TITLE 206 BEHAVIORAL HEALTH SERVICES

CHAPTER 6-000 STANDARDS OF CARE

6-001 CONSUMER RIGHTS: The following rights apply to consumers receiving behavior health services through Nebraska's public behavioral health system. All consumers have the right to:

1. Be treated respectfully, impartially, and with dignity;
2. Communicate freely with individuals of their choice including, but not limited to, family, friends, legal counsel, and his/her private physician~~, and to~~
3. Have clinical records made available to themselves and t~~hese~~ individuals of their choice by his/her written request;
4. Actively and directly ~~P~~participate in decisions which incorporate independence, individuality, privacy, and dignity and to make decisions regarding care and treatment;
5. Refuse treatment or therapy, unless treatment or therapy was authorized by the consumer's legal guardian or was ordered by a mental health board or court;
6. Have privacy and confidentiality related to all aspects of care;
7. Be protected from neglect; physical, emotional or verbal abuse; and exploitation of any kind;
8. Actively and directly ~~P~~participate in developing an individual treatment, rehabilitation, and recovery plan and decision-making regarding his/her behavioral health care;
9. Receive care from providers who adhere to a strict policy of non-discrimination in the provision of services;
10. Be free of sexual exploitation, ~~or~~ harassment, or re-traumatization;
11. Voice complaints and file grievances without discrimination or reprisal and to have those complaints and grievances addressed in a timely manner(see 206 NAC 6-003); and
12. Receive behavioral health services in the most integrated setting appropriate for each consumer~~'s needs~~ based on an individualized and person-centered assessment.

6-002 COMPLAINTS: Consumers must be able to freely voice complaints and recommend changes without being subject to coercion, discrimination, reprisal, or unreasonable interruption of care, treatment, and services.

6-003 CONSUMER GRIEVANCES: Each provider must establish a written consumer grievance policy with the following components:

1. Consumers and their families must be informed of and given a copy of written procedures for addressing and resolving grievances established by each provider (see consumer rights in 206 NAC 6-001);
2. Consumers, families, staff, and others must have access to the provider's grievance process;
3. The consumer's grievance must be responded to by the provider in a timely manner and the provider must document its response to the consumer;

4. If the consumer's grievance is not addressed satisfactorily through the provider's complaint process, the provider must give adequate information, including telephone numbers and addresses, to the consumer to enable the consumer to contact the Division of Behavioral Health, Office of Consumer Affairs; the Division of Public Health, Facility Complaint Intake and the Investigations Section; ~~and/or~~ the Consumer Specialist of the Regional Behavioral Health Authority (RBHA)~~,~~; ~~and~~ the office of the Ombudsman; the Department's System Advocate, and vendor who is contracted for system managment. This information must also be readily available to consumers, families, staff, and others.

6-004 TRAUMA-INFORMED SERVICES: All state funded behavioral health providers must be informed about the effects of psychological trauma. Providers must consistently screen for trauma symptoms and history of traumatic events, provide ongoing assessment of trauma symptoms and problems related to that trauma, and offer services that are recovery-oriented and trauma-sensitive.

6-005 FINANCIAL AND CLINICAL ELIGIBILITY OF CONSUMERS: The Division of Behavioral Health will reimburse service providers for behavioral services for consumers who meet:

1. Clinical eligibility criteria for the service as specified in the Behavioral Health/Medicaid Adult Services Definitions;
2. Financial eligibility criteria as established by the Division of Behavioral Health; and
3. Citizenship/lawful presence requirements of state law.

For persons who meet the Division of Behavioral Health's clinical eligibility and financial eligibility criteria, the provider will be paid the rate set by the Division for the services provided which ~~are pre-authorized by System Management~~ have an established statewide rate.

6-005.01A The Division of Behavioral Health is the payer of last resort for consumers who meet the Division's Clinical Criteria for an identified level of care and who are without the financial resources to pay for care. The Division will not reimburse for:

1. Medicaid covered services provided to Medicaid consumers; or
2. Services covered under other health insurance benefits. RBHAs are responsible for insuring providers maximize claims/payment opportunities from other payers.

6-005.01B Citizenship/Lawful Presence: An applicant for public benefits attest that:

1. S/he is a citizen of the United States of America; or
2. S/he is a qualified alien under the federal Immigration and Nationality Act 8 USC 1101 et seq., as such existed on January 1, 2009, and is lawfully present in the United States.

6-005.01B1 The attestation must be in the format prescribed by the Department of Administrative Services or in an electronic format prescribed by the Department.

6-005.01C Management Of Consumer's Funds: The provider must have a written policy on whether the provider will be involved in the management of consumer funds. If the provider elects to be involved in the management of consumer funds, there must be written policies and procedures approved by the governing body which identify the system to be used when the provider exercises control over the funds of a consumer to ensure that the provider maintains proper accountability for those funds.

6-005.01C1 The consumer's file must document when and how it was determined that the provider would exercise control over a consumer's funds, including:

3. The circumstances leading to this action;
4. The rationale for this action;
5. The protocol followed in taking this action; and
6. The plan for revoking this action, including methods and timeframes for implementation.

6-005.01C1a Unless the consumer has a payee, conservator, or guardian, the consumer must agree in writing with the provider's involvement in the management of these funds.

6-005.01C2 Each consumer must have an individual financial record that includes:

1. Documentation of all cash funds, savings and/or checking accounts, deposits and withdrawals;
2. An individual ledger which provides a record of all funds received and disbursed and the current balance; and
3. Documentation that the individual has access to and opportunities to handle his/her money.

6-005.01C3 If the provider has the responsibility for the management of consumers' funds,

1. A separate accounting is maintained for each consumer;
2. Account balances and records of transactions are provided to the consumer or the consumer's fiscal representative as requested, but at least quarterly;
3. The consumer, as well as the parents, guardian, advocate, and/or fiscal representative, are advised as required by law or agreed to by the conservator:
   a. Prior to depletion of funds;

b. When large balances are accrued; and/or
c. When entitlement program eligibility can be affected.

6-005.01C4 The provider must have policies and procedures to prohibit the borrowing of personal funds from the consumer by staff and/or other consumers.

6-005.01C5 The provider must have policies and procedures approved by the governing body regarding the repair of damaged property or the replacement of destroyed property (either private or public), using a consumer's personal funds.

6-005.01C6 The provider must not withdraw any consumer's funds without the written approval of the consumer, the consumer's legal representative, or by an order of a judge or a court.

6-005.01C7 The provider must have written policies and procedures on how financial errors, overdrafts, and missing money will be handled.

6-006 ASSESSMENT OF CONSUMER'S ABILITY TO PAY: Providers must use the current version of the ~~Division of Behavioral Health Financial Eligibility Fee Schedule.~~ financial eligibility criteria established by the Division of Behavioral Health to determine the consumer's ability to pay for the cost of his/her care. The assessment of a consumer's ability to pay the cost of his/her care must be completed annually or when significant permanent changes impact his/her financial status.

~~The assessment of a consumer's ability to pay is an ongoing process. The consumer's financial eligibility status must be re-assessed when changes occur.~~

6-006.01 Consumers who refuse to provide financial information must be charged full cost of services.

6-007 RECORDS: Records must be maintained for all consumers admitted to a service funded by the Nebraska Behavioral Health Services Act. Documentation in the record must reflect the consumer's treatment/rehabilitation experience and be of the type and quality to facilitate service planning, evaluation, and continuity of care.

6-007.01 Policies and Procedures: Each organization/provider must have written policies and procedures regarding the maintenance of service records that:

1. Govern the compilation, storage, dissemination, and accessibility of the consumer's service records;
2. Are designed to assure that the program fulfills its responsibility to safeguard and protect consumer records against loss and unauthorized alteration or disclosure that are compliant with HIPAA regulations and other relevant state and federal law;
3. Are designed to assure that each record contains all information required by organizational policy and is consistent with professional practice;

4. Are designed to assure uniformity in the format and forms used in consumer service records;
5. Require entries in the consumer service records to be legible, dated, and signed;
~~6. Do not allow the use of symbols and abbreviations in the recording of diagnoses;~~

~~7~~6. Include an explanatory legend approved ~~by the governing body or~~ by management staff ~~specifically authorized by the governing body~~ for the abbreviations used;

~~8~~7. Require maintenance of records at the site where the consumer is served to ensure that the records are directly accessible to the staff providing services. If only partial records are maintained at the program site, the policies and procedures must describe the information to be kept in each record, including a minimum of identifying information; current assessment; current Individual Treatment, Rehabilitation, and Recovery Plan; emergency information; all applicable progress notes; legal information; and medical history;

a. Providers of multiple services must indicate how significant consumer issues are shared between providers.

~~9~~8. Specify time frames for the completion of assessments, assessment updates, emergency information updates, service plans, progress notes, service plan reviews, discharge summaries, and any other standard treatment/rehabilitation/recovery documentation that are consistent with services as described in this chapter; and

~~10~~9. Govern the disposal of consumer service records, including the following provisions:

b. Records must be maintained for at least five years from the date the consumer is discharged from the program or until at last five years following the end of the contract year in which services were billed, whichever is longer; and
c. Methods of disposal are designed to assure the confidentiality of information.

6-007.02 Clinical Documentation: Behavioral health providers must maintain a clinical record that is confidential, complete, accurate, and contains up-to-date information relevant to the consumer's care and services. The record must sufficiently document assessments; individual treatment, rehabilitation, and recovery plans and plan reviews; and important provider discussion. The clinical record must document consumer contacts describing the nature and extent of the services provided, such that a clinician unfamiliar with the service can identify the consumer's service needs and services received. The documentation must reflect the rehabilitative services provided, and is consistent with the goals in the individual treatment, rehabilitation, and recovery plan, and based upon the comprehensive assessment. The absence of appropriate, legible, and complete records may result in the recoupment of previous payments for services. Each entry must identify the date, ~~beginning and end of time spent providing the service~~ ~~and~~ location of service, and ~~identify by~~ the name and title of the staff person ~~entering the information~~ providing the service.

Documentation requirements for day rehabilitation and for residential rehabilitation must provide a daily summary of the treatment describing consumer's condition, treatment and rehabilitation interventions provided and consumer's response to those interventions. Providers of multiple services must indicate how significant consumer issues are shared between providers.

Records must be kept in a locked file when not in use. For purposes of confidentiality, disclosure of treatment/rehabilitation/recovery information is subject to all the provisions of applicable State and Federal laws. The consumer's clinical record must be available for review by the consumer (and his/her guardian with appropriate consent) unless there is a specific medically indicated reason to preclude this availability. The specific reason must be documented in the clinical record and reviewed periodically.

6-007.02A The clinical record must include, at a minimum:

1. Consumer identifying data, including demographic information and the consumer's legal status;
2. Assessment and Evaluations;
   a. Pre-Authorization/Referral Screening
   b. Comprehensive Assessment
   c. Psychiatric assessment substantiating the consumer's diagnosis, and referral for treatment/rehabilitation/recovery service; and
   d. Other appropriate assessments.
3. Consumer's Diagnostic Formulation (including all five axes);
4. Individual Treatment, Rehabilitation, and Recovery Plan and updates to plans;
5. Documentation of review of Consumer Rights with the consumer;
6. A chronological record of all services provided to the consumer. Each entry must include the staff member who performed the service received. Each entry includes the date the service was performed, the duration of the service ~~(beginning and end time)~~, the place of the service, and the staff member's identity and legible signature, (name and title);
7. Documentation of the involvement of family and significant others;
8. Documentation of treatment, rehabilitation, and recovery services and discharge planning;
9. A chronological listing of the medications prescribed (including dosages and schedule) for the consumer and the consumer's response to the medication;
10. Documentation of coordination with other services and treatment providers;
11. Discharge summaries from previous levels of care;
12. Discharge summary (when appropriate); and
13. Any clinical documentation requirements identified in the specific service.

6-007.02B The record must contain documentation that the consumer and guardian, as applicable, has participated in the program orientation.

6-007.02C The record must contain documentation of the consent of the consumer, and/or appropriate family members or guardians, as applicable, to treatment, rehabilitation, and/or recovery services, medication usage, and other services to be provided as stated in the individual treatment, rehabilitation, and recovery plan.

6-007.02D Consent to each of these services includes the concomitant right to refuse services, unless the treatment is court-ordered or required under the Nebraska Mental Health Commitment Act (Neb. Rev. Stat. §§ 71-901 to 71-962).

6-007.02E The risks and benefits of every service for which consent is sought and the right to refuse the service must be explained to the consumer at a level educationally appropriate to the individual, in the consumer's native language, or in sign language, as appropriate.

6-007.02F The record must contain correspondence to and from the program regarding the services received. Signed and dated progress notes of all telephone calls concerning these services must also be present.

6-007.03 Medications: For each consumer who is receiving prescribed medication, the record must contain a medication use profile. This profile must include:

1. A listing of all medications and dosages currently prescribed by the psychiatric prescribing clinician (MD, APRN, or PA);
2. A listing of all medications and dosages currently prescribed by any other prescriber;
3. A listing of all over-the-counter medications, herbal preparations, or other alternative treatment being used by the consumer;
4. Documentation from the program's physician, including, upon discontinuation, the date and reason each drug is discontinued;
5. Documentation that medication education/health teaching has occurred and the consumer is informed regarding each medication prescribed and that the consumer understands the information; and
6. Documentation of the consumer’s response to the teaching and medications prescribed, for example, adverse effects, therapeutic effects, adherence issues.

6-008 ASSESSMENT: An assessment must be completed for each consumer upon entrance/admission of the individual to the service, and on an ongoing basis as determined by the service description and the program's rehabilitation/clinical practice policy. The assessment must include a review of referral information and, through appropriate evaluation procedures, must supplement this information as needed for initiation or continuation of treatment, rehabilitation, and recovery. Areas covered in the assessment must be consistent with program requirements as specified in the service description and are determined by the needs of the consumer served as well as the service mission of the program. If the consumer demonstrates

needs that fall outside the scope of the service, referral to and cooperation with other appropriate services/programs must be demonstrated and documented.

6-008.01 The assessment must be completed within the timeframe specified in the program's policies and procedures, however, no more than the timeframe prescribed in the Behavioral Health/Medicaid Adult Services Definitions. The assessment must include the following components:

1. Consumer name, Medicaid identification number, emergency contact (name, relationship and contact information), and other information of the consumer that is relevant;
2. Provider demographics including: provider name, address, phone, fax, and e-mail, and other contact information;
3. Individual strengths and presenting problem, primary complaint including:
   a. Signs, symptoms, and problems relating to mental illness;
   b. Reason for referral to treatment, rehabilitation, and recovery services and referral source.
   c. Name and title of the referral individual, such as MD, psychologist, APRN, or LIMHP;
   d. Presenting problem from the consumer's and provider's perspective.
   e. External leverage to seek evaluation (courts, family and other).
4. Medical History:
   a. Dental history and current needs.
   b. Current medication list.
   c. Compliance with medication (historical and current).
   d. Current primary care physician (name and contact information).
   e. Date of last physical exam and physician providing that assessment.
   f. Recent hospitalizations.
   g. Major health concerns (such as STD's, HIV, Tuberculosis, Hepatitis, ~~and~~ pregnancy, diabetes, obesity, and nicotine dependency).
5. Employment/Education/Military History:
   a. History of employment.
   b. Educational history.
   c. Military involvement.
   d. Strengths.
6. Alcohol/Drug History:
   a. Primary drug(s) of choice.
   b. Amount, frequency and duration of use.
   c. Prior treatment(s), location and length of stay.
   d. Current compliance with relapse prevention plan.
   e. Periods of abstinence (supports needed).
   f. Tolerance level/withdrawal/history of complications from withdrawal.
   g. Prior alcohol/drug evaluations/recommendations.
   h. Family history of alcohol/drug use.
   i. Other addictive behaviors (gambling, food, etc.).
7. Legal History (Information from Criminal Justice System):
   a. Criminal history and consequences of criminal involvement.

b. Connection to alcohol/drug use.
c. Current legal charges/disposition of charges.

8. Family/Social/Peer
   a. Family members (age and level of involvement with consumer).
   b. Adult or minor children (names, ages and level of involvement).
   c. Parenting knowledge or skill level, history of system involvement (courts).
   d. Social supports utilized by consumer (previous and current).
   e. Housing (ability to maintain housing, type of current housing, need for assistance).
   f. Recreational activities (consumer's preference).
   g. Collateral information.
   h. Consumer strengths as perceived by consumer and collateral contacts.
9. Psychiatric/Behavioral History:
   a. Current diagnosis(s).
   b. Previous treatment(s) and outcome(s) of treatment(s).
   c. Current mental health and substance use providers and treatment currently provided.
   d. Current psychiatric medication list.
   e. Compliance with medication (historical and current).
   f. History of self harm or threats to harm others.
   g. Board of mental health commitments (reason and dates of commitment).
   h. Abuse (to include sexual abuse, physical abuse, emotional abuse, neglect, witness domestic violence, victim/witness of community violence, physical assault);
   i. Trauma (serious accident/injury, sexual assault/rape, life-threatening medical illness, traumatic loss of a loved one, terrorist act, war/political violence/torture, disasters [tornado, earthquakes], sanctuary trauma [trauma while institutionalized], prostitution/sex trafficking).
10. Clinical Impressions: (must be completed a licensed clinician whose scope of practice includes diagnosing major mental illness).
    a. This section should include the information that supports/justifies the recommendations in section J and must integrate mental health and substance use co-occurring disorders.
    b. DSM diagnosis, Axis 1-5.

11 Recommendations:
   a. Primary/ideal level of care.
   b. Available level of care/barriers to ideal level of care.
   3. Consumer/family's response to recommendations.

12. Signature of fully licensed clinician approving this assessment.
13 Date of signature.

<u>6-009 DISCHARGE PLANNING</u>: Discharge planning must occur in advance of a consumer's discharge from the any service. The discharge plan must be strength-based, recovery-oriented, trauma-informed and include participation by the consumer and family/legal guardian. The discharge plan must be documented in the consumer's record. The discharge plan must:

1. Begin on admission and be updated on an ongoing basis with ~~input and~~ the direct and active participation of the consumer and family/legal guardian, as appropriate and with the consumer's consent;
2. Be a component of the Individual Treatment, Rehabilitation, and Recovery plan and be consistent with the goals and objectives identified with the direct and active participation of the consumer, family, and guardian as appropriate;
3. Address the consumer's need for ongoing services to promote recovery. A crisis/safety/relapse prevention plan must be in place and address triggers, helpful intervention strategies, and contact information for resources useful in a crisis;
4. Document all referrals; and
5. Document pre-discharge planning, recommendations, and/or arrangements for a post-treatment/rehabilitation/recovery plan including but not limited to:
   a. Accessing and using medication
   b. Housing
   c. Employment
   d. Transportation
   e. Social connectedness – formal and informal support systems
   f. Plans to address unmet goals

6-010 INDIVIDUAL TREATMENT, REHABILITATION, AND RECOVERY PLAN: For treatment and rehabilitation services, a plan must be developed. Each record must contain a recovery-oriented individual treatment, rehabilitation, and recovery plan for all services provided in the program based on the individualized and person-centered assessment of the consumer ~~strengths, service needs,~~ and the Behavioral Health/Medicaid Adult Services Definitions. This plan must:

1. Be oriented to and apply the principles of recovery – inclusion, ~~meaningful~~ direct and active participation, and a meaningful life in the community of one's choosing;
2. Incorporate and be consistent with best practices;
3. Include the consumer's individualized goals and expected outcomes;
4. Contain prioritized objectives that are measurable and time-limited;
5. Describe therapeutic interventions that are recovery-oriented, trauma-informed, and strength-based;
6. Identify staff responsible for implementing the therapeutic interventions;
7. Specify the planned frequency or duration of each therapeutic intervention;
8. Delineate the specific behavioral criteria to be met for discharge or transition to a lower level of care;
9. Include a component to avoid crises or admission to a higher level of care using principles of recovery and wellness;
10. Include the signature of the consumer and/or guardian to indicate agreement with the plan;
11. Document that the individual treatment, rehabilitation, and recovery plan is completed within the time frame specified in the policies and Behavioral Health/Medicaid Adult Service Definitions;
12. Document that the plan has been developed, reviewed, updated, and revised with the direct and active ~~consumer~~ involvement of the consumer. If documentation

shows that the consumer is not achieving his/her goals, timely revision of the plan must be documented; and

13. Be approved and signed by the licensed clinical supervisor.

6-011 PROGRESS NOTES: Each record must contain progress notes that document implementation of the individual treatment, rehabilitation, and recovery plan.

6-011.01 Progress notes must document:

4. All services provided,
3. How services provided relate specifically to goals and priorities identified in the individual treatment, rehabilitation, and recovery plan;
4. Consumer's participation in the review and revision of goals and treatment activities,
5. Consumer's opinion of progress being made (in consumer's own words, if possible).

6-011.02 Progress notes must be completed within the time frame specified in the program's policies and procedures.

6-011.03 Progress notes document the unit(s) provided to the consumer.

6-012 DISCHARGE SUMMARY: A discharge summary must be documented in the consumer's record and contain the signature of a licensed clinician and date of signature. The discharge summary must:

1. Be provided within the time frame specified in the program's policies and procedures which considers the prompt transfer of clinical records and information to ensure continuity of care;
2. Provide a summary of service provided;
3. Document the consumer's progress in relation to the individual treatment/rehabilitation/recovery plan, addressing recovery oriented goals identified by the consumer and how strengths have been utilized;
4. Describe the reason(s) for discharge;
5. Describe referral information; and
6. Include recommendations and/or arrangements not limited to:
   a. Accessing and using medication
   b. Housing
   c. Employment
   d. Transportation
   e. Social connectedness – formal and informal support systems.

6-012.01 Documented telephone calls, collateral contacts or other outreach activities that demonstrate continuing treatment/rehabilitation responsibility are considered services for the purpose of this regulation.

6-012.02 The program must complete discharge process from the Division data system. ~~and evidence must be in the consumer file.~~

~~6-012.03 Consumers who have received no face-to-face services for 90 days or more must be discharged and the record must contain a discharge summary.~~

6-012.0~~4~~3 For consumers committed to a program by a board of mental health, the provider must notify the commitment board of the discharge.

6-013 STAFFING: All programs must be staffed according to standards in the Behavioral Health/Medicaid Adult Services Definitions by appropriately licensed treatment professionals who are able to assess consumers for both mental health and substance-related issues. Staff must be able to assess the consumer's biopsychosocial needs and be knowledgeable about the biopsychosocial dimensions of mental illness, substance-related disorders, trauma-related issues, and co-occurring disorders. Staff must be capable of recognizing any instability of consumers with mental health and/or substance-related disorders and treat or make the appropriate referrals.

6-014 LENGTH OF STAY: The length of stay must be individualized according to the consumer's needs and the consumer's response to treatment and recovery.

6-015 STANDARDS COMMON TO ALL BEHAVIORAL HEALTH TREATMENT AND REHABILITATION PROGRAMS: Behavioral Health programs must meet the standards in 175 NAC 18, Licensure of Substance Abuse Treatment Centers; 175 NAC 19, Licensure of Mental Health Centers. Services to be covered by Medicaid must meet the requirements of 471 NAC 20, Psychiatric Services for Individuals Age 21 and Older (Medicaid); 471 NAC 32, Mental Health and Substance Abuse Treatment Services for Children and Adolescents; and 471 NAC 35, Rehabilitative Psychiatric Services.

6-016 BEHAVIORAL HEALTH SERVICES FOR ADULTS: Services funded by the Nebraska Behavioral Health System must meet the service definitions listed in the ~~most recent version of~~ Behavioral Health~~/Medicaid~~ Adult Services Definitions.

6-017 BEHAVIORAL HEALTH SERVICES FOR CHILDREN AND YOUTH (Reserved)

(continued on next page)

6-018 SUBSTANCE ABUSE PREVENTION SERVICES

6-018.01 Administration of Funded Community-Based Prevention Initiatives: The Department provides leadership and oversight to prevention systems by distributing funds received from the state and the federal government to Regional Behavioral Health Authorities.

1. The prevention systems funded must comply with requirements set forth by the state and federal government in the attainment and continuation of federal prevention funding. Prevention system activities are designed to prevent the onset and reduce the progression of substance abuse, reduce substance abuse-related problems in communities, and build prevention capacity and infrastructure at the State/Tribal and community level.
2. Prevention initiatives funded through the State of Nebraska must follow the Strategic Prevention Framework and include the following:
   a. Universal Prevention: activities targeted to the general public or a whole population group that has not been identified on the basis of individual risk;
   b. Selective Prevention: activities targeted to individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average;
   c. Indicated Prevention: activities targeted to individuals in high-risk environments, identified as having minimal but detectable signs or symptoms foreshadowing disorder or having biological markers indicating predisposition for disorder but not yet meeting diagnostic levels.

6-018.02 Availability of Funds: The Department distributes prevention funds contingent upon their availability from the federal government.

1. If the Division lacks the funds necessary to fulfill its fiscal responsibility under this program due to the lack of state or federal funds, the contracts/agreements will be renegotiated or terminated.
2. In any year in which funds are available for prevention systems, the Division will award contracts/agreements to Regional Behavioral Health Authorities to organize efforts to serve Nebraska communities.
3. The Division may enter into contracts/agreements to provide statewide activities including but not limited to training, helpline services, research and evaluation, and/or promotion of other professional or educational activities.

6-018.03 Accountability: Funded prevention systems will ensure expenditures for prevention initiatives reflect objective analysis of data, evidence-based or promising practices, and alignment with the community's strategic prevention plan.

1. Initiatives will include an evaluation plan that describes the plan to collect, analyze, and disseminate process, outcome, and impact evaluation data, including plans to monitor for continuous improvement and plans to use lessons learned from evaluation to improve the performance of the funded initiative.

2. The Regional Behavioral Health Authority will be responsible for providing technical assistance to funded prevention initiatives in the region and organizing and preparing any supporting documentation required by the Department.

6-019 GAMBLERS ASSISTANCE PROGRAM

6-019.01 AVAILABILITY OF FUNDS: In any year in which funds are available for problem gambling services, the Division of Behavioral Health will award contracts/agreements to eligible providers to serve Nebraska residents, including significant others, affected by problem gambling. In addition, the Division may enter into contracts/agreements to provide training, helpline services, to conduct research, and to promote education on problem gambling. The Division will administer the funds for this program contingent upon their availability. If the Division lacks the fund necessary to fulfill its fiscal responsibility under this program, the contracts/agreements will be renegotiated or terminated.

6-019.02 SERVICES

6-019.02A Assessment: The initial problem gambling assessment must be a biopsychosocial assessment. The assessment must include screening for medical, substance abuse, and mental health symptoms/disorders; contacts must be obtained when possible with significant others or family members to gather relevant information about individual and family functioning. Additional collateral contacts with former and current healthcare providers, friends, and legal contacts should also be obtained to verify medical history, gambling history, substance use, and legal history. The biopsychosocial assessment must include all of the following:

1. Demographics;
2. Presenting problems;
3. Gambling history, including screening tool(s), score, and results;
4. Alcohol and drug history;
5. Legal history;
6. Family, social, and peer history;
7. Employment and education history;
8. Financial history (in accordance with 206 NAC 6-005);
9. Psychological history;
10. Medical history;
11. Collateral information;
12. Other screening tools, scores, and results;
13. A typed assessment summary;
14. Clinical impressions; and
15. Recommendations.

6-019.02B Crisis Intervention consists of professionally directed intervention for non-admitted persons in distress as a result of problem gambling behavior. Crisis intervention services can apply to a problem gambler or to a family member of a problem gambler. This service is designed to provide comprehensive interventions

to an individual and/or significant others who are at a crucial or decisive point or situation related to problem gambling that caused them to seek counseling for an emotionally stressful event or traumatic change in their life that creates an unstable condition related to his/her social and/or economic affairs.

6-019.02B1 The sessions must be conducted in a face-to-face manner with one or more non-admitted person(s) for the purpose of managing a crisis situation related to problem gambling behavior.

6-019.02B2 If the session is with more than one person, the time is billed as one unit and documented for the main person in crisis, or the time can be divided evenly according to the amount of time devoted to each person.

6-019.02B3 A maximum of six crisis contact hours per person are reimbursable during a 12-month period with a limit of 60 minutes per visit. All time must be rounded to the nearest quarter hour.

6-019.02C Outpatient Treatment consists of professionally directed evaluation, treatment, and recovery services for persons and families experiencing a wide range of problems related to gambling that causes disruptions in the persons' lives. Such services may be provided in regularly scheduled one-hour individual sessions and/or group sessions of no more than six contact hours a week. Services are consumer driven goal oriented interactions in one of three treatment modalities including:

1. Individual therapy with a problem gambling provider;
2. Group therapy including the consumer and a problem gambling provider in a group setting of at least two participants and no more than eight participants with a staff to consumer ratio not to exceed 1:8.; and
3. Family therapy, with or without the consumer, performed by a problem gambling provider in a session with at least two family members or the consumer and at least one family member present.

6-019.02D Outreach Services: Outreach services are intended to address those at risk for problem gambling, and/or in need of problem gambling treatment. An example of outreach services is activities at a local level such as public education presentations that seek to increase community awareness of problem gambling and to reach persons in need of problem gambling services.

6-019.02E Educational Programs: Educational programs are intended to increase community awareness of problem gambling, increase recognition of the risk and protective factors of problem gambling, and-reach persons in need of help to access problem gambling services. Educational programs target a specific population~~s~~ at the local level and utilize a more formalized public education presentation process.

6-019.02F Prevention Programs

6-019.02F1 Primary prevention activities intend to prevent and reduce that onset of problem gambling behavior in a particular population who as yet has no identified problem but may have different levels of risk. Primary prevention activities seek to reduce risk factors and/or strengthen protective factors of problem gambling, and to train the necessary personnel designated to carry out primary prevention activities.

6-019.02F2 Secondary prevention activities intend to target those in a particular population who have significant risk factors and may have exhibited problem gambling behaviors. Secondary prevention activities are designed to intervene when risk factors or early indicators of problem gambling is present. Secondary prevention strategies include the early detection of problem gambling or others designee to reduce the rates of established cases of the disorder in the population.

6-019.02F3 Tertiary prevention activies intend to address those already diagnosed with problem gambling. Tertiary prevention programming (also known as treatment) may include attempts made to restore individuals to their highest functioning, to minimize the negative effects of problem gambling, and to prevent further problems related to problem gambling through the promotion of quality of life.

6-020 HOUSING RELATED ASSISTANCE: For the Housing Related Assistance Program, the Division will contract with each RBHA for the provision of housing-related assistance in accordance with policies and procedures established by the Division implementing the State Housing-Related Assistance Program as authorized by Neb. Rev. Stat. §71-812(3). Each RBHA may contract with qualifying public or private nonprofit entities for the provision of housing-related assistance as specified in the policies and procedures.

6-020.01 Definitions: The following definitions apply to the housing related assistance program:

Adult with serious mental illness means a person age 18 or older who has, or at any time during the immediately preceding 12 months has had, a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders and which has resulted in functional impairment that substantially interferes with or limits one or more major life functions. Serious mental illness does not include DSM V-codes, substance abuse disorders, or developmental disabilities unless the conditions exist concurrently with a diagnosable serious mental illness.

Extremely Low Income means a household income of between zero and 30 percent of the Median Family Income (MFI) as defined by the U. S. Department of Housing and Urban Development.

Very Low Income means a household income of 50 percent or less of the applicable median family income estimate as established defined by the U. S. Department of Housing and Urban Development.

Housing-related assistance means rental payments, utility payments, security and utility deposits, and other housing-related costs and payments.