

Children's Behavioral Health Plan

Prepared by
The Children's Behavioral Health Task Force
Pursuant to LB 542 (2007)

Task Force Members

Senator Jim Jensen, Chair
Scot Adams
Beth Baxter
Judge Elizabeth Crnkovich
Senator Lavon Heidemann
Ruth Henrichs

Senator Joel Johnson
Candy Kennedy
Todd Landry
Tom McBride
Kathy Bigsby Moore
Terri Nutzman

December 2007

Children's Behavioral Health Task Force

Task Force members and their method of appointment pursuant to LB 542 (2007) are as follows:

Chairperson, Health and Human Services Committee
Nebraska Legislature

Senator Joel Johnson
District #37
Kearney, NE

Chairperson, Appropriations Committee
Nebraska Legislature

Senator Lavon Heidemann
District #1
Elk Creek, NE

Chairperson, Behavioral Health Oversight Commission

Former Senator Jim Jensen
Omaha, NE

Two providers of community-based behavioral health services to children, appointed by the Chairperson, Health and Human Services Committee
Nebraska Legislature

Ruth Henrichs, President and CEO
Lutheran Family Services
Omaha, NE

Tom McBride, CEO
Epworth Village
York, NE

One regional administrator appointed under section 71-808, appointed by the Chairperson, Health and Human Services Committee
Nebraska Legislature

Beth Baxter, Regional Administrator
Region 3
Kearney, NE

Two representatives of organizations advocating on behalf of consumers of children's behavioral health services and their families, appointed by the Chairperson, Health and Human Services Committee
Nebraska Legislature

Candy Kennedy, Director
Nebraska Federation of Families for
Children's Mental Health
Upland, NE

Kathy Bigsby Moore, Exec. Dir.
Voices for Children in Nebraska
Omaha, NE

One juvenile court judge, appointed by the
Chief Justice of the Supreme Court

Judge Elizabeth Crnkovich
Douglas County Juvenile Court
Omaha, NE

Two representatives of the Department of Health
and Human Services, appointed by the Governor

Scot Adams, Director
Division of Behavioral Health,
Department of Health and Human
Services
Lincoln, NE

Todd Landry, Director
Division of Children and Family
Services, Department of Health and
Human Services
Lincoln, NE

The administrator of the Office of Juvenile Services

Terri Nutzman, Administrator
Office of Juvenile Services
Division of Children and Family
Services, Department of Health and
Human Services
Lincoln, NE

Children's Behavioral Health Plan

**Prepared by
The Children's Behavioral Health Task Force
Pursuant to LB 542 (2007)**

December 2007

TABLE OF CONTENTS

INTRODUCTION.....	1
THE CURRENT “SYSTEM”	9
PLANNING CONSIDERATIONS AND OBJECTIVES.....	17
PLANNING RECOMMENDATIONS	23
APPENDICES	29

Introduction

The State of Nebraska has a unique opportunity to make significant improvements in the delivery of behavioral health care services to children. Children's behavioral health planning legislation was adopted by the Nebraska Unicameral earlier this year.¹ The state has received a multi-million-dollar, multi-year federal infrastructure grant for children's behavioral health (the Children's Mental Health and Substance Abuse State Infrastructure Grant). Comprehensive behavioral health legislation was adopted in 2004 to provide a direction and foundation for further change.²

Over the past several years, various other legislative bills and resolutions related to children's behavioral health have been introduced.³ Many Nebraska studies and related initiatives have been undertaken⁴ and there are numerous sections of Nebraska law relating to the subject of children's behavioral health.⁵

Many Nebraska children have significant behavioral health needs. State and local government, the courts, and the private sector must all work together to ensure that all Nebraska children have timely access to quality and affordable behavioral health care services.

It is hoped that this document will contribute something meaningful to the process of improving the children's behavioral health system. It does not intend to repeat past studies or replace current initiatives. Its purpose is to supplement and help direct those efforts into meaningful action steps and substantive change.

Change is needed, and it is hoped that this report will provide a clear vision for change. This report not only attempts to describe what the children's behavioral health "system" currently is, but what it should be.

The report also contains a limited number of planning recommendations. Research and data collection for their implementation should rely on previous and current initiatives, including, but not limited to, the Children's Mental Health and Substance Abuse State Infrastructure Grant (SIG grant).

LB 542 (2007) mandates and provides legislative direction for establishment of the Children's Behavioral Health Task Force and the preparation of this report.

LB 542 (2007)

In 2007, the Nebraska Legislature passed LB 542⁶ to create the Children's Behavioral Health Task Force (task force). The bill was signed by Governor Heineman on May 24, 2007. The bill required the task force, under the direction of, and in consultation with, the Health and Human Services Committee of the Legislature and the Department of Health and Human Services, to prepare a children's behavioral health plan by December 4, 2007.

¹ LB 542 (2007); Neb. Rev. Stat. §43-4001 to §43-4003.

² LB 1083 (2004); Neb. Rev. Stat. §71-801 to §71-818.

³ See Appendix A.

⁴ See Appendix B.

⁵ See Appendix C.

⁶ See Appendix D.

The scope of the plan must include all juveniles accessing public behavioral health resources. Specifically, the plan must include, but is not limited to:

1. Plans for the development of a statewide integrated system of care to provide appropriate educational, behavioral health, substance abuse, and support services to children and their families. The integrated system of care should serve both adjudicated and nonadjudicated juveniles with behavioral health or substance abuse issues;
2. Plans for the development of community-based inpatient and subacute substance abuse and behavioral health services and the allocation of funding for such services to the community pursuant to subdivision (4) of section 43-406;
3. Strategies for effectively serving juveniles assessed in need of substance abuse or behavioral health services upon release from the Youth Rehabilitation and Treatment Center-Kearney or Youth Rehabilitation and Treatment Center-Geneva;
4. Plans for the development of needed capacity for the provision of community-based substance abuse and behavioral health services for children;
5. Strategies and mechanisms for the integration of federal, state, local, and other funding sources for the provision of community-based substance abuse and behavioral health services for children;
6. Measurable benchmarks and timelines for the development of a more comprehensive and integrated system of substance abuse and behavioral health services for children;
7. Identification of necessary and appropriate statutory changes for consideration by the Legislature; and
8. Development of a plan for a data and information system for all children receiving substance abuse and behavioral health services shared among all parties involved in the provision of services for children.⁷

LB 542 also requires the Department of Health and Human Services to provide a written implementation and appropriations plan for the children's behavioral health plan to the Governor and the Health and Human Services Committee of the Legislature by January 4, 2008.⁸ The chairperson of the Health and Human Services Committee is required to prepare appropriate legislation for introduction in the 2008 legislative session.⁹

The task force is required to oversee implementation of the children's behavioral health plan until June 30, 2010.¹⁰

The Children's Behavioral Health Task Force

The Children's Behavioral Health Task Force (task force) met seven times prior to final approval and submission of this report. Administrative support for the task force was provided by the Health and Human Services Committee of the Legislature and the Appropriations Committee of the Legislature. The task force received a significant amount of information and held lengthy discussions on a wide variety of topics. All meetings of the task force were recorded and transcribed. The task force met at the Hastings Regional Center (HRC) and toured HRC. All other meetings of the task force were held at the State Capitol in Lincoln. All task force meetings were open to the public, and public comment was solicited at each meeting.

⁷ Neb. Rev. Stat. §43-4002(2) (Laws 2007, LB 542, §2).

⁸ Neb. Rev. Stat. §43-4002(2) (Laws 2007, LB 542, §2).

⁹ Neb. Rev. Stat. §43-4002(3) (Laws 2007, LB 542, §2).

¹⁰ Neb. Rev. Stat. §43-4003 (Laws 2007, LB 542, §3).

The task force received a presentation from the Division of Behavioral Health (division) within the Department of Health and Human Services (department) and received additional data and information from the Children's Mental Health and Substance Abuse State Infrastructure Grant (SIG grant). The task force conducted a number of small working group sessions on a variety of topics as assigned by the chair. The task force was presented with an overall draft outline for this report and a more detailed outline of draft recommendation topics for their review and comment. On November, 14, 2007, the task force was given a rough draft of proposed recommendations for their consideration and approval.

This report was drafted by legal counsel to the Health and Human Services Committee of the Legislature, under the direction of Senator Jensen as chair of the task force and Senator Johnson as chair of the committee, with assistance from members of the task force, the Nebraska Department of Education, SIG grant project managers and staff, and others. Their participation and input is gratefully acknowledged. This document represents a consensus of task force opinion, but does not necessarily represent the views of every member of the task force.

Children's Mental Health and Substance Abuse State Infrastructure Grant (SIG)

In October 2004, the Nebraska Department of Health and Human Services was awarded a Children's Mental Health and Substance Abuse State Infrastructure Grant (SIG grant)¹¹ from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) in the amount of \$750,000 per year for five years. The grant was designed to help states improve their infrastructure for community-based systems of substance abuse and mental health services for children and their families. The third fiscal year of the grant was completed in September 2007, with two years still remaining.

The SIG grant has already developed, or is the process of developing, much of the foundational work product needed for sound planning and decision-making for improvements to the children's behavioral health system. The SIG grant, for example, has considered and analyzed various models for coordination of the children's behavioral health system and various funding integration models. The SIG grant has received input from family and provider focus groups, recommended the implementation of various pilot projects, and analyzed a significant body of evidence-based best practices research.

The SIG grant will provide valuable data, information, and analysis to assist in the implementation of planning recommendations contained in this report. The ongoing work of the SIG grant should be recognized and incorporated into future children's behavioral health planning efforts as mandated by LB 542. The infrastructure and funding attached to the SIG grant process should be relied upon by the Division of Behavioral Health in their own behavioral health planning and development.

LB 1083 (2004)

In 2004, the Nebraska Legislature passed LB 1083 to adopt the Nebraska Behavioral Health Services Act (act).¹² The bill addressed seven key focus areas of behavioral health reform: (1) state leadership; (2) regional administration; (3) community-based services and

¹¹ See Appendix E.

¹² Neb. Rev. Stat. §71-801 to §71-818.

regional centers; (4) funding; (5) statewide advocacy; (6) legislative oversight; and (7) planning. The bill also recodified provisions of the Nebraska Mental Health Commitment Act.

LB 1083 provides the following purpose statement for the public behavioral health system:

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

(1) The public safety and the health and safety of persons with behavioral health disorders;

(2) Statewide access to behavioral health services, including, but not limited to, (a) adequate availability of behavioral health professionals, programs, and facilities, (b) an appropriate array of community-based services and continuum of care, and (c) integration and coordination of behavioral health services with primary health care services;

(3) High quality behavioral health services, including, but not limited to, (a) services that are research-based and consumer-focused, (b) services that emphasize beneficial treatment outcomes and recovery, with appropriate treatment planning, case management, community support, and consumer peer support, (c) appropriate regulation of behavioral health professionals, programs, and facilities, and (d) consumer involvement as a priority in all aspects of service planning and delivery; and

(4) Cost-effective behavioral health services, including, but not limited to, (a) services that are efficiently managed and supported with appropriate planning and information, (b) services that emphasize prevention, early detection, and early intervention, (c) services that are provided in the least restrictive environment consistent with the consumer's clinical diagnosis and plan of treatment, and (d) funding that is fully integrated and allocated to support the consumer and his or her plan of treatment.”¹³

“Public behavioral health system” is defined in the act as “the statewide array of behavioral health services for children and adults provided by the public sector or private sector and supported in whole or in part with funding received and administered by the [Department of Health and Human Services], including behavioral health services provided under the medical assistance program” (emphasis added).¹⁴

Current state law governing the public behavioral health system applies to both children and adults. Children’s behavioral health planning efforts must consider and incorporate existing state law and suggest necessary and appropriate changes to existing infrastructure and policy as articulated in LB 1083.

LB 1083 also mandated the development of community-based behavioral health services and a reduction in the utilization of regional center services. Neb. Rev. Stat. §71-810 provides, in part, “(1) The [Division of Behavioral Health] shall encourage and facilitate the statewide development and provision of an appropriate array of community-based behavioral health services and continuum of care for the purposes of (a) providing greater access to such services and improved outcomes for consumers of such services and (b) reducing the necessity and demand for regional center behavioral health services.” This provision of law, among other factors, resulted in the transfer of adolescent services from the Lincoln Regional Center (LRC) to

¹³ Neb. Rev. Stat. §71-803.

¹⁴ Neb. Rev. Stat. §71-804.

the Hastings Regional Center (HRC) in 2006. Currently HRC provides adolescent residential substance abuse treatment (40 beds) and adolescent residential mental health services (8 beds). The Lincoln Regional Center operates 24 beds for adolescent sex offenders (an 8-bed treatment group home and 16 residential treatment beds). LB 542, as originally introduced, proposed the transfer of HRC adolescent services and funding to the community.

The “Chinn Report”

The “Nebraska Juvenile Correctional Facilities Master Plan Update” (Chinn Report) was prepared in 2007 for the Nebraska Juvenile Project Steering Committee by Chinn Planning and Carlson West Povondra Architects. The report contained seven “system recommendations,” seven “operational recommendations,” a “capacity recommendation,” and two “facility options.” The report focused primarily on the Youth Rehabilitation and Treatment Centers in Kearney and Geneva, and adolescent treatment services at the Hastings Regional Center.¹⁵

Nebraska Health Care Funding Act

LB 692 (2001) adopted the Nebraska Health Care Funding Act (act),¹⁶ and established a perpetual endowment using tobacco settlement¹⁷ and Medicaid intergovernmental transfer (IGT)¹⁸ revenues for the purpose of appropriating several million dollars a year for health care in Nebraska.

The act requires the transfer of a total of \$55 million per year to the Nebraska Health Care Cash Fund from two separate trust funds (the Tobacco Settlement Trust Fund and the Medicaid Intergovernmental Trust Fund). The transferred funds are appropriated annually by the Legislature for several health-related purposes, including behavioral health (\$19.1 million) and public health (\$8.9 million). Behavioral health funding is allocated for provider reimbursement (\$10.1 million), increased service capacity (\$6.5 million); emergency protective custody costs (\$1.5 million) and services to juvenile offenders under Neb. Rev. Stat. §43-407 (\$1 million).¹⁹

Provisions of the Nebraska Health Care Funding Act and the existence and utilization of the Nebraska Health Care Cash Fund will be important factors in future children’s behavioral health planning.

¹⁵ See Appendix F.

¹⁶ Neb. Rev. Stat. §71-7605 to §71-7614.

¹⁷ The State of Nebraska has been awarded several million dollars annually under the nationwide tobacco settlement (1998). The State of Nebraska filed a lawsuit against the tobacco industry on August 21, 1998, in the District Court of Lancaster County. On November 23, 1998, the State of Nebraska and forty-five other states settled their lawsuits against the tobacco industry, under terms of the Master Settlement Agreement (MSA). Nebraska’s lawsuit against the tobacco industry was dismissed by the District Court of Lancaster County on December 20, 1998, and “State Specific Finality” under the MSA was achieved in the State of Nebraska on January 20, 1999. Annual payments to Nebraska under the MSA are approximately \$40 million.

¹⁸ Medicaid Intergovernmental transfers (IGTs) involve a transfer of funds among or between different levels of government. Under statutory authority, state-owned or operated facilities or “units” of local government (city, county, special purpose district or other governmental unit within a state) can make an IGT. In the case of Medicaid, one of these “units” of government transfers funds to the state Medicaid agency, which then uses the money to draw down the federal match for payment to a publicly owned provider for Medicaid services. The federal government’s match is based on the state’s federal matching rate (National Conference of State Legislatures).

¹⁹ LB 321 (2007).

Children's Behavioral Health

The Report of the Surgeon General's Conference on Children's Mental Health²⁰ noted that "Mental health is a critical component of children's learning and general health. Fostering social and emotional health in children as a part of healthy child development must therefore be a national priority. Both the promotion of mental health in children and the treatment of mental disorders should be major public health goals."

The consequences of mental and emotional disorders can be severe and may include family disruption, poor school performance and attendance, assaultive behavior, withdrawal, anxiety, addiction, commission of status offenses, self harm, risky behaviors, illegal activities, and in some situations, death. Behavioral health disorders in childhood are caused by a combination of biological and environmental factors and encompass a broad spectrum of symptoms and behaviors that occur in a variety of different contexts. Some of the major types of disorders include the following:

1. Depression. Studies show that 2 of every 100 children may have major depression, and as many as 8 of every 100 adolescents may be affected (National Institutes of Health, 1999). Symptoms include the child feeling worthless or hopeless, losing interest in school or activities, and withdrawing from friends and family. Some children with depression may not value their lives and are at high risk of suicide.

2. Conduct Disorder. Youth with conduct disorder usually have little concern for others and repeatedly violate the basic rights of others and the rules of society. Conduct disorder causes children and adolescents to act out their feelings or impulses in destructive ways. Often children with conduct disorders end up in the juvenile justice system for status offenses such as ongoing truancy, running away, or more serious offenses such as assault, theft, and arson.

3. Bipolar Disorder. Children who demonstrate large mood swings that range from extreme highs (intense excitement or manic phases) to extreme lows (depression) may have bipolar disorder. During manic phases, children may talk nonstop, need very little sleep, and show unusually poor judgment. At the low end of the mood swing, children experience severe depression.

4. Anxiety Disorders. Youth who experience excessive fear, worry, or uneasiness may have an anxiety disorder, which affects as many as 13 of every 100 adolescents. Anxiety disorders include phobias (unrealistic and overwhelming fear of objects or situations); panic attacks, which may include rapid heartbeat or dizziness; obsessive-compulsive disorders which cause children to be trapped in a pattern of repeated thoughts or behaviors; and post-traumatic stress disorder, caused by a psychologically distressing event such as abuse or witnessing violence.

5. Attention-Deficit/Hyperactivity Disorder. Youth with attention-deficit/hyperactivity disorder are unable to focus their attention and are often impulsive and easily distracted. Many of these children have difficulty in school and are at high risk of dropping out, leading to negative outcomes in adulthood.

6. Eating Disorders. Children who are intensely afraid of gaining weight and do not believe that they are underweight may have eating disorders. Eating disorders can be life threatening.

²⁰ "Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda" (2001).

7. Autism. Children with autism have problems interacting and communicating with others. Autism appears before the third birthday, causing children to act inappropriately, often repeating behaviors over long periods of time. Children with autism may have a very limited awareness of others and are at increased risk for other mental disorders.

8. Schizophrenia. Youth with schizophrenia have psychotic periods that may involve hallucinations, withdrawal from others, and loss of contact with reality. Other symptoms include delusional or disordered thoughts and an inability to experience pleasure.

9. Substance Abuse. Children may use and become dependent on alcohol and other drugs such as over-the-counter medications; inhalants, including glue or paint; or illegal drugs, including marijuana, cocaine, methamphetamine, or heroin. Substance abuse often leads to physical, family, school, financial, and social problems. In some cases, a child may have both a substance abuse disorder and another mental health disorder. These multiple disorders are referred to as “co-occurring” disorders.

Prevalence

The Division of Behavioral Health reports that approximately 90,000 children in Nebraska have a mental health or substance abuse disorder, approximately 47,000 of those children experience significant impairment from such disorders, and approximately 21,000 experience extreme impairment.

Published national rates of youth with serious emotional disturbance (SED) were the same as Nebraska at 8%. The number of youth served who were under age 18 and at 300% of the federal poverty level was 18,607 or 79%, leaving an unmet need of 5,083 (WICHE, 2001)²¹

The National Comorbidity Study (NCS) is the most recent random survey of the adult population in the United States. This study looks at specific populations in households below 300% and 200% of the federal poverty level and found that, from both sources in conjunction, there are between 92,626, and 112,777 youth and adults estimated to have SED or serious mental illness (SMI) in Nebraska (WICHE, 2007)²². Youth prevalence estimates range from 22,146 (excluding youths under 9 years of age) to 32,768 (7.3%), which includes household, institution, and group populations.

The NCS methodology used to gather youth data was modified due to the range of demographic variables related to the diagnoses of mental health disorders in children. The study was therefore conducted only on the poverty status of the child.

All youth age groups have similar rates of SED, but very young children ages 0-5 in poorer households, (<200% or <100% of poverty) have an increasing prevalence. The three youth age cohorts, (0-5, 6-11, and 12-17) are approximately equal in percentage, as are the male and female cohorts. The eastern portion of the state has the highest rates of youth with SED. Regions 5 (Lincoln and surrounding counties) and 6 (Omaha and surrounding counties) have the highest number of estimated cases of SMI and SED, and Regions 1 (Scottsbluff and surrounding counties) and 2 (North Platte and surrounding counties) have the lowest estimated percentages (WICHE, 2007).

²¹ “Nebraska MHSIP: Prevalence, Utilization and Penetration,” WICHE Mental Health Program (October 30, 2001).

²² “Nebraska: Prevalence Estimates for Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED),” WICHE Mental Health Program (January 5, 2007).

The federal Substance and Mental Health Services Administration (SAMHSA) estimated a total of 228,421 Nebraska youth with serious emotional disturbance in 2002, with 10.9% of those youth living below the federal poverty level (SAMHSA, 2004).

The Current “System”

The current Nebraska behavioral health care “system” for children is multifaceted, fragmented, and complex. “System” as used here means the statewide patchwork of persons and organizations that currently (1) provides services and supports to children with behavioral health disorders and their families or (2) is in some way involved in the assessment, identification, or referral of children for such services and supports. This section will briefly describe some of the main components of the “system.”²³

The current behavioral health “system” for children is actually a complex web of many different “systems,” including (1) the state health and human services “system”; (2) the education “system;” (3) the judicial “system;” (4) the child and family advocacy and support “system;” (5) the behavioral health care delivery “system;” (6) the primary health care delivery “system;” (7) the law enforcement and criminal justice “system;” (8) the public health “system;” (9) the private or quasi-governmental human services “system;” and (10) the foster care and adoption “system.” The existence of multiple “systems” has led in many instances to significant fragmentation and ineffectiveness. A lack of coordination and integration of the various systems has caused hardships for children and families.

The State Health and Human Services “System”

The state health and human services “system” consists of various programs and services administered by the Department of Health and Human Services (department) and its six divisions: the Divisions of Behavioral Health, Children and Family Services, Developmental Disabilities, Medicaid and Long-Term Care, Public Health, and Veteran’s Homes.²⁴

The Division of Behavioral Health administers three state hospitals for the mentally ill (regional centers) in Hastings, Lincoln, and Norfolk and publicly funded community-based behavioral health services and oversees six statutorily created regional behavioral health authorities. The Hastings Regional Center (HRC) currently operates 40 adolescent residential substance abuse treatment beds, 8 adolescent residential mental health beds, and a 14-bed unit for adults with developmental disabilities. The Lincoln Regional Center operates 24 beds for adolescent sex offenders (an 8-bed treatment group home and 16 residential treatment beds).

The Division of Children and Family Services administers child welfare programs, juvenile services programs and the Office of Juvenile Services, and various public assistance and family support programs and services. The Office of Juvenile Services oversees the operation of two Youth Rehabilitation and Treatment Centers (YRTCs) in Kearney and Geneva.

The Division of Medicaid and Long-Term Care administers the state’s Medicaid program, and other related programs and services. An administrative services organization (Magellan Behavioral Health) assists both the Medicaid and Behavioral Health divisions in utilization management, claims payment, and data collection for the public (Medicaid and non-Medicaid) behavioral health system. The Medicaid managed care program for children is also operated under an administrative services only contract with Magellan Behavioral Health.

²³ A description of the current “system” was also presented to the task force by the Division of Behavioral Health. The division’s presentation, along with additional information provided at the request of the Task Force is included as Appendix G.

²⁴ Neb. Rev. Stat. §81-3110 to §81-3124.

The Division of Public Health administers preventive and community health programs and services, the regulation and licensure of health-related professions and occupations, and the regulation and licensure of health care facilities and health care services.

Regional Behavioral Health Authorities

Nebraska is divided into six geographic behavioral health regions. Each region has a regional behavioral health authority overseen by a regional governing board consisting of one county board member from each county in the region. The administrator of the regional behavioral health authority is appointed by the regional governing board.

The administrative offices of the six regional behavioral health authorities are located in Scottsbluff (Region 1), North Platte (Region 2), Kearney (Region 3), Norfolk (Region 4), Lincoln (Region 5), and Omaha (Region 6). State law relating to the powers and duties of regional behavioral health authorities is found in Neb. Rev. Stat. §71-807 to §71-809.

Each regional behavioral health authority employs a Regional Youth Specialist to provide youth system coordination by assisting in the development, implementation and evaluation of regional service needs, goals, programs, and service delivery systems. The Regional Youth Specialist also works closely with service providers, community representatives, consumer groups, and representatives of judicial, education, child welfare, health, and juvenile justice to facilitate a climate for interagency collaboration and systems integration of behavioral healthcare services as gaps and needs are identified within the region.

Integrated Care Coordination Units (ICCU)

Integrated care coordination units (ICCU) exist in all six behavioral health regions as a collaboration between regional behavioral health authorities and the Department of Health and Human Services. The ICCUs are designed to integrate care for children with multiple and complex needs in the child welfare and juvenile justice systems. The youth served through the units are high-need state wards (birth through age 18) who are in agency-based foster care (therapeutic foster care) and higher levels of care. ICCUs utilize an integrated care coordination collaborative that includes DHHS Protection and Safety workers (child welfare and juvenile justice) and Region Care Coordinators (mental health and substance abuse service system) who work in conjunction with family support organizations in each region to provide advocacy for youth and their families in the program.

The Education “System”

The education “system” consists of 465 public and private schools serving youth in early childhood education through high school.²⁵ The “system” also has 17 educational service units (ESUs) that provide core services and other services as identified and requested by member school districts. There are 247 private schools in Nebraska, serving nearly 40,000 children in elementary, middle and high schools.

Interim-program schools located in or operated by county detention homes, public or private institutions not owned or operated by a school district, or juvenile emergency shelters

²⁵ Nebraska Department of Education.

also provide regular and/or special education services to temporary resident students who are unable for reasons of health or safety to attend the regular public school in their home school district.

The Nebraska Department of Education also administers state and federal education funding and has collaborated with the Division of Behavioral Health in the Department of Health and Human Services on school-based mental health services, early childhood mental health programs and vocational services for transitioning youth.

The Child and Family Advocacy and Support “System”

The child and family advocacy and support “system” consists of various privately and publicly funded organizations that advocate on behalf of children with behavioral health disorders and their families. Such organizations include, but are not limited to; Nebraska Advocacy Services, the Nebraska Chapter of the National Alliance for the Mentally Ill, the Mental Health Association of Nebraska, the Nebraska Federation of Families for Children’s Mental Health, and Nebraska child advocacy centers.

The Nebraska Federation of Families for Children’s Mental Health (federation) is a statewide family support and advocacy organization that includes six regional incorporated family organizations. Primary funding for the federation is a grant from the United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA). Local family support organizations receive funding from a variety of funding sources including fund raising and state/local contracts and grants.

The Judicial “System”

The judicial “system” consists of appeals courts (the Nebraska Supreme Court and the Nebraska Court of Appeals), district courts (general jurisdiction), county courts (limited jurisdiction), other courts as created by the Legislature (including separate juvenile courts), and probation and parole functions.²⁶

District courts are trial courts of general jurisdiction and serve as appellate courts in deciding some appeals from county courts and various administrative agencies. There are 12 judicial districts in Nebraska and 55 district judges.

County courts have original jurisdiction in probate, guardianship, conservatorship, and adoption matters. County courts also have original jurisdiction in juvenile matters in counties with no separate juvenile court. Separate juvenile courts have been established in Douglas, Lancaster and Sarpy counties. Nebraska has eleven separate juvenile court judges. Children may come before the court because of their need for protection and safety (child welfare cases) and/or delinquency (criminal) behavior.

Child welfare cases require the court to oversee case progress and remain actively involved in the lives of children and families over a period of time. Case oversight is concerned with ensuring the state’s fulfillment of its responsibilities and parental cooperation with the state. Instead of making a one-time decision concerning the care, custody, and placement of a child, the court in child welfare cases makes a series of decisions over time. Because its decisions in child welfare cases are interlocking and sequential, the court performs a more managerial and directive function than in other litigation.

²⁶ Nebraska Blue Book (2006-2007).

In delinquency cases, the role of the court, among other things, is to (1) increase public safety in communities by supporting and implementing both effective delinquency prevention strategies as well as a continuum of effective and least intrusive responses to reduce recidivism; (2) hold juvenile offenders accountable to their victims and community by enforcing completion of restitution and community service requirements; and (3) develop competent and productive citizens by advancing the responsible living skills of youth within the jurisdiction of the juvenile delinquency court.

The Behavioral Health Care Delivery “System”

The behavioral health care delivery “system” consists of a broad spectrum of providers of behavioral health care services and supports to children and their families, including both behavioral health care practitioners and behavioral health care facilities and organizations. Behavioral health facilities licensed by the Division of Public Health within the Department of Health and Human Services include psychiatric hospitals, mental health centers, and substance abuse treatment centers. Behavioral health providers licensed by the division include alcohol and drug counselors, mental health practitioners, psychologists, and physicians (psychiatrists). A wide variety of services and supports are currently being provided to children with behavioral health disorders and their families.

The Primary Health Care Delivery “System”

The primary health care delivery “system” consists of a broad spectrum of health care providers and health care facilities and services other than those specifically dedicated to the delivery of behavioral health care services and supports.

Health care facilities and services licensed by the Division of Public Health include health clinics (including ambulatory surgery centers, community health centers, and certified rural health clinics), home health agencies, general acute hospitals, and respite care services. Health care practitioners licensed by the division include audiologists, speech-language pathologists, dentists, physicians, nurses, occupational therapists, pharmacists, and physical therapists.

The Law Enforcement and Criminal Justice “System”

The law enforcement and criminal justice “system” consists of various federal, state, county, and municipal law enforcement agencies and institutions, including the state Attorney General, the Nebraska Crime Commission, the Nebraska State Patrol, county sheriffs, local police departments, and various state, county and municipal jails, prisons, and detention facilities.

The Public Health “System”

The public health “system” consists of 24 local public health departments statewide, encompassing all 93 Nebraska counties. Local public health departments receive state funding from the Nebraska Health Care Cash Fund pursuant to LB 692 (2001) and subsequent legislation.

The Private and Quasi-Governmental Human Services “System”

The private and quasi-governmental human services “system” consists of a number of publicly and privately funded organizations that serve Nebraska children and families in need, including, but not limited to, homeless shelters, local food banks, Community Action Agencies, and faith-based organizations. Community Action Agencies were created by the federal Economic Opportunity Act in 1964. Nebraska has 9 federally funded Community Action Agencies, serving all 93 Nebraska counties.

The Foster Care and Adoption “System”

The foster care and adoption “system” consists of the Department of Health and Human Services, various child placement agencies, foster care providers, and similar agencies that provide foster care and adoption services to state wards and children who are not state wards. In addition to the Department of Health and Human Services, Nebraska has 12 licensed private adoption agencies. The provision of foster care may include (1) respite care, (2) emergency foster care, (3) foster care leading to other permanent placement, or (4) foster care leading to adoption.

Relevant Legislation

The Nebraska Legislature has adopted a substantial body of law relating to the subject of children’s behavioral health. A summary of relevant legislation relating to the children’s behavioral health “system” can be found in Appendix C of this report.

Funding

A more complete summary of state funding for children’s behavioral health can be found in Appendix G of this report. For FY 06 (July 1, 2005 to June 30, 2006), the Department of Health and Human Services reported the following expenditure for children’s behavioral health: (1) The Division of Behavioral Health: \$5,311,728; (2) The Division of Medicaid and Long-Term Care: \$110,418,434; and (3) The Division of Children and Family Services: \$5,435,002. Total expenditures for FY 06 were \$121,165,164.

Data, Information Sharing, and Accountability

There are a number of existing data bases relating to the delivery of children’s behavioral health services. Some of the more prominent data bases and information systems are briefly described below.

State-Wide Data Bases

The Nebraska Family On-line Client User System (N-FOCUS) is one of the principal data systems of the Department of Health and Human Services. N-FOCUS contains many applications that may have indirect relevance to children’s behavioral health (e.g., food stamps), but also contains information regarding Medicaid eligibility. N-FOCUS also contains Nebraska’s State Automated Child Welfare Information System (SACWIS), containing information regarding child abuse/neglect investigations and state wards

The Medicaid Management Information System (MMIS) is maintained by the Department of Health and Human Services. MMIS contains information regarding Medicaid eligibility, claims submitted and claims paid.

Medstat/Advantage Suite is maintained by Magellan Behavioral Health Care, Inc. Magellan is the administrative care organization responsible for managing the State's mental health and substance abuse services. Magellan's data base provides the state management and administrative reporting, and surveillance and utilization reviews through an interface with MMIS. Magellan also maintains basic demographic and treatment information regarding clients served through Nebraska's regional behavioral health authorities.

Regional Data Bases

Each regional behavioral health authority maintains separate systems for outcome data (e.g., child functioning) on children receiving behavioral health services. Each integrated care coordination unit (ICCU) maintains separate systems for outcome data on state wards placed in the ICCUs who are receiving behavioral health services.

Other Data Bases

The Nebraska Probation Management Information System (NPMIS) is maintained by Nebraska's Office of Probation Administration and contains information regarding probationers. Data bases are maintained separately by each probation district, but data are transferred to the central administrative office on a routine basis.

The Nebraska Student and Staff Record System (NSSRS), the Special Education Student Information System (SESIS), and the Consolidated Data Collection (CDC) are maintained by the Nebraska Department of Education. The SESIS is scheduled to become part of the NSSRS in 2008-2009.

Summary

The current children's behavioral health "system" in Nebraska provides excellent services and supports to many Nebraska children and families, but significant improvement and transformation is needed. Some of the more prominent deficiencies of the current "system" as identified by the task force include, but are not limited to:

1. A lack of coordination and integration across agencies and systems
2. No single point of accountability for the system
3. No uniform and portable needs assessment tool
4. Funding that is inconsistent, fragmented, and inefficiently allocated
5. A lack of adequate community-based services capacity
6. A shortage of behavioral health providers
7. A lack of adequate data and information systems and accountability measures for the system
8. A lack of transformational vision, planning, and implementation.

Leadership of the Children's Mental Health and Substance Abuse State Infrastructure Grant (SIG grant) have provided a similar assessment of the current "system:"

"For children and families, mental health and substance abuse services are funded and regulated by a host of different agencies at both the state and regional levels. A significant challenge is that the policies across these different agencies are not coordinated and create

confusion for families seeking access to care. Nebraska's rural/frontier status and demographics, leaves many areas where services are non-existent or not easily accessed for many communities. These changing demographics have created special challenges for services in all areas, but especially for the behavioral health system. Although the majority of Nebraskans are White, the State is becoming increasingly diverse and mental health and substance abuse service providers are challenged in providing linguistically and culturally appropriate care. Finally, while some excellent services are available, Nebraska has been challenged by a lack of evidence-based and family-centered services, particularly for some of our most challenging populations including youth with co-occurring substance abuse and emotional disorders, transition-aged youth and young children from birth through age five.

Contributing to the challenges facing behavioral healthcare in Nebraska is a lack of state level infrastructure. As we have looked for solutions to the problem, there have been numerous planning processes and initiatives including the Child and Adolescent Mental Health Search Conference, the Nebraska Family Portrait, the Nebraska Substance Abuse Treatment Task Force, the Governor's Early Childhood Mental Health Report, Mental Health Block Grant Report, Substance Abuse Block Grant Report, and the Child Abuse Task Force. Each of these enterprises has led to the awareness of system deficiencies including:

1. Lack of coordination across agencies
2. Absence of family-centered approaches across systems
3. Multiple case managers and multiple, uncoordinated service plans
4. No single point of accountability
5. Lack of outcome information
6. Multiple assessments across providers and systems
7. Lack of funding for best/evidence based practices
8. Multiple and conflicting policies regulating similar services
9. Lack of prevention and early intervention focus
10. A need for community based services
11. A need for standardized process to address transition age youth
12. Underserved populations – rural, minority youth, young children.”

Planning Considerations and Objectives

A careful review and analysis of the current system of behavioral health care for children in Nebraska provides a helpful background for the consideration of appropriate system planning objectives and recommendations. This section will propose a general context for children's behavioral health planning. Specific planning recommendations will follow in the next section.

Defining the broader context of children's behavioral health planning and policy development includes, at a minimum, an assessment of: (1) what children and families need; (2) who is responsible to meet the need; (3) what resources are available to meet the need; (4) who pays for meeting the need; and (5) what can be done to prevent the need from occurring in the first place. System of care values and expectations must be clearly stated and plans must be implemented and not merely formulated.

Need

Children with behavioral health disorders and their families have a variety of needs. Various studies and reports have attempted to describe the types, acuity, and prevalence of behavioral health disorders in children. Input has been solicited and received from various focus groups and other means. Trends and causes have been proposed and analyzed. Treatment modalities and best practices have been identified and improved.

Behavioral health disorders in children present themselves in a variety of ways. The behavioral health system of care for children must be able to accurately assess a child's behavioral health and treatment-related needs.

Once behavioral health and treatment-related needs have been identified, the goal of the behavioral health system must be recovery and wellness in the most effective and efficient manner (i.e. utilizing best practices) and in the least restrictive environment possible consistent with the best interests of the child and the community. All behavioral health planning must be centered on the child and his or her needs and those of his or her family. The specific means by which those needs are addressed is the critical focus of all behavioral health planning.

Responsibility

Addressing the behavioral health needs of children requires a concerted and cooperative effort on the part of many different individuals and entities, all focused on the recovery and wellness of the child. The necessity of an integrated and interconnected system of care cannot be overstated.

Behavioral health planning must clearly identify responsibilities and expectations of various parts of the system, including families, caregivers, and communities. We must avoid the unrealistic expectation that the state or other governmental entity can or should be able to address all the behavioral health needs that exist. System planning must also recognize the fundamentally important role and responsibility of family, friends, church, providers, third-party payors, and others.

The Department of Health and Human Services plays a particularly dominant role in the provision of behavioral health services to children. Behavioral health planning, therefore, must seek to clearly define the perimeters of the state's role in the system of care, based upon a thoughtful and realistic assessment of a number of relevant factors. Removing ambiguities,

providing clear lines of responsibility and communication, and ensuring adequate accountability and support for each part of the system are all critical to behavioral health planning.

Resources

Meeting the behavioral health needs of children requires a public-private partnership and an appropriate supply of services and supports. A shortage of services and supports currently exists in most Nebraska counties. Behavioral health planning must clearly define the necessary continuum of care for children's behavioral health. Additional capacity needs within that continuum must be ascertained, planned for, and developed.

Incentives and other means to encourage the statewide training and deployment of necessary personnel must be developed and implemented. The importance of family support organizations, peer-supported services, and faith-based organizations must be fully recognized and embraced.

Behavioral health planning should promote localized decision-making in the identification of behavioral health needs and in the development of appropriate resources to meet those needs. While there may never be a full compliment of resources to meet the existing need, the goal of behavioral health planning must nevertheless be to make the greatest possible progress toward that goal.

Funding

Funding is a particularly important and necessary resource for the provision of behavioral health services to children. While LB 542 (2007) specifically addresses the publicly funded behavioral health system, behavioral health planning must also consider the extent to which the presence or absence of other funding sources impacts the public system of care. The absence or inadequacy of private insurance coverage for behavioral health disorders, for example, has a direct impact on the number of persons accessing publicly-funded services.

An adequate and stable funding source is necessary to ensure access to services and supports by those who need them. Behavioral health planning should seek to access a diversity of funding sources, and should not become excessively dependent on state or other public funding. The public behavioral health system for children and adolescents must allocate funding in a coordinated, flexible, cost-effective, and accountable manner. Behavioral health planning should first look for ways to more effectively allocate existing state appropriations before seeking additional state funding.

The Nebraska Behavioral Health Services Act (LB 1083, 2004), address the topic of behavioral health funding directly. Neb. Rev. Stat. §71-811 requires the division to “coordinate the integration and management of all funds appropriated by the Legislature or otherwise received by the [Department of Health and Human Services] from any other public or private source for the provision of behavioral health services to ensure the statewide availability of an appropriate array of community-based behavioral health services and continuum of care and the allocation of such funds to support the consumer and his or her plan of treatment. Neb. Rev. Stat. §71-812 creates the Behavioral Health Service Fund. The fund must be used “to encourage and facilitate the statewide development and provision of community-based behavioral health services, including, but not limited to, (a) the provision of grants, loans, and

other assistance for such purpose and (b) reimbursement to providers of such services.”²⁷ Money from the fund is also allocated for “housing related assistance for very low income adults with serious mental illness.”²⁸

Prevention

Arguably the greatest success in any publicly funded system of care is helping people avoid the need to access the system in the first place. Behavioral health planning must prioritize the identification and utilization of effective prevention and early intervention strategies and services for children and adolescents.

System of Care Values and Principles²⁹

The “systems of care” approach is designed to improve the provision of services for children with behavioral health disorders and their families by applying core values (child-centered and family-focused, community-based, and culturally competent) and guiding principles (comprehensive array of services, individualized care, services in the least restrictive most normative environment that meets the needs of the child, case management is provided to navigate the system and link the child and family to appropriate services and supports, early identification and intervention, smooth transition to the adult service system, and the rights of children and families are protected) to the design and delivery of services and supports. This involves reform at three levels and all levels must be impacted for system of care reform to be lasting. These levels include (1) system, (2) program, and (3) practice.

The task force believes that core values and guiding principles must be present for any system of care work to be effective. Lasting transformation cannot be achieved without a commitment from those at the system, program and practice levels to these values and principles and a willingness to implement them throughout the design, development, implementation and evaluation of the system and system components.

More than one hundred communities nationwide have implemented local systems of care. These efforts have been supported through the Comprehensive Community Mental Health Services for Children and Their Families Program; and by the Child, Adolescent and Family Branch of the Center for Mental Health Services within the federal Substance Abuse and Mental Health Services Administration (SAMHSA). These local systems of care initiatives have produced positive outcomes in the lives of the children and families being served.

An effective service delivery system has an appropriate balance between the various levels of care, particularly between the more restrictive levels and the less restrictive levels. All levels of care are essential in meeting the needs of children and their families. However, if the service delivery system is underdeveloped the child and family may not receive the appropriate services and are either “over served” or “under served”.

Within a system of care the service delivery system is designed to meet the individual and unique needs of children and their families with services being driven by the needs and preferences of the child and family. Services are community-based and their management is built on multi-agency collaborations. The services offered, the agencies participating, and the

²⁷ Neb. Rev. Stat. §71-812(2).

²⁸ Neb. Rev. Stat. §71-812(3).

²⁹ See Appendix H.

programs generated to meet the needs of children are both responsive and sensitive to the cultural context and other characteristics of the children and families being served.³⁰

Demonstrated outcomes for systems of care include improved family functioning, reduced school absenteeism and drop-out, reduced utilization of restrictive services, and improvement in the overall problem behaviors severe enough to put the children at risk of out-of-home placement.³¹

Integrated System of Care	
<i>The system is effectively managed to produce positive outcomes in a cost efficient manner.</i>	
Assessment Process	Common assessment protocol accepted by all providers. Minimize the need for multiple and duplicative assessments.
Care Coordination	Appropriate caseloads to provide for individualized services.
Service Delivery/ Continuum of Care/ Array of Services	Children and their families receive individualized care and services within the least restrictive, most normative environment that is clinically appropriate to meet their unique needs. Includes formal services along with informal supports. Services are community-based.
Family Advocacy, Education and Resources	Available to assist families
Youth Advocacy and Support	Youth develop and participate in activities designed to develop leadership skills, provide activities, reduce stigma of mental illness, and provide youth a voice in their local system of care.
Care Management	Provides utilization management and review for all children.
Cultural Competency	Services and care coordination are sensitive and responsive to the cultural differences and special needs of the children and families served.
Data Driven Decision-Making	The utilization of data by family members, service providers, program and system leadership to allow for informed decision making at all levels of program development, delivery, and improvement.
Quality Assurance	Quality improvement process designed to monitor the adherence to the system of care principles in a manner that promotes safety, permanency and positive outcomes for each child and family served.
Evaluation	Evaluation and outcome reporting at all levels: - Individualized Family Service Plan (Practice) - Program - System
Interagency Collaboration	Integrated system with system partners working in a collaborative manner to serve the child and family.
Funding	Integrated with maximum flexibility of funding to more appropriately address the needs of children and families. Ability to leverage additional resources to support the system of care.

³⁰ "Evaluation of the Comprehensive Community Mental Health Services for Children and Their Families Program: Annual Report to Congress" (1998).

³¹ Data Trends: March 2000, #8, "Research and Training Center for Family Support and Children's Mental Health" (Portland State University).

Leadership of the Children's Mental Health and Substance Abuse State Infrastructure Grant (SIG grant) noted the following lessons learned from the state and national system of care sites:

- "1. Family involvement from the very beginning is important
2. There are a variety of roles for families within the system of care (e.g., peer mentoring, evaluation, information dissemination, policy advising, building youth organizations, etc.)
3. Cultural competence is more than just training
4. A planful approach to helping family organizations thrive is a good thing
5. Interagency collaboration is not an end in itself, but should be guided by a shared vision of what the system ought to be.
6. Vision is not enough; there must be consensus about the action steps to get there.
7. Evaluation is critical to sustaining and expanding the system of care
8. True interagency integration is hard work, but worth it
9. Trust is a big issue and true sharing of power is essential."

Scope

LB 542 (2007) defines the scope of the behavioral health planning by the task force to include "all juveniles accessing public behavioral health resources."³² Specifically, the plan must include, but is not limited to:

1. Plans for the development of a statewide integrated system of care to provide appropriate educational, behavioral health, substance abuse, and support services to children and their families. The integrated system of care should serve both adjudicated and nonadjudicated juveniles with behavioral health or substance abuse issues;

2. Plans for the development of community-based inpatient and subacute substance abuse and behavioral health services and the allocation of funding for such services to the community pursuant to subdivision (4) of section 43-406;

3. Strategies for effectively serving juveniles assessed in need of substance abuse or behavioral health services upon release from the Youth Rehabilitation and Treatment Center-Kearney or Youth Rehabilitation and Treatment Center-Geneva;

4. Plans for the development of needed capacity for the provision of community-based substance abuse and behavioral health services for children;

5. Strategies and mechanisms for the integration of federal, state, local, and other funding sources for the provision of community-based substance abuse and behavioral health services for children;

6. Measurable benchmarks and timelines for the development of a more comprehensive and integrated system of substance abuse and behavioral health services for children;

7. Identification of necessary and appropriate statutory changes for consideration by the Legislature; and

8. Development of a plan for a data and information system for all children receiving substance abuse and behavioral health services shared among all parties involved in the provision of services for children.

³² Neb. Rev. Stat. §43-4002 (Laws 2007, LB 542, §2).

This report does not provide a comprehensive and detailed children's behavioral health plan in each of the foregoing areas. The report attempts to provide a limited number of planning recommendations as an outline and guideline for change. The report also emphasizes the importance of establishing realistic goals and expectations for the system and not seeking to establish the unattainable. As progress is made, additional goals can be established, and attained, thus creating a foundation for further change.

Implementation

Numerous studies and reports have discussed and provided recommendations with respect to the children's behavioral health system. Behavioral health planning must learn from these earlier efforts, but must also go beyond them in providing for an effective means of implementation and system transformation.

Planning Recommendations

The task force believes it is important to translate past and present children's behavioral health study and recommendations into specific, meaningful action steps. The recommendations contained in this report are not exhaustive but prioritized in order to sharpen the focus of children's behavioral health planning and to help ensure its successful conclusion and implementation.

The task force is mandated in LB 542 (2007) to consider the following in its behavioral health planning recommendations: (1) a statewide integrated system of care for children and families, including an integrated and comprehensive data and information system;³³ (2) service capacity, including YRTC youth and services provided under Neb. Rev. Stat. §43-406(4);³⁴ (3) funding;³⁵ (4) benchmarks and timelines;³⁶ and (5) legislation.³⁷ These will form the basis for planning recommendations that follow.

Integrated System of Care

An integrated system of care requires coordination and effective governance, and an active partnership with children and families in all aspects of service planning and delivery. The achievement of a comprehensive and integrated system of care requires the consensus development and adoption of a necessary service array and system integration plan.

Recommendation #1

The task force recommends that the Division of Behavioral Health within the Department of Health and Human Services assume primary responsibility for statewide coordination of the children's behavioral health system. The task force recognizes and applauds the fact that the Director of the Division of Behavioral Health has appointed a children's behavioral health administrator within the division to facilitate such coordination.

Recommendation #2

The task force recommends that the Division of Behavioral Health prepare a comprehensive statewide coordination plan for children's behavioral health for the task force's review. Coordination relates to the governance level of the behavioral health system and refers to the cooperative interaction of agencies and organizations charged with various administrative roles and functions within the system. Consistency and responsibility in policy and decision-making is a focal point of planning in this area.

In preparing the plan, the division should consider strategies and mechanisms that will ensure the most effective and efficient long-term coordination and integration of the children's behavioral health system, while minimizing the number of quasi-governmental advisory and other bodies for which the division is accountable. The division should form a temporary interagency working group for the development of an initial consensus on system coordination issues, concerns, and solutions.

³³ See Neb. Rev. Stat. §43-4002(2)(a), (h).

³⁴ See Neb. Rev. Stat. §43-4002(2)(b)-(d).

³⁵ See Neb. Rev. Stat. §43-4002(2)(e).

³⁶ See Neb. Rev. Stat. §43-4002(2)(f).

³⁷ See Neb. Rev. Stat. §43-4002(2)(g).

Recommendation #3

The task force recommends that the Division of Behavioral Health, in consultation with the task force, develop a proposed system integration plan for the children's behavioral health system that, in its opinion, will most effectively meet the needs of children and adolescents with behavioral health disorders and their families. Integration relates to the broader functioning of the children's behavioral health system and refers to the simplified and efficient interrelationship of all the persons, processes, and organizations involved in the delivery and funding of behavioral health services to children and their families.

Recommendation #4

The task force recommends that the Division of Behavioral Health, in consultation with the task force, develop a data and information proposal for the children's behavioral health system that, in its opinion, will most effectively enhance integration, access, and quality of behavioral health services provided to children and families and provide meaningful accountability evaluation mechanisms for the children's behavioral health system.

Capacity

An accurate assessment of need provides the basis for the identification and development of appropriate service capacity. Service capacity includes a full continuum of behavioral health services supported by adequate and sustainable funding. The development of appropriate service capacity requires coordinated planning and implementation and the effective recruitment and retention of behavioral health providers.

Recommendation #5

The task force recommends that the Division of Behavioral Health conduct a more comprehensive statewide analysis of child and adolescent behavioral health needs and current service capacity, in partnership with local public health departments, regional behavioral health authorities, family organizations, county government, providers, and others. The task force realizes that various surveys and assessments have been conducted, and intends that this analysis build upon and enhance those previous efforts. The task force recommends that the cost of the analysis be paid from a variety of sources, including but not limited to, Nebraska Health Care Cash Funds

Recommendation #6

The task force recommends that the Division of Behavioral Health, in consultation with the task force, prepare a proposed capacity development plan for the children's behavioral health system. The task force believes that the formation of a capacity development plan for children's behavioral health services should be based upon the statewide analysis of behavioral health needs and service capacity referenced above.

Recommendation #7

The task force recommends the establishment and implementation of a multidisciplinary and collaborative effort for behavioral health education to focus ongoing resources on the statewide recruitment, training, deployment, and retention of a broad spectrum of providers of children's behavioral health services and supports, including peer-provided and family support

services. The task force recommends the enactment of necessary and appropriate legislation in 2008 to establish such an initiative.

Recommendation #8

The task force recommends that residential adolescent mental health services at the Hastings Regional Center be discontinued, and transferred to appropriate community-based providers. On October 23, 2007, the Division of Behavioral Health Services provided notice of its intent to reduce capacity for adolescent residential psychiatric services at HRC from 16 beds to 8 beds. On that date, there were two youth receiving such services at HRC. Any reduction or discontinuation of regional center services must comply with relevant provisions of Neb. Rev. Stat. §71-810.

Recommendation #9

The task force recommends that the Office of Juvenile Services within the Department of Health and Human Services adopt necessary and appropriate changes to ensure that all YRTC youth with behavioral health needs are appropriately assessed. The task force recommends that the office diligently pursue alternatives to the referral of YRTC-Kearney youth to the Hastings Regional Center for residential substance abuse treatment whenever possible and appropriate.

Funding

The allocation and expenditure of funding for children's behavioral health services must be integrated, diversified, flexible, effective, and efficient. The task force believes that relevant provisions of the Nebraska Behavioral Health Services Act relating to funding should be more aggressively pursued and expanded.

Recommendation #10

The task force recommends that the Chief Executive Officer of the Department of Health and Human Services (department) be responsible for the development of a behavioral health funding integration proposal that comports with provisions of Neb. Rev. Stat. §71-811 and includes "all funds appropriated by the Legislature or otherwise received by the department from any other public or private source for the provision of behavioral health services."³⁸

The proposal should clearly identify all current behavioral health funding sources received by the department, the current policies and procedures governing the allocation and expenditure of such funds, an evaluation of the efficiency and effectiveness of such policies and procedures, and the development of alternative strategies and mechanisms to achieve a more simplified, integrated, and effective expenditure of behavioral health funding for children and adolescents. The task force recommends that the funding integration proposal be completed no later than June 30, 2008.

The task force recommends that the Director of the Division of Behavioral Health immediately ascertain and provide for the reallocation and expenditure of Hastings Regional Center funding associated with HRC services that have been reduced or discontinued pursuant to

³⁸ See Neb. Rev. Stat. §71-811.

Neb. Rev. Stat. §71-810 “for purposes related to the statewide development and provision of community-based services.”³⁹

Recommendation #11

The task force recommends the adoption of behavioral health insurance parity legislation. The task force recognizes that federal congressional action is currently pending on the issue and believes that such efforts should be closely monitored. The task force encourages the introduction and passage of state behavioral health insurance parity legislation if necessary and appropriate.

Recommendation #12

The task force recommends that the Division of Medicaid and Long-Term Care and the Division of Behavioral Health within the Department of Health and Human Services conduct an assessment and re-procurement of the current administrative services contracts with Magellan Behavioral Health. The task force recommends that such assessment and re-procurement be conducted as expeditiously as possible and completed no later than June 30, 2008.

Recommendation #13

The task force recommends that the Division of Behavioral Health and the Nebraska Legislature develop and implement administrative and legislative strategies and mechanisms to reduce the number of instances in which parents seek to have their children placed in the custody of the Department of Health and Human Services in order to access needed services.

Legislation

Recommendation #14

The task force recommends that Senator Johnson, as chair of the Health and Human Services Committee of the Legislature, oversee the preparation and introduction of necessary and appropriate legislation consistent with the foregoing recommendations, including but not limited to: (1) amendments to statutes relating to the Children’s Behavioral Health Task Force; (2) amendments to the Nebraska Behavioral Health Services Act relating to the provision of children’s behavioral health services; and (3) legislation to establish and fund a collaborative and multidisciplinary initiative focusing on the statewide recruitment and retention of behavioral health providers.

Recommendation #15

The task force recommends that the Health and Human Services Committee of the Legislature, in consultation with members of the Judiciary Committee of the Legislature, and other interested parties, review relevant provisions of the Nebraska Juvenile Code and the Health and Human Services, Office of Juvenile Services Act to identify and prepare necessary and appropriate statutory changes for consideration by the Legislature in 2009.

³⁹ Neb. Rev. Stat. §70-810 provides, in part, “. . . (4) As regional center services are reduced or discontinued under this section, the division shall make appropriate corresponding reductions in regional center personnel and other expenditures related to the provision of such services. All funding related to the provision of regional center services that are reduced or discontinued under this section shall be reallocated and expended by the division for purposes related to the statewide development and provision of community-based services. . . .”

Benchmarks and Timelines

Recommendation #16

The task force recommends and urges that the planning activities and recommendations contained in this report be pursued as expeditiously as possible and that the department include specific timelines for such activities in its plan submitted on or before January 4, 2007.⁴⁰ The task force requests that the Division of Behavioral Health provide quarterly progress reports to the task force beginning in January 2008.

Recommendation #17

LB 542 (2007) requires the Department of Health and Human Services to provide a written implementation and appropriations plan by January 4, 2008, based on the task force's report.⁴¹

The task force recommends that the department include specific timelines for completion of activities identified in the plan. The task force recommends that the chair of the task force be empowered to establish subcommittees of the task force as necessary and appropriate, in consultation with the task force and the department, to facilitate the further development and implementation of the plan submitted by the division.

⁴⁰ Neb. Rev. Stat. §43-4002(2) (Laws 2007, LB 542, §2).

⁴¹ Neb. Rev. Stat. §43-4002(2) (Laws 2007, LB 542, §2).

Appendices

- Appendix A Summary of Legislative Bills and Resolutions
- Appendix B Summary of Previous Activity Related to Children's Behavioral Health
- Appendix C Summary of Relevant Statutes
- Appendix D LB 542 (2007)
- Appendix E Summary of Key Components of The Nebraska Child and Adolescent Mental Health and Substance Abuse State Infrastructure Grant
- Appendix F Summary of "Chinn Report" Recommendations
- Appendix G Children's Behavioral Health Services
LB 542 Children's Behavioral Task Force
PowerPoint Presentation July 19, 2007
- Appendix H System of Care Diagram

Appendix A

Summary of Legislative Bills and Resolutions

Summary of Legislative Bills and Resolutions

Key:

- C = Held in Committee
- GF = Advanced to General File
- E = Enacted
- IPP = Indefinitely Postponed
- LB = Enacted as part of another Legislative Bill

1999

Bill	Subject	Disposition
360	(Dw. Pedersen) Prohibit mental health regions from being direct service providers	IPP
871	(Tyson) Create the Behavior Health Redesign Review Task Force	C

2000

Bill	Subject	Disposition
871	(Tyson) Create the Behavior Health Redesign Review Task Force	C
1022	(Robak, Kiel, Suttle, Thompson) Create the Community Criminal Justice Treatment Task Force	GF
1051	(Robak, Crosby, Suttle) Change provisions relating to medical assistance and provide assistance to persons with a medically improved disability	C
1210	(Robak, Bohlke, Kiel, Price, Schimek, Suttle) Adopt the Program for Assertive Community Treatment Act	GF
1264	(Dw. Pedersen) Require competitive bidding under the Nebraska Comprehensive Community Mental Health Services Act	IPP

2001

Bill	Subject	Disposition
13	(Dw. Pedersen) Change provisions for programs and services offered by mental health regional governing boards and requiring competitive bidding	IPP
530	(Suttle, Aguilar, Burling, Byars, Connealy, Cunningham, Engel, Erdman, Foley, Dw. Pedersen, Quandahl, Robak, Smith) Create the Mental and Behavioral Health and Substance Abuse Services Task Force	GF
682	(Jensen, Robak, Dw. Pedersen) Adopt the Nebraska Behavioral Health Services Act	GF
692	(Byars, Cunningham, Engel, Erdman, Jensen, Maxwell, Price, Suttle, Robak, Smith, Redfield, Stuhr, Thompson) Change provisions relating to local public health departments, the Nebraska Lifespan Respite Services Program, and the Nebraska Health Care Funding Act	E
Resolution		
138	(Hilgert) Interim Study to examine rates paid to behavioral health providers through publicly-funded programs	

2002

Bill	Subject	Disposition
1277	(Jensen) Provides for agreements between parents and the Department of Health and Human Services for services for their children	C

2003

Bill	Subject	Disposition
450	(Byars) Adopt the Medicaid Patients Open Access for Mental Health Treatments Act	C
710	(Jensen) Revise the Nebraska Mental Health Commitment Act	C
724	(Jensen, Thompson) Adopt the Nebraska Behavioral Health Reform Act and change release provisions for committed persons	E
Resolution		
145	(Thompson) Interim study to examine the need for mental health advance directives in Nebraska	

2004

Bill	Subject	Disposition
710	(Jensen) Revise the Nebraska Mental Health Commitment Act	LB 1083
931	(Redfield, at the request of the Governor) Authorize use of the Affordable Housing Trust Fund for rental assistance	LB 1083
1054	(Cunningham, Byars, Erdman, Jensen, Maxwell, Combs, Johnson) Provide for student loans for mental health students to practice in rural areas	LB 1005
1083	(Jensen, Redfield, Byars, Stuthman, Johnson, Maxwell, Synowiecki, Erdman) Change and eliminate provisions relating to behavioral health services, mental health commitments, affordable housing, and alcohol and drug abuse counselors	E
1237	(Connealy, Cunningham, Johnson) Adopt the Behavioral Health Rate Reimbursement Determination Act	C
Resolution		
356	(Jensen) Interim study of the Nebraska Mental Health Commitment Act and its implementation	

2005

Bill	Subject	Disposition
101	(Byars, Chambers, Jensen) Provide for early intervention services for children with autism spectrum disorder	GF
193	(Thompson) Transfer oversight of the County Juvenile Services Aid Program	E
259	(Dw. Pedersen) Create a work group for purposes of training youth services workers	E
264	(Howard, Brown, Kruse, Price, Stuhr, Aguilar) Authorize secondary prevention services and change child welfare caseload requirements	E
551	(Jensen) Change provisions relating to behavioral health services	E
606	(Thompson) Adopt the Children's Behavioral Health Act	C
618	(Flood, Burling, Cunningham, Erdman, Howard, Stuthman) Provide for tracking, reporting, and funding relating to behavioral health services	E
719	(Howard, Byars, Cunningham, Jensen, Price, Redfield) Eliminate certain payments to guardians of wards of the Department of Health and Human Services	C

728	(Stuthman, Kruse) Create the Provider Reimbursement Advisory Committee for health care reimbursement	C
Resolution		
79	(Howard) Interim study to determine the extent to which wards of the Health and Human Services System are being prescribed behavior-modifying medication	

2006

Bill	Subject	Disposition
766	(Howard) provide for a task force to study psychotropic drug use by wards of the state	GF
844	(Byars, Howard, Johnson, Connealy, Cornett, Flood, Aguilar, Combs, Kruse, Dw. Pedersen, D. Pederson, Price, Schrock) Adopt the Health and Human Services System Act	LB 994
884	(Howard) Eliminate the position of Policy Secretary of the Health and Human Services System	IPP
1132	(Price) Provide for the use of family-centered practices in providing behavioral health services	C
1155	(Howard, Bourne, Byars, Cunningham, Loudon, McDonald, Price, Redfield, Stuhr, Synowiecki, Thompson) Change provisions relating to adoption for state wards with special needs	C
1220	(Byars) Adopt the Rural Behavioral Health Training and Placement Program Act	LB 994
1232	(Jensen) Provide for a study of behavioral health insurance parity legislation	LB 1248
1244	(Howard) Provide duties for the Department of Health and Human Services Regulation and Licensure relating to prevention of alcohol-related birth defects	GF

2007

Bill	Subject	Disposition
52	(Howard, Dierks, Hudkins, Johnson, Nantkes, Pedersen) Create a task force to examine the prescription and administration of certain drugs to children who are wards of the state	IPP
296	(Johnson, Burling, Erdman, Fischer, Flood, Friend, Gay, Hansen, Howard, Hudkins, Janssen, Kruse, Loudon, Nantkes, Pankonin, Pedersen, Pirsch, Stuthman, at the request of the Governor) Reorganize the Health and Human Services System	E
616	(Pedersen, Johnson) Eliminate a provision relating to regional behavioral health authorities	IPP
617	(Pedersen, Johnson) Change provisions relating to children's behavioral health	IPP
Resolution		
205	(Johnson) Interim study to provide development of additional recommendations relating to implementation of the Nebraska Behavioral Health Services Act	
168	(Flood, Stuthman) Interim study to examine issues relating to Nebraska's emergency protective custody procedures	
203	(Johnson) Interim study to examine statewide behavioral health services	

Appendix B

Summary of Previous Activity Related to Children's Behavioral Health

Summary of Previous Activity Related to Children's Behavioral Health

1970s

Krivosha Commission Report Sarata Report – Proposed improved coordination across agencies and expand services to youth in state custody including mental health and substance abuse services.

1985

Nebraska's first **Child and Adolescent Services System Program (CASSP) Grant** – five year planning and implementation grant from SAMHSA designed to promote systems of care at state level including innovative service delivery, family involvement, cultural competence, and collaboration across agencies.

1986

Interagency agreement to develop **Interagency Collaboration and Coordination Team** involving State Court Administrator and Departments of Corrections, Education, Health, Public Institutions, and Social Services to improve the system of care for multi-need children and their families.

1987

Enactment of **Nebraska's Family Policy Act** – promoted prevention and early identification of problems, encouraged community involvement in meeting the needs of children and families, coordination of services and resources and the need for permanency planning.

1989

Development of **Child and Adolescent Mental Health Services Plan** – Identified the need for fixed point of accountability, flexible funding, single point of access, development of middle-intensity services, and family participation in decision making.

1993

Nebraska's second **CASSP Grant** – designed to promote interagency collaboration for children with mental health challenges at the state and local levels.

1994

Governor's Child and Family Mental Health Search Conference – involved 70 stakeholders and identified needs such as Professional Partners, local integrated interagency collaboration, coordination of funding streams, single points of entry, and comprehensive array of services.

1997

Region 3 receives **SAMHSA System of Care Grant** to develop local system of care focusing on family-centered care, evidence-based practices, interagency collaboration, family involvement, and data-based decision making.

1998

Lancaster County in Region 5 receives the second of Nebraska's **System of Care Grants** from SAMHSA focusing on addressing the mental health needs of youth in the juvenile justice systems.

1999

The formation of the **Justice Behavioral Health Committee**, formerly Justice Substance Abuse Team (JSAT) of the Community Corrections Council which helped develop a standardized model for substance abuse screening and assessment.

Chinn Report – Identified need for mental health and substance abuse screening, evaluation and services for juvenile offenders.

2000

Nebraska Family Portrait - strategic action plan for Protection and Safety to improving the safety, permanence and well-being of children in Nebraska. Included a focus on addressing the behavioral health needs of children who are wards of the state.

2001

Governor's Early Childhood Mental Health Symposium - design of a comprehensive, integrated and coordinated system of care to meet the mental health needs of young children. Promoted interagency collaboration, coordination of funding, and led to pilot project for early childhood mental health system of care.

Governor's Juvenile Justice Reform Plan – supported the “expansion and development of substance abuse and mental health programming” for juvenile offenders.

2002

Herz & Poland Study of Mental Health Needs of Juvenile Offenders – identified need for a coordinated response for juvenile offenders, continuum of services, standard process for assessing needs, funding that follows the child, system evaluation, training, and the development of effective services like Multisystemic Therapy.

Nebraska receives **NEBHANDS grant** to help build the capacity of small faith and community-based organizations to participate in systems of care for mental health and substance abuse.

2004

Passage of LB 1083, the **Nebraska Behavioral Health Services Act**.

Nebraska receives **SAMHSA State Infrastructure Grant (SIG)** to develop state infrastructure to support local systems of care with focus on family-centered care, evidence-based practices, blended funding, and enhancing accountability through evaluation, and coordination across agencies.

2007

LB 542 Task Force – charged with developing plans for a statewide integrated system of care for children's mental health.

Appendix C

Summary of Relevant Statutes

Summary of Relevant Statutes

<u>Statute</u>	<u>Neb. Rev. Stat.</u>
Juvenile Code	§43-245 to §43-2,129
Juvenile Courts	§43-2,111 to §43-2,129
HHS, Office of Juvenile Services Act	§43-401 to §43-423
Juvenile Detention Facilities	§43-4,124 to 43-4,134
Children committed to DHHS	§43-903 to §43-908
Juvenile Services Act	§43-2401 to §43-2413
Early Childhood Interagency Coordinating Council	§43-3401 to §43-3403
County Juvenile Services Plan Act	§43-3501 to §43-3507
Court Appointed Special Advocate Act	§43-3701 to §43-3716
Medical Assistance Act	§68-901 to §68-949
Behavioral Health Services Act	§71-801 to §71-818
Special Education Act	§79-1110 to §79-1178
Early Childhood Education	§79-1101 to §79-1104
State Institutions, Management	§83-101.06 to §83-116
Youth Rehabilitation and Treatment Centers	§83-107.01
Regional Centers	§83-305 to §83-357
Cost of Patient Care in State Institutions	§83-363 to §83-380.01
Secure Youth Confinement Facility	§83-905

Appendix D

LB 542 (2007)

LEGISLATIVE BILL 542

Approved by the Governor May 24, 2007

Introduced by Synowiecki, 7

FOR AN ACT relating to juvenile services; to amend section 43-407, Reissue Revised Statutes of Nebraska; to create the Children's Behavioral Health Task Force; to provide powers and duties; to change provisions relating to treatment programs and services; to repeal the original section; and to declare an emergency.

Be it enacted by the people of the State of Nebraska,

Section 1. (1) The Children's Behavioral Health Task Force is created. The task force shall consist of the following members:

(a) The chairperson of the Health and Human Services Committee of the Legislature or his or her designee;

(b) The chairperson of the Appropriations Committee of the Legislature or his or her designee;

(c) The chairperson of the Behavioral Health Oversight Commission of the Legislature;

(d) Two providers of community-based behavioral health services to children, appointed by the chairperson of the Health and Human Services Committee of the Legislature;

(e) One regional administrator appointed under section 71-808, appointed by the chairperson of the Health and Human Services Committee of the Legislature;

(f) Two representatives of organizations advocating on behalf of consumers of children's behavioral health services and their families, appointed by the chairperson of the Health and Human Services Committee of the Legislature;

(g) One juvenile court judge, appointed by the Chief Justice of the Supreme Court;

(h) Two representatives of the Department of Health and Human Services, appointed by the Governor; and

(i) The Administrator of the Office of Juvenile Services.

(2) All members shall be appointed within thirty days after the effective date of this act.

(3) Members of the task force shall serve without compensation but shall be reimbursed from the Nebraska Health Care Cash Fund for their actual and necessary expenses as provided in sections 81-1174 to 81-1177.

(4) The chairperson of the Behavioral Health Oversight Commission of the Legislature shall serve as chairperson of the task force. Administrative and staff support for the task force shall be provided by the Health and Human Services Committee of the Legislature and the Appropriations Committee of the Legislature.

Sec. 2. (1) The Children's Behavioral Health Task Force, under the direction of and in consultation with the Health and Human Services Committee of the Legislature and the Department of Health and Human Services, shall prepare a children's behavioral health plan and shall submit such plan to the Governor and the committee on or before December 4, 2007. The scope of the plan shall include juveniles accessing public behavioral health resources.

(2) The plan shall include, but not be limited to:

(a) Plans for the development of a statewide integrated system of care to provide appropriate educational, behavioral health, substance abuse, and support services to children and their families. The integrated system of care should serve both adjudicated and nonadjudicated juveniles with behavioral health or substance abuse issues;

(b) Plans for the development of community-based inpatient and subacute substance abuse and behavioral health services and the allocation of funding for such services to the community pursuant to subdivision (4) of section 43-406;

(c) Strategies for effectively serving juveniles assessed in need of substance abuse or behavioral health services upon release from the Youth Rehabilitation and Treatment Center-Kearney or Youth Rehabilitation and Treatment Center-Geneva;

(d) Plans for the development of needed capacity for the provision of community-based substance abuse and behavioral health services for children;

(e) Strategies and mechanisms for the integration of federal, state, local, and other funding sources for the provision of community-based substance abuse and behavioral health services for children;

(f) Measurable benchmarks and timelines for the development of a more comprehensive and integrated system of substance abuse and behavioral health services for children;

(g) Identification of necessary and appropriate statutory changes for consideration by the Legislature; and

(h) Development of a plan for a data and information system for all children receiving substance abuse and behavioral health services shared among all parties involved in the provision of services for children.

(3) The department shall provide a written implementation and appropriations plan for the children's behavioral health plan to the Governor and the committee by January 4, 2008. The chairperson of the Health and Human Services Committee of the Legislature shall prepare legislation or amendments to legislation to implement this subsection for introduction in the 2008 legislative session.

Sec. 3. The Children's Behavioral Health Task Force will oversee implementation of the children's behavioral health plan until June 30, 2010, at which time the task force shall submit to the Governor and the Legislature a recommendation regarding the necessity of continuing the task force.

Sec. 4. Section 43-407, Reissue Revised Statutes of Nebraska, is amended to read:

43-407 The Office of Juvenile Services shall design and make available programs and treatment services through the youth rehabilitation and treatment centers ~~for juvenile offenders. Youth Rehabilitation and Treatment Center-Kearney and Youth Rehabilitation and Treatment Center-Geneva.~~ The programs and treatment services shall be based upon the individual or family evaluation process and treatment plan. The treatment plan shall be developed within fourteen days after admission. If a juvenile placed at the Youth Rehabilitation and Treatment Center-Kearney or Youth Rehabilitation and Treatment Center-Geneva is assessed as needing inpatient or subacute substance abuse or behavioral health residential treatment, the juvenile may be transferred to a program or facility if the treatment and security needs of the juvenile can be met. The assessment process shall include involvement of both private and public sector behavioral health providers. The selection of the treatment venue for each juvenile shall include individualized case planning and incorporate the goals of the juvenile justice system pursuant to section 43-402. Juveniles committed to the Youth Rehabilitation and Treatment Center-Kearney or Youth Rehabilitation and Treatment Center-Geneva who are transferred to alternative settings for treatment remain committed to the Department of Health and Human Services and the Office of Juvenile Services until discharged from such custody. Programs and treatment services shall address:

(1) Behavioral impairments, severe emotional disturbances, sex offender behaviors, and other mental health or psychiatric disorders;

(2) Drug and alcohol addiction;

(3) Health and medical needs;

(4) Education, special education, and related services;

(5) Individual, group, and family counseling services as appropriate with any treatment plan related to subdivisions (1) through (4) of this section. Services shall also be made available for juveniles who have been physically or sexually abused;

(6) A case management and coordination process, designed to assure appropriate reintegration of the juvenile to his or her family, school, and community. This process shall follow individualized planning which shall begin at intake and evaluation. Structured programming shall be scheduled for all juveniles. This programming shall include a strong academic program as well as classes in health education, living skills, vocational training, behavior management and modification, money management, family and parent responsibilities, substance abuse awareness, physical education, job skills training, and job placement assistance. Participation shall be required of all juveniles if such programming is determined to be age and developmentally appropriate. The goal of such structured programming shall be to provide the academic and life skills necessary for a juvenile to successfully return to his or her home and community upon release; and

(7) The design and delivery of treatment programs within through the youth rehabilitation and treatment centers as well as any licensing or certification requirements, and the office shall follow the requirements as stated within Title XIX and Title IV-E of the federal Social Security Act, as amended, ~~such act existed on the effective date of this act,~~ the Special Education Act, or other funding guidelines as appropriate. It is the intent of the Legislature that these funding sources shall be utilized to support service needs of eligible juveniles, in residence at the youth rehabilitation and treatment centers.

Sec. 5. Original section 43-407, Reissue Revised Statutes of Nebraska, is repealed.

Sec. 6. Since an emergency exists, this act takes effect when passed and approved according to law.

Appendix E

Summary of Key Components of
The Nebraska Child and Adolescent
Mental Health and Substance Abuse
State Infrastructure Grant

**Summary of Key Components of
The Nebraska Child and Adolescent
Mental Health and Substance Abuse
State Infrastructure Grant**

August 22, 2007



UNIVERSITY OF
Nebraska
PUBLIC POLICY CENTER

Summary of Nebraska's SIG Initiative

In October 2004, the Nebraska Department of Health and Human Services received a State Infrastructure Grant from the Substance Abuse and Mental Health Services Administration. This five year grant is designed to help states improve their infrastructure (e.g., information systems, funding structures, organizational frameworks, evaluation capacity) to support community-based systems of substance abuse and mental health services for children and their families.

Committee Structure: This project operates through a committee structure with a Steering Committee and several subcommittees developing recommended strategies. Attachment 1 provides an overview of some of the key activities conducted as part of the grant. Attachment 2 provides an overview of the committee structure. The Steering Committee Charter can be found in Attachment 3. A summary highlighting progress on key strategies can be found in Attachment 4.

Logic Model: Subcommittees followed a logic model to develop recommendations pertaining to key infrastructure needs in Nebraska.

Future Priority Areas: Based on the goals of SIG, there are five priority areas for developing infrastructure: Partnering with Families and Youth, Integrated Funding, Accountability Evaluation System, Evidence-Based Practice, and Integrated Organizational Structure (see Attachment 5).

Evidence-Based Practice: The SIG Academic Committee adopted a framework to classify evidence-based practices (EBP) and outlined policy options for EBP implementation. The next step in this process will be to begin piloting effective service delivery models.

Technical Assistance for Family Organizations: Through the SIG project, eight family organizations through the State conducted organizational assessments and received technical assistance to help build the infrastructure of their organizations. This assistance included board development, strategic planning, developing effective accounting systems, and enhancing youth partnerships.

Family Focus Groups: To help gain an understanding of the critical infrastructure issues facing families, focus groups were conducted in each region of the state. The full report was presented to the SIG Steering Committee.

Provider Focus Groups: To help understand issues confronting behavioral health service providers, focus groups were conducted across the state.

Medical Professional Focus Groups: To gain information about the ability of medical providers to screen, assess, and treat mental health issues in young children and perinatal depression, surveys and focus groups were conducted with medical personnel. A training curriculum was developed to help train providers.

Accountability Evaluation System: To begin development of an evaluation accountability evaluation system, a first step was to track data collected by the various information system used in the State. The next steps in this process are to define a minimum data set that can be collected across systems to indicate who is being served, how they are being served and what outcomes are produced by those services.

Transition Aged Youth: One of the key SIG strategies is to enhance services to transition aged youth. Initial efforts have been made to identify the needs of this population and enhance services.

Positive Behavioral Support: To evaluate the implementation of early childhood Positive Behavioral Support (PBS) and build competency in mental health and early childhood workforce a system of progress monitoring to inform the program on quality of implementation of the model and its impact on children, families, and staff outcomes.

Financing and Organizational Models: Two work teams focused on strategies to develop organizational structures and blended funding models to effectively integrate service delivery for children and families.

Background Research: Through the SIG project, information has been collected to assist the subcommittees develop effective strategies. Some of the key information includes prevalence estimates, organizational and funding structures in other state and local systems of care, and other initiatives in Nebraska related to children's behavioral health reform.

**Attachment 1:
Sponsor: HHSS Policy Cabinet
Leadership Role: Medicaid**

- Project Management Team
- * Key Staff Assigned
- * Project Coordinator
- * Project Director

October 2004
Grant
Received
750,000 > 5
Years

2005
4/05 Family Centered Conference - Lincoln
8/5/05 Statewide Steering Committee Initiated – Kick Off Conference
8/5/05 * Early Childhood * Youth * Evaluation/ Academic Committees Formed
10/10/05 – 12/30/05 Children's Services Initiative Focus Group Data Collection
12/8/05 Set SIG Guiding Principles Set in Motion Bob Friedman Presentation

2006
02/06 Recommendations of Youth, Early Childhood and Academic approved by SC
05/06 Organizational Structure and Finance Work Teams chartered
-5/18/06 Youth & Family Focus Group Recommendations adopted by Steering Committee - Organizational Assessments of Fam. Org. – TA begins
September 12, 2006 Family Centered Practice Conference in Lincoln. NE
Oct 25, 2006 Formal vote accepting all ten recommended strategies from the organizational structure and finance work teams Decision to expand academic committee to include more family members & providers, to work with other states on EBPs
12/07/06 Poster Presentation on Fam. Org. TA at National Fed of Families Conference

2007
2/26/07- 5/16/07 Provider Focus Group Data Collection
03/06/07 Poster Pres – EBP at Children's Mental Health Research - Tampa Florida
03/07 Project Management Team Retreat
4/26/07 JMATE Conf. Paper Presentations – Family Organization TA & EBP Implementation
4/19/07 -NMA Provider Survey and Focus Group Results; Pres: MCT by Youth Villages in Tennessee Pres. of Pilots -- CFA, EBP, Program Evaluation
06/07 Work Plan approved for TA for Youth Involvement and enhanced Family Support Work Plans approved for training MH providers on PBS and Evaluation of PBS Initiative
June 20, 2007 HHS Restructuring SIG Adopts CFA to move it beyond P&S and explore CFA by Medicaid and BH and move the pilot out of the western part of the state. Vote to explore the development of a MCR pilot through SIG and the divisions of HHS in a budget neutral environment

Attachment 2: Nebraska's Children's Mental Health and Substance Abuse State Infrastructure Grant

Purpose

Develop infrastructure for a system of
mental health and substance abuse care at
the state, regional and local levels

Goals

Support evidence-based interventions

Ensure cultural competence and family-centered approaches at all levels

Integrate across child and family serving agencies

Committee Charters

Steering Committee: set priorities, identify focus areas, establish subcommittees, coordinate and oversee the work of the subcommittees, and prepare final recommendations to further SIG goals

Youth Subcommittee: Develop state infrastructure needed to support community efforts to meet mental health and substance abuse needs of youth and their families.
Recommendations approved

Early Childhood Subcommittee: Develop state infrastructure needed to address the mental health needs of young children (ages 0-5) and their families
Recommendations approved 2/27/06

Academic Subcommittee: Promote the use of evidence-based practices and provide a forum for researchers, policy makers, consumers and service providers to plan and conduct relevant,

Finance Work Team: Develop state and regional financing structures to support local systems of care for children with mental health and substance abuse issues and their families.

Organizational Structure Work Team: Develop state and regional organizational structures to support local systems of care for children with mental health and substance abuse issues and their families

Priorities

Develop financing mechanisms and organizational structures to ...

1. support family and youth partnerships
2. ensure appropriate services and supports
3. ensure accountability
4. support realignment/integration

Attachment 3:

**NEBRASKA CHILDREN'S MENTAL HEALTH AND
SUBSTANCE ABUSE STEERING COMMITTEE**

PURPOSE: The Steering Committee will set priorities, identify focus areas, establish subcommittees, coordinate and oversee the work of the subcommittees, and prepare final recommendations on ways to strengthen the statewide system for delivering mental health and substance abuse services for children and adolescents.

BACKGROUND: Nebraska's response to children's mental health could be enhanced through increased coordination and development of infrastructure at the state, regional, and local levels. The Steering Committee will identify strategies to improve service delivery systems for children and families by building on best practices, promising practices and initiatives across the state.

CHARGE:

1. Provide guidance and oversight to project work teams
2. Monitor progress of the project
3. Review work team products
4. Assess capacity at the state, regional and local levels
5. Charter new work teams as needed
6. Review and recommend changes in policy, organizational structure, and financing of the child and adolescent mental health and substance abuse services system.
7. Prepare final recommendations

TIMELINE: August – September 2006

SPONSORING AUTHORITY: Nebraska Health and Human Services System Policy Cabinet

ROLES: Committee chairs will set agendas; facilitators are available to help run meetings; staffing is available to provide background support and to record meeting notes.

Attachment 4:

**Nebraska’s Child and Adolescent Mental Health
And Substance Abuse State Infrastructure Grant
Major Recommendations and Status**

Recommendations	Status
Outcome 1: Develop Infrastructure to Support Family and Youth Partnerships	
A. Explore ways to reduce custody relinquishment – Steering Committee recommendation 10/06	<ol style="list-style-type: none"> 1. In process of conducting state ward study 2. Reviewed structures from other states and presented to steering committee
B. Support Family Organizations – Steering Committee recommendation 10/06	<ol style="list-style-type: none"> 1. Completed organizational needs assessment of eight family organizations across state 2. Family focus groups conducted 3. Based on needs assessment, unique technical assistance provided for each organization 4. Work team developed to coordinate HHS activities with family organizations 5. Technical assistance initiated with family organizations regarding youth involvement
C. Develop infrastructure that supports family-centered practice – Steering Committee recommendation 10/06	<ol style="list-style-type: none"> 1. Provided statewide training on family-centered practice 2. Regional meetings, train-the-trainer sessions and web site put on hold 3. Review of family-centered practice language in DHHS policies and procedures completed
D. Develop pilots for comprehensive family assessment – Steering Committee recommendation 6/07	<ol style="list-style-type: none"> 1. Protection and Safety implementing pilot in western Nebraska 2. Evaluator currently designing evaluation
Outcome 2: Develop Infrastructure for Effective Services and Supports	
A. Promote evidence-based and promising practices – Steering Committee recommendation 10/06	<ol style="list-style-type: none"> 1. Academic Committee developed EBP definition, policy options based on review of other states, reviewed data bases. 2. Conducted provider focus groups 3. Project Management Team is developing specific proposal for piloting an evidence-based practice
B. Develop transition between youth and adult services – Steering Committee recommendation 10/06	<ol style="list-style-type: none"> 1. Work team has identified issues relating to transition-aged youth
C. Promote early childhood mental health - Steering Committee recommendation 10/06	<ol style="list-style-type: none"> 1. Conducted surveys and focus groups with providers to assess needs 2. Curriculum under review by stakeholders 3. Conducting behavioral health provider training and evaluating Positive Behavioral Supports 4. Early child medication review protocol

Outcome 3: Develop Infrastructure to Ensure Accountability	
<p>A. Develop performance indicators to measure success of providers and system to ensure accountability - Steering Committee recommendation 10/06; recommendation to pilot comprehensive performance evaluation approved at 6/07 meeting</p>	<ol style="list-style-type: none"> 1. Reviewed current instruments used nationally and in state 2. Developed DHHS Data Dictionary 3. Project Management Team is developing a specific proposal for piloting a performance evaluation pilot project to measure child and family characteristics, service indicators, costs, and outcomes 4. Project Management Team is developing specific proposal to evaluate pilot projects related specifically to mobile crisis response and comprehensive family assessment
Outcome 4: Develop Integrated/Coordinated Organizational Structure	
<p>A. Establish an interagency council at the state regional and local levels – Steering Committee recommendation 10/06; recommendation to develop local interagency groups to review progress of pilot projects approved at 6/07 meeting</p>	<ol style="list-style-type: none"> 1. Recommendation to keep the Steering Committee operational beyond the grant 2. Project Management Team is developing a specific proposal for piloting local interagency group to review implementation of pilots
<p>B. Develop school/mental health linkages - Steering Committee recommendation 10/06</p>	<ol style="list-style-type: none"> 1. Formed work team around positive behavioral supports 2. In fall 2007, will review local best practices for behavioral health/school collaboration
Outcome 5: Develop Integrated/Coordinated Funding	
<p>A. Develop multiple blended-funded pilots - Steering Committee recommendation 10/06; Develop pilot Mobile Crisis Response with funding from Medicaid, Protection & Safety, and Behavioral Health – Steering Committee recommendation 6/07</p>	<ol style="list-style-type: none"> 1. Reviewed national financing models 2. Project Management Team is developing a specific proposal for piloting Mobile Crisis Response using multiple funding streams

Attachment 5:

Recommended SIG Priorities For Each Outcome

Outcome 1: Develop Infrastructure to Support Family and Youth Partnerships

Continue providing technical assistance over the next grant year to the eight family organizations to support the **family support infrastructure**. The family Technical Assistance Work Group will continue monitoring the technical assistance being provided by John Ferrone.

Develop a pilot project for implementing **Comprehensive Family Assessments** standardized across service providers and child-serving systems.

- Action Steps:
 - a. Begin implementation of CFA in Western Nebraska
 - b. Identify training needs and plan for providing training
 - c. Develop evaluation design for reviewing implementation of CFA
 - d. Provide training
 - e. Develop reports summarizing evaluation findings and present to HHS leadership and SIG Steering Committee

Outcome 2: Develop Infrastructure for Effective Services and Supports

Develop a pilot service delivery model that incorporates **evidence-based practices**. Evidence-based practices are services demonstrated to benefit children with mental health and substance abuse disorders. The impact of moving toward evidence-based practices should be fewer out-of-home placements, reduced juvenile justice involvement and increased school attendance/performance.

- Action Steps:
 - a. Identify key outcomes for children desired by State (e.g., reduce out-of-home placements, reduce juvenile offenses)
 - b. Review research literature to identify practices likely to produce desired outcome
 - c. Review current HHS clinical guidelines/service requirements to assess conformity to selected evidence-based practice
 - d. Develop proposed service model guidelines and reimbursement rates across Behavioral Health, Protection and Safety, and Medicaid.
 - e. Develop budget neutral method for implementing
 - f. Pilot development of evidence-based practice including staff training, clinical supervision, fidelity monitoring, and outcome analysis
 - g. Begin implementation of CFA in Western Nebraska
 - h. Identify training needs and plan for providing training
 - i. Develop evaluation design for reviewing implementation of CFA

- k. Develop reports summarizing evaluation findings and present to HHS leadership and SIG Steering Committee

Outcome 3: Develop Infrastructure to Ensure Accountability

Develop an **accountability evaluation system** to collect and analyze data across systems regarding youth served, the quality of services provided and the outcomes produced by those services. This project will begin with a pilot in one area.

- Action Steps:
 - a. Review current DHHS Data encyclopedia and processes across systems
 - b. Establish evaluation work team that includes representatives from Medicaid, Protection & Safety, Behavioral Health, and Probation
 - c. Develop set of standardized outcome/process indicators based on consensus
 - d. Identify pilot site for implementation
 - e. Obtain agreement on implementation plan for piloting collection of data
 - f. Develop reports based on data collected to be used by local and state stakeholders
 - g. Develop report of barriers and lessons learned in implementing data collection process and results reporting

Outcome 4: Develop Integrated/Coordinated Organizational Structure

Develop **local organizational structures** around pilot project to build collaborative decision-making structures that includes government and private funders, service providers, and families. The Project Management team will produce a detailed work plan by August 31st.

- Action Steps:
 - a. Identify pilot sites
 - b. Convene local stakeholders
 - c. Develop by-laws for membership and functions
 - d. Develop protocols for sharing information about pilot progress
 - e. Document lessons learned from implementing the process

Outcome 5: Develop Integrated/Coordinated Funding

Develop a pilot project – **mobile crisis response** – that combines funding from Behavioral Health, Medicaid, and Protection and Safety. This pilot will help us understand how to blend funding across systems and lead to fewer out-of-home placements for children.

- Action Steps:

- a. Review current mobile crisis response models in Nebraska
- b. Review current mobile crisis response models nationally
- c. Review potential sources of funding across Medicaid, Protection & Safety, and Behavioral Health
- d. Identify potential costs savings resulting from implementation
- e. Develop detailed specifications for the service as basis for RFP or contract
- f. Identify program evaluation and training requirements
- g. Identify area(s) to pilot
- h. Detailed implementation plan presented for approval

Appendix F

Summary of “Chinn Report” Recommendations

Summary of “Chinn Report” Recommendations

System Recommendations

1. Create a distinct Department of Juvenile Offender Services within the Department of Health and Human Services
2. Expand Office of Juvenile Services administrative, management, and oversight capability
3. Develop single point of entry into state custody
4. Expand community-based/non-residential supervision programs (e.g. functional family therapy and multi-systemic therapy)
5. Reduce reliance on residential evaluations and placement in secure detention
6. Expand residential services for “special needs” offenders
7. Enhance efforts to keep youth in their home communities

Operational Recommendations

1. Enhance risk assessment and evaluation process
2. Expand programming for “special needs” offenders at the Youth Rehabilitation and Treatment Centers (YRTCs)
3. Reduce length of stay at the YRTCs
4. Develop new treatment program at YRTC Kearney
5. Expand direct care and treatment staffing levels at the YRTC’s in Kearney and Geneva
6. Enhance aftercare programming
7. Expand vocational programming for older youth

Capacity Recommendation

The report recommends that the Office of Juvenile Services and Nebraska State Building Division plan for a total capacity of 346 youth YRTC placements in 2010, including the Hastings Regional Center, and 457 total youth in 2025.

Facility Options

1. Close the Hastings Regional Center and expand capacity at the YRTCs in Kearney and Geneva
2. Expand capacity at the Hastings Regional Center and maintain existing capacity at the YRTCs in Kearney and Geneva.

Appendix G

Children's Behavioral Health Services
LB 542 Children's Behavioral Health Task Force
PowerPoint Presentation July 19, 2007

Children's Behavioral Health Services

LB 542 Children's Behavioral Health Task Force

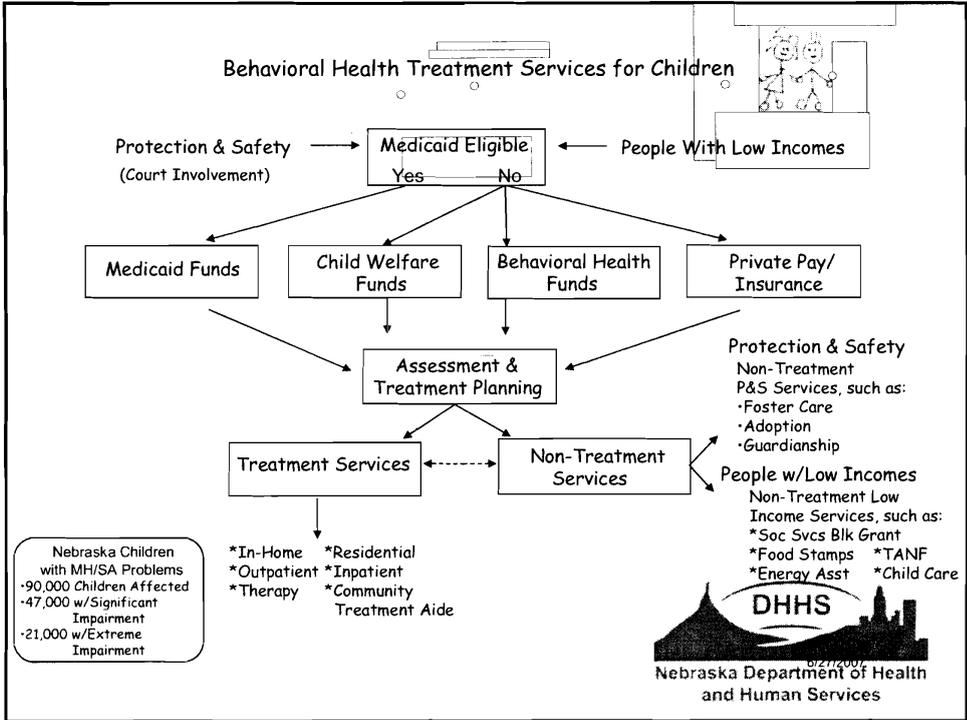
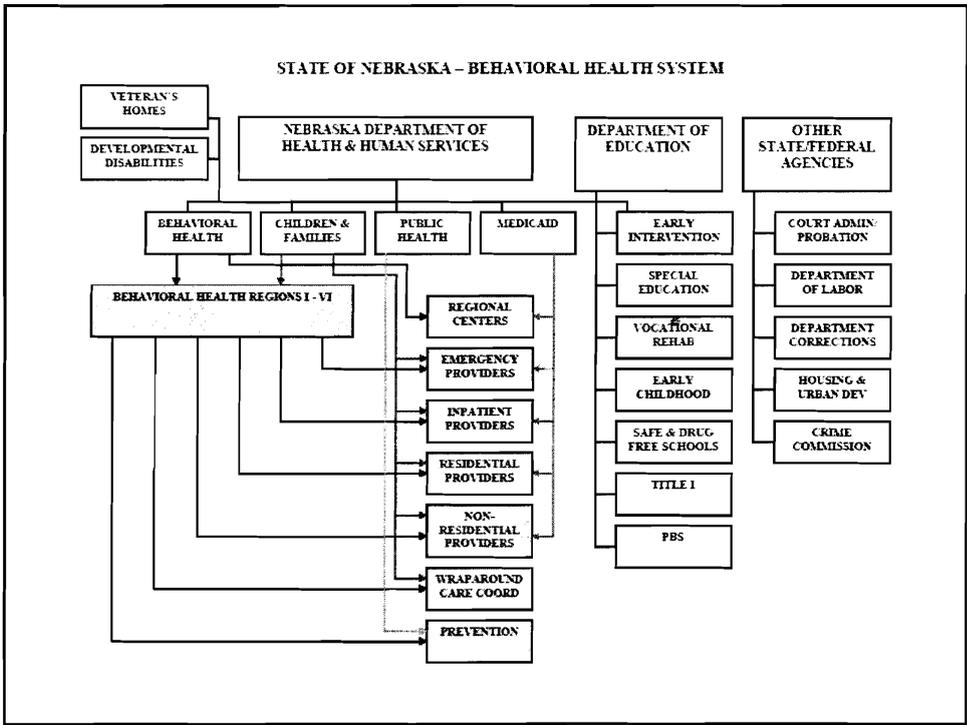
July 19, 2007

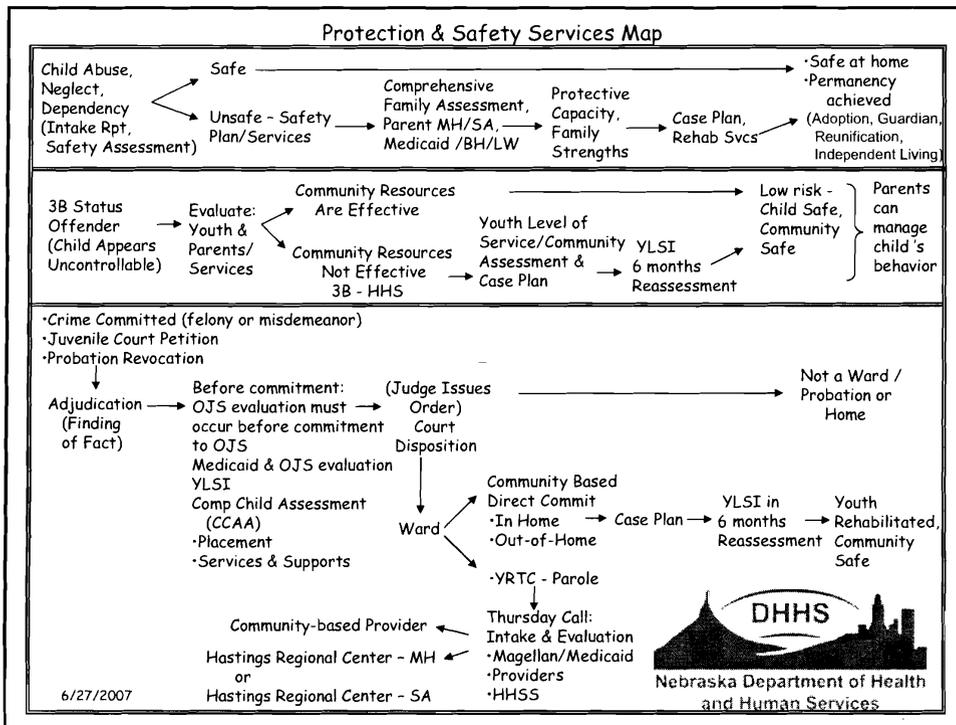


Overview

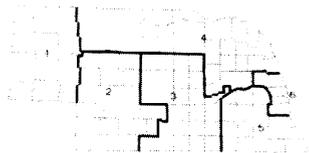
- **Overview of HHS Structure:**
 - Review of reorganized agency
- **Service Entry:**
 - Existing Pathways to Enter HHS Services
- **Types of Services and Numbers Served:**
 - Array of services provided through HHS
- **Financing of Services:**
 - Existing financing sources and expenditures from HHS
- **Strategic Infrastructure Grant (SIG):**
 - Role related to children's behavioral health services within HHS







Regional Behavioral Health Network System



- **Community Based Behavioral Health Services**

- Six Behavioral Health Regions

- Region 1 = 11 counties (Scottsbluff)
- Region 2 = 17 counties (North Platte)
- Region 3 = 22 counties (Kearney)
- Region 4 = 22 counties (Norfolk)
- Region 5 = 16 counties (Lincoln)
- Region 6 = 5 counties (Omaha)



Division of Behavioral Health Children's Services Funded/Person's Served*

Mental Health

- Outpatient/Ax - 1932
- Professional Partner – 607
- Medication management–30
- Respite care - 18
- Day Treatment - 7
- Home-based services – 1
- Therapeutic Consultation - 0

Substance Abuse

- Outpatient Assessment–617
- Intensive Outpatient – 149
- Therapeutic Community- 80
- Youth Assessment - 41
- Partial care - 7
- Community Support - 0

*Source: Magellan 7/17/07



Regional Youth Services Coordination

- Region wide leadership for children/youth mental health and substance abuse services
- Coordinate across child-serving systems (mental health, substance abuse, child welfare, Medicaid, juvenile justice/criminal justice system, probation, education, and other state systems of services).
- Implement strategies and provide system planning for the integration of service delivery and resources
- Develop linkages between the prevention and treatment service systems



Hastings Regional Center Number of Children Served FY06*

- Adolescent Chemical Dependency Unit for Youth Rehabilitation and Treatment Center-Kearney youth = approximately 126
- Adolescent Acute = approximately 14
- Adolescent Residential Psych = approximately 40

*Hastings Regional Center no longer provides Acute Care
HRC provides care to youth who are State Wards



Children's Medicaid Mental Health and Substance Abuse Services

Acute Psychiatric Hospitalization	Inpatient Services in an Institute for Mental Disease
Biopsychosocial Assessment & Addendum	Injected Medications and Injection
Community Support	Intensive Outpatient Therapy Services
Community Treatment Aides	Interpreters
Conferences about the Client's Treatment	Medication Checks
Customer Assistance Program	Mileage to Client's Home for Family Therapy
Day Treatment	Non-residential Crisis Intervention
Day Residential Crisis	Observation Room (23:59)
Enhanced Treatment Group Home	Psychological Testing
Evaluation & Management by Physician or Psychologist	Residential Crisis
Family Assessment	Residential Treatment Center
Family Therapy & Counseling	Travel to the Home of a Handicapped Client
Group Therapy & Counseling	Transportation
Individual Therapy & Counseling	Treatment Foster Care
Initial Psychiatric Diagnostic Interview (Part II of PTA)	Treatment Group Home



Protection and Safety Services

Agency Based Foster Care	Maternity Group Home
Agency Based Foster Care - Continuity Care	Non-Residential Evaluation
Electronic Monitoring	Reporting Center
Emergency Shelter Center	Residential Evaluation
Emergency Shelter Home - Ag Based	Respite Center
Emergency Shelter Home - (individual)	Respite Home
Expedited Family Group Conf	Staff Secure / Detention
Family Support Services	Tracker
Family Group Conferencing	Visitation / Supervision Service
Traditional Foster Care***	Visitation Center (NORTHERN SA)
Group Home	Region 1 ICCU
Group Home A	Region 3 ICCU
Home Based Family Therapy	Region 4 ICCU
Intensive Individualized Services	Region 5 ICCU
Intensive Family Preservation	Region 6 ICCU



Economic Assistance Services

- Family Support
- Transportation / Escort
- Emergency Assistance
- Child Care
- Aid to Aged, Blind and Disabled
- Child Support Enforcement
- TANF (Temporary Assistance for Needy Families)
- Food stamps



State Wards in Care as of 12-31-06

Total Wards in State Care: 7,212

Wards in In-Home Care: 2,458

OJS: 582

HHS: 1,876

Wards in Other Out-of-Home Care: 4,764

OJS: 797

- Average Daily Census YRTC-K: 194
(162 at YRTC and 32 at HRCCD Program)
- Average Daily Census YRTC-G: 88

HHS: 2,689

Wards Placed with Relatives: 1,248

- OJS: 52
- HHS: 1,196

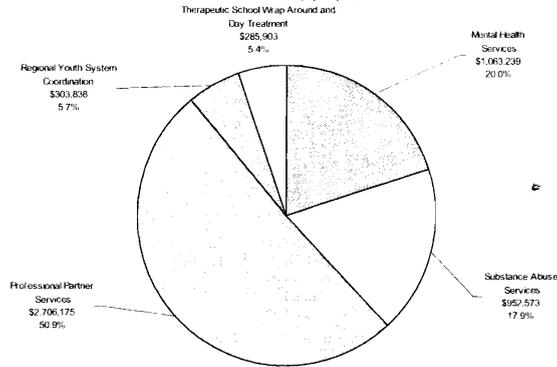
DHHS Funding Sources for Children's Behavioral Health Services

- Behavioral Health Division:
\$5,311,728
- Medicaid Division: \$110,418,434
- Children and Family Services Division
: \$5,435,002



Behavioral Health Expenditures

FY2006 Nebraska Behavioral Health Revenue by Category
Total \$5,311,728

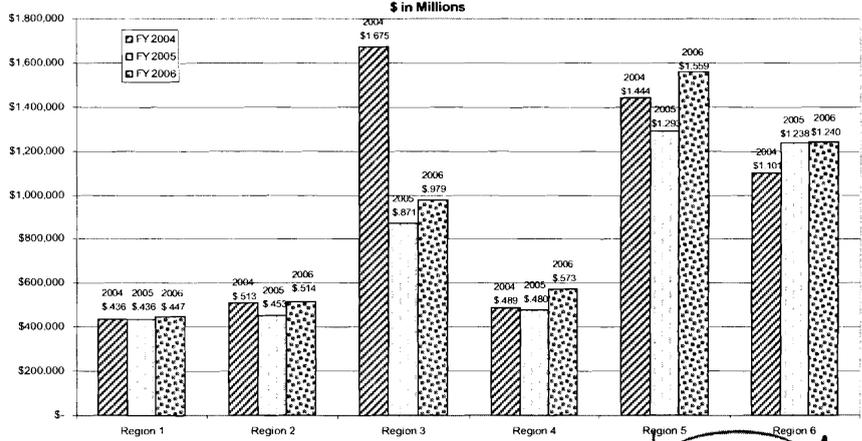


Source: Region Actuals
The Revenue displayed includes funds that are allocated to the regions by the Behavioral Health Division of the State of Nebraska. Funds include only local, state and federal mental health and substance abuse funds, and do not include Medicaid funds. Updated 10/24/06

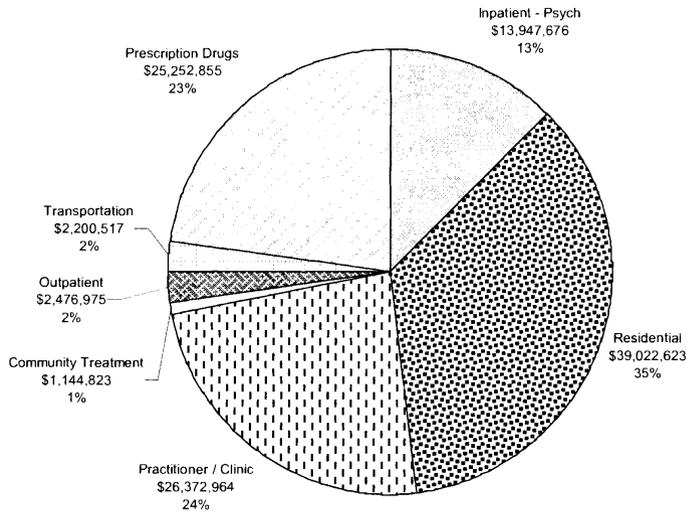


Behavioral Health Division Children's Expenditures (cont.)

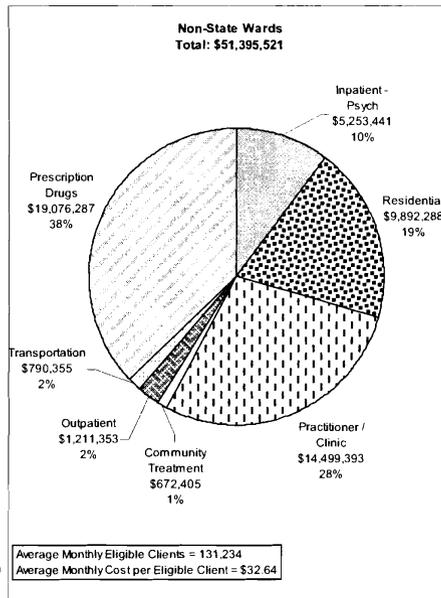
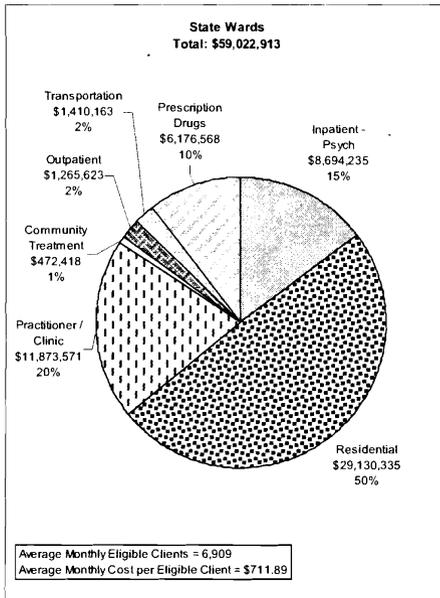
Nebraska Behavioral Health Revenue Total by Region for Fiscal Years 2004, 2005, 2006

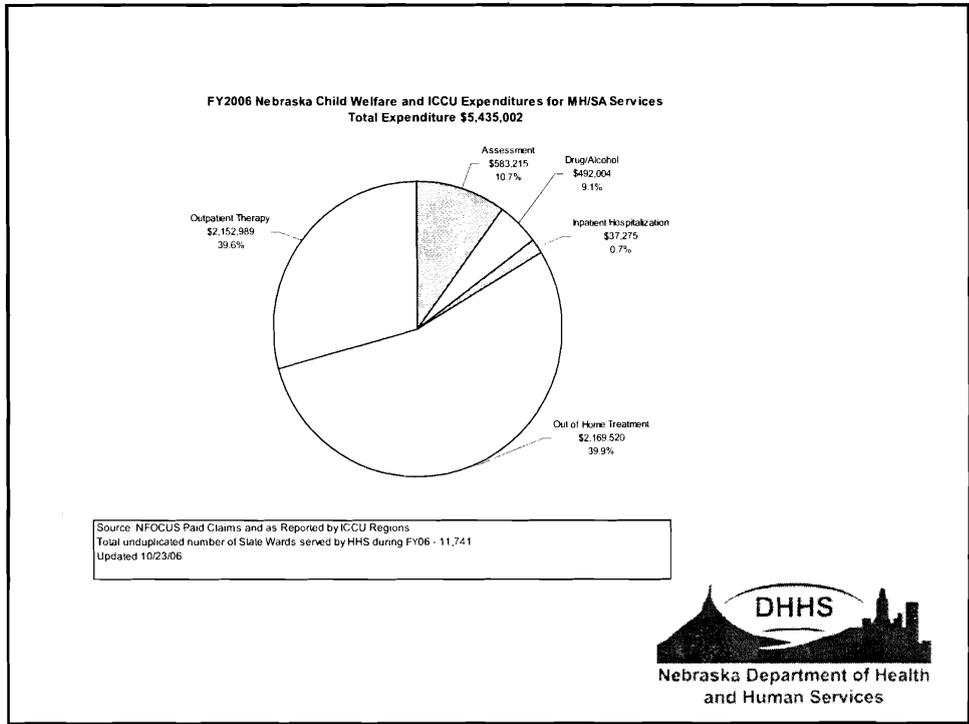
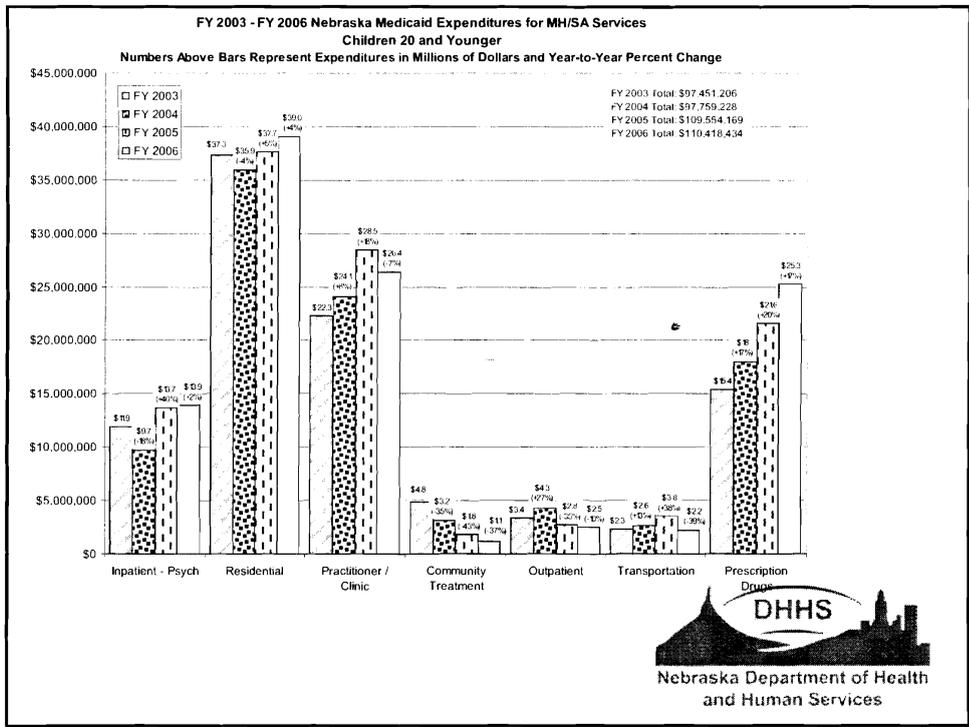


**FY 2006 Nebraska Medicaid Expenditures for MH/SA Services
Children 20 and Younger
Total: \$110,418,434**



**FY 2006 Nebraska Medicaid Expenditures for MH/SA Services
Children 20 and Younger by State Ward Status**





**Nebraska Medicaid Behavioral Health Expenditures by Service Date
Payments through May 2007
Out Of State Psychiatric Residential Care (SubAcute) Recipients by Location of Provider
Children Ages 0 to 19**

Time Period (Service Month)	Payments excluding Border Providers			Payments to Border Providers*			Time Period (Service Month)	Total Payments		
	Net Payment**	Days	Unduplicated Recipients	Net Payment**	Days	Unduplicated Recipients		Net Payment**	Days	Unduplicated Recipients
Apr 2007	\$ 131,182	555	20	\$ 57,568	283	10	Apr 2007	\$ 188,750	838	30
Mar 2007	\$ 205,636	804	28	\$ 128,276	596	23	Mar 2007	\$ 333,912	1,400	51
Feb 2007	\$ 184,709	720	28	\$ 115,904	535	21	Feb 2007	\$ 300,612	1,255	49
Jan 2007	\$ 228,065	874	30	\$ 89,394	438	21	Jan 2007	\$ 317,459	1,312	51
Dec 2006	\$ 242,354	963	34	\$ 102,400	508	23	Dec 2006	\$ 344,754	1,471	57
Nov 2006	\$ 260,750	951	38	\$ 75,648	357	14	Nov 2006	\$ 336,399	1,308	52
Oct 2006	\$ 274,336	1,088	39	\$ 81,843	386	14	Oct 2006	\$ 356,179	1,474	53
Sep 2006	\$ 277,780	1,120	38	\$ 68,349	312	13	Sep 2006	\$ 346,129	1,432	51
Aug 2006	\$ 327,798	1,341	45	\$ 93,529	416	16	Aug 2006	\$ 421,326	1,757	61
Jul 2006	\$ 322,111	1,360	46	\$ 104,877	495	18	Jul 2006	\$ 426,988	1,855	64
Jun 2006	\$ 332,846	1,387	52	\$ 110,113	534	20	Jun 2006	\$ 442,959	1,921	72
May 2006	\$ 392,048	1,624	54	\$ 121,992	606	21	May 2006	\$ 514,040	2,230	75
Apr 2006	\$ 384,922	1,635	58	\$ 94,146	426	17	Apr 2006	\$ 479,069	2,061	75
Mar 2006	\$ 386,334	1,565	55	\$ 105,348	506	24	Mar 2006	\$ 491,682	2,071	79
Feb 2006	\$ 334,754	1,393	52	\$ 115,981	577	24	Feb 2006	\$ 450,735	1,970	76
Jan 2006	\$ 367,568	1,526	52	\$ 144,635	691	26	Jan 2006	\$ 512,203	2,217	78
Dec 2005	\$ 335,740	1,392	50	\$ 131,205	562	22	Dec 2005	\$ 466,946	1,954	72
Nov 2005	\$ 315,722	1,310	46	\$ 97,706	476	21	Nov 2005	\$ 413,428	1,786	67
Oct 2005	\$ 291,841	1,195	43	\$ 122,825	583	22	Oct 2005	\$ 414,666	1,778	65
Sep 2005	\$ 233,904	968	36	\$ 107,430	514	21	Sep 2005	\$ 341,335	1,482	57
Aug 2005	\$ 238,594	995	36	\$ 107,605	511	20	Aug 2005	\$ 346,199	1,506	56
Jul 2005	\$ 266,387	1,114	40	\$ 112,815	551	21	Jul 2005	\$ 379,202	1,665	61

*Border providers include the following facilities located near Nebraska's border:

- Sioux City , IA Jackson Recovery Centers
- Sioux City , IA Boys & Girls Home
- Torrington, WY St. Josephs Childrens Home

**Payments included through April 2007 - Monthly Data will change due to Claim Lag

The section below was not updated because April data was incomplete. Data will be updated next month.

Note: The monthly average of unduplicated recipients for FY06 compared to the monthly average of FY07 YTD indicates:

- Recipients of Out of State Border Providers have decreased 19%
- Recipients of Out of State Non Border Providers has decreased 32%
- Total Recipients of Out of State Providers has decreased 29%

Prepared by Karen Brandt, Health and Human Services, Financial and Program Analysis on 1/4/2008

SOURCE:

Advantage - Incurred View with Claims Paid as of April 2007

SUBSET:

Age in Years Claim 0-19, Provider Specialty = Psychiatry/MH/SA
Type of Service = 1- Inpatient Mental

Nebraska Child and Adolescent Behavioral Health State Infrastructure Grant - SIG

- **Five Year grant**
- **October 2004 – September 2009**
- **From SAMHSA**
- **\$750,000/per year**
- **Both mental health and substance abuse for children**
- **Infrastructure, not services (e.g., needs assessment, strategic planning, financial structures, organizational structures, training, policy changes)**
- **Nebraska is one of seven jurisdictions to receive SIG**



Children's Behavioral Health Challenges

- System inconsistencies
- No single point of accountability for children's behavioral health
- Reimbursement issues
- Relationship of courts to children's behavioral health
- Data Infrastructure
- Capacity for Community Based Services
- Role of State Infrastructure Grant related to LB542



Regional Center and YRTC Appropriations for Adolescent Services

FY 2007-2008

Source: DHHS, Legislative Fiscal Office
Additional information added at the request of the Task Force

	YRTC Kearney	YRTC Geneva	HRC Adolescent MH (16 beds)	HRC Adolescent CD (40 beds)	LRC Adol and Fam Serv SO Prog (16 beds)	LRC Adol and Fam Whitehall Tx Group Home (8 beds)
General Funds	\$8,710,278	\$6,198,691				
Cash Funds	394,246	97,831				
Federal Funds	410,967	156,032				
Total	\$9,515,491	\$6,452,554	\$2,589,604	\$5,527,647	\$1,407,316	\$795,142

Appendix H

System of Care Diagram

