Working Draft – Summary of previous planning documents
Last Updated April 30, 2010

Following is a synopsis of Nebraska behavioral health strategic planning documents. It is representative, but not comprehensive. The purpose of creating this brief synopsis is to capture key recent recommendations from other major behavioral health planning efforts in Nebraska that involved stakeholders in their development.

Previous planning documents are presented in four (4) categories: 1) General documents; 2) Mental health; 3) Substance abuse; and 4) Gambling.

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Community-based Behavioral Health: Funds, Efficiency, and Oversight **Report of the Legislative Audit Office, Committee Report Vol. 16, No. 3**
April 2010
Who was involved?
Report conducted by the Legislative Audit Office for the Performance Audit Committee and public
Key Recommendations
The Committee is extremely concerned about the audit findings, which it believes demonstrate serious failings in the Department's implementation of the 2004 Nebraska Behavioral Health Services Act (LB 1083). Six years after enactment of LB 1083, the Department has failed to develop a statewide comprehensive plan for behavioral health services, which would provide the behavioral health regions and others with needed guidance about the goals for behavioral health reform in the state. In addition, the Department has failed to promulgate regulations as required. Under LB 1083, the behavioral health regions are required to follow the Department's regulations as part of the balance between the Department's broader authority over behavioral health compared to each region's narrower responsibility for the services within its boundaries. The absence of regulations undermines the Department's role in this regard. The Committee concludes that the audit identifies significant problems and that the agency's response to the audit findings is insufficient, in some cases failing to take the identified problem seriously. The Committee makes the following specific recommendations. **Recommendation 1:** The Committee will ask the Auditor of Public Accounts to conduct an audit of, at a minimum, whether the Department and regions are maintaining the appropriate separation between funds designated for services and those designated for administration. The Auditor may also wish to consider whether the Department has established appropriate internal controls over the funds that flow to the regions. **Recommendation 2:** The Committee will forward its concerns about the need for DHHS to develop a comprehensive strategic plan for behavioral health services to the Legislature's Health and Human Services Committee for follow-up. **Recommendation 3:** The Committee has begun a preaudit inquiry into the timeliness of regulation promulgation by state agencies, including DHHS. **Discussion:** The Administrative Procedure Act, which governs the regulation promulgation process, contains no deadline for completion of regulations that are required by statute. Consequently, six years after enactment of LB 1083, the Committee finds itself in the frustrating position of being unable to find the Department in violation of any statute although the Committee fully believes that the lengthy delay has undermined the legislature's intention that regulations be in place to facilitate LB 1083's implementation. In his written response to the draft audit report, the Director noted that the development of the LB 1083 regulations has been coordinated with related regulations and that the draft regulations have been revised five times to incorporate stakeholder input. The Committee

appreciates that efficiencies may be gained by such coordination and that input prior to initial of the formal rulemaking process may be beneficial for complex regulations. However, such efforts *must be balanced* with the reality that regulations cannot serve their intended purpose if they are not promulgated within a reasonable period of time after a statute's enactment. The Committee believes that six years after enactment is unreasonable.

Recommendation 4:
The Committee directs the audit staff to follow-up and report back to the Committee on when the draft regulations implementing LB 1083 are scheduled for public hearing, which the Director suggested would happen in "early 2010."

Recommendation 5:
The Committee believes that services provided by regions when competitive bidding fails to produce a qualified bidder should subsequently be put out for competitive bid and will draft legislation for the 2011 legislative session to accomplish that.

Recommendation 6:
The Committee directs audit staff to follow-up to determine whether all of the financial and program audits required of the regions take place this year as the Department indicates will happen, in contrast to inconsistencies in completing audits in the past. If the Department finds in the future that it is unable to conduct all of these audits due to staffing concerns, as it reports has happened in the past, the Committee recommends that the Department notify the Committee immediately.

Recommendation 7:
The Committee recommends that the Department revise the minimum standards for audits of services purchased by behavioral health regions to include a single allowable error rate and a sanction policy for noncompliance. The Committee requests that the Department provide a copy of the revised standards to the Committee with the implementation plan due following the release of this report.

Recommendation 8:
The Committee recommends that the Division review the behavioral health regions' policies for all types of audits and ensure that those policies comply with minimum standards established by the Division.

Summary

With the passage of the Nebraska Behavioral Health Services Act (LB 1083) in 2004, the Legislature undertook statewide behavioral health reform, which emphasized community-based services. The Act provides the structure for the administration and provision of community-based behavioral health services in Nebraska, including the promulgation of rules and regulations, authority to set service rates, and requirements for audits and oversight.

This performance audit examined whether: (1) funds intended to pay for community-based behavioral health services differentiated from funds intended to pay for administrative costs; (2) administrative responsibilities between the Division and the regions are clear and efficient; and (3) oversight mechanisms are adequate. Audit staff identified a number of concerns, many of which are described as part of the following recommendations from the Legislative Performance Audit Committee.

Gallup: Behavioral Health Support Foundation Report
March 2010
Who was involved?
The Behavioral Health Support Foundation Steering Committee asked Gallup to conduct research analyzing the current behavioral health system in Region 6, highlighting issues related to care continuity and coordination and to prepare a report detailing findings and recommendations. Stakeholder interviews were conducted in-person with leaders from health systems, hospitals, social service agencies, and with other interested parties. Interviews took place between May and November, 2009.
Key Recommendations

Tactical Changes
Tactical changes focus largely on education and communication. They are a logical first step for this effort because they can be initiated in the near term with minimal investment and can be driven from the outside in.

They won't change the system, per se, but they would begin to alleviate some of the problems referenced in this section. More importantly, tactical changes provide the necessary momentum for future change efforts.

Initial recommendations here include the following:

1. *Quantify demand across the network*.
2. *Increase clarity about point of entry*.
3. *Create a provider portal to offer greater transparency across providers*.

Transitional Changes
Transitional changes are more significant than tactical changes, and they speak more directly to the nature of care provided in Region 6. But they are still largely grounded in the status quo. In some cases, best practice examples of these changes already exist with the region.
Recommendations are offered here in four areas: communication and collaboration, co-occurring disorders, residential services, and follow-on support. Some of the recommendations are aspirational in nature — meaning they are worthy of additional discussion and analysis but can't necessarily be implemented without intervening changes to the system.

Communication and Collaboration
Existing Best Practices:

- *Clinical Review Team*.
- *ACT Teams*.

Additional Recommendations:

1. *Evolve the role and perception of Region 6*.
2. *Shift more to a community case management model*.
3. *Create a central intake system for all patients who enter the system*.
4. *Have behavioral health disorders identified in a primary care setting and see that as the ideal level of care for interventions to begin*.
5. *Integrate behavioral health professionals into the primary care setting.*

6. *Implement a central electronic medical record (EMR) in Region 6*.
7. *Create more specialization in the region*.

Co-Occurring Disorders
Existing Best Practices:

- *Co-Occurring Task Force*.

Additional Recommendations:

1. *Restructure how treatments for those dealing with co-occurring disorders are paid for*.
2. *Work with the new administration at the Nebraska Department of Health and Human Services to assure that there is a fluid and comprehensive funding structure in place that mirrors what patients need from a clinical perspective*.
3. *Create incentives for organizations to train staff to become co-occurring capable*.

Residential Services
Existing Best Practices:

- *Salvation Army*.

Additional Recommendations:

1. *Explore intermediate or step-down residential services*.
2. *Expand services for specific patient segments*.
3. *Help to reduce the stigma of behavioral health disorders (as a means of securing additional funding).*

Lack of Follow-Through and Support
Existing Best Practices:

- *Alegent Health's Nurse Navigator Program*.
- *VA's 90-Day Aftercare Program and Friendship Program's 90-Day Follow-Up Calls*.

Additional Recommendations:
1. *Introduce a central patient support system*.
2. *Establish standards for following up with patients within a certain time frame and incentivize providers based on compliance*.
3. *Creating mobile support units*.
4. *Put additional incentives in place for providers to thoroughly follow up with their patients to assure adherence to their care plans*.

Transformational Changes
Transformational changes upend the status quo, and are therefore more difficult to come by. Change of this magnitude is often the product of great vision and leadership. One such change occurred recently with the opening of Lasting Hope, which added capacity and a more immediate source of urgent care into the region. It is unlikely that we'll see that level of change again in the near term — at least not without substantial influx of funding or calls for change at the state level.

A long-term vision needs to be created by the state of Nebraska for the behavioral health system and goals and objectives made at the state level need to be in alignment with those of community providers.

These goals and objectives should be focused on what is best for patients. Currently, glaring gaps in care and inefficiencies exist within the behavioral health system. Some of these gaps exist due to the fact that the current system is not an outcomes driven system.

Summary

In speaking with providers and interested parties throughout Region 6, it is apparent that there is a lack of alignment between and across state and local governments, care providers (including hospitals, regional centers, primary care providers, etc.), and community support agencies. This lack of alignment ultimately has led to a system that does not put the patient and the patient's family at the center of care. It requires the patient to adjust to the needs and circumstances of the system, rather than having the system adjust and adapt to the needs of the patient.

There are several key factors that are contributing to the current state:

1. This is not an outcomes-driven system.

2. In the absence of a system, providers will create their own.

3. Patient education alone cannot solve the problem.

4. Collaboration between providers is limited primarily to committees and task forces.

5. Given that, there is limited coordination of care.

6. Each provider tends to know the other providers, but not necessarily the depth and breadth of their offerings.

7. The system is still catching up to the realities of co-occurring illnesses.

8. There are other "outside" factors at play.

9. Wait times are often traced back to capacity and funding.

10. It is not just the number of beds, but how they are used.

11. Even where effective care is provided, there isn't enough support for patients once they are discharged.

Nebraska Behavioral Health System Strategic Planning Report

March 2010

Who was involved?

Prepared by "Open Minds" and commissioned for the Behavioral Health Support Foundation

Key Recommendations

• Priority One: Assure accountability of behavioral health system by developing performance measurements for best use of funding.

• Priority Two: Develop standards for timely access to behavioral health services for all Nebraskans.

• Priority Three: Optimize the use of available funding for behavioral health services by initiating.

Summary

The OPEN MINDS team approach included working closely with the Nebraska behavioral health system Planning Group and Consensus Panel, an ex officio community coalition of stakeholders representing the range of state and local government, professionals, provider organizations, consumers, and consumer advocates.

The Planning Group and the Consensus Panel were engaged to provide:
• Information about the current behavioral health system
• Feedback on the findings of the research and analysis of the Nebraska behavioral health system
• Priorities to move toward the envisioned behavioral health system

Building on the established vision, the Consensus Panel members identified the system goals, elements considered in Nebraska behavioral health system planning, Consensus Panel priority issues, and the development of a preliminary system plan based on recommendations from Consensus Panel meetings. Four system goals were identified:

1. Universal and timely access to all behavioral health services for all Nebraskans
2. System design that supports recognition of and early intervention in behavioral disorders
3. System focus on consumer recovery and wellness
4. Funding of cost effective services with demonstrated value

The OPEN MINDS team conducted a gap analysis comparing the current Nebraska behavioral health system with the system vision identified in the BHOC 2009 report. The following gaps were identified:

1. The current behavioral health system is not a system that has a unified and fully developed performance measurement process or outcomes that support decision-making.

2. The Consensus Panel members identified a continued concern over the lack of continuity and inclusion in a meaningful planning process with the Division of Behavioral Health as evidenced by:

- No current transparent communication process between DBH, Division of Medicaid, RBHAs, providers, and consumers.

3. The current system lacks a collaborative model for establishing new initiatives such as integrating physical health and behavioral health needs for consumers.

4. No state effort has been initiated to develop a common or cooperative strategic plan to achieve the goal.

- Without a targeted set of objectives and accompanying timeline, progress cannot be monitored and success cannot be measured or assured.

As a result of this analysis, the OPEN MINDS team, the Planning Group, and the Consensus Panel members identified three critical priorities that must be addressed to achieve a strategic vision for the envisioned behavioral health system.

Behavioral Health Oversight Commission Final Report
June 2009
Who was involved?
Behavioral Health Oversight Commission
Key Recommendations

1. Moving Behavioral Health Forward

"Moving Behavioral Health Forward" recognizes that it is critical to adopt a Strategic Vision for implementation by the Division of Behavioral Health as the primary leader in behavioral health and for establishment of trusting and effective partnerships with key stakeholders in the system. This Commission recognizes the importance of strategic visioning to a planning process and believes it is imperative for this visioning and planning to occur in fiscal year 2010.

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

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

B. 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 service;

C. 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;

D. Focus on prevention and early intervention;

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

F. Encourage public/private partnerships;

G. 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;

H. 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.

2. Behavioral Health Workforce Shortage

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

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.

Summary

LB 928 revised existing law and created a Behavioral Health Oversight Commission to support implementation of the Nebraska Behavioral Health Services Act. The Commission was to assist DHHS in developing a strategic vision for the behavioral health division.

The three areas of Strategic Focus adopted by the Commission were:
1. Moving Behavioral Health Forward;
2. Behavioral Health Workforce Shortage;
3. Enhanced Communication and Partnering.

Draft Considerations for a Strategic Vision

January 2009

Who was involved?

Submitted to the Behavioral Health Oversight Commission by the Nebraska Division of Behavioral Health, Department of Health and Human Services

Key Recommendations

Recommendation #1: General principles should guide strategic planning.
The Division recommends five principles to guide strategic planning for the public behavioral health system in Nebraska:

- Access – Strategic planning should include discussion of how to equalize accessibility to quality public behavioral health services so people who are eligible can receive them in urban, rural and frontier areas of the State.
- Accountability – Strategic planning must address fiscal, management and service accountability. The public behavioral health system is ultimately accountable to the taxpayers of Nebraska. Structures that foster accountability without overburdening consumers and providers of service should be considered in the strategic planning process.

- Integration – Behavioral health issues and problems impact many areas of an individual's life. A vision for strategic planning should recognize the interconnections of health, mental health, substance abuse and other special needs. A strategic plan should incorporate assessment and planning that has already taken place in these areas.
- Quality – Services and administrative structures developed or implemented as a result of strategic planning must be of high quality across the State of Nebraska. Strategic planning driven by data must be balanced by consideration of local needs and the state vision to ensure consistent definitions of quality across the State.
- Wellness – Strategic planning emphasizing wellness and recovery is preferable to planning based solely on treatment of illness alone. Planning must emphasize the role of community supports, consumer choice of service providers, and the hope of recovery. Wellness includes consideration of vocational and housing needs of people in recovery along with treatment needs related to behavioral health services. The emphasis on wellness must be balanced with the public behavioral health system's special responsibilities related to public safety.

Recommendation #2: Critical issues including public safety and cost effectiveness should be addressed.

The Division strongly believes that any plan resulting from this process must recognize the responsibilities of the public behavioral health system in public safety and managing government funds. The strategic plan should result in a public behavioral health system that is responsive to these responsibilities. A strategic vision document should embrace:

- Strengths-based approaches
- Data-driven decisions
- Community-based services
- Culturally competent practitioners
- Recovery/wellness focused philosophies
- Integrated solutions to complex problems involving health, mental health and addictions
- Limits of sustainable resources

Recommendation #3: A strategic vision should be inclusive and comprehensive.

The Division recommends the vision for strategic planning include values related to how the planning process will unfold. Specifically, a process must be:

- Inclusive – Including fair representation of stakeholders based on geography and involvement in the public behavioral health system
- Culturally sensitive – Processes should take into account different needs and styles of participation to maximize participation from groups that may be underserved in the public behavioral health system
- Transparent – The planning process should be openly available and reported while respecting the privacy of planning participants
- Statewide – A vision should guide development of a plan that has statewide applicability

Summary

Behavioral health reform efforts in Nebraska have already resulted in a number of successes. Recently, the Division of Behavioral Health asked stakeholders from each Behavioral Health Region to help identify the critical successes to build upon, challenges yet to be addressed and strategies to ensure diverse, inclusive participation in a strategic planning initiative. The discussion and suggestions from these stakeholders helped shape the recommendations from the Division of Behavioral Health related to development of a vision to guide later strategic planning efforts.

Creating Change and Providing Hope for Nebraska's Children, Adolescents and Their Families, Pursuant to LB 542
January 2008
Who was involved?
Nebraska Department of Health and Human Services
Key Recommendations
The purpose of this report was to develop an implementation plan for the Governor and Legislature to consider based upon the LB 542 Children's Behavioral Health Task Force Report. The key elements and action steps included in the Department's plan include: ● Uniform assessment process ● Balanced array of services ● Accessible services ● Strategic use of evidence-based practices ● Strengthen training to behavioral health workforce ● Ensure cultural and linguistic competence at all levels of practice ● Coordinated responses for families involved in multiple systems ● Focus on community based services ● Develop highly secure facility to serve violent juvenile offenders This plan is intended to provide direction as we move forward with developing a system of care across Nebraska.
Summary
LB 542 created the Children's Behavioral Health Task Force. This legislatively created body was charged with creating a plan for the behavioral health needs of children, adolescents and their families in Nebraska. The Department of Health and Human Services (DHHS) has developed the following plan in order to improve Nebraska's Children's Behavioral Health system.

LB 542 Implementation Plan
December 2008
Who was involved?
Based on the Children's Mental Health State Infrastructure Grant (SIG) activities which included broad base public involvement including families, providers, state agencies, and other stakeholders
Key Recommendations
• Implement changes leading to family centered practice including policy changes, support of family organizations, provider training, and funding of family peer support

- Expand capacity to deliver community based services to prevent out of home and out of community placement
- Implement changes to improve cultural and linguistic competence including workforce training and recruitment/retention strategies
- Implement Child and Family Assessment and improve sharing assessment information across providers and systems
- Expand access to services and consultation through telehealth
- Expand evidence based practices through changes in policy, reimbursement, monitoring, and training
- Close HRC services for youth and develop secure program for high risk youth
- Ensure appropriate care coordination and system coordination
- Develop uniform system for collection and analysis of data
- Develop a coordinated and accountable funding model including performance based contracting

Summary

Developed as the implementation plan for the Children's Behavioral Health Plan under LB 542

Nebraska Justice Behavioral Health Initiative Strategic Plan

October 2008

Who was involved?

This report was prepared by the University of Nebraska Public Policy Center under contract with the Nebraska Department of Health and Human Services, Division of Behavioral Health. This activity was supported in whole by funds received from the U.S. Department of Justice / Office of Justice Programs / Bureau of Justice Assistance - Justice and Mental Health Collaboration Program.

Key Recommendations

Desired outcomes are:

- Persons with behavioral health issues accused of nonviolent offenses are identified early in the process
- Treatment is available in the least restrictive environment and is effective at meeting the unique needs of each individual served
- Housing/employment and other support services are accessible
- Persons with behavioral health issues accused of nonviolent offenses receive care designed from collaborative, data-driven decisions

Opportunities for intervention ("Interception Points") exist at the point of:

- Community and Law Enforcement
- Initial Detention and Initial Court Hearing
- Courts and Jails
- Re-entry
- Probation/Parole

Five goals were identified:

Goal 1: Provide consistent statewide training for Nebraska Law Enforcement officers to improve responses to people with mental illness.

Goal 2: Expand or improve access to crisis response services in Nebraska
Goal 3: Implement standardized mental health and substance abuse screening instruments in the jails that prompt referrals for services.
Goal 4: Increase resources to community mental health to provide diversion services through the use of Forensic Intensive Case Management.
Goal 5: Enhance affordable supportive housing for justice involved youth transitioning to adulthood.

Ten other recommendations were identified that apply across all five priority areas:
1. Planning and implementation efforts should involve consumers who are directly affected by the strategic plan (18-24 year olds with behavioral health challenges). Nebraska's Behavioral Health Initiative will recruit consumers from the target population to participate on work teams and will solicit additional input through outreach and public engagement efforts.

2. Nebraska's Behavioral Health Justice Initiative should focus on youth younger than 18 years of age since transition issues begin well before this age. The Initiative will partner with Nebraska's Child and Adolescent Behavioral Health State Infrastructure Grant to target younger children and youth in the juvenile justice system or at risk of justice involvement.

3. There should be more law enforcement involvement in the Behavioral Health Justice Initiative; there were too few law enforcement professionals at the strategic planning meeting. The Initiative will recruit law enforcement professionals to participate on work teams and will solicit additional input through outreach and public engagement efforts.

4. The Justice Behavioral Health Initiative should focus on veterans, particularly given the age group of emphasis (18- 24 year olds). This population is an important area nationally and a focus of the Substance Abuse and Mental Health Services Administration (SAMHSA). The Initiative should work with the Veteran's Administration to address these issues. Each work team under the initiative will examine opportunities to partner with veterans organizations and to develop additional strategies to address the unique needs of this population. Work teams will also examine potential funding opportunities to assist in implementation of these strategies.

5. A major focus for this initiative should be to reduce recidivism and prevent persons with mental health and substance abuse disorders from coming into the juvenile/criminal justice system. We need to collect data to determine what impact we are having in this area. Nebraska's Justice Behavioral Health Initiative will collect data reflecting service utilization and outcomes required by the Department of Justice Planning and Implementation Grant. The Initiative will also work across state agencies to develop data sharing arrangements to collect this data.

6. The initiative should focus on enhancing case management, which is important to link services and systems together. One of the five priority areas includes the development of enhanced case management.

7. The Initiative should focus on high quality assessments to determine competency or fitness for incarceration. The Initiative should address the needs of persons who are too ill to be in correctional facilities and jails but too dangerous to be in behavioral health programs. The work team addressing behavioral health screening and referral in jails will incorporate this issue in its work plan.

8. The Initiative should ensure that behavioral health regions have input into the plan and that there is

coordination between regional and state level planning. The Justice Behavioral Health Initiative will continue to communicate and coordinate strategies between the state and regional levels.

9. There should be a focus on sustainability and access to resources for the target population such as an increased alcohol tax. Financing issues will be addressed by the Justice Behavioral Health Steering Committee.

10. The Initiative should collaborate with the Tribes to address unique issues with the Native American population. The Justice Behavioral Health Steering Committee will develop a process and timeline to meet with Tribes in Nebraska, to communicate about the Justice Behavioral Health Initiative, and to better understand the needs and the opportunities.

Summary

Nebraska Received a U.S. Department of Justice Planning Grant designed to result in a strategic plan for addressing the needs of justice involved person with behavioral health disorders. The vision is to develop a seamless system of behavioral health screening, assessment, treatment and supports accessible at appropriate points throughout involvement in the juvenile and criminal justice systems.

The strategic planning process was designed to build collaborative partnerships through interagency coordination and communication to implement system improvements for persons with behavioral health disorders in the Nebraska's criminal justice system. The process included an initial meeting in December 2007 that focused on developing initial state and regional strategies; forming a steering committee and work teams, which established five priority areas and developed preliminary action steps for each area.

Additionally, the initial meeting resulted in the development and submission of a second Department of Justice grant application for funding to implement the priority strategies, and plans for a final planning meeting. The final strategic planning meeting was held on October 10, 2008, during which participants provided feedback on the strategies and identified additional areas for planning.

Report to Behavioral Health Oversight Commission & 15 Year History of New Service Development

June 2008

Summary

<u>Timeline</u>

1987 – Federal OBRA law (moving SPMI from nursing homes)
1989 – LB846 (regional youth system coordinator); LB257 (MI/Dangerous cannot be placed in jail; First Crisis Center established in Region 5)
1993 – Federal Block Grant funds allowed to be used for regional youth system coordination for substance abuse to comply with LB846 (1988)
1995 – Adult behavioral health system redesign; Legislature appropriates funds to implement children's road map
1996 – Legislature passes Rehabilitation Act to implement Medicaid Rehab Option (MRO)
1998 – LB1354 Task force focuses on financing for redesign; Legislature appropriates funding to implement MRO
1999 – Increase in federal substance abuse block grant funding to expand community support SA

2001 – LB692 Increased funding made available for community based services through tobacco settlement funds
2003 – LB724 Legislative roadmap for adult system reform
2004 – LB1084 Adult system reform – movement to community based services from regional centers
2007 – LB296 Reorganized Nebraska Department of Health and Human Services

Voices for Children Report – Spare some change: An account of the Nebraska Juvenile Justice and Children's behavioral health care systems

2008

Key Recommendations

- Keep youth in their home communities whenever possible
- Create standardized procedures for youth evaluation and placement
- Increase funding and attention to behavioral and emotional issues of youth
- Invest in community services that facilitate responsible community involvement

Timeline

1974 – Sarata report (calls for increased coordination for youth in custody across systems)

1984 - Choices & Challenges: Report of the Study Commission on Programs and Services for Dependent Youth and Youth Offenders in Nebraska
1985 – CASSP grant (5 year planning grant)
1986 – Interagency Collaboration and Coordination Team formed
1987 – Nebraska Family Policy Act
1989 – Development of Child and Adolescent Mental Health Services Plan
1993 – Nebraska's CASSP grant
1994 – Governor's Child & Family Mental Health Search Conference
1997 – Region 3 System of Care Grant
1998 – Region 5 System of Care Grant
1999 – Justice Behavioral Health Committee formed & Chinn Report released
2000 – Nebraska Family Portrait (strategic plan for Protection and Safety)
2001 – Governor's Juvenile Justice Reform Plan & Early Childhood Mental Health Symposium
2002 – Herz & Polland study of mental health needs of juvenile offenders & NEBHANDS Grant
2004 – SAMHSA children's state infrastructure grant & LB1083, behavioral health reform legislation
2007 – LB542, children's behavioral health task force

Children's Behavioral Health Plan

December 2007

Who was involved?
Children's Behavioral Health Task Force

Key Recommendations

- BH Division assume primary leadership for children's behavioral health
- Develop statewide integration plan
- Develop data and accountability evaluation system

- Conduct analysis of needs and service capacity
- Develop capacity development plan
- Develop workforce development plan
- Discontinue children's services at Hastings Regional Center
- Assess BH needs of youth at YRTCs
- Develop funding integration proposal
- Develop BH insurance parity legislation
- Assess current ASO contract with Magellan
- Reduce parents making their children wards of the state to access BH services
- Develop legislation to improve recruitment and retention

Summary

Developed by the Children's Behavioral Health Task Force under LB 542

State Strategic Partnership Session Final Report for the State of Nebraska

November 2007

Who was involved?

US Department of Health and Human Services, Health Resources and Services Administration, and the Nebraska Department of Health and Human Services

Key Recommendations

Both breakout sessions had similar responses regarding EPC and behavioral health issues. Seven major categories summarized the issues, needs, and actions requested by the participants. The highest priority for Nebraska is developing a statewide, as well as regional, strategic plan to address their critical issues and bring parity to the system.

1) Attendees requested an overall State plan to (1) eliminate regional disparities; (2) create a uniform definition of roles, responsibilities, and handoffs; and (3) discuss the economic impact. Primary issues here were the disparity between the two major urban areas' challenges and the rural areas of Nebraska. A state strategic plan would not only have to introduce financial parity for providers and law enforcement agencies but also address the issues of remote Nebraska regions crossing state borders to provide behavioral health (BH) facilities and services. Regions wanted to help develop the plan at the regional level on a preliminary basis and then have ideas rolled into a comprehensive strategic plan.

2) The State Strategic Plan should not only provide vision, mission, and purpose for BH, but use the "Logic Model" presented by C.J. Johnson to create appropriate benchmarks for data driven decisions. Each region should have some specific benchmarks based on their demographics and level of services but other benchmarks should be based on statewide initiatives for improving the BH system.

3) The plan should also address and implement some methodology for single point of contact for service delivery, bed availability, and entry into the system. A web-based system or call-in hotline number were both considered. Such a system could also be helpful in communicating additional resources, such as peer services, services for wait-listed clients, and community alternative services, such as clerical counseling or homeless shelters.

4) A critical issue was training, not only for Law Enforcement, but also for providers and community services. De-criminalizing the process of entry into the BH system was paramount to clients and service

agencies as well. The Crisis Intervention Team training (CIT) received the highest recommendation at each breakout session. Extending this training to awareness of other services, processes and new tools would create a stronger network of support for the BH system. Increasing the Assertive Community Training (ACT) teams was mentioned by a third of the breakout groups, as well as the use of CRT (Crisis Response Teams) who have CIT training and full awareness of area services.

5) Using state employees from previous BH state facilities as Regional Treatment Staff would be an effective and economic answer for many rural regions. Following Minnesota's lead of selling or donating the old regional centers back to the communities for re-use was also well received.

6) Minnesota's 16-bed facilities that were highlighted in Wes Kooistra's presentation were referenced frequently throughout the day. There appeared to be a high level of support by the respondents that this regionalized approach should be considered in the Nebraska State Strategic Plan.

7) Address the issues surrounding patients who are discharged from acute in-patient care with only seven days of medications, yet are unable to schedule follow-up outpatient psychiatric appointment for 4-6 weeks. The audience identified this circumstance as the key factor in patients having to "re-enter" the BH system, mainly via another EPC. The benefit of managing these patients through medication and quicker follow-up appointments would, the group felt, assist in alleviating the bed shortages and would result in fewer EPC calls for law enforcement.

8) Recommended Next Steps:
a. Convene a working group, led by Nebraska DHHS, to develop a list of standards.

b. Gain individual and regional feedback through the development of an Implementation Plan. Each region would work with Nebraska DHHS to define critical needs, prioritize budgeting and support allocation requests, and establish the implementation timeline. Nebraska DHHS will suggest plan adjustments as appropriate.

c. Roll the regional plans and innovations into the Nebraska Statewide Plan.

Summary

The Nebraska Department of Health and Humans Services (DHHS) was approached by representatives from HRSA/OPR earlier in 2007 asking Nebraska DHHS to partner with HRSA/OPR on important public health issues in Nebraska. In August, a second meeting occurred where agreement was reached to conduct a facilitated conversation on two related behavioral health topics. The first topic was "how to improve the Emergency Protective Custody (EPC) process" given the closure of the Regional Behavioral Health (BH) Treatment Centers throughout Nebraska. The second topic was "how to improve the overall systems of care in Nebraska's Behavioral Health Model."

The objectives of this strategic partnership session included the following:

1. Assess Emergency Protective Custody (EPC) issues in Nebraska and identify suggested changes.
2. Address how a community-based system of care can provide solutions.
3. Define what a community-based system of care should look like (telehealth, hubs.)
4. Provide conversation on Nebraska's mental health workforce shortages (both current and projected) and the mal-distribution of that workforce statewide.
5. Share potential resources and best practices among stakeholders to help overcome current

challenges.
6. Identify "lessons learned."
7. Include feedback on policy or programmatic change within HRSA that can better support state-level grantees during health care reform.

Nebraska Strategic Partnership Session
January 2007
Who was involved?
Over 100 stakeholders representing health, behavioral health, consumers, families, justice, law enforcement, corrections, military, advocacy groups and legislators.
Key Recommendations
Report writers stated that "Clearly, the highest priority for Nebraska is developing a statewide, as well as regional, strategic plan to address their critical issues and bring parity to the system." • Convene a working group, led by Nebraska DHHS, to develop a list of standards. • Gain individual and regional feedback through the development of an Implementation Plan. Each region would work with Nebraska DHHS to define critical needs, prioritize budgeting and support allocation requests, and establish the implementation timeline. Nebraska DHHS will suggest plan adjustments as appropriate. • Roll the regional plans and innovations into the Nebraska Statewide Plan.
Summary
The Nebraska Department of Health and Humans Services (DHHS) was approached by representatives from HRSA/OPR earlier in 2007 asking Nebraska DHHS to partner with HRSA/OPR on important public health issues in Nebraska. Two topics were chosen, "how to improve the Emergency Protective Custody (EPC) process" and "how to improve the overall systems of care in Nebraska's Behavioral Health Model." Attendees requested an overall State plan to (1) eliminate regional disparities; (2) create a uniform definition of roles, responsibilities, and handoffs; and (3) discuss the economic impact. Primary issues were the disparity between the two major urban areas' challenges and the rural areas of Nebraska. A state strategic plan would not only have to introduce financial parity for providers and law enforcement agencies but also address the issues of remote Nebraska regions crossing state borders to provide behavioral health (BH) facilities and services. Regions wanted to help develop the plan at the regional level on a preliminary basis and then have ideas rolled into a comprehensive strategic plan. The State Strategic Plan should provide vision, mission, and purpose and create appropriate benchmarks for data driven decisions. Each region should have some specific benchmarks based on their demographics and level of services but other benchmarks should be based on statewide initiatives for improving the BH system. The plan should also address and implement some methodology for single point of contact for service delivery, bed availability, and entry into the system.

Behavioral Telehealth
June 2005
Who was involved?
Academic Workgroup on Telehealth of the Behavioral Health Reform Project
Key Recommendations
A Proposed Action Plan

1. Recruit/Develop Behavioral Telehealth Providers. To begin, Nebraska needs providers that are not only interested in the mission of behavioral telehealth for this State, but also have the requisite training to provide state-of the-art treatment services using this modality. To meet this objective, the following steps should be taken:

a. Provide training for an identified core group of behavioral health professionals. These individuals should represent a variety of disciplines including Psychiatry, Psychology, Social Work, and Psychiatric Nursing. In addition, these should include those who specialize in work with children, adults, and geriatrics, as specialized services are what makes telehealth especially meaningful to shortage area providers and patients. A call to extant providers should be a first step as there may be individuals within each discipline, already familiar with the State, who would respond to this challenge if some kind of incentive were provided (see below). Subsequently, the State should consider hiring telehealth experts from outside.

b. Provide funding academic positions focused on the advancement of behavioral telehealth services. In order to provide core faculty with time to train, develop a new system, and engage in telehealth services, funding should be available to offset part or all of their salary. Anecdotal reports from pilot sites and from Dr. Chelsea Chesen of the Arizona Telemedicine Project suggest there is significant time spent in the "start-up" of this kind of operation. As this core group builds an efficient program, it will be easier to "build in" additional faculty or providers with minimum effort/cost.

c. Integrate telehealth service program into training programs. To insure the growth and future vitality of the program, telehealth training should be integrated into training programs across disciplines. All behavioral health training programs should provide students some experience in telehealth service provision with the option to "specialize" in that area. In addition, other health professions (e.g., family medicine, nursing) should also integrate some behavioral telehealth exposure into their curricula to insure the professionals with the greatest referral needs for behavioral health are familiar with this treatment modality.

2. Develop support system. As the core group is trained and is able to devote time to the development of behavioral telehealth service provision and training in the State, a structure to enable the "clinician system" should be developed. To meet this objective, the State should:

a. Identify a central site. As each member of the core group becomes an "expert" in his or her field (e.g., psychiatry, psychology, nursing, etc.) for telehealth service provision, it would be helpful to have a shared site, where interdisciplinary service, training, and research could be developed.

Following from the Arizona Telemedicine Program, each core faculty might have a telehealth "clinic" at his or her home department, but also a caseload at a shared site, where interdisciplinary work, training and research would be ongoing. The Center of Excellence in Omaha would be the logical choice for such a site given its proximity to many of the graduate training programs in the behavioral sciences.

b. Involve primary care. Approximately 60% of health care visits for mental health concerns occur in the context of primary care (Magill & Garrett, 1988).

Particularly in rural areas, primary care physicians are usually the first medical professionals to encounter patients' behavioral health problems and are the identified gatekeepers of specialty services including mental health (Bray & McDaniel, 1998). Thus, because a vast majority of referrals to an

extant telehealth program would come through community-based primary care offices, it will be important to involve these groups in the development of the telehealth system. In general, this recommendation is made to keep physicians involved in a process that will be, in part, dependent on their referral activity.

In addition, this recommendation is made because the involvement of rural physicians in such a system might improve their retention in rural communities and improve the quality of care they provide. According to deGruy (1997), 25% of rural physicians report they will leave their job in the next two years due to the overwhelming demands of working in an underserved area. Familiarity with telehealth may allow physicians more comfort with making referrals to behavioral health professionals working through this technology. In addition, other activities may relieve the burden for rural physicians including training in telehealth technology (both as part of their initial education and ongoing) as well as in-office telehealth capability for direct service provision to patients in primary care sites as well as for consultation-liaison and training services.

c. Communicate capabilities to the regional boards that are charged with community-based planning. Following the Arizona model, regions could elect to develop telehealth sites/facilities that are in coordination with the core group and allow individuals in mental health profession shortage areas access to such services while remaining in their own communities. Funding designated to assist regions in linking to and coordinating with the core group may facilitate this process.

d. Provide money to support research. Ultimately, faculty who will best keep Nebraska's telehealth program at a "cutting edge" standard will be those interested in engaging research in this area, networking with experts at the national level. To this end, Nebraska's telehealth program should have regular competitive grants available to clinical researchers in various disciplines as well as allow researcher to compete for other national grants.

e. Re-visit State law regarding the use of telehealth and its reimbursement by State programs.

f. Involve consumers in the planning and training stages of development, particularly consumers from rural settings who can provide insights as to the confidentiality and acceptability of this treatment modality.

3. Expand Telehealth Use. Ultimately, to maximize the system's potential, increase providers' comfort with the use of two-way videoconferencing, and expand knowledge and training in the field, the use of telehealth in the field of behavioral health must be expanded to uses beyond service provision. Some important areas for expansion will include:

a. Supervision for trainees.
b. Consultation for professionals.
c. Ongoing continuing education.
d. Support groups for consumers.

Summary

Objectives:
1. To increase behavioral health providers in rural shortage areas.
2. To increase community based services in response to recent legislation.

Significance:
1. 88 of 93 Nebraska counties are Mental Health Profession Shortage Areas (HRSA, 2000) with less than 1/3 of all providers practicing in the rural areas of the State.
2. The Nebraska Telehealth Project is moving toward a comprehensive technological network, however, little effort/funding has been devoted to the commensurate development of a network of behavioral health personnel to utilize this technology.

Current Barriers:
1. Most providers in the State are already busy and have little incentive to engage telehealth.
2. There are no providers in the State who have received specialized training in the area of telehealth service provision.
3. There is no mechanism for coordinating behavioral telehealth services or training in this area.
4. There are ongoing concerns about whether such services will be reimbursed by third party payers including Medicare/Medicaid.

Proposed Action Plan:
1. Recruit/develop behavioral telehealth providers.
• Provide training for an identified core group of behavioral health professionals from a variety of disciplines (e.g., psychology, psychiatry, social work, nursing).
• Provide funding for academic positions focused on the advancement of evidence-based behavioral telehealth services.
• Integrate telehealth service program into training programs.

2. Develop a support system.
• Identify a central site where interdisciplinary service, training, and research could be developed.
• Involve primary care.
• Engage the regional boards as they plan for community-based services.
• Provide funding for research.
• Re-visit State law regarding telehealth reimbursement.
• Include consumers in planning process.

3. Expand telehealth use.
• Supervise trainees.
• Consult with professionals in rural areas.
• Provide ongoing continuing education.
• Provide mechanism for consumer interaction.

Best Practices – For serving people under civil commitment, court ordered or guardian petitioned treatment in Nebraska
January 2005
Who was involved?
Academic Workgroup of the Behavioral Health Reform Project
Key Recommendations
SOCIAL VALUES

1. The primary and overriding purpose of services for people with SMI, and people in the population of primary concern in particular, must be the benefit of those people;

2. Services for people in the population of concern must be appropriate to their individual needs, modern and high quality, guided by a Best Practices model that identifies relevant values, policies and evidence-based clinical practices, and provided in the least restrictive and most integrated settings appropriate to their needs and with necessary and sufficient supports (see especially the Report of the President's New Freedom Commission, Goal 2.4);

3. Mental health administrators and providers must be held directly accountable for the quality, appropriateness and effectiveness of the services they administer or provide;

4. People who are civilly committed, under guardianship or under court-ordered treatment must have the same access to appropriate, modern, quality services as people who are not;

5. The concept of recovery provides the best, most comprehensive integration of social values, scientific understanding of SMI and effective clinical practices, the most important domain of operational outcome measurement, and the best overall goal and outcome criterion for services (see especially the Surgeon General's report, U.S. Public Health Service, 1994, chapter 2, and the Report of the President's New Freedom Commission, Goal 2.2);

6. In the population of primary concern for the WBPM, a key aspect of recovery is regaining personal autonomy and resolving the circumstances that led to civil commitment, guardian-petitioned treatment or court-ordered treatment;

7. At any and every point in the recovery process, people in recovery must be supported in their self determination and served with the least intrusive, least restrictive services possible, in the least restrictive and most integrated settings possible;

8. The experience and involvement of people with SMI is integral to and a priority in all aspects of the research, planning, administration and provision of mental health services (see Salzer, 2002);

9. Services provided to the population of concern should meet the criteria for trauma informed services and should be provided in environments that are trauma and coercion free (Blanch, 2003; Finklestein, et. al. 2004; Jennings, 2004a; Jennings, 2004b;)

10. Services provided to the population of concern should be delivered in a culturally competent manner within a culturally responsive environment.

11. In order to foster and promote the human dignity of people who live with SMI, mental health clinicians, researchers and providers should adopt the use of person first language, e.g., "persons diagnosed with mental illness, people who live with schizophrenia."

POLICY, ADMINISTRATION AND REGULATION

1. Policy, administrative practices and regulatory practices must all be congruent with the social values enumerated in the work group best practices model;

2. Policy, administrative practices and regulatory practices must all be congruent with generally accepted standards and accreditation criteria such as those of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the Commission on Accreditation of Rehabilitation Facilities (CARF), and must require relevant accreditation for facilities and services in the mental health system;

3. Policy, administrative practices and regulatory practices must effectively support provision of the best services and clinical practices enumerated in the work group best practices model, in particular those that most effectively support the process and goal of recovery from disabilities associated with severe mental illness;

4. Policy, administrative practices and regulatory practices must support effective collaboration among the consumer, the mental health system and the legal/judicial system, so that clinical decisions and legal/judicial decisions are optimally informed by each other and the first person narrative.

5. Policy, administrative practices and regulatory practices must support effective interdisciplinary collaboration and optimum use of professionals practicing within the full legal scope of their respective disciplines;

6. Policy, administrative practices and regulatory practices must be subjected to continuous data-based evaluation to ensure they effectively support the best services and clinical practices and generate the best possible outcomes;

7. Policy, administrative practices and regulatory practices must hold providers accountable for providing quality services at fair cost.

CLINICAL SERVICES: ORGANIZATION AND ADMINISTRATION

1. The organization and administration of clinical services must all be congruent with the social values enumerated in the work group best practices model;

2. The concept of psychiatric rehabilitation provides the best, most comprehensive approach to organizing the services and clinical practices that most effectively realize the goals of recovery for people with SMI.

3. Psychiatric rehabilitation is a collaboration of the person in recovery, family (where applicable), advocates, peers, service providers and substitute decision makers (where applicable), formally organized and working together as an interdisciplinary team;

4. Psychiatric rehabilitation is systematically provided according to a formal, documented treatment or rehabilitation plan, tailored to the individual needs and goals of the person in recovery (see especially the Report of the President's New Freedom Commission, Goal 2.1);

5. The treatment or rehabilitation plan is comprehensive, addressing all factors pertinent to the biological, psychological and social functioning of the person in recovery, and his or her environment, that are barriers to recovery (for this reason, psychiatric rehabilitation is also known as biopsychosocial rehabilitation);

6. The treatment or rehabilitation plan for each person who receives services is subjected to periodic,

data-based review and evaluation, to ensure the person is making progress toward specified goals;

7. The professional members of the treatment or rehabilitation team are held directly accountable for their participation on the team and the quality of their services.

Summary

This document was developed by the Academic Support Workgroup of the Behavioral Health Reform Project in response to the Workgroup's charter. The purpose of the Workgroup is "To ensure academic support for excellence in behavioral health services for consumers in the state public behavioral health system." One goal specified in the Workgroup's charter is "to develop evidence based "best practices" to improve access to and delivery of behavioral health services in urban as well as rural/frontier areas of the state." This document is the "deliverable" associated with that goal.

A Behavioral Health Education and Research System for Nebraska

January 2005

Who was involved?

Academic Workgroup of the Behavioral Health Reform Project

Key Recommendations

The current education and research system in Nebraska is lacking the following:

- Training for professionals in teamwork and collaborative care
- Matching the local need for professionals with the education efforts in institutions
- Retaining trained providers in the state
- Recruiting high school and college students into behavioral health care professions
- Recruiting persons with psychiatric diagnoses into behavioral health care professions
- Support for rehabilitation workers and peer providers
- Academic support for rural rotations
- Support to keep providers updated on new treatments and best practices
- Developing research infrastructure
- Research to answer the questions important to the state and to consumers in order to inform the state about services, supports, evaluations and suggested changes

To address these shortcomings, a Nebraska Behavioral Health Education System, composed of a Behavioral Health Education and Research Center, and six Behavioral Health Education Sites across the State, should be developed.

A Behavioral Health Education Center would coordinate education across academic institutions and professions, support training for substance abuse, rehabilitation and peer providers, support clinical training in all areas of the state, and enhance research that improves the system of care.

The Center would have academic leadership with an Executive Committee, including representation from each participating academic institution, and would include consumers of services in sufficient numbers to make an impact and representation from the state. Faculty from UNO, UNK, UNL, Creighton, and UNMC and the consumers must work together to develop interdisciplinary education for trainees in

undergraduate through post-graduate practitioners.

Every area in the state needs well trained providers of behavioral health care. Sites in all areas of state would be provided their own budget and support from Area Health Education Centers (AHEC). These plans for behavioral health education sites follow the successful Rural Health Education Network model already available in Nebraska. Each training site would have local control of the professions that are the focus of training as well as recruitment and retention and would be expected to work with the Behavioral Health Regions and their Advisory Committees.

Academic support for system and outcome research should focus on the questions of most interest to the state:

What services work best?
What is the most efficient and effective delivery of service for each problem?
Are our educational efforts being translated into improved service delivery?

With some state support, Nebraska can develop a multi-institutional, inter-disciplinary academic group oriented towards developing a comprehensive, statewide research infrastructure for policy-relevant mental health services research.

Summary

Nebraska is reforming the state behavioral health system, moving from institutional care to community care and increasing the recovery focus of services.

It is essential that Nebraska have a well-organized behavioral health education and research system to develop the state-wide workforce necessary to support behavioral health reform.

The education system lags behind in translating current research into training and thus into service delivery. In addition, consumers, now active in policy discussions and direct care, have been neglected in the training and education process.

The Nebraska behavioral health reform would be enhanced by the development of a behavioral health education system that would increase the availability of behavior health providers to all areas of the state, assure that local service providers have knowledge and expertise in the best behavioral health practices, and ensure that the consumer's perspective be a component of education for providers.

Nebraska Women's Health Strategic Plan 2004-2010

Fall 2004

Who was involved?

Stakeholders from across Nebraska, state agencies and advocacy groups. The Nebraska Women's Health Advisory Council convened the New Dimensions of Health for Nebraska Women Partnership with internal state agency stakeholders

Key Recommendations

- Reduce isolation within the overall health services system
- Increase access to culturally and linguistically appropriate health services
  - Put services where people live and work that are reflective of the local cultures.
  - Increase the number of racial/ethnic minority and rural health care providers.
  - Educate providers about the cultural dimensions of healthcare and encourage the implementation of CLAS standards (Culturally and Linguistically Appropriate Services).
- Reduce stigmas, fears and taboos
- Increase women's mutual support systems
- Improve funding

Summary

Mental health and mental disorders were prioritized as one of five primary goal areas. Access to mental health and substance abuse treatment for women was highlighted as a challenge.

Behavioral Health Reform: Supporting Employment

September 2004

Who was involved?

Employment team of the Behavioral Health Reform Strategic Planning Effort

Key Recommendations

OBJECTIVE:
Increased Employment Opportunities for Persons with Serious Mental Illness or Substance Dependence who are or have been committed to the state for inpatient services.

ACTION PLAN:
• Expand existing employment programs within their respective communities.
• Expand employment programs into other communities.
• Increase understanding of Consumers, Providers, & Advocates on how to use current work incentives available to them.
• Explore and implement policies, policy changes or strategies that would enable continued medical supports for working persons in NE with Serious Mental Illness beyond the established Substantial Gainful Activity (SGA) limit of earnings.

TEN PRINCIPLES THAT SUPPORT EFFECTIVE MENTAL HEALTH EMPLOYMENT PROGRAMS:

1. Community Partnerships – Build community partnerships and consensus with agencies, employers and community supports. Look to day programs, shelters, faith-based groups, and local mental health providers to be the focal point by which the various groups can coordinate services on behalf of each consumer. The entity that provides housing or day services is a natural place through which partnerships and collaboration can occur.

2. Long-term Supports – Plan for Long-term support because of the cyclical nature of mental illness. Face-to-face communication and encouragement are necessary in preparing for work. Support will be needed at the worksite and off the worksite during non-work hours. Peer support can be extremely effective in helping a consumer prepare for, obtain, and maintain employment.

3. Belief In Work – Establish among all partners and service providers an unwavering belief that with support people with mental illness can be productive workers. This must be a shared belief and modeled by staff. Create a natural sense of hope for the consumer.

4. Consumer Choice – Respect a consumers desire to choose to work and be independent. Provide opportunity for continuous consumer input. The consumer should be involved, engaged and develop a strong sense of ownership for their employment goal. Provide complete information to the consumer so they can make decisions that best meet their needs, interests and abilities.

5. Integration of Services – Integrate services and supports through a shared philosophy, clear communication and agreed upon goals. Since employment will depend on the services and supports of more than one partner, a clear understanding of an agreed upon approach is critical.

6. Real Work – Create opportunities for real work. Work should be community based, competitive, in a normalized setting, involving multiple employers that can lead to increased financial stability and security. As much as possible provide employment experiences in the natural work setting – not sheltered settings.

7. Flexibility – Assure that services and supports are flexible. This is critical because of the cyclical nature of mental illness. Traditional employment programs place a heavy emphasis on being "work ready". Mental health employment programs need to be flexible and start employment opportunities at the lead of the consumer, perhaps before they would be considered "work ready". People who experience mental illness may do better with a place and support model rather than a traditional train and place model.

8. Employer Needs – Respond to employers needs. Employers have a right to expect an employee to do a good job. Even though consumers may require reasonable accommodation, employers should not be expected to hire a consumer out of sympathy. If the consumer does not meet the employer's requirements, reasonable accommodations should be considered. Thus, finding another way to meet the employer's needs. If the consumer is not the right match for the job other work opportunities should be considered.

9. Consumer Needs – Structure continuous evaluation and planning into your program. Meaningful work must be built on the broad range of interests, concerns, desires and abilities of the consumer. Continually evaluating and planning with the consumer will assure that their changing needs and concerns are being met.

10. Developmental Model – Establish a program build on a developmental philosophy. If provided the right support, consumers will learn through practice, reinforcement of skill and responsibilities, which will lead to real work expectations. The model must support the belief that consumers can develop and change in ways that will lead to successful employment.

The Road to Recovery: Balancing new adult behavioral health community supports (Lewin Report)
January 2004
Who was involved?

NE HHS retained The Lewin Group to recommend changes to the state's behavioral health system, particularly in regards to the closings of the Hastings and Norfolk Regional Centers.
Key Recommendations
Moving Regional Center clients to community based settings for treatment. It was recommended that adequate service capacity and ancillary supports (e.g., housing) be established across Nebraska.
Summary
The recommendations were based on four principles: Individualized services, recovery focus, realignment of stakeholder responsibilities and leveraging resources.

LB 433 Report Fiscal Year 2003
2003
Who was involved?
LB433 requires each Region to submit an annual report to summarize the quantity and quality of substance abuse and mental health services offered for youth by each Region.
Key Recommendations
A number of recommendations have been suggested by all the Regions in Nebraska. The desire to pursue extra funding for a variety of reasons has been expressed. Specific areas in which additional dollars are needed are to expand the Professional Partner Program (Region 1 and 4); to help parents with the cost of mental-health related medications (Region 2); to have access to long-term sustainable and expandable funding (Region 3); and to enhance communication and coordination in order to follow the progress of children in the system of care (Region 5). Additionally, all six Regions of the state of Nebraska are interested in funding that will help expand all children's mental health services. The desire to expand services appears throughout the state, and takes a variety of forms. Region 1 recommends finding a new facility for PAL, offering more community education and outreach efforts, and creating a more formalized mentoring program. Region 2 suggests expanding access to services, and introducing case management services for ADHD youth. Region 3 recommends providing integrated treatment to youth with co-morbid disorders, providing integrated services to transitioning youth, and expanding adolescent intensive outpatient treatment to all 22 counties of Region 3. Region 4 suggests expanding Treatment Group Home services to adolescent females. Region 5 suggests creating a communication and referral mechanism to allow flexibility and choice to families. And lastly, Region 6 recommends promoting the services available through the Family Support Network, improving decision making and communication about the level of needed placement for youth, and creating specialized programs for sex offenders and children with behavior disorders and/or mental illnesses who also have developmental disabilities. A number of Regions would like to see improvement in the areas of training and assessment. Region 2 suggests the continuous training of substance abuse counselors in the CASI (Comprehensive Adolescent Severity Index). Region 3 suggests providing substance abuse and mental health training to all primary care providers, educators, and case managers. Region 5 would like to address gaps in training for psychiatrists and psychologists specific to serving adolescent populations, as well as a gap in general mental health training for educators, respite providers, and other community service employees. Region 6 recommends training providers in accurate assessment for the specialized

programs (sex offenders, developmentally disabled youth, and behaviorally aggressive youth) into which they would like to expand services.

It has been recommended that the communication and collaboration be improved between medical and mental health services. Region 2 will be asking the state to request that the managed care company give rural exemptions for families so they can receive all assessment services that they need in one day/trip. Region 2 would also like to see an increase in the partnerships between pediatricians, doctors, psychologists, and therapists. Region 3 recommends a technology update (i.e., tele-medicine) so that rural areas can be reached with services. Region 5 would like to improve communication and coordination within the Regional Systems of Care and with other agencies providing services for the purposes of establishing definitions, setting rates, and creating a directory of services. Region 6 recommends increasing the communication between Medicaid, Child Welfare, and other funding sources in an effort to reduce duplication and maximize funding resources.

In summary, all six Regions across the state of Nebraska would like to pursue additional funding, recommend expanding services, suggest specific assessment and training goals, and would like to see an improvement in the communication and collaboration between medical and mental health services. All Regions would like to move toward a more bilingual staff, and recommend reviewing and planning to implement the identified gaps in service.

Summary

Substance Abuse Services

All six Regions offer substance abuse services to youth. Youth have access to outpatient therapy services in all Regions. Prevention services are available in all Regions. Assessment of substance abuse problems is available in Regions 2, 3, 5, and 6, and residential or partial care services are offered in Region 6. Intensive outpatient services can be seen in Regions 3 and 5, and will soon be introduced to Region 1. Region 6 also offers services through the Tobacco Free Nebraska Project, Provider Network Information Services, and the Regional Prevention Center. Scottsbluff County has established an Adolescent Drug Court in cooperation with Region 1. In summary, five Regions offer substance abuse outpatient therapy services, and some mixture of prevention, community support, assessment, and residential services.

Mental Health Services

All six Regions in the state of Nebraska offer mental health services to youth. Outpatient therapy services can be seen in all six Regions. The Professional Partner Program (wraparound) is offered in all six Regions and Regions 1, 3, 4, and 6 offer additional wraparound services in area schools. Youth mental health assessment services are offered by Regions 1, 2, 3,and 5. Integrated Care Coordination Unit (ICCU) exists in Lancaster County and Regions 1, 3, 4, and 6. Therapeutic consultation services are available in Regions 2 and 5, while medication management services are available in Regions 1, 2, 3, and 6. A number of Regions offer services unique to their area. Region 1 offers services through their Program for Alternative Learning (PAL). Region 2 offers a youth assessment program in three area schools and offers Emergency Protective Custody (EPC) provided by two hospitals. Region 3 has day treatment services, Multisystemic Therapy services, mobile crisis and youth crisis services, and a 24-hour clinician/crisis line. Region 5 offers intensive outpatient services. Region 6 offers EPC through one hospital and has a crisis line for professionals. In summary, mental health services for youth are available throughout the state of Nebraska. Youth can access outpatient services, the Professional Partner Program (wraparound), and a

variety of community, family, and youth support services.

Gaps in Services
A number of gaps in services were reported by each Region. All of the six Regions throughout the state of Nebraska have expressed the need for more qualified staff and professionals, more specialized training for all staff and professionals, and the need to expand facilities and services in order to serve more youth and more rural areas. The state of Nebraska would benefit from more education and training in the community and schools, and more early intervention and assessment services. The need for more psychiatric services, specialized training for professionals, specialized programs/treatments for youth with various substance abuse and mental health problems, and more placements have been noted by all six Regions. Furthermore, the need for more cooperation and communication between the medical, mental health system, and judicial system, and the need for more culturally competent services was emphasized.

LB 433 Report Fiscal Year 2002

2002

Who was involved?

LB433 requires each Region to submit an annual report to summarize the quantity and quality of substance abuse and mental health services offered for youth by each Region.

Key Recommendations

A number of recommendations have been suggested by all of the Regions in Nebraska. The desire to pursue extra funding for a variety of reasons has been expressed. Specific areas in which additional dollars are needed are to expand the Professional Partner Program (Region 1), to help parents with the cost of mental health-related medications (Region 2), to have access to long-term sustainable and expandable funding (Region 3), and to help youth "falling through the cracks" (Region 4). Additionally, all 6 Regions of the state of Nebraska are interested in funding that will help to expand services.

The desire to expand services appears throughout the State, and takes a variety of forms. Region 1 recommends finding a new facility for day treatment, offering more community education and public relations with the area schools, and creating a more formalized mentoring program.
Region 2 suggests expanding access to services, and introducing case management services for ADHD youth. Region 3 recommends providing integrated treatment to youth with co-morbid disorders, providing integrated services to transitioning youth, and allowing access to services through waivers. Region 5 suggests creating a communication and referral mechanism to allow flexibility and choice to families. And lastly, Region 6 recommends creating more services, especially residential services, finding more beds, improving decision making and communication about the level of needed placement for youth, creating specialized programs for sex offenders and physically aggressive youth, and developing a Youth Crisis Center. Lastly, Region 1 would like to create a more structured and consistent evaluation process of their own services.

A number of Regions would like to see improvement in the areas of training and assessment. Region 2 recommends training substance abuse counselors in the CASI (Comprehensive Adolescent Severity Index). Region 3 suggests providing substance abuse and mental health training to all primary care providers, educators and case managers. Region 3 would also like to initiate a substance

abuse and mental health assessment/screening procedure for area schools and the juvenile justice system. Region 5 would like to address gaps in training for psychiatrists and psychologists specific to serving adolescent populations, as well as a gap in general mental health training for educators, respite providers, and other community service employees. Region 6 recommends training providers in accurate assessment for the specialized programs (sex offenders and physically aggressive youth) into which they would like to expand services.

It has been recommended that the communication and collaboration be improved between medical and mental health services. Region 2 will be asking the state to request that the managed care company give rural exemptions for families so they can receive all assessment services that they need in one day/trip. Region 2 would also like to see an increase in the partnerships between pediatricians, doctors, psychologists and therapists. Region 3 recommends a technology update (i.e., tele-medicine) so that rural areas can be reached with services. Region 5 would like to improve communication and coordination within the Regional System of Care and with other agencies providing services for the purposes of establishing definitions, setting rates, and creating a directory of services.
In summary, all 6 Regions across the state of Nebraska would like to pursue additional funding, recommend expanding services, suggest specific assessment and training goals, and would like to see an improvement in the communication and collaboration between medical and mental health services. All Regions would like to move toward a more bilingual staff, and recommend reviewing and planning to implement the identified gaps in service.

Summary

Substance Abuse Services

Regions 1, 2, 3, 5, and 6 offer substance abuse services to youth. Region 4 does not fund substance abuse services specifically for youth. Youth have access to outpatient therapy services in all 5 Regions that offer substance abuse services. Prevention services are available in all
Regions. Assessment of substance abuse problems is available in Regions 2, 3 and 5, and residential or partial care services are offered in Regions 6. Intensive outpatient services can be seen in Regions 3 and 5, and will soon be introduced to Region 1. Region 6 also offers services through the Tobacco Free Nebraska Project and Provider Network Information Services.
Scottsbluff County will soon be establishing an Adolescent Drug Court in cooperation with
Region 1. In summary, five Regions offer substance abuse outpatient therapy services, and some mixture of prevention, community support, assessment and residential services.

Mental Health Services

All 6 Regions in the state of Nebraska offer mental health services to youth. Outpatient therapy services can be seen in all 6 Regions. Professional Partner Program wraparound services are
offered in all 6 Regions, and Regions 1, 3 and 4 offer additional wraparound services in area schools. Youth mental health assessment services are offered by Regions 1, 2, 3, and 5.
Integrated Care Coordination Unit exists in Lancaster County and Regions 1, 3 and 6. ICCU will soon be introduced to Region 4. Therapeutic consultation services are available in Regions 2 and
5, while medication management services are available in Regions 2, 3 and 6. A number of
Regions offer services unique to their area. Region 1 offers services through their Program for Alternative Learning and will soon be establishing a Mentoring Coalition. Region 2 offers a youth assessment program in three area schools and a specialty clinic for the diagnosis of ADHD that includes a pediatrician and a psychologist in partnership. Region 3 has day treatment services, Multisystemic Therapy services, mobile crisis and youth crisis services, and a 24-hour clinician/crisis line. Region 5 offers intensive outpatient services, and Region 6 helps youth through their Regional Wellness and

Prevention Center. In summary, mental health services for youth are available throughout the state of Nebraska. Youth can access outpatient services, the
Professional Partner Program Wraparound services, and a variety of community, family and youth support services.

Gaps in Services
A number of gaps in services were reported by each Region. All of the 6 Regions throughout the state of Nebraska have expressed the need for more qualified staff and professionals, more specialized training for all staff and professionals, and the need to expand facilities and services in order to serve more youth and more rural areas. The state of Nebraska would benefit from more education and training in the community and schools, and more early intervention and assessment services. The need for more psychiatric services, transitional services, mentoring and respite services, integrated treatment for youth with co-morbid disorders, and more placements have been noted by all 6 Regions. Furthermore, the need for more cooperation and communication between the medical and mental health systems, and the need for more culturally competent services was emphasized.

Assessing the Need for and Availability of Mental Health Services for Juvenile Offenders

January 2002

Who was involved?

The Nebraska Coalition of Juvenile Justice commissioned the University of Nebraska-Omaha Department of Criminal Justice to write this report.

Key Recommendations

Overall Recommendations
1. Create a statewide juvenile justice policy that defines a "system of care" and emphasizes:
- Interagency communication and collaboration
- Treatment providers and Regions as a part of juvenile justice
-The current and future role of juvenile justice "best practices" in Nebraska

2. Once a strategic plan is created, prioritize its recommendations at the state level and ensure that all legislative changes are consistent with mission and goals of the plan.

3. Eliminate fragmentation and duplication throughout the system in the following ways:
-Form formal linkages between Probation and OJS to create a continuum of treatment and supervision care
-Formally include treatment providers in juvenile justice
- Formally include Regions in juvenile justice
- Implement standards and consistent processes across all juvenile justice entities (i.e., get everyone on the same page and talking the same language).

Identifying Need
1. Consistently identify the need for mental health or substance abuse treatment through the use of a standardized process (i.e., screening, assessment, and evaluation) and instruments (e.g. the Nebraska Substance Abuse Task Force's Standardized Model; Herz, 2001a).

2. Implement a process that incorporates all juvenile justice agencies, requires information sharing, and utilizes team decision-making.

3. Develop formal linkages between juvenile justice agencies and clearly identify the role and responsibility of each agency with regard to juvenile justice policy, process, and communication.

Access to Treatment

1. Increase treatment capacity throughout the state, especially in rural areas.

2. Create and maintain a continuum of programming options that includes programming for sex offenders and young (less than 12 years old) offenders.

3. Create, maintain, and encourage community-based programming with wrap-around services.

4. Develop incentives for providers to become Medicaid approved providers.

5. Create "placement facilitator" positions that work with providers and detention facilities to decrease the time that an offender must wait for a placement and improve the appropriateness of the placement.

Service Appropriateness

1. Focus on "out of the box" initiatives, designing interventions that "fit" juvenile offender needs.

2. Implement wraparound services (e.g., multi-systemic therapy, team management approaches) throughout the state and across juvenile justice agencies.

3. Formally partner with schools to enhance educational retention and services.

4. Develop mental health and substance abuse treatment programs (community-based and institutional) for offenders—i.e., programming that integrates treatment with behavior modification approaches.

5. Develop programming for mental health problems (i.e., temporary in nature) that do not require a disorder label.

6. Reduce administrative responsibilities for caseworkers and increase contacts between caseworkers and youths, families, and treatment providers.

7. Implement transitional and aftercare programming as standard part of interventions and treatment programming.

8. Develop creative programming and incentives to increase family involvement.

9. Provide initial level of screening for treatment need and services at detention facilities.

10. Standardize language and regulations for substance abuse services in partnership with the Division of Mental Health, Substance Abuse, and Addiction Services.

11. Identify the need for and develop gender and culturally appropriate programming.

12. Implement a continuum of care across Probation and OJS using clear risk/need criteria to determine where an offender should be placed. This includes identifying youths in the juvenile justice system that should be 100% behavioral health clients (i.e., serious emotional disturbance).

Funding

1. Make Medicaid more appropriate for juvenile justice (i.e., services covered, approval process).

2. Reduce barriers to Medicaid funding by implementing behavioral health criteria in place of medical necessity criteria.

3. Streamline service approval process in order to eliminate delays in service provision.

4. Increase state funding for treatment services, making funds available to Probation for treatment services.

5. Ensure that the funding follows the child (i.e., need for service) rather than the services (i.e., service availability).

6. Include Probation in the development of Medicaid Managed Care contract provisions.

7. Create juvenile justice Medicaid liaison positions within Probation and the Office of Juvenile Services.

Accountability

1. Develop goals and objectives as part of a juvenile justice policy and strategic plan.

2. Fund a research arm for juvenile justice to measure system's ability to obtain goals and objectives on a regular basis.

3. Evaluate standardized processes and tools used to identify risks and needs.

4. Require standard reporting for pre-determined measures from all service providers working with juvenile offenders.

5. Implement competency based standards and measures for all juvenile justice service providers.

6. Implement a statewide juvenile justice information system that overlays all juvenile justice agencies.

7. Examine the treatment needs of and access to treatment for juvenile offenders in the adult criminal justice system.

Training

1. Integrate training on substance abuse and mental health problems into current detention facility, Probation and OJS training programs (i.e., all juvenile justice agencies).

2. Provide regular training to juvenile justice personnel as well as providers on how to understand the language and processes that comprise the juvenile justice system.

3. Provide regular training to juvenile justice personnel as well as providers on the purpose, role, and requirements for standardized screening, assessments, and evaluations.

4. Provide regular training to providers on the special needs of and "best practices" for treating juvenile offenders.

5. Provide regular training to all juvenile justice personnel and providers on the Medicaid process.

Summary

The Nebraska Coalition of Juvenile Justice formally recognized mental health problems as a juvenile justice issue in its 2000 state plan. Specifically, the Coalition was interested in the following questions:

* What is the prevalence of mental health problems among juvenile offenders in Nebraska?

* How do offenders currently access mental health services in Nebraska?

* How can access to appropriate mental health services be improved?

In September 2000, the Coalition commissioned the University of Nebraska-Omaha, Department of Criminal Justice to examine these questions. This report presents the findings from this effort.

Governor's Working Group on the Management of Sex Offenders

August 2001

Who was involved?

Over 60 professionals from law enforcement, probation and parole, the State Patrol, victim advocacy, juvenile justice, developmental disabilities services, community mental health practitioners, DHHSS, and DCS.

Key Recommendations

Two major recommendations: (1) the development of a Governor's Council on the Management and Treatment of Sex Offenders and (2) the addition of components necessary to develop a full continuum of options in the treatment and management of offenders

Summary

Three working groups were convened to explore legislative, assessment / treatment and law enforcement issues related to management of sex offenders in Nebraska. The groups agreed that the number one guiding principle was related to community safety to lead off a set of 14 values statements. The Working Groups recommended a number of legislative and administrative changes to make it possible for increased collaboration among systems serving sex offenders. This included increasing training opportunities for professionals and facilitating information sharing among systems. It was strongly recommended that a number of barriers between juvenile and adult systems be addressed to

increase continuity of service and supervision between them.

Nebraska's Public Mental Health and Substance Abuse System: A Status Report with Recommendations for Improvement
January 5, 2001
Who was involved?
46 people representing DHHS, Regions, Regional Centers and Magellen
Key Recommendations
Three key recommendations were offered: Increase funding, increase rates and improve overall operations of NBHS (including development of measures to monitor movement toward success).
Summary
This report examined problems in the adult mental health and substance abuse system (excluding prevention) and made recommendations for next steps to the DHHS Policy Cabinet.

Nebraska Critical Incident Stress Management Program Strategic Plan 2000
September 2000
Who was involved?
In 1999, the CISM Interagency Management Team began developing the strategic planning process, with the overall goal in mind being to work towards a sustainable program.
Key Recommendations
#1 – SUPPORT REGIONAL MANAGEMENT COMMITTEES – In order to carry out these priorities, the CISM Interagency Management Committee needs to work on maintaining the organizational structure for the program. The key to this is support for the Regional Management Committees. Therefore, the CISM Interagency Management Committee will work to support each of the Regional Management Committees in the six Troop Areas. The Regional Management Committees have an important role to complete, per the Critical Incident Stress Management Act (§71-7110), Regulations Governing the Critical Incident Stress Management Program, as well as the work being done on statewide Policy & Procedures. Regional Management Committee needs to organize the local area CISM program, including planning, directing, implementing, coordinating and improving the services offered. This may include: ♦ Recruit, train and deploy CISM Team members (peer and mental health). The Interagency Management Committee will provide support to a Regional Management Committee working on recruitment of CISM members. ♦ Have a system in place so that the local area dispatchers and callout people have the information on debriefings and contacts required to process a request. ♦ Promotion and marketing of the program including contact CISM customers every two years on how to activate a debriefing. ♦ Develop a coordinated effort between the Interagency Management Team and the Regional Management Committees to systematically develop and implement the CISM Act, regulations, and policies/procedures. For example, on November 16, 2000, the use of the statewide video conference

system to coordinate the next steps in developing and implementing this work.

#2 - RETENTION OF CISM TEAM MEMBERS – the statewide strategy needed to keep trained peers and mental health team members. This should be a joint effort between the Interagency Management Committee and each of the Regional Management Committees. This includes the development of camaraderie, recognition of team members, and other related strategies such as:
♦ Mental health volunteers provide continuing education in troop areas.
♦ Implementation of the Active/Inactive Team Membership Policy
♦ Providing continuing education credits for CISM Troop Area training events

#3 – CONTINUING EDUCATION – the training needed to maintain and further develop the skills required by Team Members to provide CISM interventions. The CISM Interagency Management Committee will explore the development of:
♦ Crisis Intervention & Peer Support Course (Two day, ICISF Approved). Develop the Nebraska Edition of this class by March 2001. The program is targeted for existing CISM Team Members.
♦ Advance Crisis Intervention – develop a six segment, two hours for each program, which can be used at Regional Troop Area meetings. The material will be designed to be taught by either the Regional Clinical Director or designee.
♦ Every two years, the annual CISM Statewide Conference will be used for continuing education. The intent is to offer the CISM Team Members the opportunity to enhance their knowledge and skill. This will include simulated debriefings.
♦ Explore the development of "Applied Suicide Intervention Skills Training" (ASIST)

#4 – ACTIVE TEAM MEMBERSHIP – Active and Inactive status is based on the individual's willingness to participate with the CISM program. The Active Team Members are those who avail themselves for training, meetings and critical incident stress interventions.
♦ ACTIVE MEMBER - Routinely respond to requests to provide CISM interventions and keeps the program informed of current address, telephone number, etc.
♦ INACTIVE MEMBER - is not asked to participate in CISM interventions; keeps program informed of current address, telephone number; is willingness to provide CISM services in the event of a major crisis or disaster. The individual may remain in an inactive status for two (2) years.
The issue here is one of implementation of the new policies and procedures approved by the Interagency Management Committee
♦ CISM Program Membership (January 18, 2000)
♦ Active and Inactive Membership Categories (May 4, 2000)

#5 – PROMOTION OF CISM – The systematic effort to increase the awareness of the Statewide CISM program. This should be a joint effort between the Interagency Management Committee and each of the Regional Management Teams.
♦ Interagency Management Committee develops information packages (brochures/video/other).
♦ Regional Management Teams use these packages to systematically disseminate information through various media to attract notice of the agencies served by CISM.
♦ The goal is the Regional Management Committee will contact the agencies listed in the CISM mission statement every two years.

Summary

This strategic plan is being used as a way to help focus on issues that are impacting the CISM program. To have a sustainable operation, CISM needs to take conscious and pro-active efforts to shape the

direction the program will follow for the next 5 to 10 years. This document is one effort intended to help shape that future direction.

The first phase of the CISM Strategic Plan 2000 involved an internal review. This phase included completing the revision of the CISM Regulations, starting the process of developing policy and procedure, revising the program's mission statement, and updating the program's Core Functions.

The second phase of strategic planning started when the CISM Interagency Management Team approved of the Troop Area Strategic Planning on November 18, 1999. CISM Interagency Management Team and the CISM Regional Management Teams organized a three-hour strategic planning meeting in each of the six troop areas.

The third phase involved review on June 2, 2000 of the "Nebraska Critical Incident Stress Management Program Priorities 2000"at the Nebraska Statewide Critical Incident Stress Management Twelfth Annual Conference in Grand Island, NE.

LB 1354 Task Force: Final Report to the Governor and the Nebraska Legislature on Nebraska's Mental Health and Substance Abuse Services and Behavioral Health Redesign

December 1998

Who was involved?

Jessie Rasmussen, Chair
Director, Dept. of Health and Human Services

Steve Albrect, Vice President
Region West Medical Center

Anne Buettner
Mental Health Practitioner

Judy Byrns
Psychologist in Private Practice

Henry (Wayne) Dorr

Beth Holthusen
Region III Program Administrator

Linda Jensen
President of National Alliance for the Mentally III - Nebraska

Morgan Kupsinel
Norfolk Regional Center

Joanna Lloyd

Region VI Program Administrator

Aleisa McKinlay
Nebraska Advocacy Services

Russell Pierce
Past Chair, Nebraska Mental Health Planning & Evaluation Council

The task force held five public meetings, including two public input sessions, to arrive at their recommendations.

Key Recommendations

1. Major revision of Nebraska's Community Mental Health, Substance Abuse, and Regional Center statutes to:
• Integrate Regional Center and community-based funding streams and ensure a fixed point of fiscal accountability for behavioral health services at the regional level.
• Provide point of entry into public behavioral health services and responsibility for assuring consumer needs are met at the regional/community level. This will stimulate development of community-based services, provide fiscal and clinical incentives for treating people in the community, and eliminate the current perverse incentives which often result in people being inappropriately admitted to or staying in Regional Centers for longer than therapeutically necessary.
• Direct HHS to develop and institute a standardized grievance and appeals process for use throughout the behavioral health system.
• Require development of a comprehensive state mental health and substance abuse four-year plan to be updated biennially and to be used as the working and planning blueprint for Nebraska's behavioral health care system.
• Require that local regions divest themselves of the role of direct provider of services, with the exception of management of benefits and services (service coordination, Professional Partner, and related services). The elimination of the provider role for the regions should be done incrementally over a four-year period.
• Provide mechanisms to ensure a level playing field for providers of services, encouraging the use and development of new providers and services, including private providers.
• Establish in statute, population priorities for the expenditure of state behavioral health funds. Priority populations for adults include persons with serious mental illnesses (based on diagnosis and functional impairment), persons with chemical dependency disorders, and persons dually diagnosed with serious mental illness and chemical dependency. In the future, new legislative appropriations should include service population priorities, while ensuring that all Federal set-aside requirements are met and HHS cornerstone services are maintained/prioritized.
• Direct HHSS to take needed steps to use Medicaid to cover adult substance abuse services.

2. Adopt Mental Health/Substance Abuse Health Insurance Parity legislation. This has been done in 19 other states and will save the State at least $17M annually in costs which are currently shifted from insurance companies into the public sector. Payment by insurance companies for effective early diagnosis and treatment will allow Nebraskans with mental illness to continue in productive social roles, and prevent the needless debilitation which now results in lifetime disability, and the need for government support.

3. If parity legislation is not enacted, increase behavioral health appropriations by

$9,481,000 annually, focusing on the next phase of Behavioral Health Redesign implementation and increasing community mental health and substance abuse services to reduce reliance on Regional Centers.

4. Strengthen the Mental Health Planning and Evaluation Council, possibly combined with the State Alcoholism and Drug Abuse Advisory Council. The strengthened Planning and Evaluation Council should have a powerful mandate and be sufficiently funded to achieve the following:

• Providing training (leadership development) for consumers of behavioral health services and their and families, with a focus on consumer empowerment and recovery.
• Building infrastructure of consumer and family organizations such as the National Alliance for the Mentally III and the Mental Health Association.
• Serving in a monitoring, promotion, advocacy, and evaluation role throughout the system.
• Providing training for providers on consumer empowerment and how to deliver recovery oriented services.
• Active monitoring and reporting to the Legislature on the LB 1354 requirement that Regional Center bed reductions not outpace the development of effective, community based replacement services.
• If combined with the Alcoholism and Drug Abuse Council, the Planning and Evaluation Council should clearly include representatives of both the mental health and substance abuse communities and provide for maintaining the integrity of both fields within a behavioral health context. The new Council, like the current Mental Health Planning and Evaluation Council, should clearly include at least 51% consumers of behavioral health services and family members.

Summary

LB 1354, enacted in 1998, called for a Task Force to examine the delivery and financing of services for adults with mental illnesses or addiction to alcohol or controlled substances, and current efforts to redesign Nebraska's behavioral health system. The term "behavioral health" refers to both mental health and substance abuse services.

The impetus for LB 1354 and the creation of the Task Force was that Nebraska initiated a major Behavioral Health Redesign effort in 1995. Redesign included several major strategies, but its major focus was on providing the behavioral health services people need when and where they are needed. This Redesign involves rehabilitation services now provided by the three state psychiatric hospitals (Regional Centers), as well as services delivered by community-based providers. Regional Centers will· continue to provide primarily indigent acute and secure inpatient services to Nebraskans, but will have approximately 200 fewer beds to address the need for more services to be provided in the community.

An underlying premise of the Redesign effort is that Nebraska consumers of mental health and substance abuse services continue to use costly, restrictive Regional Center services due to the lack of community-based alternatives. The State spends $52M on Regional Centers and only $27M on community mental health and substance abuse services. Therefore, a strategy of redesign is to build up community mental health and substance abuse service alternatives, and to reduce reliance on Regional Centers as a primary focus of Nebraska's mental health service system.

MENTAL HEALTH

Pillars of Peer Support: Transforming Mental Health Systems of Care Through Peer Support Services – Report from the Pillars of Peer Support Services Summit

January 2010

Who was involved?
The Pillars of Peer Support Services Summit was supported by: Substance Abuse and Mental Health Services Administration (SAMHSA) and Center for Mental Health Services (CMHS), National Association of State Mental Health Program Directors (NASMHPD), Depression and Bipolar Support Alliance (DBSA), Wichita State University Center for Community Support and Research, Appalachian Consulting Group (ACG), Carter Center, OptumHealth, and Georgia Mental Health Consumer Network.
Key Recommendations
Recommendations for the Implementation of the Pillars of Peer Support The participants in the summit built upon the development of the Pillars with a set of recommendations for their implementation. This set of recommendations is a compilation of three summit work groups who proposed next action steps. In general these divided into a set of guidelines for various stakeholders. The framework for these recommendations includes an identified stakeholder, a proposed set of actions, and a time line for implementation. Due to the framework and goals of the summit, these recommendations are specifically tied to state-based mental health systems of care and Medicaid-funded services. They are however, broadly applicable to other systems of care including the Veterans Administration, managed care organizations, and other service delivery systems. These six recommendations were developed from the summit and should be tracked for progress and implementation over the period outlined in each. There was also a consensus from the summit that this group should continue as a working group to monitor and track progress, if sustainable funding can be generated. 1. NASMHPD should adopt and endorse the Pillars of Peer Support and use their resources to disseminate and promote them both within their organization and with their stakeholder groups within the next year. 2. SAMHSA/CMHS should adopt and endorse the Pillars of Peer Support and use their resources to disseminate and promote them both within their organization and with their stakeholder groups within the next year. 3. SAMHSA should create a National Center of Excellence for Peer Support, endorse the Pillars of Peer Support as a best practice for peer support implementation, and identify funding to assist all states on implementing peer support in two years. 4. NASMHPD, SAMHSA/CMHS, and CMS should issue a letter to State Medicaid Directors in support of the Pillars of Peer Support and recommendations for their implementation by 6/1/10. 5. NASMHPD/NRI and SAMHSA/CMHS should convene a task force to develop common data standards and service codes for peer support that are based upon the Pillars of Peer support, and incorporate them into the NOMS and other data collected from all states for the 2010 data year. 6. Managed care entities that operate state mental health contracts should adopt and endorse the Pillars of Peer Support and use their resources to disseminate and promote them both within their organization and with their stakeholder groups within the next year.
Summary
The role of peer support services in mental health services and person centered recovery has been

actively developing and evolving in recent years (Davidson, Chinman, Kloos, Weingarten, Stayner & Tebes, 1999). Formal training programs for peer support services have been established, and an emerging Peer Support Specialists (PSS) workforce is providing a range of services that includes but is not limited to: serving on ACT Teams, in peer support programs, in psychiatric inpatient facilities and group and one-on-one settings in mental health systems of care (Fricks, 2005). At the state level the role of peer support has changed since Medicaid (Medicaid, 2007 – also see appendix 1.) designated peer support as a billable service for adults. As this role expands across states and other payer systems, Peer Support Specialists will continue to gain an increased role in systems of care.

In November 2009, the Pillars of Peer Support Services Summit was convened at the Carter Center in Atlanta, GA. The intent of the Summit was to bring together those states that currently provide formal training and certification for peer providers working in mental health systems to examine the multiple levels of state support necessary for a strong and vital peer workforce able to engage in states' efforts at system transformation, including recent innovations in Whole Health. The Pillars of Peer Support Services Summit was supported by the following leaders in peer support development: Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services (CMHS), National Association of State Mental Health Program Directors (NASMHPD), Depression and Bipolar Support Alliance (DBSA), Wichita State University Center for Community Support and Research, Appalachian Consulting Group (ACG), Carter Center, OptumHealth, and Georgia Mental Health Consumer Network.

The summit collected data on those states that are currently utilizing peer support services under Medicaid reimbursement. Participants were surveyed prior to attendance and summary state reports were provided to all participants. In the survey, participants responded to questions addressing the unique attributes of each state's program.

On the second day of the Pillars of Peer Support Services Summit the state representatives were introduced to three states Transformation Transfer Initiative (TTI) Grants funded in 2009 by SAMHSA to promote Peer Support Whole Health. The presentations of the TTI grants from representatives of Michigan, Georgia and New Jersey shared efforts to offset the average 25-year premature death of consumers served in the public sector by training peer specialists in whole health recovery. The presentations were so well received that Peer Support Whole Health was unanimously added as a national Pillar of Peer Support Services.

States were provided with a rough, informal draft identifying some of the lessons learned or "pillars" based on successes various states have already identified. In the Summit these pillars were reviewed and redefined with the intention of proposing a framework or blueprint for other states interested in developing or expanding their peer support programs. In addition, newly defined pillars of peer support services have been recommended to advance the implementation and ongoing support for peer support services in the mental health field.

This report provides a comprehensive summary of the results and findings of the Pillars of Peer Support Services Summit. The report begins with a review of the relevant literature as it pertains to the evolving policy for mental health services and peer support services. It is followed by a review of existing state level data of peer support services that was collected as part of the Summit. For the purpose of this report and from the content of the summit, the terms Certified

Peer Specialist (CPS) and Peer Support Specialist (PSS) are used interchangeably. A set of twenty five

pillars of peer support services were developed in conjunction with this summit. Finally, based upon the results of the summit a series of six recommendations are advanced to promote the role of the pillars in the promulgation of peer support services and the peer support workforce at the state and federal level.

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Nebraska's Consumer Voice: Leading a Change in Mental Health Services
April 2009
Who was involved?
The Mental Health Association of Nebraska generated this report with the input of approximately 800 consumers and other specialists. It was intended to be a series of recommendations or "rules" to guide mental health services in Nebraska, based on consumer perspectives and experiences.
Key Recommendations
The Rules for Quality Mental Health Services in Nebraska 1. Transportation barriers must be eliminated 2. It must be recovery focused 3. There must be access to services

4. There must be peer provided services
5. There must be access to complete medical records
6. Care must be based on a partnership between consumer and provider
7. There must be access to affordable housing
8. There must be more recovery education
9. There must be opportunity for competitive employment
10. There must be access to information regarding benefits
11. Do no harm

Summary

The information provided in this paper is the collective voice of mental health consumers from all behavioral health regions in Nebraska, and is a result of our experiences within the system. It is a movement toward infusing recovery principles into Nebraska's mental health service delivery system that will guide individuals toward Self-Help, Self-Determination, and Empowerment. Furthermore, this is an attempt to bring all stake holders, including consumers, providers, family members, and policy makers together to create a new vision of a system that is more Person -centered and Recovery-focused. Through full consumer participation this paper establishes 11 rules to implement into Nebraska's current and future method of Behavioral Health service delivery.

Nebraska Justice Mental Health Needs Assessment

June 2008

Who was involved?

Compilation of work group activities with representative stakeholders from Justice, Behavioral Health, Corrections, Housing and Consumers

Key Recommendations

- Develop collaborative partnerships for interagency coordination and communication to implement system improvements for persons with persons with mental illness in the criminal justice system
- Provide mental health training for law enforcement, probation, parole, jail personnel, and community corrections staff
- Improve access to crisis stabilization services and other mental health services with improved coordination with law enforcement
- Implement standardized behavioral health screening in jails
- Dedicate resources to community mental health for diversion services
- Enhance affordable supportive housing for justice involved youth transitioning to adulthood

Summary

Nebraska statistics were reviewed to illustrate challenges and potential opportunities in Justice Behavioral Health collaborations. Challenges in serving individuals with mental health problems in justice settings include the following:

- Law enforcement officers and others (e.g., jail personnel, probation officers often do not have the skills to work effectively with individuals with behavioral health disorders.
- Mental health providers often do not have the skills to effectively address the needs of justice involved individuals
- Mental health services are not always coordinated with justice
- Diversion services are not available in many parts of the state

- Local jails have difficulty identifying the behavioral health needs of inmates and there currently is no standardized assessment process.
- Local jails often send persons with mental health disorders to state correctional facilities as "safekeepers" (1365 over the last eight years). Annual cost to serve safekeepers is estimated at $1.32 million, not including medical costs.
- A subpopulation of individuals tends to cycle through correctional and psychiatric facilities. These consumers have higher prevalence of severe mental illness, substance related disorders, and personality disorders.
- It is estimated that 20% of individuals with mental health disorders released from prison are homeless.

Transforming Services for Persons with Mental Illness in Contact with the Criminal Justice System
January 28, 2008
Who was involved?
49 Stakeholders including: Consumers, Regional Behavioral Health staff, law enforcement, mental health service providers, the Legislature, and state agencies (the Division of Behavioral Health, Division of Children and Family Services, Protection and Safety Administrators, Nebraska Homeless Assistance Program, Department of Correctional Services, Community Corrections Council, Office of Probation Administration, Crime Commission, and Division of Vocational Rehabilitation)
Key Recommendations
• Enhance Emergency Management System and/or Local Crisis Response Teams (LCRT) role to effectively interface with other consumer involved agencies for diversion efforts, with funding to offset extended responsibilities • Provide statewide Crisis Intervention Team training for law enforcement officers and make clear linkages with the LCRT with expanded capacity where appropriate • Expand or Improve access to crisis stabilization beds as needed with improved coordination with law enforcement officers • Establish statewide committees to focus on persons with mental illness in the criminal justice system. This committee could be subsumed within the Community Corrections Council • Each regional Behavioral Health Authority should insure the stakeholder groups attending the workshop follow up on the action plans they developed and establish Regional Planning Committees that report to a state level oversight committee that coordinates statewide efforts • Increase resources to the local community mental health system to provide diversion and re-entry services through the use of Forensic Intensive Case Management • Increase jail diversion at post-arrest across the state • Implement standardized screening instruments in the jails that prompt referrals for services and explore funding options for services and medications in the jails • Expand or increase trauma informed care and gender specific treatment capacity in the prisons and jails • Re-entry planning and services need to be systematically provided prior to release from prisons and jails • Expand affordable housing • Information sharing across all systems of care needs to be enhanced

- Expand Nebraska's extensive efforts on consumer involvement to the criminal justice areas with a forensic focus to include: a) participation in all state and local planning efforts, b) Forensic Peer Support and c) training and employment for Forensic Peer Specialists
- Expand efforts on planning and service delivery to include veterans in the justice system

Summary

This was a report of a workshop designed to introduce the sequential intercept model to Nebraska with the goal of identifying a long term vision for area of criminal justice and behavioral health over the next five years. Regional and state needs and priorities were identified by invited participants after a series of educational presentations related to each intercept and best practices. The workshop was facilitated by the Policy Research Group out of Delmar, NY.

Statewide Consumer Housing Need Study

September 2003

Who was involved?

Prepared by Hanna:Keelan Associates for the Nebraska Department of Economic Development, Community and Rural Development Division, and the Nebraska Department of Health and Human Services, Office of Mental Health, Substance Abuse and Addiction Services

Key Recommendations

The following provides "summary statements" regarding housing and services issues for persons of extremely low income with a serious mental illness, in the State of Nebraska, as determined via consumer and provider input and survey results.

● In each of the six mental health regions, both providers and consumers consider affordable and safe housing, with the appropriate level of services, to be a critical need.

● Create housing that maximized the consumer's independence, with effective supportive services.

● Consumer input to residential programs.

● Create a system of housing that meets a continuum of residential need, as consumer's needs change.

● Consumers who are happy with their current housing conditions liked the location of their housing because of convenience, nearby services and pleasant neighbors and/or neighborhoods.

● Consumers who are unhappy with their current housing conditions frequently noted their housing was of substandard condition, was unsanitary, unsafe and/or in need of repair and/or lacked adequate space.

● Both providers and consumers frequently identified a need for easier access to affordable services, such as medication, insurance coverage and other mental health services.

● Providers identified stereotypes and stigmas as major concerns and stressed a need for community education and involvement in order to lessen this barrier.

● Providers identified a need for flexible supportive services to be tied into housing and allow consumers to access varying levels of services without having their housing situations threatened.

●Both providers and consumers expressed concern because as consumers become more independent, they often lose access to various resources and services that are critical to their well-being.

Summary

The partnership of the Nebraska Department of Economic Development (DED), Community and Rural Development Division (CRDD) and the Nebraska Department of Health and Human Services (HHS), Office of Mental Health, Substance Abuse and Addiction Services (OMH, SA, AS) retained Hanna:Keelan Associates, P.C. to conduct a statewide assessment of the housing needs of extremely low income persons with a serious mental illness, to guide the efficient delivery of both appropriate, affordable housing types and related housing and mental health supportive services, in Nebraska, for the next five years, starting in the year 2003.

Multiple research activities, both qualitative and quantitative, were conducted in conjunction with the Nebraska Statewide Consumer Housing Need Study. Quantitative data collection was needs driven, in that planned qualitative activities involving experts in the fields of mental health and affordable housing and consumers, resulted in the identification of critical housing and supportive services needs. Support data, identified by these individuals, was in turn, collected to enhance the understanding of important critical housing needs of extremely low income persons with a serious mental illness, in Nebraska.

Nebraska Children's Mental Health Search Conference

July 1994

Who was involved?

70 stakeholders including families, providers, state agencies, and other stakeholders

Key Recommendations

- One call will provide access for children and families to services with a clear point of 24 hour/7 day a week access
- Each family should have access to a professional partner who can help the family navigate the system
- Develop an integrated system of care with clear point of accountability located in each region
- Develop a blended funding model where funding is based on need, flexible and invisible to the family
- There should be state level accountability for an accountable, efficient, effective system
- Develop a comprehensive array of effective prevention, early intervention, assessment, treatment, aftercare and care coordination services

SUBSTANCE ABUSE

Nebraska Substance Abuse Prevention Strategic Plan

March 2008

Who was involved?

Nebraska Substance Abuse Epidemiology Workgroup (24 members); Nebraska Partners in Prevention (23 members)
Key Recommendations
Specific goals and indicators are offered in substance abuse prevention using the SPF SIG framework.
Summary
This report was developed as part of the state's commitment to fulfilling the requirement to have a state plan for the strategic prevention framework state incentive grant. There are three overarching goals of the project: prevent substance abuse, including underage drinking; reduce substance abuse related problems in communities; and build prevention capacities and infrastructure.

GAMBLING

Nebraska Gamblers Assistance Program Biennial Report Fiscal Years 2006-2007
January, 2008
Summary
The GAP utilizes expertise from an advisory committee, service providers, and consumers to coordinate activities, manage resources, direct services and reduce the impact of problem gambling for all Nebraskans. In 2000 and again in 2006, the GAP engaged in strategic planning processes to develop five-year plans for the program. Plan development involved advisory commission/ committee members, providers and other stakeholders. As a result of these planning processes, priorities for limited funds and decision making were established.