



Nebraska Justice Behavioral Health Initiative Strategic Plan

October 31, 2008

UNIVERSITY OF
Nebraska
PUBLIC POLICY CENTER

Acknowledgements

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 (CDFA #16.745) under a Category I: Planning grant (from 11/01/2007 to 10/31/2008).

Questions about this report should be directed to:

Mark B DeKraai
Senior Research Director
University of Nebraska
Public Policy Center
215 Centennial Mall South, Suite 401
Lincoln , NE 68588-0228
402-472-1496
mdekraai@nebraska.edu

Table of Contents

Executive Summary	4
Strategic Plan	5
Strategic Planning Process	8
Needs Assessment	13
Literature Review	16
Strategies (18)	18
Work Plan and Time Line (24)	24
Attachments	
Attachment A: Joint Crisis Work Group for Nebraska Justice Behavioral Health, Charter	33
Attachment B: Diversion/Screening Work Group, Agenda	24
Attachment C: Justice Behavioral Health Housing Work Group, Charter	36
Attachment D: Nebraska Justice Behavioral Health Statewide Strategic Planning Meeting, October 10, 2008	38
Attachment E: Nebraska Justice Mental Health Statewide Strategic Planning Meeting, October 10, 2008 Opening Remarks by Scot Adams	40
Attachment F: Region 6 Presentation: “Justice Mental Health Initiatives”	42
Attachment G: Strategic Planning Process Planning, “Nebraska Justice Behavioral Health Initiative: Strategic Planning Process” by Mark DeKraai	45
Attachment F: Presentation by Probation Division	51
Attachment I: “Tribal Partnerships: Some Basic Considerations” By Larry Voegele	53
Attachment J: Nebraska Justice Behavioral Health Statewide Strategic Planning Meeting, Oct. 10, 2008, Minutes	58
Attachment K: Overview of Revised Strategic Plan	70
Attachment L: “The Ultimate Intercept – Evidence Based Treatment Services”	79

Executive 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. The five priority areas are:

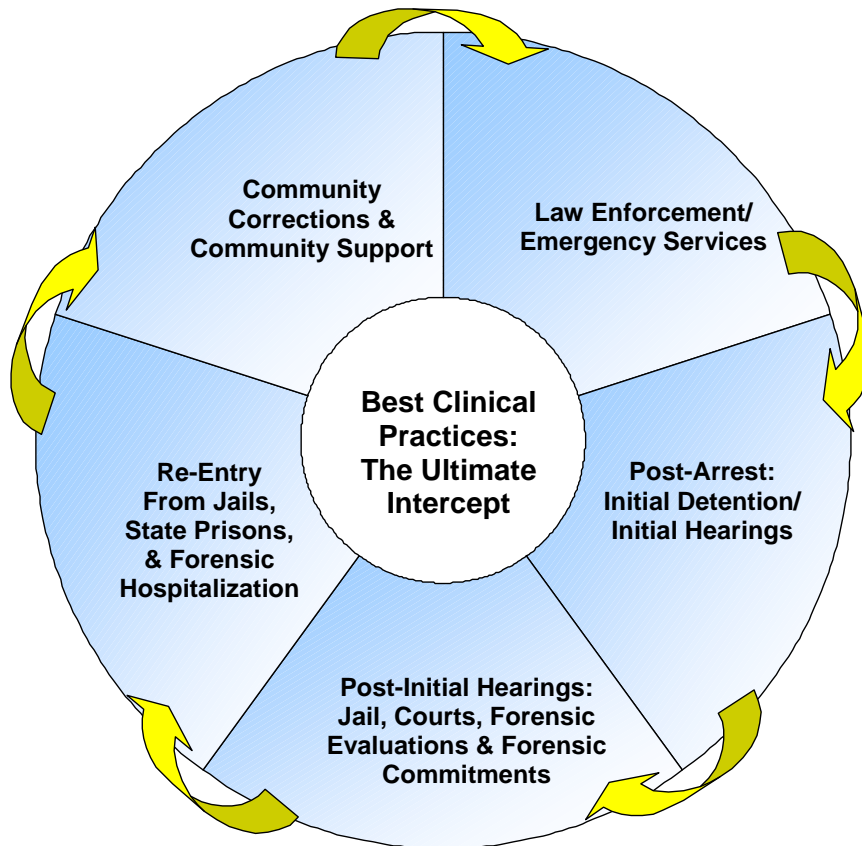
- Provide statewide Crisis Intervention Team (CIT) training for Law Enforcement officers and make clear linkages with local crisis response teams
- Expand or improve access to crisis stabilization services with improved coordination with law enforcement officers
- Implement standardized mental health and substance abuse screening instruments in the jails that prompt referrals for services
- Increase resources to community mental health to provide diversion services through the use of Forensic Intensive Case Management
- Enhance affordable supportive housing for justice involved youth transitioning to adulthood.

Nebraska's Justice Behavioral Health Initiative will continue work to refine strategies in these priority areas and to implement the strategies through the Department of Justice Planning and Implementation grant that runs from October 2008 through September 2011.

NEBRASKA JUSTICE BEHAVIORAL HEALTH INITIATIVE STRATEGIC PLAN

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

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



The following is a summary of each intercept and potential strategies derived from the December 2007 strategic planning session.

INTERCEPT 1 --- Community and Law Enforcement

People with mental illness, who are not stabilized by the treatment offerings of their community, often have their first contact with the justice system through law enforcement personnel. Police departments across the country are forced to address the issues of people with mental illness because they are usually the first line of intervention. Some innovative approaches implemented nationally at this intercept include Crisis Intervention Team (CIT) training for law enforcement officers and other justice professionals to better respond and refer individuals with behavioral health disorders, the use of mental health professionals to work side by side or within police departments, mental health crisis lines and mobile crisis response teams (CRT) to respond to individuals in distress who have been identified by police officers.

INTERCEPT 2 --- Initial Detention and Initial Court Hearing

The next point of interception involves diversion options that are offered after arrest. This can include services that are organized in jails, within the initial court hearing process and by outside entities that work with all the service providers that interface at this juncture. Strategies to more effectively respond to individuals with behavioral health disorders at this intercept include behavioral health and suicide screening in jails and detention centers, referral processes to link individuals with needed mental health and substance abuse services, and developing screening and referral protocols for mental health diversion programs.

INTERCEPT 3 --- Courts and Jails

When diversion has not been possible through law enforcement referral or a post arrest diversion at the initial court hearing, the courts and the jails get involved. The jails have had to develop a number of treatment options to provide safe and secure housing, while the courts have initiated mental health dockets, or problem solving courts that attempt to use the leverage of the court to address the needs of people with mental illness. Other strategies include good classification systems in jail to link people to good quality treatment during incarceration, improve access to medications in jails, and use of data connectivity to identify a person with mental illness and link them to their current or past treatment provider.

INTERCEPT 4 --- Reentry

Reentry planning is critical in ensuring the success of individuals released from prisons and jails and integrating back into the community. Strategies include improved planning well before release from incarceration, efforts to reduce the stigma of mental illness in the community including the use of peer specialists, developing collaborative networks across community programs focused on this population including information sharing

agreements, developing processes to improve access to benefits such as Medicaid funding for services, and offering case management services to coordinate care across agencies.

INTERCEPT 5 --- Probation/Parole

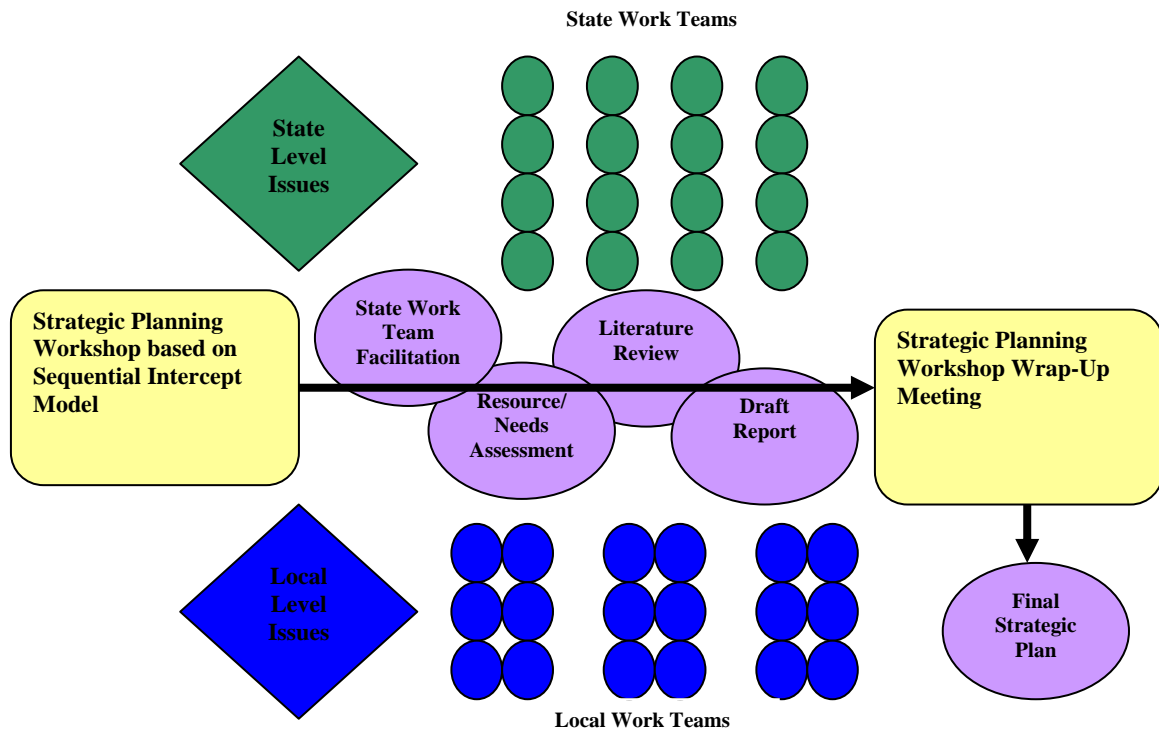
Typically probation and parole agencies have a difficult time accessing mental health services. Many probation and parole agencies have developed dedicated mental health caseloads characterized by smaller caseloads and trained officers. Additional strategies include providing evidence based behavioral health services such as Forensic Assertive Community Treatment (FACT) and Forensic Intensive Case Management (FICM), developing programs to ensure affordable supported housing options, and partnering with systems such as vocational rehabilitation to develop integrated employment programs that specialize in serving the forensic mental health population.

I. Strategic Planning Process

The strategic planning process is intended to result in a plan to improve the cross-disciplinary system of care for persons with mental illness who encounter the criminal justice system in Nebraska by strengthening early intervention efforts to mitigate recidivism and prevent persons, especially juveniles, from cycling through institutionalized settings throughout their lives. Funded by a Department of Justice planning grant, the inclusive planning process focused on juveniles transitioning to adult services. The process was designed to result in a Strategic Action Plan and implementation strategies for a sustainable, collaborative infrastructure across criminal justice, mental health and other relevant systems. The desired outcomes of the process included the following:

- 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

Nebraska's Justice and Mental Health Planning Process



Kick Off Strategic Planning Meeting

Nebraska's Justice Behavioral Health Initiative kicked off with a strategic planning meeting held December 5-6, 2007 in Lincoln, Nebraska. The purpose of the workshop was to 1) understand the characteristics and service needs of the target population, 2) use the Sequential Intercept Model as a framework to design and prioritize interventions, 3) assess gaps and strengths in areas of services and programs, agency coordination and collaboration and policy and legislation, and 4) prioritize gaps and develop a plan of action. Fifty nine stakeholders from across the state attended the workshop. These stakeholders represented mental health 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). Participants worked in six regional groups to plan for local needs, while a state level work team developed a strategic plan for state level issues. The output of the strategic planning process was a vision reached through consensus to have a seamless system to identify, support and treat children and adults with mental and emotional disorders involved across the justice system. Policy Research Associates facilitated the planning and developed the report which included 14 recommendations. The full report of this strategic planning meeting can be found at:

http://www.hhs.state.ne.us/beh/NE_CriminalJusticeMHReport&Attachmts-Jan28_2008.pdf

Steering Committee and Work Teams

A Steering Committee was developed for the project and involved state agencies including DHHS Division of Behavioral Health, DHHS Office of Consumer Affairs, DHHS Division of Children and Family Services, Department of Correctional Services, Administrative Office of the Courts Probation Administration, and the Nebraska Crime Commission (Community Corrections Council and Jail Standards). The Steering Committee prioritized strategies into five areas: 1) providing Crisis Intervention Team Training (CIT) for law enforcement, 2) expanding access to behavioral health crisis stabilization services, 3) implementing standardized mental health and substance abuse screening instruments in the jails that prompt referrals for services, 4) increasing resources to community mental health to provide diversion services and forensic intensive case management, and 5) enhance affordable supportive housing for justice involved youth transitioning to adulthood. Three work teams were chartered by the Steering Committee to address these five issue; the Crisis Team tackled the first two issues (see Attachment A); the Screening and Diversion Team addressed the next two issues (see Attachment B); and the Housing Team focused on the fifth area (see Attachment C).

The three work teams developed initial strategies by April 2008. The Nebraska Department of Health and Human Services in consultation with the Steering Committee decided to apply for a second U.S. Department of Defense Grant, this one for both planning and implementation. The five priority areas and the strategies developed by the work teams were the basis for the application. Ultimately the application was successful and Nebraska was awarded the three year \$250,000 grant starting October 1, 2008. The three work teams continued their efforts and refined strategies in the summer of 2008. The revised strategies were then presented at a final strategic planning meeting on October 10th in Lincoln (see Attachment D for the agenda).

October Strategic Planning Meeting

The October strategic planning meeting was designed to accomplish the following outcomes:

1. Provide participants with an understanding of the urgency of addressing these critical issues in Nebraska
2. Provide participants with an understanding of planning and implementation efforts at the regional level
3. Provide participants with an understanding of the proposed strategies in the five priority areas
4. Provide participants with an understanding of agency perspectives and background on justice behavioral health
5. Receive participant feedback to improve the strategies as part of Nebraska's Strategic Plan
6. Receive participant input in identifying additional strategies and action steps to enhance the strategic plan

Jim Harvey and Scot Adams from the Nebraska Department of Health and Human services Division of Behavioral Health and Bob Houston from the Nebraska Department of Correctional Services welcomed meeting participants and provided their perspectives on the importance of the issue and the need to accomplish significant system improvements as a result of the strategic planning process (see Attachment E for a summary of the opening remarks). Representatives from each of Nebraska's six behavioral health regions then provided updates on the progress they had made in the last year in improving services for justice involved persons with behavioral health challenges. Some of the highlights are listed below.

Region 1 – Pamela Richardson. Region 1 is providing access to a peer support specialist prior to release from prison or jails. The emergency community support program has been working with jail officials to identify persons with behavioral health challenges. The jail has moved to new facility, with staffing changes and policy changes, so there have been significant changes in the relationship. They have been discussing the use of standardized screening instruments in jails. Access to medication to those detained continues to be a challenge; they have been working with state agencies to recognize

what information is needed and how to get that information so that individuals would be eligible at time of release. The Region has also been working with the drug court.

Region 2 – Corey Brockway. Region 2 has been working with law enforcement on an abbreviated Crisis Intervention Team training. The traditional model of CIT does not work well in their region because, due to limited staffing, it is challenging in rural areas to have someone away from the job for multiple days or even one day of training. Instead they have been approaching law enforcement personally and training on site. The Region instructs them on what is available to them, and they can call 24/7 for assistance in situations. The Region has been working with a crisis unit in Grand Island to provide needed coverage. They have also been working on screening in jails and developing transition housing for youth entering adulthood.

Region 3 – Melinda Ferritor and Denise Anderson. CIT training has been delayed due to changes in staffing, but they have been working on developing this training. Regular stakeholder meetings have been held to improve crisis stabilization services, and cross training in mental health and substance abuse was identified as a key area. Richard Young Hospital developed screening process for persons in jails; discussions have been held about implementing throughout the region. They have also been working on housing and collaboration with adult and family drug courts.

Region 4 - Ingrid Gansebom. Region 4 has been working with law enforcement and has increased crisis beds. They are trying to develop capacity so people do not need to be served far from their home communities. They have been conducting training with law enforcement. It is important to bring training to the officers due to small rural departments. Region 4 has also been working with jails and providing jail personnel with training on mental health. They have crisis response teams that cover the whole region and have increased the capacity of the crisis response teams to respond to youth. One challenge has been providing services for youth under Emergency Protective Custody; generally they are placed out of region. Region 4 has also been working with probation on housing.

Region 5 – Linda Wittmus. Region 5 has crisis response teams that operate in all counties and will go into jails and do assessments. A hallmark has been to identify what training needs to be done and implement it. Region 5 has focused on training law enforcement. Information sharing is a major initiative that Region 5 has started in partnership the behavioral health network to develop an info sharing network. It increases access to pertinent information. A project manager has been hired and other staff is in the process of being hired. One of the major issues is individuals with behavioral health and physical health challenges - people in Region 5 systems cannot access health care. Region 5 has expanded housing alternative and has developed a youth in transition team which staffs youth who are transition age. Additionally, Region 5 has added professional partners specifically for transition age youth.

Region 6 – Taren Petersen. In Region 6 CIT training has been implemented for three years and has trained almost 190 individuals including school officers, 911 officers,

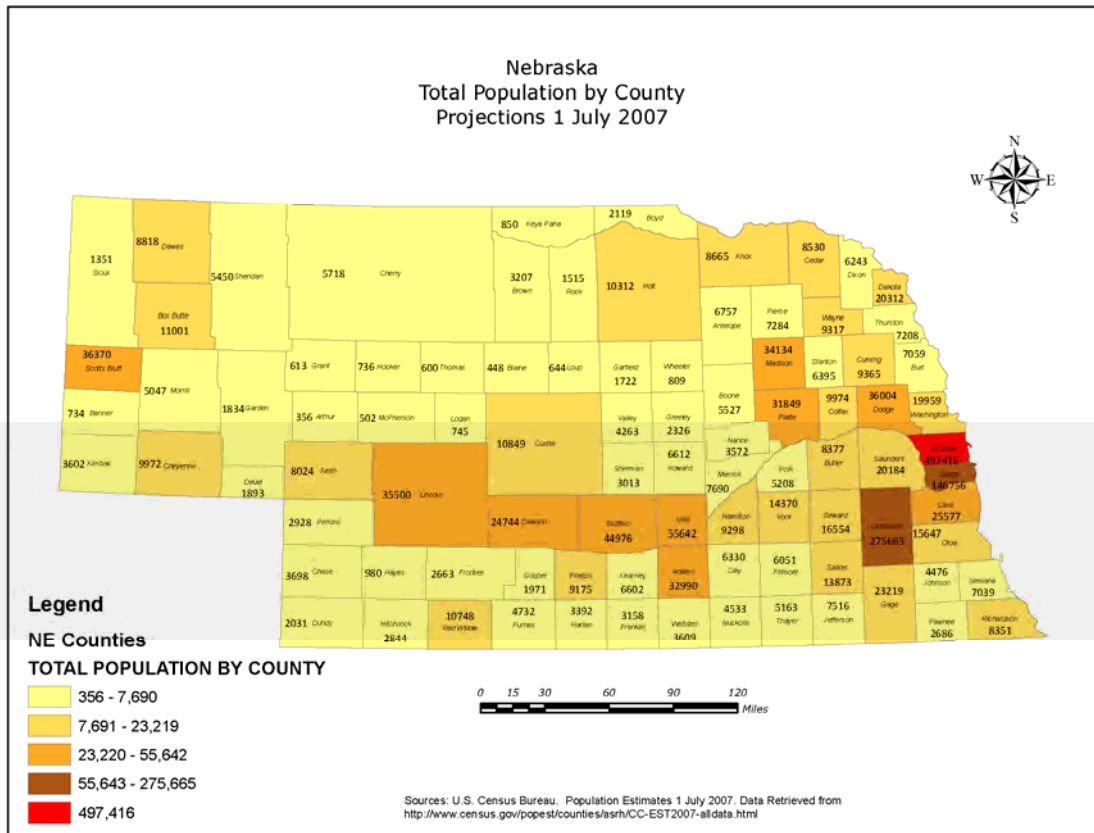
correctional staff, and others. They are now ready to enter an evaluation phase looking at data. Omaha has pledged to have 10% of its officers to go through the training. Now CIT training is available for other counties. There are new developments with crisis stabilization. The new Lasting Hope Recovery Center has 64 beds and has agreed to take all of the EPCs. Sarpy County has a new Crisis Response Team that has been successful. Region 6 has a task force that is multidisciplinary that meets every other month where the task force reviews cases and coordination of emergency services and engages in problem solving. Region 6 has also been working on standardized screening in Douglas County and has been collaborating with the diversion program which provides intensive case management services. There is also a transition youth planning meeting that takes place monthly where transition youth cases are staffed; they also have the housing voucher program (see Attachment F for the power point presentation).

Following the reports from the 6 regional representatives, Mark DeKraai from the University of Nebraska provided an update on the strategic planning process (see Attachment G for the presentation). Additionally, a panel of representatives from different state agencies provided perspectives on justice involved persons with behavioral health disorders. Terri Nutzman from DHHS Division of Children and Family Services provided information from the Youth Rehabilitation and Treatment Centers in Kearney and Geneva and the need for community programs that can address acting out behavior. Linda Krutz from the Nebraska Crime Commission provided an overview of the Community corrections Council and its work in this area. Steve Rowaldt provided information from Probation regarding screening and assessment to determine the correct level of care and services to address mental health and substance abuse diagnoses (see attachment H). Betty Medinger from the DHHS Division of Children and Family Services provided information about the needs of the target population for a decent place to live, help making rent payments, and the support of the community to help people stay housed. She discussed a new web site for finding housing across the state, expanding Rent-Wise Training to help the individuals in the target population become better tenants, and training outreach workers to help individuals access appropriate benefits.

Larry Voegelé from the DHHS Office of Minority Health presented information on cultural considerations in working with Nebraska Native American Tribes (see Attachment I). J. Rock Johnson provided historical information about mental health services in Nebraska and stressed the need for consumer involvement. Cameron White from the Department of Correctional Services discussed expanding treatment for offenders in prison, addressing the behavioral health needs of violent offenders, expanding services for inmates with sexual disorders, and providing services for inmates with substance abuse or co-occurring disorders. During a working lunch, Betty Medinger presented a video on a successful approach for housing homeless individuals. In the afternoon, meeting participants were asked to provide input on each of the five strategies and to identify other issues that should be addressed. The input was recorded and changes were included in the strategic plan (see Attachment J). Attachment K provides an overview of how the revised strategic plan from the October 10th, 2008 meeting compares to the original strategic plan developed in December 2007.

II. Needs Assessment

Nebraska has a population of 1.7 million, and almost half (811,425) live in six metropolitan counties. The balance of the population is scattered across the state in 87 other micropolitan, rural and frontier counties. Nebraska is diverse geographically and demographically. As one of the nation’s refugee resettlement states, Nebraska is experiencing an increase in Sudanese and Somali refugees. Additionally, Nebraska has one of the highest growth rates of Hispanic/Latino populations. Nebraska is also home to four federally recognized Native American Tribes. Between the 1990 and 2000 censuses, the overall percentage of Whites declined from 94% to 90% while the number of Hispanic/Latinos increased 255% to 5.5% of the total population. Each race and culture brings uniqueness and varying perspectives on mental health and justice issues. Ensuring that youth and young adults of all races and ethnicities are appropriately served is a priority in all planning and implementation efforts.



It is estimated that 40,168 individuals in Nebraska have a serious mental illness and are below 200% of the poverty level (WICHE, 2007); this is the population likely to require publicly funded mental health services. Of these individuals, 6,958 or about 18%, fall between the ages of 18-24 – the target population for this project. Service utilization data indicate this age group is underserved in comparison to other age groups (44% compared

to 65% for all age groups; WICHE, 2001). Older adolescents and young adults are over represented in the justice system. For example, 56% of individuals on probation in Nebraska (10,483 of 18,563) are ages 16-29.

There are unique challenges in addressing the needs of young adults with mental illness who come in contact with the justice system. In the Omaha metropolitan area, approximately 10% of law enforcement officers have been trained in CIT, which has led to significantly improved interactions between law enforcement and persons with mental illnesses. However, in other parts of the state this training has been lacking for law enforcement, and throughout the state there is a lack of mental health training for probation and parole officers. Even when law enforcement is trained in interacting with persons with mental illnesses, often there is a lack of coordination between law enforcement and mental health services. One reason is the lack of mental health services available for justice involved individuals. According to current estimates, approximately 2,000 mental health professionals are available in Nebraska, and only 16% of these professionals are licensed clinical psychologists. Furthermore, according to the Nebraska Psychiatric Society, there are only 191 psychiatrists in the state and only nine psychiatrists were located in the western half of Nebraska. The U.S. Department of Health and Human Services has designated over 70% of Nebraska's counties as mental health shortage areas, and 86 of Nebraska's 93 counties are psychiatric shortage areas. There is also a shortage of licensed alcohol/drug abuse counselors (LADC), with a current ratio of 1 LADC to every 3,068th resident. The implications of the shortage of mental health and substance abuse professionals is that for the behavioral health system to be effective, it must work in coordination with other systems such as law enforcement, corrections, probation/parole, housing and employment.

Local, county and state law enforcement officers report having difficulty accessing crisis beds in hospitals under contract with behavioral health regions for Emergency Protective Custody (EPC) care. Law enforcement officials often must contact multiple facilities to find an available bed and transport individuals long distances. In Nebraska, the responsibility for crisis beds has been shifting from state operated psychiatric hospitals to community based services including private hospitals; more than 200 state psychiatric beds have closed since 2003. Private beds for people needing EPCs, have also decreased in some Nebraska communities (Policy Research Associates, 2008, Attachment 12). In response to the lack of crisis services, several solutions have been developed including adding more community beds (Norfolk, LRC, Richard Young Hospital, Lasting Hope Recovering Center in Omaha) developing crisis respite beds (CRB), Crisis Response Teams (CRT), and Intensive Case Management (ICM).

There is a gap in the State Behavioral Health System regarding mentally ill inmates who discharge from the Nebraska state prison system into the community. Discharging inmates who are mentally ill represent a relatively large, but generally unrecognized population. These former inmates need access to behavioral health services including psychiatric, mental health, substance abuse and dual diagnosis treatment to address their needs. Data collected by the Nebraska Department of Correctional Services (DCS) between July 1, 2006 and June 30, 2007, reveal that 31.4% of inmates who completed

evaluations at intake had a DSM IV mental health diagnosis and 87.7% had a substance abuse diagnosis. As of June 2006, 19.7% (858 inmates) of Nebraska's total inmate population was prescribed psychiatric medication. The percentage of inmates with mental health diagnoses has increased in recent years, and the rate of mental illness found in the Nebraska prison population exceeds national prevalence estimates – 31.4% percent in Nebraska versus 16 to 18 percent nationally (U.S. Dept. of Justice, National Institute of Corrections, 2004).

One issue challenging Nebraska's correctional system is the transfer of "safekeepers" (inmates transferred from local jails to state facilities for safekeeping) from jails across Nebraska to state correctional facilities because the local facilities cannot adequately address their mental health or medical needs. Over the last eight years 1,365 safekeepers has been sent to the Department of Correctional Services, an average of 170 per year. Currently, the charge for safekeepers is \$75.78 per day, plus additional medical charges that could be added for mental health and medical services in DCS and external to DCS. Annual costs to serve safekeepers are estimated to be \$1.32 million not including medical expenses. The largest age group for safekeepers is 19 to 25 year olds. About 95% of safekeepers are sent from rural jails reflecting challenges managing behavior in local jails, difficulty accessing behavioral health resources and challenges in coordination between justice and mental health in rural and frontier communities.

Individuals with mental illness discharged from jails and prisons often face challenges in finding adequate housing and sustainable employment. Many face homelessness or move in and out of shelters. As an alternative to costly shelter services, supportive housing, is a reasonable and much needed housing approach for homeless persons with mental health problems in Nebraska. Data from 2005-2006 indicate that 27 homeless individuals utilized emergency services in Lincoln; an annual cost of \$25,943 per person living on the street. In comparison, the annual cost for a person to live in an efficiency apartment is estimated at \$7,344, an annual cost savings of \$18,600 per person (Chicoine, 2007).

The target population for Nebraska's Justice Mental Health Initiative is young adults and youth transitioning to adulthood who have mental illness and are in contact with the justice system. Individuals to be served through the initiative include 1) members of the target population who come into contact with law enforcement, 2) individuals who are in Nebraska's 80 local jails who will be screened for mental health needs, 3) persons who come into contact with law enforcement or jails who are screened and determined to require mental health crisis services, 4) individuals screened by law enforcement and jails and determined to need mental health diversion and case management services, and 5) members of the target population returning from jails and correctional facilities who need mental health and supported housing/employment services. These five groups have been identified as the priority population for this initiative. The full needs assessment can be found at the following web address:

<http://www.hhs.state.ne.us/beh/NEJusticeMHInitiative-Needs%20AssessmentReport06102008.pdf>

III. Literature Review

It is estimated that approximately 50% of individuals lodged in U.S. prisons and jails have mental health concerns (BJS, 2006). A body of scholarly research has developed over the past few years aimed at investigating the issue and developing potential solutions. This review of the literature follows the Sequential Intercept Model developed by Munetz and Griffin (2006). The Sequential Intercept Model consists of five different intercepts, or critical points in the criminal justice process, where criminal justice and mental health systems can collaborate to meet the needs of individuals with mental illness involved in the criminal justice system: 1) involvement with law enforcement, 2) post arrest procedures, 3) post initial hearing procedures including incarceration in jails and prisons, 4) re-entry into the community, and 5) community corrections including parole and probation. In addition, the intercept model includes an “ultimate intercept” which refers to the importance of the use of a strong community mental health system based in evidenced based practices (see Attachment L for more information) The following conclusions are a result of the literature review:

Intercept One

1. Crisis Intervention Team (CIT) training has the most substantial research support and consists of specially trained law enforcement officers who develop the skills to effectively interact with mentally ill individuals and refer to appropriate services.
2. To be effective, CIT require access to emergency mental health services. Critical elements include high visibility of location, a single entry point, a no-refusal policy, streamlined and efficient intake procedures for police officers, established legal authority and policies for detaining mentally ill individuals, extensive and intensive cross-training and, procedures for linking mentally ill individuals with community services.
3. Other Intercept One interventions such as community based specialized mental health response and police based mental health response have limited empirical support and can be considered emerging practices.

Intercepts Two and Three

4. There is preliminary empirical evidence supporting mental health diversion programs, which may be considered a promising practice. Research indicates that individuals in diversion programs spend less time incarcerated and receive more treatment than non-diverted persons.
5. Preliminary evidence indicate pre-booking diversion programs may be more effective than post-booking diversion programs.
6. Critical elements to ensure effective diversion programs include 1) screening groups of detainees for mental illness, 2) evaluation by mental health professionals of those

identified during screening, and 3) collaboration among diversion personnel, defense attorneys, prosecutors and judges.

7. There is preliminary empirical evidence for the efficacy of mental health courts; however, unlike drug courts, there is not a uniform model for mental health courts. Mental health courts can be considered an emerging practice.

Intercepts Four and Five

8. Critical Time Intervention (CTI) is a promising practice designed to strengthen the individual's ties to services, build problem-solving skills, and provide support during transition back to the community. This approach has been demonstrated to reduce days in psychiatric institutions, homeless nights, drug use, and negative symptoms of psychopathology.

9. Other interventions such as Forensic Assertive Community Treatment (FACT) and Assess Plan Identify Coordinate (APIC) have some preliminary empirical support and can be considered emerging practices. FACT promotes stability and independent community living through comprehensive mental health treatment for justice involved individuals. APIC focuses on transition planning based on accurate assessment of needs, planning for services to address needs across multiple domains (e.g., mental health, substance abuse, housing, healthcare, employment, income support), identifying effective services, and coordination of efforts across systems.

10. Guidelines for re-entry services include 1) forming partnerships to coordinate mental health and other support services (e.g., housing, employment), 2) integration of service delivery for co-occurring disorders, 3) involvement of community members and families in service planning and delivery, 4) use of evidence based treatment practices, and 5) ensuring culturally appropriate mental health services for racial, cultural and ethnic minorities.

In addition to approaches that are specific to the five intercepts, the Sequential Intercept Model recognizes the need for effective treatment interventions (the ultimate intercept). Some evidence based practices appropriate for the target population include Multidimensional Family Therapy for Adolescents (MDFT), Motivational Interviewing (MI), Multisystemic Therapy (MST), Functional Family Therapy, Multidimensional Treatment Foster Care (MTFC) and Assertive Community Treatment Teams (ACT). See Attachment K for a more thorough discussion of these interventions.

The full literature review can be found at the following web address:

<http://www.hhs.state.ne.us/beh/NEJusticeMHInitiative-LiteratureReviewReport06102008.pdf>

IV. Strategies

Initially at the December planning meeting, 14 recommendations were identified. The Justice Behavioral Health Steering Committee considered these recommendations and developed five priority areas. Three work teams were chartered to develop strategies about each of the five priority areas. The Strategies and timelines were then reviewed at the October 2008 strategic planning meeting and recommendations for changes were made (An overview of the changes to the original five priority areas can be found in Appendix K). These changes were incorporated into the final work plan and timelines. The following goals and objectives are the result of this work.

Goal 1: Provide statewide Crisis Intervention Team (CIT) training for Law Enforcement officers and make clear linkages with local crisis response teams.

CIT training has been adopted in parts of the state, particularly the Omaha metropolitan areas; however, CIT training is lacking in many parts of the state and often law enforcement officers are not linked to community services. The whole community benefits when there are trained law enforcement officers who understand the signs and symptoms of mental illness and know how to make referrals and involve local community providers for the purpose of diversion. In addition, other juvenile justice personnel such as probation, parole officers, and jail personnel benefit from CIT training. Our goal is to train 20 law enforcement officers, 50 probation officers and 50 parole officers in the initial training.

- Objectives:
- 1.1 Build on CIT training curriculum and adapt for rural areas and various professions (parole, probation, jail personnel, etc.)
 - 1.2 Expose Region/Law enforcement teams to CIT model and proposed modifications for customized delivery
 - 1.3 Evaluate customized training programs with core knowledge components
 - 1.4 Sustain statewide crisis intervention training for law enforcement

Goal 2: Expand or improve access to crisis stabilization services with improved coordination with law enforcement officers.

There are crisis services available in each of the six behavioral health regions; however, often law enforcement is not aware of which facilities have beds available causing problems for persons with mental illness in crisis. At this time, it falls on the law enforcement officials to search for a bed, which takes valuable patrol time and can be very disruptive for consumers in crisis. When law enforcement cannot locate an inpatient bed, jails can become a default placement if there is a chargeable offense. Centralized coordination of local crisis response duties among law enforcement, Crisis Response

Teams and Emergency Inpatient Facilities can ensure timely transport and effective utilization of crisis beds, while each Regional Health Authority can develop a strategy to track bed availability and capacity issues. We estimate the crisis pilot will affect between 100 and 200 individuals in crisis during the first year.

- Objectives:
- 2.1 Refine model for crisis intervention for transition aged youth through consultation with national expert.
 - 2.2 Pilot model for crisis intervention coordination in one community based on local plan for 100 – 200 individuals
 - 2.3 Study impact of crisis intervention pilot
 - 2.4 Implement crisis intervention model statewide
 - 2.5 Implement strategies for sustaining crisis programs

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

Many of Nebraska jails are utilizing some form of screening, but clear identification of mental health risk and needs is not consistently being done nor are there clear linkages to services. We anticipate that the standardized screening will be provided to every inmate in all 80 Nebraska jails and detention centers by the beginning of the second year.

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

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

Forensic Intensive Case Management services are appropriate along the entire Sequential Intercept Model. Forensic case management and diversion programs as key components in the community mental health system can prevent people with mental illness from entering the justice system. Forensic case management is essential to help broker the multiple service systems that may be part of an individual’s reentry plan. In addition, close coordination with probation and parole is required so the service and supervision is coordinated.

- Objectives:
- 4.1 Adopt lessons learned from Nebraska’s two urban jail diversion programs to develop a rural model
 - 4.2 Pilot rural jail diversion program for transition aged youth in one area of the state in coordination with crisis response teams
 - 4.3 Examine service definitions for community support/case management and examine financing approaches for sustainability
 - 4.4 Study impact of jail diversion pilot
 - 4.5 Implement coordinated jail diversion programs in other areas

- 4.6 Implement strategies for sustaining jail diversion programs through 2009 – 2010 contracts

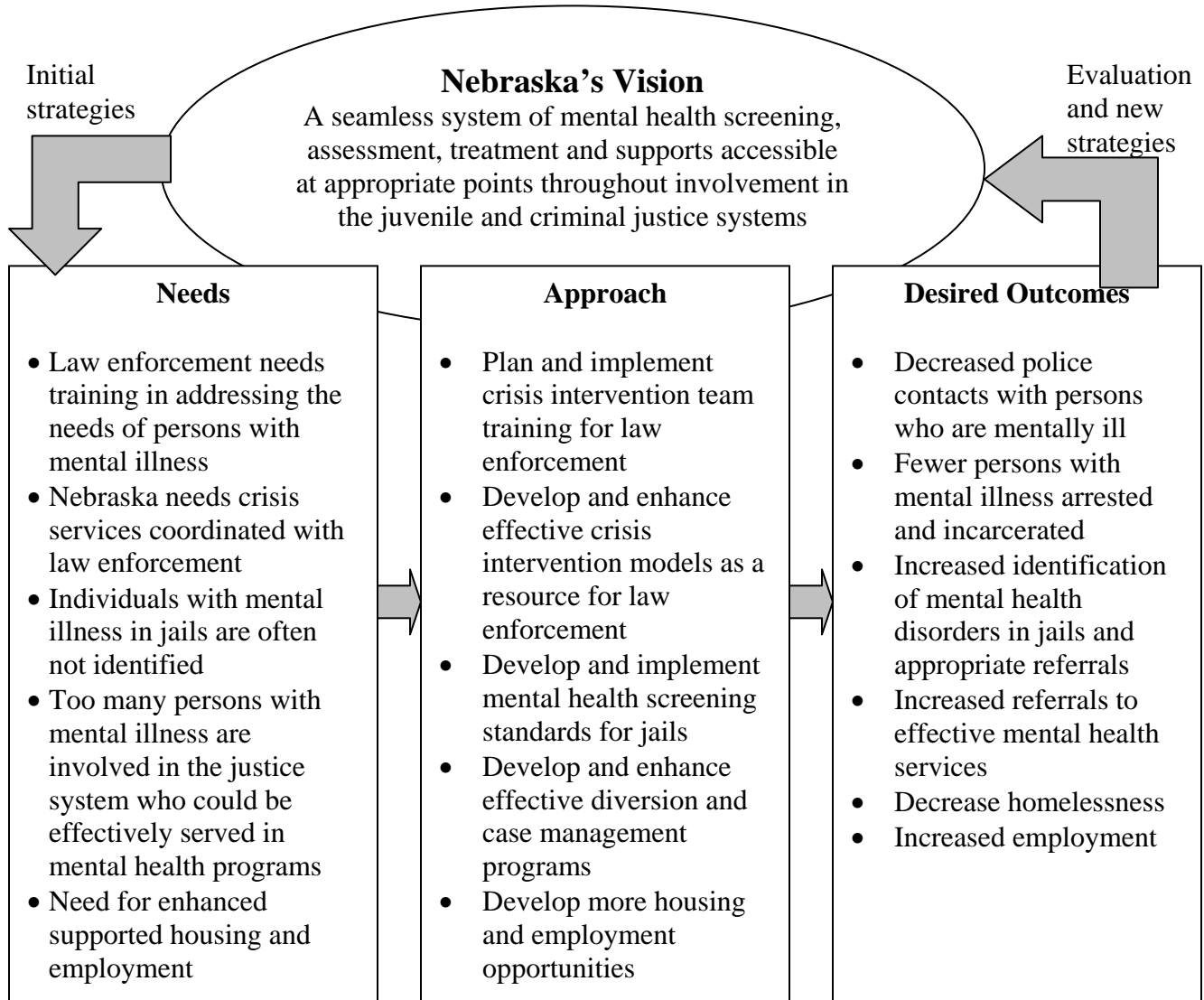
Goal 5: Enhance affordable supportive housing for justice involved youth transitioning to adulthood.

Affordable and sustainable housing is important to decrease recidivism and provide the necessary supports for people with mental illness. Data collected in Nebraska indicates supported housing is a cost effective intervention and can prevent more costly crisis and shelter services. Strategies to help ensure housing for persons with mental illness include the use of Forensic Case Managers to coordinate support, provide Rent-Wise education for renters, have discharge planners utilize websites to assist with housing plans, develop an affordable housing website and link the statewide effort with Omaha’s continuum on homelessness 10 year plan. The Nebraska Housing Related Assistance program is designed to address the housing cost burden for adults who are extremely low income with a serious mental illness. The resources from the Mental Health Justice Collaboration grant will allow Nebraska to expand its training and coordination effort resulting in lower homeless rates for persons with mental illness.

- Objectives:
- 5.1 Collaborate with Nebraska’s Action Plan For Increasing Access to Mainstream Services for Persons Experiencing Chronic Homelessness to identify individuals in Department of Correctional Facilities with mental illness ready for release
 - 5.2 Develop protocols for developing housing plan and linking individuals with supported housing, case management and supported employment including assessing for Medicaid eligibility for both urban and rural areas
 - 5.3 Pilot protocols in Omaha area and a rural location for 250 transitioning young adults beginning at age 17
 - 5.4 Connect to Rent-Wise coalition to provide education for 150 consumers in the urban and rural pilot sites
 - 5.5 Study impact of pilot sites
 - 5.6 Implement statewide

These strategies incorporate a process to provide standardized screening across Nebraska’s 80 local jails and correctional facilities using a screening instrument validated through the GAINS center. The Jail Standards Division is represented on the Steering Committee for this initiative and has the authority to make regulatory changes and provide technical assistance in implementation. The project will develop a process for connecting individuals with mental health disorders to appropriate mental health services including crisis response teams and mental health diversion programs. One of the features of these programs is intensive forensic case management, which helps connect consumers to both formal services and informal supports offered through faith based and community organizations and helps coordinate other benefits for which the consumer is eligible. The project will establish a process for transition planning from correctional facilities to community re-entry focusing on linkages to behavioral health programs, including

services for individuals with co-occurring disorders and support services including supported housing and employment. The project will also focus on providing CIT training for law enforcement officers, probation and parole officers, and jail personnel, which will allow justice professionals to understand, identify and appropriately respond to the needs of persons with mental health disorders. The following diagram provides a logic model depicting the linkages among project vision, needs, strategies and anticipated outcomes of the initiative.



In addition to the strategies around the five priority areas, work teams and strategic planning participants proposed additional cross cutting strategies that would apply across the five priorities. The recommendations are presented below with the methods to address the recommendations in italics.

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.*

The Initiative should focus on the development of peer relationships with the target population. *Each work team and the Steering Committee will have consumer representation and will examine strategies for developing peer relationships. The Initiative will also partner with other planning and implementation processes to explore opportunities for enhancing peer support for the target population.*

The Justice Behavioral Health Initiative should address cultural and linguistic competence. *Each work team will be asked to address cultural and linguistic competence as it refines the action steps. The Initiative will also partner with other efforts that are addressing cultural and linguistic competence such as the Child and Adolescent Behavioral Health State Infrastructure Grant.*

Outlined below are the five priority areas (goals), action steps (objectives), activities, groups and individuals responsible for carrying out the activities, and the timelines for completion. The work plan and timeline is considered a fluid document and will be modified as work progresses and new opportunities emerge.

Work Plan and Time Lines			
Objective	Activities	Responsibility	Completion Date
Goal 1: Provide statewide crisis intervention training for Law Enforcement officers and make clear linkages with local crisis response teams			
1.1 Build on CIT training curriculum and adapt for rural areas and various professions (parole, probation, jail personnel, etc.)	1. Review Omaha training curriculum 2. Develop training curriculum guide for rural areas 3. Incorporate consumer voice in training 4. Disseminate curriculum guide for review 5. Make modifications and finalize	Crisis Work Tm PPC Off Cons Affairs BH Region BH Region	12/08 3/09 3/09 4/09 5/09
1.2 Expose Region/Law enforcement teams to CIT model and proposed modifications for customized delivery	1. Support attendance of 6 individuals at CIT training in Omaha 2. Contract to prepare standardized knowledge modules for delivery in customized training programs 2. Convene (via teleconference) interested Region(s) and their partners (law enforcement, consumers, families, providers) to discuss plans for customizing curriculum 3. Pilot customized curriculum in interested Region(s)	PPC & Alegent. PPC PPC, BH Region BH Region	11/09 5/09 6/09 8/09
1.3 Evaluate customized training programs with core knowledge components	1. Develop evaluation design 2. Collect data and conduct interviews 3. Develop evaluation report	PPC PPC PPC	6/09 8/09 10/09
1.4 Sustain statewide crisis intervention training for law enforcement	1. Disseminate evaluation results 2. Embed knowledge modules with Regions and law enforcement training entities across the state 3. Involve Regional coordinators of customized training in dissemination to other groups	PPC BH Regions BH Regions	11/09 5/10 8/10

Goal 2: Expand or improve access to crisis stabilization services with improved coordination with law enforcement officers			
2.1 Refine model for crisis intervention for transition aged youth through consultation with national expert. Build on existing models of crisis intervention in the regions for transition aged youth.	1. Identify national consultant Establish statewide meetings to look at existing models and resources in the regions. Follow principles of 1) one point of entry; 2) case management/mediator to facilitate transition; 3) model needs to be flexible – appropriate for the location based on resources available; 4) 24/7 availability 5) determine who pays for what; 6) custodial legality, regulatory analysis, influence of guardianship; 7) identify crisis levels; 8) HIPPA – sharing of info 9) logistics of placement.	DHHS - DBH DHHS, DBH, PPC, Regions, Agencies, Regional Emergency Coordinators, Stakeholders, Consumers	12/08
	2. Assess needs of the regions	DHHS	1/09
	3. Agree on a model	DHHS - DBH	5/09
	4. Report outlining model	DHHS - DBH	7/09
2.2 Pilot model for crisis intervention coordination in one community based on local plan for 100 – 200 individuals	1. Select pilot site based on regional plans	Steering Comm.	3/09
	2. Agreement with Regional Behavioral Health Authority	DHHS - DBH	6/09
	3. Conduct training of crisis response teams	DHHS - DBH	10/09
	4. Conduct training with law enforcement, parole, probation, and jails	DHHS - DBH	12/09
	5. Begin new service model in one region	BH Region	2/10
	6. Develop communication plan and coordinate within the community	BH Region	2/10
2.3 Study impact of crisis intervention pilot	1. Develop evaluation design	PPC	12/09
	2. Collect data and conduct interviews	PPC	6/10
	3. Conduct cost benefit analysis	PPC	7/10
	4. Analyze data and develop evaluation report	PPC	7/10

2.4 Implement crisis intervention model statewide	1. Conduct train the trainers in each region	DHHS - DBH	8/10
	2. Train crisis response teams in each region	DHHS - DBH	10/10
	3. Train law enforcement, parole, probation, and jail personnel in each region	DHHS - DBH	10/10
	4. Monitor implementation Monitor implementation and sustain on-going training.	Steering Comm.	Ongoing
2.5 Implement strategies for sustaining crisis programs	1. Conduct review of other state efforts	Crisis Work Tm	1/10
	2. Review Medicaid/BH service definitions	Crisis Work Tm	2/10
	3. Review Medicaid coverage for medications	Crisis Work Tm	3/10
	3. Cost analysis for Medicaid coverage	Crisis Work Tm	3/10
	4. Make necessary changes in policies	DHHS	7/10
5. Incorporate into contract	DHHS	7/10	

Goal 3: Implement standardized mental health and substance abuse screening instruments in the jails that prompt referrals for services			
3.1 Refine plan for standardized screening and assessment process	1. Review planning work team product <ul style="list-style-type: none"> • Screenings considerations should include issues of: • Application and validation with diverse groups of individuals (e.g. gender, race, etc.) • Consider validity of screenings translated into other languages. • Ability of non-mental health professionals to give the screenings (i.e. need to be designed with typical jail personnel in mind) • Screenings need to be appropriate for various locations across the state (rural vs. urban etc.) • Instrument should screen for several things (e.g. Fitness for confinement, health/mental health screenings, medication, and suicide assessment). 	Steering Comm.	12/08
	2. Agree on standard screening instrument/protocol <ul style="list-style-type: none"> • Collaborate with Jail Standards Board 	Crime Commiss	2/09
	3. Consultation in developing protocols <ul style="list-style-type: none"> • Collaborate with Jail Standards Board 	Travis Parker	3/09
	4. Review by consumer groups	Off Cons Supp	4/09
	5. Disseminate to 80 local jails and obtain feedback	Crime Commiss.	6/09

3.2 Incorporate processes into Nebraska jail standards	1. Develop draft standards • Collaborate with Jail Standards Board	Crime Commiss	7/09
	2. Public review	Crime Commiss	9/09
	3. Finalize standards	Crime Commiss	12/09
3.3 Develop and provide training and technical assistance for jail personnel	1. Develop training curriculum	Travis Parker	12/09
	2. Train Jail Standards Division Staff in standards	Crime Commiss	1/10
	3. Provide technical assistance to local jails	Crime Commiss	2/10
	4. Incorporate technical assist materials on web site	Crime Commiss	4/10
3.4 Evaluate impact of change in standards	1. Develop evaluation design	PPC	9/09
	2. Collect data	PPC	9/10
	3. Issue evaluation report	PPC	12/10
Goal 4: Increase resources to community mental health to provide diversion services through the use of Forensic Intensive Case Management			
4.1 Adopt lessons learned from Nebraska's two urban jail diversion programs to develop a rural model	1. Hold lessons learned forum for two sites	Diversion Team	1/09
	2. Develop lessons learned report	Travis Parker	2/09
	3. Examine how staffing (based on availability and/or shortages) and training might differ in rural areas from urban areas	Diversion Team	02/09
	4. Disseminate report to stakeholders, including members of the Unicameral who are interested	Diversion Team	4/09
	5. Reviews and revisions of the report by rural professionals, law enforcement officials, consumers, etc. prior to any action steps being initiated	Diversion Team	04/09
4.2 Pilot rural jail diversion program for transition aged youth in one area of the state in coordination with crisis response teams	1. Conduct national review of best practices	Diversion Team	1/09
	2. Develop rural model with a focus on transitional age youth	Diversion Team	2/09
	3. Include "rural members" on Diversion Team	Diversion Team	02/09

	4. Establish partnerships with Native American Tribes	Diversion Team/ Larry Voegele	02/09
	5. Review of model by consumers and family members	Off Cons Supp	3/09
	6. Review regional plans to determine location	Steering Comm	3/09
	7. Select site	Steering Comm	3/09
	8. Obtain agreement on roles and responsibilities	DHHS/BH Reg	6/09
	9. Implement pilot	BH Region	7/09
4.3 Examine service definitions for community support/case management and examine financing approaches for sustainability	1. Conduct review of other state efforts	Travis Parker	3/09
	2. Review Medicaid/BH service definitions	Diversion Team	4/09
	3. Examine roles and definitions of Forensic Intensive Case Management, Re-entry Case Management, etc.	Diversion Team	04/09
	4. Cost analysis for Medicaid coverage	Diversion Team	5/09
	5. Make necessary changes in policies	DHHS	7/09
	6. Incorporate into contracts	DHHS	7/09
4.4 Study impact of jail diversion pilot	1. Develop evaluation design	PPC	3/09
	2. Collect data	PPC	12/09
	3. Issue evaluation report	PPC	3/10
4.5 Implement coordinated jail diversion programs in other areas	1. Review local plans for regional role out	Steering Comm	1/10
	2. Examine resource development and capacity building	Steering Comm.	1/10
	3. Incorporate in regional contracts	DHHS	7/11
	4. Implement diversion protocols	BH Regions	7/11
4.6 Implement strategies for sustaining jail diversion programs through 2009 – 2010 contracts	1. Conduct review of other state efforts	Diversion Team	6/09
	2. Review Medicaid/BH service definitions	Diversion Team	10/09
	3. Cost analysis for Medicaid coverage	Diversion Team	1/10
	4. Make necessary changes in policies	DHHS	7/11
	5. Educate policy makers, prosecutors, public defenders, judges, and state senators	Diversion Team/ DHHS	7/11

	6. Incorporate into contracts	DHHS	7/11
--	-------------------------------	------	------

Goal 5: Enhance affordable supportive housing for justice involved youth transitioning to adulthood			
5.1 Collaborate with Nebraska’s Action Plan For Increasing Access to Mainstream Services for Persons Experiencing Chronic Homelessness to identify individuals in Department of Correction Facilities with mental illness ready for release	1. Review Action Plan	Housing Team	12/08
	2. Review data of discharging youth from YRTC Kearney, Geneva, and the Omaha Facility for youth charged as adults, and DHHS youth D/C from state custody. <ul style="list-style-type: none"> Use data to determine location for rural pilot site 	Housing Team	2/09
	3. Develop review protocols for DCS facilities		
	4. Organize consumer review of protocols	Off Cons Affairs	3/09
	5. Pilot protocols	DCS/YRTCs/D HHS	7/09
	6. Ongoing collaboration between DCS facilities and Community Service Providers on referral procedures	DCS/Comm serv providers	8/09
5.2 Develop protocols for developing housing plan and linking individuals with supported housing, case management (vital service), and supported employment including assessing for Medicaid eligibility for both urban and rural sites.	1. Conduct national review of promising practices <ul style="list-style-type: none"> Include models using mentors and/or peer support. Consider family housing needs Address barriers (e.g. felony convictions) to housing through flexible resources (i.e. state rental assistance) 	Housing Team/PPC?	1/09
	2. Identify and connect with stakeholders in Omaha and rural project site (e.g. transitional living services and supported housing services, case management and supported employment for youth and adults). <ul style="list-style-type: none"> Work with Independent Living Plan (Omaha) to coordinate processes 	Housing Team	2/09

	3. Develop model for supported housing and supported employment 4. Organize consumer review of model 5. Implement process in pilot areas	Off Cons Affairs Pilot Project Leaders	3/09 8/09
5.3 Pilot protocols in Omaha area and a rural location for 250 transitioning young adults (beginning at age 17).	1. Train Independent Living Plan case managers • Include information on getting a current mental health status exam prior to terminating state ward status to facilitate access to adult services planning. 2. Pilot test protocols 3. Review and modify protocols	Housing Team/Pilot Project Leaders Pilot Project Leaders Housing Team/Pilot Project Leaders	8/09 1/10 4/10
5.4 Connect to the Rent-Wise coalition to provide education for 150 consumers in the urban and rural pilot sites.	1. Conduct train the trainers on Rent- Wise Education	Housing Team/Rent-wise coalition	8/09
	2. Develop public information materials	Housing Team/Rent-wise coalition	8/09
	3. Convene interested landlords in pilot areas to learn about Rent-Wise	Housing Team/Rent-wise coalition	10/09
	4. Train persons transitioning from DCS facilities	DCS	12/09
5.5 Study impact of pilot sites.	1. Develop evaluation design 2. Collect data 3. Develop and disseminate evaluation report	PPC/NCFE PPC/NCFE PPC/NCFE	6/09 12/09 3/10

5.6 Work with Children and Family Foundation and Omaha area foundations to sustain and implement statewide	1. Meet with five Omaha foundations and Children and Families Foundation	Housing Team	6/10
	2. Develop sustainability plan	Housing Team	9/10
	3. Implement plan	Steering Comm	3/11
5.7 Implement statewide	1. Provide information to each mental health region	Housing Team	10/10
	2. Identify role out plan	Housing Team	1/11
	3. Conduct train the trainers	Housing Team	3/11
	4. Implement statewide for DCS inmates	Steering Comm	6/11

Attachment A

**JOINT CRISIS WORK GROUP FOR
NEBRASKA JUSTICE BEHAVIORAL HEALTH
NEBRASKA CHILDREN'S BEHAVIORAL HEALTH**

PURPOSE: The crisis work group will focus on the state infrastructure needed to meet the behavioral health crisis needs of youth in transition to adulthood (ages 17-24) in Nebraska.

BACKGROUND: The Nebraska State Strategic Partnership Summit Report (November 15, 2007) recommended formation of a work team as a follow up to the work done by the group around improving the emergency protective custody process in Nebraska. The children's mental health state infrastructure grant activities includes goals related to improving the crisis response system for children and youth in transition to adulthood in the 2007-2008 and 2008-2009 work plans. The Nebraska Justice Behavioral Health planning grant follows the intercept model which identifies the first contact between law enforcement a person in behavioral health crisis as a critical time for intervention and diversion from the justice system. The convergence of all of these state initiatives is recognized through the charter of this work group. The initial focus of this work is identified as youth in transition to adulthood.

CHARGE: Recommend a strategy to prevent detention by law enforcement of youth in transition to adulthood with behavioral health crises and serve them in community settings.

1. Identify implementation steps for moving the proposed strategy to action including:
 - a. Outcome measurements to gauge success
 - b. Description of how existing State and Regional resources can be used or enhanced for implementation of recommendations
 - c. Description of existing funding structures that can be used for implementation of the recommendations
 - d. Timeline for full implementation of recommendations
 - e. Infrastructure needs associated with implementation steps (State and Regional)

TIMELINE: April – August 2008

ROLES:

The University of Nebraska Public Policy Center will provide facilitation, background support and meeting minutes. Recommendations will be reported to the Division of Behavioral Health and forwarded to the Children's mental health state infrastructure steering committee and the Nebraska Justice Behavioral Health Steering Committee. The Work Group will coordinate with the Community Corrections Council Behavioral Health Committee.

PROPOSED MEMBERS:

- Cpt. Joe Wright, Lincoln Police Department & State Police Academy Trainer
- Cpt. Gregg Ahlers, Hall County Sheriff's Office
- Sgt. Colene Hinchey, Omaha Police Department
- Lt. Dennis Leonard, Nebraska State Patrol
- Linda Krutz, Community Corrections
- Michael Jones, Sarpy County Attorney's Office
- Mary O'Hare, NDHHS
- Dan Powers, NDHHS
- Blaine Shaffer, NDHHS
- Vicki Maca, NDHHS
- Corey Steel – State Probation
- Regional Behavioral Health Authority(s)
 - Calvin Prouty, I
 - Robyn Schultheiss II
 - Beth Reynolds, III
 - Melinda Crippen IV
 - Kristin Nelson V
 - Dennis Snook VI
- Ron Namuth, Nebraska Recovery Network
- Candy Kennedy, Nebraska Federation of Families
- Alan Green, Nebraska Mental Health Association

Attachment B

Nebraska's Justice Behavioral Health Planning Initiative

**Diversion/Screening Work Group
Wednesday August 6, 2008; 10:00 – 12:00
University of Nebraska Public Policy Center
215 Centennial Mall South, Suite 401, Lincoln, NE**

AGENDA

- | | |
|---|------------|
| I. Welcome and Introductions | 5' |
| II. Progress on Justice BH Initiative | 15' |
| A. Initial Strategic Plan | |
| B. Literature Review | |
| C. Needs Assessment | |
| D. Regional Planning | |
| E. State Work Teams | |
| F. Grant Application | |
| G. October Conference | |
| III. Overview of Proposed Diversion/
 Screening Strategies | 30' |
| IV. Upgrades to Strategies | 60' |
| A. Are the strategies right? –
 additions, deletions, changes | |
| B. Are the action steps right? | |
| C. Are there other groups/people who
 should be involved? | |
| D. Is the project timeline reasonable? | |
| E. How will we measure our success? | |
| V. Questions/Next Steps/Adjourn | 10' |

Attachment C

JUSTICE BEHAVIORAL HEALTH HOUSING WORK GROUP

PURPOSE: The Justice Behavioral Health Housing Work Group will develop strategies to ensure affordable supportive housing for youth in transition to adulthood (ages 17-24) in Nebraska.

BACKGROUND: There was widespread agreement during the December 2007 Justice Mental Health Summit about the importance of affordable and sustainable housing to decrease recidivism and provide the necessary supports for people with mental illness involved in the justice system. There was also recognition that meaningful employment is important to reduce recidivism and increase the ability of the target population to afford appropriate housing.

CHARGE: Develop strategies to assess affordable housing and ensure supportive housing and supportive employment for individuals transitioning from youth to adult services who are involved in the justice system across the five intercepts. Conduct a feasibility analysis to prioritize strategies. Identify implementation steps for priority strategies. Identify resources needed to implement strategies. Identify outcome measures to gauge success. Identify infrastructure needs associated with implementation steps.

TIMELINE: April – August 2008

ROLES: The University of Nebraska Public Policy Center will provide facilitation, background support and meeting minutes. Recommendations will be reported to the Division of Behavioral Health and forwarded to the Children's Behavioral Health State Infrastructure Steering Committee and the Nebraska Justice Behavioral Health Steering Committee. Recommendations from the Work Group will be made to the Director of the Department of Health and Human Services Division of Behavioral Health and the Justice Mental Health Steering Committee. The Work Group will coordinate with the Community Corrections Council Behavioral Health Committee.

MEMBERSHIP:

State Government

Jean Chicoine - DHHS Division of Children and Family Services -
Jim Harvey - DHHS Division of Behavioral Health
Ken Mossenback - Department of Corrections
Joni Minor - Department of Education – Voc Rehab
Joel McCleary DHHS Office of Consumer Affairs
Mary Visek – State Probation (Omaha)
Betty Medinger – DHHS Division of Children and Family Services

Providers

Gale Jungeman-Schulz - Lutheran Family Services – The Bridge
Dennis Hoffman - Center Point
Suzanne Blue - Matt Talbot

Behavioral Health Regions

John Turner - Region 5
Denise Anderson - Region 3
Alice Drake – Region 6

Others

Jennifer Scala – Nebraska Children and Families Foundation
Diana Waggoner – Kim Foundation
Eric Evans – Nebraska Advocacy Services
Michael Snodgrass – Lincoln Housing Association
Conan Schafer - Lincoln Police Department
David Thomas - Omaha Housing Committee
Gay Flandis –Lincoln Housing
Bob Peterson - Homebuilders
Elizabeth Dugger – SPEAK OUT

Attachment D

**Nebraska Justice Behavioral Health Statewide Strategic Planning Meeting
October 10, 2008; 9:00 – 4:00
Country Inns and Suites
Lincoln, NE**

VISION: A seamless system of behavioral health screening, assessment, treatment and supports accessible at appropriate points throughout involvement in the juvenile and criminal justice systems

PURPOSE: To provide input on Nebraska’s Draft Strategic Plan 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.

DESIRED OUTCOMES OF THE MEETING:

- 1. Understand the urgency of addressing these critical issues in Nebraska**
- 2. Understand planning and implementation efforts at the regional level**
- 3. Understand the proposed strategies in the five priority areas**
- 4. Understand agency perspectives and background on justice behavioral health**
- 5. Improve the strategies as part of Nebraska’s Strategic Plan**
- 6. Identify additional strategies and action steps**

AGENDA

- I. 9:00 – 9:15** Welcome and overview of day – Jim Harvey
Importance of addressing the issue of behavioral health in justice populations
 - Scot Adams – Department of Health and Human Services
 - Bob Houston – Department of Correctional Services

- II. 9:15 – 10:00** Regional Planning and Implementation
 - Region 1 – Pamela Richardson
 - Region 2 – Corey Brockway
 - Region 3 – Melinda Ferritor and Denise Anderson
 - Region 4 - Ingrid Gansebom or Melinda Crippen
 - Region 5 – Linda Wittmus
 - Region 6 – Taren Petersen

- III. 10:00 – 10:30** Overview - Strategic Planning Process – Mark DeKraai
 - Planning Framework
 - December planning meeting

- Literature Review
 - Needs Assessment
 - Priority Areas
 - Proposed Strategies
 - Initial Implementation Efforts
 - Planning and Implementation Grant
- IV. 10:30 – 10:45 BREAK**
- V. 10:45 – Noon Brief Perspectives of System Partners – Panel**
- DHHS Behavioral Health – Scot Adams
 - Corrections – Bob Houston
 - DHHS Children & Family Services – Terri Nutzman
 - Community Corrections Council – Linda Krutz
 - Probation – Steve Rowoldt
 - Homeless Assistance – Betty Medinger
 - American Indian Tribes – Larry Voegele
- VI. 12:00 – 1:00 Working Lunch (provided) – Homeless Video – Betty Medinger**
- VII. 1:00 – 1:15 Opening Remarks for the afternoon**
- Jim Harvey
- VIII. 1:15 – 2:45 Round Robin Discussion on each of the Five Strategies (Five content experts facilitate each strategy – five groups rotate across five strategies to provide feedback)**
- Crisis Intervention Training – Denise Bulling
 - Crisis Services – Peg Barner
 - Diversion – Travis Parker
 - Jail Screening - Denny Macomber
 - Housing – Betty Medinger
- IX 2:45 – 3:00 BREAK**
- X. 3:00 – 3:30 Report Back**
- Facilitators summarize feedback for each strategy
- XI. 3:30 – 3:50 Facilitated Group Discussion of Additional Strategies**
- XII. 3:50 – 4:00 Next Steps and Adjourn**
- Summary of next steps – Jim Harvey
 - Overall comments from participants
 - Adjourn

Attachment E

Opening Remarks by Scot Adams

Nebraska Justice Mental Health Statewide Strategic Planning Meeting October 10, 2008 approximately 9:10 – 9:15

THEME:

Understand the urgency of addressing the critical issues of Justice and Behavioral Health in Nebraska by Scot Adams – DHHS Division of Behavioral Health

Welcome. Thank you for taking your time to join us today. I expect we will have a very productive meeting. While on an individual basis we may look at only the current situation, it is important on days like today to look at a longer view. We are not the first leaders and advocates trying to address the difficult issues involving Justice and Behavioral Health in Nebraska.

Let me provide you a brief history of mental health services in Nebraska. Before Nebraska became a state, arrangements were made with Iowa to care for people with mental illness. Using the language at that time, in 1865, nine of Nebraska's insane were admitted to the asylum located at Mount Pleasant, Iowa. Nebraska then became a state in 1867. In 1869, the Nebraska legislature authorized the construction of a facility to care for mentally ill persons. In July 1870, Iowa was unable to further care for Nebraska's insane. Nebraska's governor was forced to move six of the incurable patients and confine them in the **Pawnee county jail** until the asylum at Lincoln was completed. The Nebraska Hospital for the Insane in Lincoln (later known as Lincoln Regional Center), was completed in December 1870, but was destroyed by fire the following April. A new building was eventually completed in 1872. The patients from the Iowa hospital and the **different jails throughout the state**, numbering thirty in all, were then moved to the new Lincoln facility. We as a state placed individuals with mental illness near, but not in population centers, in order to get a workforce but to keep us safe if any of "them" got out. The Norfolk Regional Center first opened in 1888 as the Norfolk Hospital for the Insane. The Hastings Regional Center first opened in 1889 as the "State Asylum for the Incurably Insane" in Ingleside, Nebraska. By 1890, the total census in the three Nebraska facilities was **681**.

Over the years the names changed. Finally, the inpatient census peaked in 1955 when the Nebraska reached a record high of **4,746 patients**. With new treatment approaches available, the behavioral health leaders and advocates then worked hard to change the system. By the end of the 1981 reporting period, there were **650 inpatients** in the three Nebraska Regional Centers. By the end of 2008, we have about **330 people** in occupied beds under a Mental Health Commitment, due to a court order, or are convicted sex offenders.

In a parallel fashion, some of them ended up in Corrections. Today, both systems are engaged in significant efforts to help persons with behavioral health disorders achieve success including integration within society because it makes clinical sense, it is economical, and it is the right thing to do.

LB 1083, passed in 2004 started another process in Behavioral Health Reform. Four years of efforts to create more community-based behavioral health services, so people can be served closer to their homes and families, paid off. The LB1083 Behavioral Health Reform focused on increasing access to community-based care, moving people from Regional Centers to local care, and preventing people from being institutionalized whenever appropriate. Under LB 1083

Behavioral Health Reform, \$30.1 million was transferred from Regional Centers to Community based behavioral health services.

So, here is the problem. I do not want places like homeless shelters, local jails, and state prisons to become the replacement locations for people formerly served by the Regional Centers. Our goal with behavioral health reform was to improve the capacity of the community-based behavioral health services so people can be served closer to their homes and families. We are today's behavioral health leaders and advocates. This is our watch. The question is, what can we do in our time in NE to prevent shifting people out of community settings into these higher more restrictive, levels of care? We need your help today to find some of these answers for tomorrow.

Thank you.

Attachment F
Region 6 Presentation

Justice Mental Health Initiatives

Region 6 Behavioral
Healthcare

Strategy #1: Provide statewide Crisis Intervention Team (CIT) training for Law Enforcement officers and make clear linkages with local crisis response teams.

- CIT Training for 3 years
- Trained 187 Individuals
- Law Enforcement Officers, School Resource Officers, 911 Operators, Corrections Staff, etc.
- Starting Formal Evaluation Phase

Strategy #2: Expand or improve access to crisis stabilization services with improved coordination with law enforcement officers.

- New -April 2008 Lasting Hope Recovery Center
- New – July 2008 Sarpy Crisis Response Team

Strategy #3: Implement standardized mental health and substance abuse screening instruments in the jails that prompt referrals for services.

- DC Corrections Programs Housing
 - SSI, GAINS Short, Texas Christian University

Strategy #4: Increase resources to community mental health to provide diversion services through the use of Forensic Intensive Case management.

- April 2006 Douglas County Mental Health Diversion Program
- Intensive Case Management Services –
 - help establish independent living skills
 - help folks manage their mental illness
 - help reduce contacts with criminal justice system
 - no forensic insensitive case management

Strategy #5: Enhance affordable supportive housing for justice involved youth transitioning to adulthood.

- Not at this Time

Attachment G

Strategic Planning Process Presentation



NEBRASKA JUSTICE BEHAVIORAL HEALTH INITIATIVE

STRATEGIC PLANNING PROCESS




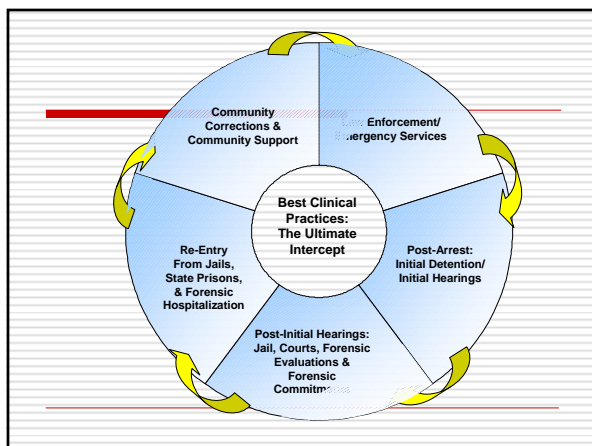
Department of Justice Justice Mental Health Program

- ❑ Designed to increase public safety through innovative cross-system collaboration for individuals with mental illness who come into contact with the criminal or juvenile justice systems.
- ❑ Supports the Sequential Intercept Model
- ❑ Promotes early intervention
- ❑ Supports communication across systems

Department of Justice Justice Mental Health Program

- ❑ Award Categories
 - Planning Grants - \$50,000 for 12 months
 - Planning and Implementation Grants - \$250,000 for 36 months
 - Implementation and Expansion Grants - \$200,000 for 24 months

The Sequential Intercept Model as a Planning Framework

Nebraska's Application

- ❑ Submitted December 12, 2006
- ❑ Applicants - The Nebraska Health and Human Services – Division of Behavioral Health Services, the Nebraska Department of Correctional Services and the Nebraska Commission on Law Enforcement and Criminal Justice

Nebraska's Application...

- An inclusive planning process focused on juveniles transitioning to adult services resulting in a Strategic Action Plan and implementation strategies for a sustainable, collaborative infrastructure across criminal justice, mental health and other relevant systems

Nebraska's Application...

- To improve the cross-disciplinary system of care for persons with mental illness who encounter the criminal justice system in Nebraska by strengthening early intervention efforts to mitigate recidivism and prevent persons, especially juveniles, from cycling through institutionalized settings throughout their lives

Nebraska's Application...

- Desired Outcomes
 - 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

December Meeting

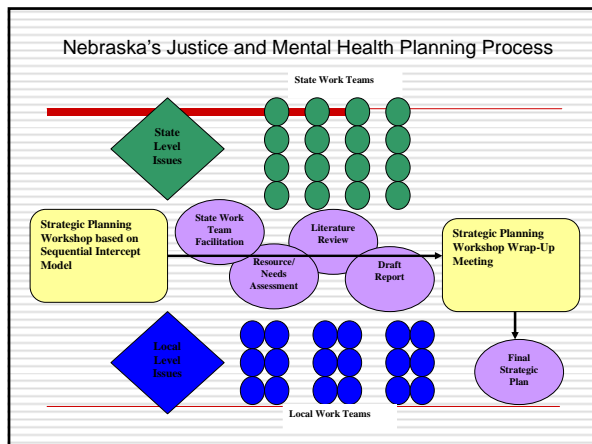
- Report available at:
 - http://www.hhs.state.ne.us/beh/NE_CriminalJusticeMHReport&Attachmts-Jan28_2008.pdf
- Process
 - Sequential Intercept Model and National Programs
 - Background information
 - Regional Planning –strengths, gaps, priorities
 - State issues
 - Strategic planning process

December Meeting Recommendations

1. Enhance local crisis response teams
2. Provide CIT training for law enforcement
3. Improve access - crisis stabilization beds
4. Form statewide committee on persons with mental illness in justice system
5. Follow up with regional planning
6. Enhance diversion and re-entry through forensic case management
7. Increase post-arrest diversion programs

December Meeting Recommendations

8. Implement standard screening in jails
9. Enhance trauma informed care and gender specific treatment
10. Improve re-entry planning and services prior to release from prisons and jails
11. Ensure affordable housing
12. Improve information sharing across systems
13. Expand consumer involvement
14. Address needs of veterans



Literature Review

- ❑ Available at:
 - <http://www.hhs.state.ne.us/beh/NEJusticeMHInitiative-LiteratureReviewReport06102008.pdf>
- ❑ CIT training is an evidence based practice
 - Good empirical support for urban areas
 - Requires access to emergency mental health services to be effective

Literature Review

- ❑ Crisis mental health services are effective when:
 - Visible location
 - Single point of entry
 - Streamlined and efficient intake for police officers
 - Cross training
 - Collaboration with justice system
- ❑ EBPs for Transitioning Youth – MST, FFT, MDTFC, MI

Literature Review

- ❑ Diversion programs are a promising practice
 - Pre-booking programs appear to be more effective than post-booking programs
 - Critical elements – good process for screening for behavioral health disorders, good evaluation for positive screens, good collaboration between diversion programs and justice professionals

Literature Review

- ❑ Good evidence for drug courts
- ❑ Some preliminary evidence for mental health courts, but not a uniform model
- ❑ Critical Time Intervention is promising practice – builds problem solving skills in transition back to community
- ❑ Preliminary empirical support for Forensic Assertive Community Treatment and Assess, Plan, Identify, Coordinate (APIC) for re-entry

Needs Assessment

- ❑ Available at:
 - <http://www.hhs.state.ne.us/beh/NEJusticeMHInitiative-Needs%20AssessmentReport06102008.pdf>
- ❑ Key Needs:
 - State corrections inmates have high rates of mental illness (31.4%) and substance abuse disorders (87.7%)
 - Local jails send “safekeepers” to state at a cost over \$1.32 million per year

Needs Assessment

- Needs...
 - Estimated 20% of individuals with mental illness released from prison are homeless
 - No standard mental health screening in jails and detention centers
 - Subpopulation cycle through correctional and mental health facilities: those with severe mental illness, substance abuse disorders, and personality disorders
 - Access to effective BH practices such as diversion, crisis services, re-entry programs

Needs Assessment

- Assets
 - CIT in Omaha
 - Diversion programs in Lincoln and Omaha
 - Adult crisis services
 - Nebraska Action Plan for Increasing Access for Persons Experiencing Homelessness
 - Omaha Youth Independent Living Program
 - Transition planning in regions
 - CA-SIG development of EBPs – FFT, MI, Outcome feedback, CIT

Goal 1: Provide statewide CIT training for Law Enforcement officers and linkages with local crisis response teams.

- 1.1 Build on CIT training curriculum and adapt for rural areas and various professions (parole, probation, jail personnel)
- 1.2 Conduct CIT train the trainers training
- 1.3 Study impact of training
- 1.4 Sustain statewide CIT training for law enforcement

Goal 2: Improve access to crisis stabilization services with improved coordination with law enforcement officers

- 2.1 Refine model for crisis intervention for transition aged youth through consultation with national expert
- 2.2 Pilot model for crisis intervention coordination
- 2.3 Study impact of crisis intervention pilot
- 2.4 Implement crisis intervention model statewide

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

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

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

- 4.1 Adopt lessons learned from Nebraska's two urban jail diversion programs to develop a rural model
- 4.2 Pilot rural jail diversion program
- 4.3 Examine service definitions for community support/case management and examine financing approaches for sustainability
- 4.4 Study impact of jail diversion pilot

Goal 4...

- ❑ 4.5 Implement coordinated jail diversion programs in other areas
- ❑ 4.6 Implement strategies for sustaining jail diversion programs

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

- ❑ 5.1 Collaborate with Nebraska's Action Plan to identify individuals in Department of Correction Facilities with mental illness ready for release
- ❑ 5.2 Develop protocols for developing housing plan and linking individuals with supported housing and supported employment including assessing for Medicaid eligibility

Goal 5...

- ❑ 5.3 Pilot protocols in Omaha area for transitioning young adults
- ❑ 5.4 Provide Rent-Wise Education for consumers
- ❑ 5.5 Study impact of pilots
- ❑ 5.6 Implement statewide
- ❑ 5.7 Study impact of Omaha Youth Transition Living Program
- ❑ 5.8 Work with Children/Family Foundation to sustain/implement statewide

Overarching Themes

- ❑ Improve data collection and coordination across services and systems
- ❑ Enhance consumer involvement
- ❑ Continue coordination across state agencies and between state and local efforts

DOJ Planning and Implementation Grant

- ❑ Project Period: 11/01/2008 to 10/31/2011
- ❑ Grant Funding: \$250,000 (\$100,000 year one; \$100,000 year two; \$50,000 year three)
- ❑ NE Theme: collaborative partnerships to address interagency coordination & communication in order to implement system improvements for persons with MI in the Criminal Justice System.
- ❑ Target Population: Young adults 18 to 24 years of age.

Attachment H
Probation Presentation

PROBATION

Level of Service Case Management Inventory

LS/CMI

- Criminal History
- Education/Employment
- Family/Marital
- Leisure/Recreation
- Companions
- Alcohol/Drug Problems
- Procriminal Attitude
- Antisocial Patterns

LS/CMI Flags

- Previous diagnosis of depression
- Suicide attempts/threats
- Low self-esteem
- Withdrawn
- Previous diagnosis of a mental disorder
- Evidence of Emotional distress

Officer Training

- LSCMI Training and Proficiency
- Motivational Interview Training and Proficiency
- Mental Health Training 8 hours (New Officers)
- Substance Abuse Training 8 hours (New Officers)
- Specialized Training for Officers

Probation Efforts

- Collaboration
- Hiring of LMHP and LADC Probation Officers
- Continued development of the Probation Management Information System

Community Corrections Council
Subcommittee is the
Justice Behavioral Health
Committee
JBHC

Standardized Model

- Consistent Screens
- Consistent Assessments/Evaluation
- Consistent Treatment
- Consistent Follow-Up
- Consistent System Connectivity
- Consistent Collection of Data

Nebraska Division of Alcoholism and Drug Abuse

Technical Review Report
April 30, 1993

"The Division on Alcoholism and Drug Abuse, State Probation Administration, Department of Corrections and Community-Based Services have been working for approximately two years to develop frameworks for integrating services at all levels of our systems and to coordinate institutional and community-based programming."

"Anecdotal reports indicate that Nebraska's probation and treatment systems probably have a serviceable working relationship. However, the lack of uniform guidelines and formal systems to coordinate and properly case manage offenders who are released into the community has created an "ad hoc" system. Such an ad hoc system is dependent on the good will and energy of each individual probation officer and each individual treatment provider to follow an individual through screening and assessment, evaluation, treatment admission, treatment tracking and discharge follow up. The limitations and liabilities of such a situation are obvious. In addition to the most immediate operational concerns, such an arrangement will not be able to accommodate the explosion of new information and techniques that are rapidly becoming accepted practice for offender case management, such as pretrial diversion, intermediate sanctions, community reintegration, etc."

Attachment I

Tribal Considerations Presentation



Tribal Partnerships: Some Basic Considerations

Larry Voegelé

NE DHHS Division of Public Health
Office of Minority Health and Health Equity

Summary

- Basic Demographics and DCS Data
- Considerations
- Preliminary Tribal Feedback & Next Step

Nebraska Population Estimates, 2007

	Number	Percent
White alone	1,625,144	91.6%
Black or African American alone	78,581	4.4%
American Indian and Alaska Native alone	17,576	1.0%
Asian alone	30,317	1.7%
Native Hawaiian and Other Pacific Islander alone	1,270	0.1%
Two or more races	21,683	1.2%
Hispanic or Latino	1,774,571	100.0%
	133,832	7.5%

Growth 2000 to 2007: American Indian over 3x higher (12.4% vs. 3.7%)

Nebraska DCS Data, 2007

	New Sentences and Revocations		Institutional Releases	
	#	%	#	%
White	1339	54.7%	1473	58.8%
Black	626	25.6%	587	23.4%
Hispanic	319	13.0%	303	12.1%
Native American	130	5.3%	125	5.0%
Asian	24	1.0%	15	0.6%
Other	8	0.3%	3	0.1%
Unknown	1	0.0%	0	0.0%
	2447	100.0%	2506	100.0%

American Indians and Alaska Natives in Nebraska Alone or in Combination 2007 Estimates

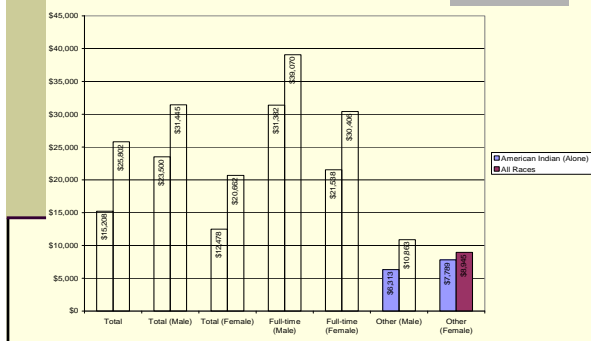


Source: U.S. Census Bureau Population Estimates Program

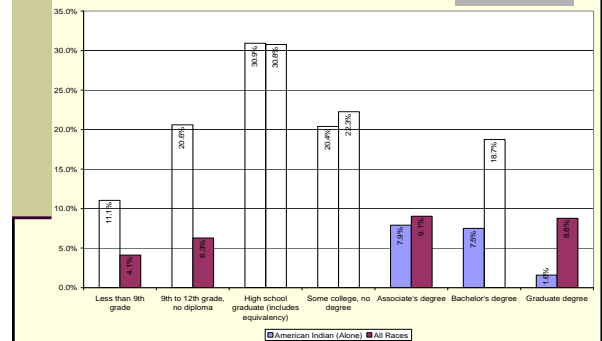
Poverty, 2007.



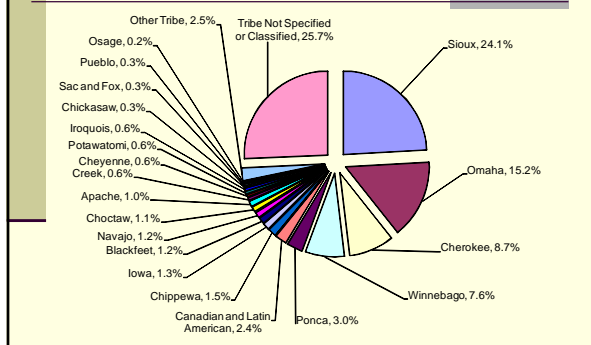
Median Earnings, 2007.



Education, 2007.



Tribal Affiliation of Residents

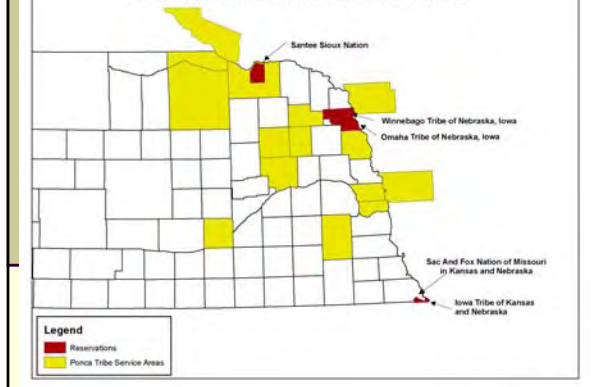


Tribe vs. Race

- Sovereign Entities
- Over 560 Federally Recognized Tribes
- Government-to-Government relationship
- 4 Headquartered in Nebraska (others with land here)



Federally Recognized Tribes of Nebraska Reservations and Ponca Tribe Service Areas



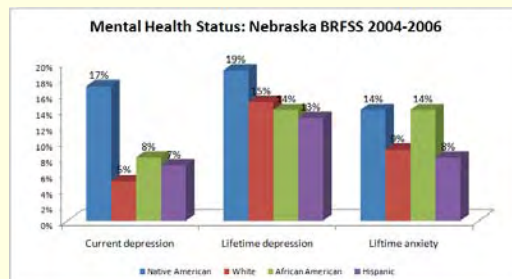
Mental Health and Substance Abuse among DCS intakes

- 40 % MH; 89% SA – FY 2008
- Data requested for American Indian Population

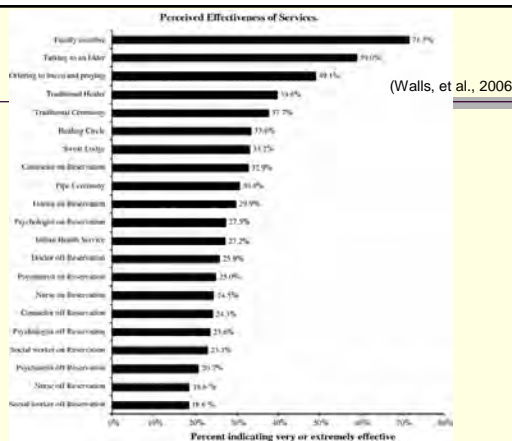
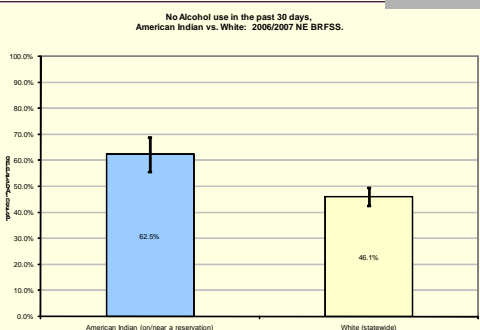
American Indian Mental Health and Substance Abuse

- Higher Rates of Mental Illness and Substance Abuse; and lower use overall
 - Alcohol Disorder (NSDUH, 2007) 10.7% vs. 7.6
 - Alcohol Use (NSDUH, 2007) 60.8% vs. 65.8
- Possible differences in screening/assessment and Tx
- Community and Cultural Strengths
 - Formal Tribal Behavioral Health / Substance Abuse Programs
 - Family, Elders, Sweat lodge, Talking circle, Spiritual practices (Some perceive as more eff.)
 - Protective Factors (e.g. Depression / Discrim.)

Depression and Anxiety Indicators



Alcohol Use On/Near Reservations



Tribal Law Enforcement

- PL 280 (1953) & Mandatory States
- Retrocession (Possible in 1968; can change)
 - Omaha (1970 – criminal, not mv, not civil)
 - Winnebago (1986 – criminal, not mv, not civil)
 - Santee (2001 – criminal and civil)
 - Why not Ponca (civil jurisdiction)
- Jurisdiction Complications (e.g. race, crime)
- Jail existence, capacity, percent of capacity
 - Omaha (2004): Peak 37, Max 32, POC 116%
- Rel. to corrections/Tx in other States / Fed

Initial Feedback (informal)

- Silence (Can't speak for Tribe)
- Most cases are Federal
- Tribes' place in Intercept Model needs to be examined
- Currently working with state inmates
- Currently working with offenders upon release (Treatment and Housing)
- Need to see statistical details
- Arrange local meetings involving Council and other Tribal Stakeholders
- Crisis Intervention Training likely useful
- Come and visit with us

Next Step

- Considerations Recap
 - Government to Government relations
 - State Intercept Model Appropriate?
 - Possible screening/assessment and treatment differences
 - Formal/Informal community resources
 - Current efforts, issues, and Interest in this partnership

- Formally initiate a dialogue with each of the Tribes of Nebraska

Contact Information

Larry A. Voegele

Nebraska Department of Health and Human Services
Division of Public Health
Office of Minority Health and Health Equity

402-471-9045

larry.voegele@dhhs.ne.gov

Attachment J

October 10, 2008 Meeting Notes

Crisis Intervention Team Training Meeting Notes

Group 1

- Question is research for CIT and rural use.
- If it's not "CIT" – call it something else.
- Look at CIT model parameters design and develop by community.
- Must incorporate consumer and family in developing CIT rural models and presenting.
- Relationships are important (professionals and consumers and families).
- Incorporate experiential pieces (visits to facilities and with consumers).
- Can protection and safety workers benefit from this? 911 operators and school officials?
- Should target first responders first.
- Maybe a "spinoff" and more specialized training for certain groups and not as long (not 40 hours), but maintaining a certain set of standards?
- Education is always good – but make sure we get this to cops.
- Collaboration and communication between agencies.
- Invite someone from Gering to Omaha for a consultation..
- Use a different term than "CIT" training.
- Evaluating training vs. evaluation of outcomes.
- Do those who need the training have enough time for the training?
- One size doesn't fit all rural areas – more community specific.
- Have common parameters and /or principles to work from.
- Law enforcement and professionals should "own it".

Group 2

- Define audience for this training – who gets this?
- Can you teach it in stages over a longer time frame? Maybe lower some resistance and increase motivation by catering to their needs.
- Ask Chief Cassidy to help. Could help you when it comes to the approach and manner of suggesting this training.
- Not just adult situation focused – what about youth? Do you treat those situations the same?
- Positive response from probation officers who have gone through this.
- Include probation and parole – should they train together with law enforcement officers as they will have different sets of standards?
- How do you select the trainers? Who is responsible for organizing the training?
- Not just training "new" folks but also the "veterans".
- How do you get volunteers in rural areas who may already be understaffed?

Group 3

- This type of training makes sense, but should consider where you hold the training.
- Adaption for rural areas - - who will look into that?
- Can you do a “facility” training? (Actually come into their facility so they don’t have to drive?)
- Can the PD pass along what they are seeing on to corrections so they can know what to look for when it comes their way?
- Something like a continuing education program would be helpful.
- First collect info about the types of crises that each area are seeing - - ask folks directly involved about what helped.
- Change the tone from a “could” take this training to one of “should” take this training. People can make it work in order to attend, just need to get creative about the how.
- Has this training been adapted to look at the different perspectives folks might encounter within a single city/town? (Tribal areas vs. South Omaha vs. North Omaha, etc.)
- What about those who work second and third shifts? Who will train them?
- Need different methods of delivery – online, videos, in person, etc.

Group 4

- Could part of this be a competency-based training? Do some online testing for existing skills and then also some on the job learning?
- Didactic and experiential stuff. Should include not only classroom training but also some in the field training.
- Needs to be flexible for rural areas.
- Community alliances are key components. Consumers and families help with curriculum development. They can say what works and what doesn’t.
- May meet more “systemic” resistance and not much “content” resistance.
- For Lincoln – it may be a matter of enhancing what already exists instead of adding another training session.
- Should remember that law enforcement is different in different areas!
- Ask individuals from each area for input. (Rural, frontier, and urban.)
- Adjust training for differing audiences
- Would federal agencies be helpful resources? (FBI, CIA, etc.)

Group 5

- Who are the targeted trainers? (“Coordinator” would be a good synonym for trainer.)
- What are other options for those who can’t do 40 hours away from home?
- Train a nurse, train the regions, train law enforcement, and they can share information from the pieces they were trained on. (Specialized training in sections and create “teams”.)

- Train the 6 regions and make sure they are accessible resources. They can act as interventionist and will be a 3rd party team. (This suggestion will still need to be adjusted for rural/frontier areas.)
- CIT coalition – a county coalition.
- Expand the language in section 1.2
- Coalition/collaboration
- More than 1.5hrs on consumer perspective.
- Crisis services and train the trainers (crossover).

Crisis Intervention Meeting Minutes

Justice Behavioral Health Meeting

October 10, 2008

Group 1 Notes: Crisis Services

- I. Look at existing models and resources in the regions. Then develop and implement communication.
- II. Coordination within community, know who to contact, who to go to
- III. Make sure there is one point of entry
- IV. Determine who pays for what
- V. Custodial issues—who can take over, regulatory analysis, influence of guardianship
- VI. HIPPA—the sharing of information, release form at the scene
- VII. Define crisis levels
- VIII. Increased & sustained funding
- IX. Case management/mediator
- X. flexibility

Group 2 Notes: Crisis Services

- I. Coordination within community—know who to contact, who to go to when crisis is occurring
- II. Training for law enforcement
- III. Make sure one point of entry (where are they going?, appropriate placement)
- IV. Determine who pays for what, no matter who initiates
- V. Look at standardized model for substance abuse
- VI. Coordination between hospitals and outsourcing, how to pay?
- VII. Increased and sustained funding
- VIII. Case management/mediator to facilitate transition
- IX. Publicity for services—outreach and education
- X. Define stabilization and intervention
- XI. Flexibility—appropriate for the location based on resources available
- XII. Priority to law enforcement double responsibilities
 - a. Ex: assault in bar involving
- XIII. Custodial issue—who can take over (legality)
- XIV. HIPPA sharing information, keeping law enforcement informed for during a crisis
 - a. Leeway in HIPPA
 - b. Release for at the scene
- XV. Define crises levels
- XVI. Who besides law enforcement can be the first to call
 - a. Ex. Domestic dispute

Group 3 Notes: Crisis Services

- I. How to build on the existing models of crises intervention in the regions
- II. Regulatory analysis—influence of guardianship

III. 2.1 crises stabilization, what is everyone doing/using

Group 4 Notes: Crisis Services

- I. Identify current models/resources, then assessing needs, then develop model & implement
 - a. Consumer input, what worked best
- II. 24/7 care
- III. Have the PPC do a lit. review and see what other states are doing
- IV. 2.4 what about continued training—implement & sustained training?

Group 5 Notes: Crisis Services

- I. Institutional model—logistics of placement
 - a. Crises = stabilization
 - b. Follow-up diagnosis, etc.
- II. How to increase communication
- III. Regional emergency coordinators-more involved

Jail Screening Meeting Minutes:

- Don't make jail staff MHP's.
- Standardized screening with Follow-up at the Regional Level
- **Screening tools for the lay person & tools that trigger referrals (for evaluation)**
- In Lancaster col., juveniles aren't confined based on screening.
- Jails not seen as Behavioral Health Centers.
- Adult & juvenile facilities aren't able to communicate on these issues right now
- Screening must be in different languages
- Screening must bring up bigger issues
- Want to avoid EPC (too long), but still do a screening
- Video-conferencing or Video-Nursing to reach areas away from services?
- Screening at front to determine who should be admitted to the facility & screens for Mental Health
 - o Until screening is done, currently, local law enforcement takes responsibility
- Even jails in more rural areas should do the appropriate screening
- Need to talk to law enforcement
 - o We are already implementing standard procedures
- Jail staff are often Moms, and get 8 hours of training.
 - o We want to give them more technical information
- Use Validated practices in(from?) 2008
 - o If it hasn't been tested cross-gender/ cross-race, etc., develop a mentod to validated the practice
- Formalize partnership with tribes
- Do evaluation to look at the screening down the road.
- Screening asks if people are suitable for admission to jail: a "Fitness For Confinement" (FFC) and it asks if they nee treatment right away
- How can we make screening work for everyone, no matter where in the state
- Review current screening tools with MHP's.
- Do we want to Add or Replace part of the screening?
- Jails and Hospitals do FFC screening – emergency facilities; Dr's need to be trained.
- **Qualifications of assessors & assessment tool must match**
- **Juvenile centers do screenings for first 5-7 days of confinement – adults don't so you have to be thorough.**
- Even DUI's need screening – impulsive, depression
- Currently do Suicide Prevention Training + 4 hrs of Mental Health training
- Mentally Ill can't handle a lot of questions, which is actually part of the screening
- Should we rewrite Goal #3 to say what is the ultimate goal?
- Trigger or flag questions to repeat
- Hard to train lay staff
- Front line of law enforcement is responsible for initial issues (medical, mental, etc)
 - o Want to identify who is in MOST need of services? Who can't go to jail?

- Training & Referral
- **MHP's should do assessment? Risk for hurting oneself or others? Is screening looking at meds and how to get them back on the psychotropic drugs?**
- MHPs aren't always there – do telehealth if available?
- Can we take the burden off of the Law Enforcement so it's more black and white?
- Contact and make sure there is networking in the Regions with the RBH Authority & Law Enforcement / Corrections
 - o **Need on-call MHP for jails in 75% of the state**
 - o How does an 8-man jail get services? And then, if they don't pass the assessment, then what?
 - Bad for the budget, law enforcement, and the consumer to do all the sitting and waiting.
- Mental Health shouldn't be a job of the jail
- Recurring / Recidivism issues when jails are a mental health facility
- Training on Mental Health, Substance Abuse, Level of Risk (for self & others)
- Exemption for lawsuit
- What can we do with the screening tool at the gate, before they are in jail?
- Jail needs to be able to tell law enforcement where one should go: jail or a MH Facility or other?
 - o Need to know that they can hold them before admittance
- No jail in NE has an MHP on staff /site for 24 hrs/day
- Is what we are doing the BEST that we can do?
 - o We've had 36 suicides since 2002
- They have to do a screening to book
- Jails are willing to do this as long as it's not too complicated and it is validated
- YLS and DISK(?) screening tools used with youth in Omaha
- One that needs meds, then they should get meds.
- At-risk adults are separate from other adults
 - o Most or all jails in NE do this already
 - o Is it good though to put those people *alone*?
- Most on screening team should be MHPs
- Need to utilize the Regions
- What training to do we need for the lay person?
 - o SASE – 8 hours?
 - o Short, simple & effective
 - o Can't indicate that I AM mentally ill
 - o Motivational Interviewing
- Diversion Program
- Brief jail screening
- Have to have:
 1. FFC
 2. Health Screening (medical conditions, psychotropics, etc.)
 3. Suicide screening, SA, Depression, identify mental health issues
- Want to use MHPs on screening
 - o Need to have qualified people making recommendations – Psychiatrists

- Need financial resources to validate it.

Goal 4 – Diversion Notes

Group 1

- Re-entry case management
- Systems – navigator
- Rural areas – psychologist on team
- Professionals trained in correction services, mental health, and substance abuse

Group 2

- Supports for family members
 - Increase capacity for family members to be support
 - Family support group
- Educating policy makers and legislature
 - Including city prosecutors, local judges, public defenders
- Don't spread money thin
 - Each party contributes

Group 3

- Older vs. younger populations – have different needs
- Probation – hooking in with services especially in crisis
- Connecting link of information between probation, parole, and behavioral health

Group 4

- Youths – transfer of custody from law enforcement to a guardian
- Need for focus on transitional age youth
- Establish partnership with tribes

Group 5

- Integrate psychiatrist on team
- Rural members should be included on “Diversion Team”
- Resource development and capacity building

Justice Behavioral Health Meeting
October 10, 2008

Group 1 Notes: Housing

- I. Rentwise
 - a. Is going on in pockets across state
 - b. (t) like it to go statewide
 - c. Some landlords giving money incentive for Rentwise certificate
- II. Need data for all strategies
- III. Identify important players
 - a. MAECH in Omaha
- IV. Juvenile justice plans in Omaha—including this? (Don Kline’s office)
- V. Housing arrest for young adults-develop appropriate (Omaha Home for Boys)
- VI. Be more specific on “implement what” statewide
 - a. If it is focused on Omaha, say it-evaluate it
- VII. Go to URTC’s data on where youth are discharging to
- VIII. You say 250 or 150 in goals based on what?
- IX. Make sure Omaha Rentwise is connected to statewide coalition
- X. Housing youth in a central area vs. dispersed-which is best?
- XI. Clarify action steps re: housing plans evidence based/conduct needs assessment
- XII. Identify urban vs. rural needs
 - a. Do a needs assessment with both. Do a project in rural.
 - b. What data look at to determine pilot location in rural area?
 - i. Youth in transition teams (have to make plans)
 - ii. County AH (have to make plans)

Group 2 Notes: Housing

- I. Housing needs should include family housing. Partners/children etc.
- II. Offer Rentwise while in institutions (YRTC)
- III. Address limitations of finding renters/landlords who will rent to people in the criminal justice system
- IV. Need units first then wraparound services
- V. Omaha Home for Boys-need more, there is a wait list
- VI. OJT before getting out
- VII. Intensive case manager should follow housing changes of youth. Allow for individualized needs to be addressed (e.g. no specific time frames—allow for flexibility with allowability)
- VIII. Like the idea of structured family living facility
- IX. Addressing limitations for housing—sex offenders and felony charges (e.g. locations, funds)
- X. Include financial issues under housing (e.g. medications, behavioral health services, disability, vocational training, etc.)
 - a. Use services like Lincoln Action Program
 - i. Partners with Clinic With a Heart concept
 - b. Assess for Medicaid early, prepare for it long before release

- i. Try to suspend vs. reapplying?
 - c. Ensure clinical assessment includes all domains
- XI. Educate consumers and state about steps (e.g. access to mainstream resources such as Medicaid)
- XII. Address criminalization through consumers & services so that consumers take the services
- XIII. Work with local tribal partners to ID resources

Group 3 Notes: Housing

- I. Involve Region VI in Omaha planning
- II. Need individual living housing
- III. Expand Rentwise
- IV. Address policy issues—restrictions for felons (adults)
- V. Youth Links—currently pilot
 - a. Youth released from YRTCs
 - b. In Omaha
- VI. Individual Laurie with Child and Family Services living
- VII. Include partner with education/schools (child care coverage, rehousing)
- VIII. Data from YRTCs about P/C to establish rural pilot
 - a. And foster care system
- IX. Make sure have recent mental health assessment
 - a. After transition to adult system, but also around age 17
 - b. Statewide should have one at 17
- X. Consider lowering age range—16 or 17
- XI. Professional Partners—have trans age and/or expand to 25 years old for program PPs
 - a. Some regions have

Group 4 Notes: Housing

- I. Omaha—Voc Rehab re-entry project not used out of State Office Building in Omaha
- II. Lincoln—Parole generally requires some sort of treatment placement first before individual living (for people with Mental Health/Substance Abuse needs)
- III. Need to get the word out about Voc Rehab—no age limits, good support
- IV. Collaborate with day reporting facility (Omaha)
 - a. Build on their services
 - b. Work to establish screening for eligible individuals (probation and parole, parole board, corrections)
 - i. Include Rentwise training and housing information
- V. Collaborate with N. Kenney—Warden at NCYF

Group 5 Notes: Housing

- I. Consider including jails across the state for goal 5.1
- II. Look into SAMHSA program
 - a. Housing, expense account (other elements included)

- b. Look at data on this program
- III. Address HUD limitations for felons
- IV. Utilize early parole/collaborate
- V. Fix Medicaid restrictions for those in jail—suspend or allow streamlined services immediately upon release

Objective	Activities	Completion Date	Responsibility
Goal 1: Provide statewide Crisis Intervention Team (CIT) training for Law Enforcement officers and make clear linkages with local crisis response teams			
1.1 Build on CIT training curriculum and adapt for rural areas and various professions (parole, probation, jail personnel, etc.)	1. Review Omaha training curriculum	Crisis Work Tm	8/08
	2. Develop training curriculum for rural area	Alegent BH	9/09
	3. Incorporate consumer voice in training	Off Cons Affairs	9/09
	4. Disseminate curriculum for review	BH Region	9/09
	5. Make modifications and finalize	BH Region	10/09
1.2 <u>Expose Regional/Law enforcement teams to CIT model and proposed modifications for customized delivery</u>	1. <u>Support attendaces of 6 individuals at CIT training in Omaha.</u>	<u>PPC and Alegent</u>	10/08
	2. <u>Contract to prepare standardized knowledge modules for delivery in customized training programs.</u>	<u>PPC</u>	10/08
	3. <u>Convene (via teleconference) interested Regions(s) and their partners (law enforcement, consumers, families, providers) to discuss plans for customizing curriculum.</u>	<u>PPC, BH Region</u>	10/08
	4. <u>Pilot customized curriculum in interested Regions.</u>	<u>BH Region</u>	12/08
1.3 Study impact of training	1. Develop evaluation design	PPC	12//09
	2. Collect data and conduct interviews	PPC	6/09
	3. Develop evaluation report	PPC	10/09
1.4 Sustain statewide <u>crisis intervention</u> training for law enforcement	1. Disseminate evaluation results	PPC	11/09
	2. <u>Embed knowledge modules with Regions and law enforcement training entities across the state.</u>	<u>BH Regions</u>	1/10
	3. <u>Involve Regional coordinators of customized training in dissemination to other groups.</u>	<u>BH Regions</u>	1/10
Goal 2: Expand or improve access to crisis stabilization services with improved coordination with law enforcement officers			
2.1 Refine model for crisis intervention for transition aged youth through consultation with national expert. <u>Build on existing models of crisis intervention in the regions for transition aged youth.</u>	1. Identify national consultant <u>and establish statewide meetings to look at existing models and resources in the regions. Follow principles of 1) one point of entry; 2) case management/mediator to facilitate transition; 3) model needs to be flexible- appropriate for the location based on resources available; 4) 25/7 availability; 5)</u>	<u>DHHS-DBH, PPC, Regions, Agencies, Regional Emergency Coordinators, Stakeholders.</u>	12/08

- Formatted: Font: 11 pt
- Deleted: Conduct CIT train the trainers training for up to 30 law enforcement, DCS, probation, DHHS Child and Family Service, and local jail trainers
- Deleted: . Identify interested justice/BH persons
- Deleted: Steering Comm.
- Deleted: Send out invitations to state/regional trainers
- Deleted: Steering Comm.
- Deleted: . Contract for training
- Deleted: PPC
- Deleted: Agreement by trainers to conduct trainings
- Deleted: PPC
- Deleted: CIT
- Deleted: Develop plan for sustainability
- Formatted: Font: 11 pt
- Deleted: Crisis Work Tm
- Deleted: Obtain agreement by other local organizations to sustain training
- Deleted: State Patrol/local law enforcement
- Formatted: Font: 11 pt
- Formatted: Font: 11 pt
- Formatted: Tabs: 1.23", Right
- Deleted: Mary O'Hare
- Formatted: Font: 11 pt
- Formatted: Font: 11 pt

	<u>determine who pays for what; 6) custodial legality, regulatory analysis, influence of guardianship; 7) identify crisis levels; 8) HIPAA—sharing info; 9) logistics of placement</u>	<u>Consumers</u>	
	2. <u>Assess needs of the regions</u>	<u>DHHS</u>	1/09
	3. <u>Agree on a model</u>	<u>DHHS-DBH</u>	5/09
	4. Report outlining model	<u>DHHS-DBH</u>	7/09
2.2 Pilot model for crisis intervention coordination in one community based on local plan for 100 – 200 individuals	1. Select pilot site based on regional plans	Steering Comm.	3/09
	2. Agreement with Regional Behavioral Health Authority	DHHS - DBH	6/09
	3. Conduct training of crisis response teams	<u>DHHS-DBH</u>	10/09
	4. Conduct training with law enforcement, parole, probation, and jails	<u>DHHS-DBH</u>	12/09
	5. <u>Begin new service model in one region</u>	<u>BH Region</u>	
	6. <u>Develop communication plan and coordinate within the community</u>	BH Region	2/10
2.3 Study impact of crisis intervention pilot	1. Develop evaluation design	PPC	12/09
	2. Collect data and conduct interviews	PPC	6/10
	3. Conduct cost benefit analysis	PPC	7/10
	4. Analyze data and develop evaluation report	PPC	7/10
2.4 Implement crisis intervention model statewide	1. Conduct train the trainers in each region	<u>DHHS-DBH</u>	8/10
	2. Train crisis response teams in each region	<u>DHHS-DBH</u>	10/10
	3. Train law enforcement, parole, probation, and jail personnel in each region	<u>DHHS-DBH</u>	10/10
	4. Monitor implementation	Steering Comm.	Ongoing
2.5 Implement strategies for sustaining crisis programs	1. Conduct review of other state efforts	Crisis Work Tm	1/10
	2. Review Medicaid/BH service definitions	Crisis Work Tm	2/10
	3. Review Medicaid coverage for medications	Crisis Work Tm	3/10
	3. Cost analysis for Medicaid coverage	Crisis Work Tm	3/10
	4. Make necessary changes in policies	DHHS	7/10
	5. Incorporate into contract	DHHS	7/10

Formatted: Font: 11 pt

Formatted: Font: 11 pt

Deleted: Contract with consultant

Formatted: Font: 11 pt

Deleted: Mary O'Hare

Formatted: Font: 11 pt

Deleted: Strategic planning meeting with consultant

Formatted: Font: 11 pt

Deleted: Mary O'Hare

Formatted: Font: 11 pt

Deleted: Mary O'Hare

Formatted: Font: 11 pt

Deleted: Mary O'Hare

Formatted: Font: 11 pt

Deleted: Mary O'Hare

Formatted: Font: 11 pt

Deleted: Mary O'Hare

Formatted: Font: 11 pt

Deleted: 5. Begin new service model in one region

Formatted: Font: 11 pt

Deleted: Mary O'Hare

Formatted: Font: 11 pt

Deleted: Mary O'Hare

Formatted: Font: 11 pt

Deleted: Mary O'Hare

Formatted: Font: 11 pt

Deleted: Mary O'Hare

Formatted: Font: 11 pt

Goal 3: Implement standardized MH/SA screening instruments in the jails that prompt referrals for services			
3.1 Refine plan for standardized screening and assessment process	1. Review planning work team product	Steering Comm.	12/08
	<ul style="list-style-type: none"> • <u>Screenings considerations should include issues of:</u> • <u>Application and validation with diverse groups of individuals (e.g. gender, race, etc.)</u> • <u>Consider validity of screenings translated into other languages.</u> • <u>Ability of non-mental health professionals to give the screenings (i.e. need to be designed with typical jail personnel in mind)</u> • <u>Screenings need to be appropriate for various locations across the state (rural vs. urban etc.)</u> • <u>Instrument should screen for several things (e.g. Fitness for confinement, health/mental health screenings, medication, and suicide assessment).</u> 		
	2. Agreement on standard screening instrument and protocol	Crime Commission	2/09
	3. Consultation in developing protocols	Travis Parker	3/09
	4. Review by consumer groups	Off Cons Supp	4/09
5. Disseminate to 80 local jails and obtain feedback	Crime Commiss.	6/09	
3.2 Incorporate processes into Nebraska	1. Develop draft standards	Crime Commiss	7/09

Formatted: Bullets and Numbering

Formatted: Bullets and Numbering

Formatted: Bullets and Numbering

jail standards	<ul style="list-style-type: none"> <u>Collaborate with Jail Standards Board</u> 	Crime Commiss	9/09
	2. Public review	Crime Commiss	12/09
3.3 Develop and provide training and technical assistance for jail personnel	1. Develop training curriculum	Travis Parker	12/09
	2. Train Jail Standards Division Staff in standards	Crime Commiss	1/10
	3. Provide technical assistance to local jails	Crime Commiss	2/10
	4. Incorporate TA materials on web site	Crime Commiss	4/10
3.4 Evaluate impact of change in standards	1. Develop evaluation design	PPC	9/09
	2. Collect data	PPC	9/10
	3. Issue evaluation report	PPC	12/10
Goal 4: Increase resources to community mental health to provide diversion services through the use of Forensic Intensive Case Management			
4.1 Adopt lessons learned from Nebraska's two urban jail diversion programs to develop a rural model	1. Hold lessons learned forum for two sites	Diversion Team	1/09
	2. Develop lessons learned report	Travis Parker	2/09
	<u>3. Examine how staffing (based on availability and/or shortages) and training might differ in rural areas from urban areas.</u>	<u>Diversion Team</u>	
	<u>4. Disseminate report to stakeholders, including members of the Unicameral who are interested.</u>	Diversion Team	4/09
4.2 Pilot rural jail diversion program for transition aged youth in one area of the state in coordination with crisis response teams	1. Conduct national review of best practices	Diversion Team	1/09
	2. Develop rural model <u>with focus on transitional age youth</u>	Diversion Team	2/09
	<u>3. Include "rural members" on the Diversion Team</u>	<u>Diversion Team</u>	3/09
	<u>4. Establish partnerships with Native American Tribes</u>	<u>Diversion Team/Larry Voegele</u>	3/09
	<u>5. Review model by consumers and family members.</u>	<u>Off Cons Supp</u>	3/09
	<u>6. Review regional plans to determine location.</u>	<u>Steering Comm</u>	6/09
	<u>7. Select site</u>	<u>Steering Comm</u>	

Formatted: Bullets and Numbering

Deleted: Review of model by consumers

Deleted: Off Cons Supp

Deleted: Review regional plans to determine location

Deleted: Steering Comm

Deleted: Steering Comm

Deleted: Select site

Deleted: Obtain agreement on roles and responsibilities

Deleted: DHHS/BH Reg

	<u>8. Obtain agreement on roles and responsibilities</u>	<u>BH Region</u>		
	<u>9. Implement pilot</u>	BH Region	7/09	Deleted: 7. Implement pilot
4.3 Examine service definitions for community support/case management and examine financing approaches for sustainability	1. Conduct review of other state efforts	Travis Parker	3/09	
	2. Review Medicaid/BH service definitions	Diversion Team	4/09	
	<u>3. Examine roles and definitions of Forensic Intensive Case Management, Re-entry Case Management, etc.</u>	<u>Diversion Team</u>		
	3. Cost analysis for Medicaid coverage	Diversion Team	5/09	
	4. Make necessary changes in policies	DHHS	7/09	
4.4 Study impact of jail diversion pilot	5. Incorporate into contracts	DHHS	7/09	
	1. Develop evaluation design	PPC	3/09	
	2. Collect data	PPC	12/09	
4.5 Implement coordinated jail diversion programs in other areas	3. Issue evaluation report	PPC	3/10	
	1. Review local plans for regional role out	Steering Comm	1/10	
	<u>2. Examine resource development and capacity building</u>	<u>Steering Comm</u>		
4.6 Implement strategies for sustaining jail diversion programs through 2009 – 2010 contracts	<u>3. Incorporate in regional contracts</u>	DHHS	7/11	Deleted: 2
	<u>4. Implement diversion protocols</u>	BH Regions	7/11	Deleted: 3
	1. Conduct review of other state efforts	Diversion Team	6/09	
	2. Review Medicaid/BH service definitions	Diversion Team	10/09	
	3. Cost analysis for Medicaid coverage	Diversion Team	1/10	
	4. Make necessary changes in policies	DHHS	7/11	
	<u>5. Educate policy makers, prosecutors, public defenders, judges, and state senators</u>	<u>DHHS/Diversion Team</u>		
	<u>6. Incorporate into contracts</u>	DHHS	7/11	Deleted: 5
Goal 5: Enhance affordable supportive housing for justice involved youth transitioning to adulthood				Formatted Table
5.1 Collaborate with Nebraska's Action Plan For Increasing Access to Mainstream Services for Persons	1. Review Action Plan	Housing Team	12/08	
	<u>2. Review data of discharging youth from YRTC Kearney, Geneva, and the Omaha Facility for youth</u>	<u>Housing Team</u>		

<p>Experiencing Chronic Homelessness to identify individuals in Department of Correction Facilities with mental illness ready for release</p>	<p><u>charged as adults, and DHHS youth D/C from state custody.</u></p> <p>3. <u>Develop review protocols for DCS facilities</u></p> <p>4. <u>Organize consumer review of protocols</u></p> <p>5. <u>Pilot protocols</u></p> <p>5. <u>Train community providers in referral processes</u></p> <p>6. <u>Ongoing collaboration between DCS facilities and Community Service Providers on referral procedures.</u></p>	<p>Housing Team</p> <p><u>Housing Team</u></p> <p><u>Off Cons Affairs</u></p> <p><u>DCS/YRTCs/DH</u></p> <p><u>HS</u></p> <p><u>DCS/Comm serv providers</u></p>	<p>2/09</p> <p>3/09</p> <p>7/09</p> <p>8/09</p> <p>10/09</p>	<p>Deleted: 2</p> <p>Deleted: 3</p> <p>Deleted: Off Cons Affairs</p> <p>Deleted: 4</p> <p>Deleted: DCS</p> <p>Deleted: Homeless Assist</p> <p>Deleted: Implement process in Omaha area</p> <p>Deleted: Homeless Assist</p>
<p>5.2 Develop protocols for developing housing, <u>case management (vital service)</u>, plan and linking individuals with supported housing and supported employment including assessing for Medicaid eligibility <u>for both urban and rural sites</u></p>	<p>1. <u>Conduct national review of promising practices</u></p> <ul style="list-style-type: none"> • <u>Include models using mentors and/or peer support</u> • <u>Consider family housing needs</u> • <u>Address barriers (e.g. felony convictions) to housing through flexible resources (i.e. state rental assistance)</u> <p>2. <u>Identify and connect with stakeholders in Omaha and rural project site (e.g. transitional living services and supported housing services, case management and supported employment for youth and adults).</u></p> <ul style="list-style-type: none"> • <u>Work with Independent Living Plan (Omaha) to coordinate processes</u> <p>3. <u>Develop model for supported housing and supported employment</u></p> <p>4. <u>Organize consumer review of model</u></p> <p>4. <u>Implement Process in pilot areas</u></p>	<p>Housing Team/PPC</p> <p>Housing Team</p> <p>Off Cons Affairs</p> <p><u>Pilot Project Leaders</u></p>	<p>1/09</p> <p>2/09</p> <p>3/09</p> <p>8/09</p>	<p>Formatted: Bullets and Numbering</p> <p>Formatted: Bullets and Numbering</p> <p>Deleted: 2</p> <p>Deleted: 3</p> <p>Deleted: Train case managers in model</p> <p>Deleted: Housing Team</p>

<p>5.3 Pilot protocols in Omaha area <u>and a rural location</u> for 250 transitioning young adults <u>(beginning at age 17).</u></p>	<p>1. Train Independent Living Plan case managers</p> <ul style="list-style-type: none"> <u>Include information on getting a current mental health status exam prior to terminating state ward status to facilitate access to adult services planning</u> <p>2. Pilot test protocols</p> <p>3. Review and modify protocols</p>	<p>Housing Team/<u>Pilot Project Leaders</u></p> <p><u>Pilot Project Leaders</u></p> <p><u>Pilot Project Leaders/Housing Team</u></p>	<p>8/09</p> <p>1/10</p> <p>4/10</p>	<p>Deleted: 5. Work with Independent Living Plan to coordinate processes</p> <p>Deleted: Housing Team</p> <p>Deleted: 10/09</p> <p>Formatted: Bullets and Numbering</p>
<p>5.4 <u>Connect to the Rent-Wise coalition to provide education</u> for 150 consumers in <u>the urban and rural pilot sites.</u></p>	<p>1. Conduct train the trainers on Rent- Wise Education</p> <p>2. Develop public information materials</p> <p>3. Convene interested landlords in <u>pilot areas</u> to learn about Rent-Wise</p> <p>4. Train persons transitioning from DCS facilities</p>	<p>Housing Team/<u>Rent-wise coalition</u></p> <p>Housing Team/<u>Rent-wise coalition</u></p> <p>Housing Team/<u>Rent-wise coalition</u></p> <p>DCS</p>	<p>8/09</p> <p>8/09</p> <p>10/09</p> <p>12/09</p>	<p>Deleted: P</p> <p>Deleted: Rent-Wise Education</p> <p>Deleted: Omaha area</p> <p>Deleted: Omaha</p> <p>Deleted: Housing Team</p> <p>Deleted: 3/10</p> <p>Deleted: 1. Provide information to each mental health region</p> <p>Deleted: 5.6 Implement statewide</p>
<p>5.5 Study impact of pilot <u>sites</u></p>	<p>1. Develop evaluation design</p> <p>2. Collect data</p> <p>3. Develop and disseminate evaluation report</p>	<p>PPC/<u>NCFE</u></p> <p>PPC/<u>NCFE</u></p> <p>PPC/<u>NCFE</u></p>	<p>6/09</p> <p>12/09</p> <p>3/10</p>	<p>Deleted: 2. Identify role out plan</p> <p>Deleted: Steering Comm</p> <p>Deleted: 3/10</p>
<p><u>5.6 Work with Children and Family Foundation and Omaha area foundations to sustain and implement.</u></p>	<p><u>1. Meet with five Omaha foundations and Children and Families Foundation.</u></p> <p><u>2. Develop sustainability plan.</u></p> <p><u>3. Implement plan.</u></p>	<p><u>Housing Team</u></p> <p><u>Housing Team</u></p> <p><u>Steering Comm</u></p>	<p><u>6/106/09</u></p> <p><u>9/109/09</u></p> <p><u>3/119/09</u></p> <p><u>6/09</u></p>	<p>Deleted: 3. Conduct train the trainers</p> <p>Deleted: Housing Team</p> <p>Deleted: 6/10</p>
<p><u>5.7 Implement Statewide</u></p>	<p><u>1. Provide information to each</u></p>			<p>Deleted: DCS/Housing Tm</p> <p>Deleted: 7/10</p>

	<u>mental health region</u>		
	<u>2. Identify role out plan</u>		
	<u>3. Conduct train the trainers</u>		
	<u>4. Implement statewide for DCS inmates</u>		

Overview of Changes:

Goal 1: The majority of the changes made to Goal 1 were based on significant feedback that the traditional CIT training and implementation methods are not always conducive to NE law enforcement, particularly those located in rural areas. Therefore changes were made to the goal regarding CIT training to recognize and incorporate goals and activities that were fitting for both urban and rural settings and their unique needs. Overall, the goal was rewritten to be more flexible and adaptable to the specific needs of Nebraska.

Goal 2: The most significant change made to Goal 2 was the addition of more specific criteria for establishing crisis intervention strategies. Feedback from stakeholders as well as national research was used to establish specific principles that need to be considered when establishing crisis stabilization services across the state; this information was added as further clarification and direction for Goal 2. Furthermore, additional stakeholders were added to the list of those responsible for the goals activities in an effort to have a more comprehensive, multi-faceted approach, with multi-stakeholder input.

Goal 3: The significant change to Goal 3 was the addition of several considerations that need to be included when developing a standardized screening and assessment process. Additional information was added based on feedback from stakeholders across the state regarding specific issues that need to be considered when developing a standardized screening device. In addition, collaboration with the Jail Standards Board was also identified as an important addition to Goal 3.

Goal 4: The main change made to Goal 4 was to recognize and incorporate considerations of rural areas in the activities of goal 4. The goal has been changed to include more input from and attention to the specific needs of rural locations. Additionally, the revised goal includes the importance of partnering with Native American Tribes and focusing specifically on transitional age youth.

Goal 5: The most significant change to Goal 5 was to expand the original goal of piloting housing protocols in Omaha to include an additional, rural site. The original goal only included a pilot site in Omaha, however stakeholder feedback strongly suggested that a pilot in both an urban and a rural area was necessary in order for successful data collection and statewide implementation. Additionally, the goal was expanded to include general issues of case management in addition to housing. Feedback from stakeholders indicated that housing could not be viewed or addressed in isolation and that it must be considered in the broader sense of case management which would address not only housing but also general issues of daily living.

Attachment L

The Ultimate Intercept – Evidence Based Treatment Services

In addition to the five intercepts in the Sequential Intercept Model, Munetz and Griffin (2006) stress the importance of a strong community mental health system which they refer to as “the ultimate intercept” (p. 545). The authors emphasize that the community mental health system has to be strong and based in a foundation of the best clinical practices or Evidenced Based Practices (EBPs). Several different interventions appropriate for justice involved transition age youth are available and can be included in a community mental health system. Examples of such EBPs include: Multidimensional Family Therapy for Adolescents (MDFT), Motivational Interviewing (MI), Multisystemic Therapy (MST), Functional Family Therapy, and Multidimensional Treatment Foster Care (MTFC). The following section will provide brief overviews of these EBPs.

Multidimensional Family Therapy for Adolescents is a comprehensive and flexible family based program for adolescents at high risk for problem behaviors, including substance abuse. Interventions target the research-derived risk factors and processes that have created and perpetuate the youth’s problems such as conduct disorder, substance use and delinquency. MDFT also intervenes systematically to help individuals and families develop empirically derived protective and healing factors and processes that offset behavioral problems. MDFT is a multicomponent and multilevel intervention system. (Substance Abuse and Mental Health Services Administration, nd, p.1)

Motivational Interviewing is a directive, client centered, counseling style of eliciting behavior change by helping clients to explore and resolve ambivalence. Compared with nondirective counseling, it is more focused and goal-oriented. The examination and resolution of ambivalence is its central purpose, and the counselor is intentionally directive in pursuing this goal. Essential components of MI include expressing empathy, supporting self efficacy, rolling with resistance and developing discrepancy (Motivational Interviewing Organization, 2007, ¶ 3).

Multisystemic Therapy (MST) is a multifaceted treatment that addresses the factors associated with serious antisocial behavior in children and adolescents, including those who abuse drugs. These factors include characteristics of the adolescent (for example, favorable attitudes toward antisocial behavior and/or drug use), the family (poor discipline, family conflict, parental drug abuse), peers (positive attitudes toward antisocial behavior and/or drug use), school (dropout, poor performance), and neighborhood (criminal subculture). By participating in intense treatment in natural environments (homes, schools, and neighborhood settings) most youths and families complete a full course of treatment. MST significantly reduces adolescent drug use during treatment and for at least 6 months after treatment. Reduced numbers of incarcerations and out-of-home placements of juveniles offset the cost of providing this intensive service and maintaining the clinicians' low caseloads (National Institute of Drug Abuse, 2005, ¶ 1).

Functional Family Therapy is for youth ages 10-18 who have problems ranging from acting out and conduct disorder to alcohol/substance abuse. FFT has been utilized to help youth and their families deal with their difficulties in a variety of contexts, including schools, child welfare, probation, parole/aftercare, mental health and as an alternative to incarceration or out-of-home placement. FFT works through three specific phases, engagement/motivation, behavior change, and generalization in a coherent manner which allows clinicians to maintain focus in the context of considerable family and individual disruption. Each of the different phases includes specific goals, assessment foci, and specific techniques for intervention. The model is conducted as an outpatient therapy and as a home-based model of treatment (FFT, 2007).

Multidimensional Treatment Foster Care (MTFC) is a multi-modal treatment approach that can be implemented by an agency or an organization. MTFC is for youth with chronic disruptive behaviors problems and is used as an alternative to regular foster care, group or residential treatment, and incarceration. The goal of the MTFC program is to decrease problem behavior and to increase developmentally appropriate normative and prosocial behavior in children and adolescents placed in out of home care. The goals for the program are accomplished by providing fair and consistent limits, predictable consequences for rule breaking, close supervision, a supportive relationship with at least one mentoring adult, and reduced exposure to peers with similar problems. Specific components of the model include behavioral parent training and support for MTFC foster parents, family therapy for family of origin, youth skill training, youth individual therapy, school-based behavioral interventions and support, and psychiatric consultation and medication management (TFC Consultations, INC, n.d.).

References

Functional Family Therapy (2007). Retrieved October 22, 2008 from:
<http://www.fftinc.com/Contact.aspx>

Motivational Interviewing Organization (2007). *Motivational Interviewing*. Retrieved on September 27, 2007, from
<http://motivationalinterview.org/clinical/Adolescents.html>

National Institute on Drug Abuse. (1999). *Principles of drug addiction treatment: A research-based guide*. NIH Publication No. 99-4180

Substance abuse and mental health services administration model programs (nd).

Multidimensional Family Therapy. Retrieved September 27, 2007 from
<http://www.modelprograms.samhsa.gov/pdfs/model/multi.pdf>

TFC Consultations, INC, (n.d) Retrieved October 22, 2008 from:
http://www.mtfc.com/TFC_Consultants.html