



Nebraska Summit on Navigating Acute Psychiatric Inpatient Admission Pathways

July 2026

SAMHSA's GAINS Center Policy Research Associates, Inc.

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Shannon Bader, Ph.D., ABPP

Mary Elizabeth (M.E.) Wood, Ph.D., ABPP

SAMHSA's GAINS Center

Policy Research Associates





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Introduction

Since 1995, SAMHSA's GAINS Center for Behavioral Health and Justice Transformation, operated by Policy Research Associates, has worked to expand community-based services and reduce justice involvement for adults with mental and substance use disorders in the criminal justice system. SAMHSA's GAINS Center focuses on five areas: criminal justice and behavioral health systems change, criminal justice and behavioral health services and supports; trauma-informed care; peer support and leadership development, and courts and judicial leadership.

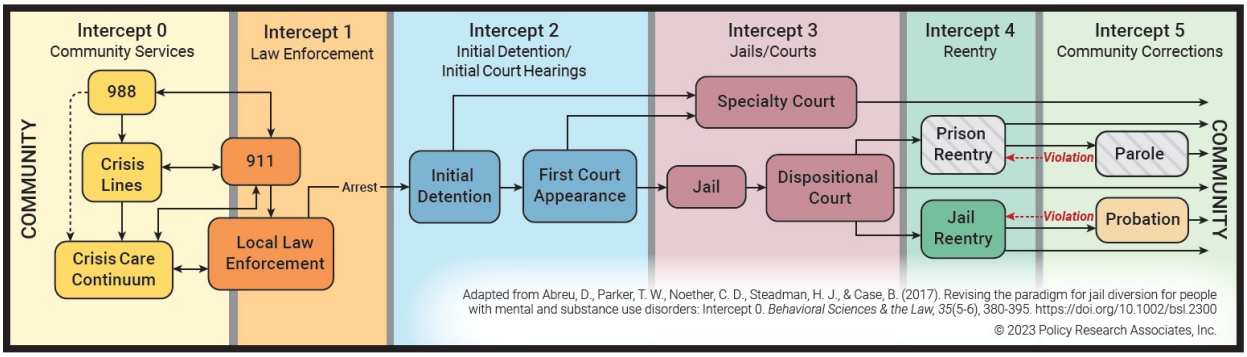
This report documents the July 2026 Summit facilitated by Policy Research Associates, Inc. (PRA) focused on the long waits for admission into the Lincoln Regional Center. The Summit was hosted by Region 5 (southeast corner of the state) and convened in Lincoln, Nebraska. Sections of this report describe the background on Nebraska's hospital system and current concerns, the planning process and methodology for the Summit, and summaries of the concerns and opportunities identified by participants, along with facilitator analysis and recommendations. This report is intended as a shared reference and planning tool for the six Nebraska behavioral health regions, courts, the Nebraska Department of Health and Human Services (DHHS), community behavioral health providers, defense and prosecution, jails and law enforcement, and the many other system partners working to strengthen Nebraska's response to people experiencing complex or severe psychiatric illness.



Background

Lancaster County, Nebraska applied for a Sequential Intercept Mapping workshop in January 2026 and specifically identified the need for targeted system coordination and diversion strategies for individuals with severe and complex psychiatric illness. The application identified that the need to improve coordination and align resources was especially necessary because the state was facing a $500 million budget shortfall that would further constrain behavioral health services at a time when there was increasing demand.

The Sequential Intercept Model (SIM), developed by Mark R. Munetz, M.D. and Patricia A. Griffin, Ph.D.,[1] is a framework that communities use to identify opportunities and gaps and to plan for change. The model describes how people with behavioral health needs come into contact with and move through the criminal legal system across six intercepts: (0) Community Services; (1) Law Enforcement; (2) Initial Detention and Initial Court Hearings; (3) Jails and Courts; (4) Reentry; and (5) Community Corrections and Community Support. Using the SIM framework assists stakeholders across the mental health and criminal justice systems to identify gaps in available services, opportunities to collaborate and expand treatment opportunities, and collectively plan for community change.



As discussions about Nebraska Region 5's concerns continued, it became apparent that long wait times before admission to the Lincoln Regional Center was a primary issue. These long waits resulted in individuals identified as needing acute, inpatient treatment residing in inappropriate treatment environments, such as jails, crisis centers, and local hospitals (including emergency departments) for hours to months. Early conversations revealed that the long waits for regional center admission came from two pathways, individuals after a mental health board commitment (the civil pathway) and individuals found incompetent to stand trial and ordered for competence restoration at the regional center (the forensic pathway). The SIM was used as an organizing framework for Summit attendees to discuss and consider the two pathways into Regional Center admission. However, it was noted that the civil commitment process, including mental health board commitments and inpatient admission to a state hospital, is not represented on the SIM

[1] Munetz, M., & Griffin, P. (2006). A systemic approach to the de-criminalization of people with serious mental illness: The Sequential Intercept Model. *Psychiatric Services*, *57*, 544-549.

at this time. A civil commitment focused map is currently under development at PRA to address this need and will be available for dissemination and use in 2027.

Region 5 developed a list of priorities for the Summit that reflected this focus on long waits before admission to the Lincoln Regional Center. These priorities also identified an intent to focus on the available psychiatric treatment and services available before inpatient care in necessary as well as appropriate step-down placements after an individual meets discharge criteria at the Lincoln Regional Center. These priorities are summarized here:

1. Define the Lincoln Regional Center's role and admission priorities.
2. Reduce wait times for admission to the Lincoln Regional Center.
3. Address the growing demand for competency restoration services.
4. Improve discharge planning and community transitions from the Lincoln Regional Center.
5. Strengthen data sharing and accountability between the Lincoln Regional Center, criminal justice partners, and behavioral health regions.
6. Identify policy, legislative, funding, and operational changes necessary to improve statewide behavioral health system performance.

After reviewing the priorities, the goal of the Summit was clarified as improved coordination between community and criminal justice partners for the individuals at risk of a mental health board commitment and within the competence to stand trial process.

Planning and Summit Agenda

Planning

Planning calls began in February 2026 and continued through June 2026 in preparation for the Summit. Planning calls included the facilitation team and the Region 5 team, but later expanded to include partners from other Nebraska Behavioral Health Regions, criminal justice partners, and DHHS administrators. These planning calls often included discussion of priorities for the Summit, as well as review and feedback on the agenda.

Materials Review

Before the workshop, the facilitation team reviewed available background materials to understand the context of Nebraska's mental health system and to avoid duplicating work already underway. These materials included the Nebraska Mental Health and Substance Use Research Study (2025), the Region 5 Annual Report (FY 24-25), the Addressing the Needs of the Unsheltered Population of Downtown Lincoln Final Report (2025), Lancaster County Criminal Justice System Assessment: Final Report (2025), and the State of Nebraska Legislative Mental Health Care Capacity Strategic Planning Committee report on Inpatient Mental Health Care Bed Capacity (2024). The Region 5 planning team also shared data dashboards from the Lancaster County Attorney's Office and the Lancaster County Jail.

Participant Representation

Because the civil commitment system and admission to the Lincoln Regional Center crosses multiple systems, it was crucial to have representation from mental health, substance use, law enforcement, pretrial services, courts, jails, community corrections, housing, health, social services, peers, and family members present at the Summit. Although Region 5 proposed and hosted this event, they acknowledged that these are statewide concerns and are credited with inviting partners from all the behavioral health regions to participate. Invitations were also given to mental health outreach officers, jail administrators, sheriffs, police chiefs, public defenders, county attorneys, probation, behavioral health providers, crisis center staff, peer support organizations, the local housing authority, state corrections administrators, legislators, local researchers, and administrators at DHHS and the Lincoln Regional Center. This wide invitation list resulted in 124 participants from across the state, representing both rural and urban areas. A complete participant list appears in Appendix A.

Agenda Development

Throughout the planning calls, the facilitation team reviewed the priorities of the Summit and also identified two key themes. First, there were three key participants in the long waits for Lincoln Regional Center admission; the mental health regions representing the Boards of Mental Health and local hospitals and providers,, the jail administrators and sheriffs managing the competence to stand trial defendants, and the Lincoln Regional Center. These three groups often operated in parallel, without much interaction, leading to misunderstandings. Second, all three groups agreed about the need to strengthen and expand certain outpatient treatment options

and services to prevent individuals with severe mental illness from needing inpatient treatment at the Lincoln Regional Center. These themes dictated the two-day agenda with the first day focused on learning more about each group's experience of long waits for admission, creative strategies developed in the face of the long waits, and continued barriers. Three panel discussions were included in the morning to provide more information from the behavioral health regions, the criminal justice community, and from the Lincoln Regional Center.

The second day focused on sharing best practices from across the country to reduce the use of state hospital admissions for competence to stand trial populations and emerging practices around civil commitment. The repeated question on day two was what can be done beforehand to prevent Nebraskans from needing inpatient admission at the Lincoln Regional Center.

Both days concluded with small group discussions. On the first day, Summit participants chose a topic of interest. They were encouraged to meet participants and then share something new they had learned about the behavioral health regions, jails, or Lincoln Regional Center, as well as what they viewed as continued barriers related to their specific topic. Before adjourning for the day, each small group shared these barriers. On the second day, time was devoted to action planning. Summit participants were assigned to small groups based on their preferences and then asked to discuss what programs or innovations from other states could be successful in Nebraska. Considering the barriers discussed the previous day, plus the information provided on the second day, they were asked to generate some priorities and solutions for Nebraska and then devise an action plan for implementing these solutions. Each group's action plans are included in Appendix B.

See the Summit agenda below.



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Nebraska Summit on Navigating Acute Psychiatric Inpatient Admission Pathways

DAY 1 AGENDA

June 30, 2026

8:00 a.m. – 8:30 a.m.	**Registration and Networking**
8:30 a.m. – 9:00 a.m.	**Welcome and Overview of the Day** • Opening Remarks: Mark Foxall, Ph.D., University of Nebraska-Omaha, School of Criminology and Criminal Justice • Establishing the Goals of the Summit
9:00 a.m. – 10:15 a.m.	**Nebraska Overview:** Shannon Bader and ME Wood **Regional Perspective Panel:** Lorie Thomas, Robyn Schultheiss, Beth Reynolds, and Kristin Nelson
10:15 a.m. – 10:30 a.m.	**Break**
10:30 a.m. – 12:00 p.m.	**Criminal Justice Perspective Panel:** Vicki Maca, Brad Johnson, Mike Myers, Justine Wall, Jo Martin, and Wesley Ludlow **Lincoln Regional Center Overview:** Mitchell Bruening, Roger Donovick, and Jennifer Cimpl-Bohn
12:00 p.m. – 1:00 p.m.	**Lunch**
1:00 p.m. –1:30 p.m.	**The Changing Role of State Psychiatric Hospitals:** Shannon Bader and ME Wood
1:30 p.m. – 1:45 p.m.	**Introduce Small Groups**
1:45 p.m. – 3:00 p.m.	**Small Group Breakouts** • Defining populations inappropriate for LRC • Treatment environment for patients waiting in jails • Improving communication between system players • Data collection and data sharing • Gaps in community mental health care • Collaborative discharge planning- Regions and LRC

- Legislative and policy changes
- Statewide training needs on clinical and forensic pathways
- Step-down options: forced meds, 24 hour supervision

3:00 p.m. – 3:15 p.m.	**Break**
3:15 p.m. – 4:15 p.m.	**Small Group Report Out**
4:15 p.m. – 4:30 p.m.	**Review and Preview Tomorrow** • Submit preferences for small group topics day two

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Nebraska Summit on Navigating Acute Psychiatric Inpatient Admission Pathways

DAY 2 AGENDA

July 1, 2026

8:30 a.m. – 8:45 a.m.	**Welcome and Overview of the Day:** Shannon Bader and ME Wood
8:45 a.m. – 9:00 a.m.	**Improved Crisis Services: Pathway to Reduced Admissions**
9:00 a.m. – 10:30 a.m.	**Factors Contributing to Restoration Admissions: Nationwide Trends to Reduce Hospital Admissions:** Kris Pothast
10:30 a.m. – 10:45 a.m.	**Break**
10:45 a.m. – 12:00 p.m.	**Factors Contributing to Mental Health Board Commitments: Nationwide Trends to Reduce Admissions and Length of Stay**
12:00 p.m.- 1:00 p.m.	**Lunch**
1:00 p.m. -2:15 p.m.	**Break Out Groups** • Crisis Services • Competence Restoration Expansion (JBCR, OCR) • Medication Over Objection in Jails • Diversion for defendants at risk for competence to stand trial • Workforce Development • Community Alternatives to LRC • Guardianship and Supported Decision Making • Gaps in Discharge Planning/Community Gaps • Funding, Braided Resources, Collaborative Grants • Rural Considerations • Technology and Data • Innovations and Creative Solutions (How do we turn the elephant into a zebra)
2:15 p.m.- 2:30 p.m.	**Break**

2:30 p.m.- 3:15 p.m.	**Strategic Action Planning** • In small group • Identify 1-2 priorities • Develop action plans for these priorities
3:15 p.m.- 4:15 p.m.	**Share Group Plans**
4:15 p.m. -4:30 p.m.	**Quick Fixes, Next Steps, and Adjourn**

Acute Inpatient Psychiatric Care in Nebraska

THEMES

The document review, planning calls, and responses during the Summit revealed several key themes for addressing the admission, treatment, and discharge of individuals needing inpatient care at the Nebraska Regional Centers.

Define the Role of the Lincoln and Norfolk Regional Centers

Throughout the Summit, there were repeated questions about how the two Nebraska Regional Centers could utilize their existing facilities to best serve the needs of both the mental health board committed patients, as well as the forensically committed patients. During the Summit, the leadership team from the Lincoln Regional Center highlighted that they are required to follow statutory requirements for admission percentages (RS 83-338). These guidelines dictate 70% of the admissions and allow for discretion in 30% of admissions as needed to reduce waiting lists. They shared that 38% of the Lincoln Regional Center beds are treating mental health board committed patients, and 62% of the beds are treating forensic patients. The leadership team described many recent initiatives to reduce waitlists and adapt to evolving needs. These included adding more staff, raising wages to recruit and retain staff, renewed focus on staff safety, analysis of bed utilization, implementation of a planned discharge date, and increasing urgency around admission scheduling.

Despite these important initiatives, the Nebraska Regional Center continues to admit a wide range of patients, some that may be inappropriate for the treatment available. Indeed, the 2024 Inpatient Mental Health Care Bed Capacity Review emphasized that the regional centers required a focused target population and suggested that patients requiring general acute inpatient care should be treated in local hospitals, not state facilities. Attendees at the Summit disagreed with this suggestion somewhat, noting that state hospitals have always been available to treat the patients with the most acute symptoms and complex needs. Summit attendees wanted to retain a patient population with these complex psychiatric needs, but find alternative treatment environments for individuals with primary personality disorders, intellectual disabilities, brain injuries, autism spectrum disorders, and neurocognitive disorders such as dementia.

It was notable that most Summit attendees focused on the Lincoln Regional Center and little attention was paid to the Norfolk Regional Center. Although DHHS leadership often spoke about the two hospitals as a system, most other community partners did not. As DHHS considers other ways to define their patient population and statewide role, it may be useful to clarify if DHHS envisions each hospital to have specialty units for identified patient populations or consider both facilities part of one unified system with transfers between each to allow flexibility for admissions.



Needed Changes in Service Definitions

Throughout the Summit, mental health providers across the continuum of care discussed the need to change service definitions in Nebraska. Specifically, Summit participants indicated that the current definitions complicate funding and make calculating budgets for the upcoming years difficult. Perhaps most importantly, Summit participants emphasized that the restrictive service definitions limit the opportunity to bill for peer support services. DHHS is currently involved in a revision to all mental health and substance use disorder service definitions; however, these changes have not yet impacted daily operations.

Civil Conversions

Summit participants had numerous questions about patients civilly committed after found not restorable to trial competence. There were concerns that their direct admission from restoration treatment to civil commitment treatment may bypass more acutely ill patients waiting for admission in community settings that were not able to meet their clinical needs. Summit participants familiar with regional center procedures explained that continued admission in these cases provided continuity of care and fewer transportation or logistical concerns. Regional administrators questioned whether a local analysis of which patients committed by the mental health board, including the newly converted forensic patients, should be prioritized at the regional level. They reasoned that some patients found not restorable and converted to a civil commitment may be less acutely ill because of their hospitalization and that the priority for admission is best determined by their view of all the patients waiting for civil admission.

Misdemeanor Restoration

Summit attendees repeatedly commented that the high number of restoration patients waiting for restoration treatment at the Lincoln Regional Center have misdemeanor charges. They expressed frustration that these cases, which were considered less serious or not dangerous, led to other individuals with acute psychiatric needs waiting for inpatient treatment. Attendees emphasized that the number of misdemeanor restoration cases was disproportionately high in Lancaster County, resulting in longer waits for other counties. Many states have faced similar challenges and either prohibited inpatient competence restoration for certain low-level, non-violent charges or shifted the burden for restoration to the county, not the state, so that these defendants are no longer admitted to the state hospital. Relatedly, many Summit participants questioned whether the judicial system could emphasize diversion for individuals at risk of being found incompetent to stand trial.

Importantly, many Summit participants noted that restoration treatment is not a long-term mental health treatment. There was concern expressed that no ongoing treatment was established for individuals after restoration, leading to a quick return into the competence to stand trial system.

Jails as Treatment Environments

During the Summit, larger jails in Sarpy and Douglas counties shared their plans to open specialized behavioral health units and possibly provide jail-based trial competence restoration



programming. Other jails from smaller counties emphasized that they do not have the capacity to provide specialized services to this degree. All jails highlighted that the physical size and design of county jails limit their ability to safely house individuals with severe mental illness that need inpatient psychiatric care. There is continued nationwide debate about jails shouldering the burden of state hospital waitlists, but many counties have decided that providing specialized treatment benefits the jail and correctional officers.

Collaborative Discharge Planning

Community partners emphasized that the Lincoln Regional Center waitlist is complicated by patients with a delayed discharge. They identified that the state hospitals and many local hospitals have a 'backdoor' problem. Indeed, a patient may be ready for discharge to a lower level of care, but there is no appropriate treatment environment available in the community. This limits the number of patients that can be admitted, therefore lengthening waits for all patients. Summit participants discussed the need for more collaborative discharge planning, including community programs coming into the hospitals to meet with patients and begin transition plans with the hospital treatment team.

Housing, Residential Services, and Intermediate Levels of Care

Summit participants routinely remarked on the need for additional housing and residential treatment opportunities throughout the state. Both urban and rural communities identified the lack of safe housing options and the need for additional housing programs with available support and treatment of staff members on-site. There were frequent discussions about individuals with chronic and persistent psychiatric illness that can leave the state hospital setting but require intensive outpatient services available for days, evenings, and weekends. Many Summit participants lamented that patients became 'stuck' at the state hospital because there was no appropriate residential program for discharge. These concerns point to an urgent need to create specific, community-based housing and treatment options for individuals with psychiatric illness and complex presentations. Importantly, the availability of intensive, residential treatment options intended for years long lengths of stay would provide a feasible discharge to many patients at the Regional Centers, allowing admission for more acutely ill patients.

The group discussions during the Summit also revealed an absence of intermediate level of care options. Intensive Outpatient Programs or Partial Hospitalization Programs can provide brief crisis stabilization or intensive treatment for individuals that do not necessarily require inpatient care, but do need more services than their previous treatment plan. Similarly, Summit participants reported an inadequate number of respite options available for individuals with psychiatric illness. Short-term respite stays between days to two weeks can often prevent exacerbation of symptoms and the need for a mental health board commitment.

Recommendations

The recommendations below are based on the document review, planning calls with various community partners, panel discussions at the Summit, small group reports, and action plans. These recommendations are intended to complement discussions and efforts already underway in Nebraska.

1. **Nebraska Regional Center Utilization and Definition**: As discussed above, the role of state hospitals across the county has evolved in the last ten years and the Nebraska Regional Centers require a redefinition of their target population and role within the statewide continuum of care. Clarification of the state hospital role was recommended in the 2024 Inpatient Mental Health Care Bed Capacity Review and was further identified during this Summit as a needed step. Specific questions to consider:
    a. DHHS is encouraged to collaborate with community partners and consult with similar states to consider the target patient population for the regional centers. This includes identifying the patient populations that are not best served by the state hospital system.
    b. Lincoln Regional Center leadership noted that there has been a 60% increase in the Not Responsible by Reason of Insanity (NRRI) population. Because of the NRRI legal statutes, many experience long hospital admissions that are due more to their original charges and history of significant violence risk than their actual current acuity. Indeed, these patients often have serious psychiatric conditions, but many have achieved stabilization and would be appropriate for discharge to a residential placement with continued intensive services. DHHS is encouraged to consider creative and innovative treatment plans for NRRI's that would prioritize inpatient hospital treatment for those patients requiring acute care and provide ongoing support for NRRI patients at a location that mitigates their risk to the community but meets their lower level of psychiatric need.
    c. Once there is clarification of the appropriate patient populations at the state hospitals, Neb. Rev. Stat. § 83-338 should be revised to reflect these changes and reduce or eliminate the strict percentage allocations. The revision can provide more discretion for DHHS to respond to immediate waitlist needs and adapt to changing population needs.

2. **Diversion and Competence Restoration:** The high number of Nebraskans admitted to the Lincoln Regional Center for competence restoration after being charged only with a misdemeanor was a topic of concern for the Summit participants. As discussed above, many states have encountered this same phenomenon and decided to either prohibit misdemeanor restoration outright or require the county to provide restoration services locally if they choose to pursue the charge[2]. Eliminating defendants with misdemeanor

[2] See Murrie, D. C., Gardner, B. O., & Torres, A. N. (2022). The impact of misdemeanor arrests on forensic mental health services: A state-wide review of Virginia competence to stand trial evaluations. *Psychology, Public Policy, and Law, 28*(1), 53–66 for a discussion of the rate of misdemeanors in restoration programs.



charges only from the state hospitals has reduced wait lists and encouraged other diversion programs or local restoration solutions.

a. The legislature may want to undertake a study to determine if Nebraska should continue to support misdemeanor restoration at the state hospitals. Both Ohio and Florida have eliminated misdemeanor restoration and can serve as models for statutory language. When Ohio changed their statute in 2021, the Department of Behavioral Health provided funding for counties to start their own outpatient restoration programs. Now, defendants with misdemeanors found not competent to stand trial are directed into these county level programs. Nebraska already has an existing state-level outpatient restoration program and could consider a similar pathway for misdemeanor cases that would eliminate state hospital admission.
b. Legislators may also want to consider revising existing statutes to both allow for and encourage dismissing charges and referring to treatment when the individual is found not competent after an arrest for a non-violent incident. Some jurisdictions have created programs that pair the dismissal with entry into certain community-based treatment programs or Assisted Outpatient Treatment (AOT) through the civil court.
c. Judges, prosecutors, and defense attorneys may be unaware of the scope of the waitlist for competence evaluations and restoration treatment. It will be essential to provide education about the current waits for Lincoln Regional Center admission, current diversion opportunities, and the existing outpatient restoration program. If there are statutory revisions that provide for additional diversion options, widespread education, training, and support for implementing these changes will be necessary for all court partners.

3. **Focus on Acuity:** Throughout discussions of admission to the regional centers, there was often a lack of evaluation or measure of patient acuity. Although there was appropriate discretion used by regions, jail administrators, and DHHS administrators, Lincoln Regional Center admission appeared to be based on waitlist position more than current acuity. Court timelines dictate significant aspects of competence to stand trial evaluations and treatment; however, civil commitment and civil conversions after a finding of non-restorability appeared to be influenced by the person's 'place in line' instead of clinical need. Because the regions often needed to advocate for mental health board commitments' admission, their effective advocacy and persuasiveness could result in quicker admission at times. This raises concern that some more convincing regional emergency systems coordinators could unintentionally sway admission decisions when a more acute patient remained waiting. While there is a waitlist for admission, it will be especially important to demonstrate transparency in those decisions.
    a. Nebraska is encouraged to consider implementation of a standardized clinical assessment measure or tool as part of the admission decisions. Even the score from the Brief Psychiatric Rating Scale would provide a clinical anchor to include when prioritizing admissions.



b. As noted above, there are questions about whether patients found not restorable and converted to a mental health board commitment should *automatically* remain at the Lincoln Regional Center when the region may prefer to prioritize admission for another patient waiting for treatment. An assessment of current symptom acuity may allow for a more equitable evaluation of how to prioritize all mental health board committed patients from a region.
c. Further considerations for how to best prioritize mental health board committed patients and patients found not restorable will require a broad view that takes into account staffing levels, community resources, and Emergency Medical Treatment and Labor Act (EMTALA) requirements.

4. **Identification of Community Hospital Beds in Region 5:** Region 5 provides a disproportionate number of mental health board admissions to the Lincoln Regional Center. The Lincoln Regional Center is a limited resource and disparate numbers of admissions from one region limit the flexibility to prioritize admissions from other areas. Furthermore, the waitlist for admission to the regional center has required the Lancaster County Mental Health Crisis Center to provide treatment for patients for a much longer time than that facility was intended. Summit participants described ongoing discussions with local hospitals in Region 5 and other nearby communities to identify contracted hospital partners. Region 5 is encouraged to continue those discussions or consider innovative alternatives, such as contracting with a behavioral health company to provide inpatient level of care in a non-hospital facility.

5. **Expand Statewide Training on Mental Health Board Commitment Criteria:** Summit participants expressed that there can be inconsistent application of the statutory civil commitment criteria between areas in Nebraska. Especially as the target population for the Nebraska regional centers is identified and statutory changes occur, it will be crucial to provide statewide training for the boards. Nebraska is also encouraged to develop a system of consultation between boards that would allow boards who disagree about a case to have contact with other boards for input and support. There may also be value in implementing a validity check process. This would involve all the state mental health boards receiving identical case samples and soliciting their decisions. The results could be shared, anonymously, with the boards to identify areas of confusion and areas of consistency.

6. **Develop Programs Within the Continuum of Care:** As discussed above, Summit participants identified several gaps in the existing continuum of care and emphasized that these missing treatment environments often led to delayed discharges for patients ready to leave the regional centers. The following types of treatment were identified as missing or insufficient for the population;
    a. Long-term residential options- Summit attendees identified a need for residential treatment programs for long-term tenancy. Ideally, these programs would have integrated staffing and treatment programs. Most importantly, these programs would be considered a permanent housing option for individuals

with a history of eviction or poor rental history. The following resource can identify strategies Interim Strategies for Responding to Unsheltered Homelessness, NAEH (December 2024). Another model is the Denver Supportive Housing Social Impact Bond Initiative, launched in 2016 and aimed to increase housing stability and decrease jail stays among people who were experiencing chronic homelessness and had frequent interactions with the criminal justice and emergency health systems. The initiative provided supportive housing and intensive services.

b. Programs for co-occurring psychiatric symptoms and substance abuse- There is a need for both locked, unlocked, and intensive outpatient programs that can address co-occurring substance use and psychiatric disorders. It is especially important that these programs support the use of medications for opioid use disorder (MOUD), as well as psychiatric medications, including long-acting injectables.
c. Respite programs- Nebraska already has successful programs, including Keya House in Lincoln, Nebraska, which operates peer-run hospital diversion homes with lengths of stay of generally a few days. These respite options can both prevent the need for crisis services and also provide an option before community hospitalization. There is a need to expand these programs to provide respite options in Western Nebraska.
d. Re-entry programs- Nebraska would also benefit from additional jail re-entry programs. Honu Home, a transitional housing program designed for individuals returning to the community from state corrections can serve as a model for similar jail re-entry programming. Providing support and connection to community mental health treatment during the critical re-entry period may reduce the need for crisis level of care or further arrest and competence to stand trial evaluations.
e. Navigator programs- Throughout the Summit, community partners described the success of the MHB Coordinator program in Sarpy County. This existing model can be expanded and tailored specifically for forensic and/or mental health board committed patients.
f. In times of budget strain, it can be difficult for mental health agencies to create new programs, especially intensive programs like the ones discussed. Financial incentives or start-up funds from the state, county, region, and block grant funds can support community mental health providers with interest in standing up these kinds of new programs. Additionally, creation of new programs can be bolstered with technical assistance or support from similar existing programs within the state or nearby states.

7. **Enhance Cross-Agency Information Sharing:** The action plans created during this Summit showed innovative strategies to connect various data systems.
    a. Numerous small groups suggested adding information about the Board of Mental Health Commitments and guardianship to the NCJIS system.



b. The regions shared significant data and had access to important data dashboards. Investigate whether there is a need for further data sharing with criminal justice partners and LRC to enhance coordination of care.
c. Consider joining the Arnold Foundation and National Association of Counties (NACo) Data-Driven Justice Initiative (DDJ). The publication "Data-Driven Justice: A Playbook for Developing a System of Diversion for Frequent Utilizers | National Association of Counties" provides guidance on the development of data driven strategies and use of data to develop programs and improve outcomes.
d. Summit attendees identified that misunderstanding about the Health Insurance Portability and Accountability Act (HIPAA) and patient confidentiality often inhibit data sharing. This published article can provide some guidance and reassurance to any workgroups or committees implementing cross-agency information collaboration, Dispelling the Myths of Information Sharing Between the Mental Health and Criminal Justice Systems (Petrila, 2007).



Additional Resources

Competence Evaluation and Restoration

SAMHSA. (2023). Foundation Work for Exploring Incompetence to Stand Trial Evaluations and Competence Restoration for People with Serious Mental Illness/Serious Emotional Disturbance. https://store.samhsa.gov/

- Policy Research Associates. Competence to Stand Trial Microsite.

Policy Research Associates. (2007, re-released 2020). Quick Fixes for Effectively Dealing with Persons Found Incompetent to Stand Trial.

Pinals, D., and Callahan, L. (2020). Evaluation and Restoration of Competence to Stand Trial: Intercepting the Forensic System Using the Sequential Intercept Model. *Psychiatric Services, 71,* 698-705.

Callahan, L. and Pinals, D. (2020). Challenges to Reforming the Competence to Stand Trial and Competence Restoration System. *Psychiatric Services, 71,* 691-697.

- Finkle, M., Kurth, R., Cadle, C., and Mullan, J. (2009) Competency Courts: A Creative Solution for Restoring Competency to the Competency Process. *Behavioral Science and the Law, 27,* 767-786.

Crisis Care, Crisis Response, and Law Enforcement

- National Council for Behavioral Health. (2021). Roadmap to the Ideal Crisis System: Essential Elements, Measurable Standards and Best Practices for Behavioral Health Crisis Response.
    - Executive Summary
- National Association of State Mental Health Program Directors. Crisis Now: Transforming Services is Within our Reach.
- National Association of Counties. (2010). Crisis Care Services for Counties: Preventing Individuals with Mental Illnesses from Entering Local Corrections Systems.
- Abt Associates. (2020). A Guidebook to Reimagining America's Crisis Response Systems.
- Urban Institute. (2020). Alternatives to Arrests and Police Responses to Homelessness: Evidence-Based Models and Promising Practices.
- Open Society Foundations. (2018). Police and Harm Reduction.
- Center for American Progress. (2020). The Community Responder Model: How Cities Can Send the Right Responder to Every 911 Call.
- Vera Institute of Justice. (2020). Behavioral Health Crisis Alternatives: Shifting from Policy to Community Responses.
- National Association of State Mental Health Program Directors. (2020). Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies.

- National Association of State Mental Health Program Directors and Treatment Advocacy Center. (2017). Beyond Beds: The Vital Role of a Full Continuum of Psychiatric Care.
- R Street. (2019). Statewide Policies Relating to Pre-Arrest Diversion and Crisis Response.
- Substance Abuse and Mental Health Services Administration. (2014). Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies.
- Substance Abuse and Mental Health Services Administration. (2019). Tailoring Crisis Response and Pre-Arrest Diversion Models for Rural Communities.
- Substance Abuse and Mental Health Services Administration. (2020). Crisis Services: Meeting Needs, Saving Lives.
    - Substance Abuse and Mental Health Services Administration. (2020). National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit.
- Crisis Intervention Team International. (2019). Crisis Intervention Team (CIT) Programs: A Best Practice Guide for Transforming Community Responses to Mental Health Crises.
- Suicide Prevention Resource Center. (2013). The Role of Law Enforcement Officers in Preventing Suicide.
- Bureau of Justice Assistance. (2014). Engaging Law Enforcement in Opioid Overdose Response: Frequently Asked Questions.
- International Association of Chiefs of Police. One Mind Campaign: Enhancing Law Enforcement Engagement with People in Crisis, with Mental Health Disorders and/or Developmental Disabilities.
- Bureau of Justice Assistance. Police-Mental Health Collaboration Toolkit.
- Policy Research Associates and the National League of Cities. (2020). Responding to Individuals in Behavioral Health Crisis Via Co-Responder Models: The Roles of Cities, Counties, Law Enforcement, and Providers.
- International Association of Chiefs of Police. Improving Police Response to Persons Affected by Mental Illness: Report from March 2016 IACP Symposium.
- Optum. (2015). In Salt Lake County, Optum Enhances Jail Diversion Initiatives with Effective Crisis Programs.
- The Case Assessment Management Program (CAMP) is a joint effort of the Los Angeles Department of Mental Health and the Los Angeles Police Department to provide effective follow-up and management of selected referrals involving high users of emergency services, abusers of the 911 system, and individuals at high risk of death or injury to themselves.

Brain Injury

- National Association of State Head Injury Administrators. (2020). Criminal and Juvenile Justice Best Practice Guide: Information and Tools for State Brain Injury Programs.
- National Association of State Head Injury Administrators. Supporting Materials including Screening Tools and Sample Consent Forms.

Housing

- CSG Justice Center and BJA. (2020). How State-led Housing Initiatives can Break the Cycle of Criminal Justice Involvement.
- Alliance for Health Reform. (2015). The Connection Between Health and Housing: The Evidence and Policy Landscape.
- Economic Roundtable. (2013). Getting Home: Outcomes from Housing High Cost Homeless Hospital Patients.
- 100,000 Homes. Housing First Self-Assessment.



    - Milwaukee County Housing First.
- Community Solutions. Built for Zero.
- Urban Institute. (2012). Supportive Housing for Returning Prisoners: Outcomes and Impacts of the Returning Home-Ohio Pilot Project.
- Corporation for Supportive Housing. Guide to the Frequent Users Systems Engagement (FUSE) Model.
    - Corporation for Supportive Housing. NYC Frequent User Services Enhancement – Evaluation Findings.
- Corporation for Supportive Housing. Housing is the Best Medicine: Supportive Housing and the Social Determinants of Health.
- Substance Abuse and Mental Health Services Administration. (2015). TIP 55: Behavioral Health Services for People Who Are Homeless.
- National Homelessness Law Center. (2019). Housing Not Handcuffs 2019: Ending the Criminalization of Homelessness in U.S. Cities.
- SAMHSA's GAINS Center. Moving Toward Evidence-based Housing Program for Persons with Mental Illness in Contact with the Justice System.
- Stefancic, A., Hul, L., Gillespie, C., Jost, J., Tsemberis, S., and Jones, H. (2012). Reconciling Alternative to Incarceration and Treatment Mandates with a Consumer Choice Housing First model: A Qualitative study of Individuals with Psychiatric Disabilities. Journal of Forensic Psychology Practice, 12, 382–408.
- Tsemberis, S. (2010). Housing First: The Pathways Model to End Homelessness for People with Mental Illness and Addiction. Center City, MN: Hazelden Press.
- Stefancic, A., Henwood, B. F., Melton, H., Shin, S. M., Lawrence-Gomez, R., and Tsemberis, S. (2013). Implementing Housing First in Rural Areas: Pathways Vermont, *American Journal of Public Health*, *103*, 206–209.

Information Sharing/Data Analysis and Matching

- Legal Action Center. (2020). Sample Consent Forms for Release of Substance Use Disorder Patient Records.
- Council of State Governments Justice Center. (2010). Information Sharing in Criminal Justice-Mental Health Collaborations: Working with HIPAA and Other Privacy Laws.
- American Probation and Parole Association. (2014). Corrections and Reentry: Protected Health Information Privacy Framework for Information Sharing.
- The Council of State Governments Justice Center. (2011). Ten-Step Guide to Transforming Probation Departments to Reduce Recidivism.
- Substance Abuse and Mental Health Services Administration. (2019). Data Collection Across the Sequential Intercept Model: Essential Measures.
- Substance Abuse and Mental Health Services Administration. (2018). Crisis Intervention Team (CIT) Methods for Using Data to Inform Practice: A Step-by-Step Guide.
- Data-Driven Justice Initiative. (2016). Data-Driven Justice Playbook: How to Develop a System of Diversion.
- Urban Institute. (2013). Justice Reinvestment at the Local Level: Planning and Implementation Guide.
- Vera Institute of Justice. (2012). Closing the Gap: Using Criminal Justice and Public Health Data to Improve Identification of Mental Illness.
- New Orleans Health Department. (2016). New Orleans Mental Health Dashboard.

- The Cook County, Illinois Jail Data Linkage Project: A Data Matching Initiative in Illinois became operational in 2002 and connected the behavioral health providers working in the Cook County Jail with the community mental health centers serving the Greater Chicago area. It quickly led to a change in state policy in support of the enhanced communication between service providers. The system has grown in the ensuing years to cover significantly more of the state.

Jail Inmate Information/Services

- NAMI California. Arrested Guides and Medication Forms.
- NAMI California. Inmate Mental Health Information Forms.
- Urban Institute. (2018). Strategies for Connecting Justice-Involved Populations to Health Coverage and Care.
- R Street. (2020). How Technology Can Strengthen Family Connections During Incarceration.

Medication-Assisted Treatment (MAT)/Opioids/Substance Use

- American Society of Addiction Medicine. Advancing Access to Addiction Medications.
- American Society of Addiction Medicine. (2015). The National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use.
    - ASAM 2020 Focused Update.
    - Journal of Addiction Medicine. (2020). Executive Summary of the Focused Update of the ASAM National Practice Guideline for the Treatment of Opioid Use Disorder.
- National Commission on Correctional Health Care and the National Sheriffs' Association. (2018). Jail-Based Medication-Assisted Treatment: Promising Practices, Guidelines, and Resources for the Field.
- National Council for Behavioral Health. (2020). Medication-Assisted Treatment for Opioid Use Disorder in Jails and Prisons: A Planning and Implementation Toolkit.
- Substance Abuse and Mental Health Services Administration. (2019). Use of Medication-Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings.
- Substance Abuse and Mental Health Services Administration. (2019). Medication-Assisted Treatment Inside Correctional Facilities: Addressing Medication Diversion.
- Substance Abuse and Mental Health Services Administration. (2015). Federal Guidelines for Opioid Treatment Programs.
- Substance Abuse and Mental Health Services Administration. (2020). Treatment Improvement Protocol (TIP) 63: Medications for Opioid Use Disorder.
- Substance Abuse and Mental Health Services Administration. (2014). Clinical Use of Extended-Release Injectable Naltrexone in the Treatment of Opioid Use Disorder: A Brief Guide.
- Substance Abuse and Mental Health Services Administration. (2015). Medication for the Treatment of Alcohol Use Disorder: A Brief Guide.
- U.S. Department of Health and Human Services. (2018). Facing Addiction in America: The Surgeon General's Spotlight on Opioids.

Mental Health First Aid

- Mental Health First Aid. Mental Health First Aid is a skills-based training course that teaches participants about mental health and substance-use issues.
- Illinois General Assembly. (2013). Public Act 098-0195: Illinois Mental Health First Aid Training Act.

- Pennsylvania Mental Health and Justice Center of Excellence. City of Philadelphia Mental Health First Aid Initiative.

Peer Support/Peer Specialists

- Policy Research Associates. (2020). Peer Support Roles Across the Sequential Intercept Model.
- Department of Behavioral Health and Intellectual disability Services. Peer Support Toolkit.
- University of Colorado Anschutz Medical Campus, Behavioral Health and Wellness Program (2015). DIMENSIONS: Peer Support Program Toolkit.

Pretrial/Arraignment Diversion

- Substance Abuse and Mental Health Services Administration. (2015). Municipal Courts: An Effective Tool for Diverting People with Mental and Substance Use Disorders from the Criminal Justice System.
- CSG Justice Center. (2015). Improving Responses to People with Mental Illness at the Pretrial Stage: Essential Elements.
- National Resource Center on Justice Involved Women. (2016). Building Gender Informed Practices at the Pretrial Stage.
- Laura and John Arnold Foundation. (2013). The Hidden Costs of Pretrial Diversion.

Procedural Justice

- Center for Court Innovation. (2019). Procedural Justice at the Manhattan Criminal Court.
- Chintakrindi, S., Upton, A., Louison A.M., Case, B., & Steadman, H. (2013). Transitional Case Management for Reducing Recidivism of Individuals with Mental Disorders and Multiple Misdemeanors.
- American Bar Association. (2016). Criminal Justice Standards on Mental Health.
- Hawaii Opportunity Probation with Enforcement (HOPE) Program Profile. (2011). HOPE is a community supervision strategy for probationers with substance use disorders, particularly those who have long histories of drug use and involvement with the criminal justice system and are considered at high risk of failing probation or returning to prison.

Racial Equity and Disparities

- Actionable Intelligence for Social Policy. (2020). A Toolkit for Centering Racial Equity Throughout Data Integration.
- The W. Haywood Burns Institute. Reducing Racial and Ethnic Disparities: A NON-COMPREHENSIVE Checklist.
- National Institute of Corrections. (2014). Incorporating Racial Equality Into Criminal Justice Reform.
- Vera Institute of Justice. (2015). A Prosecutor's Guide for Advancing Racial Equity.

Reentry

- Substance Abuse and Mental Health Services Administration. (2017). Guidelines for the Successful Transition of People with Behavioral Health Disorders from Jail and Prison.
- Substance Abuse and Mental Health Services Administration. (2016). Reentry Resources for Individuals, Providers, Communities, and States.



- Substance Abuse and Mental Health Services Administration. (2020). After Incarceration: A Guide to Helping Women Reenter the Community.
- National Institute of Corrections and Center for Effective Public Policy. (2015). Behavior Management of Justice-Involved Individuals: Contemporary Research and State-of-the-Art Policy and Practice.
- The Council of State Governments Justice Center. (2009). National Reentry Resource Center
- Community Oriented Correctional Health Services. Technology and Continuity of Care: Connecting Justice and Health: Nine Case Studies.
- Washington State Institute of Public Policy. (2014). Predicting Criminal Recidivism: A Systematic Review of Offender Risk Assessments in Washington State.

Screening and Assessment

- Substance Abuse and Mental Health Services Administration. (2019). Screening and Assessment of Co-occurring Disorders in the Justice System.
- The Stepping Up Initiative. (2017). Reducing the Number of People with Mental Illnesses in Jail: Six Questions County Leaders Need to Ask.
- Center for Court Innovation. Digest of Evidence-Based Assessment Tools.
- Urban Institute. (2012). The Role of Screening and Assessment in Jail Reentry.
- Steadman, H.J., Scott, J.E., Osher, F., Agnese, T.K., and Robbins, P.C. (2005). Validation of the Brief Jail Mental Health Screen. *Psychiatric Services*, 56, 816-822.

Sequential Intercept Model

- Policy Research Associates. The Sequential Intercept Model Microsite.
- Munetz, M.R., and Griffin, P.A. (2006). Use of the Sequential Intercept Model as an Approach to Decriminalization of People with Serious Mental Illness. *Psychiatric Services*, 57, 544-549.
- Griffin, P.A., Heilbrun, K., Mulvey, E.P., DeMatteo, D., and Schubert, C.A. (2015). The Sequential Intercept Model and Criminal Justice. New York: Oxford University Press.
- Urban Institute. (2018). Using the Sequential Intercept Model to Guide Local Reform.

SSI/SSDI Outreach, Access, and Recovery (SOAR)

Increasing efforts to enroll justice-involved persons with behavioral disorders in the Supplement Security Income and the Social Security Disability Insurance programs can be accomplished through utilization of SSI/SSDI Outreach, Access, and Recovery (SOAR) trained staff. Enrollment in SSI/SSDI not only provides automatic Medicaid or Medicare in many states, but also provides monthly income sufficient to access housing programs.

- The online SOAR training portal.
- Information regarding FAQs for SOAR for justice-involved persons.
- Dennis, D., Ware, D., and Steadman, H.J. (2014). Best Practices for Increasing Access to SSI and SSDI on Exit from Criminal Justice Settings. Psychiatric Services, 65, 1081-1083.

Telehealth

- Remington, A.A. (2016). 24/7 Connecting with Counselors Anytime, Anywhere. National Council Magazine. Issue 1, page 51.

Transition-Aged Youth

- National Institute of Justice. (2016). Environmental Scan of Developmentally Appropriate Criminal Justice Responses to Justice-Involved Young Adults.
- Harvard Kennedy School Malcolm Weiner Center for Social Policy. (2016). Public Safety and Emerging Adults in Connecticut: Providing Effective and Developmentally Appropriate Responses for Youth Under Age 21.
- Roca, Inc. Intervention Program for Young Adults.
- University of Massachusetts Medical School. Transitions to Adulthood Center for Research.

Trauma and Trauma-Informed Care

- SAMHSA. (2014). SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach.
- SAMHSA. (2014). TIP 57: Trauma-Informed Care in Behavioral Health Services.
- SAMHSA, SAMHSA's National Center on Trauma-Informed Care, and SAMHSA's GAINS Center. (2011). Essential Components of Trauma Informed Judicial Practice.
- SAMHSA's GAINS Center. (2011). Trauma-Specific Interventions for Justice-Involved Individuals.
- National Resource Center on Justice-Involved Women. (2015). Jail Tip Sheets on Justice-Involved Women.
- Bureau of Justice Assistance. VALOR Officer Safety and Wellness Program.

Veterans

- SAMHSA's GAINS Center. (2008). Responding to the Needs of Justice-Involved Combat Veterans with Service-Related Trauma and Mental Health Conditions.
- Justice for Vets. (2017). Ten Key Components of Veterans Treatment Courts

Appendix

Appendix A	**Participant List** – Nebraska Summit on Navigating Acute Psychiatric Inpatient Admission Pathways
Appendix B	**Action Plans**

APPENDIX A: SUMMIT PARTICIPANT LIST

Name	Title or Role	Agency or Organization
Jana Andrews	Program Manager	Douglas County Community Mental Health Center
Elizabeth Atterberry	Mental Health Director	Nebraska Department of Correctional Services
Sara Baker	Director of Outpatient Services	Douglas County Community Mental Health Center
Wendy Baumeister	Director of Justice and Behavioral Health	Region 5
Nicki Behmer-Popp	Executive Director	Nebraska Organization of Behavioral Health Organizations
Martin Bland	Associate Public Guardian	Nebraska Office of Public Guardian
Mark Bless	Program and Services Specialist	Nebraska State Probation
Carolyn Bosn	State Senator	Nebraska Legislature
Jenny Brandle	Clinical Coordinator	METHODIST FREMONT HEALTH
Holly Brandt	Region 1 Administrator	Region 1
Anna Brokaw	Deputy County Attorney	Hall County Attorney's Office
Mitchell Bruening	LRC Hospital Administrator	DHHS - Division of Behavioral Health
Brandi Brunz	Justice Systems Coordinator	Region 1 Behavioral Health Authority
Denise Bulling	Sr Research Director	University of Nebraska Public Policy Center
Kim Burry	Director of Network Services	Region 1 Behavioral Health Authority
Arrow Caryl		Region 6 Behavioral Health Authority
Jennifer Cimpl-Bohn	Director of Forensic Services	DHHS - Division of Behavioral Health
Kimberly Clawson	Assistant Professor	UNMC
Patrick Condon	Lancaster County Attorney	Lancaster County
Gene Cotter	Probation Administrator	Nebraska Administrative Office of the Courts and Probation
Kerri Culver	VP Patient care Behavioral Health services	CHI Health
Jeff Curry	Chief Probation Officer	Adult Lancaster County Probation
Shawn Curtis	Senior Administrator Adult Facilities	DHHS- DBH
John Danforth	Director of Youth & Family Behavioral Health Services	Region 5 Systems
Tom Dargy	Asst. County Administrator	Sarpy County Nebraska
Jena Davenport	Associate Public Guardian	Nebraska Office of Public Guardian
Roger Donovick	Medical Director	Lincoln Regional Center
Sara Draus	Manager of Social Work and Therapy	Bryan Medical Center
Sherry Driver	Administrator	Douglas County CMHC
Kristi Egger	Lancaster County Public Defender	Lancaster County Public Defender's Office
Scott Etherton	Director	Mental Health Crisis Center
Renee Faber	Provider Network Specialist	Probation Administration
Marla Fischer	Director	Office of Public Guardian
Dylan Folchert	County Deputy Attorney	Sarpy County Attorney's Office

Name	Title or Role	Agency or Organization
Mark Foxall	Community Service Associate, Master of Science in Criminal Justice Program Coordinator	School of Criminology and Criminal Justice
Jennifer Fugit	Deputy Sheriff	Sarpy County Sheriff's Office
Crystal Fuller	Director of Network Services	Region 6 Behavioral Healthcare
Jeffrey Funke	Chief Justice	Nebraska Supreme Court
Ingrid Gansebom	Regional Administrator	Region 4 Behavioral Health System
Miles Glasgow	Senior Manager of System Coordination	Region 6 Behavioral Healthcare
Tiffany Gressley	Regional Administrator	Region 3 Behavioral Health Services
Andee Hardesty	Problem Solving Court Coordinator	District 12 Probation
Maria Hatfield	Re-Entry and Rehabilitation Administrator	Lancaster County Department of Corrections
Doug Headlee	Mental Health Response Coordinator	Lincoln Police Department
Julia Hebenstreit	Consultant	JRH Collaborative Strategies
Dawn Herlacher	Mental Health Deputy	Sarpy County Sheriff's Office
Laura Hill	Therapist Supervisor	Mary Lanning Healthcare
Sara Hoyle	Director	Lancaster County
Mary Jacobsen		Nebraska Legislature
Thomas Janousek	Director, DHHS Division of Behavioral Health	DHHS
Brad Johnson	Director	Lancaster County Department of Corrections
Chelsea Johnson	Lancaster County Commissioner	Lancaster County
Jessica Kerkhofs	Chief Assistant City Attorney	City of Lincoln
Kim Kern	Director of Behavioral Health	Mary Lanning Healthcare
Molly Klocksin	Advocacy Specialist	Disability Rights Nebraska
Ben Kopsa	Captain	Lincoln Police Department
Patrick Kreifels	Regional Administrator	Region 5 Systems
Scott Larson	Jail Diversion Research Committee member	Justice in Action
Lisa Logsden	psychologist	Mental Health Crisis Center
Melinda Lowe	Director of Network Services	Region 4 Behavioral Health System
Wesley Ludlow	Captain	Cass County Sheriff's Office
Vicki Maca	Dir. Criminal Justice and Behavioral Health Initiatives	Region 6 Behavioral Health
Jo Martin	Director	Sarpy County Department of Corrections
Jason Mayo	Captain/Court Services	Lancaster County Sheriff's Office
Katie McCarthy	Regional Administrator	Region II Human Services
Paige McDowell	Youth and Crisis Systems Administrator	Division of Behavioral Health
Diana Meadors		DHHS-DBH
Rachel Meier	Clinical Services Administrator	DHHS-DBH
Rebecca Meinders	Mitigation Specialist	Lancaster County Public Defender's Office
Kay Meints	Director Behavioral Health	Methodist Fremont Health

Name	Title or Role	Agency or Organization
Lisa Meyer	Deputy Director	NE Office of Public Guardian
Dan Moss	Captain	Beatrice PD
Rachel Mulcahy	BHAC Member Region 5 & Board Member Justice in Action	BHAC; Justice in Action
Kimberley Mundil	Assistant Deputy Administrator for Rehabilitative Services	Administrative Office for the Courts and Probation
Benjamin Murry	Chief of Police	City of Nebraska City
Mike Myers	Director of Corrections	Douglas County Department of Corrections
Brad Negrete	Director of Crisis Services-Eastern Region	Lutheran Family Services
Kristin Nelson	Director of Emergency Services R5	Region 5 Systems
Monica Nelson	Probation Supervisor	State Probation
Michelle Nunemaker	Central Region Vice President	Lutheran Family Services
Gary Olson	County Attorney	York County Attorney Office
Kasey Parker	Executive Director	MHA
David Partsch	County Court Judge	2nd Judicial District; State of Nebraska
Amber Pendley	Director of Operations	MHA
Dawn Peters	Administrator	DHHS- Division of Behavioral Health
Mandy Peth	Behavioral Health and Wellness Sergeant	Douglas County Sheriff's Office
Kris Pothast	Justice Behavioral Health Administrator	DHHS
Amy Prenda	Deputy Administrator for Court Services	Nebraska Judicial Branch - AOCP
Melissa Puls	Associate Public Guardian	Nebraska Office of Public Guardian
Dan Quick	Senator	Nebraska Legislature
Arnold Remington	Program Director	TASC
Beth Reynolds-Lewis	Emergency System Director	Region 3 Behavioral Health Services
Reid Richter	Captain	Cass County Sheriff's Office
Colter Robertus	Forensic Behavioral Health Navigator	Division of Behavioral Health
Alicia Rosno	Mental Health Specialist	Lancaster County Department of Community Corrections
Victor Rountree	Senator	Nebraska Legislature
Erin Rourke	Director of CQI	Region 5 Systems
Christy Rupe	LICSW - Director of Social Work	DHHS - Lincoln Regional Center
Mario Scalora	Director	Public Policy Center/University of Nebraska
Kelli Schadwinkel	Deputy Ombudsman for Institutions	Office of Public Counsel
Dan Schleusener	Chief Deputy Sheriff	Buffalo County Sheriff's Office
Robyn Schultheiss	Emergency Systems Director	Region II
Jamie Scott	Chief Crisis and Outreach Officer	Integrated Behavioral Health Services
Chris Seifert	Deputy County Attorney	Lancaster County Attorney's Office
Corey Steel	Nebraska State Court Administrator	Nebraska Administrative Office of the Courts & Probation
Amy Stolzenburg		Nebraska Legislature
Sue Teal	Director of Emergency Services	Region 1 Behavioral Health Authority
Lorie L. Thomas	Manager of Emergency Services	Region 6

Name	Title or Role	Agency or Organization
Ed Thornbrugh	Executive Director	Bridge Behavioral Health
Taryn Tolliver	Program Manager	Community Corrections
Sarah Wagelie	Associate	Kissel, Kohout ES Associates
Jordan Wall	Family Support Specialist	Lincoln Housing Authority
Justine Wall	Rehabilitative Services Administrator	Douglas County Department of Corrections
Todd West	Public Defender	Sarpy County Public Defender's Office
Heather Wiese	Medical Director	Lutheran Family Services
Ashley Wilksen	Director of Operations	MHA
Tim Young	Legal Counsel	Legislature - Judiciary Committee
Thomas Zimmerman	Judge	Lancaster County Court

APPENDIX B: ACTION PLANS

Priority Area #1: Crisis Response			
Objective	**Action Step**	**Who**	**When**
Create a stakeholder definition of crisis response (who responds, what is provided)	Develop a group of statewide stakeholders (providers, consumers, law enforcement, regions, DBH, Medicaid, 1st responders, 988/911, schools, hospitals inclusive of LRC) to define who on CR team, who responds, expectations of what happens during a crisis response, decide the crisis continuum, align recommendations – need flexibility, who/what # should be called	Chief Murray (NE City) with support of this workgroup	By 1/2/27 1st planning meeting of this workgroup will occur by 9/1/27

Group Participants: Holly Brandt, Miles Glasgow, Benjamin Murry, Michelle Nunemaker, Erin Rourke, Christy Rupe, Jamie Scott, Sue Teal, and Todd West

Priority Area #2: CRT			
Objective	**Action Step**	**Who**	**When**
Increase utilization of OCR	Educate judicial and legal system partners across NE, meet with presiding judges	Kris Pothast, CJ from Regions	Develop plan of attack/timeline by Oct. 1
	Increase community-based providers awareness of OCR	Regions with Regional Network Providers	Annually, beginning Fall 2026
Develop and Implement JBCRT	Develop criteria and funding structure, needs assessment, rev. info from other states	Workgroup, Dr. Jennifer Sarpy, Douglas Co and other interested jails and attorneys (PD and CA)	Next 6 months to convene workgroup
	Eval stat changed needed and implement	DHHS legal and local CA's	September 2026
	Evaluate how small jails could utilize JBCRT	Wes Ludlow	August 2026
	Develop standardized protocol for continuity of care for competency restoration	Kris P lead need judicial and legal partner	Start December 2026

Group Participants: Jana Andrews, Brandi Brunz, Jennifer Cimpl-Bohn, Tom Dargy, Wesley Ludlow, Vicki Maca, Mike Myers, Kris Pothast, Alicia Rosno, and Kelli Schadwinkel

Priority Area #3: Medication Over Objection

Objective	Action Step	Who	When
Clarification on state law • Appliable to counties of 150k+ population • Only for those who have been restored to competency in order to maintain competency • Must include competency support services (in reach)	Get an opinion from Attorney General on what if any charged are required	Corrections Depts County Attorneys County Boards Lobbyist	In 2026 (prior to 2027)
	Identify Senators on Judiciary Committee to introduce legislation		By Fall of 2026
	Lobby		2027 session
Court orders must include jails in regards to medication over objection	Work with State Supreme Court to standardize court orders	County Attorney? District Courts?	In conjunction with efforts to amend statute

Group Participants: Maria Hatfield, Brad Johnson, Justine Wall, Heather Wiese, and Tim Young

Priority Area #4: Diversion from Competency (Pre Arrest)			
Objective	**Action Step**	**Who**	**When**
Sharing of statewide MHB commitment info or treatment provider	Statutory Changes/Funding	Legislature – Judiciary/HHS (Pat/Kristi)	November 1, 2026
	Learn more about treatment	Mandy/Jessica	October 1, 2026
	Determine criteria • Info shared • Who has access • What platform	Wait for treatment info- Amy/AOC	TBD
Expand/create mental health diversion programming to assist those at risk for competency proceedings	Statutory changes/funding	Legislature – Judiciary/HHS (Pat/Kristi)	November 1, 2026
	Learn more about South Carolina "pre eval"	Mandy/Jessica	October 1, 2026
	Navigators	Mitchell	TBD

Group Participants: Mitchell Bruening, Patrick Condon, Roger Donovick, Kristi Egger, Jessica Kerkhofs, Rachel Mulcahy, Amy Prenda, Mandy Peth, Taryn Tolliver, and Thomas Zimmerman

Priority Area #5: Workforce Development			
Objective	**Action Step**	**Who**	**When**
Generate interest in MH fields	Promotion/survey input	BHECN Dr. Atterberry/Jenny/Advisor Board	August 2026 – survey nursing, social etc. professions
Value these MH fields	Intentional loan forgiveness	BHECN	August 2026 – refresh info
Fill gaps in MH field	Expansion-current First Responder and Recruitment Act	Professional Associations NPA-Dr. Atterberry	Starts with an email September 2026
Promote future generations			

Group Participants: Elizabeth Atterberry, Mark Bless, Jenny Brandle, Denise Bulling, Jeff Curry, and Brad Negrete

Priority Area #6: Community Alternatives to LRC			
Objective	**Action Step**	**Who**	**When**
Longterm residential care	Research (with in person visit) the WA residential model	Lorie	October 2026-December 2026
	Visit with WA BH director to learn more of program	Dr J	August 1, 2026
Geriatric care LTC	Learn more about new behavioral health supports in nursing homes	Lorie and Dr. L	September 1, 2026
Respite/step down, wait for residential from acute care			
Borderline residential – medical monitor and DBT	Look up residential treatment and program for Borderline Personality	Sara	September 1, 2026

Group Participants: Sara Baker, Martin Bland, Scott Etherton, Ingrid Gansebom, Molly Klocksin, Jo Martin, Monica Nelson, Lorie Thomas, and Jessica West

Priority Area #7: Guardianship and Supported Decision Making			
Objective	**Action Step**	**Who**	**When**
Central information re: guardianship, sub decision makers	Identify who is in charge of Justice 2.0	David Partsch	August 1, 2026
	Create flag in NCJIS	Dawn Herlacher	August 1, 2026
	Offer input in Justice 2.0	AOCP (Marla as liaison)	In by June 2027
	Contact Hospital Association for software process	Pat K and Katie M	September 30, 2026
Create a plan for →	Training and awareness agreements (MOUs) with law enforcement, medical, behavioral health providers • After database is updated with guardianship info		June 2028 adjust depending on implementation above ↑
Education on forms of sub decision making	Create statewide education plan WRAP- 988, Wellness, Recovery, Action, Plan speaking, marketing, 5 wishes form, materials	OPG, Region	June 2027
Implement plan for education on forms of sub decision making			

Group Participants: Jena Davenport, Marla Fischer, Dawn Herlacher, Patrick Kreifels, Scott Larson, Katie McCarthy, David Partsch, and Dawn Peters

Priority Area #8: Gaps in Discharge Planning			
Objective	**Action Step**	**Who**	**When**
Info sharing between involved disciplines	Speak to officials in Texas about programs- how they are working, who uses, hurdles and solutions		
	Research difference in treatment vs NE privacy laws		
Long term placement facilities, group homes, community services – no place to discharge to (secure)	Talk directly to heritage program to view operations	Regions	Within 30 days
	Collect data, use to		Within 45 days (+30 days)
	Compare to NE system and see what needs to be changed, address laws and statute changes needed		Within 45 days (+30 days)
	Funding		TBD
	Building-land-structure		3-5 yrs
	Agency/staffing		1 yr

Group Participants: Arrow Caryl, Jennifer Fugit, Doug Headlee, Laura Hill, Ben Kopsa, Lisa Meyer, Kristin Nelson, Amber Pendley, and Colter Robertus

Priority Area #9: Funding			
Objective	**Action Step**	**Who**	**When**
Conduct a cost analysis of transitioning LRC to a 6-month LOS facility 1. Assessment of current cost services provided Civil vs. CR 2. What level of staffing needed to provide services showing consumer outcomes 3. Service plan for Civil vs. CR	Explore prevention/diversion and past discharge placements 1. Review available funding sources – county, federal, state, opioid, Medicaid 2. Best practice models for diversion and discharged (analysis with geography in mind) 3. Statute language changes to reduce flow into LRC	1. Diana 2. Crystal and team 3. Renee	2. January 2027

Group Participants: Renee Faber, Crystal Fuller, Sara Hoyle, Paige McDowell, Diana Meadors, and Jordan Wall

Priority Area #10: Rural Considerations

Objective	Action Step	Who	When
Add BOMH commitment information, to include only the date and county of commitment, and date of discharge, if applicable, to NCJIS so it is accessible to authorized NCJIS users.	Prepare potential statute language.	Senator Quick and support staff; Anna	Before 2028 legislative session
	Connect with a CDC to determine how commitment information is stored and how information gets added to NCJIS.	Anna	Before December 2026
	Research how guardian information could be added/included to NCJIS for both private and public guardians.	Melissa	
	Prepare to introduce legislation by meeting with stakeholders, other senators, etc.	Senator Quick and support staff; everyone in group	Before 2028 Legislative
	Introduce legislation to the confidentiality requirement to permit MHB commitment information (commitment date, county, discharge date) to be accessible on NCJIS.	Senator Quick	2028 Legislative Session
	Beth Reynolds-Lewis testifies in support of proposed legislation.	Beth	

Group Participants: Anna Brokaw, Kim Burry, Tiffany Gressley, Melinda Lowe, Kay Meints, Kimberley Mundil, Melissa Puls, Dan Quick, Reid Richter, Robyn Schultheiss

Priority Area #11: Innovative and Creative Solutions			
Objective	**Action Step**	**Who**	**When**
Evaluate and standardize training and practice for MHB reporting	Promote and model the Lancaster Co. database		
	Evaluate this model for the other counties needs		
Review and identify needs within current legislation	Recommend implement language changes		
Create navigators to track the date			
Create enforcement for reporting the data			

Group Participants: Shawn Curtis, Mary Jacobsen, Julie Reiter, Arnold Remington, and Beth Reynolds-Lewis