

State Advisory Committee on Mental Health Services
February 5, 2008 – 9:00 A.M. to 4:00 P.M.
Country Inn & Suites – 5353 No. 27th St. Lincoln, NE
MINUTES

Committee Members Present:

Adria Bace, Pat Compton, Cheryl Crouse, Bev Ferguson, Dwain Fowler, Joleine Hall, Clint Hawkins, Nancy Kratky, Susan Krome, Kathy Lewis, Frank Lloyd, Roxie Cillessen, Chelsea Chesen

Committee Members Absent:

Jimmy Burke, Beth Baxter, Chris Hanus, Scot Ford, Colleen Manthei, Jerry McCallum, Pat Talbott, Mary Wells

DHHS Staff Present:

Sue Adams, Alexandra Castillo, Jim Harvey, Joel McCleary, Dan Powers, Scot Adams, Vicki Maca,

Guests Present:

Alan Green, J. Rock Johnson, Linda Jensen, Bryson Bartel, Kurt Weiss

I. CALL TO ORDER

Bev Ferguson, Chairperson called the meeting to order at 9:00 a.m.

The official meeting process was altered because Nebraska was encountering a major snow storm. At the official start of the meeting, roll call of members determined a quorum was not officially met. At the start of the meeting, 7 of the 22 appointed members were present. A quorum was established at 10:12 a.m. with a total of 13 members present. The meeting continued with the agenda submitted but no actions or votes occurred.

II. BH DIVISION REPORTS

Division of Behavioral Health Discussion

Scot Adams distributed a copy of his presentation to committee members. As part of his presentation, Scot briefly stated what Behavioral Health has been doing and how it's moving forward. The big challenges in the system are; supporting assisted living beds, decreasing Emergency Protective Custody, increasing consumer involvement and establishing how to measure Behavioral Health success. **Item # 3**

Mental Health Block Grant Implementation Report Review

Jim explained the Center for Mental Health Services is suggesting to have The Federal Community Nebraska Mental Health Services Block Grant support the transformation of the Mental Health System consistent with the "President's New Freedom Commission on Mental Health". Committee members are asked to read the materials distributed and send comments to Jim Harvey. The input will be used for developing the instructions to the six Regions on use of the MH Block Grant funds for FY2009. **Item #4**

Question:

Is there a plan for services to take care of the Military men returning home? There needs to be a plan to avoid chronic homeless of veterans.

A workgroup which includes representatives from the Nebraska National Guards, Department of Defense, Nebraska Health and Human Services, the State and Federal Veteran Administration are working together in collaboration to provide services and support to our returning veterans and their family. Trainings include establishing a system of communication among hospitals and clinics to exchange information, and a training to work with veterans that are experiencing post traumatic stress injury and to help Law Enforcement to desensitized issues.

Request for clarification on the definition of EPC.

Information can be found on the HHS website regarding the Mental Health Commitment Board.
www.hhs.state.ne.us/beh/commit/commit.htm

- EPC (Emergency Protective Custody) Core Definition refers to someone being a danger to self and others which allows a hold of a person in a facility of 72 hours.
- CPC (Civil Protective Custody) definition refers to a point of intoxication that would cause someone to be a danger to self and others which allows a hold of a person in a facility of 24 hours.

Children's Service Administrator

Vicki Maca, Division's Children's Service Administrator has an extensive background of working with Children's Behavioral Health. She also has experience with adult's substance abuse and mental health as well as a strong commitment to kid's services. Ms. Maca presentation covered LB542 report. The report, "Creating Change and Providing Hope for Nebraska's Children, Adolescents and Their Families Pursuant to LB 542 (2007)", is posted on the Division of Behavioral Health's web site at <http://www.dhhs.ne.gov/Behavioral%5FHealth/> Presentation is **Item #5**

Kathy Lewis suggested, John Ferrone to come and speak with the committee.

Legislative Update

Bryson Bartel is the Legislative Coordinator. A copy of LB882 and LB1084 was distributed to committee members. Bryson highlighted the main point of the bills and listed other 2008 bills that the committee members may be interested to review or monitor, such as; LB1119 LB1168, LB1199, LB1058 Gambling Assisted Program, LB1018, LB994. **Item #6**

Committee asked to check on the Federal/National parity bill. **Item #7**

Risk Factor Surveillance System

Kurt Weiss with DHHS Division of Public Health discussed how the annual Behavioral Risk Factor Surveillance System (BRFSS) is completed. **Item # 8**

2007 Consumer Survey Report

Joel McCleary handed out the summary report of the Consumer Survey. He reviewed and pointed out some main points. The survey is used to find out information regarding services directly from the people that receive the services, and to measure the distribution and quality of the services. Youth surveys are completed by the parents. **Item #9**

The Division will continued using the survey provided by the federal government so there can be equal comparisons with other states.

Joel posed a question for the committee to think about. What are the committee's recommendation/advise to Division on how to improve/increase consumer involvement?

PATH Report

Dan Powers handed out and reviewed a funding summary table. Applications for FY09 will be out soon. Community Alliance does outreach with shelters. The State of Nebraska also has a homelessness assistance program. Region 2 and Region 4 do not handle the PATH program in their regions. **Item #10**

Criminal Justice Meeting Report

Jim Harvey reported on the December 5-6, 2007 workgroup on Criminal Justice Mental Health Strategic Planning. The discussion was targeted on people with mental illness becoming part of the Criminal Justice System. 59 people plus two consultants attended. The final report with attachments is posted in the DHHS Division of Behavioral Health web site at:

http://www.dhhs.ne.gov/beh/NE_CriminalJusticeMHReport&Attachmts-Jan28_2008.pdf

III. PUBLIC COMMENT

Linda Jensen from NAMI – invited the all to join the first NAMI walk in Omaha.

Alan Green of Mental Health Association handed out a copy his public comment and his letter to Senator Joel Johnson. He wants to add “Recovery Measures to include quality of life” to the Critical success indicators. He is strongly in favor of funds allocated for the President’s New Freedom Commission on Mental Health Goals. **Item #11**

J. Rock Johnson

- Pointed out that the measures don’t include Prevention and Recovery.
- The Office of Consumer Affairs needs to report at every meeting and wants to see a written report at the quarterly advisory meetings.
- What kind of data are the Regions sharing with the state?
- Suggests LB994 and LB1149 be reviewed by the committee.

IV. MENTAL HEALTH ADVISORY COMMITTEE RECOMMENDATIONS TO BH DIVISION

Committee expressed concerns of patient at LRC escaping and would like to know “what is the level of security”.

Committee recommends the Division to increase Substance Abuse programs for youth and Adults. They consider this a Gap in services.

Committee asks the Division for a definition or the intention of Peer Support Services, what is happening with Peer Support and Crisis Intervention, what are the funding possibilities, and who will do the education/training of the Peer Support individuals? They recommend there be a state framework to provide consistency within the regions.

V. OTHER AGENDA ITEMS

- New Freedom Commission
- Division’s Response to recommendations
- Education System in HRC Development
- Region 2 BH Report
- Criminal Justice Report
- SIG Report – Beth Baxter
- Medical Advisory Meeting-Mary Wells
- Office of Consumer Report on Consumer Specialist

VI. NEXT MEETING & ADJOURNMENT

The next meeting date is Tuesday, May 6, 2008 at Country Inn and Suites.
Meeting adjourned at 2:15 pm.

Prepared by: Alexandra Castillo, Staff Assistant

Approved by _____
Quality Improvement Coordinator
Division of Behavioral Health Services

Date 4/21/08

Item 3

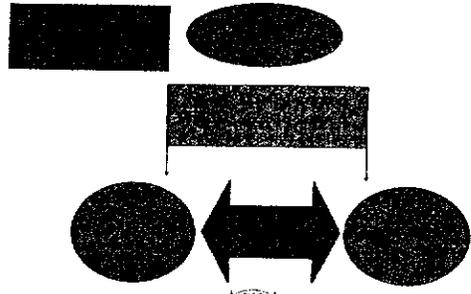
State Advisory Committee on Mental Health Services

Scot L. Adams, Ph.D., Director
Division of Behavioral Health

February 5, 2008



Behavioral Health in Nebraska 2007
Where we are doing well



From Report to Behavioral Health Oversight Commission of the Legislature (9/14/07)

Behavioral Health in Nebraska 2007
Where we are doing well

- Increase in Persons Served in Community Hospitals and Reduction in Number Served in Regional Centers
 - Between 2004 and 2007, closed 232 adult and 16 adolescent MH beds at Regional Centers
- Transferred over \$60M in Regional Center Dollars to Community Based Services since July 2004.



Behavioral Health in Nebraska 2007
Where we are doing well (con't)

- Closed Hastings Regional Center adult services.
- Reduced Hastings Regional Center adolescent services.
- Greater consumer input into the System
- LB 95 meds clarification and focus
- Established the Office of Children's Behavioral Health.
- Submitted LB 542 plan for behavioral health services for children and adolescents on time on Jan. 4, 2008.



Behavioral Health in Nebraska 2007
Where we are doing well (con't)

- Completed the Emergency Protective Custody "Roadshows" with the Regions.
- Completed an Integration Study of Regional Centers.
- Developed Lasting Hope Recovery Center contract.
- Established an Assisted Living Facility study group.
- Established a Veterans/Behavioral Health study group.
- Planning an Annual Conference.



Behavioral Health in Nebraska 2007
Where we are doing well (con't)

- Supporting and Expanding Opportunities for Living Situations Outside of Hospitals
 - Nursing Home Needs
 - Assisted Living Task Force
- Increased Housing Related Assistance
 - 127 people received in 2006; 557 in 2007
- Implemented Supported Employment in FY 08
- Normalizing Dual Treatment
- Codification of Behavioral Health as term of choice



Behavioral Health in Nebraska 2007

Where we are doing well (con't)

- Developed a Safety Committee at Regional Centers
- Worked with the Department of Correctional Services
- Visited with other states
- External experts engaged
- Internal staff engagement
- Regional Center space planning committee

- Established Trauma Informed Network



Behavioral Health in Nebraska 2007

Where we are having challenges

- Supporting Assisted Living beds
- Decreasing Emergency Protective Custody rates
- Increasing access to crisis care
- Increasing consumer involvement beyond the few
- Integrating recovery focus appropriately with other treatment visions
- Special Populations
 - Developmental Disabilities
 - Elderly
 - Criminal Justice
- Fully integrating mental health and substance abuse into Behavioral Health



Goals for Behavioral Health

- LB 1083 – complete behavioral health reform
- Integrate children's behavioral health into the Division
- Nurture the Behavioral Health System
- Be recognized as a Top Five state in providing behavioral health services in the areas of consumer involvement, safety, accessibility and effectiveness of treatment.



How LB 1083 Impacted Funding

Behavioral Health Reform resulted in *one-time, new, or redirected* funding since July 2004.

- \$60 M+ in Regional Center funds redirected to community services since 2004
- \$ 6 M during FY'05 (one year only) to jump-start development of community-based services.
- \$ 1.5 M beginning in FY'05 to fund emergency psychiatric services.
- \$ 6.5 M in federal Medicaid matching funds to expand community-based services (\$4M Medicaid Rehab Option, \$2.5M through adoption of Medicaid Substance Abuse waiver).
- \$ 2.6 M in new funding for rental assistance for adults with serious mental illness.



Additional Funds for Community Services

- Behavioral health reform created additional funds for community behavioral health services. The Division established priorities and guidelines and will give final approval to Region plans for using increased funding.
- Funding included operational costs associated with inpatient beds at Regional Centers, the Hastings ACT program, outpatient services, and increases granted by the Unicameral and approved by the Governor since passage of LB 1083.
- Some funding may be used to address one-time transitional costs for expenses resulting from reducing staffing at Regional Centers that continued into FY 07-08.



Additional Funds (con't)

- In FY 07-08, \$5.4 million transferred to the community:
- \$2.9+ M to Regions to achieve greater balance with agreed-upon formula for distribution (population 75%, poverty 25%).
 - Beginning FY 08-09, \$3.3 M per year with a focus on special populations (at least \$250,000 for each Region)
 - Up to \$2 M to Region 6 to secure residential treatment in the community for 16 individuals currently at Norfolk Regional Center.
 - \$500,000 used by DHHS with Regions to facilitate resolution of Emergency Protective Custody situations.



Additional Funds (con't)

In FY 07-08 and FY 08-09:

- \$3.5 M retained to address the costs of care for up to 30 individuals residing at the Norfolk Regional Center. DHHS will continue to work with Regions to move people to community settings wherever possible.



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SAMHSA Block Grant Allocations 1/25/08

Mental Health Block Grant

- FY 2007 Final Allotment \$2,006,207
- FY 2008 Allotment \$1,973,901

Substance Abuse Block Grant

- FY 2007 Final Allotment \$7,865,512
- FY 2008 Allotment \$7,865,700

PATH (Projects for Assistance in Transition from Homelessness)

- FY 2007 Final Allotment \$ 300,000
- FY 2008 Allotment \$ 300,000



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We need your input on how to measure success.



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Draft Critical Success Indicators
Lincoln / Norfolk Regional Centers (public psychiatric hospitals)

- # Persons admitted
- # Persons ordered by MH Board to receive treatment at a Regional Center
- # Persons receiving Regional Center services
- Average Length of Stay at Regional Centers
- Readmission Rates to Regional Centers
- Client perception of care
- Dollars expended
- What else ?



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Draft Critical Success Indicators
Adult Community Behavioral Health (age 18+)

- # Persons ordered by MH Board to receive inpatient or outpatient treatment services
- # Persons admitted to BH crisis center or inpatient care under Emergency Protective Custody
- Average length of stay in the community
- Client perception of care
- # Persons receiving MH, SA or Dual Services
- Dollars expended
- What else ?



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Draft Critical Success Indicators
Child Community Behavioral Health (ages 0-17)

- Client perception of care
- # Youth receiving community MH, SA and Dual Services
- Average length of stay in the community
- Dollars expended
- What else?



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Draft Critical Success Indicators
Gamblers Assistance Program

- # People Receiving Services
- Average Length of Stay in the Community
- Client Perception of Services
- Dollars Expended
- What else ?



Public Comments on Federal MH Block Grant Instructions

Starting in FY2009, MHBG funding used to support mental health transformation will be reported per the goals stated in the

“President's New Freedom Commission on Mental Health: Achieving the Promise: Transforming Mental Health Care in America
DHHS Pub. No. SMA-03-3832, Rockville, MD: 2003.



Public Comments on Federal MH Block Grant Instructions

Federal Register: January 29, 2008
(Volume 73, Number 19)]

is seeking public comment on changes to

“Community Mental Health Services Block Grant Application Guidance and Instruction, FY 2009-2011”



Goals from the “President's New Freedom Commission on Mental Health”

GOAL 1	Americans Understand that Mental Health is Essential to Overall Health
GOAL 2	Mental Health Care is Consumer and Family Driven
GOAL 3	Disparities in Mental Health Services are Eliminated
GOAL 4	Early Mental Health Screening, Assessment, and Referral to Services are Common Practice
GOAL 5	Excellent Mental Health Care Is Delivered and Research Is Accelerated
GOAL 6	Technology Is Used to Access Mental Health Care and Information



Federal Mental Health Block Grant FY 2008 Allotment (\$1,973,901)

Available to allocate to the six Regional Behavioral Health Authorities	\$1,870,206
State Administration (5%) Adult Goal: Empower Consumers	\$98,695
Independent Peer Review (Federal Requirement)	\$5,000
FY2008 Final Allocation	\$1,973,901

Should the funds allocated to the six Regions in FY2009 be used to support MH transformation per the goals in the “President's New Freedom Commission on Mental Health”?



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Use of Federal Mental Health Block Grant in FY2009

Recent Funding History – Nebraska Allocation under the Federal Community Mental Health Services Block Grant:

	Federal MH Block Award
FY 2004	\$2,105,983
FY 2005	\$2,086,159
FY 2006	\$2,050,210
FY 2007	\$2,006,208
FY 2008	\$1,973,901
Fund cut (amount) FY2004 to 2008	\$132,082
Fund cut (percent) FY2004 to 2008	6%

PURPOSE – the funds are used in three ways:

- (1) The primary purpose was to purchase community mental health services via contracts with the six Regional Behavioral Health Authorities.
- (2) The 5% administrative portion was used to support Adult Goal #2: Empower Consumers.
- (3) Funds used to help support the "Independent Peer Review" (per Section 1943 in Attachment A - Community Mental Health Services Block Grant Funding Agreements).

Summary	FY2009
(1) Allocation available to Regions in FY2009 Contracts	\$1,870,206
(2) State administration 5% set aside from final allocation for Adult Goal: Empower Consumers	\$98,695
(3) Independent Peer Review (Federal Requirement per Section 1943 in Attachment A - Community Mental Health Services Block Grant Funding Agreements).	\$5,000
Total Federal Community Mental Health Services Block Grant Fiscal Year 2008 Award (actual)	\$1,973,901

Should the funds allocated to the six Regions in FY2009 be used to support MH transformation per the goals in the "President's New Freedom Commission on Mental Health"?

- Residential Rehabilitation (Psych Res Rehab) – 24 hour, residential facility in the community for persons with severe and persistent mental illness. Persons in this service need the 24-hour structured psychosocial rehabilitation and medication management to regain or relearn skills that will allow them to live independently in their communities. Length of service varies depending on individual needs but is not longer than 4-8 months. Length of service varies depending on individual needs but is usually not longer than 9-18 months.
- Community Support – With 24 hour, 7-day/week availability, provides consumer advocacy, ensures continuity of care, active support in time of crisis, provides direct skill training in the residence and community, provide or arrange for transportation, arrange for housing, acquisition of resources and assistance in community integration for individuals with severe and persistent mental illness. Length of service varies depending on individual needs but is usually not longer than 6 months – 2 years.

DESCRIPTION OF ACTIVITIES / CHILDREN/YOUTH SERVICES

- Professional Partner – Strength-based, family centered approach to working with children with serious emotional disturbances and their families. Access to services on a 24-hour, 7day/week basis. Uses a wraparound approach to coordinate services and supports to families. Includes coordinated assessment, flexible funding to provide support, based on needs as outlined by a multidisciplinary team. Emphasizes family empowerment and involvement in planning.
- School Wraparound – In this variation of the Professional Partner Program, a special education teacher, team teacher, or school social worker works with the Professional Partner and the Child and Family Team to coordinate the school plan. Based on the LaGrange Area Department of Special Education (LADSE) approach in LaGrange, Illinois, a team of two wraparound service coordinators are based in the school. Planning efforts around the child and family create an environment in which the school is an integral part of the overall assessment and support for the child and his/her family. This School-Based Wraparound Approach allows the teacher and/or other school personnel to feel comfortable voicing classroom based concerns (academic and behavioral) and members of the Child and Family Team are also able to understand these concerns. The two individuals work closely together as a team to assist and coordinate services to a combined caseload of approximately 20 children/families. Both individuals bring specific strengths to the team from their varied backgrounds in the school and in the community.
- Day Treatment – Facility based program serving children and adolescents with Severe Emotional Disturbance. Intensive, non-residential service providing counseling and family services, education, behavior modification and skill building, promoting reintegration back to the child's regular school.
- Outpatient/Assessment – Assessment, diagnosis and psychotherapy/counseling for mental health problems which disrupt a youth's home, school, family functioning; treatment focuses on changing behavior, modifying thought patterns, coping with problems, improving functioning and may include coordination to other services to achieve successful outcomes. Length of service varies depending on individual needs but is usually not longer than 10 sessions no more than once per week.
- Therapeutic Consultation – Collaborative, clinical intervention for youth with early indications of Severe Emotional Disturbance. Multidisciplinary based interventions with family, teachers and mental health professional involvement in the school or other natural setting.

OMB No. XX
Approval Expires XX

**COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT APPLICATION GUIDANCE AND
INSTRUCTIONS
FY 2009 – FY 2011**

**TRANSFORMING MENTAL HEALTH CARE
IN AMERICA**

CFDA No. XXXXX



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
www.samhsa.gov

C. Transformation Activities

In this section, States are requested to provide information describing how MHBG funding is used to support mental health transformation activities. States are encouraged to complete Table C below, which describes the extent to which the State uses the MHBG to implement specific transformation goals defined by the President's New Freedom Commission on Mental Health.

For each mental health transformation goal provided in Table C, please briefly describe transformation activities that are supported by the MHBG. You may combine goals in a single description if appropriate. If your State's transformation activities are described elsewhere in this application, you may simply refer to that section(s).

Table C. MHBG Funding for Transformation Activities

	Column 1	Column 2	
	Is MHBG funding used to support this goal? If yes, please check.	If yes, please provide the actual or estimated amount of MHBG funding that will be used to support this transformation goal in FY2009.	
		Actual	Estimated
GOAL 1: Americans Understand that Mental Health Is Essential to Overall Health			
GOAL 2: Mental Health Care is Consumer and Family Driven			
GOAL 3: Disparities in Mental Health Services are Eliminated			
GOAL 4: Early Mental Health Screening, Assessment, and Referral to Services are Common Practice			
GOAL 5: Excellent Mental Health Care Is Delivered and Research Is Accelerated			
GOAL 6: Technology Is Used to Access Mental Health Care and Information			
Total MHBG Funds	N/A		

(a) Authority Delegated.

Authority to conduct public awareness and information activities under the Trafficking Victims Protection Act of 2000 (TVPA), Public Law No. 106-386, § 106(b), 22 U.S.C. 7104(b).

(b) Limitations and Conditions.

1. This Delegation shall be exercised under the Department's existing delegation of authority and policy on regulations.

2. This delegation shall be exercised under financial and administrative requirements applicable to all Administration for Children and Families' authorities.

3. The Director of the Anti-Trafficking in Persons Division must report to the Director, Office of Refugee Resettlement, and the Director, Office of Refugee Resettlement, must report to the Assistant Secretary prior to carrying out public awareness and information activities.

(c) Effective Date.

This delegation of authority is effective upon the date of signature.

(d) Effect on Existing Delegations.

None.

In addition, I have affirmed and ratified any actions taken by the Director, Anti-Trafficking in Persons Division which involved the exercise of this authority prior to the effective date of this delegation.

Dated: January 15, 2008.

Brent Orrell,

Acting Director, Office of Refugee Resettlement.

[FR Doc. E8-1517 Filed 1-28-08; 8:45 am]

BILLING CODE 4184-01-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

Agency Information Collection Activities: Proposed Collection; Comment Request

In compliance with section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 concerning opportunity for public comment on proposed collections of information, the Substance Abuse and Mental Health Services Administration (SAMHSA) will publish periodic summaries of proposed projects. To request more information on the proposed projects or to obtain a copy of the information collection plans, call the SAMHSA Reports Clearance Officer on (240) 276-1243.

Comments are invited on: (a) Whether the proposed collections of information are necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the proposed collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology.

Project: Community Mental Health Services Block Grant Application Guidance and Instruction, FY 2009-2011 (OMB No. 0930-0168)—Revision

Sections 1911 through 1920 of the Public Health Services Act (42 U.S.C. 300x through 300x-9) provide for annual allotments to assist States to establish or expand an organized, community-based system of care for adults with serious mental illnesses and children with

serious emotional disturbances. Under these provisions of the law, States may receive allotments only after an application is submitted and approved by the Secretary of the Department of Health and Human Services.

For the FY 2009-2011 Community Mental Health Services Block Grant application cycle, SAMHSA will provide States guidance and instructions to guide development of comprehensive State applications/plans and implementation reports. In order to develop this guidance, SAMHSA convened a working group of State representatives to provide input and suggestions regarding the organization and content of the guidance. To the extent possible, these suggestions were incorporated into proposed revisions for the 2009-2011 application cycle. These proposed revisions to the guidance include:

(1) Streamlining the process for reporting States' use of the block grant to support mental health transformation. Revisions to the FY2008 guidance required a new request for information regarding funding for mental health transformation. A number of States indicated that their fiscal processes did not permit reporting in the manner requested. Other States suggested that the reporting burden was significantly increased while the information provided did not accurately reflect the range of transformation activities they were engaged in.

This issue was the principal focus of the State working group, and the proposed FY2009-2011 guidance makes significant revisions based on the input of the group. The revisions include narrowing from 20 to six (6) the number of transformation categories for which States are asked to provide the amount of block grant funding used to support specific activities in FY2009. The new Table C which States are requested to complete follows:

	Column 1	Column 2	
	Is MHBG funding used to support this goal? If yes, please check.	Actual	Estimated
GOAL 1: Americans Understand that Mental Health Is Essential to Overall Health			
GOAL 2: Mental Health Care is Consumer and Family Driven			
GOAL 3: Disparities in Mental Health Services are Eliminated			
GOAL 4: Early Mental Health Screening, Assessment, and Referral to Services are Common Practice			
GOAL 5: Excellent Mental Health Care Is Delivered and Research Is Accelerated			

	Column 1	Column 2	
	Is MHBG funding used to support this goal? If yes, please check	If yes, please provide the actual or estimated amount of MHBG funding that will be used to support this transformation goal in FY2009.	
		Actual	Estimated
GOAL 6: Technology Is Used to Access Mental Health Care and Information			
Total MHBG Funds	N/A		

In addition to revising the transformation data table, the guidance makes additional changes, including: (a) Eliminating the requirement that transformation activities be tracked within the context of the five (5) block grant statutory criteria; (b) consolidating requests for narrative regarding transformation activities into a single section; and (c) eliminating redundancy by allowing States to refer to other sections that include similar material. In collaboration with the State working group, SAMHSA identified and eliminated requests for data regarding transformation activities that are collected through other State funding sources.

With these revisions, SAMHSA has simplified the reporting process for States while still ensuring that it receives data and information necessary to understand and monitor the role of the block grant in supporting State mental health transformation efforts.

(2) Reorganizing and consolidating sections of the guidance to improve readability and clarity and to reduce redundancy. For example, instructions regarding the general format of the application now are found in one section of the guidance. In addition, specific provisions in sections requiring applications to track the five (5) statutory criteria and in sections regarding reporting performance indicators in the State Implementation

Report were reorganized to improve the logical flow of the application. In addition, the guidance clarifies that States may refer to other sections of the application where appropriate, rather than repeating identical information in multiple sections of the application. All sections of the guidance were edited for clarity.

(3) Eliminating Table 18 from the Uniform Reporting System (URS) tables that States must submit. The URS is a set of standardized tables designed to track individuals State performance over time and to aggregate State information to develop a national picture of State public mental health systems. Table 18 was intended to produce a profile of adults with schizophrenia receiving new generation medications during the year. A review of all URS tables determined that the data reported on table 18 is not comparable across States and has limited usefulness to CMHS or States in planning and improving mental health systems. In addition, Table 18 was reported to have the lowest amount of utility but the greatest reporting burden for States.

(4) Eliminating the requirement that States complete a State-Level Reporting Capacity Checklist for submission to the State Data Infrastructure Coordinating Center.

This MHBG Guidance has been developed based on current statute. The

agency is aware that Congress is currently considering legislation to reauthorize SAMHSA. The reauthorization bill proposes substantive changes to the MHBG that would affect this Guidance. Upon passage of reauthorization legislation, the Center for Mental Health Services (CMHS) will contact States to provide additional guidance that may be needed to complete the MHBG application and Implementation Report. If significant changes to MHBG requirements, State plans, or data collection are included in the final reauthorization law, CMHS may revise and re-submit this guidance for public comment through the Federal Register.

SAMHSA is requesting approval of this guidance for FY 2009, 2010, and 2011. The 2007-2011 SAMHSA Data Strategy has just been released to the public. Goal #2 of the Data Strategy specifically deals with performance data and includes specific milestones for the next few years, including the development of client level outcome measures for the states by 2011. CMHS may revise and re-submit this guidance to reflect the adoption of client level measures for future block grant applications if sufficient progress is made over the next 3 years.

The following table summarizes the annual burden for the revised application.

Application	Number of respondents	Responses/ respondent	Burden response (hrs)	Total burden hours
Plan:				
1 year	44	1	180	7,920
2 year	6	1	150	900
3 year	9	1	110	900
Implementation Report	59	1	75	4,425
URS Tables	59	1	40	2,360
Total	59			16,595

Send comments to Summer King, SAMHSA Reports Clearance Officer, Room 7-1044, One Choke Cherry Road, Rockville, MD 20857 and e-mail her a copy at summer.king@samhsa.hhs.gov. Written comments should be received within 60 days of this notice.

Dated: January 22, 2008.

Elaine Parry,

Acting Director, Office of Program Services.
[FR Doc. E8-1484 Filed 1-28-08; 8:45 am]
BILLING CODE 4162-20-P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

[Docket No. USCG-2007-0173]

Area Maritime Security Committee, South Texas; Vacancies

AGENCY: Coast Guard, DHS.

ACTION: Solicitation for membership.

SUMMARY: The Coast Guard seeks applications for membership in the Area Maritime Security Committee, South Texas. The Committee assists the Captain of the Port, Corpus Christi, in developing, renewing, and updating the Area Maritime Security plan for their area of responsibility.

DATES: Requests for membership should reach the Captain of the Port, Corpus Christi, on or before February 1, 2008.

ADDRESSES: Submit applications for membership to the Captain of the Port, Corpus Christi, Commander, USCG Sector Corpus Christi, 8930 Ocean Drive, Hangar 41, Corpus Christi, Texas 78419.

FOR FURTHER INFORMATION CONTACT: Mr. John Zarbock at 361-888-3162 (X501).

SUPPLEMENTARY INFORMATION:

The Committee

The Area Maritime Security Committee, South Texas (The Committee) is established under, and governed by 33 CFR part 103, subpart C. The functions of the committee include, but are not limited to, the following:

- (1) Identifying critical port infrastructure and operations
- (2) Identifying risks (i.e., threats, vulnerabilities and consequences).
- (3) Determining strategies and implementation methods for mitigation.
- (4) Developing and describing the process for continuously evaluating overall port security by considering consequences and vulnerabilities, how they may change over time, and what additional mitigation strategies can be applied.

(5) Advising and assisting the Captain of the Port in developing, reviewing, and updating the Area Maritime Security Plan under 33 CFR part 103, subpart E.

Positions Available on the Committee

There are three vacancies on the Committee. Members may be selected from

- (1) The Federal, Territorial, or Tribal government;
- (2) The State government and political subdivisions of the State;
- (3) Local public safety, crisis management, and emergency response agencies;
- (4) Law enforcement and security organizations;
- (5) Maritime industry, including labor;
- (6) Other port stakeholders having a special competence in maritime security; and
- (7) Port stakeholders affected by security practices and policies.

In support of the Coast Guard's policy on gender and ethnic diversity, we encourage qualified women and members of minority groups to apply.

Qualification of Members

Members must have at least 5 years of experience related to maritime or port security operations. Applicants may be required to pass an appropriate security background check before appointment to the Committee.

The terms of office for each vacancy is 5 years. However, a member may serve one additional term of office. Members are not salaried or otherwise compensated for their service on the Committee.

Format for Applications

Applications for membership may be in any format. However, because members must demonstrate an interest in the security of the area covered by the Committee, we particularly encourage the submission of information highlighting experience in maritime security matters.

Authority

Section 102 of the Maritime Transportation Security Act (MTSA) of 2002 (Pub. L. 107-295) (The Act) authorizes the Secretary of the Department in which the Coast Guard is operating to establish Area Maritime Security Committees for any port area of the United States. See 33 U.S.C. 1226; 46 U.S.C.: 33 CFR 1.05-1, 6.01; Department of Homeland Security Delegation No. 0170.1). The Act exempts Area Maritime Security Committees from the Federal Advisory

Committee Act (FACA), 5 U.S.C. App. (Pub. L. 92-463)

Dated: January 7, 2008.

P. S. Simons,

Captain U. S. Coast Guard, Acting Captain of the Port, Corpus Christi.

[FR Doc. E8-1473 Filed 1-28-08; 8:45 am]

BILLING CODE 4910-15-P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

[Docket No. USCG-2007-0055, formerly CGD08-07-029]

Lower Mississippi River Safety Advisory Committee; Vacancies

AGENCY: Coast Guard, DHS.

ACTION: Request for applications; extension of application deadline.

SUMMARY: The Coast Guard extends the deadline for applications for membership in the Lower Mississippi River Safety Advisory Committee. This Committee advises and makes recommendations to the Coast Guard on matters relating to navigation safety on the Lower Mississippi River.

DATES: Application forms should reach us on or before February 28, 2008.

ADDRESSES: You may request an application form by writing U.S. Coast Guard, Sector New Orleans, Attn: Waterways Management, 1615 Poydras Street, New Orleans, LA 70112-2711 or by calling 504-565-5108. Send your application in written form to the above street address. A copy of this notice and the application form are available in our online docket, CGD08-07-029, at <http://frwebgate.access.gpo.gov/cgi-bin/leaving.cgi?from=leaving&FR.html&log=linklog&to=http://regulations.gov>.

FOR FURTHER INFORMATION CONTACT:

LTJG Tonya Harrington, Assistant to Executive Director of Lower Mississippi River Waterway Safety Advisory Committee at 504-565-5108.

SUPPLEMENTARY INFORMATION: On October 30, 2007, we published a request in the *Federal Register* (72 FR 61362) for applications for membership in the Lower Mississippi River Safety Advisory Committee. The deadline for applications announced in that notice is being extended until February 28, 2008. If you applied in response to the initial notice, you do not need to send another application form.

The Lower Mississippi River Waterway Safety Advisory Committee is a Federal advisory committee under 5 U.S.C. App. (Pub. L. 92-463). This

President's New Freedom Commission on Mental Health

Achieving the Promise: Transforming Mental Health Care in America

Source: <http://www.mentalhealthcommission.gov/reports/FinalReport/toc.html>

Goal 1: Americans Understand that Mental Health Is Essential to Overall Health

Recommendations

- 1.1 Advance and implement a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention.
- 1.2 Address mental health with the same urgency as physical health.

Goal 2 - Mental Health Care Is Consumer and Family Driven

Recommendations

- 2.1 Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance.
- 2.2 Involve consumers and families fully in orienting the mental health system toward recovery.
- 2.3 Align relevant Federal programs to improve access and accountability for mental health services.
- 2.4 Create a Comprehensive State Mental Health Plan.
- 2.5 Protect and enhance the rights of people with mental illnesses.

Goal 3: Disparities in Mental Health Services Are Eliminated

Recommendations

- 3.1 Improve access to quality care that is culturally competent.
- 3.2 Improve access to quality care in rural and geographically remote areas.

Goal 4: Early Mental Health Screening, Assessment, and Referral to Services Are Common Practice

Recommendations

- 4.1 Promote the mental health of young children.
- 4.2 Improve and expand school mental health programs.
- 4.3 Screen for co-occurring mental and substance use disorders and link with integrated treatment strategies.
- 4.4 Screen for mental disorders in primary health care, across the life span, and connect to treatment and supports.

Goal 5: Excellent Mental Health Care Is Delivered and Research Is Accelerated

Recommendations

- 5.1 Accelerate research to promote recovery and resilience, and ultimately to cure and prevent mental illnesses.
- 5.2 Advance evidence-based practices using dissemination and demonstration projects and create a public-private partnership to guide their implementation.
- 5.3 Improve and expand the workforce providing evidence-based mental health services and supports.
- 5.4 Develop the knowledge base in four understudied areas: mental health disparities, long-term effects of medications, trauma, and acute care.

Goal 6: Technology Is Used to Access Mental Health Care and Information

Recommendations

- 6.1 Use health technology and telehealth to improve access and coordination of mental health care, especially for Americans in remote areas or in underserved populations.
- 6.2 Develop and implement integrated electronic health record and personal health information systems.

Creating Change and Providing Hope
A New Strategic Direction
for Behavioral Health
for Nebraska's Children and Adolescents



Pursuant to LB 542 (2007)
February 5, 2008



1

Common Vision for Children and Adolescent Behavioral Health

To provide children, adolescents and their families with the right services, in the right amount, at the right location, for the right length of time, at an affordable, sustainable cost.



2

Background

- LB 1083 (2004)
 - Reformed Nebraska's adult behavioral health system. Focused on developing community-based services and reducing use of three Regional Centers.
- LB 542 (2007)
 - Created the Children's Behavioral Health Task Force
 - Charged the Task Force and the Department with developing plans to improve Nebraska's Children's Behavioral Health system.



3

Key elements of DHHS plan

- Balanced array of services.
- Accessible services.
- Strategic use of evidenced-based approaches.
- Explore new facilities and services to address most challenging adolescents.
- Develop common language and goals.



4

Key elements (cont'd)

- Definition of the State's role, which includes:
 - Facilitating private treatment where possible.
 - Coordinating different systems to work together for a common vision.
 - Supporting evidence-based practices.
 - Securing high-risk, violent juvenile offenders.



5

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

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

- Support evidence-based interventions
- Ensure cultural competence and family-centered approaches at all levels
- Integrate child and family serving agencies



6

Creating Change, Providing Hope

System Opportunities

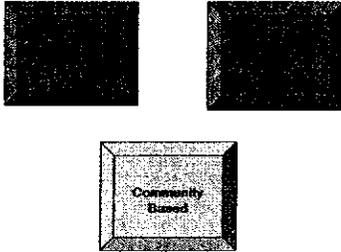
- Need for uniform screening, assessment and referral process.
- Increase availability of mental health professionals and services statewide.
- Promote effective services.
- Develop standard measures for determining outcomes.
- Provide coordinated responses for children with multiple needs spanning child welfare, juvenile justice and education.



7

Creating Change, Providing Hope

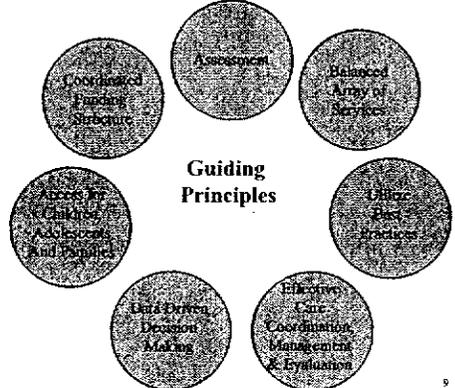
Core Values




8

Creating Change, Providing Hope

Guiding Principles



9

Creating Change, Providing Hope

Implementation Strategies for Improving the Lives of Nebraska's Children, Adolescents and Their Families

I. Assessment

- Statewide implementation of the Comprehensive Family Assessment.
- Work with juvenile court system utilizing the "Through the Eyes of the Child" Initiative
- Strengthen existing community supports through family organizations such as SPEAK OUT and Nebraska Family Support Network.
- Complete necessary revisions to data system.



10

Creating Change, Providing Hope

Implementation Strategies

2. Access for Children, Adolescents and their Families

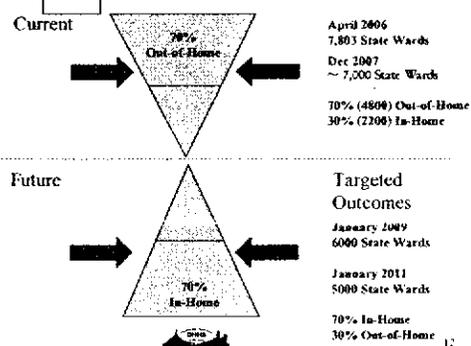
- Expand access to telehealth with the Office of Rural Health.
- Ensure that an array of evidence-based services from prevention to treatment to follow up will be available across the state.



11

Creating Change, Providing Hope

Benefits of a Balanced Service Array



Time Period	State Wards	Out-of-Home (%)	In-Home (%)
Current (April 2006)	7,803	70%	30%
Current (Dec 2007)	~7,000	70% (4,800)	30% (2,200)
Future (January 2009)	6,000	70%	30%
Future (January 2011)	5,000	70%	30%



12

Creating Change, Providing Hope

Implementation Strategies

3. Balanced Array of Services

- Enhance capacity for services to support in-home placements for specific populations
- Ensure that services are individualized and allow children and adolescents to live in a safe, stable, permanent family environment.
- Provide training to workforce and stakeholders on the service array.
- Complete application process for the Substance Abuse and Mental Health Services Administration's (SAMHSA) Systems of Care Grant.



13

Creating Change, Providing Hope

Implementation Strategies

Balanced Array of Services - continued

- Develop expanded and cost-efficient capacity for chemical dependency treatment for juvenile offenders.
- Explore development of needed infrastructure and facility construction through a public/private partnership.
- Develop a Level 5 (highly secure) facility to serve high-risk, violent juvenile offenders.
- Closed the mental health unit for adolescents at the Hastings Regional Center effective January 1, 2008.



14

Creating Change, Providing Hope

Implementation Strategies

4. Evidence Based Practices

- Provide leadership and training to the workforce in order to increase common behavioral health terms and language.
- Support evidence-based practices to reduce out-of-home and out-of-state placements.
- Implement evidence-based practices for transitioning children and adolescents to successful adult living.



15

Creating Change, Providing Hope

Implementation Strategies

5. Effective Care Coordination, Management and Evaluation

- Review existing case review procedures at the community and state levels and develop strategies and resources to ensure children and adolescents are served in the least restrictive, appropriate manner
- Examine whether current practices allow for ample communication and collaboration among agencies.
- The Children's Behavioral Health Administrator will also assume management of the State Infrastructure Grant and System of Care Grants and all activities related to these grants.



16

Creating Change, Providing Hope

Implementation Strategies

Effective Care Management (continued)

- Continue to evaluate the appropriate role of front-end care coordination and management.
- Designate the State Infrastructure Grant Steering Committee as the interagency working group for statewide input, coordination and problem solving.
- Review the membership of the current State Infrastructure Grant Steering Committee to ensure it is appropriate in size and composition.



17

Creating Change, Providing Hope

Implementation Strategies

6. Data Driven Decision Making

- Develop a uniform system to collect and analyze data across systems regarding youth served, the quality of services provided, and outcomes.
- Bid the Administrative Service Organization contract.



18

Creating Change, Providing Hope

Implementation Strategies

7. Coordinated Funding Structures

- Develop a coordinated funding model.
- Ensure accountability for all funds.
- Implement performance-based contracting.



19

Questions and Answers



www.dhhs.ne.gov

20

LB 882

LB 882

LEGISLATURE OF NEBRASKA
ONE HUNDREDTH LEGISLATURE
SECOND SESSION

LEGISLATIVE BILL 882

Introduced by Johnson, 37.

Read first time January 11, 2008

Committee: Health and Human Services

A BILL

1 FOR AN ACT relating to mental health; to amend section
2 83-380.01, Reissue Revised Statutes of Nebraska; to
3 change provisions relating to prescription medication for
4 indigent persons; and to repeal the original section.
5 Be it enacted by the people of the State of Nebraska,

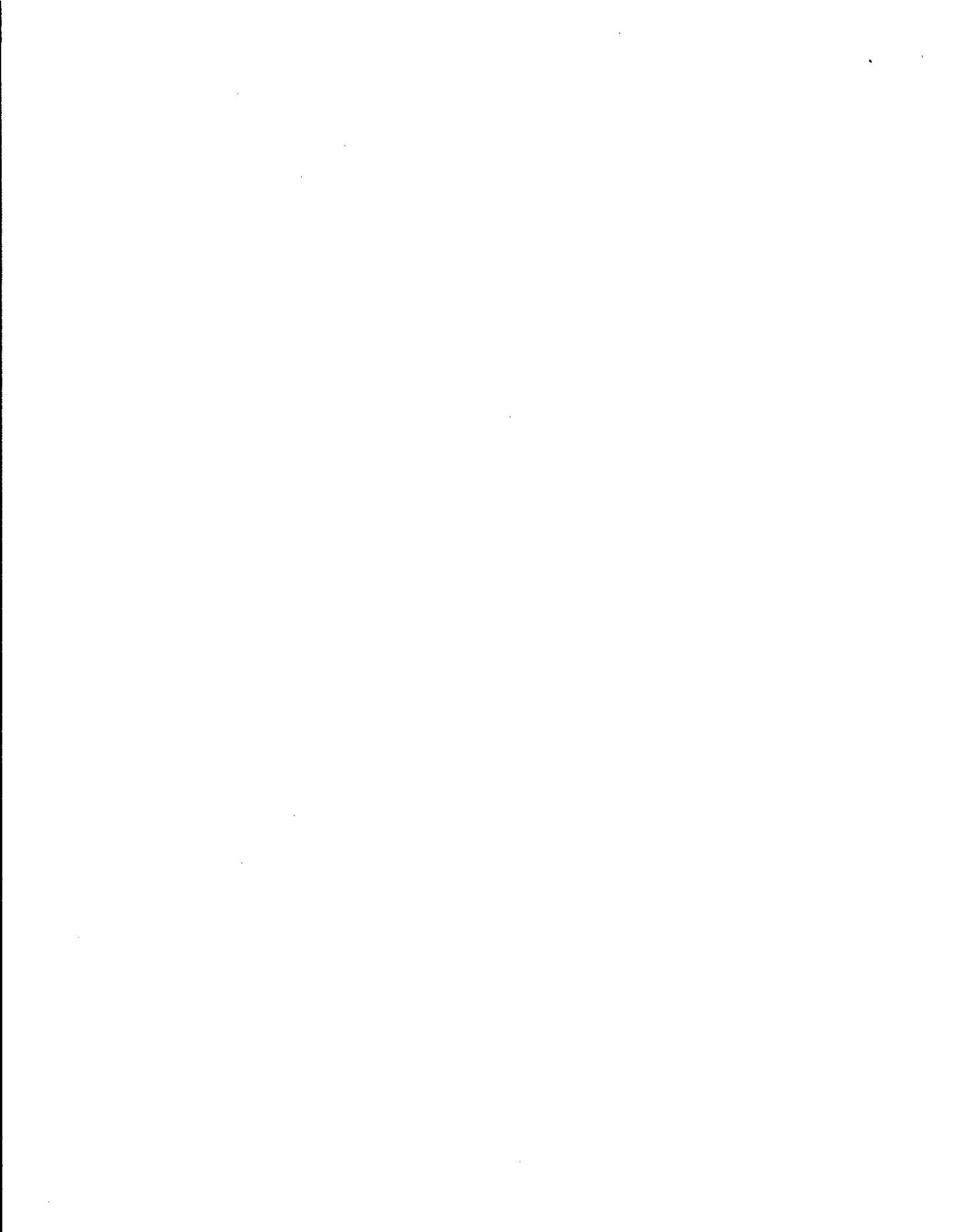
1 Section 1. Section 83-380.01, Reissue Revised Statutes of
2 Nebraska, is amended to read:

3 83-380.01 Upon the discharge from a treatment facility,
4 an indigent person who has received mental-health-board-ordered
5 inpatient or outpatient treatment may file an affidavit with the
6 Department of Health and Human Services ~~or the mental health board~~
7 requesting that prescription medicine which the regional center
8 treating psychiatrist or the patient's treating physician has
9 prescribed as necessary for the patient's mental health treatment
10 be provided to him or her. Such affidavit shall include the
11 following: (1) That the patient qualifies as an indigent person who
12 is unable to pay under the same standards of ability to pay as set
13 forth in sections 83-363 to 83-380; and (2) that such prescription
14 medicine has been prescribed by the regional center's treatment
15 psychiatrist or the patient's treating physician as necessary for
16 the patient's mental health treatment. The mental health board
17 ~~shall refer such requests it receives to the Department of Health~~
18 ~~and Human Services and~~ department shall review the affidavit to
19 determine if the patient qualifies as an indigent person and that
20 the prescription medicine is appropriate for treatment of mental
21 illness. The patient shall supply sufficient financial information
22 to enable the department to make a determination as to whether
23 the patient is indigent and the patient's ability to pay. If the
24 affidavit meets the requirements for approval as set forth by the
25 department, the department shall provide such prescription medicine

1 as may be necessary for such former patient's mental health
2 treatment so long as he or she remains an outpatient and his or
3 her treating physician continues to prescribe and certify that such
4 prescription medicine is necessary for the patient's mental health
5 treatment and he or she continues to be an indigent person as
6 determined under the same standards of ability to pay as set forth
7 in sections 83-363 to 83-380. The department may, when necessary to
8 insure the patient's access to the prescribed medication, contract
9 with a licensed pharmacy to provide such prescription medicine.

10 The Department of Health and Human Services department
11 may adopt and promulgate rules and regulations to carry out the
12 provisions of this section in accordance with the Administrative
13 Procedure Act, including, but not limited to, hearings necessary
14 to determine whether such person is qualified to receive such
15 medications, the definition of indigent person, standards of
16 ability to pay, the types of medications to be dispensed, and
17 whether such medication is necessary for the patient's mental
18 health treatment.

19 Sec. 2. Original section 83-380.01, Reissue Revised
20 Statutes of Nebraska, is repealed.



LB 1084

LB 1084

LEGISLATURE OF NEBRASKA
ONE HUNDREDTH LEGISLATURE
SECOND SESSION

LEGISLATIVE BILL 1084

Introduced by Flood, 19.

Read first time January 22, 2008

Committee: Judiciary

A BILL

1 FOR AN ACT relating to crimes and offenses; to amend sections
2 28-929, 28-930, 28-931, and 28-931.01, Revised Statutes
3 Cumulative Supplement, 2006; to change provisions
4 relating to assault on an officer; and to repeal the
5 original sections.
6 Be it enacted by the people of the State of Nebraska,

1 Section 1. Section 28-929, Revised Statutes Cumulative
2 Supplement, 2006, is amended to read:

3 28-929 (1) A person commits the offense of assault on
4 an officer in the first degree if he or she intentionally or
5 knowingly causes serious bodily injury to a peace officer, a
6 probation officer, an employee of the Department of Health and
7 Human Services providing behavioral health services as that term
8 is defined in section 71-804, or an employee of the Department of
9 Correctional Services while such officer or employee is engaged in
10 the performance of his or her official duties.

11 (2) Assault on an officer in the first degree shall be a
12 Class II felony.

13 Sec. 2. Section 28-930, Revised Statutes Cumulative
14 Supplement, 2006, is amended to read:

15 28-930 (1) A person commits the offense of assault on an
16 officer in the second degree if he or she:

17 (a) Intentionally or knowingly causes bodily injury with
18 a dangerous instrument to a peace officer, a probation officer, an
19 employee of the Department of Health and Human Services providing
20 behavioral health services as that term is defined in section
21 71-804, or an employee of the Department of Correctional Services
22 while such officer or employee is engaged in the performance of his
23 or her official duties; or

24 (b) Recklessly causes bodily injury with a dangerous
25 instrument to a peace officer, a probation officer, an employee of

1 providing behavioral health services as that term is defined in
2 section 71-804, or an employee of the Department of Correctional
3 Services (a) by using a motor vehicle to run over or to strike such
4 officer or employee or (b) by using a motor vehicle to collide with
5 such officer's or employee's motor vehicle, while such officer or
6 employee is engaged in the performance of his or her duties.

7 (2) Assault on an officer using a motor vehicle shall be
8 a Class IIIA felony.

9 Sec. 5. Original sections 28-929, 28-930, 28-931, and
10 28-931.01, Revised Statutes Cumulative Supplement, 2006, are
11 repealed.

02/06/2008

To jim.harvey@dhhs.ne.gov

From: Elizabeth Prewitt, Director, Government Relations

NASMHPD - 66 Canal Center Plaza, Suite 302, Alexandria, VA 22314

SubjectRe: Mental Health Insurance Parity

Jim, the Senate passed by unanimous consent a mental health parity bill (S. 558) in September and the three committees with jurisdiction over mental health parity in the House have approved legislation. The House has not voted on parity this session but the Speaker, Nancy Pelosi, has indicated her support. There is a cost associated with the bill so it will require a budget offset. I understand that House leaders are looking for a source of savings to offset the cost. The following article reports on a scheduled vote on the narrow parity law that expired but it goes on to talk about the broader parity legislation. Hope this is helpful. Elizabeth

CQ TODAY PRINT EDITION - HEALTH

Feb. 5, 2008 - 7:50 p.m.

Mental Health Parity Extension Pending as Talks on Broader Bill Continue

By Drew Armstrong, CQ Staff

As the House works to finalize a broad expansion of mental health benefits, lawmakers will take up an extension of a mental health law that expired in 2001.

The bill (HR 4848), scheduled on the House floor Wednesday, would extend until the end of this year a law (PL 104-204) that bans health plans offering medical and surgical benefits from using different lifetime or annual limits on mental health coverage. The 1997 law does not require coverage for any mental health conditions.

Congress has passed one-year extensions since the original law expired. The most recent extension (PL 109-432) lapsed Dec. 31.

The broader mental health parity legislation (HR 1424) is sponsored by Patrick J. Kennedy, D-R.I., and has 273 cosponsors. It would expand mental health regulations and require plans offering mental health benefits to make them equal in cost and scope to any medical or surgical benefits offered. The bill includes provisions on which mental health conditions would have to be covered.

House Democratic leaders have not scheduled that bill for a floor vote but have said it is a priority. A Democratic leadership aide said it would be considered "soon."

Senate Companion Bill Kennedy's father, Sen. Edward M. Kennedy, D-Mass., and Sen. Pete V. Domenici, R-N.M., shepherded a companion bill (S 558) through their chamber on Sept. 18 by voice vote.

While the Senate version isn't as far-reaching as the House measure, it has the support of business and insurance groups.

House lawmakers are trying to find an offset for their bill, and the two Kennedys have been negotiating its policy provisions. The Congressional Budget Office estimated in November the House bill would reduce federal tax revenue by \$1.1 billion over five years.

The younger Kennedy also has been holding out to try to win concessions from the Senate.

The two bills have split the mental health community, many of whom consider the House measure stronger but believe the Senate version has a greater chance of becoming law.

Source: CQ Today Print Edition Round-the-clock coverage of news from Capitol Hill.

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**Behavioral Risk Factor Surveillance System
2008 Questionnaire
Draft**

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COMPLETED INTERVIEWS	Real	Estimated
	2007	2008
Statewide BRFSS – Nebraska # A	5223	5200
Statewide BRFSS – Nebraska # B	5203	5200
Statewide BRFSS - Nebraska # C	0	5200
Statewide BRFSS - Cell phone	0	600
Minority BRFSS –	3252	3200
Lancaster County BRFSS -	1628	1500
Buffalo County BRFSS -	1700	0
Saline County BRFSS -	1085	1000
Douglas County BRFSS -	2795	2500
Agriculture Worker Study	0	360
Youth Asthma Study -	150	225
Adult Asthma Study -	550	825
Adult Tobacco Study -	5302	5000
Caseworker Statewide	1851	1800
Caseworker Western Nebraska -	257	250
YRTC Study -	284	300
Mental Health -	1527	1500
State Patrol Study –	2278	2300
Total completed interviews in 2007 -	33085	36960
Completes per Month	2757	3080
Completes per Week	662	739.2
Completes per Day	95	105.6

Nebraska 2007 Behavioral Health Consumer Surveys Summary of Results

Methodology

In 2007, the Department of Health and Human Services' (DHHS) Division of Public Health, Data Management Unit, under contract with the Division of Behavioral Health Services ("the Division"), conducted the Behavioral Health Consumer Surveys.¹

The sample for the surveys was persons receiving mental health and/or substance abuse services from the Nebraska Behavioral Health System, a statewide network of publicly funded community-based mental health and substance abuse providers. (Not included in the sample were persons receiving services from the Gamblers Assistance Program.) The Division sent a list of 10,467 names and addresses of current mental health/substance abuse consumers to the DHHS Division of Public Health's Data Management Unit. The Unit subcontracted with a private company to take the list of names and addresses and provide phone numbers for the consumers on the list.

The survey instruments used for the behavioral health consumer surveys were designated by the Center for Mental Health Services to meet the Federal Community Mental Health Services Block Grant, Uniform Reporting System requirements for Table 9: Social Connectedness & Improved Functioning and Table 11: Summary Profile of Client Evaluation of Care. This instrument consists of the *28-Item Mental Health Statistics Improvement Program (MHSIP) Consumer Satisfaction Survey* (augmented with 11 questions on improved functioning and social connectedness), the *MHSIP Youth Services Survey (YSS)*, and the *MHSIP Youth Services Survey for Families (YSS-F)*.

The Division contracted with the Data Management Unit to conduct the phone interviews and to enter the responses from the phone and mail surveys into a database. Data from the surveys were compiled and analyzed by the Research and Performance Measurement unit in DHHS - Financial Services - Operations.

A letter to the consumer was prepared by the Division which introduced the survey and explained how the Unit would be contacting the consumer by phone over the next few weeks. The phone number of the consumer was included in the introductory letter. The letter was sent by the Unit to the consumers in the sample, providing the consumer with three options: 1) to be interviewed over the telephone by a professional interviewer; 2) to be sent a mail survey; or 3) to decline participation in the survey. The consumer was given a toll-free number to indicate their choice to participate, by phone or mail, or to

¹ Questions regarding the 2007 Behavioral Health Consumer Surveys should be directed to Jim Harvey, Nebraska Department of Health and Human Services, Division of Behavioral Health at: 402-471-7824 or email: jim.harvey@dhhs.ne.gov.

decline participation. If the consumer did not respond to the letter, they were contacted by phone, when they were again given an opportunity to decline participation.

Interviewers for the Behavioral Risk Factor Surveillance System (BRFSS) were used to conduct the telephone interviews. For those consumers electing to be interviewed over the phone, BRFSS interviewers attempted each phone number up to 15 times. (After the 15th unsuccessful attempt, the consumers' name was dropped from the list.) Consumers electing to receive a mail survey were sent a survey. If they did not respond within the designated time, they were sent a follow-up survey.

Of the 5,198 persons in the adult sample, some refused to participate. An incorrect or non-working telephone number, or an incorrect address, had been provided for a significant number of consumers, so they could not be contacted. In all, 1,173 adult consumer surveys were completed, a 48% increase over 2006. (The confidence interval for the Adult survey was +/- 3% at the 95% confidence level.) Of the 1,037 youth (or parents) in the sample, 254 completed the survey, down about 45% from 2006. (The confidence interval for the Youth survey was +/- 6% at the 95% confidence level.) Again, incorrect telephone numbers or addresses were a major issue for the Youth survey.

Survey Results

Adult Survey

A little over half (53%) of the adult respondents were female. The respondents ranged in age from 17 to 87, with an average age of 42 years. Most were White (90.0%), followed by Black/African American (3.8%), and American Indian (2.2%). Less than five percent were Hispanic or Latino.

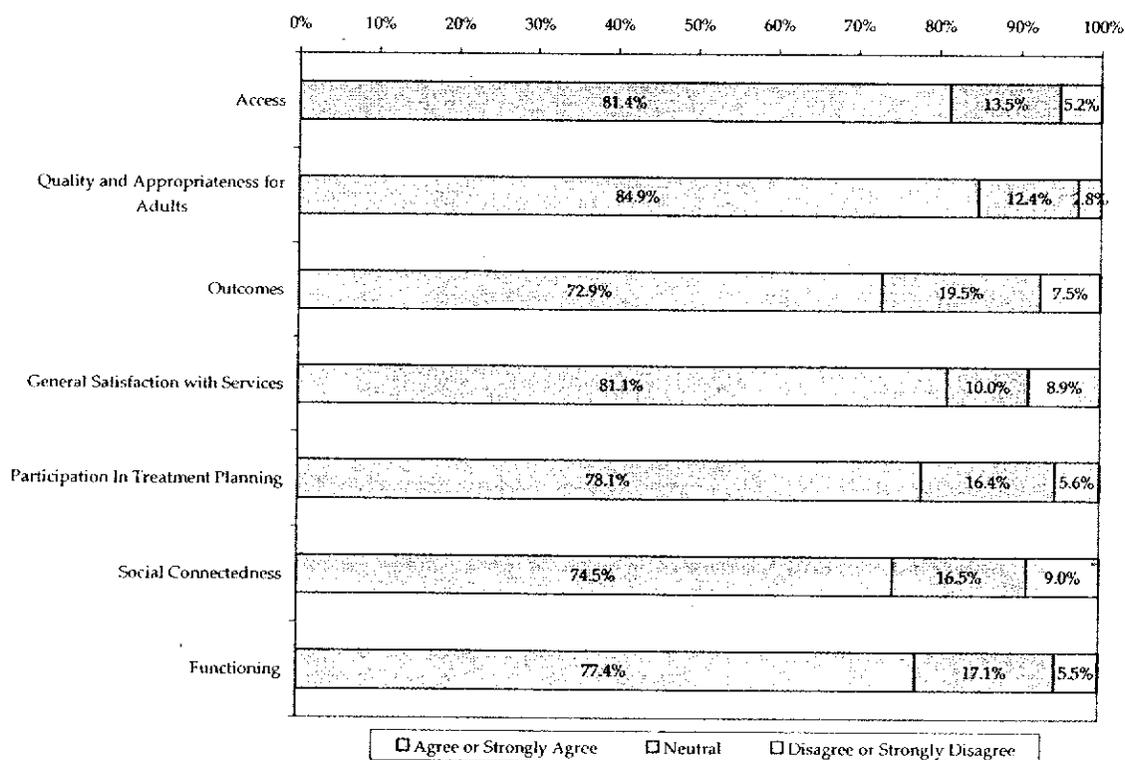
Survey data were analyzed by gender and age. In addition, the responses for multiple questions were combined into the following seven scales or "domains" (see Appendix A for the questions included in each scale, an explanation of the calculation of scale scores, and information on scale reliability):

- Access
- Quality and Appropriateness of Services
- Outcomes
- Participation in Treatment Planning
- General Satisfaction
- Functioning
- Social Connectedness

Summary of Results – Adult Survey

Generally speaking, consumers appeared to be satisfied with the services they received. In the area of General Satisfaction, most adult respondents (81%) were satisfied with services (Figure 1). Less than nine percent were dissatisfied with services, and 10% were neutral. More than three-fourths (78%) were satisfied with their level of involvement in treatment planning. Nearly three-fourths (73%) responded positively about outcomes. Almost 85% responded positively to the questions related to the quality and appropriateness of services, and more than 81% thought that the services were accessible.

Figure 1
Statewide Summary – MHSIP Scales – Adults



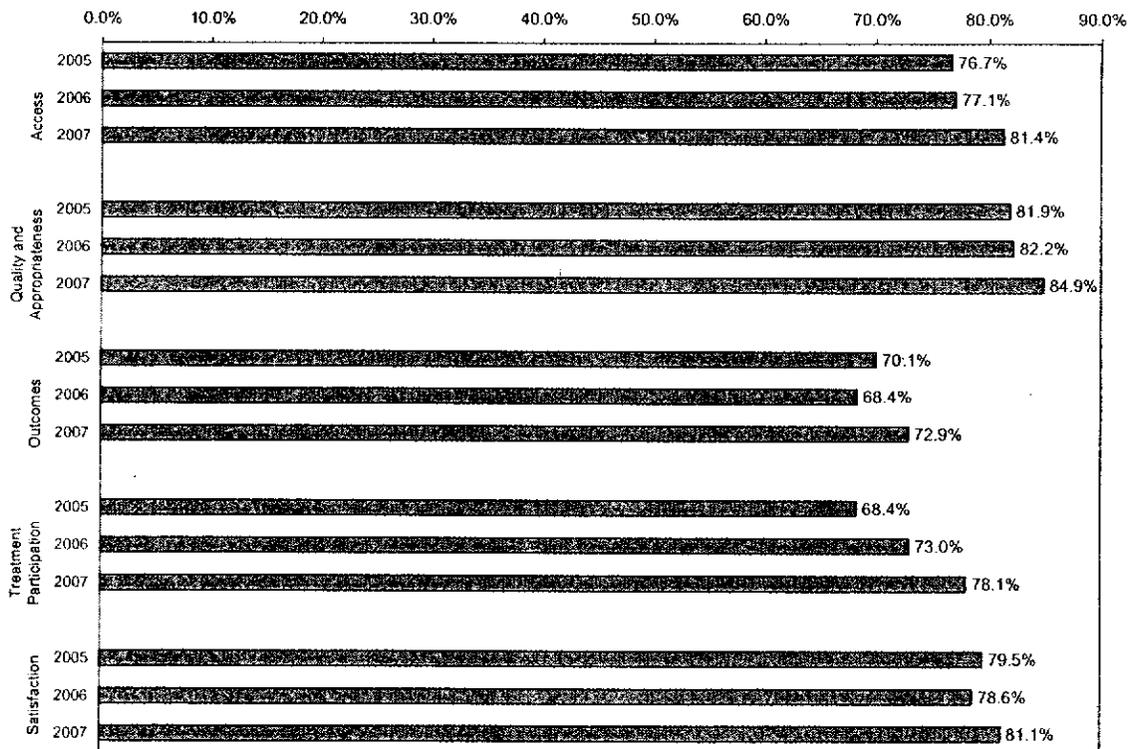
Women tended to respond more positively than men on all seven scales, although none of the differences were statistically significant. There were also no significant differences between responses between White, non Hispanic adults and Non-White or Hispanic adults (see Tables 1 and 2 in Appendix B). Older persons (aged 65 and over) responded significantly more positively to questions regarding **General Satisfaction with Services** than persons under 45 years of age. Otherwise, there were no significant differences in scale scores by age.

Responses to most of the questions were more positive in 2007 than in 2006. For three questions there was a significantly more positive response in 2007 than in 2006 (see Table 3 in Appendix B for confidence intervals for each survey question):

- Services were available at times that were good for me.
- Staff were sensitive to my cultural background (race, religion, language, etc.).
- I have people with whom I can do enjoyable things.

Figure 2 compares the responses from the 2005, 2006 and 2007 adult surveys for each of the five MHSIP domains. There was an improvement in all five domains from the 2006 survey to the 2007 survey. The greatest improvement from 2006 to 2007 was in the Treatment Participation domain.

Figure 2
Percent of Respondents Agreeing – 2004 - 2007
By MHSIP Domain



A summary of the responses to the 28-item MHSIP survey for adults for 2007, plus the 11 new questions related to Improved Functioning and Social Connectedness can be found in Table 4, Appendix B.

Youth Survey

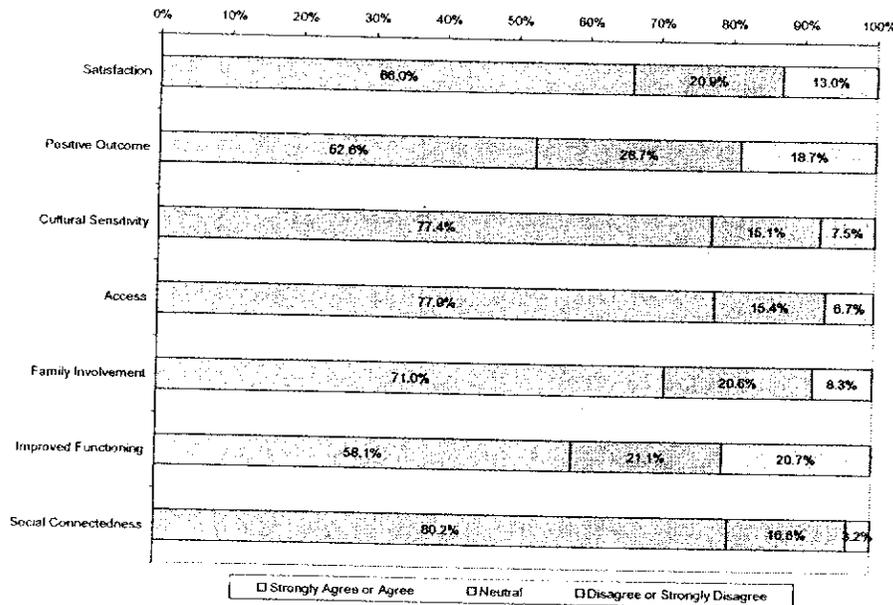
A total of 254 MHSIP youth surveys were completed in 2007, a little over half of the number completed in 2006. In most cases, a parent or guardian responded on behalf of the child receiving services. More surveys were completed for boys (63%) than for girls (37%). The youth's ages ranged from 2 years to 19 years, with an average age of 12.8 years. Most of the respondents were White, non Hispanic (80%); 20% were non-White or Hispanic.

For the Youth survey, responses for multiple questions were combined into the following five scales or "domains" (see Appendix A for the questions included in each): Satisfaction, Positive Outcome, Cultural Sensitivity, Access and Family Involvement.

Summary of Results – Youth Survey²

Most of the respondents (66%) indicated that they were satisfied with the services their child received (Figure 3). Thirteen percent (13%) were dissatisfied with the services their child received, and 21% were neutral. The most positive responses were in the **Social Connectedness** domain - 80% of the respondents reported positively. Half (53%) responded positively to the questions regarding **Positive Outcome** – down from 2006.

Figure 3
Statewide Summary – MHSIP Scales – Youth



² Because of the small sample size, and the large confidence interval (+/-6%), caution should be exercised in interpreting the results of the Youth Survey.

A summary of the responses to the MHSIP survey for youth for 2007 can be found in Table 5, Appendix B.

Table 1 shows a summary of sample size and response rates for the last four years. For the Adult survey the response rate has gone up each year. For the Youth survey, the response rate dropped from 53% in 2006 to 47% in 2007.

Table 1
Survey Sample Size and Response Rates – 2004-2007

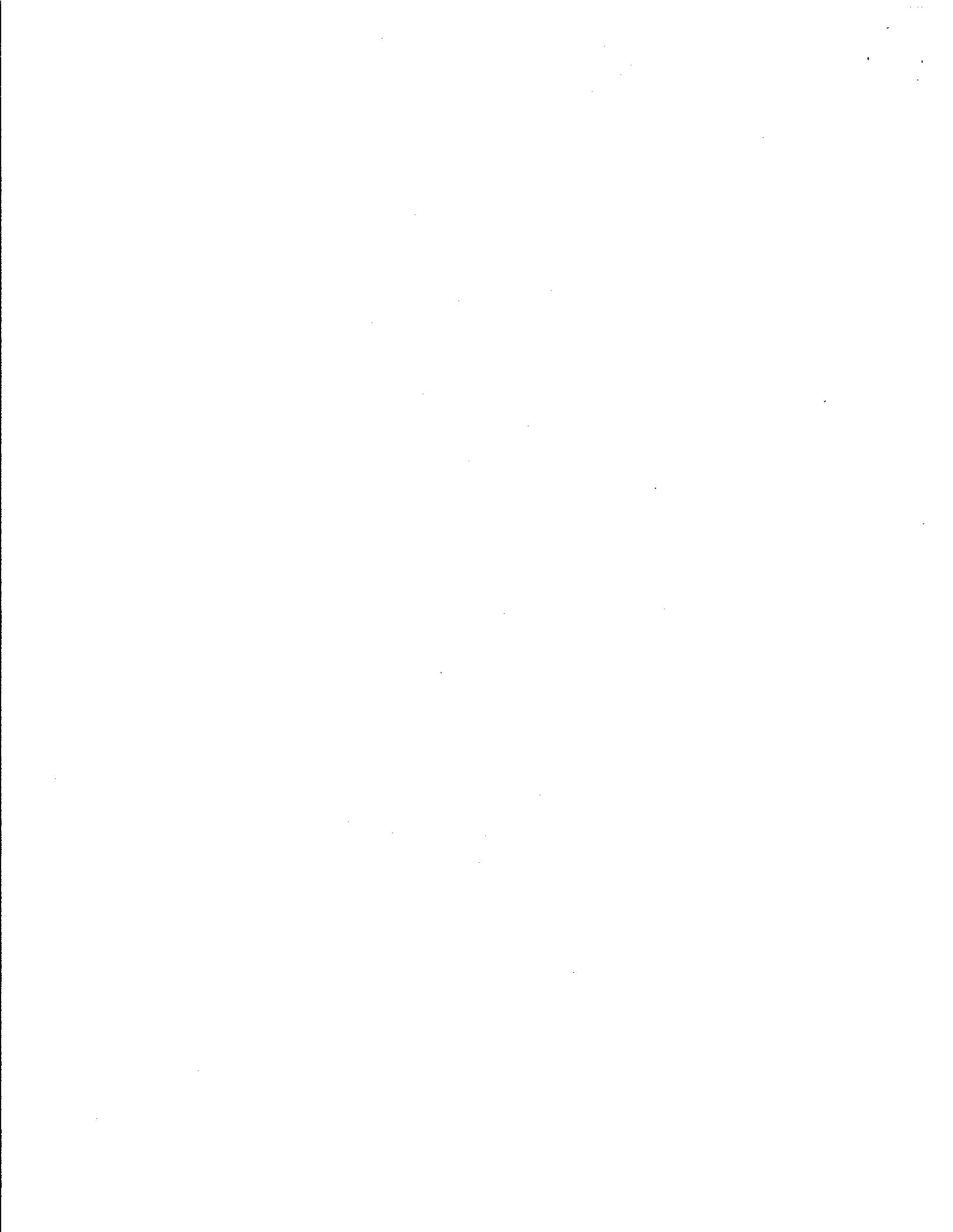
Adult Survey	2004	2005	2006	2007
a. How many Surveys were Attempted (sent out or calls initiated)?	4,412	4,821	3,592	5,198
b. How many survey Contacts were made? (surveys to valid phone numbers or addresses)	3,760	1,567	1,471	2,145
c. How many surveys were completed? (survey forms returned or calls completed)	657	749	795	1,173
d. What was your response rate? (number of Completed surveys divided by number of Contacts)	17%	48%	54%	55%

Youth Survey	2004	2005	2006	2007
a. How many Surveys were Attempted (sent out or calls initiated)?	592	768	1,567	1,037
b. How many survey Contacts were made? (surveys to valid phone numbers or addresses)	541	497	880	537
c. How many surveys were completed? (survey forms returned or calls completed)	67	235	465	254
d. What was your response rate? (number of Completed surveys divided by number of Contacts)	12%	47%	53%	47%

Below is a summary of the data reported by the Division to the Center for Mental Health Services for the Federal Community Mental Health Services Block Grant, Uniform Reporting System Table 11: Summary Profile of Client Evaluation of Care for 2005 through 2007.

Table 11: Summary Profile of Client Evaluation of Care / Nebraska Consumer Survey Summary Results

Report Year (Year Survey was Conducted)	2005			2006			2007		
	Number of Positive Responses	Responses	Percent	Number of Positive Responses	Responses	Percent	Number of Positive Responses	Responses	Percent
Adult Consumer Survey Results:									
1. Percent Reporting Positively About <u>Access</u> .	569	742	76.7%	612	794	77.1%	925	1,137	81.4%
2. Percent Reporting Positively About <u>Quality and Appropriateness</u> for Adults.	598	730	81.9%	639	777	82.2%	948	1,117	84.9%
3. Percent Reporting Positively About <u>Outcomes</u> .	513	732	70.1%	532	778	68.4%	802	1,100	72.9%
4. Percent of Adults Reporting on <u>Participation In Treatment Planning</u> .	486	711	68.4%	547	749	73.0%	801	1,026	78.1%
5. Percent of Adults Positively about <u>General Satisfaction</u> with Services.	594	747	79.5%	625	795	78.6%	942	1,161	81.1%
Child/Adolescent Consumer Survey Results:									
1. Percent Reporting Positively About <u>Access</u> .	176	233	75.5%	354	457	77.5%	197	253	77.9%
2. Percent Reporting Positively about <u>General Satisfaction</u> for Children.	166	233	71.2%	333	460	72.4%	167	253	66.0%
3. Percent Reporting Positively about <u>Outcomes</u> for Children.	138	226	61.1%	291	436	66.7%	132	251	52.6%
4. Percent of Family Members Reporting on <u>Participation In Treatment Planning</u> for their Children.	172	232	74.1%	308	448	68.8%	179	252	71.0%
5. Percent of Family Members Reporting High <u>Cultural Sensitivity</u> of Staff. (Optional)	202	223	90.6%	382	416	91.8%	195	252	77.4%



Appendix A Adult Survey Questions¹ and MHSIP Scales

The 28 items on the MHSIP Adult Survey were grouped into five scales. The grouping of the items into the five scales is consistent with the groupings required for the national Center for Mental Health Services' Uniform Reporting System. Below are the five scales and the survey questions included in each scale.

Access:

1. The location of services was convenient (parking, public transportation, distance, etc.).
2. Staff were willing to see me as often as I felt it was necessary.
3. Staff returned my call in 24 hours.
4. Services were available at times that were good for me.
5. I was able to get all the services I thought I needed.
6. I was able to see a psychiatrist when I wanted to.

Quality and Appropriateness:

1. I felt free to complain.
2. I was given information about my rights.
3. Staff encouraged me to take responsibility for how I live my life.
4. Staff told me what side effects to watch out for.
5. Staff respected my wishes about who is and who is not to be given information about my treatment.
6. Staff here believe that I can grow, change and recover.
7. Staff were sensitive to my cultural background (race, religion, language, etc.).
8. Staff helped me obtain the information I needed so that I could take charge of my managing my illness.
9. I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.)

Outcomes:

As a Direct Result of Services I Received:

1. I deal more effectively with daily problems.
2. I am better able to control my life.
3. I am better able to deal with crisis
4. I am getting along better with my family.
5. I do better in social situations.
6. I do better in school and/or work.
7. My housing situation has improved.
8. My symptoms are not bothering me as much.

¹ Possible Responses: Strongly Agree, Agree, Neutral, Disagree, and Strongly Disagree

Participation in Treatment Planning:

1. I felt comfortable asking questions about my treatment and medication.
2. I, not staff, decided my treatment goals.

General Satisfaction:

1. I like the services that I received here.
2. If I had other choices, I would still get services from this agency.
3. I would recommend this agency to a friend or family member.

Two additional scales (and the questions included in each) were included in the 2007 survey.

Functioning:

As a Direct Result of Services I Received:

1. My symptoms are not bothering me as much.
2. I do things that are more meaningful to me.
3. I am better able to take care of my needs.
4. I am better able to handle things when they go wrong.
5. I am better able to do the things that I want to do.

Social Connectedness:

1. I am happy with the friendships I have.
2. I have people with whom I can do enjoyable things.
3. I feel I belong to my community.
4. In a crisis, I would have the support I need from family or friends.

Youth Survey Questions and MHSIP Scales

The Youth survey questions and MHSIP scales were:

Satisfaction:

1. Overall I am satisfied with the services my child received.
2. The people helping my child stuck with us no matter what.
3. I felt my child had someone to talk to when he/she was troubled.
4. The services my child and/or family received were right for us.
5. My family got the help we wanted for my child.
6. My family got as much help as we needed for my child.

Positive Outcome:

As a result of the services my child and/or family received:

1. My child is better at handling daily life.

2. My child gets along better with family members.
3. My child gets along better with friends and other people.
4. My child is doing better in school and/or work.
5. My child is better able to cope when things go wrong.
6. I am satisfied with our family life right now.

Cultural Sensitivity:

1. Staff treated me with respect
2. Staff respected my family's religious/spiritual beliefs.
3. Staff spoke with me in a way that I understood.
4. Staff were sensitive to my cultural/ethnic background.

Access:

1. The location of services was convenient for us.
2. Services were available at times that were convenient for us.

Family Involvement:

1. I helped to choose my child's services.
2. I helped to choose my child's treatment goals.
3. I participated in my child's treatment.

Calculation of Survey Scale Scores

The following methodology was used to calculate the survey scale scores:

1. Respondents with more than 1/3rd of the items in the scale either missing or marked "not applicable" were excluded.
2. For those respondents remaining, an average score for all items in the scale was calculated
3. For each scale, the number of average scores from Step 2 that were 2.49 or lower were counted (scores that, when rounded, represent "Agree" or "Strongly Agree" responses).
4. For each scale, the count from Step 3 was divided by the count of "remaining" records from Step 1 to obtain a percent of positive responses.

For example:

1. Of the 1,173 Adult surveys, 36 had more than 1/3rd of the items in the **Access** scale either missing or marked "not applicable". Those 36 surveys were excluded from the calculation of the **Access** scale, leaving 1,137 surveys to be included in the calculation.
2. Average scale scores were calculated for each of the 1,137 surveys

3. Of the 1,137 remaining surveys:
 - 925 had average scores of 2.49 or lower (Agree/Strongly Agree)
 - 153 had average scores between 2.50 and 3.49 (Neutral)
 - 39 had average scores of 3.50 or higher (Disagree/Strongly Disagree)
4. The percent of "positive" responses for the **Access** scale was 925 (from Step 3) divided by 1,137 (from Step 1) = 81.4

Scale Reliability

The standard deviations on the five MHSIP survey scales for Adults ranged from .68 for the **Quality and Appropriateness** scale to .94 for the **General Satisfaction** scale. Cronbach's alpha was used to measure internal consistency among the items in each scale. With the exception of the **Adult Participation in Treatment Planning** scale and the **Youth Access and Family Involvement** scales, the results show consistency in measurement (reliability) among the items included in each scale.

Adult Scales (# of Items)	Alphas
Access (6)	.860
Quality and Appropriateness (9)	.916
Outcomes (8)	.944
Participation in Treatment Planning (2)	.687
General Satisfaction (3)	.909

Additional Adult Scales (# of Items)	Alphas
Improved Functioning (5)	.929
Social Connectedness (4)	.854

Youth Scales (# of Items)	Alphas
Satisfaction (6)	.880
Positive Outcome (6)	.908
Cultural Sensitivity (4)	.764
Access (2)	.653
Family Involvement (3)	.699

Appendix B

Table 1
2007 Adult Survey Scales by Race/Hispanic Origin

Scale	% Agree White Non-Hispanic	% Agree Non-White / Hispanic
Access	81.6%	81.1%
Appropriateness	85.3%	84.9%
Outcomes	72.7%	76.0%
General Satisfaction	80.6%	86.9%
Participation in Treatment Planning	77.9%	81.6%
Functioning	78.1%	77.2%
Social Connectedness	75.3%	79.0%

Table 2
2007 Adult Consumer Survey
Summary of Results By Race

	% Agree or Strongly Agree	
	White, non Hispanic	Non-White or Hispanic
1. I like the services that I received here.	84.8%	87.0%
2. If I had other choices, I would still get services from this agency.	77.8%	85.2%
3. I would recommend this agency to a friend or family member.	83.4%	86.9%
4. The location of services was convenient (parking, public transportation, distance, etc.).	83.5%	86.0%
5. Staff were willing to see me as often as I felt it was necessary.	85.7%	86.0%
6. Staff returned my calls within 24 hours.	82.3%	82.9%
7. Services were available at times that were good for me.	89.7%	85.2%
8. I was able to get all the services I thought I needed.	80.3%	84.4%
9. I was able to see a psychiatrist when I wanted to.	76.9%	78.1%
10. Staff here believe that I can grow, change and recover.	89.6%	87.2%
11. I felt comfortable asking questions about my treatment and medication.	89.0%	90.7%
12. I felt free to complain.	82.1%	82.5%
13. I was given information about my rights.	91.1%	85.2%
14. Staff encouraged me to take responsibility for how I live my life.	90.8%	92.5%
15. Staff told me what side effects to watch out for.	77.7%	78.3%
16. Staff respected my wishes about who and who is not to be given information about my treatment.	90.6%	89.8%
17. I, not staff, decided my treatment goals.	79.6%	81.9%
18. Staff were sensitive to my cultural background (race, religion, language, etc.).	91.2%	88.1%
19. Staff helped me obtain the information that I needed so that I could take charge of managing my illness.	84.5%	87.2%
20. I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.).	76.3%	79.6%

	% Agree or Strongly Agree	
	White, non Hispanic	Non-White or Hispanic
As a result of the services received:		
21. I deal more effectively with daily problems.	77.6%	86.5%
22. I am better able to control my life.	78.9%	88.4%
23. I am better able to deal with crisis.	77.4%	81.0%
24. I am getting along better with my family.	78.3%	80.4%
25. I do better in social situations.	72.0%	76.3%
26. I do better in school and/or work.	70.9%	74.2%
27. My housing situation has improved.	62.2%	71.6%
28. My symptoms are not bothering me as much.	72.8%	73.5%
29. I do things that are more meaningful to me.	77.0%	82.5%
30. I am better able to take care of my needs.	80.5%	77.1%
31. I am better able to handle things when they go wrong.	77.9%	79.5%
32. I am better able to do the things that I want to do.	76.6%	76.1%
33. I am happy with the friendships I have.	83.4%	85.9%
34. I have people with whom I can do enjoyable things.	87.5%	82.0%
35. I feel I belong in my community.	76.0%	77.0%

Table 3
2006 and 2007 Adult Consumer Survey
Confidence Intervals

	2006			2007		
	Mean	SD	Confidence Interval	Mean	SD	Confidence Interval
1. I like the services that I received here.	1.93	0.962	1.86 - 2.00	1.89	0.953	1.84 - 1.94
2. If I had other choices, I would still get services from this agency.	2.16	1.106	2.08 - 2.24	2.09	1.097	2.03 - 2.15
3. I would recommend this agency to a friend or family member.	1.99	1.037	1.92 - 2.06	1.93	1.023	1.87 - 1.99
4. The location of services was convenient (parking, public transportation, distance, etc.).	2.03	0.947	1.96 - 2.10	1.98	0.959	1.92 - 2.04
5. Staff were willing to see me as often as I felt it was necessary.	1.94	0.955	1.87 - 2.01	1.90	0.951	1.84 - 1.96
6. Staff returned my calls within 24 hours.	2.05	0.986	1.97 - 2.13	2.00	0.976	1.94 - 2.06
7. Services were available at times that were good for me.	1.97	0.927	1.91 - 2.03	1.85	0.859	1.80 - 1.90
8. I was able to get all the services I thought I needed.	2.12	1.043	2.05 - 2.19	2.05	1.055	1.99 - 2.11
9. I was able to see a psychiatrist when I wanted to.	2.25	1.085	2.16 - 2.34	2.17	1.085	2.10 - 2.24
10. Staff here believe that I can grow, change and recover.	1.91	0.832	1.85 - 1.97	1.80	0.821	1.75 - 1.85
11. I felt comfortable asking questions about my treatment and medication.	1.94	0.909	1.87 - 2.01	1.82	0.865	1.77 - 1.87
12. I felt free to complain.	2.06	0.977	1.99 - 2.13	2.01	0.998	1.95 - 2.07
13. I was given information about my rights.	1.90	0.825	1.84 - 1.96	1.83	0.820	1.78 - 1.88
14. Staff encouraged me to take responsibility for how I live my life.	1.86	0.804	1.80 - 1.92	1.77	0.744	1.73 - 1.81
15. Staff told me what side effects to watch out for.	2.16	1.002	2.08 - 2.24	2.11	1.036	2.05 - 2.17
16. Staff respected my wishes about who and who is not to be given information about my treatment.	1.82	0.837	1.76 - 1.88	1.77	0.830	1.72 - 1.82
17. I, not staff, decided my treatment goals.	2.19	1.013	2.12 - 2.26	2.07	0.974	2.01 - 2.13
18. Staff were sensitive to my cultural background (race, religion, language, etc.).	1.92	0.812	1.86 - 1.98	1.80	0.724	1.76 - 1.84
19. Staff helped me obtain the information that I needed so that I could take charge of managing my illness.	2.03	0.941	1.96 - 2.10	1.96	0.923	1.91 - 2.01
20. I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.).	2.18	1.012	2.10 - 2.26	2.12	1.010	2.06 - 2.18

	2006			2007		
	Mean	SD	Confidence Interval	Mean	SD	Confidence Interval
As a result of the services received:						
21. I deal more effectively with daily problems.	2.11	0.913	2.04 - 2.18	2.05	0.967	1.99 - 2.11
22. I am better able to control my life.	2.10	0.906	2.04 - 2.16	2.04	0.940	1.98 - 2.10
23. I am better able to deal with crisis.	2.11	0.894	2.05 - 2.17	2.10	0.965	2.04 - 2.16
24. I am getting along better with my family.	2.14	0.984	2.07 - 2.21	2.06	0.949	2.00 - 2.12
25. I do better in social situations.	2.29	0.985	2.22 - 2.36	2.21	0.997	2.15 - 2.27
26. I do better in school and/or work.	2.29	0.973	2.21 - 2.37	2.22	1.038	2.15 - 2.29
27. My housing situation has improved.	2.34	0.999	2.26 - 2.42		1.062	2.30 - 2.44
28. My symptoms are not bothering me as much.	2.33	1.064	2.25 - 2.41	2.23	1.047	2.17 - 2.29
29. I do things that are more meaningful to me.	2.11	0.879	2.05 - 2.17	2.10	0.916	2.05 - 2.15
30. I am better able to take care of my needs.	2.06	0.857	2.00 - 2.12		0.925	2.03 - 2.13
31. I am better able to handle things when they go wrong.	2.21	0.949	2.14 - 2.28	2.13	0.942	2.07 - 2.19
32. I am better able to do the things that I want to do.	2.21	0.946	2.14 - 2.28	2.16	0.969	2.10 - 2.22
33. I am happy with the friendships I have.	2.09	0.952	2.02 - 2.16	1.99	0.902	1.94 - 2.04
34. I have people with whom I can do enjoyable things.	2.04	0.908	1.98 - 2.10	1.91	0.851	1.86 - 1.96
35. I feel I belong in my community.	2.26	1.038	2.19 - 2.33	2.16	1.008	2.10 - 2.22
36. In a crisis, I would have the support I need from family or friends.	1.96	0.923	1.90 - 2.02	1.86	0.894	1.81 - 1.91

Table 4

2007 Adult Consumer Survey
Summary of Results

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	% Agree/ Strongly Agree
1. I like the services that I received here.	435	546	90	50	38	84.6%
2. If I had other choices, I would still get services from this agency.	361	534	78	114	54	78.4%
3. I would recommend this agency to a friend or family member.	437	525	74	72	46	83.4%
4. The location of services was convenient (parking, public transportation, distance, etc.).	354	590	76	73	35	83.7%
5. Staff were willing to see me as often as I felt it was necessary.	415	558	68	63	34	85.5%
6. Staff returned my calls within 24 hours.	316	511	74	74	30	82.3%
7. Services were available at times that were good for me.	399	618	43	57	24	89.1%
8. I was able to get all the services I thought I needed.	368	558	67	115	43	80.5%
9. I was able to see a psychiatrist when I wanted to.	243	450	74	97	43	76.4%
10. Staff here believe that I can grow, change and recover.	405	563	73	27	21	88.9%
11. I felt comfortable asking questions about my treatment and medication.	404	554	53	44	23	88.9%
12. I felt free to complain.	348	566	82	80	40	81.9%
13. I was given information about my rights.	391	629	47	44	20	90.2%
14. Staff encouraged me to take responsibility for how I live my life.	410	604	60	36	7	90.8%
15. Staff told me what side effects to watch out for.	284	483	84	109	30	77.5%
16. Staff respected my wishes about who and who is not to be given information about my treatment.	433	559	48	40	19	90.3%
17. I, not staff, decided my treatment goals.	298	563	102	88	31	79.6%
18. Staff were sensitive to my cultural background (race, religion, language, etc.).	349	595	71	13	13	90.7%
19. Staff helped me obtain the information that I needed so that I could take charge of managing my illness.	339	577	73	75	24	84.2%
20. I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.).	279	506	99	116	24	76.7%

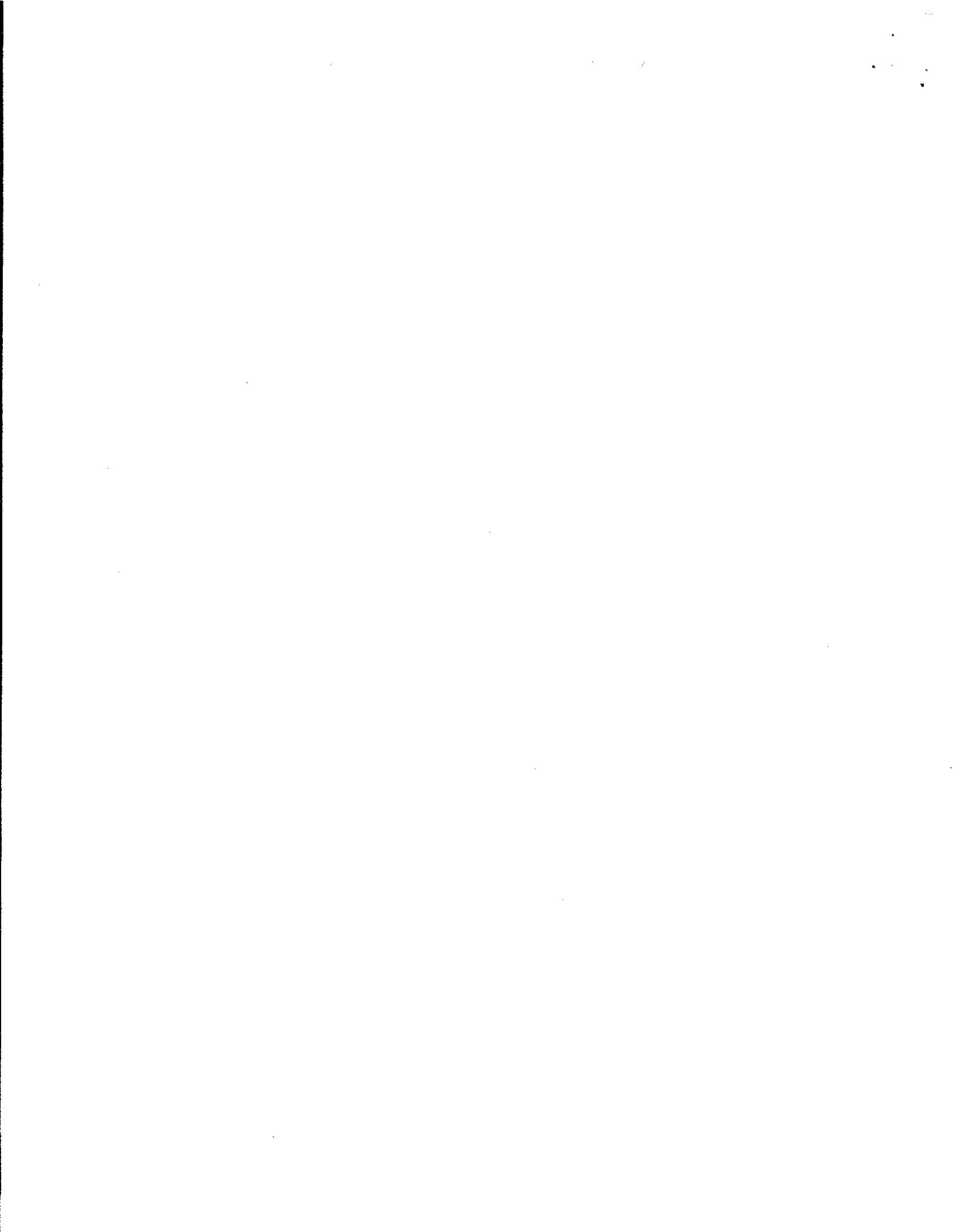
As a result of the services received:	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	% Agree/ Strongly Agree
21. I deal more effectively with daily problems.	321	551	128	83	29	78.4%
22. I am better able to control my life.	314	579	123	78	27	79.7%
23. I am better able to deal with crisis.	286	578	134	88	31	77.4%
24. I am getting along better with my family.	293	540	128	79	25	78.2%
25. I do better in social situations.	240	530	162	99	34	72.3%
26. I do better in school and/or work.	210	405	136	86	32	70.8%
27. My housing situation has improved.	187	385	194	106	38	62.9%
28. My symptoms are not bothering me as much.	245	536	130	120	42	72.8%
29. I do things that are more meaningful to me.	266	595	146	78	24	77.6%
30. I am better able to take care of my needs.	264	617	123	67	33	79.8%
31. I am better able to handle things when they go wrong.	252	612	129	88	30	77.8%
32. I am better able to do the things that I want to do.	248	598	135	93	35	76.3%
33. I am happy with the friendships I have.	326	630	97	74	24	83.1%
34. I have people with whom I can do enjoyable things.	352	644	77	58	20	86.5%
35. I feel I belong in my community.	286	577	128	120	33	75.4%
36. In a crisis, I would have the support I need from family or friends.	420	587	59	60	25	87.5%

37. Are you currently (still) getting behavioral health services from this provider?	Yes	No	Other	% Yes	
	537	618	18	46.5%	
38. How long have you received behavioral health services from this provider?	< 12 Mos.	12+ Mos.	Other		
	723	393	57		
39. Were you arrested since you began to receive behavioral health services?	Yes	No	Other	% Yes	
	44	674	460	7.0%	
40. Were you arrested during the 12 months prior to that?	Yes	No	Other	% Yes	
	177	539	457	24.7%	
41. Since you began to receive behavioral health services, have your encounters with the police	Been Reduced	Stayed Same	Increased	No Police Encounters	Other
	148	36	12	517	460

	Yes	No	Other	% Yes
42. Were you arrested during the last 12 months?	23	419	731	5.2%
43. Were you arrested during the 12 months prior to that?	34	405	734	7.7%
	Been Reduced	Stayed Same	Increased	No Police Encounters
44. Over the last year, have your encounters with the police...	46	10	13	368
				Other
				736

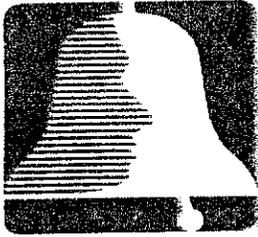
Table 5
2007 Youth Consumer Survey – Summary of Results

	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree	Other	% Agree/ Strongly Agree
1. Overall I am satisfied with the services my child received.	67	139	19	18	3	8	83.7%
2. I helped to choose my child's services.	66	126	14	29	4	15	80.3%
3. I helped to choose my child's treatment goals.	67	130	12	29	6	10	80.7%
4. The people helping my child stuck with us no matter what.	90	106	21	19	3	15	82.0%
5. I felt my child had someone to talk to when he/she was troubled.	65	122	21	21	6	19	79.6%
6. I participated in my child's treatment.	88	128	6	18	6	8	87.8%
7. The services my child and/or family received were right for us.	56	131	30	20	6	11	77.0%
8. The location of services was convenient for us.	81	143	7	14	6	3	89.2%
9. Services were available at times that were convenient for us.	68	142	9	23	5	7	85.0%
10. My family got the help we wanted for my child.	59	122	31	25	7	10	74.2%
11. My family got as much help as we needed for my child.	48	121	37	25	11	12	69.8%
12. Staff treated me with respect.	110	130	5	5	1	3	95.6%
13. Staff respected my family's religious/spiritual beliefs.	78	128	10	2	1	35	94.1%
14. Staff spoke with me in a way that I understood.	93	146	4	3	1	7	96.8%
15. Staff were sensitive to my cultural/ethnic background.	65	140	8	0	1	40	95.8%
As a result of the services my child and/or family received:							
16. My child is better at handling daily life.	45	103	49	28	11	18	62.7%
17. My child gets along better with family members.	38	127	35	29	9	16	69.3%
18. My child gets along better with friends and other people.	36	126	40	26	7	19	68.9%
19. My child is doing better in school and/or work.	36	114	40	34	7	23	64.9%
20. My child is better able to cope when things go wrong.	31	113	45	40	11	14	60.0%
21. I am satisfied with our family life right now.	33	138	31	39	7	6	69.0%
22. My child is better able to do the things he/she wants to do.	34	130	40	35	5	10	67.2%
23. I know people who will listen and understand me when I need to talk.	49	160	19	11	2	13	86.7%
24. I have people that I am comfortable talking with about my child's problem.	55	172	13	7	0	7	91.9%
25. In a crisis, I have the support I need from family or friends.	65	155	12	16	1	5	88.4%



Projects for Assistance in Transition from Homelessness

REGION	FY09 FUNDS BY Region	% of PATH Fed \$ by Region
1	\$ 11,333	3.78%
3	\$ 11,334	3.78%
5	\$ 65,000	21.67%
6	\$ 200,333	66.78%
HHS Admir	\$ 12,000	4.00%
TOTAL	\$ 300,000	100.00%



**Mental Health
Association
Of Nebraska**

file.

Item 11

1645 "N" Street, Suite A, Lincoln, Nebraska • 402-441-4371 • www.mha-ne.org

February 5, 2008

State Advisory Committee on Mental Health Services

RE: Public Comment

On January 14, 2008, the Division held a meeting to discuss the allocation of the \$8.9 million of "found money", funds originally allocated to both Norfolk and Hastings Regional Centers that should have been earmarked as support for the development of community-based services as outlined in the Behavioral Health Reform Act of 2004.

During the meeting we learned that \$6 million was "off the table" because it had already been allocated to sustain a 30 bed psych unit at NRC (\$3.5 million), the development of a 16 bed secure "mini-regional center" in Region 6 (\$2 million), and \$500,000 for emergency protective service support. Of the remaining \$2.9 million, each Region was to receive \$250,000 (no reason given), and \$1.4 million to be distributed to the Regions based upon existing allocation formulas.

We also learned that the \$10 million that has yet to be distributed to the Regions (so called "one-time" funding originally allocated under LB 1083) was being held back by the Governor for some yet to be determined action. Given that the \$8.9 million mention above should have been distributed back in July, and the fact that there is only 5 months left in this fiscal year, it is likely a significant portion of these dollars will be added to the pool of missing one-time funding.

We are very concerned about these decisions, decisions that ignore the promises made and codified in state law.

I have attached a copy of a letter I wrote to all 49 State Senators regarding this situation, as well as copies of the information distributed by the Division at the January 14th meeting for your review.

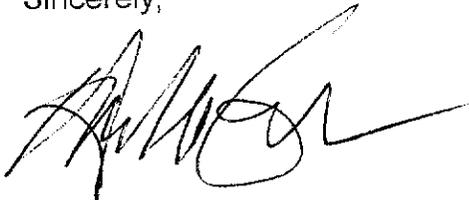
As members of the State Advisory Committee on Mental Health Services, it is your duty and responsibility to advocate for "the interests of consumers and their families" through "the development, implementation, provision, and funding of organized peer support services." Providing on-going funding to support traditional state hospital beds and creating new "community-based" locked

facilities does not meet Olmstead "least restrictive" requirements nor promote the development of evidence-based recovery programming in Nebraska.

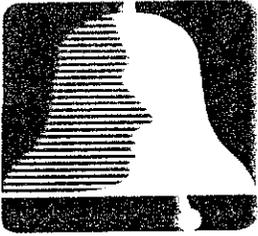
It is in the scope of your responsibilities to formally request that all dollars realized from the closure of the two regional centers be allocated as originally intended. Without these dollars to cover the development and delivery of necessary community-based services, the burden of supporting the increasing demand for local services will fall on each community, communities where each of you live.

The process that was begun with the passage of LB 1083 identified Nebraska as a national leader in mental health service reform. Good things have happened and many have benefitted from the new services that have been developed. But the job is not finished. Let's not stop "remodeling the house" only after painting the exterior. Complete and true reform will benefit and improve the lives of thousands of Nebraska citizens while showing good stewardship of tax payer dollars. This also needs to be done simply because it is the right thing to do.

Sincerely,

A handwritten signature in black ink, appearing to read 'Alan M. Green', with a long horizontal flourish extending to the right.

Alan M. Green, Executive Director
Mental Health Association of Nebraska



**Mental Health
Association
Of Nebraska**

1645 "N" Street, Suite A, Lincoln, Nebraska • 402-441-4371 • www.mha-ne.org

January 28, 2008

Senator Joel Johnson
District 22, State Capitol
Lincoln, NE 68509-4604

Dear Senator Johnson:

With the passage of the Behavioral Health Reform Act of 2004 (LB1083), the Nebraska State Legislature began the process mandated by the Olmstead Decision requiring "States to place qualified individuals with mental disabilities in community settings, rather than in institutions, whenever treatment professionals determine that such placement is appropriate."¹ The Act was the result of extensive planning involving Governor Johanns, consumers, providers, advisors, legislators, representatives from Health and Human Services and Regional Behavioral Health administrations. Collectively, these partners made a commitment to changing the face and philosophy of behavioral healthcare in Nebraska.

All partners understood that Reform would happen incrementally, and initial activities have proven to positively affect how and where life sustaining services are provided. However, recent actions by the Nebraska Division of Behavioral Health Services will seriously affect on-going reform efforts.

The long-term vision and commitment outlined in LB 1083 is in jeopardy and requires us to renew our support to see reform through. Issues requiring attention are as follows:

1. Approximately \$10 million dollars, designated as Program 38 behavioral health funding, is available in FY08, now on a "one time only basis" to the system and has, as of yet, not been released. These funds are necessary to ensure reform efforts continue and need to be utilized as soon as possible.

¹ President George W. Bush, *Executive Order: Community-based Alternatives for Individuals with Disabilities*; June 19, 2001.

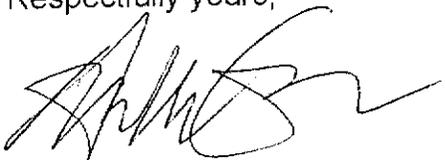
2. The Behavioral Health Reform Act committed institutional (Regional Center) funding to be leveraged and reinvested in community services. To date, \$21.1 million of \$30 million has been transferred to carry that out. On January 14, 2008, DHHS reported that \$8.9 million more funds are to be transferred to the community in FY08. However, DHHS intends to retain \$3.5 million for regional center services that "may be needed" to sustain 30 inpatient psychiatric beds at Norfolk Regional Center. That capacity is already funded through LB1199 funding and is included in the NRC budget.
 - **Rather than appropriating re-occurring funds to the Norfolk Regional Center, we recommended that the one-time Program 38 funds be retained for the NRC and reinvested in the community if not needed. This would release the \$3.5 million continuation funding into the community system.**
3. LB 1083 states that the planning for and allocation of resources for behavioral health is intended to be a collaborative process among DHHS and regional and local stakeholders.
 - **Decision making must occur in an open and accountable manner with partners in the system. LB 1083 promised that stakeholders would be involved "in all aspects of service planning and delivery."**

Failure to re-invest institutional funds in the community places the system and the commitment made to consumers in jeopardy by not complying with the intent and purpose of legislation. A classic "Catch 22" situation now exists where the development and delivery of community-based services needed to ensure adequate and effective services for individuals transferring out of the state system cannot be accomplished without the funds realized by the closing of the state hospitals. And without community-based services, the likelihood for the need of renewed institutional services increases.

Actions of the Division of Behavioral Health Services violate both the letter and intent of the Behavioral Health Reform Act. The demand for public behavioral health services continues to grow, and meeting the demand requires our attention and ongoing stewardship.

As a member of the Health and Human Services Committee during the passage of LB 1083, you know first hand the promises that were made and the collaborative effort that was needed to make reform a reality. We need your help again to ensure existing transformation efforts are not made in vain.

Respectfully yours,



Alan M. Green, Executive Director

BEHAVIORAL HEALTH FUNDING FOR FISCAL YEAR 2007 - 2008

ORIGINAL PROPOSAL FOR FUNDING BEHAVIORAL HEALTH REFORM

	Amount
Hastings Regional Center	\$11,049,349
Norfolk Regional Center	<u>\$14,840,533</u>
TOTAL	\$25,889,882

TRANSFERS MADE TO DATE FROM REGIONAL CENTERS

FY 05 HRC to Community-Based	\$4,967,000
FY 06 HRC to Community-Based	\$2,045,734
FY 08 NRC to Community-Based	<u>\$14,092,518</u>
TOTAL TRANSFERRED FROM RCs	\$21,105,252

FUNDING TO BE TRANSFERRED IN FY 08

Funds held for 30 patients at NRC	\$3,500,000
Emergency System	\$500,000
Funds for Region 6 Longer Term Care Facility	\$2,000,000
\$250,000 for Each Region	\$1,500,000
Funds Remaining to be Distributed	<u>\$1,400,000</u>
TOTAL FUNDING TO BE TRANSFERRED	\$8,900,000

TOTAL ALL FUNDS TRANSFERRED THROUGH FY 08 \$30,005,252

NOTE: Funding Transfers include funding from regional center adult inpatient services only

Behavioral Health System Priorities

- Behavioral Health System Funding—funds being transferred from regional center budgets to the regions for community-based services.
- (1) Development or expansion of community-based services necessary to reduce the demand for inpatient services and keep consumers of behavioral health services in the community.
 - (2) Improve emergency system access to reduce law enforcement and provider time in managing crises and to meet consumer needs in the least structured environment.
 - (3) Development of peer support and other consumer delivered services
 - (4) Implement strategies for serving persons with unique needs such as individuals with traumatic brain injuries, developmental disabilities, or co-occurring disorders.
 - (5) Implement strategies for supporting consumers with behavioral health needs living in nursing homes or assisted living facilities
 - (6) Develop and implement strategies for transitioning youth aged 17 and older to the adult behavioral health system
 - (7) Improving EPC responses

'Found money' to help mental health programs

By NANCY HICKS / Lincoln Journal Star
Friday, Dec 14, 2007 - 11:52:56 pm CST

They call it the "found money" — about \$20 million in state tax dollars that was supposed to be diverted from state psychiatric hospitals in Hastings and Norfolk to community programs as those institutions closed and sent patients to local programs across the state.

It's money that somehow got lost in the system and is now found.

The issue arose several months ago when local behavioral health leaders heard the state would have very little new money for local programs.

Some of the local leaders had been trying to follow the promised \$25 million that was to be diverted from state institutions into local programs as part of behavioral health reform begun in 2004.

"A few of us had been tracking this money. And this spring we began to hear that there was no more money," said C. J. Johnson, director of Region V Behavioral Health System, which oversees mental health and substance abuse treatment programs in Southeast Nebraska.

"This was not new money. This was (reform) money that didn't get spent or money that was supposed to move forward into communities.

"But we were getting the message that behavior health reform was up and running and we didn't need more money," he said.

Carole Boye, director of Omaha's Community Alliance, raised the issue publicly during meetings of the Behavioral Health Oversight Commission, created to monitor the progress of the reform, said former Sen. Jim Jensen of Omaha, who led the reform movement.

Jensen, who chairs that group, said he recently called for a meeting with state Health and Human Services leaders and others to iron out just how much money should be going into community programs.

About \$20 million was the answer. There's about \$10 million in one-time funding, money leftover when new or expanded local programs did not get started quickly enough to use money budgeted for them. There's another \$9.3 million in money that will continue each year.

The "found money" justifies the existence of the oversight commission, Jensen said in an interview Friday.

Scot Adams, director of HHS's Behavioral Health Division, said the issue arose because of a difference of opinion over what should go to community programs.

"I don't know that it was ever lost," he said of the \$20 million. "There were legitimate differences of perspective on what counted as money to the community."

But Topher Hansen, a Lincoln agency director who is on the oversight commission, says trust is an issue.

"The history is that the money disappears, and it doesn't come into the community," he said Friday.

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In fact, he questioned the proposed use of the \$9.3 million in ongoing funding outlined by Adams at Friday's oversight commission meeting.

Just one-third of the \$9.3 million will be divided among the behavioral health regions. The rest is going to other specific programs.

There was \$9.3 million, and all of a sudden, through an executive decision, "some is going here and there," Hansen said.

The ongoing \$9.3 million would help create more services in local communities, where, he said, "there are giant needs."

Adams said the money will be used this way.

- * \$3.3 million to the six regions for local programs

- * \$3.5 million to maintain a 30-patient long-term care program at Norfolk

- * \$500,000 to help regions with emergency protective services, where people are cared for short-term until they can go home or to a longer-term program.

- * \$2 million to Omaha to create a 16-bed, long-term care secure residential program for people now in Norfolk who likely will never be able to move to a group home or program without locked doors.

The agency will decide in January how to spend the \$10 million in one-time funding, Adams said.

Reach Nancy Hicks at 473-7250 or nhicks@journalstar.com.

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