptions of Outcomes questions as reported under URS Table 11.

Sources of Information: Numerator and Denominator Data Source: Nebraska annual consumer survey as reported on Uniform Reporting System/Implementation Report-Table 11.

Special Issues: The annual Nebraska Behavioral Health Consumer Survey is funded by the Federal Mental Health Data Infrastructure Grants for Quality Improvement (State DIG). FY2009 consumer survey data not available at the time this was prepared. Thus, no reasonable basis for estimating. As a result, the FY2007 and FY2008 data were used for FY2009 estimated and FY2010 target.

Significance:

Action Plan:

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Child - Return to/Stay in School (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--
Denominator	N/A	N/A	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan: At this time, Nebraska does not have the capacity to report on this measure.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Child - Decreased Criminal Justice Involvement (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--
Denominator	N/A	N/A	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan: At this time, Nebraska does not have the capacity to report on this measure.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Child - Increased Stability in Housing (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--	--
Denominator	N/A	N/A	--	--	--

Table Descriptors:

Goal:

Target:

Population:

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator:

Measure:

Sources of Information:

Special Issues:

Significance:

Action Plan: At this time NE does not have the capacity to report this measure.

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Child - Increased Social Supports/Social Connectedness (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	80.24	81.10	80	80	N/A
Numerator	203	103	--	--	--
Denominator	253	127	--	--	--

Table Descriptors:

Goal: Maintain Child - Increased Social Supports/Social Connectedness (Percentage)

Target: Maintain Child - Increased Social Supports/Social Connectedness (Percentage)

Population: Youth age 0-17 who were served in the Nebraska Behavioral Health System and selected under a random sample to receive the annual consumer survey.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services

Indicator: Using data reported under URS Table 9: SAMHSA NOMs: SOCIAL CONNECTEDNESS AND IMPROVED FUNCTIONING (Child/Adolsecent Consumer Survey Results/ 3. Social Connectedness); Performance Indicator-Percent Positive (calculated); Numerator-Number of Positive Responses; and Denominator-Responses.

Measure:

Sources of Information: Nebraska annual Behavioral Health consumer survey

Special Issues: The annual Nebraska Behavioral Health Consumer Survey is funded by the Federal Mental Health Data Infrastructure Grants for Quality Improvement (State DIG). FY2009 consumer survey data not available at the time this was prepared. Thus, no reasonable basis for estimating. As a result, the FY2007 and FY2008 data were used for FY2009 estimated and FY2010 target.

Significance:

Action Plan:

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Child - Improved Level of Functioning (Percentage)

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	58.13	60.80	59	59	N/A
Numerator	143	76	--	--	--
Denominator	246	125	--	--	--

Table Descriptors:

Goal: Maintain Child - Improved Level of Functioning (percentage)

Target: Maintain Child - Improved Level of Functioning (percentage)

Population: Youth (age 0-17) served in the Nebraska Behavioral Health System and selected using a random sample to receive the annual consumer survey

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems
3:Children's Services
4:Targeted Services to Rural and Homeless Populations

Indicator: Using data reported under URS Table 9: SAMHSA NOMs: SOCIAL CONNECTEDNESS AND IMPROVED FUNCTIONING - Child/Adolsecent Consumer Survey Results (4. Functioning) ... Performance Indicator-Percent Positive (calculated); Numerator-Number of Positive Responses; Denominator-Responses.

Measure:

Sources of Information: Annual Nebraska Behavioral Health Consumer Survey

Special Issues: The annual Nebraska Behavioral Health Consumer Survey is funded by the Federal Mental Health Data Infrastructure Grants for Quality Improvement (State DIG). FY2009 consumer survey data not available at the time this was prepared. Thus, no reasonable basis for estimating. As a result, the FY2007 and FY2008 data were used for FY2009 estimated and FY2010 target.

Significance:

Action Plan:

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Maintain capacity of Professional Partner Program

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	650	552	416	415	N/A
Numerator	N/A	N/A	--	--	--
Denominator	N/A	N/A	--	--	--

Table Descriptors:

Goal: To maintain the capacity of the Professional Partner Program (Wraparound) for children with serious emotional disturbance.

Target: The number of children participatein in the Professional Partner (wraparound) Program will be maintained.

Population: Children and adolescents with serious emotional and behavioral disorders.

Criterion: 1:Comprehensive Community-Based Mental Health Service Systems

Indicator: The number of children participating in the Professional Partner Services.

Measure: Count of number of children participating in Professional Partners as of June 30 each year.

Sources of Information: Magellan Beahvioral Health

Special Issues: FY2009 preliminary data are reported. In January 2009, the Division of Behavioral Health cleaned its data system by administratively discharging nearly 18,000 records of admission to program prior to November 2003 and of which had no acitivity in the last year. This reduced the number of active cases in the system.

Significance:

Action Plan:

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Maintain number of persons age 0-17 receiving services through the Nebraska Behavioral Health System

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	4,135	4,049	2,617	2,600	N/A
Numerator	N/A	N/A	--	--	--
Denominator	N/A	N/A	--	--	--

Table Descriptors:

Goal: To maintain the number of persons age 0-17 receiving services through the Nebraska Behavioral Health System

Target: The number of children receiving services will be maintained.

Population: Children and adolescents receiving Mental Health Services

Criterion: 2:Mental Health System Data Epidemiology

Indicator: The number of children and adolescents receiving services

Measure: Count of number of children receiving services

Sources of Information: URS Table 2A for FY2007 and FY2008. For FY2009, projected based on Division of Behavioral Health analysis.

Special Issues: In January 2009, the Division of Behavioral Health cleaned its data system by administratively discharging nearly 18,000 records of admission to program prior to November 2003 and of which had no acitivity in the last year. This reduced the number of active cases in the system.

Significance:

Action Plan:

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Maintain per capita State Expenditures for Community Mental Health Services

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	9.03	9.15	9.94	9	N/A
Numerator	4,108,818	4,120,066	--	--	--
Denominator	450,242	450,242	--	--	--

Table Descriptors:

Goal: Maintain per Capita State Expenditures for Community Mental Health Services

Target: there will be at least the same level of spending in per capita state expenditures for children's community mental health services.

Population: Total children's population ages 0-17 years served in the Nebraska (Nebraska 2000 Census data youth age 0-17 = 450,242).

Criterion: 3:Children's Services

Indicator: per Capita state expenditures

Measure: Performance Indicator: youth Capita State Expenditures; Numerator: funding levels as reported under Set-Aside for Children's Mental Health Services Report; Denominator: Youth population in Nebraska ages 0-17 years (450,242)

Sources of Information: Numerator: Set-Aside for Children's Mental Health Services Report
Denominator: Nebraska Databook, Last updated on 5/21/01 based on data from the U.S. Bureau of the Census Web site (www.census.gov) 2001

Special Issues:

Significance:

Action Plan:

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Maintain services to all children with serious emotional disorders in non-Metropolitan areas

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	1,871	1,820	1,111	1,100	N/A
Numerator	N/A	N/A	--	--	--
Denominator	N/A	N/A	--	--	--

Table Descriptors:

Goal: To maintain services to all children with serious emotional disorders in non-Metropolitan areas.

Target: Maintain the number of children in non-Metropolitan areas receiving mental health services.

Population: Children served in Nebraska Behavioral Health System receiving mental health services living in non-Metropolitan areas.

Criterion: 4:Targeted Services to Rural and Homeless Populations

Indicator: Number of non-Metropolitan children with serious emotional disorders receiving services.

Measure: Count of non-Metropolitan children receiving mental health services.

Sources of Information: Megallan Behavioral Health Information System, as under contract with NE DHHS Division of Behavioral Health.

Special Issues: -- There are 93 Counties in Nebraska. For the FY2010 application, the November 2007 Metropolitan counties per U.S. Census Bureau were used: Cass, Dakota, Dixon, Douglas, Lancaster, Sarpy, Saunders, Seward, Washington. For the purposes of reporting this measure, the remaining 84 Nebraska Counties are classified as rural. In prior fiscal years only six counties were counted as Metropolitan counties (Douglas, Sarpy, Cass, Washington, Lancaster, and Dakota county).
-- In January 2009, the Division of Behavioral Health cleaned its data system by administratively discharging nearly 18,000 records of admission to program prior to November 2003 and of which had no acitivity in the last year. This reduced the number of active cases in the system.

Significance:

Action Plan:

CHILD - GOALS TARGETS AND ACTION PLANS

Transformation Activities: ☐

Name of Performance Indicator: Provide a system of integrated services for all children with serious emotional disorders who have multiple and complex needs

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY 2007 Actual	FY 2008 Actual	FY 2009 Projected	FY 2010 Target	FY 2011 Target
Performance Indicator	1,791	1,703	1,500	0	N/A
Numerator	N/A	N/A	--	--	--
Denominator	N/A	N/A	--	--	--

Table Descriptors:

Goal: To provide a system of integrated services for all children with serious emotional disorders who have multiple and complex needs.

Target: The number of children who are in the custody of the state and who receive integrated care coordination will be maintained.

Population: Children served who are wards of the state.

Criterion: 5:Management Systems

Indicator: The number of children receiving integrated care coordination.

Measure: Count of children receiving intergrated care coordination.

Sources of Information: Program administrator report.

Special Issues: In July 2008, the Department of Health and Human Services, Division of Children and Family Services (CFS), began the process of improving the manner in which the State of Nebraska purchases services for Child Welfare and Office of Juvenile Services clients. CFS implemented contracts with five lead agencies to provide safety and in-home services to CFS clients, a reduction from over 100 contracts. The new contracts contain incentives to encourage exceptional contractor performance and performance is tied directly to outcomes that have been shown to provide safety, permanency, and well-being for children, youth, and the community. CFS is still in the contractor selection process.
The integrated care coordination function was being populated with data from the contracts between the Regions and CFS. Those contracts ended in 2009. For now, the Division of Behavoral Health is on hold with this measure pending the new contractor selection.

Significance: Emerging body of research indicates intensive case management using the wrap around approach can be effective in ensuring appropriate services and reducing expenses of using high cost services.

Action Plan: New plans for a system of integrated services for all children with serious emotional disorders who have multiple and complex needs performance measure will be developed after CFS completes the contractor selection process.

Nebraska

Planning Council Letter for the Plan

Upload Planning Council Letter for the Plan

Nebraska State Advisory Committee on Mental Health

August 17,2009

Barbara Orlando
Grants Management Specialist
Division of Grants Management, OPS, SAMHSA
1 Choke Cherry Road, Room 7-1091
Rockville, Maryland 20857

Dear Ms Orlando:

Please regard this letter as documentation that the State Plan was shared with the Planning Council. Specifically, on August 13, 2009 the Nebraska State Advisory Committee on Mental Health, (Planning Council), reviewed a draft of the FY 2010 Nebraska Community Health Services Block Grant Application.

Many issues were discussed during the review. Some highlights of that discussion included:

A question concerning the lack of children's data in the draft. The Division responded with an explanation that data was still being gathered and will be made available for the Committee to review. The Committee was reminded they have the ability to view the data as it was being entered online and enter their feedback directly on the site. The feedback will be included with the grant.

There was a question about available data on people with Mental Illness in jail. Has the numbers gone up?

The language in the Block Grant regarding peer support workforce and definition of peer support was not mentioned in the steering committee. Consumers need to be involved in the earlier stage of the planning.

Services based on the recovery model — listen more carefully to consumers.

There was discussion on Supported Employment numbers and clarification of those numbers reflected in the grant.

Are more people being served for the same dollar amount now?

Were consumers involved in jail screening process?

Huge gap with the disparity and disincentive to work.

Access to mental health related medications and necessary laboratory testing is a critical piece of enhancing mental health services. The need to fill this gap in services is a vital element.

As Chair of this committee, I was pleased by the amount of feedback and input. I was equally impressed by the depth of knowledge and passion the Committee demonstrates in the continuing effort to improve mental health services, and the delivery process of those services. The barrier of a tight time frame to review and give input continues to be a source of frustration for some committee members. This year the draft of the grant was earlier than in the past and the availability for review and input online was beneficial for some.

In Closing, the Advisory Committee would like to emphasize while 95% of the MHBG monies are allocated regionally to provide services and the remaining 5% of those funds are being used by the Office of Consumer Affairs for Consumer related activities; a crucial need for additional funding still exist.

Sincerely,

Bev Ferguson, Chair
Nebraska State Advisory Committee on Mental Health Service

Nebraska

Appendix A (Optional)

OPTIONAL- Applicants may use this page to attach any additional documentation they wish to support or clarify their application. If there are multiple files, you must Zip or otherwise merge them into one file.

This is regarding the Nebraska Revise the Maintenance of Effort (MOE) for the FY2010 Community Mental Health Services Block Grant Application.

The Nebraska revised MOE for FY2008 is $47,482,195. This change was approved by Barbara Orlando (Grants Management Officer at the Center for Mental Health Services) on May 6, 2009.

Actual FY 2007	$48,888,467
Revised Actual FY2008	$47,482,195
Actual/Estimate FY 2009	$54,560,767

As of July 27, 2009, John Morrow, Chief, State Planning and Systems Development Branch at the Center for Mental Health Services had asked the webBGAS contractor to make the change on FY2010 Maintenance of Effort (MOE).

As of August 31, 2009, the NE MOE was still listed as Actual FY 2008 = $64,518,621.

Below are the emails showing the approval.

From: Orlando, Barbara (SAMHSA/OPS)
Sent: Wednesday8:01 AM
To: 'Jim.Harvey@nebraska.gov'
Cc: DiGeronimo, Richard (SAMHSA/CMHS)
Subject: FW: NE Revised MOE for FY2008
Importance: High

Jim,
I have reviewed the request, as Richard asked me to, and have approved the changes and requested that the amount that was submitted as the FY 2008 Estimate/Actual with the FY 2009 application be revised. Even with the changes you still met the MOE requirement.

Barbara Orlando
1 Choke Cherry Rd. - Rm. 7-1091
Rockville, MD 20857 (regular mail) 20850 (overnight delivery)
240-276-1422 (office)
240-276-1430 (fax)

From: DiGeronimo, Richard (SAMHSA/CMHS)
Sent: Monday, May 04, 2009 9:13 AM
To: Orlando, Barbara (SAMHSA/OPS)
Cc: Morrow, John (SAMHSA/CMHS)
Subject: FW: NE Revised MOE for FY2008
Importance: High

Barbara, I am going to defer to you on this issue from Nebraska re: their MOE calculation. I am also attaching a voice message from Jim Harvey that further explains what the State's submission means.

Richard di Geronimo, MSW, LICSW
Public Health Advisor
DSCSD/CMHS/SAMHSA
1 Choke Cherry Road
Room 2-1099
Rockville, MD 20857
240-276-1749
240-276-1770 (FAX)
richard.digeronimo@samhsa.hhs.gov

From: Harvey, Jim [mailto:Jim.Harvey@nebraska.gov]
Sent: Thursday, April 30, 2009 1:11 PM
To: DiGeronimo, Richard (SAMHSA/CMHS)
Subject: NE Revised MOE for FY2008

April 30, 2009

To: Richard di Geronimo, Public Health Advisor, CMHS/SAMHSA

From: Jim Harvey, NE Division of Behavioral Health

Re: NE Revised MOE for FY2008

The Nebraska Division of Behavioral Health needs to revise the Maintenance of Effort (MOE) Report as submitted under the FY2009 Community Mental Health Services Block Grant application.

The requirement is for the State to maintain 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. Using this standard, the previously reported MOE for FY2006 and FY2007 were

Actual FY 2006	$42,214,436
Actual FY 2007	$48,888,467

This means the actual MOE needed for FY2008 is $45,551,452.

The previously reported MOE for FY2008 needs to be revised.
FY2008 Actual/estimated (as reported in the FY2009 application) $64,518,621

The revised State expenditures for community mental health in Fiscal Year 2008 was
to FY2008 Actual (as of April 30, 2009) $64,582,195

However, this revised state expenditure number did not exclude a one time payment of the $17,100,000 to the six Regional Behavioral Health Authorities. Under LEGISLATIVE BILL 959 (Approved by the Governor April 2, 2008, with line-item vetoes overridden April 7, 2008), under Program No. 38 - Behavioral Health Aid (Section 119, page 19)

The unexpended General Fund appropriation balance existing on June 30, 2007, is hereby reappropriated. The unexpended reappropriated General Fund balance shall be distributed to regional behavioral health authorities on or before May 30, 2008, for one-time purposes related to the statewide development and provision of community-based behavioral health services. The funds shall be distributed pursuant to the allocation formula developed by the Division of Behavioral Health Services in consultation with regional behavioral health authorities.

See the following web site for the complete LEGISLATIVE BILL 959 (2008).
http://uniweb.legislature.ne.gov/FloorDocs/100/PDF/Slip/LB959.pdf.

The actual State MOE for FY2008 is:

Actual FY 2008 state expenditures for MOE	$47,482,195
one time FY2008 state expenditures	+ $17,100,000
total FY2008 Actual State Expenditures	$64,582,195

As a result of this analysis, the correct FY2008 MOE for the NE Division of Behavioral Health is $47,482,195.

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Please note my new e-mail address ==> Jim.Harvey@nebraska.gov

Jim Harvey
Nebraska Department of Health and Human Services
Division of Behavioral Health
301 Centennial Mall South, Third Floor
PO Box 98925, Lincoln, NE 68509
phone 402-471-7824