



Mental Health Practice Board News

Volume 2

June 2006

Nebraska

Visions for Tomorrow

By Gail Lorenzen, MHP Public Board Member

I was alone. I had the support of my husband, my doctor, and later our case worker. I was alone – for none of these people understood anymore than I did what was happening to my daughter and to our family. Our ignorance slowed the process of getting help, of feeling inadequate and guilty, of surviving. Fortunately we had the skills to find resources for our family, to bring some stability to our lives, and to continue moving forward. My first experience with mental illness occurred about 25 years ago, however I still remember the feeling of being incredibly alone.

As stated by Project Relate

(http://www.projectrelate.org/mental_illness_stats.html)

there are more than 91,000 people with serious mental problems in Nebraska. Of that number, 23,000 are children under the age of 17 or 5% of our youth. One out of five children in Nebraska are affected by mental health issues – their own or their parents. Two thirds of those suffering from mental illness are not getting the help they need. Suicide is the third leading cause of death in Nebraska for young people between the ages of 8 and 24. This is a serious and growing problem for our population. People need to know and understand the disease of mental illness, families should know how to advocate for themselves and their children, and people should never have to feel isolated or alone because of mental illness.

Recently a new curriculum was brought into Nebraska, designed specifically for families who are dealing with mental illness with one or more of their children. This curriculum developed by NAMI Texas is designed and taught by parents and direct caregivers. Visions for Tomorrow is a series of workshops for direct caregivers of children and adolescents with a brain disorder. Participants in Visions for Tomorrow should be those who are direct care givers and depending on family circumstances, may be an extended family member, respite care provider, or foster parent. There is no charge to family members or primary caregivers who wish to take this course. The basic requirement is direct involvement with a child suffering from mental illness.

Visions for Tomorrow teachers are trained family members who have experienced first hand the rewards and challenges of raising children with brain disorders. Visions teachers go through intensive three day training before they can work directly with the material. Topics covered during the course work include:

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- Introduction/Brain Biology
- ADD/ADHD,PDD/Autism, Tourette's Disorder, Conduct Disorder
- Bipolar Disorder, Depressive Disorder, Eating Disorder
- Anxiety Disorder, Obsessive-Compulsive, Post-Traumatic Stress, Panic, Phobia, Generalized Anxiety, Separation Anxiety
- Early On-set Schizophrenia and Schizoaffective
- Empathy and Sharing Our Unique Life Experiences
- Organization of Data and Record Keeping
- Communication Skills, Caregiver, System, and Sibling Support
- Coping and Self Care
- Problem Management
- Rehabilitation, Recovery & Transition

The course offers caregivers the opportunity to share mutual experiences and learn valuable lessons from one another. Visions for Tomorrow covers educational material and provides the basics for day-to-day care giving skills. Hopefully by the end of the course participants have developed a high level of rapport and want to continue as a support group.

Last summer there was a statewide training for the Visions material – so there are trainers throughout the state. If you are interested in sponsoring a Visions class in your community, please contact Eve Blaha at 402-345-8101 to get the needed information for your area. If you are located in the Region V area, you may contact Gail Lorenzen - Families Inspiring Families - 441- 4369.

In Lincoln we have completed three full sets of classes and have established a support group. We have many positive reactions to the curriculum and several success stories. As a co teacher for the fall session I had a private smile, when in session four one of the Mom's looked around and said "Now I don't feel so alone".

Nebraska Behavioral Health All-Hazards Disaster Response and Recovery Plan

By: Mona McGee-Snyder, MHP Board Member

The Nebraska Behavioral Health All-Hazards Disaster Response and Recovery Plan was formally adopted in January 2005. The plan is available for viewing at this web site: www.disastermh.nebraska.edu. A number of questions about the role of licensed mental health practitioners in disaster response have been asked since the plan was rolled out. What follows is a synopsis of a few of the most frequent questions/answers:

How is disaster behavioral health different than traditional clinical practice?

Disaster work is done as outreach in the field, not in an office. It emphasizes and normalizes common reactions to stress and trauma. The disaster behavioral health responder recognizes that while some people affected by the disaster may still need referral to a licensed mental health professional, most will not.

How do I sign up to be a disaster behavioral health volunteer?

Right now there are three formal ways to take part in the organized disaster behavioral health disaster response. As this process evolves it is likely that licensed mental health practitioners will be able to indicate interest and competency in disaster response as a part of the regular licensure process.

- Become an American Red Cross (ARC) Disaster Mental Health Volunteer
- Register with your Regional Behavioral Health Authority. In the Omaha area, you can register with the United Way of the Midland's Medical Reserve Corp.
- Become a member of Nebraska's Critical Incident Stress Management (CISM) Team

Will I be compensated for any of the work I do in disaster response?

No, this is a volunteer service and you will generally not be compensated for your time. In rare instances there may be federal funds made available to reimburse agencies for disaster response. Nebraska wants to be ready to capitalize on any funding that becomes available, so it is important to track the time and activities of all volunteers in a disaster response. Some employers will release staff on paid time to take part in disaster response.

Who are the "Community Responders" that are referred to in the State Plan?

Community responders are other professionals who can augment a behavioral health disaster response. They are school teachers, case managers or other caring adults who have completed a psychological first aid course. In many areas of Nebraska there just aren't enough licensed professionals to provide needed outreach and education about common psychological responses to disaster. The Community Responders can augment the disaster response by listening, educating and serving as a link to professionals if needed. A special category of community responder is the "Disaster Chaplain." Interchurch Ministries of Nebraska is charged in the state plan with organizing and credentialing disaster chaplains across the state.

What are the implications of "supervising" Community Responders?

There is a section of the State Plan that addresses supervision and presents guidelines for clinicians to consider prior to taking on this responsibility. (See page 28 and 29 of the plan narrative.) Generally, the plan recognizes that adequate supervision protects both service recipients and responders.

What about liability?

The Nebraska Emergency Management Act limits liability exposure for behavioral health disaster volunteers who are registered and deployed by emergency management. That is why it is so important to respond within the context of an organized response. The personal liability of clinicians increases greatly when they respond on their own. Of course there is no protection for those who engage in gross misconduct regardless of how they are deployed or registered.

It is important to remember that the field of disaster behavioral health is evolving. That also means that the plans we rely on must be dynamic documents that are subject to change as new evidence is available to support interventions or approaches used in the field.

For more information about disaster behavioral health:

- Resource materials for conducting disaster-related assessments <http://www.proventionconsortium.org>
- Disaster Technical Assistance Center of the Substance Abuse and Mental Health Services Administration, United States Dept. of Health and Human Services <http://www.mentalhealth.samhsa.gov/dtac>
- National Center for Post Traumatic Stress Disorder <http://www.ncptsd.va.gov>
- National Child Traumatic Stress Network <http://www.nctsn.org>

The Nebraska Health and Human Services System is committed to affirmative action/equal employment opportunity and does not discriminate in delivering benefits or services.

Compassion Fatigue: Consequences for mental health/crisis counselors as a result of working with the psychological effects of traumatized clients

By: Nancy F. Myers, Ph.D., LMHP, Former MHP Board Member

An area that is most neglected is that of the care and renewal of mental health therapists, especially those who work with clients exhibiting extreme trauma and dysfunction. Recognition of one's own limits is difficult in any profession; for the mental health practitioner, the desire to ameliorate a client's extreme emotional pain or suffering can subtly encourage a counselor to push beyond his or her own healthy boundaries. Acknowledging the difficult work that we as therapists do and our inherent need for renewal and balance makes it less likely that personal burnout, exhaustion or client error occurs.

The following terms and tips are summaries of recent research conducted with crisis counselors and mental health providers. It is hoped that this summary and the accompanying bibliography will help the mental health community recognize symptoms of overwork and fatigue and serve as a springboard for personal reflection, prevention or intervention.

Vicarious Traumatization:the enduring psychological consequences for therapists of exposure to the traumatic experiences of victim clients. (Schauben and Frazier, 1995)

Compassion Fatigue:a state of tension and preoccupation with individual/cumulative trauma of clients as manifested in one or more ways:

- Re-experiencing the traumatic event
- Avoidance or numbing or reminders of the event
- Persistent arousal (Figley, 1995)

Secondary Traumatic Stress: ...the presence of post-traumatic stress disorder symptoms in caregivers, which are probably connected to the patient's experience rather than the caregivers' (Figley, 1995, Pearlman & Saakvitne 1995, Stamm 1995)
Reactions include:

1. Indicators of psychological distress or dysfunction for the counselor

- Distressing emotions, including sadness or grief, depression, anxiety, dread and horror, fear, rage or shame
- Intensive imagery by the trauma worker of the client's traumatic material
- Numbing or avoidance of efforts to elicit or work with traumatic material from the client
- Somatic complaints, including sleep difficulty, headaches or gastrointestinal distress
- Addiction or compulsive behaviors
- Physiological arousal such as palpitations and hypervigilance
- Impairment of day to day functioning in social and personal roles, including missed or cancelled appointments, feelings of isolation, lack of appreciation, etc

2. Cognitive shifts for the counselor, including changes along the dimensions of:

- Dependence/trust to reveal a chronic suspicion of others
- Safety to a heightened sense of vulnerability
- Power to an extreme sense of helplessness
- Independence to a loss of personal control and freedom

3. **Relational disturbance** means the impact of working with traumatized clients on personal and professional relationships of the mental health provider. This disturbance can result in decreased trust and intimacy, isolation, detachment and withdrawal. A social worker or professional counselor can sometimes over-identify with the client, either consciously or unconsciously.

Countertransferencethe emotional reactions of the trauma workers to clients' experiences can.....sometimes can be projected onto the client (Stamm, 1997)

Burn-out ...a state of physical, emotional and mental exhaustion caused by long-term involvement in emotionally demanding situations. (Pines and Aronson, 1988)

Compassion Satisfaction (Stamm, 1998) ...a feeling and acting with deep empathy and sorrow for those who suffer. Trauma workers can feel a deep sense of satisfaction, especially when characteristics of hardiness, resiliency and social support are present in the trauma worker.

How mental health therapists and trauma workers can practice self-care after working with emotionally traumatized clients and/or victims of disaster and violence:

Professional Activities:

- Try to take regular short breaks (can be as little as 5-to-10 minutes), especially when working at a disaster site or during long clinical work days
- Participate in a group or individual debriefing developed for the crisis counselor within 48-72 hours of completing disaster work or after especially traumatic work

- Don't over schedule
- If a counselor is performing continuous crisis work, debriefings should take place on a regular basis
- Acknowledge the value of your contributions
- Talk to colleagues/supervisors about cases
- Talk to colleagues/supervisors about non-work events
- Recognize the successes of your work
- Engage in regular supervision or consultation
- Consider a professional support group
- Read professional materials and attend workshops
- Take a personal vacation of a least a week or two every year

Personal and Self-Care Activities:

- Develop a consistent, fail-safe stress management plan
- Learn more about developing resiliency and hardiness
- Exercise regularly and eat right
- Learn meditative breath work
- Have a body massage
- Create a spiritual connection
- Develop creative expressions such as in writing, drawing or music
- Join a support group
- Spend uninterrupted, fun time with family members and friends
- Laugh a lot
- Allow yourself to be outrageously goofy

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Joint Task Force for the Study of Electronic Practice Standards

By: Amanda Duffy Randall, Ph.D., LCSW, Chair of the MHP Board

The National Association for Social Workers (NASW) and the Association of Social Work Boards (ASWB) have combined efforts to form a joint task force to develop standards for electronic practice. The group is called the Social Work Practice and Technology Work Group, and met for the first time in June 2004 at ASWB offices in Culpeper, Virginia. The members of the task force include ASWB representatives Charlotte McConnell (Washington, DC), co-chair, Mary Burke (Maryland), Andrew Marks (Texas), Roger Kryzaneck(Oregon), and Amanda Duffy Randall (Nebraska).

NASW representatives include co-chair Yvette Colon, Director of Education and Internet Services for the American Pain Foundation, Rebecca Sager Ashery of the U.S. Public Health Service, Susan Mankita, host of AOL's Social Work Forum, Dick Schoesch of University of Texas School of Social Work, and Robert Vernon of the Indiana University School of Social Work.

The work of the task force will be to develop standards for the delivery of services through electronic means, including assessment, referral, psychotherapy, and advocacy. The use of electronic means to provide social work services has mushroomed very quickly in the past few years, with little to no regulation, supervision, or means to protect the public from harm. It was agreed that this method of service delivery offered numerous advantages, but that the potential for abuses also existed. The likelihood that the practitioner and client will reside in different jurisdictional regions is great. ASWB has taken the position in the Model Social Work Practice Act that social work practice through electronic means takes place in the client/patient jurisdiction of residence irrespective of the location of the social work practitioner.

During the initial meeting, task force members discussed the complexity of issues and problems associated with electronic practice, in addition to the benefits derived by clients, practitioners, and the public. Topic areas for further study were assigned, and committee members drafted standards for review and discussion, which was conducted through e-mail and the Internet. The task force met and reviewed the standards developed on November 19, 2004, at the NASW office in Washington, D.C. Public comments were solicited in 2005 and the publication, entitled *Standards for Technology and Social Work Practice* is now available on the web site at <http://www.aswb.org/TechnologySWPractice.pdf>.

While the work of the task force is complex, the essential question of how to set standards for the best practice of mental health services, and how to protect the consumer of those services, remains the goal. What the differences are in meeting the client in the office or home setting, or communicating electronically are yet to be determined.....

SUPERVISION

By: Mona McGee-Snyder, MHP Board Member



The role of the supervisor for the provisionally licensed or practicum professional is critical in shaping the "next generation of therapists" in our state. NAC 172 defines a 'Qualified Supervisor' as an individual who assumes the responsibility of supervision during the 3,000 hours of post-master's experience.

There are specifics defined for social work and marriage and family therapists, however the essential requirements for the LMHP supervisor are:

- a. Holds a current active license; and
- b. Has not had his/her license disciplined, limited, suspended, or placed on probation during the 1-year immediately preceding the application for a provisional license. At least 1 year must have elapsed following completion of any disciplinary terms and conditions. If any of these actions are taken by the Department during the supervisory agreement period, the supervisor must terminate the supervision immediately and notify the Department.

For the prospective supervisor, issues to consider in the assurance of a quality experience for the practicum professional or the PLMHP are:

1. What are my Roles and Functions of Clinical Supervision? -- Includes the unique purposes, goals and foci of supervision, the appropriate conditions for supervision, and the distinction between supervision and other professional roles.
2. What are the types of Clinical Supervision Models? -- Includes the major approaches for conceptualizing supervision (e.g. psychotherapy, theory-based models of supervision, developmental models, and social role models).
3. What is my Role in the Professional Development of the PLMHP?—Includes topics such as individual learning styles, cognitive development levels, differences in experience levels, stages of professional development, and critical transition points, as well as how to create an appropriate educational environment or climate based on developmental differences.
4. What Methods and Techniques in Clinical Supervision will I ensure occur for the best possible professional experience of my "supervisee"? -- Includes supervision methods for assessing and intervening with supervisees (e.g., audiotape review, live supervision, self-report), as well as the appropriate use of, and benefits and limitations of, each supervision method.
5. What are Possible Supervisory Relationship Issues? -- Includes the inter and intrapersonal variables that affect supervision such as the parameters of a working alliance, conflict within supervision, supervisee anxiety, social influence, and parallel process.
6. What are the Possible Cultural Issues in Supervision? -- Includes the implications of cultural differences and/or similarities between supervisee and supervisor such as race, gender, sexual orientation, and belief systems, and how these impact the process and outcome of supervision.
7. What is my Role in Group Supervision? -- Includes topics such as the structure and processes of group supervision, the unique tasks of the supervisor in the group context, ground rules and stages of group supervision, and the advantages and limitations of the group modality.
8. What are Legal and Ethical Issues that Could Impact My Role as a Supervisor? -- Includes major ethical and legal tenets that affect supervision such as due process, confidentiality, informed consent, dual relationships, competence, duty to warn, and direct and vicarious liability, and the implications of these tenets for supervisees, clients, and the supervisor.
9. What is my Role in Ensuring that a Constructive Ongoing Evaluation Occurs with the PLMHP or the Practicum Student? -- Includes studies that address the role of evaluation as central to supervision, criteria for evaluation, sources of feedback, the process and outcomes of evaluation, and the role of documentation in evaluation, as well as procedures for the evaluation of the supervision experience.

Corey, Gerald; Marianne Schneider Corey and Patrick Callanan. Chapter 9 "Issues in Supervision and Consultation" in *Issues and Ethics in the Helping Professions*. New York: Brooks/Cole Publishing Co., 1998.

Note: Post-Master's experience hours earned prior to proper registration with the Credentialing Division and issuance of a PLMHP will not be considered acceptable towards licensure; said experience will be considered as practicing without a license (a fine can be imposed). Any change in supervisor must be filed within 30 days after said change.

The Legal Corner

By: Brad Shaff, Former Assistant Attorney General



The following is a review of the mandatory reporting requirements under Nebraska's Uniform Licensing Law, specifically Neb. Rev. Stat. §71-168 and how it addresses: (1) general reporting requirements, (2) some exceptions to the requirement, (3) the protections from civil and criminal liability offered by the statute.

Mandatory Reporting Requirements of the Uniform Licensing Law: As previously mentioned, Neb. Rev. Stat. §71-168 is the portion of the law that deals extensively with mandatory reporting requirements. My intention is to highlight the general rules, a couple important exceptions to the rule, and lastly, the protections from civil and criminal liability for complying with the reporting requirements. However, §71-168 is only two pages long, and I strongly encourage every person subject to its provisions to take the time to obtain a copy, read it and know your responsibilities under the law.

Self Reporting: Every credentialed/licensed person is responsible for self reporting to HHS any of the following occurrences within **30 days of the occurrence:**

- Loss of privileges in a hospital or other health care facility for alleged incompetence, negligence, unethical or unprofessional conduct, or physical, mental or chemical impairment and other reasons. (Please see §71-168 for a complete list)
- Loss of employment due to alleged incompetence, negligence, unethical or unprofessional conduct, or physical, mental or chemical impairment.
- Adverse judgments, settlements, or awards arising out of professional liability claims. (Don't count on the insurance company doing this for you)
- Denial of credential due to alleged incompetence, negligence, unethical or unprofessional conduct, or physical, mental or chemical impairment.
- Disciplinary action against any credential or other form of permit by another jurisdiction, or voluntary surrender of credential or other form of permit to another jurisdiction.
- Loss of membership in a professional organization due to alleged incompetence, negligence, unethical or unprofessional conduct, or physical, mental or chemical impairment.
- Conviction of any misdemeanor or felony in this or any other jurisdiction.

Remember, timely reporting may not result in adverse action, but a failure to timely report is a violation of the law and may subject you to adverse action.

Reporting Others: Every credentialed/licensed person has the following reporting responsibilities:

- To report any person without a credential believed to be engaged in the practice of any profession requiring a credential.
- Any credentialed person who is required to report a loss or theft of a controlled substance to the DEA shall provide a copy to HHS.
- If a credentialed person has first-hand knowledge of facts giving him or her reason to believe that a person in their profession, has committed acts indicative of gross incompetence, a pattern of negligent conduct, unprofessional conduct or who may be practicing while their ability is impaired by alcohol, controlled substances, or physical, mental or emotional disability, or has otherwise violated regulations governing the practice of their profession, they shall report said person.
- If a credentialed person has first-hand knowledge of facts giving him or her reason to believe that a person in any other regulated profession has committed acts indicative of gross incompetence or who may be practicing while their ability is impaired by alcohol, controlled substances, or physical, mental or emotional disability, they shall report said person.

Exceptions to Reporting: The requirement to report others shall not apply to:

- The spouse of a person.
- A practitioner who is **providing treatment to such person in a practitioner-patient relationship** concerning information obtained or discovered in the **course of treatment UNLESS** the treating practitioner determines that the condition of the person may be of a nature which constitutes a **danger to the public health and safety** by the person's continued practice.
- When a credentialed person who is chemically impaired enters the Licensee Assistance Program (see §71-172.01 for details).
- For exceptions related to witnesses before certain committees and certain committee members, please see §71-168(5).

Immunity from Civil or Criminal Liability: Any person making a report to HHS under §71-168 (except those self-reporting) shall be completely immune from criminal or civil liability of any nature, whether direct or derivative, for filing a report or for disclosure of documents, records, or other information to HHS under this section. In addition, a report made to HHS under §71-168 is confidential.

In summary, this information is intended to raise awareness of a credentialed or licensed person's responsibility under the Mandatory Reporting Requirements of §71-168. Please take the time to read and understand these standards to which you are held accountable.

Web site for additional information relating to mandatory Reporting information: <http://www.hhs.state.ne.us/reg/investi.htm>

Disciplinary & Non-Disciplinary Information from January 1, 2005 to January 1, 2006

Disciplinary Actions

#	Action Taken	License Type	Basis
1.	Voluntary Surrender	PLMHP	Sexual contact
2.	Limitation	LMHP, CPC	Sexual contact
3.	Civil Penalty (\$500), Censure	LMHP	Failed to report conviction
4.	Probation	PLMHP	Alcohol related convictions
5.	Suspension, Probation	LMHP, CPC	Dual relationship, boundaries, confidentiality
6.	Voluntary Surrender	LMHP	Sexual relationship
7.	Civil Penalty (\$500), Probation	LMHP, MSW	No records on a number of clients
8.	Probation	LMHP	NA
9.	Probation	CSW	Alcohol related convictions
10.	Probation	LMHP	Practice without PLMHP, failed to report employment termination
11.	Suspension, Probation	PLMHP	Probation violation (alcohol consumption)
12.	Probation	LMHP, CPC	Failure to keep adequate records
13.	Voluntary Surrender	LMHP	Sexual intimacy with client, lied to investigator
14.	Voluntary Surrender	PLMHP	Theft of client's controlled substance, consumed CS and impaired while providing therapy
15.	Civil Penalty \$500), Censure	LMHP	Paperwork not filed within appropriate timeframes
16.	Revocation	LMHP, CMSW	Failed to remain accessible to clients
17.	Probation	LMHP, CPC	NA
18.	Censure, Probation	LMHP	Dual relationship, boundaries

Non-Disciplinary Actions

#	Action Taken	License Type	Basis
	Assurance of Compliance	CSW	Practice outside of scope
	Assurance of Compliance	LMHP, CPC	NA
	Assurance of Compliance	LMHP	Failure to refer to neutral party (undue influence on client)

Board Meeting Dates



Meetings of the Nebraska Board of Mental Health Practice convene at 9:00 a.m.; however, the Board usually immediately goes into closed session to review investigative reports. Members of the public may not be present during closed session. Following closed session, the Board will return to open session.

Agendas for the meetings are posted on our Web site at <http://www.hhs.state.ne.us/crl/brdmtgs.htm#Mental> and are noted on the next page.

Date	Room Location	Time
07/07	6Z	9:00 am
09/01	6Z	9:00 am
11/03	6Z	9:00 am

All meetings are held at the State Office Building,
301 Centennial Mall South, Lincoln, Nebraska

The Board welcomes 2 new members:

- Janice Whalen Fitts (Gering) was appointed by the Board of Health as the other Master Social Worker Representative; she replaces Tom Perkins who served 10 years.
- Vickie Frizzell-Pratt (Lincoln) was appointed by the Board of Health as the other Mental Health Practitioner Representative; she replaces Nancy Myers who served 9 years.

Additionally, Susan Strong, JD, Assistant Attorney General, has been assigned to work with the Board of Mental Health Practice (along with a number of other professional boards). She replaces Brad Shaff, JD, who accepted a job in Omaha, Nebraska.

Renewal Information

Your license and/or certificate will expire September 1, 2006. To renew you will need to have obtained 32 hours of continuing education, pay the renewal fee and complete the renewal form. Renewal notices will be sent at least 30 days prior to September 1st. We suggest you check your address on-line to make sure it is correct <http://www.nebraska.gov/LISSearch/search.cgi>

Late Fee and Administrative Penalty: If the renewal fee and/or the completed renewal document are postmarked or submitted in person after the Expiration date, a penalty fee of \$25.00 will be assessed and you **may not practice** until the license is renewed. Licenses not renewed or placed on inactive or lapsed status will be Revoked 30 days after the expiration date.

An individual who practices mental health or represents himself/herself as certified or as a social worker after the expiration of his/her credential is subject to assessment of an Administrative Penalty of \$10 per day up to \$1,000 pursuant to 172 NAC 94-020 or such other action as provided in the statutes and regulations governing the credential.

Continuing Education Categories

- **Academic Credit**
 - 1 semester hour of academic credit = 15 continuing education credit hours.
 - 1 semester hour credit audited = 8 hours of continuing education.
 - 1 quarter hour of academic credit = 10 continuing education credit hours.
 - 1 quarter hour credit audited = 5 hours of continuing education.
 - 1 trimester hour of academic credit = 14 continuing education credit hours.
 - 1 trimester hour credit audited = 7 hours of continuing education.
- **Home Study Programs** may accumulate up to 20 hours of continuing education per renewal period.
- **Publications** written by the licensee and published in a refereed professional journal or book may accumulate up to 20 hours of continuing education per renewal period.
- **Teaching** a college/university course is calculated the same as academic credit; a licensee or certificate holder may accumulate up to 30 of the 32 hours per renewal period (if credentialed as a CMSW or LMHP, you must teach graduate level course to be considered acceptable for CE).
- **Dissertations** may accumulate up to 32 hours of continuing education per renewal period.
- **Educational/Training Videos** may accumulate up to 10 hours of continuing education within a renewal period utilizing educational/training videos.
- **Workshop/Seminar/Lecture, etc** 1 continuing education hour or credit = 60 minutes of participation, for each fraction of an hour, record in 15 minute increments (ie 1.25, 1.5, 1.75). Workshop presenters may receive credit for the initial presentation only.



Two (2) of the 32 hours of continuing education each renewal period must relate to ethics. If you have not already obtained these hours, you might consider researching the various professional association websites, check with hospitals or mental health organizations, etc.

For More Information Contact

For questions not answered on our Web site <http://www.hhs.state.ne.us/crl/profindex1.htm> or if you do not have access to the Internet:

<p>PLMHP Questions Pam Weise, Credentialing Specialist (402-471-0183 pam.weise@hss.ne.gov</p>	<p>Complaint Filing Investigations Division (402) 471-0175 www.hhs.state.ne.us/reg/investi.htm</p>
<p>LMHP Questions, Examination & Renewal Information Cindy Kelley, Credentialing Specialist (402) 471-4905 cindy.l.kelley@hss.ne.gov</p>	<p>Probation Compliance Monitoring Ruth Schuldt, RN, BS (402) 471-0313 ruth.schuldt@hss.state.ne.us</p>
<p>Non-Routine Licensure Issues Nancy Herdman, Program Specialist (402) 471-0556 nancy.herdman@hss.ne.gov</p>	<p>Mailing Labels/Listings Carla Brandt (402) 471-0178 carla.brandt@hss.ne.gov</p>
<p>Non-Routine Licensure Issues Kris Chiles, Section Administrator (402) 471-2117 kris.chiles@hss.ne.gov</p>	