

State Advisory Committee on Mental Health Services
November 5, 2009 – 9:00 A.M. to 4:00 P.M.
Country Inn & Suites – 5353 No. 27th St. Lincoln, NE
MINUTES

Committee Members Present:

Beth Baxter, Leslie Byers, Chelsea Chesen, Pat Compton, Cheryl Crouse, Sharon Dalrymple, Bev Ferguson, Scot Ford, Dwain Fowler, Clint Hawkins, Kathy Lewis, Dave Lund, Vicki Maca, Colleen Manthei, Jerry McCallum, Mark Schultz, Pat Talbott, Diana Waggoner

Committee Members Absent:

Adria Bace, Chris Hanus, Roxie Cillessen, Kasey Moyer

DHHS Staff Present:

Scot Adams, Alexandra Castillo, Carol Coussons de Reyes, Maya Chilese, Paula Hartig, Jim Harvey, Nancy Heller

Interested Individuals Present:

Alan Green

I. CALL TO ORDER

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

Roll call of members determined a quorum was met. **17 Members** of 22 appointed members were present at the beginning of the meeting. Each member introduced themselves and gave a brief statement about themselves.

New Member, Mark Schultz is with Nebraska Department of Vocational Rehabilitation in Lincoln Nebraska.

Jim Harvey stated a proposal to have the May 6, 2010 meeting be a joint meeting including the Mental Health Advisory Committee, the Substance Abuse Committee and the Problem Gambling Committee. The theme of the meeting will be Co-Occurring Disorders. The committee agreed to the proposal.

II. APPROVAL of MAY 5, 2009 MINUTES

√ Motion was made by Scot Ford and seconded by Cody Manthei to approve the August 13, 2009 minutes as submitted. Voice vote was unanimous and motion carried.

III. APPROVAL of AGENDA

√ Motion was made by Beth Baxter and seconded by Pat Compton to accept the November 5, 2009 agenda as submitted. Voice vote was unanimous and motion carried.

IV. PUBLIC COMMENT

Alan Green, Mental Health Association

Attachment 1

- Mr. Green distributed a Keya House informational flyer. The Keya house is a peer run crisis aversion house with trained peers. Keya House is similar to the Rose House Model and completely non-clinical. It's all recovery based and 100% run by peers.
- He attended the Alternative Conference and stated Nebraska came across doing very well.
- He feels some inclusion regarding strategic planning was missing in the August minutes.

V. BH DIVISION REPORTS

Vocational Rehabilitation - Mark Schultz

Attachment 2

Mr. Schultz briefly stated a few future projects his office is occupied on: 1) developing individualized services while being flexible so consumers can make choices, 2) providing direct services via team support and 3) community partnerships. A Supported Employment Summary was distributed to committee members.

National Health Care Reform - Scot Adams

Director Scot Adams welcomed every one for coming together. He urges everyone to pay attention to the National Health Care Reform: 1) Substance abuse service agencies may see changes because if the government takes charge of health care they may do away with Federal Block Grants 2) also urges all individuals to be informed on the IMD Inclusion (this is complex). The short version of this is the federal government pays for services to providers that have more than 16 beds.

Role of Recovery & Liberty Center CARF/ICCD- Bev Ferguson

Ms. Ferguson attended an international seminar in Florida. The seminar was attended by over 800 individuals from all over the world. Glenn Close has a sister with bi-polar and Ms. Close along with her sister are working to developed a foundation targeted at anti-stigma of mental illness. A 60 second DVD was shown to Committee.

CARF

Liberty Center is CARF certified in Employment, Day Rehab, Community Support Services and Res Rehab. There were no modifications/recommendations requested. In order to be accredited as club house, Liberty Center needed to be certified by the International Standard Club House Development. There are 36 standards that you have to abide by and uphold. It's much more difficult than providing day rehab services. The integrity level is very high and very different than a CARF accreditation. The sole purpose of Club House accreditation from ICCTD is to insure that services are consumer driven services, consumer oriented and the consumer has power in the decision making.

Response to Committee Recommendations of August 13, 2009 – Vicki Maca

Ms. Maca briefly reviewed the response handout and suggested the members review the written response. **Attachment 3**

Suicide Prevention Grant – Maya Chilese

Ms. Chilese mentioned DBH received the announcement of the Suicide Grant. At this time DBH is starting the three year grant with activities of best approaches targeted at youth suicide, transition age with strong partners such as Inter-church Ministries. DBH will start first with a call to the Technical Assistance (TA) Center, a great resource. There will be a lot of core activities and a contract will be established to include peers, teachers, friends, hairdresser etc. 85% of funds need to be into direct services. The contract will also include awareness of cultural competencies and continue out reach. Handout of Nebraska State Suicide Prevention Summit was distributed. **Attachment 4**

LB603 Children & Family Behavioral Health Support Act Update – Maya **Attachment 5**

Ms. Chilese handed out the DBH report that was presented to the Oversight Committee. The report was an outline of the Request for Proposals (RFP) for Children's Behavioral Health Help line and Family Navigator Services.

Motion was made by Pat Talbott and seconded by Dwain Fowler to recommend to the Division to have this committee be a part of strategic planning at the beginning of the planning stages of both adult and children starting now and also to monitor the existing plan as it progresses. Voice vote was unanimous and motion carried.

Office of Consumer affairs Report & TTI Grant – Carol Coussons de Reyes Ms. Reyes reviewed the RFP for the Transformation Transfer Initiative (TTI) Grant hand out. The theme will be a National level of peer support training with core competencies needed in Nebraska. OCA wants a five day training and then be followed by train the trainer. OCA is working closely with the Nebraska Recovery Center, NAMI and Mental Health Association. The Town Hall meeting report handout was also reviewed. **Attachments 6 & 7**

BRFFS-Prevalence of Serious Psychological Distress (SPD) – Paula Hartig

Ms. Hartig presentation reviewed the BRFFS-Prevalence of Serious Psychological Distress via overhead projector. **Attachment 8**

Consumer Survey- Paula Hartig

Jim Harvey explained the DBH contract with UNMC to do the Consumer Survey. Telephone and mail out surveys are done.

Paula Hartig reviewed the survey questions and the choices they can mark. Next year's survey will include the question of "Are you not getting treatment due to being asked to pay for services or medication?" **Attachment 9**

Draft Implementation Report Review – Jim Harvey & Nancy Heller

Jim Harvey pointed out and briefly reviewed the Implementation report which is in 4 sections: 1) Narrative 2) Expenditures 3) State Plan Approval and 4) URS Tables.

State Plan Approval

The Mental Health Block Grant Review (MHBG) and State Plan approval were conducted via video conferencing on October 30, 2009. The video conference went well. Pat Talbott attended the MHBG review as the Committee's representative. Nebraska did well on the State plan for adult and child, no modifications were requested. **Attachment 10**

Nancy Heller reviewed the Narrative. **Attachment 11**

Jim Harvey reviewed the MH Block Grant Implementation report and the following comments were collected:

- Dr. Chesen suggested/recommended DBH ask Creighton University and the University of Nebraska for an implementation report regarding LB603, on what is their plan to increase the number of professional staff/medical residents. It was suggested to invite Dr. Susan Boust or Dr. Bill Rocckforte, Director of Residency at UNMC to a Committee meeting.
- Tele-Health gives services to the rest of the state.
- Jim Harvey stated the Justice Grant award goes through August 2011, DBH recommended the target be Standards of Jail Screening.
- Page 10 shows good points. There is more collaboration with DD going on.
- Good point, is the marking of unmarked graves was included in the MHBG
- Children's area - implementation of programs will start on January 1, 2010.
- Out of Home Reform-60% is a high number and so much work needs to be done.
- The Division of Family and Children funds are not getting cut, they are moving in the right direction but significant changes need to be seen with in one year.
- Out of Home Reform is under funded and makes it a challenge to the private sector.
- Accountability is needed on why so many are being taken out of the home. One reason is the parents are out of money and give up custody to get services.
- DBH needs to have a solution base for the family within the strategic planning.
- MHBG needs to show how system of care is helping. The proper cultural of care for parents and children is unknown.
- How does LB542 and LB603 fit together?
- Suggestion was made for the committee to read LB542 to be informed and it would help the committee.
- DBH, Vicki Maca will arrange to give the committee a progress report presentation on the LB542.
- Tables shown 10% of state wards are in out of home placement, but where are those wards? This does not mean this is a success unless you know where they are. Jim responded Nebraska has increased in permanency within 15 months. The compass report on the DHHS web page gives information on permanency.
- What is the Division of Children and Family doing about their philosophy regarding the steps families go through? Each family goes through a set of steps but it is not successful.

Expenditures

Nancy Heller reviewed the Expenditures and there were no comments from the committee regarding expenditures. **Attachment 12**

URS Tables

Jim Harvey briefly reviewed the tables and pointed out table number 9 and 20a. **Attachment 13**

Elections of Officers

Jim Harvey informed the Committee the current officers are: Bev Ferguson is Chairperson, Pat Talbott is Vice Chairperson and Secretary was previously held by Jimmy Burke but is currently vacant. The three offices up for re-election are: Chairperson, Vice Chairperson and Secretary. Committee agreed on open nominations and voice voting.

Nominations for Chairperson

Nomination for Bev Ferguson for Chair was made by Chelsea Chesen and seconded by Cody Manthei.

√ Motion made by Jerry McCallum and seconded by Scot Ford to close the nominations. Voice vote was unanimous. Motion passed.

Bev Ferguson accepted the position of Chairperson.

Nominations for Vice Chair Person

Nomination for Pat Talbott for Vice Chairperson was made by Leslie Byers and seconded by Diana Waggoner. No more nominations were made, nominations were closed.

Pat Talbott accepted the position of Vice Chairperson.

Nominations for Secretary

Nomination for Diana Waggoner for Secretary was made by Kathy Lewis and seconded by Leslie Byers. No more nominations were made, nominations were closed.

Diana Waggoner accepted the position of Secretary.

The new officers are:

Chairperson: Beverly Ferguson

Vice Chairperson: Pat Talbott

Secretary: Diana Waggoner

Trauma Informed Systems of Care – Beth Baxter & Cheryl Crouse Attachment 14

Beth Baxter and Cheryl Crouse distributed "Community Connections" a self-assessment and planning protocol.

They pointed out several things/incidents that would trigger trauma. Program facilities need to have a mechanism tool on how to deal with trauma victims. There are many women of all ages that have been traumatized sexually as a child. There is a need for programs to understand and carefully review their facilities' layout, reorganize and develop procedures to avoid re-traumatizing individuals again and again. It was suggested to invite Kim Carpenter, Trauma Inform Nebraska, to speak to the Committee.

VI. Public Comment

Alan Green, Mental Health Association

- Congratulated Liberty Center on their CARF certification.
- Stigma- he noticed in the brief Glenn Close DVD that only the MI persons were wearing the T-shirts but not the disabled persons.
- Stigma - a consumer as a volunteer in crisis disaster. He feels the consumer has the right to decide to volunteer and he plans to discuss with Denise Bulling.

Dr. Chesen supports MI consumers as good out reach workers at disasters.

Dwain Fowler also supports consumers as volunteer out reach workers.

VII. Mental Health Committee Recommendations/Questions/Recommendations To DBHS

- The MH Committee be a part of strategic planning at the beginning of the planning for both adult and children and also monitor the existing plan as it progresses.
- DBH to ask Creighton University and the University of Nebraska for an implementation report regarding LB603, on what is their plan to increase the number of professional staff/medical residents. Suggestion was to invite Dr. Susan Boust or Dr. Bill Rocckforte, Director of Residency at UNMC to a committee meeting.
- Recommends DBH to have a solution base within the Strategic Planning for the family. The Division of Children and Family be involved, to have a grievance process for the family to use as a form of accountability when the family becomes an unfriendly issue.
- Vicki Maca will have a member of Children and Family present some information on LB542.

VIII. Next Meeting Agenda Items

- Invite MHA – Consumer Voice presentation by Melissa Donechske
- Invite Kasey Moyer- Her role regarding supported employment
- OCA Report by Carol Coussons de Reyes
- Dr. Susan Boust – Shortage of Professional staff
- Trauma issues – Kim Carpenter –future item
- LB542 – Division of Children and Family
- Region 4 Presentation

IX. Plus/Delta

Noise of the furnace makes it hard to hear.
Suggested we request microphones.
Good carrot cake.
Good discussion level within the committee.
Success is achieved
Jim and BH staff did a great job

X. Adjournment & Next Meeting

Meeting adjourned at 4:20 pm.

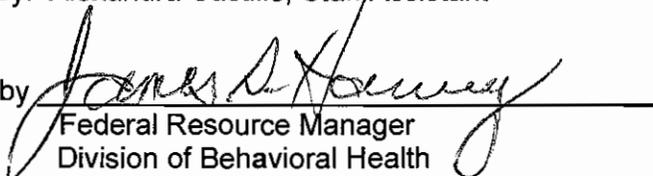
The next meeting date is **Thursday, February 4, 2010** at Country Inn and Suites.

Meeting dates for 2010 are all on Thursdays:

February 4, 2010; May 6, 2010; August 12, 2010; November 4, 2010

Prepared by: Alexandra Castillo, Staff/Assistant

Approved by


Federal Resource Manager
Division of Behavioral Health

Date January 14, 2010



Keya House

The word "Keya" means "turtle" in Lakota, a Native American language.

Keya is believed to be a symbol of good health and long life. Keya demonstrates the ability to adapt to changes and new surroundings by living in and out of water—a trait symbolizing the power of individuals to adapt to healthier activities and a new lifestyle.

Keya is also accepting and uncomplaining, and it moves with a slow and steady pace forward—traits symbolizing an individual's realization that health improvements don't happen quickly and it takes a steady pace of growth and change in order to recover and attain a state of wellness.

How Can You Help?

To help ensure that Keya House delivers the best possible services and care for our guests, we accept any donations that promote recovery and wellness. For more information, contact David Tafoya at 402-441-4371 or dtafoya@mha-ne.org.

Who We Are

The Mental Health Association of Nebraska (MHA-NE) is a consumer-run, voluntary, non-profit, statewide association with chapters located in communities throughout Nebraska.

MHA-NE brings together service recipients, families, professionals, advocates, and concerned citizens to address all aspects of mental health and mental illness.

We are dedicated to ensuring that public mental health policy is just, fair, and promotes equality and opportunity.

MHA-NE supports freedom for individuals with mental illness. Freedom to take advantage of life's opportunities. Freedom to decide where one lives, works, the important things they will do with their lives, the relationships they establish, how they choose to contribute to the community, and what services they will use.

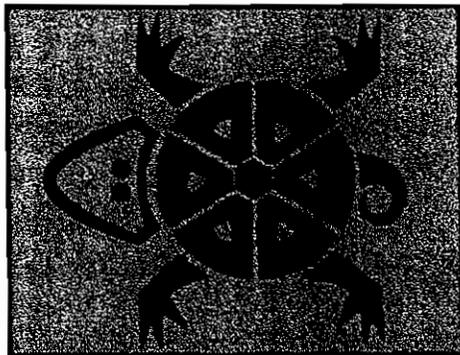


Mental Health
Association of
Nebraska

1645 "N" Street, Suite A
Lincoln, NE 68508
Phone: 402-441-4371
Fax: 402-441-4377
Email: dtafoya@mha-ne.org

KEYA HOUSE

A ROSE HOUSE MODEL



A PEER-RUN,
SUPPORTIVE ENVIRONMENT
THAT PROMOTES EMPOWERMENT,
RECOVERY, AND HEALING.

2817 S. 14th Street
Lincoln, NE 68502 -
4525

402-261-5959



Who Qualifies?

Keya House is for adults at least nineteen years old with a behavioral health diagnosis, and who live in the Region V Systems service area.

What We Offer

-  Peers helping peers with crisis prevention and diversion from psychiatric distress that may lead to hospitalization.
-  A comfortable, clean, and furnished four-bedroom house in a quiet and safe neighborhood.
-  Self help and proactive recovery tools to regain and maintain wellness.
-  Trained peer companions who are compassionate, understanding, empowering, and available twenty-four hours a day.

Why Peers?

Peers have all experienced what it is like to be on the verge of crisis, if not surrounded by it. We understand the need for support during those difficult times, which is why we offer strength, hope, and knowledge about recovery to those individuals who need a supportive and healing environment.

How It's Done

-  This program is strictly voluntary and free of charge. You can self-refer or be referred by a health professional or a family member. There is a registration process to ensure the appropriateness of the program for each individual as well as for the comfort of other guests.
-  We offer a stay of up to five days.
-  Peer companions staff the house twenty-four hours a day.
-  Staff can maintain contact and support at your request after you finish your stay.

Guidelines

-  You must not be in crisis or severe emotional distress.
-  You must have transportation to and from the house.
-  You must not have any known physical illness (e.g., fever, flu symptoms, intestinal distress).
-  You must be able to maintain acceptable personal hygiene.
-  You must be responsible for preparing your meals and cleaning up after yourself.
-  You must understand and sign a safety and responsibility contract.
-  You must have permanent housing after your stay.
-  You must follow the house rules which will be fully explained when you enter the house.

Attachment 2

Supported Employment Summary in Nebraska (as of Aug 18, 2009; revised Oct 13, 2009) pg 1

Summary of the funding between the NE Division of Behavioral Health and Vocational Rehabilitation for State Fiscal Years 2009 July 1, 2008-June 30, 2009) and SFY2010.

	FY2009	FY2010
BH	\$683,931	\$776,533
VR	\$1,075,000	\$1,320,000
total	\$1,758,931	\$2,096,533

NE Division of Behavioral Health - Supported Employment

Region	Provider	total FY2009	total FY2010
1	Cirrus House	\$16,050	\$16,291
2	Goodwill Industries-NP	\$43,418	\$44,069
3	Goodwill Industries-GI/K/H	\$115,392	\$138,565
4	Liberty Centre	\$75,641	\$76,776
4	Rainbow Center	\$47,067	\$47,773
5	Mental Health Association	\$202,517	\$266,455
6	Community Alliance	\$183,846	\$186,604
TOTALS		\$683,931	\$776,533

Increase from FY2009 to FY2010 \$92,602 11.9%
 Reported FY2009 total \$633,931
 Actual additional contracted total FY2009 \$50,000

Source: Regional Behavioral Health Authorities Contracts
 FY09 & FY10 Attachment G Summaries

July 23, 2009

Nebraska Vocational Rehabilitation Services

FY2009

Region	Provider	City	Outcomes		Agreement Amount	Consumers Served
			Achieved	Projected		
1	Cirrus House	Scottsbluff	10	10	\$50,000	38
2						
3	Goodwill Industries	GI/H/K	88	87	\$435,000	307
4	Liberty Centre	Norfolk	13	14	\$70,000	25
5						
6						
			225		\$1,075,000	786

Supported Employment Summary in Nebraska (as of Aug 18, 2009; revised Oct 13, 2009) pg 2

FY2010

Region	Provider	City	Outcomes		Agreement Amount
			Achieved	Projected	
1	Cirrus House	Scottsbluff		15	\$75,000
2					
3	Goodwill Industries	GI/H/K		97	\$485,000
4	Liberty Centre	Norfolk		15	\$75,000
5					
6					
					\$1,320,000

Vocational Rehabilitation American Recovery and Reinvestment Act funds were used to provide a temporary increase in funding for additional Supported Employment outcomes for FY 2010 and FY 2011.

Outcomes Achieved – First, the individual has to be successfully employed for 30 days to establish stability. Then the person needs to be successfully employed 90 days or longer. This means there needs to be a total of 120 days of successful job placement before Vocational Rehabilitation can document the outcome.



November 5, 2009

To: Beverly Ferguson, Chair
State Advisory Committee on Mental Health Services

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

Re: Division of Behavioral Health Responses to State Advisory Committee on Mental Health Services Questions and Comments from August 13, 2009

Based on the minutes of the meeting from August 13, 2009 the following Committee questions and comments were identified. The Division of Behavioral Health responses were reviewed at the State Advisory Committee on Mental Health Services on November 5, 2009.

The Committee Asked

Were there consumers involved in the Criminal Justice Jail Screen team?

Division of Behavioral Health Response

Travis Parker (Deputy Director of the Community Mental Health Center of Lancaster County) has been the Lead person for the Goal 3 (Implement standardized mental health and substance abuse screening protocols in the jails that prompt referrals for services) under the U.S. Department of Justice grant (Justice and Mental Health Collaboration Program). According to Mr. Parker, Corey Brockway, Region 2 Consumer Specialist, did attend meetings, review the draft reports, and related activities.

The Committee Asked

Trilogy resources-what is the core cost and usage rate?

Division of Behavioral Health Response

The Division of Behavioral Health signed a contract with Trilogy Integrated Resources, LLC in August 2008. On March 18, 2009, the new Behavioral Health "Network of Care" Web Site was officially launched. Trilogy Integrated Resources LLC of San Rafael, Calif., created, developed and maintains the Network of Care for Behavioral Health for the Division of Behavioral Health in the Department of Health and Human Services.

From April 1, 2009 to September 30, 2009, there were a total number of 9,639 sessions on the Network of Care. One session means a series of "hits" to the site over time by one visitor.

Region	1	2	3	4	5	6	total
Sessions	1,441	1,656	1,814	1,297	1,639	1,792	9,639

The contract term is from July 1, 2008 to June 30, 2010. The construction cost for the NE Network of Care was \$103,250. The monthly maintenance is \$9,000.

The Committee Asked

During public comments Alan Green included a reference to “Nebraska’s Consumer Voice: Leading a Change in Mental Health Services” by Melissa Donechske (Mental Health Association of Nebraska | April 2009). During the meeting, the Committee made two recommendations:

1. Melissa Donechske be invited to speak at the next Committee meeting.
2. Recommends “Consumer Voices” be used as foundation base for strategic planning.

Division of Behavioral Health Response

Melissa Donechske was invited to speak at the next Committee meeting. However, due to scheduling problems, she was not available. However, she will be able to present at the February 4, 2010 meeting.

The Division of Behavioral Health has been preparing for a strategic planning effort. The Division will be able to integrate “Nebraska’s Consumer Voice: Leading a Change in Mental Health Services” when the strategic planning process starts.

Here is a quick summary of the document “Nebraska’s Consumer Voice: Leading a Change in Mental Health Services”.

ABSTRACT - The information provided in this paper is the collective voice of mental health consumers from all behavioral health regions in Nebraska, and is a result of our experiences within the system. It is a movement toward infusing recovery principles into Nebraska’s mental health service delivery system that will guide individuals toward Self-Help, Self-Determination, and Empowerment. Furthermore, this is an attempt to bring all stake holders, including consumers, providers, family members, and policy makers together to create a new vision of a system that is more Person-centered and Recovery-focused. Through full consumer participation this paper establishes 11 rules to implement into Nebraska’s current and future method of Behavioral Health service delivery.

Here are the 11 Rules.

- Rule 1: Transportation Barriers Must Be Eliminated
- Rule 2: It Must Be Recovery Focused
- Rule 3: There Must Be Access to Services
- Rule 4: There Must Be Peer Provider Services
- Rule 5: There Must Be Access to Complete Medical Records
- Rule 6: Care Must Be Based on Partnership between Consumer and Provider
- Rule 7: There Must Be Access to Affordable Housing
- Rule 8: There Must Be More Recovery Education
- Rule 9: There Must Be Opportunity for Competitive Employment
- Rule 10: There Must Be Access to Information Regarding Benefits
- Rule 11: Do No Harm (providers be trained in trauma-informed care)

The Committee Asked

A decision was made that consumers cannot become volunteer outreach workers in the event that a disaster is declared and a Federal crisis counseling grant is received, consumers are not allowed to apply. Those involved in making this decision must not have realized that consumers had already served in those positions.

Division of Behavioral Health Response

People with serious behavioral health problems are considered a vulnerable population in the aftermath of a disaster. According to Dr. Denise Bulling (University of Nebraska Public Policy Center), research supports the decision to protect consumers from unnecessary exposure to disaster situations. However, just being a behavioral health consumer is not reason enough for exclusion from the disaster response and recovery workforce. It is highly dependent on the nature of the disaster and the particulars of the consumer's personal situation and characteristics.

Other states have struggled with this issue and have taken a similar approach to Nebraska. A large, inclusive steering committee developed Nebraska's All Hazards Disaster Behavioral Health Plan in 2004/2005 recommending that persons with serious mental illness NOT be part of the immediate disaster response workforce. This plan and group did not specifically address the inclusion or exclusion of consumers from the disaster recovery outreach workforce.

Dr. Bulling informally polled national trainers from a number of states. Based on this informal poll, these states do not use consumers for disaster response (New York; New Hampshire; New Jersey; Maryland; California; Maryland; Louisiana; Texas; Florida; Wisconsin). In addition, these national trainers, Federal Emergency Management Agency (FEMA) and the Federal Substance Abuse Mental Health Services Administration (SAMHSA) representatives were not immediately able to recall any other states that purposefully expose people with a history of serious mental illness to disaster conditions as responders.

There are varying approaches to inclusion of consumers as recovery workers.

- The Crisis Counseling Assistance and Training Program (CCP) is one of a number of programs funded by the Federal Emergency Management Agency (FEMA) under the authority of the Robert T. Stafford Disaster Relief and Emergency Assistance Act of 1974 (Stafford Act). The Stafford Act was designed to supplement the efforts and available resources of State and local governments in alleviating the damage, loss, hardship, or suffering caused by a federally declared disaster. Specifically, section 416 of the Stafford Act authorizes FEMA to fund mental health assistance and training activities in affected areas for a specified period of time. This mental health assistance is called crisis counseling.
- However, it is important to remember that the likelihood of getting federally declared disaster for individual assistance, which is a requirement for CCP, is not high in most situations.
- Although people with serious behavioral health problems are considered a vulnerable population, the preferred way to reach this vulnerable population is to work through their regular service providers. This is in keeping with the CCP philosophy of getting people reconnected with existing supports as soon as possible after a disaster, not replacing that service. In the case of behavioral health consumers, they are consuming service from existing providers and any peer delivered service should come through that source, not through the CCP.
- New York is putting together a training module for peers interested in assisting other behavioral health consumers after a disaster that should be finished soon. They plan to train peers to assist within the context of their agency and organizational affiliation and do not plan to employ peers as a regular part of a CCP workforce unless they are able to perform the work of the crisis counselor within the community.

NEBRASKA STATE SUICIDE PREVENTION COALITION



Nebraska State Suicide Prevention Summit

This is intended to provide information to video conference sites interested in hosting a community event highlighting suicide prevention in Nebraska

Event: Suicide prevention in Nebraska

Goal: Increase awareness of suicide as a public health concern

Date: January 29, 2010

Time: 10:00 am to 3:00 pm (CST) 9:00 am to 2:00 pm (MST)

(The last hour of the event is optional and will feature technical assistance for community members interested in applying for seed grants to implement youth suicide prevention practices.)

Intended audience:

Community members, professionals, suicide survivors, and/or youth and adults interested in promoting suicide prevention practices in their communities.

Background:

This community event will provide an overview of suicide as a public health concern in Nebraska; present opportunities to discuss local needs related to suicide prevention; and will feature an introduction to proven suicide prevention practices (sometimes referred to as evidence informed or best practices).

The event will originate in Lincoln, NE at the BryanLGH Conference Center. It will be made available to sites in Nebraska interested in hosting a gathering of community members participating via video conference.

Site Requirements:

- Sites hosting the videoconference will be provided with a list of registered attendees prior to the event.
- There will be a 30 minute break for lunch during which participants at the Lincoln site will be provided lunch. Sites will be asked to provide their participants with information about where lunch can be found nearby, but will not be required to provide it.
- Sites will be asked to provide the seating limits of their site and coordinates to the originating site (BryanLGH).
- Materials will be sent to registered attendees in advance. An additional set of handouts will be emailed to a representative named by the site.
- Organizers will work with each site to identify a person or persons interested in facilitating discussion at the site with participants.

Event Sponsors:

Nebraska State Suicide Prevention Coalition; Nebraska Department of Health and Human Services; BryanLGH Medical Center; Interchurch Ministries of Nebraska; University of Nebraska Public Policy Center

For more information, contact:

Dave Miers,
402-481-5165
dave.miers@bryanlgh.org

Denise Bulling
402-472-1509
dbulling@nebraska.edu



BryanLGH
MEDICAL CENTER
Lincoln, Nebraska

UNIVERSITY OF
Nebraska
PUBLIC POLICY CENTER

DHHS
Nebraska Department of Health
and Human Services

Attachment 5



Division of Behavioral Health

State of Nebraska

Dave Heineman, Governor

LB603 Children's Behavioral Health Oversight Committee

October 23, 2009

Division of Behavioral Health Report

1. Children's Behavioral Health Help Line and Family Navigator Services (RFP2981Z1)
 - a. Released July 24, 2009 by DAS
 - b. 3 Intent to Bids received on August 25, 2009
 - c. Opened September 3, 2009 with 3 bidders
 - d. Proposals reviewed and scored independently by Review Team of 5
 - e. Intent to Contract with Region V Systems posted Sept 23, 2009
 - f. DAS received protest from Boys Town
 - g. Withdrawal of Intent to Contract with Region V Systems posted October 21, 2009 based upon LB1083 language
 - h. Intent to Contract with Boys Town posted October 21, 2009
 - i. Contract Award pending

2. Evaluation Services for the Children's Behavioral Health Help Line, Family Navigator and Post Adoption/Post Guardianship Services (RFP3037Z1)
 - a. Released September 18, 2009 by DAS
 - b. 5 Intent to Bids received on October 13, 2009
 - c. Opened on October 16, 2009 with 5 bidders
 - d. Proposals currently being reviewed and scored independently by Review Team of 6
 - e. Letter of Intent to Contract scheduled to occur on November 2
 - f. Contract Award scheduled to occur on November 13
 - g. Contract Start Date scheduled to occur on November 16

3. Funding to Regional Behavioral Health Authorities

Region	Funding Amount	Estimated Capacity	Program
Region 1	\$25,662	3	Professional Partners
Region 2	\$30,105	3	Professional Partners
Region 3	\$65,731	7	Professional Partners
Region 4	\$96,014	10	Professional Partners
Region 5	\$121,475	x	Pilot: 'Prevention Professional Partners'
Region 6	\$195,069	x	Pilot: 'Rapid Response Professional Partners' and Adol. Therapist in Mobile Crisis Response Team

Attachment 6

RFP for TTI GRANT from NASMHPD to provide PEER SUPPORT TRAINING
Awarded to:

FOCUS ON RECOVERY-UNITED, INC. (FOR-U)
In Partnership with:

SHERY MEAD CONSULTING

And

DR. CHYRELL BELLAMY,
YALE PROGRAM FOR RECOVERY AND COMMUNITY HEALTH

Attachment A
Peer Support Steering Committee Members

Name	Position
Carol Coussons de Reyes	Administrator, DHHS Office of Consumer Affairs
Phyllis McCaul	DHHS
Dan Powers	DHHS
Judie Moorehouse	Region 1
Corey Brockway	Region 2
Nancy Rippen	Region 2
Tammy Fiala	Region 3
Lisa Sullivan	Region 4
Lisa Rehwaldt-Alexander	Region 5
Ken Timmerman	Region 6
Candy Kennedy	Nebraska Federation of Families
J. Rock Johnson	Legislative BH Oversight Commission
Alan Green	Mental Health Association of Nebraska
C. J. Zimmer	Nebraska Independent Living Council
Jack Buehler	NAADAC Regional Director
Kim Carpenter	Nebraska Coalition for Women's Treatment



ABOUT US

Our Mission

Focus On Recovery-United, Inc. (FOR-U), is dedicated to promoting a culture of wellness by encouraging positive change in the lives of adults, their family members, providers and the community.

Our Values

Mutual Respect
Shared Responsibility
Honesty
Hope
Education
Self-Advocacy
Support

Our Vision

FOR-U envisions a statewide network of peer-provided recovery education and support opportunities for adults in Connecticut.

Who Is FOR-U?

FOR-U is a peer-support program staffed entirely by paid and volunteer peers. Our training center is located in Middletown, CT. We offer the following workshops (please see calendar for more info and schedule):

Wellness Recovery Action Plan (WRAP I and WRAP II Facilitator Training)
Self-Esteem 101
Healthy Relationships 101
Pathways FOR-U (Workshop and Facilitator Training)
Intentional Peer Support (IPS Workshop and Facilitator Training)

Connecticut Recovery Employment Consultation Services (C-RECS) is also a part of FOR-U. For more information on C-RECS, [click here](#)

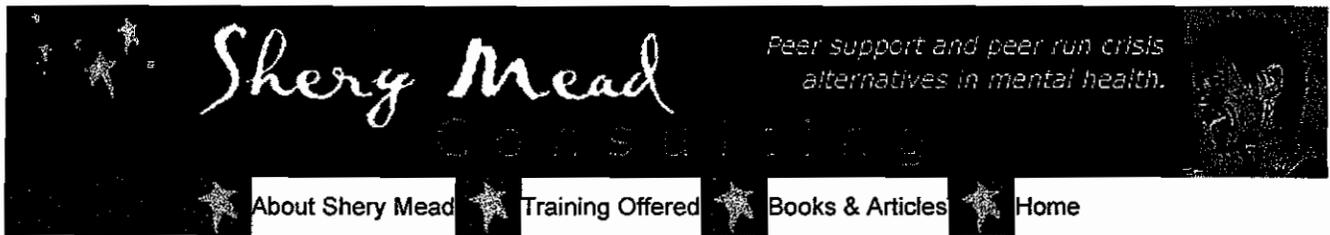
Board Of Directors

The Board of Directors is comprised of community members, family members, providers and elected officials who are supportive of our mission (with at least 51% being consumers). The following is a list of our current Board of Directors.

Paul Acker
Alice Fitzmorris
Theresa Goode
Carolyn Rosenswieg, President

FOR-U/C-RECS is a small, statewide independent non-profit organization.
We are grant funded by the Department of Mental Health and Addiction Services.





About Shery Mead

Shery offers a broad range of training based on individual needs. These may include training in intentional trauma-informed peer support, warmline skills, peer run crisis alternatives, co-supervision, Facilitator training and training for professionals in recovery-based practice. All training is very interactive using role play to demonstrate "values in action." Training time ranges from 1 – 8 days.

Shery has written two books with Mary Ellen Copeland and one (Intentional Peer support) on her own. They are available for purchase on this website.

Shery now speaks at many conferences and trains locally, nationally and internationally. Her current interests include:

- Peer support as social action and social change
- The development and implementation of trauma informed peer programs and groups
- Narrative and participatory evaluation and research
- Peer run crisis alternatives
- Training professionals in recovery based practices

Shery is also available for conferences as a keynote speaker and workshop presenter.

Please contact Shery Mead Consulting to plan your event. Allow as much advance notice as possible.

302 Bean Rd. Plainfield, NH 03781 | Phone: (603) 469-3577 | shery@mentalhealthpeers.com

Yale Program for Recovery and Community Health

[people](#) » Chyrell Bellamy, MSW, PhD

Chyrell Bellamy, MSW, PhD

Assistant Clinical Professor, Department of Psychiatry



Chyrell.Bellamy@Yale.edu
Phone: 203.841.7365
Fax: 203.772.2265

Program for Recovery & Community Health
Department of Psychiatry
Yale University School of Medicine
319 Peck Street, Bldg. One
New Haven, CT 06513

Role in Program:

My work at PRCH primarily focuses on peer support services. I am currently the Director of Peer Services and Research. I am also involved in the following programs related to this topic area: the Culturally Responsive Person Centered Care (PCP) Project, which has a strong peer component; and in a research project examining the role of Social Clubs in Connecticut for people in recovery.

Professional Interests:

I consider my life a walking narrative. My work is centered on my personal recovery journey from various issues and concerns (including addictions, mental illness, and PTSD). So far it has been an awesome journey, of course with amazing twists and turns; so I am indeed blessed to have the opportunity to give back to the community at large and look forward to my continual evolvement. I am a graduate of the joint PhD in Social Work and Social Psychology at the University of Michigan, and was a postdoctoral fellow at the Center for Mental Health Services and Criminal Justice Research at Rutgers University. My research interest includes the exploration of sociocultural factors (gender, race, ethnicity, class, culture, and illness status) and how they influence recovery from psychiatric illness and substance use, primarily through qualitative research methods. I also have a strong interest and expertise in Supported Education, a program model that assists adults with psychiatric illnesses who are transitioning to post-secondary education.

I am presently on the Board of the Connecticut's chapter of the U.S. Psychiatric Rehabilitation Association, and was a former board member of Michigan USPRA. In addition, I was a research associate on several psychosocial rehabilitation research projects including the Michigan Supported Education Program (MSEP), Supported Education Community Action Group (SECAG), and Assessing Consumer-Centered Services (ACCS) all at the University of Michigan, formerly directed by the late, Dr Carol T Mowbray – my mentor, colleague, and hero.

My practice concerns as well as research, also center on the needs of women and people of color with

HIV. I received my MSW from Rutgers in 1993 in Health Social Work and served some time as a clinician and then as the Assistant Director of the NJ Women and AIDS Network (a non-profit education and advocacy organization).

For fun... My work with peers is fun and exciting. It keeps me grounded, thus more in touch with the essence of recovery. In short, I love what I do and hope this is evident through my passion for my work, for connecting with people, and for life. I do enjoy canoeing, trying to sing and dance (I do neither well, but have fun pretending), listening to music, loving my black cat-Llerych, talking with friends and family, and reading novels each night before falling asleep.

Curriculum Vitae



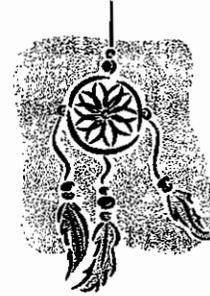
Copyright © 2006 Yale School of Medicine, Department of Psychiatry. All rights reserved.
Comments or suggestions to the site editor. Last modified: August 4, 2009 (LMc).
Site designed by ITS Web Services, Yale University.

Statewide Town Hall Meetings Report On Peer Support

What Nebraskan's Want from Peer Support

September 18, 2009

The Office of Consumer Affairs of the Division of Behavioral Health in the Department of Health and Human Service of Nebraska hosted a town hall meeting to discuss peer support and the concept of a consumer network. Funding was provided by the National Association of Mental Health Program Directors and the State Mental Health Association of



Capturing the Hopes and Dreams of Nebraskans!

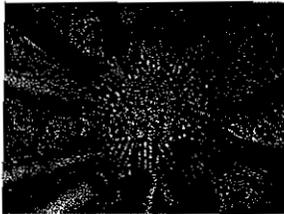
Charles Willis, Heather Peck, and Stuart Perry Speak

Heather Peck shared the success of Vocal Virginia in supporting 780 members, writing educational materials, hosting annual conferences, meeting with the commissioner of mental health, and using mental health and addiction block grant dollars for peers in the state of Virginia to start their own businesses. Some of the peer-run businesses included computer training in Microsoft Office products, a whole health center that has services such as yoga and acupressure, and peer support programs. She also share her lived experience with Addiction and Mental Health issues.

Charles Willis shared the leadership of the Georgia Mental Health Consumer Network in Georgia in supporting a membership of over 3,500 members. He described the various services that peers provide in Georgia including Double Trouble in Recovery Groups, The Peer Support and Wellness

Nebraska.

Carol Coussons de Reyes, administrator for the Office of Consumer Affairs, shared information on Nebraska's existing peer support workforce and introduced the guest speakers including: Heather Peck, Charles



Peer Support- People in recovery mentoring others in wellness and recovery thru mutual sharing of experiences and stories.

Center that has a respite for peers and groups (financial literacy, sports, cooking, Wellness Recovery Action Plan trainings, computer skills, creative writing, aromatherapy, housing, and job skills), peer mentors for folks leaving the hospital, and Medicaid billable peer supports. He talked about GMHCN's annual conference that has 500 peers in attendance. Charles candidly shared his lived experience with addiction, mental health issues, and homelessness.

Stuart Perry shared his story of how he came to lead and fund an independent peer support program in Americus, GA. This program could not survive on Medicaid funding alone because of the rates and Perry told stories about how he raised funds to support peers attending the program. He had bake sales, sold donuts, raffled off gasoline, had the mayor declare a "get your goat day" to allow use of a goat to fundraise, and had grown vegetables to sell to the community.

Highway to Recovery by Dan Powers

Charles, Heather, and Stuart were all staying in Omaha and were supposed to meet me at the fireplace at the Hilton lobby. Heather Peck followed directions, but Stuart and Charles were engrossed in a breakfast conversation and did not make it to the fireplace. Fortunately, the dining room was not busy and I asked the two people sitting in the dining room if they were our speakers. They were, so we loaded up the van and headed for Lincoln. (Continued Page 5)

What Nebraskan's Are Saying They Want from Peer Support and Networking:

Lincoln

Peer Support

Multiple Doors to Peer Support
Continue Process of Building Peer Support
Peer Support Certification
Federal Block Grant Dollars for Peer Support
Trainings Developed and Sponsored by Peers
Peer Support that is not Clinically Supervised
More Town Hall Meetings

Consumer Network

Communicate outside of email
Access to Computers
People really want a network
Funding for a Network
More Cohesive Support for Peers
Benefit- louder in numbers
Advocacy around mental health blockgrant dollars

Omaha:

Peer Support

Opportunity to Assist Others
Peer doing Peer Support b/c makes them happy
Trauma Training
Women Focus
Including Technology in Trainings/Outreach
Rural Reach
Training in Advocacy
Training in Nebraska Models of Peer Support
Training in Peer vs. Provider Perspective
Giving Back
Spreading the Word
Listening (where others are at)
Seeing other perspectives (worldview)
Role Modeling
Living Room Model Training (Arizona)
Warmline Training
Expand on AA models (get what you give)

Consumer Network

Education to Reduce Stigma
Doing what GAVA Consumer Networks Do
Regional Meetings
Study European Models of Peer Support
Create an Oral History/Record Stories
Training on Developing Your Story
More Conferences
Conferences Open to Public
Invite the Whole State to Conferences
Networking for Trained Peers
Sharing Ideas Statewide
Networking for Peers
Fundraisers with Celebrities

Native American: Omaha

Peer Support

Funding
Education on MH/Substance Abuse
Education for all People about MH
Community Forums (all inclusive)
Formation of Partnership
More Town Hall Meetings
Incorporate Families in Learning
Celebrate
Networking
Spiritual Leaders

Consumer Network

Annual Meetings
Mental Health Day at the Capitol
Fundraising



Norfolk

Peer Support

Mentoring Youth
Grief Groups/ Grief Processing

Inclusion of other Disability Groups
Variety of Settings for Peer Services
Peer Services Outside the Clinic Setting
Accepting Peers where they are at vs. changing them
Listening versus Advice
Supporting Each Other

Consumer Network

Infrastructure to Tie the Peers in Nebraska
Work for Everyone
Group Gatherings- Local and Other Places
Talk about Peer Support Education
Advocacy/Funding for Transportation
Phone Access to Peers
Easier Email Access
Email is not the same as live
New and Old Members Included at Conferences
Providers/Policy folk at Conferences
Interservice Cooperative Trainings
Venue to Connect with Providers that isn't about power
Healing for Providers

Hastings

Peer Support

Outreach to those with reading challenges
Video Educational Materials
Pictorial Educational Materials
Peer Run Programs
Whole Health- Mind, Body, Spirit
Website that connects Peer Support Groups
Website that lists area Peer Support Activities
Environments that support confidentiality
Forensic Peer Support
Male Oriented Supports and Education
Role Models
Relaxation
Coping Skills
Education for Law Enforcement
Education for Doctors
Where agencies are outside of MH system
Education on Laws (HIPPA, Confidentiality in Housing)
Jobs for peers in all agencies
Respect
Job role defined
Self-Advocacy
Alternative-funding outside Medicaid
Youth Focus Track
Education for Families
Strategic Planning Education for Peer Leadership
Provider Education

Consumer Network

Lots of Members
Advocacy around Transportation
Website about Statewide Activities
Newsletter
Funding for Speakers
Information on where Resources are



Scottsbluff:

Peer Support

MH/SA mix of experience
Focus on Physical and Mental

Trauma
Stress
Empathy vs. Sympathy
Meet me where I am
Advocacy around services
Communication Skills
Forum for Speaking
Support for Advocacy
Use easy layman language
Conflict Resolution
Consumer Run Programs
Benefits Navigation
Community Resources
Refocusing
Extended Peer Support
self-advocacy
unlimited ongoing support
talk about life outside MH
know natural supports (NAMI)
5 years experience with a diagnosis
laughter

Consumer Network

Consumer Run Programs
Services other than Cirrus
Services for those turned away by Cirrus
Training Funds for Region
Efficient Budgeting
Revolving Funds for COOP
Funds that match local banking website
Newsletter
Phone Conferences are Challenging
Enjoy Telehealth System
Telehealth is free
UN has a telesystem
Motivate folks to participate
Relationship development w/Providers
Advocacy around services
Local Networking
Training in ICCD(Clubhouse)

North Platte

Peer Support

Code of Ethics
Checks/Balances
Consistent Training
WRAP
Drop in Center Knowledge
Trained Volunteers
Training in Job Skills
Community Resource Info
Housing Info
Daily availability
Education to providers
advocacy
self-advocacy
respect
advocacy within providers
advocacy iwthin region
healing
person-centered planning
stigma reduction
understand crisis respite
celebration of successes
respect for peer support
access for folks with reading challenges

Consumer Network

peer run crisis respite
Drop in Center
list-serve email
mailing list info
support for kids
parent/family support
meetings outside Omaha
access (local weather challenges)
telehealth system
training available for peers



Nebraskan's Peer Support is Growing

by

Carol Coussons de Reyes

It was enlightening to see and hear from Nebraskans first hand about what they want from peer support. It was a tough schedule and I no idea that it would be this successful. It was amazing that folks could connect with the videotaped presenters and that one person was inspired to go out start his own business.

This is the results of your input that you can expect from the OCA, after these meetings:

- Statewide Peer Support Training Opportunities (Look for October 1st Application)
- Creation of a Code of Ethics for Peer Support
- More Networking Opportunities
- Ways to Make Technology Accessible to all Peers for Training and Networking
- Inclusion of More Partner Organizations in Planning Our Conferences
- An Certificate of Peer Association with the OCA for those qualified



Continued from Page 1

Written by Dan Powers, Consumer Liaison with Office of Consumer Affairs

There was a good attendance at the Bennet Martin Library in Lincoln, the Omaha Public Library, and at the Native American meeting at the Ponca Tribe's Fred Leroy Health and Wellness Clinic in South Omaha. This was the last location where we had live presenters. For the remaining four presentations, a video of the presentations was used.

On Thursday we headed to Norfolk to the Lifelong Learning Center and on Friday to the Hastings Public Library. We realized at the Hastings Library we didn't have speakers. Without sweating Carol quickly asked me to ask the librarians to assist, and recovery prevailed as speakers for the computer system were found.

We had covered five locations in five days and spent the Labor day week in the office.

On Monday we headed to Scottsbluff, because Carol's baby is too young to understand she is gone and is nursing we had her family in tow. We passed under the Arch in Kearney and stopped at Ole's in Paxton to see this legendary Nebraska attraction that includes a mounted polar bear, giraffe, and numerous other deceased animals. Carol's husband said his father was a hunter and would have been very impressed by Ole's.

We continued on West on the interstate then headed North at the Sidney exit. We were following a truck and I decided to pass. I thought we were going to crash, when I got about halfway around the truck I observed that there was a car making a left hand turn in front of the truck. I slowed and then the car in front of the truck pulled into the passing lane. I had to let a line of cars that was following the truck pass me before I could get back in the northbound lane. The recovery tour, Carol's family, and the state vehicle prevailed as we got back into the proper lane.

Carol and her husband were appreciative of the beauty of chimney rock. The presentation went well in Scottsbluff and we headed for North Platte. Things went smoothly, however when we reached North Platte, Carol discovered that she had left her diaper bag in the McDonalds in Sidney. I offered to go back and get the diaper bag, but Carol said she had more. Thanks to the manager it is on its way back to Lincoln, and once again recovery prevailed.

The North Platte presentation was well attended and we headed back to Lincoln. It was an unprecedented travel schedule for our section and very productive in gathering insight into what peers want from peer support in Nebraska.

**Prevalence of
Serious Psychological Distress (SPD)
Among Adults in Nebraska**

October 2009

**Paula Hartig, MS
Research and Performance Measurement
Financial Services – Operations
Department of Health and Human Services**

copy

**Prevalence of Serious Psychological Distress (SPD)
Among Adults in Nebraska**

Table of Contents

	<u>Page</u>
Introduction	3
Mental Illness and Stigma Module	4
Results	5
Prevalence of Serious Psychological Distress (SPD).....	5
Prevalence of Mild to Moderate Psychological Distress (MPD)	7
Results for Each of the Six Component Questions of the K-6 Scale	8
Health Status of Persons with SPD.....	10
Health Conditions Associated with Serious Psychological Distress	14
Health Risk Factors Associated with Psychological Distress	14
Emotional Support and Life Satisfaction	16
Who Receives Mental Health Treatment?	17
Attitudes Toward Mental Illness and Its Treatment	19
Access to Health Care	20
Discussion	21
Limitations of the Data	22
References	23
Appendix	24

Prevalence of Serious Psychological Distress (SPD) Among Adults in Nebraska¹

Introduction

Ten years ago the Surgeon General of the United States, in the first report of its kind to address mental health issues, recognized the inseparability of mental health and physical health. The report asserted that mental health is an important component of a person's overall health. While this was not a new concept, it was an important acknowledgement that mental health needs to be included in planning for health services at the federal, state and local levels.

Part of the difficulty in planning for mental health services, however, has been the lack of a reliable method for estimating the prevalence of mental disorders at the state level. To address this deficit, the federal Center for Mental Health Services, the Centers for Disease Control and Prevention, and State health departments collaborated on the development and implementation of a special module to be included in the Behavioral Risk Factor Surveillance System (BRFSS)² that would collect information on the prevalence of serious psychological distress (SPD) among adults at the state level. The result of this collaboration was the Mental Illness and Stigma module which was included for the first time in the 2007 BRFSS.

The Mental Illness and Stigma module included ten questions intended to: a) estimate the prevalence of SPD among non-institutionalized adults in the state; b) collect data on current treatment for a mental health condition or emotional problem; and c) gauge people's attitudes toward mental illness and its treatment. Nebraska was one of 35 states (plus the District of Columbia and Puerto Rico) to include the Mental Illness and Stigma module as part of the 2007 BRFSS survey.

The value of including mental health questions in a survey such as the BRFSS can not be overstated. It provides a unique opportunity to examine the relationship between psychological distress and chronic health conditions, health risk factors, and access to health care. This report examines the prevalence of serious psychological distress among adults in Nebraska and the characteristics of persons with SPD.³

¹ This report focuses on the Mental Illness and Stigma Module of the Behavioral Health Risk Factor Surveillance System (BRFSS) and the characteristics, health status and access to care of persons experiencing serious psychological distress. The larger BRFSS report for 2007-2008 for Nebraska, which goes into more detail regarding chronic health conditions, high risk behaviors, and access to care, should be available in early 2010.

² The Behavioral Risk Factor Surveillance System (BRFSS) is an ongoing telephone health survey of adults ages 18 and over which has collected information on health conditions, health risk behaviors, preventive health practices and health care access in the U.S. since 1984. The BRFSS is used in all 50 states, the District of Columbia, Puerto Rico, Guam and the Virgin Islands. Over 350,000 persons ages 18 and over are interviewed by the BRFSS each year, making it the largest telephone survey in the world.

³ The Division of Public Health collected data for the Mental Illness and Stigma module as part of the 2007 BRFSS. The Division of Behavioral Health contracted with the Research and Performance Measurement unit in Financial Services – Operations to compile, weight and analyze the data and to prepare a report of results. The author wishes to thank Norm Nelson, Statistical Analyst III, and Meridel Funk, Lead Program Analyst, in the Research and Performance Measurement unit, for their help in weighting and analyzing the survey data.

Mental Illness and Stigma Module

The Mental Illness and Stigma module of the BRFSS uses the Kessler-6 (K-6) scale to estimate the prevalence of serious psychological distress (SPD). The K-6 scale was originally developed in 1992 for the U.S. National Health Interview Survey (NHIS) to measure non-specific psychological distress among the adult population over the previous 30 days. The K-6 scale has subsequently been used in other large-scale surveys including the National Household Survey on Drug Abuse and the National Comorbidity Survey Replication. The K-6 is strongly predictive of anxiety disorders as well as depressive disorders and has been validated in multiple settings (Dhingra, et al., 2009).

The scale consists of six questions, specifically: *“About how often during the past 30 days did you feel:*

1. *nervous?*
2. *hopeless?*
3. *restless or fidgety?*
4. *so depressed that nothing could cheer you up?*
5. *that everything was an effort?*
6. *worthless?*

Possible responses to each question include: *“all of the time,” “most of the time,” “some of the time,” “a little of the time,” and “none of the time.”* The response to each question was assigned a score from 0 (*“none of the time”*) to 4 (*“all of the time”*). The total possible score for all six questions, i.e., the *“Kessler-6 score”*, ranged from 0 to 24. A Kessler-6 score of 13 or higher indicates the presence of *“serious psychological distress”* (SPD). Persons classified as having SPD are considered to have a high likelihood of having a diagnosable mental illness or mental health problem severe enough to cause moderate to serious impairment in functioning that might require treatment (Pratt, et al., 2007).

The Mental Illness and Stigma module also included a question about current mental health medication or treatment: *“Are you now taking medicine or receiving treatment from a doctor or other health professional for any type of mental health condition or emotional problem?”* Another question was asked regarding the extent to which their mental health condition or emotional problem impacted their work or other activities: *“During the past 30 days, for about how many days did a mental health condition or emotional problem keep you from doing your work or other usual activities?”*

Two questions gauged respondents’ attitudes toward treatment for mental illness and the stigma sometimes associated with mental illness:

How much do you agree or disagree with the following statements:

Treatment can help people with mental illness lead normal lives.

People are generally caring and sympathetic to people with mental illness.

Possible responses to these questions ranged from *“strongly agree”* to *“strongly disagree”*.

The Mental Illness and Stigma module was administered to a subset of the BRFSS sample in Nebraska.

Results

Prevalence of Serious Psychological Distress (SPD)

In 2007, over 5,100 adults in Nebraska were asked questions from the Mental Illness and Stigma module of the BRFSS survey. Of these, 2.5% had a 30-day prevalence of serious psychological distress (SPD), meaning that 2.5% of the survey respondents had experienced serious psychological distress at some point in the 30 days preceding the survey. Table 1 shows the percent of the adult population in Nebraska estimated to have a 30-day prevalence of SPD by demographic category.

TABLE 1
Percent of Nebraska Adults
Having Serious Psychological Distress (SPD) in the Past 30 Days
(with 95% Confidence Intervals – SUDAAN)⁴

	<u># of Respondents</u>	<u>%</u>	<u>Confidence Interval</u>		<u># of Respondents</u>	<u>%</u>	<u>Confidence Interval</u>
Total	5,103	2.5	1.9-3.3	Race/Ethnicity (Age-Adjusted):			
				White, Non-Hispanic	4,751	2.1	1.6-2.8
Gender:				Non-White or Hispanic	338	4.7	2.0-10.7
Male	1,946	1.9	1.2-3.1	Marital Status:			
Female	3,157	3.1	2.2-4.2	Currently Married	3,214	2.3	1.6-3.4
Age:				Previously Married	1,346	4.4	3.0-6.5
18-24 years	162	1.1	0.4-3.0	Never Married	536	1.7	1.0-2.9
25-34 years	478	1.1	0.6-1.9	Employment Status:			
35-44 years	812	2.8	1.7-4.6	Employed	2,501	1.3	0.7-2.3
45-54 years	1,071	4.7	2.6-8.6	Self-Employed	575	2.1	0.6-7.8
55-64 years	981	2.2	1.3-3.7	Unemployed	89	4.7	1.7-12.2
65+ years	1,585	2.5	1.7-3.7	Homemaker	379	1.9	1.0-3.6
Place of Residence:				Student	62	0.6	0.1-3.4
Urban	707	2.2	1.2-3.8	Retired	1,250	2.6	1.6-4.1
Rural	4,396	2.8	2.3-3.5	Unable to Work	##	##	##
Education:				Behavioral Health Region:			
< High School	427	8.1	4.0-15.8	Region 1	505	1.6	0.8-3.0
High School Grad	1,938	2.8	2.1-3.7	Region 2	523	3.3	1.8-5.7
Some College	1,415	2.0	1.2-3.4	Region 3	1,008	4.4	3.0-6.3
College Graduate	1,318	1.3	0.6-2.9	Region 4	1,292	2.8	1.9-4.0
Annual Income:				Region 5	1,054	1.4	0.9-2.4
< \$15,000	456	7.9	5.1-11.9	Region 6	699	2.5	1.3-4.5
\$15,000 - \$24,999	868	7.8	4.8-12.4				
\$25,000 - \$49,999	1,510	2.0	1.0-3.7				
\$50,000 - \$74,999	776	1.4	0.6-3.5				
\$75,000+	906	0.3	0.1-0.7				

NOTE: "Number" and "Percent" exclude missing, don't know, and refused responses.

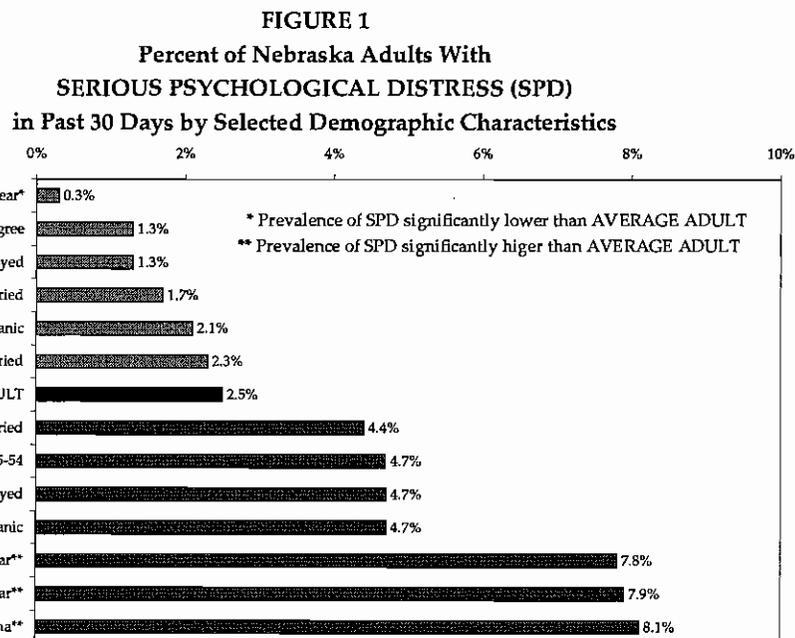
- The data are not reported if the confidence interval half width was > 10.

⁴ Technical Note: Data analysis was conducted using SUDAAN software, Release 10.0, developed for the statistical analysis of data from surveys with complex sampling designs by the Research Triangle Institute (RTI International) in Research Triangle Park, North Carolina.

Women (3.1%) were more likely to report symptoms of serious psychological distress (SPD) than men (1.9), although the difference was not statistically significant. Persons ages 45-54 were significantly more likely to have SPD than persons ages 25-34. There were no significant differences by place of residence (urban versus rural) or by race/ethnicity or employment status. Adults with less than a high school education (8.1%) were significantly more likely to have SPD than persons with a high school diploma/ GED (2.8%), persons with some college (2.0%), or college graduates (1.3%). Persons with annual incomes below \$25,000 were significantly more likely to have SPD than persons with incomes over \$25,000. Persons who were previously married (widowed, divorced or separated) were significantly more likely to have SPD (4.4%) than persons who had never married (1.7%). And persons living in Behavioral Health Region 3 (4.4%) were significantly more likely to have SPD than persons living in Behavioral Health Region 5 (1.4%).

A study published in 2009 in the International Journal of Public Health reported on state differences in the prevalence of serious psychological distress (SPD) among 35 states, the District of Columbia and Puerto Rico using the K-6 scale. The study revealed that approximately 4.0% of the respondents in the 35 states, the District of Columbia, and Puerto Rico had SPD. Only three of the other 34 states reported a lower prevalence of SPD than Nebraska: Iowa (2.3%), Alaska (2.4%), and Hawaii (2.4%). Twelve of the other 34 states had prevalence rates for SPD that were significantly higher than the rate for Nebraska – ranging from 4.1% in New Mexico to 6.6% in Mississippi. Nebraska had the lowest mean K-6 score of all 35 states, the District of Columbia and Puerto Rico (2.8).

Figure 1 shows the percent of Nebraska adults with SPD in the past 30 days by selected demographic characteristics as compared to the average respondent. Persons with less than a high school education, and persons with incomes under \$25,000 were significantly more likely than the “average adult” to have SPD. Persons with incomes in excess of \$75,000 were significantly less likely than the “average adult” in Nebraska to have SPD.



Prevalence of Mild to Moderate Psychological Distress (MPD)

The K-6 scale can also be used to identify persons experiencing less serious psychological distress. Persons with total scores on the K-6 scale of 8 – 12 were considered to have experienced mild to moderate psychological distress (MPD) in the previous 30 days. About one in fifteen respondents (6.7%) had total K-6 scores between 8 and 12, suggesting the presence of mild to moderate psychological distress. Populations most likely to have MPD were similar to those most likely to have SPD and included persons who are unable to work (14.3%), persons with less than a high school education (11.9%), and persons with an annual income of less than \$15,000 (11.5%) or \$15,000-24,999 (11.7%). Persons less likely to have MPD include self-employed persons (3.3%), and young adults ages 18-24 (3.9%) (Table 2).

TABLE 2
Percent of Nebraska Adults
Having Mild to Moderate Psychological Distress (MPD) in the Past 30 Days
(with 95% Confidence Intervals – SUDAAN)

	<u># of Resps</u>	<u>%</u>	<u>Confidence Interval</u>		<u># of Resps</u>	<u>%</u>	<u>Confidence Interval</u>
Total	5,103	6.7	5.3-8.4	Race/Ethnicity (Age-Adjusted):			
				White, Non-Hispanic	4,751	6.6	5.1-8.4
Gender:				Non-White or Hispanic	338	5.7	3.0-10.8
Male	1,946	7.7	5.4-10.9	Marital Status:			
Female	3,157	5.7	4.4-7.3	Currently Married	3,214	5.8	4.3-7.7
Age:				Previously Married	1,346	8.2	6.2-10.9
18-24 years	162	3.9	1.9-7.8	Never Married	536	8.7	4.7-15.6
25-34 years	478	8.5	4.3-16.1	Employment Status:			
35-44 years	812	5.5	3.5-8.5	Employed	2,501	6.0	4.4-8.2
45-54 years	1,071	6.8	4.4-10.4	Self-Employed	575	3.3	2.2-5.1
55-64 years	981	8.9	6.2-12.7	Unemployed	##	##	##
65+ years	1,585	5.6	4.3-7.4	Homemaker	##	##	##
Place of Residence:				Student	62	4.0	1.1-13.8
Urban	707	6.6	4.2-10.0	Retired	1,250	7.0	4.9-9.9
Rural	4,396	6.8	5.8-7.9	Unable to Work	241	14.3	9.4-21.1
Education:				Behavioral Health Region:			
< High School	427	11.9	5.0-26.0	Region 1	505	6.2	4.3-8.8
High School Grad	1,938	5.7	4.3-7.5	Region 2	523	7.5	4.6-11.9
Some College	1,415	4.9	3.4-7.0	Region 3	1,008	5.9	4.3-8.2
College Graduate	1,318	7.9	5.2-11.8	Region 4	1,292	7.4	5.7-9.5
Annual Income:				Region 5	1,054	8.3	4.8-14.1
< \$15,000	456	11.5	7.7-16.8	Region 6	699	5.6	3.7-8.5
\$15,000 - \$24,999	868	11.7	6.7-19.7				
\$25,000 - \$49,999	1,510	6.9	4.7-9.8				
\$50,000 - \$74,999	776	4.7	2.3-9.4				
\$75,000+	906	5.0	2.7-8.8				

NOTE: "Number" and "Percent" exclude missing, don't know, and refused responses.
 ## - The data are not reported if the confidence interval half width was > 10.

Results for Each of the Six Component Questions of the K-6 Scale

Figures 2-7 present data on each of the six components of the K-6 scale. Of the six manifestations of SPD, as measured by the K-6 scale, a feeling of nervousness was the most common among the respondents. One in five respondents (20.3%) indicated that they felt nervous at least some of the time in the past 30 days. A feeling of restlessness was second, with 19.4% experiencing restlessness at least some of the time in the past 30 days, followed by the feeling that everything was an effort (17.9%). About 4.4% indicated that, at least some of the time in the past 30 days, they felt so depressed that nothing could cheer them up. About 5.7% indicated that they felt worthless at least some of the time in the past 30 days, and about 6.2% indicated that they felt hopeless at least some of the time in the past 30 days.

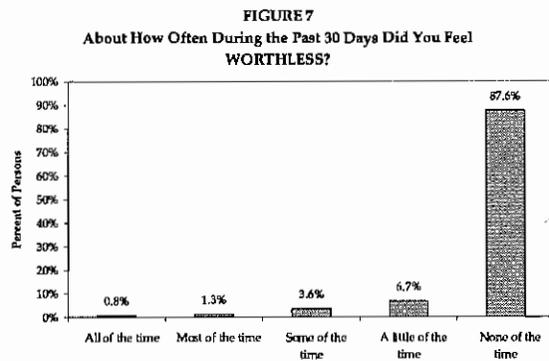
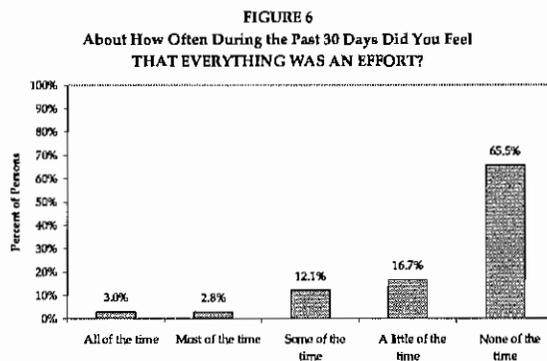
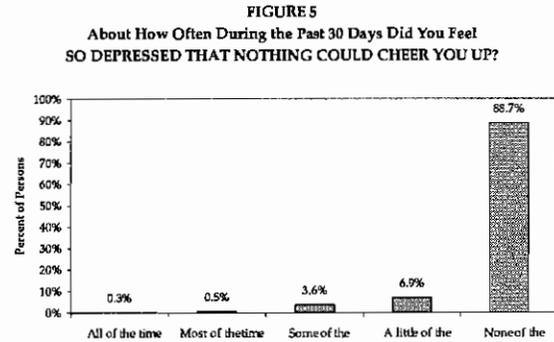
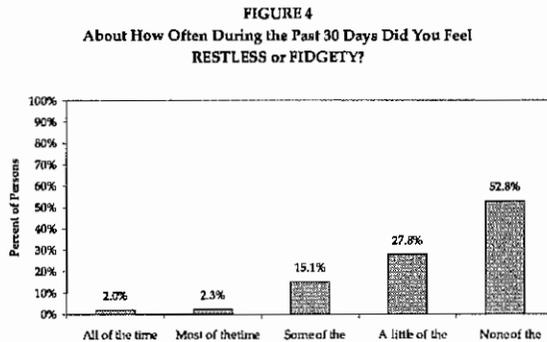
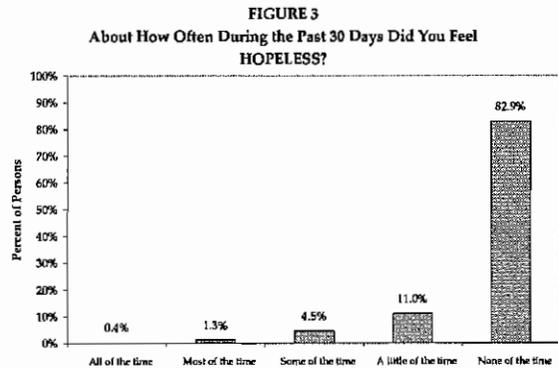
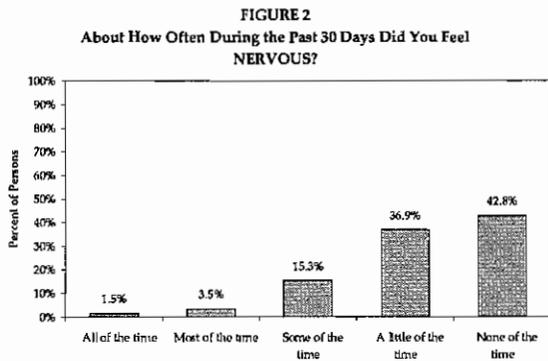


Table 3 is a summary of the statistically significant differences between population subgroups and the average respondent for each of the six questions in the K-6 scale. (Details on the responses to each of the six component questions can be found in Tables A1-A6 in the Appendix.)

There are certain population groups that are significantly more likely than the average respondent to experience one or more of the six manifestations of SPD: persons unable to work (typically because of a disability), persons with annual incomes below \$15,000, and persons with less than a high school education. On the other hand, persons with annual incomes of \$75,000 or greater are significantly less likely than the average respondent to experience feelings of hopelessness, worthlessness, or that everything is an effort. Young adults ages 18-24 are significantly less likely than the average respondent to experience feelings of worthlessness. Adults who are students are significantly less likely than the average respondent to experience feelings of depression.

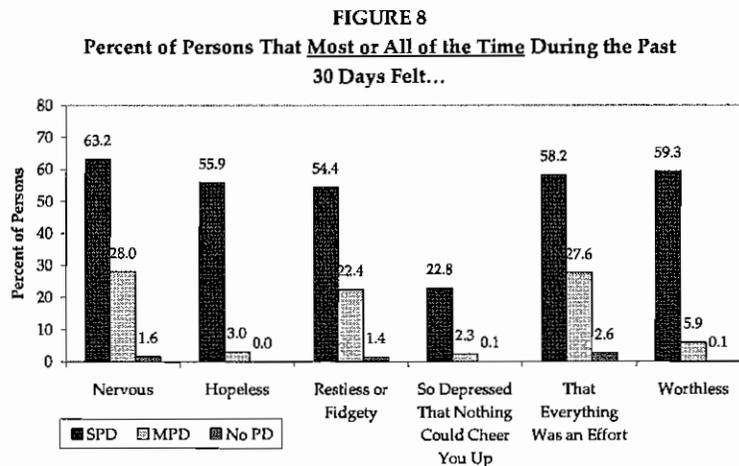
TABLE 3
Significant Differences, as Compared to the Average Respondent,
for Each of the Six Component Questions of the K-6 Scale
By Population Subgroup

About how often in the past 30 days did you feel...	Population Subgroup	Significantly More Likely Than the Average Respondent to Indicate Having the Feeling...				
		All of the Time	Most of the Time	Some of the Time	A Little of the Time	None of the Time
Nervous?	Persons unable to work* Persons with annual income less than \$15,000	X	X X			
Hopeless?	Persons with annual income less than \$15,000 Persons with annual income \$15,000-\$24,999 Persons unable to work Persons with less than a high school education Persons with annual income \$75,000+	X	X X X	X	X	X
Restless or fidgety?	Persons unable to work Persons age 65+	X	X			X
So depressed that nothing could cheer you up?	Persons with less than a high school education Persons with annual income less than \$15,000 Persons with annual income \$15,000-\$24,999 Persons unable to work Students Persons previously married	X	X X X X	X X	X	X
That everything was an effort?	Persons with annual income less than \$15,000 Persons with annual income \$15,000-\$24,999 Persons unable to work Persons with annual income \$75,000	X X	X X			X
Worthless?	Persons with less than a high school education Persons with annual income less than \$15,000 Persons with annual income \$15,000-\$24,999 Persons unable to work Persons ages 18-24 Persons with annual income \$75,000+	X X X	X X	X X X		X X X

* Interpretation - persons unable to work were significantly more likely than the average respondent to say they felt nervous most or all of the time during the past 30 days

Figure 8 shows the percent of persons with SPD, MPD and no psychological distress (No PD) that experienced each of the six manifestations of SPD most or all of the time over the past 30 days. The differences between persons with SPD and those with no psychological distress were statistically significant for all six manifestations of SPD.

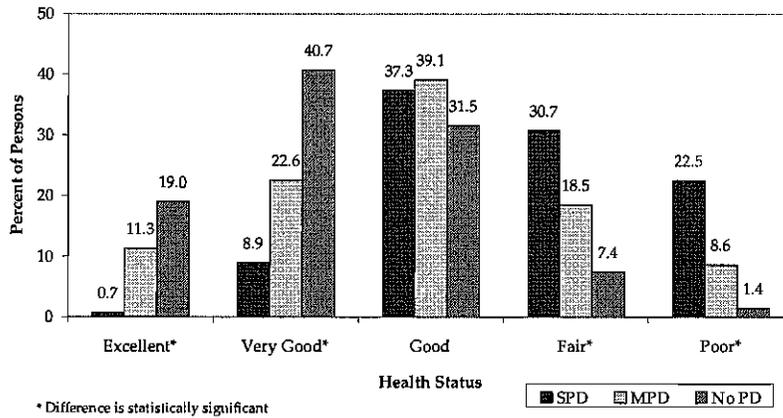
The manifestations of psychological distress included in the K-6 can be divided into two groups – depressive symptoms (feeling depressed, hopeless, worthless) and anxiety symptoms (feeling nervous, restless, fidgety). Persons experiencing mild to moderate psychological distress were more likely to experience symptoms of anxiety rather than symptoms of depression.



Health Status of Persons with SPD

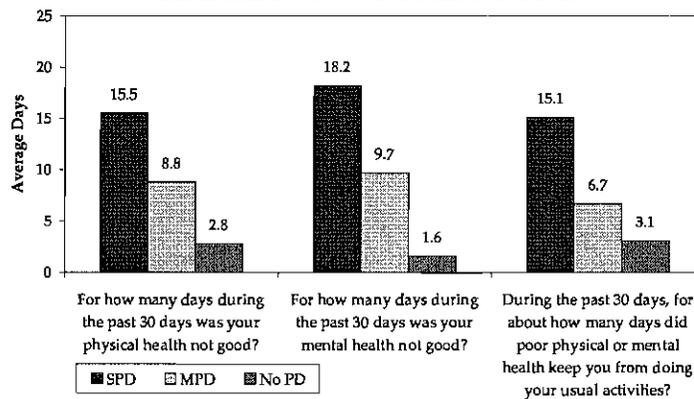
Persons experiencing serious psychological distress (SPD) often face physical health challenges as well. When asked to rate their health status (on a scale from Excellent to Poor), persons with SPD were significantly more likely than persons without SPD to identify their health status as Fair or Poor, and significantly less likely to identify their health status as Good or Excellent. Less than one percent of persons with SPD rated their health status as Excellent, compared to 19.0% of persons not experiencing psychological distress. Conversely, over half (53.2%) of persons with SPD rated their health status as Fair or Poor, compared to 27.1% of persons with mild to moderate psychological distress and 8.8% of persons not experiencing psychological distress (Figure 9).

FIGURE 9
Self-Reported Health Status for Persons Experiencing
No, Mild-Moderate or Serious Psychological Distress



When asked to indicate the number of days during the past 30 days when their physical or mental health was not good, persons with SPD said that their physical health was not good an average of 15.5 days, compared to 8.8 days for persons experiencing mild to moderate psychological distress and only 2.8 days for persons experiencing no psychological distress (Figure 10). Similarly, persons with SPD said that their mental health was not good for an average of 18.2 days in the previous 30 days, compared to an average of 9.7 days and 1.6 days for persons experiencing mild to moderate psychological distress or persons experiencing no psychological distress, respectively. When asked how many days during the past 30 days that poor physical or mental health kept them from doing their usual activities, persons with SPD reported an average of 15.1 days, compared to an average of 6.7 days for persons experiencing mild to moderate psychological distress and 3.1 days for persons not experiencing psychological distress. The differences between those with SPD and those experiencing no psychological distress were statistically significant.

FIGURE 10
Average Number of Days in Past 30 Days When Physical and/or
Mental Health Was Not Good/Affected Activities

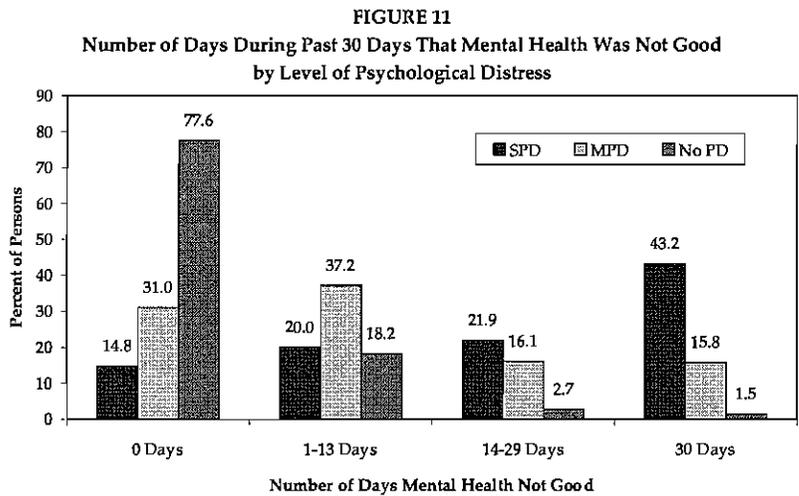


Poor physical and mental health severely limits activity for many persons. Over half (56.3%) of persons with SPD reported that poor physical or mental health kept them from doing their usual activities for 14

or more days out of the previous 30 days. Nearly one-third (31.8%) of persons with SPD reported that poor physical or mental health kept them from their usual activities every day during the previous 30 days.

Data for Nebraska were compared to data from the national sample of 35 states, the District of Columbia and Puerto Rico. The comparison revealed that respondents from Nebraska reported more days during the previous 30 days when poor physical or mental health kept them from doing their usual activities. In Nebraska, 56.3% of persons with SPD reported activity limitations 14 or more days in the previous 30 days, compared to 46.9% for the national sample. For persons without SPD the difference was even more dramatic – less than five percent of persons in the national sample reported activity limitations of 14 days or more, compared to 11.4% for Nebraska.

Three-fourths of persons not experiencing symptoms of psychological distress reported no days in the past month when their mental health was not good, compared to only 14.8% of persons with SPD and 31.0% of persons with MPD. Many (43.2%) persons with SPD reported that their mental health was not good on any of the previous 30 days compared to 1.5% of persons not experiencing psychological distress (Figure 11).



Most (69.4%) persons with SPD reported that physical, mental or emotional problems limited their physical activities, compared to only 15.1% of persons not experiencing psychological distress. When asked to indicate whether, during the past month – other than during their regular job, they participated in any physical activities or exercise such as running, calisthenics, golf, or walking for exercise, less than half (48.3%) of persons with SPD responded “yes”, compared to 79.4% of persons not experiencing psychological distress.

Respondents as a whole reported an average of less than one day (0.6) in the past 30 days when mental health or emotional problems prevented them from doing their usual activities (Table 4). Persons 45-54 years of age were significantly more likely than young adults ages 18-24 to report limited activities because of a mental health or emotional problem. Persons with annual incomes below \$25,000 were

significantly more likely to report limited activities due to a mental health or emotional problem than persons with incomes in excess of \$75,000. Persons unable to work reported almost five days in the previous 30 days when their activities were limited because of a mental health or emotional problem, significantly more than persons employed, self-employed, homemakers, students and retired persons.

TABLE 4
Average Number of Days in Past 30 Days
When Mental Health/Emotional Problems Prevented Usual Activities
(with 95% Confidence Intervals – SUDAAN)

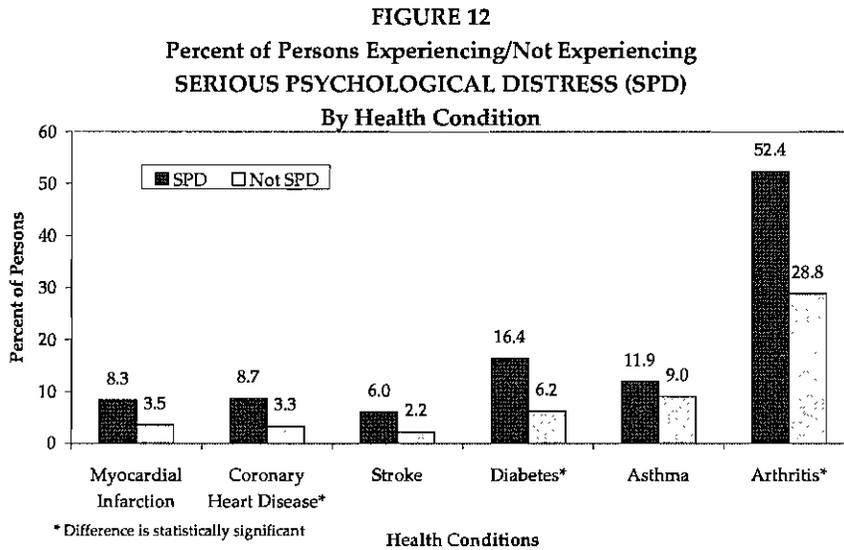
	<u># of Respondents</u>	<u>%</u>	<u>Confidence Interval</u>		<u># of Respondents</u>	<u>%</u>	<u>Confidence Interval</u>
Total	5,153	0.6	0.5-0.8	Race/Ethnicity (Age-Adjusted):			
				White, Non-Hispanic	4,792	0.6	0.4-0.8
Gender:				Non-White or Hispanic	346	0.6	0.3-0.9
Male	1,965	0.4	0.3-0.6	Marital Status:			
Female	3,188	0.8	0.5-1.0	Currently Married	3,237	0.6	0.4-0.8
Age:				Previously Married	1,366	0.9	0.6-1.3
18-24 years	163	0.2	0.1-0.4	Never Married	543	0.5	0.3-0.6
25-34 years	481	0.6	0.1-1.0	Employment Status:			
35-44 years	812	0.7	0.3-1.1	Employed	2,517	0.3	0.2-0.4
45-54 years	1,081	0.8	0.5-1.1	Self-Employed	581	0.3	0.1-0.4
55-64 years	989	0.6	0.3-0.8	Unemployed	88	3.3	0.0-6.9
65+ years	1,612	0.6	0.3-1.0	Homemaker	385	0.5	0.3-0.8
Place of Residence:				Student	63	0.3	0.0-0.6
Urban	710	0.5	0.3-0.8	Retired	1,266	0.7	0.2-1.1
Rural	4,443	0.7	0.6-0.8	Unable to Work	245	4.9	3.0-6.8
Education:				Behavioral Health Region:			
< High School	435	0.9	0.4-1.3	Region 1	510	0.8	0.4-1.1
High School Grad	4,959	0.7	0.5-0.8	Region 2	532	1.0	0.5-1.6
Some College	1,424	0.5	0.3-0.7	Region 3	1,017	0.7	0.4-1.0
College Graduate	1,330	0.6	0.2-1.0	Region 4	1,310	0.7	0.5-0.9
Annual Income:				Region 5	1,060	0.5	0.1-0.9
< \$15,000	462	1.7	1.1-2.3	Region 6	702	0.6	0.3-0.8
\$15,000 - \$24,999	881	1.2	0.7-1.6				
\$25,000 - \$49,999	1,520	0.7	0.3-1.1				
\$50,000 - \$74,999	784	0.4	0.1-0.7				
\$75,000+	905	0.2	0.1-0.3				

NOTE: "Number" and "Percent" exclude missing, don't know, and refused responses.

Persons experiencing serious psychological distress averaged 11.0 days during the previous 30 days when mental health or emotional problems prevented them from doing their usual activities, compared to an average of only 0.4 days for persons not experiencing serious psychological distress. The sample size for persons experiencing SPD was too small to analyze demographic differences in the average number of days during the past 30 days when mental health or emotional problems prevented persons from doing their usual activities.

Health Conditions Associated with Psychological Distress

Persons experiencing serious psychological distress are significantly more likely than persons not experiencing psychological distress to have been diagnosed with certain chronic health conditions including coronary heart disease, diabetes and arthritis (Figure 12). They are also more likely to have been told by a doctor or other health professional that they had had a myocardial infarction (heart attack) or a stroke, although the difference between those with SPD and those without SPD was not statistically significant. Even persons experiencing mild-to-moderate psychological distress were significantly more likely than persons with no psychological distress to have been diagnosed with coronary heart disease or diabetes.

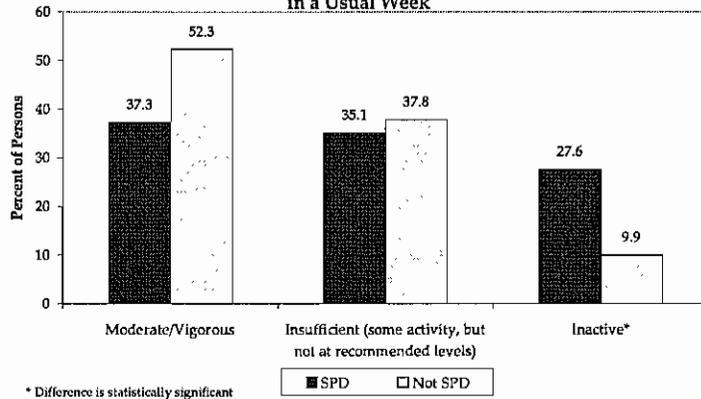


Over half (53.4%) of persons experiencing mild-to-moderate psychological distress or serious psychological distress (52.5%) reported having been told by a health care professional that their cholesterol was high, compared to 35.1% of persons not experiencing psychological distress.

Health Risk Factors Associated with Psychological Distress

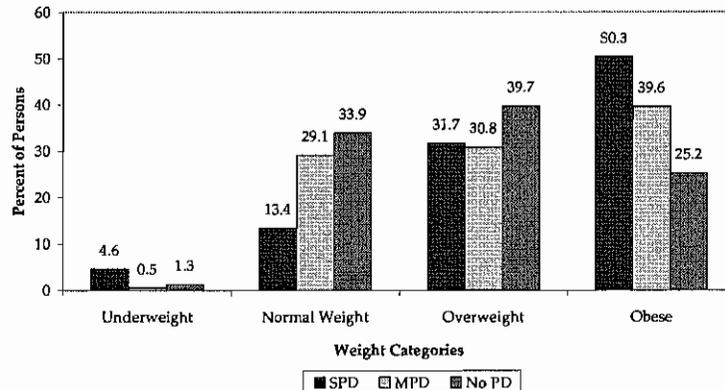
There are a number of health risk factors associated with serious psychological distress. One of those risk factors, lack of physical activity, has been found to be associated with psychological distress. To measure their level of physical activity, respondents were asked a series of questions about their level of physical activity during a usual week. Based upon their responses to those questions, respondents were classified into one of three categories: moderate to vigorous physical activity, insufficient activity (i.e., there was some physical activity, but not at recommended levels), and inactive. Persons with SPD were less likely than persons with no SPD to participate in moderate or vigorous exercise, and were significantly more likely to be classified as physically inactive (Figure 13).

FIGURE 13
Self-Reported Level of Physical Activity
in a Usual Week



Another risk factor associated with psychological distress is obesity. To determine whether respondents had problems associated with weight, each respondent was asked to report their height and weight. These data were then converted into a Body Mass Index (BMI) for each individual. For adults, a BMI of less than 18.5 is classified as **underweight**. A BMI of 18.5 – 24.9 is classified as **normal weight**. A BMI of 25.0 – 29.9 is classified as **overweight**, and a BMI of 30.0 or more is classified as **obese**. The survey found that half (50.3%) of persons experiencing serious psychological distress (SPD) were classified as obese, compared to 39.6% of persons experiencing mild to moderate psychological distress and 25.2% of persons experiencing no psychological distress in the past 30 days. Persons with SPD were slightly more likely to be classified as underweight (4.6%). Only 13.4% of persons with SPD were considered to be of normal weight (Figure 14).

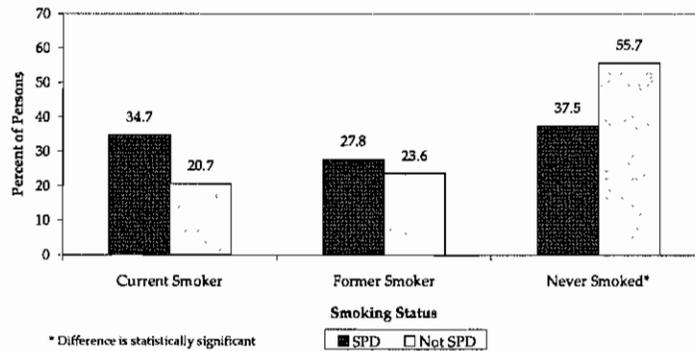
FIGURE 14
Percent of Persons Experiencing Psychological Distress
By Weight Category



Smoking is another risk factor often associated with psychological distress. About one in three (34.7%) persons with serious psychological distress (SPD) are current smokers, compared to one in five (20.7%) persons without SPD (Figure 15). Persons without SPD (55.7%) were significantly more likely than persons with SPD (37.5%) to have never smoked. Among persons with SPD who currently smoke, two-thirds (66.6%) indicated that they had stopped smoking for one day or longer within the previous 12

months because they were trying to quit smoking, compared to 47.8% of persons not experiencing psychological distress who currently smoke.

FIGURE 15
Percent of Persons Experiencing/Not Experiencing
SERIOUS PSYCHOLOGICAL DISTRESS (SPD)
By Smoking Status



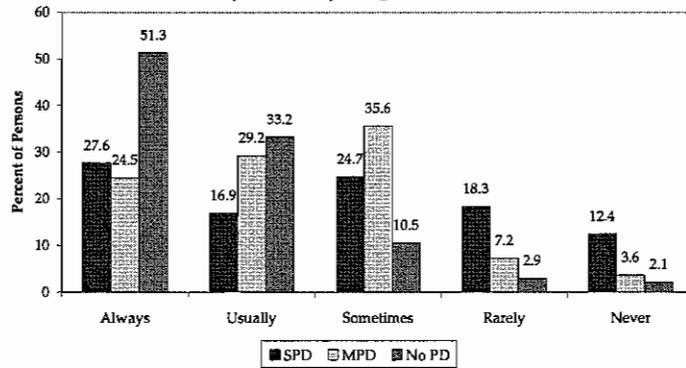
Misuse of alcohol does not appear to be a problem among persons with SPD. Persons experiencing serious psychological distress (8.8%) in the past 30 days were less likely than persons experiencing mild to moderate psychological distress (14.3%) or persons experiencing no psychological distress (17.3%) to engage in binge drinking, i.e., drinking five or more drinks on one occasion. Persons with SPD (2.5%) were also less likely in the past 30 days to have engaged in heavy drinking than persons with MPD (7.2%) or persons with no psychological distress (4.2%).

Emotional Support and Life Satisfaction

The BRFSS included two questions intended to measure the level of social and emotional support received by survey respondents (“How often do you get the social and emotional support you need?”) and their overall satisfaction with life (“In general, how satisfied are you with your life?”).

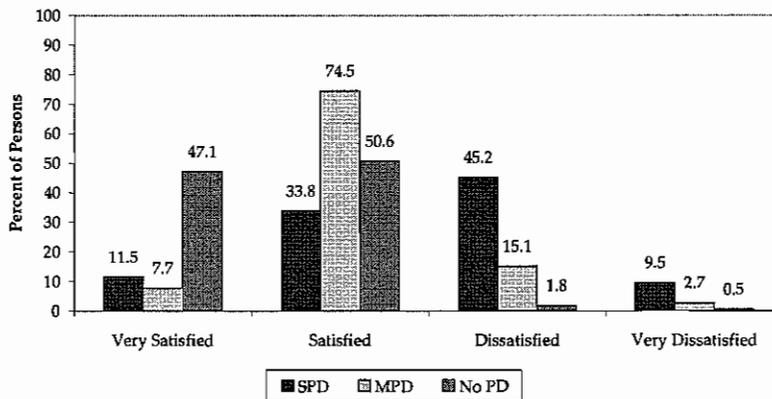
When asked how often they get the social and emotional support they need, about half of all respondents indicated “always” (49.0%). Only about 2.1% indicated that they never receive the social and emotional support they need. However, when persons with SPD were asked this question, 30.7% indicated that they rarely or never receive the social and emotional support they need, compared to 10.8% of persons with MPD and 5.0% of persons experiencing no psychological distress (Figure 16).

FIGURE 16
How Often Do You Get the Social and Emotional Support You Need?
by Level of Psychological Distress



Most persons (95.4%), when asked how satisfied they were with their life, indicated that they were either satisfied or very satisfied with their life. However, less than half (45.3%) of persons experiencing serious psychological distress indicated that they were satisfied or very satisfied with their life. About an equal number of persons with SPD indicated they were either very satisfied with their life (11.5%) or very dissatisfied with their life (9.5%) – most were between the two extremes (Figure 17).

FIGURE 17
In General, How Satisfied Are You With Your Life?
by Level of Psychological Distress



Who Receives Mental Health Treatment?

Respondents were asked whether they are currently taking medicine or receiving treatment from a doctor or other health professional for any type of mental health condition or emotional problem. Overall, 10.9% of respondents reported currently receiving treatment for a mental health condition or emotional problem. Women (13.7%) were significantly more likely than men (7.9%) to report receiving mental health treatment, and persons with incomes under \$15,000 (19.8%) were significantly more likely to report receiving mental health treatment than persons with incomes of \$25,000-49,999 (10.6%). By Behavioral Health Region, the rate of persons receiving mental health treatment ranged from 8.3% in Region 4 to 12.5% in Region 3, although the difference was not statistically significant (Table 5).

TABLE 5
Percent of Nebraska Adults
Now Taking Medication or Receiving Treatment for a Mental Health Condition or Emotional Problem
(with 95% Confidence Intervals – SUDAAN)

	<u># of Respondents</u>	<u>%</u>	<u>Confidence Interval</u>		<u># of Respondents</u>	<u>%</u>	<u>Confidence Interval</u>
Total	5,174	10.9	9.3-12.6	Race/Ethnicity (Age-Adjusted):			
				White, Non-Hispanic	4,812	10.4	8.7-12.4
Gender:				Non-White or Hispanic	347	13.4	8.5-20.5
Male	1,968	7.9	5.7-10.8	Marital Status:			
Female	3,206	13.7	11.7-16.1	Currently Married	3,238	10.2	8.5-12.3
Age:				Previously Married	1,385	14.2	11.3-17.6
18-24 years	163	7.3	2.6-18.7	Never Married	544	10.4	6.2-16.9
25-34 years	483	10.1	6.2-16.0	Employment Status:			
35-44 years	810	12.0	9.1-15.7	Employed	2,513	9.6	7.6-12.2
45-54 years	1,079	13.3	10.1-17.5	Self-Employed	582	8.5	5.0-14.2
55-64 years	995	13.1	10.0-16.9	Unemployed	89	##	##
65+ years	1,629	8.6	6.7-10.9	Homemaker	384	7.6	4.8-11.8
Place of Residence:				Student	63	3.7	1.3-10.1
Urban	713	11.5	8.8-15.0	Retired	1,284	10.4	7.8-13.8
Rural	4,461	10.2	9.1-11.5	Unable to Work	##	##	##
Education:				Behavioral Health Region:			
< High School	439	10.8	6.9-16.6	Region 1	510	11.0	8.2-14.7
High School Grad	1,975	10.7	8.2-13.8	Region 2	536	9.7	6.6-14.0
Some College	1,425	10.2	7.8-13.3	Region 3	1,022	12.5	9.9-15.8
College Graduate	1,330	11.6	8.6-15.5	Region 4	1,315	8.3	6.8-10.1
Annual Income:				Region 5	1,065	9.3	6.8-12.7
< \$15,000	469	19.8	14.3-26.7	Region 6	704	12.2	9.1-16.2
\$15,000 - \$24,999	888	13.4	10.0-17.7				
\$25,000 - \$49,999	1,520	10.6	7.8-14.1				
\$50,000 - \$74,999	782	10.4	7.2-14.7				
\$75,000+	906	10.1	6.7-15.0				

NOTE: "Number" and "Percent" exclude missing, don't know, and refused responses.

- The data are not reported if the confidence interval half width was > 10.

Urban residents were slightly more likely than rural residents to be receiving treatment. Non-white or Hispanic persons (13.4%) were more likely to report receiving mental health services than White, non-Hispanic persons (10.4%) and previously married persons (14.2%) were more likely than currently married persons (10.2%) or persons who had never married (10.4%) to report receiving mental health treatment. Again, the differences were not statistically significant.

More than half (55.0%) of persons experiencing serious psychological distress (SPD) within the previous 30 days reported receiving mental health services, compared to 37.2% of persons experiencing mild to moderate psychological distress and 7.7% of persons experiencing no mental distress. (The proportion of persons with SPD being treated for their mental health or emotional problem is higher in Nebraska than the national average, 55.0% versus 46.6%, respectively.) The confidence intervals were too large to report whether these results were statistically significant. In addition, the sample size was too small to compare

demographic differences in receipt of mental health services between persons with SPD and those with no SPD.

Attitudes Toward Mental Illness and Its Treatment

Two questions were included in the Mental Illness and Stigma module to gauge people's attitudes toward mental illness and its treatment. The first question measured respondents' level of agreement to the following statement: *Treatment can help people with mental illness lead normal lives.* Persons who were non-white or Hispanic were significantly more likely than White, non-Hispanic persons to strongly disagree with this statement. When compared to the average respondent, older adults ages 55-64 and persons with a college degree were significantly more likely to strongly agree, while persons with less than a high school education were significantly more likely to slightly or strongly disagree that treatment can help persons with mental illness lead normal lives.

Persons experiencing no psychological distress (69.0%) and persons experiencing mild to moderate psychological distress (68.6%) were more likely than persons experiencing serious psychological distress (39.0%) to strongly agree that treatment can help people with mental illness lead normal lives. However, the opposite was true for persons slightly agreeing that treatment can help people with mental illness lead normal lives: no SPD (24.8%), MPD (26.3%) and SPD (48.1%). The confidence intervals were too large to report whether these differences were statistically significant.

Persons currently receiving mental health treatment (81.0%) were significantly more likely than persons not currently receiving mental health treatment (66.5%) to strongly agree that treatment can help people with mental illness lead normal lives. Persons receiving mental health treatment in urban areas (87.8%) were significantly more likely than persons receiving mental health treatment in rural areas (73.5%) to strongly agree that treatment can help people with mental illness lead normal lives.

The second question measured respondents' level of agreement with the following statement: *People are generally caring and sympathetic to people with mental illness.* This question yielded more varied responses than the first question. Persons with less than a high school education were significantly more likely than persons with a college degree to strongly agree that people are generally caring and sympathetic to people with mental illness. Older adults ages 65 and over were significantly more likely than younger persons to strongly agree with the statement. Persons with annual incomes of less than \$15,000 were significantly more likely than persons with incomes in excess of \$75,000 to strongly agree with the statement. Non-white or Hispanic persons were significantly more likely than White, non-Hispanic persons to strongly agree with the statement and persons from Region 4 were significantly more likely than persons from Region 1 to strongly agree with the statement. Conversely, persons unable to work were significantly more likely than persons who were employed, unemployed or retired to strongly disagree that people are generally caring and sympathetic to people with mental illness. Persons previously married were significantly more likely to strongly disagree with the statement than persons currently married. Persons ages 35 and over were significantly more likely than persons under 25 years of age to strongly disagree with the statement.

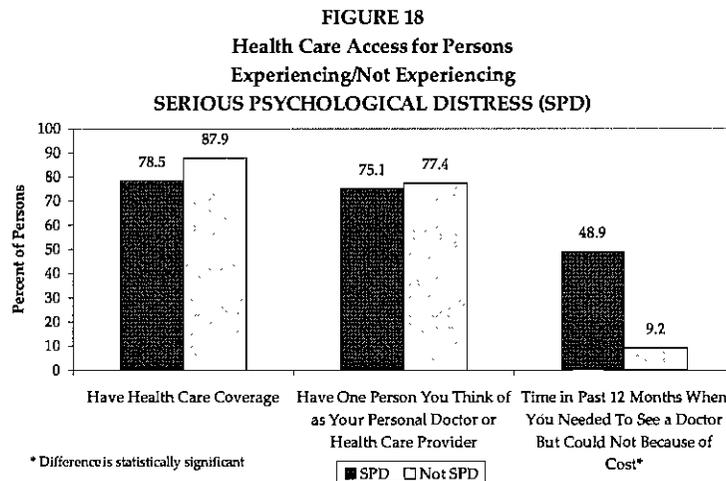
Most persons not experiencing psychological distress in the past 30 days (64.0%) agreed that people are generally caring and empathetic to people with mental illness, a view not widely shared by persons experiencing mild to severe psychological distress. About one in five persons with serious psychological distress (22.5%), or mild to moderate psychological distress (19.8%), strongly disagreed that people are

generally caring and sympathetic to people with mental illness, compared to only 7.1% of persons not experiencing psychological distress. Again, the confidence intervals were too large to report whether these differences were statistically significant.

Access to Health Care

Most (87.9%) persons without SPD reported having health care coverage, such as private or public health insurance, compared to 78.5% of persons with SPD, a difference that is not statistically significant. (These figures are a little higher than the national average of 83.6% for persons with SPD and 67.6% of persons without SPD.) While still not statistically significant, there is a difference in Nebraska in health care coverage between those 18 and 64 years of age and those 65 years of age and older. The vast majority (94.6%) of persons ages 65+ with SPD reported having health care coverage, compared to only 75.1% of persons ages 18-64 with SPD. It is important to note that the BRFSS asked respondents whether they had “any kind of health care coverage including health insurance, pre-paid plans such as HMOs, or government plans such as Medicare.” Respondents were not asked whether their health care coverage includes mental health care benefits, or the extent to which mental health care is covered.

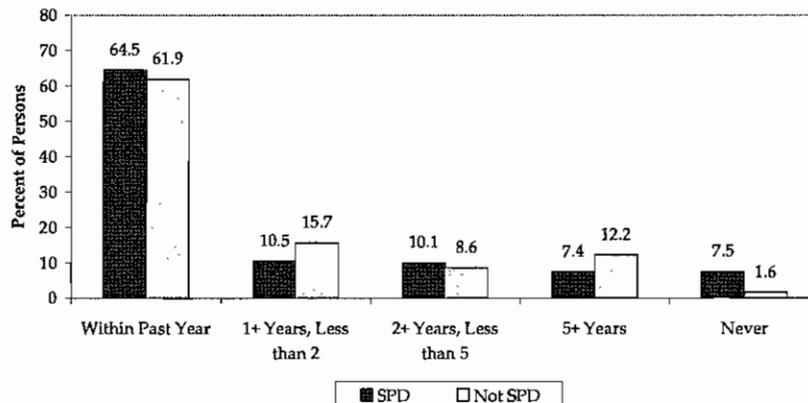
The proportion of persons reporting that they have one person who they think of as their personal doctor or health care provider was similar for both persons with SPD and persons without SPD, with 75.1% and 77.4%, respectively. However, when asked whether there was a time in the past 12 months when they needed to see a doctor but could not because of cost, nearly half (48.9%) of persons with SPD said “yes”, compared to only 9.2% of persons without SPD (Figure 18), a difference that was statistically significant. Thirty percent of persons experiencing mild to moderate psychological distress indicated that there had been a time in the past 12 months when they needed to see a doctor but could not because of cost.



However, when asked how long it had been since they last visited a doctor for a routine checkup (i.e., for a general physical exam), most persons, both those with SPD (64.5%) and those without SPD (61.9%), indicated that they had visited the doctor for a routine checkup within the past year (Figure 19). However, while the numbers are small, persons with mild-to-moderate psychological distress (4.6%)

were significantly more likely than persons with no psychological distress (1.4%) to report never having received a routine checkup.

FIGURE 19
Time Last Visited Doctor for Routine Checkup
for Persons Experiencing/Not Experiencing
SERIOUS PSYCHOLOGICAL DISTRESS (SPD)



Discussion

In 2007, 2.5% of Nebraska adults experienced serious psychological distress (SPD) in the 30 days prior to the survey. Another 6.7% of Nebraska adults experienced symptoms of mild to moderate psychological distress. The results of this study confirm what we already knew – that a person’s physical and mental health are interrelated, making a compelling argument for better integration and coordination of mental health and primary care services, especially for those persons experiencing serious psychological distress.

The results of the study also point to three health risk factors associated with serious psychological distress: lack of physical activity, obesity and smoking. Persons with SPD were significantly more likely to be considered physically inactive than persons with no SPD. They were also twice as likely as persons without SPD to be classified as obese based upon the Body Mass Index. In addition, one-third of persons with SPD reported that they currently smoke. (This last statistic is consistent with a study published in 2000 in the Journal of the American Medical Association which estimated that persons with a diagnosable mental disorder in the past month consume nearly half of all cigarettes smoked in the United States (Lasser, et al., 2000). Lasser, et al. also reported that smoking complicates the treatment of some mental disorders by decreasing blood levels of neuroleptics. As a result, persons that smoke may require larger doses of some medications to achieve therapeutic effect, thereby running an increased risk of adverse effects.) The good news is that two-thirds of the persons with SPD that smoke made at least one attempt in the previous year to quit smoking. Even a small, gradual increase in physical activity, or decrease in smoking, can lead to appreciable improvement in a person’s overall health status.

There were many positive findings in this study. For example, persons with serious psychological distress do not appear to misuse alcohol. Persons with SPD were less likely than persons with mild to moderate or no psychological distress to engage in binge drinking (i.e., drinking five or more drinks on one occasion for men and four or more drinks on one occasion for women) or in heavy drinking.

Persons in Nebraska with SPD are a little more likely than their counterparts in other states to report receiving treatment for their mental health or emotional problem (55.0% in Nebraska versus 46.6% nationwide).

Another positive finding is that most persons with SPD have some form of health care coverage, although it is not known whether mental health care is included in their health care coverage. In addition, most persons with SPD have one person that they think of as their personal doctor or health care provider. Most reported having received a routine checkup within the past year. Unfortunately, nearly half of persons with SPD reported that there had been at least one time in the past year when they needed to see a doctor but could not because of cost. This suggests that work still needs to be done to improve access to health care services for persons with serious psychological distress.

Limitations of the Study

The study was subject to several limitations. First, the BRFSS is a telephone survey of non-institutionalized adults. This raises the possibility of self-report bias resulting in an under reporting of psychological distress. In addition, persons without land line telephones, including those with cellular phones only, were not included. Persons in institutions such as nursing homes or psychiatric hospitals were not included, suggesting the possibility that the 30-day prevalence of serious psychological distress may actually be higher in Nebraska than 2.5%.

Second, the author followed the practice of the Centers for Disease Control and Prevention of suppressing data when the denominator for a percent or rate was less than 50, or when the confidence interval half-width was greater than 10. These rules are followed because of the questionable reliability of rates having these characteristics. As a result, some survey results were not reported. A larger sample size should eliminate this problem. Therefore, for the 2009 report, data will be combined from the 2007 and 2009 BRFSS. This combining of data for two years should allow for more analysis of differences among persons with serious psychological distress and a more detailed breakout of the race/ethnicity category.

References

- Dinghra, S.S., Strine, T.W., Holt, J.B., Berry, J.T., and Modkad, A.H. (2009). *Rural-Urban Variations in Psychological Distress: Findings From the Behavioral Risk Factor Surveillance System, 2007*. *International Journal of Public Health*, 54, 16-22.
- Kessner, R.C., Andrews, G., Colpe, L.J., Hiripi, E., Mroczek, D.K., Normand, S.L.T., Walters, E.E., and Zaslavsky, A.M. (2002). *Short Screening Scales to Monitor Population Prevalences and Trends in Non-specific Psychological Distress*. *Psychological Medicine*, 32, 959-976.
- Lasser, K., Boyd, J.W., Woolhandler, S., Himmelstein, D.U., McCormick, D., and Bor, D.H. (2000). *Smoking and Mental Illness: A Population-Based Prevalence Study*. *Journal of the American Medical Association*, 284, 2606-2610.
- McKnight-Eily, L.R., Elam-Evans, L.D., Strine, T.W., Zack, M.M., Perry, G.S., Presley-Cantrell, L., Edwards, V.J., and Croft, J.B. (2009). *Activity Limitation, Chronic Disease, and Comorbid Serious Psychological Distress in U.S. Adults – BRFSS 2007*. *International Journal of Public Health*, 54, 111-119.
- Pratt, L. A., Dey, A. N., & Cohen, A. J. (2007). *Characteristics of Adults with Serious Psychological Distress as Measured by the K6 Scale: United States, 2001-04*. *Advance Data*, 382, 1-19.
- Strine, T.W., Satvinder, S.D., Okoro, C.A., Zack, M.M., Balluz, J.T.B., and Mokdad, A.H. (2009). *State-Based Differences in the Prevalence and Characteristics of Untreated Persons with Serious Psychological Distress*. *International Journal of Public Health*, 54, 9-15.
- U.S. Department of Health and Human Services (1999). *Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

Appendix

Table A1

Q1. About how often during the past 30 days did you feel nervous?

	Total # of Respondents	All of the time		Most of the time		Some of the time		A little of the time		None of the time	
		%	CI	%	CI	%	CI	%	CI	%	CI
Total	5,197	1.5	0.9-2.5	3.5	2.7-4.5	15.3	13.3-17.6	36.9	34.2-39.6	42.8	40.1-45.7
Gender:											
Male	1,982	1.6	0.8-3.3	3.6	2.4-5.4	13.9	11.1-17.4	35.0	30.9-39.3	45.8	41.5-50.3
Female	3,215	1.4	0.7-2.7	3.4	2.6-4.4	16.6	13.9-19.8	38.7	35.3-42.2	39.9	36.6-43.4
Age:											
18-24	163	2.5	0.8-7.7	2.0	0.6-6.6	12.3	6.1-23.3	43.5	30.9-57.1	##	##
25-34	485	1.6	0.4-6.5	2.7	1.2-5.7	18.6	12.6-26.6	39.7	32.1-47.8	37.4	30.3-45.0
35-44	819	1.0	0.5-2.0	4.3	2.6-6.9	13.4	9.5-18.6	34.4	28.8-40.4	47.0	40.6-53.5
45-54	1,083	2.2	0.8-5.8	5.3	3.2-8.5	14.3	10.9-18.6	38.3	33.6-43.2	39.9	35.1-44.9
55-64	998	1.5	0.7-3.0	2.5	1.6-3.9	15.7	12.0-20.3	32.8	28.3-37.7	47.6	42.1-53.1
65+	1,634	0.7	0.4-1.3	3.5	2.3-5.2	15.9	13.1-19.2	34.5	31.0-38.1	45.5	41.7-49.4
Place of Residence:											
Urban	716	1.6	0.6-3.7	3.3	2.0-5.2	15.9	12.2-20.3	35.1	30.2-40.3	44.2	39.1-49.5
Rural	4,481	1.5	1.1-2.0	3.7	3.1-4.5	14.7	13.4-16.2	38.7	36.8-40.6	41.4	39.5-43.4
Education:											
<High School	443	5.2	1.8-13.6	3.5	2.0-6.2	15.8	11.3-21.6	##	##	##	##
High School	1,985	1.7	0.9-3.0	4.0	2.8-5.6	13.7	10.9-17.1	39.0	34.2-44.0	41.7	37.0-46.6
Some College	1,431	0.7	0.3-1.3	2.9	1.6-5.0	15.1	11.4-19.7	40.0	35.0-45.3	41.4	36.2-46.8
College Degree	1,333	1.2	0.4-4.2	3.5	2.1-5.7	17.0	12.9-22.1	33.5	29.1-38.1	44.8	39.9-49.9
Income:											
< \$15,000	474	2.7	1.4-5.1	10.0	5.8-16.6	19.0	13.8-25.5	30.7	23.7-38.7	37.6	29.8-46.2
\$15,000-24,999	887	5.2	2.5-10.5	3.9	2.6-5.7	22.9	16.4-31.0	33.2	26.4-40.8	34.8	28.8-41.4
\$25,000-49,999	1,529	0.7	0.4-1.3	4.3	2.6-7.0	14.3	10.9-18.6	38.6	33.9-43.6	42.1	37.0-47.3
\$50,000-74,999	783	0.5	0.2-1.2	2.3	1.2-4.5	16.4	11.3-23.3	35.2	29.2-41.7	45.6	39.0-52.4
\$75,000+	911	1.5	0.4-5.1	1.5	0.7-3.3	12.0	8.5-16.7	40.2	34.4-46.3	44.8	39.0-50.8
Race/Ethnicity (age-adjusted):											
White, non-Hispanic	4,830	1.0	0.7-1.5	3.4	2.6-4.4	15.3	13.1-17.9	38.5	35.4-41.7	41.8	38.7-45.0
Non-White or Hispanic	352	4.8	1.7-12.7	3.0	1.4-6.5	14.9	8.9-23.9	30.6	23.3-39.1	46.7	37.8-55.8
Marital Status:											
Currently Married	3,253	1.4	0.7-2.8	3.1	2.3-4.1	14.4	12.1-17.0	36.1	33.2-39.2	45.0	41.8-48.3
Previously Married	1,389	1.9	1.2-3.3	4.2	2.9-6.1	17.3	13.7-21.5	33.6	29.2-38.3	43.0	38.2-48.0
Never Married	548	1.6	0.6-4.3	4.5	2.3-8.5	16.5	10.7-24.8	42.3	33.7-51.4	35.0	27.0-44.0
Employment:											
Employed	2,530	1.2	0.5-2.7	3.4	2.4-4.8	16.4	13.4-20.0	37.2	33.4-41.2	41.8	37.9-45.9
Self-employed	580	2.2	0.6-8.5	2.3	1.4-3.8	13.9	9.6-19.5	37.5	31.3-44.2	44.1	37.5-50.9
Unemployed	91	2.9	1.0-8.6	4.0	1.6-9.7	20.1	7.6-43.5	##	##	##	##
Homemaker	388	0.6	0.2-1.8	1.1	0.5-2.1	11.4	8.0-16.1	##	##	##	##
Student	63	##	##	4.4	0.8-20.2	7.1	2.8-16.8	##	##	##	##
Retired	1,285	1.0	0.5-1.9	3.0	1.9-4.9	13.5	10.7-17.0	34.1	30.1-38.3	48.4	44.0-52.9
Unable to Work	252	5.8	3.2-10.2	13.4	7.3-23.6	19.1	12.5-28.0	19.8	13.9-27.5	##	##
Behavioral Health Region:											
Region 1	515	1.2	0.5-2.5	2.9	1.7-5.0	11.4	8.8-14.8	40.7	35.1-46.6	43.8	38.1-49.6
Region 2	537	0.8	0.3-2.0	5.4	2.9-9.8	13.4	9.6-18.3	36.8	30.8-43.2	43.6	37.2-50.4
Region 3	1,026	2.4	1.4-4.0	4.1	2.9-5.7	15.9	12.9-19.3	40.3	36.3-44.4	37.3	33.4-41.5
Region 4	1,319	2.0	1.2-3.3	3.7	2.7-5.1	16.2	13.8-18.9	38.9	35.8-42.1	39.2	36.1-42.5
Region 5	1,070	0.5	0.2-1.2	3.4	1.9-6.0	12.6	9.3-16.8	41.9	35.8-48.2	41.6	36.0-47.4
Region 6	708	1.9	0.8-4.7	3.0	1.8-5.1	17.4	13.2-22.6	31.7	26.8-37.1	46.0	40.4-51.7

NOTE: "Number" and "Percent" exclude missing, don't know, and refused responses.

- The data are not reported if the confidence interval half width was > 10.

Table A2

Q2. About how often during the past 30 days did you feel hopeless?

	Total # of Respondents	All of the time		Most of the time		Some of the time		A little of the time		None of the time	
		%	CI	%	CI	%	CI	%	CI	%	CI
Total	5,196	0.4	0.3-0.6	1.3	0.8-1.9	4.5	3.5-5.8	11.0	9.4-12.8	82.9	80.7-84.8
Gender:											
Male	1,985	0.2	0.1-0.5	0.9	0.4-1.8	4.3	2.8-6.6	8.7	6.8-11.0	85.9	82.9-88.5
Female	3,211	0.5	0.3-0.9	1.6	0.9-2.8	4.7	3.6-6.2	13.3	10.9-16.1	79.8	76.8-82.6
Age:											
18-24	163	0.3	0.0-2.1	0.3	0.1-1.3	2.0	1.0-4.3	9.5	5.1-17.0	87.9	80.3-92.8
25-34	485	0.3	0.1-0.7	0.3	0.1-0.7	3.1	1.5-6.4	14.7	9.5-22.0	81.8	74.4-87.3
35-44	817	0.5	0.2-1.6	1.8	0.9-3.4	5.6	3.1-10.2	8.3	6.3-10.9	83.8	79.2-87.5
45-54	1,082	0.2	0.1-0.6	3.3	1.5-6.9	6.7	4.0-11.0	10.0	7.6-13.0	79.8	74.9-84.0
55-64	999	0.4	0.2-0.8	0.7	0.3-1.3	3.7	2.1-6.3	11.5	8.5-15.4	83.9	79.6-87.4
65+	1,635	0.6	0.3-1.3	0.7	0.4-1.3	4.9	3.5-6.7	11.3	9.2-13.9	82.5	79.5-85.1
Place of Residence:											
Urban	715	0.2	0.1-0.6	1.3	0.6-2.8	4.1	2.4-6.7	10.1	7.4-13.7	84.3	80.2-87.7
Rural	4,481	0.6	0.4-0.9	1.2	0.9-1.6	5.0	4.2-5.9	11.9	10.7-13.2	81.4	79.8-82.8
Education:											
<High School	443	1.3	0.5-2.9	5.5	2.1-13.8	5.8	3.7-8.9	16.7	10.7-25.1	70.7	61.3-78.6
High School	1,982	0.5	0.2-0.9	1.1	0.7-1.9	4.5	3.1-6.3	11.6	9.4-14.4	82.3	79.2-85.1
Some College	1,431	0.4	0.1-1.0	0.9	0.3-2.1	3.2	2.2-4.7	9.3	7.1-12.1	86.2	83.1-88.9
College Degree	1,335	0.1	0.0-0.5	0.6	0.3-1.5	5.3	3.1-8.9	10.3	7.1-14.7	83.6	78.7-87.6
Income:											
< \$15,000	471	2.3	1.2-4.4	2.4	1.2-4.9	9.7	6.1-15.0	17.7	12.4-24.6	67.9	60.2-74.7
\$15,000-24,999	889	1.0	0.5-2.3	4.9	2.4-9.5	6.3	4.3-9.2	20.3	14.0-28.5	67.5	59.6-74.5
\$25,000-49,999	1,529	0.1	0.0-0.4	0.8	0.4-1.8	5.5	3.4-8.7	12.4	9.6-15.9	81.2	77.0-84.8
\$50,000-74,999	784	0.4	0.1-1.3	0.7	0.1-3.5	2.0	1.1-3.8	8.2	5.2-12.7	88.7	84.0-92.2
\$75,000+	909	0.1	0.0-0.4	0.1	0.0-0.3	3.1	1.3-7.1	5.5	3.7-8.1	91.3	87.4-94.0
Race/Ethnicity (age-adjusted):											
White, non-Hispanic	4,829	0.3	0.2-0.6	1.0	0.7-1.6	4.3	3.3-5.7	9.5	8.1-11.1	84.8	82.9-86.6
Non-White or Hispanic	352	0.5	0.1-1.6	2.9	0.8-9.9	6.0	2.7-12.7	18.2	12.0-26.6	72.4	62.9-80.2
Marital Status:											
Currently Married	3,253	0.3	0.1-0.6	1.3	0.7-2.3	4.3	3.1-6.1	8.8	7.3-10.6	85.3	82.9-87.4
Previously Married	1,388	0.9	0.5-1.7	1.7	0.9-3.1	7.2	5.1-10.0	12.7	10.3-15.5	77.5	73.8-80.9
Never Married	548	0.3	0.1-1.1	0.8	0.4-1.6	3.1	1.7-5.4	17.1	11.6-24.6	78.7	71.2-84.6
Employment:											
Employed	2,528	0.2	0.1-0.4	0.8	0.3-1.8	4.2	2.9-6.0	9.9	7.8-12.5	85.0	82.0-87.6
Self-employed	581	0.4	0.1-2.2	2.3	0.6-8.2	2.3	1.2-4.7	8.7	5.6-13.2	86.3	80.7-90.4
Unemployed	91	0.7	0.1-3.5	0.8	0.2-3.4	##	##	##	##	##	##
Homemaker	387	0.7	0.2-2.1	0.4	0.1-1.2	3.6	2.1-6.2	15.4	9.3-24.3	80.0	71.2-86.6
Student	63	0.0	---	0.6	0.1-3.1	1.5	0.5-4.5	##	##	##	##
Retired	1,287	0.4	0.1-1.1	0.9	0.5-1.5	4.2	2.8-6.3	11.5	8.9-14.6	83.1	79.6-86.1
Unable to Work	251	3.6	1.6-7.7	10.0	5.1-18.8	14.7	8.3-24.8	11.3	7.4-16.8	##	##
Behavioral Health Region:											
Region 1	514	0.7	0.2-2.0	1.4	0.7-2.8	4.2	2.8-6.3	12.8	9.5-17.0	80.9	76.4-84.7
Region 2	537	0.3	0.1-1.5	2.4	1.2-4.7	5.1	2.7-9.6	10.5	7.0-15.4	81.7	76.0-86.3
Region 3	1,025	1.0	0.4-2.3	1.0	0.6-1.9	5.2	3.8-7.1	12.2	9.9-15.0	80.6	77.4-83.5
Region 4	1,319	0.5	0.3-1.0	0.9	0.5-1.7	5.4	4.1-7.0	13.3	11.2-15.7	80.0	77.2-82.5
Region 5	1,071	0.2	0.1-0.6	0.8	0.4-1.4	3.6	2.0-6.3	9.9	6.9-14.0	85.6	81.1-89.1
Region 6	708	0.2	0.1-0.7	1.5	0.6-3.5	4.6	2.7-7.6	10.5	7.5-14.5	83.2	78.6-87.0

NOTE: "Number" and "Percent" exclude missing, don't know, and refused responses.

- The data are not reported if the confidence interval half width was > 10.

Table A3

Q3. About how often during the past 30 days did you feel restless or fidgety?

	Total # of Respondents	All of the time		Most of the time		Some of the time		A little of the time		None of the time	
		%	CI	%	CI	%	CI	%	CI	%	CI
Total	5,185	2.0	1.3-3.1	2.3	1.7-3.2	15.1	12.9-17.5	27.8	25.3-30.5	52.8	49.9-55.6
Gender:											
Male	1,979	2.7	1.5-4.8	2.5	1.5-4.1	14.6	11.4-18.6	26.1	22.4-30.3	54.0	49.6-58.4
Female	3,206	1.3	0.8-2.2	2.2	1.5-3.2	15.5	12.8-18.6	29.5	26.2-32.9	51.6	48.0-55.1
Age:											
18-24	163	2.3	0.6-7.9	1.0	0.3-3.1	##	##	##	##	##	##
25-34	483	2.7	0.8-8.6	3.1	1.6-5.9	19.4	12.9-28.0	24.0	17.9-31.4	50.8	42.8-58.8
35-44	816	2.2	1.3-3.8	2.6	1.3-5.3	13.6	9.6-19.0	30.2	24.7-36.5	51.3	44.9-57.7
45-54	1,083	2.3	1.1-4.5	2.8	1.1-6.6	15.1	11.8-19.1	27.6	23.4-32.3	52.2	47.1-57.3
55-64	997	1.6	0.8-3.2	1.9	1.0-3.5	14.5	11.3-18.5	28.0	23.2-33.4	54.0	48.5-59.4
65+	1,628	0.9	0.5-1.6	1.9	1.2-2.9	11.7	9.5-14.3	25.5	22.3-29.0	60.1	56.3-63.8
Place of Residence:											
Urban	715	2.2	1.1-4.5	2.1	1.1-4.0	15.3	11.5-20.2	28.9	24.3-34.0	51.5	46.2-56.8
Rural	4,470	1.9	1.4-2.5	2.6	2.0-3.3	14.8	13.4-16.2	26.7	25.0-28.5	54.1	52.1-56.1
Education:											
<High School	443	3.3	1.1-9.6	4.8	1.9-11.7	##	##	21.0	14.2-30.0	##	##
High School	1,978	1.8	1.1-3.1	2.7	1.7-4.3	15.2	11.8-19.5	27.3	22.8-32.2	53.0	48.0-57.9
Some College	1,426	2.6	1.2-5.4	1.0	0.5-1.8	15.1	11.6-19.5	29.1	24.3-34.5	52.2	46.8-57.5
College Degree	1,333	1.4	0.5-4.2	2.5	1.3-4.6	14.3	10.5-19.1	28.9	24.8-33.5	52.9	47.8-58.0
Income:											
< \$15,000	471	1.3	0.6-2.9	4.1	2.3-7.3	20.6	15.1-27.4	22.9	17.4-29.5	51.1	42.9-59.2
\$15,000-24,999	888	4.8	2.5-9.0	5.4	3.0-9.4	18.2	11.5-27.5	22.5	17.9-28.0	49.2	41.8-56.6
\$25,000-49,999	1,529	1.1	0.7-1.8	2.6	1.3-5.0	16.8	13.0-21.4	27.4	22.9-32.5	52.1	46.9-57.2
\$50,000-74,999	781	1.1	0.5-2.5	0.7	0.3-1.7	15.7	10.4-22.9	31.4	25.3-38.1	51.2	44.3-58.0
\$75,000+	909	2.4	0.8-6.9	1.3	0.4-3.6	11.7	8.1-16.6	29.8	24.5-35.7	54.9	48.7-60.9
Race/Ethnicity (age-adjusted):											
White, non-Hispanic	4,821	1.6	1.0-2.5	2.3	1.6-3.2	15.3	12.8-18.1	29.2	26.2-32.3	51.7	48.4-54.9
Non-White or Hispanic	349	3.5	1.3-8.9	3.2	1.0-9.9	16.8	10.3-26.0	18.1	12.9-24.7	58.5	49.0-67.4
Marital Status:											
Currently Married	3,248	2.2	1.3-3.7	2.1	1.4-3.2	13.7	11.6-16.2	27.0	24.2-30.0	55.1	51.8-58.3
Previously Married	1,382	1.7	1.0-3.1	2.3	1.5-3.7	15.1	12.0-18.8	26.9	22.7-31.6	53.9	49.0-58.7
Never Married	548	1.8	0.7-4.6	3.2	1.5-6.8	19.6	12.5-29.3	31.6	23.7-40.7	43.9	35.4-52.9
Employment:											
Employed	2,527	2.0	1.1-3.6	1.9	1.1-3.2	15.5	12.5-19.1	27.9	24.2-31.8	52.8	48.7-56.8
Self-employed	582	2.0	0.4-8.6	1.9	0.9-4.2	12.8	8.6-18.6	30.1	23.9-37.1	53.2	46.3-60.0
Unemployed	90	3.6	1.5-8.6	##	##	##	##	##	##	##	##
Homemaker	387	1.1	0.5-2.4	2.0	0.9-4.5	##	##	30.3	22.3-39.6	##	##
Student	63	##	##	1.9	0.4-8.3	##	##	##	##	##	##
Retired	1,280	0.7	0.3-1.7	1.7	1.1-2.8	13.2	10.3-16.7	25.3	21.7-29.3	59.1	54.7-63.4
Unable to Work	248	6.6	3.5-12.0	9.6	5.4-16.5	24.7	16.6-35.0	16.5	10.4-25.0	##	##
Behavioral Health Region:											
Region 1	513	0.9	0.4-2.2	2.5	1.2-5.0	17.2	13.0-22.3	26.9	22.0-32.5	52.5	46.7-58.3
Region 2	533	2.4	1.3-4.4	2.6	1.3-5.3	15.7	11.3-21.5	25.9	20.9-31.7	53.4	46.8-59.8
Region 3	1,026	2.6	1.4-4.6	3.8	2.4-6.1	14.7	12.2-17.5	28.0	24.5-31.8	50.9	46.8-55.1
Region 4	1,317	1.6	0.9-2.7	2.3	1.4-3.6	14.2	12.1-16.6	26.2	23.4-29.2	55.8	52.5-59.0
Region 5	1,067	1.1	0.5-2.2	1.6	0.7-3.9	16.2	11.6-22.3	27.6	22.4-33.4	53.5	47.4-59.6
Region 6	707	2.6	1.2-5.5	2.3	1.2-4.4	14.3	10.4-19.4	29.0	24.0-34.5	51.8	46.1-57.5

NOTE: "Number" and "Percent" exclude missing, don't know, and refused responses.

- The data are not reported if the confidence interval half width was > 10.

TABLE A4

Q4. During the past 30 days, about how often did you feel so depressed that nothing could cheer you up?

	Total # of Respondents	All of the time		Most of the time		Some of the time		A little of the time		None of the time	
		%	CI	%	CI	%	CI	%	CI	%	CI
Total	5,193	0.3	0.2-0.5	0.5	0.3-0.8	3.6	2.8-4.7	6.9	5.7-8.2	88.7	87.1-90.2
Gender:											
Male	1,981	0.4	0.2-0.7	0.3	0.1-0.7	3.4	2.2-5.2	6.6	4.9-8.8	89.4	86.8-91.6
Female	3,212	0.3	0.1-0.5	0.7	0.4-1.2	3.9	3.0-5.1	7.1	5.7-9.0	88.0	85.9-89.8
Age:											
18-24	163	---	---	0.6	0.1-2.5	1.9	0.9-4.1	4.1	2.2-7.6	93.4	89.3-96.0
25-34	485	0.2	0.1-0.9	0.3	0.1-0.8	3.2	1.4-7.0	7.4	4.3-12.4	88.9	83.4-92.7
35-44	816	0.6	0.2-1.7	1.0	0.3-2.8	4.1	2.5-6.7	6.4	4.5-9.0	88.0	84.4-90.9
45-54	1,082	0.1	0.0-0.4	0.6	0.3-1.1	5.0	2.9-8.4	8.8	6.3-12.3	85.5	81.3-88.9
55-64	995	0.3	0.1-0.9	0.3	0.1-0.6	4.1	2.7-6.1	7.9	4.8-12.8	87.5	82.8-91.1
65+	1,637	0.5	0.2-1.0	0.4	0.2-0.7	3.0	2.1-4.4	5.6	4.3-7.3	90.6	88.5-92.3
Place of Residence:											
Urban	715	0.1	0.0-0.4	0.2	0.0-1.1	3.6	2.2-5.6	5.8	3.9-8.5	90.5	87.3-92.9
Rural	4,478	0.6	0.3-0.9	0.8	0.6-1.3	3.7	3.1-4.5	8.0	7.0-9.1	86.9	85.6-88.1
Education:											
<High School	445	1.5	0.6-3.8	1.6	0.7-3.5	5.8	3.0-11.3	8.2	4.6-14.3	82.9	75.6-88.3
High School	1,980	0.4	0.2-0.8	0.5	0.3-0.9	4.2	3.1-5.6	6.0	4.7-7.5	88.9	86.8-90.7
Some College	1,429	0.1	0.0-0.2	0.3	0.1-0.9	3.2	2.1-4.8	6.2	4.4-8.5	90.3	87.6-92.5
College Degree	1,334	0.1	0.0-0.5	0.4	0.1-1.5	3.0	1.5-5.8	8.1	5.5-11.7	88.5	84.5-91.6
Income:											
< \$15,000	472	0.5	0.2-1.5	2.1	1.1-3.9	8.8	6.0-12.7	8.8	6.0-12.8	79.8	74.4-84.4
\$15,000-24,999	890	0.6	0.3-1.3	1.2	0.6-2.7	7.4	4.9-10.9	10.3	7.2-14.6	80.5	75.3-84.8
\$25,000-49,999	1,527	0.2	0.1-0.7	0.4	0.1-1.7	2.9	2.0-4.1	8.5	6.0-11.9	88.1	84.6-90.9
\$50,000-74,999	783	0.6	0.2-1.8	0.0	0.0-0.2	3.8	1.6-8.8	4.9	3.1-7.5	90.7	86.1-93.9
\$75,000+	909	0.1	0.0-0.3	0.1	0.0-0.3	1.9	0.8-4.6	4.4	2.5-7.7	93.6	90.0-96.0
Race/Ethnicity (age-adjusted):											
White, non-Hispanic	4,827	0.3	0.2-0.6	0.4	0.3-0.8	3.4	2.6-4.6	6.2	5.2-7.5	89.6	88.0-91.0
Non-White or Hispanic	351	0.1	0.0-0.8	0.8	0.3-2.1	4.2	2.6-7.0	9.8	5.6-16.7	85.1	78.3-90.0
Marital Status:											
Currently Married	3,253	0.3	0.2-0.6	0.3	0.1-0.8	3.4	2.3-4.8	6.7	5.2-8.5	89.3	87.2-91.2
Previously Married	1,384	0.3	0.2-0.8	1.5	0.9-2.6	5.6	4.1-7.8	8.3	6.3-10.9	84.2	81.0-87.0
Never Married	549	0.2	0.1-0.5	0.3	0.1-1.0	3.2	2.0-5.0	6.4	4.0-10.3	89.9	85.8-92.9
Employment:											
Employed	2,525	0.3	0.1-0.6	0.5	0.2-1.0	2.6	1.7-4.2	7.1	5.5-9.1	89.6	87.2-91.5
Self-employed	582	0.1	0.0-0.5	0.2	0.1-0.6	3.7	1.5-8.5	4.7	3.0-7.5	91.4	86.8-94.5
Unemployed	90	0.6	0.1-4.0	0.4	0.1-1.9	7.4	3.0-17.3	##	##	##	##
Homemaker	387	0.2	0.0-0.8	0.4	0.1-1.4	2.5	1.2-4.9	4.0	2.6-6.3	92.9	89.7-95.2
Student	63	0.0	---	0.5	0.1-3.3	1.4	0.5-4.5	0.7	0.1-3.6	97.4	93.7-99.0
Retired	1,288	0.5	0.2-1.2	0.3	0.1-0.7	3.9	2.7-5.7	6.6	4.6-9.4	88.8	85.7-91.3
Unable to Work	250	1.3	0.4-3.8	2.7	1.3-5.5	20.1	13.1-29.5	13.1	8.3-20.1	##	##
Behavioral Health Region:											
Region 1	510	0.5	0.2-1.7	0.2	0.1-1.0	4.6	2.6-8.1	8.9	6.3-12.4	85.8	81.4-89.3
Region 2	537	0.5	0.1-3.4	1.3	0.5-3.9	2.5	1.5-4.2	8.1	5.1-12.7	87.5	82.7-91.2
Region 3	1,027	0.7	0.3-1.7	1.3	0.7-2.5	4.5	3.1-6.4	6.9	5.3-8.9	86.7	83.9-89.0
Region 4	1,319	0.4	0.2-0.8	0.5	0.2-1.1	3.9	2.8-5.5	8.4	6.6-10.6	86.8	84.3-89.0
Region 5	1,070	0.1	0.0-0.4	0.3	0.1-0.7	3.9	2.1-6.9	6.1	3.9-9.3	89.6	85.7-92.6
Region 6	708	0.2	0.1-0.7	0.3	0.1-1.3	3.2	2.0-5.2	6.4	4.3-9.4	90.0	86.6-92.6

NOTE: "Number" and "Percent" exclude missing, don't know, and refused responses.

- The data are not reported if the confidence interval half width was > 10.

Table A5

Q5. During the past 30 days, about how often did you feel that everything was an effort?

	Total # of Respondents	All of the time		Most of the time		Some of the time		A little of the time		None of the time	
		%	CI	%	CI	%	CI	%	CI	%	CI
Total	5,160	3.0	2.0-4.3	2.8	2.1-3.7	12.1	10.0-14.5	16.7	14.7-18.9	65.5	62.7-68.3
Gender:											
Male	1,963	3.2	1.8-5.8	3.1	2.0-4.9	12.0	9.0-15.8	17.7	14.5-21.5	64.0	59.4-68.3
Female	3,197	2.7	1.7-4.2	2.5	1.8-3.3	12.1	9.4-15.4	15.7	13.5-18.2	67.1	63.5-70.4
Age:											
18-24	162	2.3	1.1-5.0	3.0	1.3-6.9	##	##	15.6	8.1-27.9	##	##
25-34	482	3.2	0.9-10.9	2.1	1.1-4.0	13.1	8.0-20.5	15.2	10.8-21.0	66.4	58.3-73.7
35-44	812	4.3	2.1-8.6	4.0	1.7-9.0	10.3	6.9-15.0	20.5	15.3-27.0	60.9	54.1-67.3
45-54	1,076	2.5	1.3-5.0	2.9	1.7-4.8	12.5	9.0-17.1	14.2	11.2-17.9	67.9	62.8-72.6
55-64	990	3.4	1.9-5.9	1.8	1.0-3.0	7.8	5.7-10.6	20.5	16.0-25.9	66.5	61.0-71.5
65+	1,624	1.9	1.3-2.9	2.9	1.9-4.4	10.0	8.2-12.1	14.7	12.2-17.5	70.5	67.1-73.7
Place of Residence:											
Urban	710	2.9	1.4-5.9	2.1	1.1-4.0	13.1	9.3-18.0	17.4	13.9-21.7	64.6	59.1-69.7
Rural	4,450	3.0	2.4-3.8	3.5	2.8-4.4	11.0	9.8-12.4	15.9	14.6-17.3	66.5	64.6-68.4
Education:											
<High School	438	##	##	5.6	3.0-10.3	12.6	8.1-19.0	17.7	10.9-27.2	##	##
High School	1,964	3.8	2.4-6.1	2.9	2.1-4.2	13.0	9.1-18.0	15.3	12.0-19.4	65.0	59.8-69.8
Some College	1,427	1.7	1.1-2.8	2.1	1.2-3.5	12.5	9.0-17.2	15.4	12.5-18.7	68.3	63.3-72.9
College Degree	1,326	1.8	0.9-3.5	2.5	1.1-5.3	10.6	7.2-15.3	18.9	15.1-23.4	66.2	60.9-71.1
Income:											
< \$15,000	467	6.9	4.0-11.9	7.2	4.2-12.3	17.3	12.3-23.8	14.7	10.2-20.7	53.9	45.7-61.9
\$15,000-24,999	880	9.4	4.4-19.1	5.8	3.7-9.1	15.3	9.8-23.0	15.5	11.7-20.3	54.0	46.3-61.4
\$25,000-49,999	1,522	2.3	1.3-4.1	2.2	1.3-3.8	13.2	9.8-17.5	19.2	15.4-23.7	63.1	57.9-68.0
\$50,000-74,999	779	1.6	0.8-3.0	2.8	0.9-8.5	10.1	5.6-17.5	16.6	12.8-21.3	69.0	62.0-75.2
\$75,000+	907	0.8	0.4-1.9	0.4	0.2-0.8	7.1	4.8-10.5	17.0	12.4-22.9	74.7	68.7-79.8
Race/Ethnicity (age-adjusted):											
White, non-Hispanic	4,800	2.9	1.9-4.4	2.3	1.7-3.1	12.4	9.9-15.3	16.7	14.4-19.2	65.8	62.5-68.9
Non-White or Hispanic	38	2.8	1.0-8.0	5.4	2.7-10.5	14.9	9.0-23.8	16.8	10.9-25.2	60.0	50.5-68.8
Marital Status:											
Currently Married	3,237	1.9	1.3-2.7	1.9	1.2-3.1	10.4	8.4-12.7	15.1	12.9-17.5	70.8	67.8-73.7
Previously Married	1,374	3.4	2.0-5.6	3.2	2.2-4.5	13.5	10.9-16.6	20.7	16.8-25.2	59.3	54.4-64.0
Never Married	542	6.4	2.8-13.94	5.6	3.5-8.9	17.0	9.8-27.8	19.4	13.3-27.3	51.7	42.5-60.7
Employment:											
Employed	2,516	2.1	1.3-3.5	1.8	1.0-3.2	12.0	9.0-15.9	17.9	15.0-21.2	66.2	62.0-70.2
Self-employed	578	1.2	0.6-2.6	1.9	0.7-5.1	15.6	9.8-23.7	16.6	12.6-21.6	64.8	57.5-71.4
Unemployed	89	2.2	0.9-5.4	8.6	3.2-21.3	##	##	##	##	##	##
Homemaker	386	##	##	2.7	1.1-6.6	7.1	4.6-10.7	15.4	10.0-23.1	##	##
Student	62	0.8	0.2-3.3	5.9	1.7-18.2	3.5	1.2-9.9	##	##	##	##
Retired	1,278	1.8	1.1-2.9	2.6	1.8-3.7	12.0	9.4-15.2	14.4	11.6-17.8	69.2	65.1-73.1
Unable to Work	245	17.1	9.9-28.0	16.0	9.9-24.9	18.7	12.6-26.9	12.7	7.6-20.5	##	##
Behavioral Health Region:											
Region 1	508	4.1	2.3-7.0	1.9	1.0-3.5	13.6	9.5-19.0	15.7	12.1-20.0	64.8	59.0-70.3
Region 2	533	3.0	1.6-5.7	3.6	1.9-6.6	12.3	8.7-17.0	15.2	11.8-19.4	65.9	59.9-71.5
Region 3	1,021	3.6	2.3-5.4	4.6	3.0-7.1	10.0	7.8-12.6	16.1	13.4-19.3	65.8	61.8-69.6
Region 4	1,310	2.7	1.8-4.1	3.0	2.0-4.3	10.4	8.5-12.7	16.2	13.9-18.7	67.8	64.6-70.8
Region 5	1,065	3.1	1.0-9.1	1.9	1.1-3.2	11.3	7.3-17.1	15.6	12.1-20.0	68.1	61.8-73.7
Region 6	701	2.6	1.4-4.9	2.7	1.4-5.1	13.4	9.4-18.8	18.1	14.1-23.0	63.3	57.4-68.8

NOTE: "Number" and "Percent" exclude missing, don't know, and refused responses.

- The data are not reported if the confidence interval half width was > 10.

Table A6

Q6. During the past 30 days, about how often did you feel worthless?

	Total # of Respondents	All of the time		Most of the time		Some of the time		A little of the time		None of the time	
		%	CI	%	CI	%	CI	%	CI	%	CI
Total	5,176	0.8	0.4-1.3	1.3	0.9-1.9	3.6	2.7-4.9	6.7	5.5-8.1	87.6	85.8-89.3
Gender:											
Male	1,975	0.3	0.2-0.6	1.2	0.6-2.1	3.2	1.8-5.8	6.7	4.8-9.3	88.6	85.4-91.2
Female	3,201	1.2	0.6-2.2	1.5	1.0-2.2	4.1	3.2-5.1	6.7	5.3-8.3	86.7	84.5-88.5
Age:											
18-24	163	0.3	0.0-2.1	1.1	0.2-4.4	1.6	0.5-4.7	1.0	0.4-2.1	96.1	92.6-98.0
25-34	482	0.3	0.1-0.7	0.2	0.1-0.8	4.1	1.5-10.9	9.2	5.3-15.6	86.1	78.7-91.2
35-44	815	0.5	0.2-1.2	1.6	0.8-3.2	2.8	1.5-5.2	4.8	3.4-6.9	90.3	87.2-92.7
45-54	1,081	1.7	0.6-5.0	2.2	1.0-5.0	2.7	1.5-4.7	6.6	4.4-9.9	86.8	82.5-90.2
55-64	992	0.4	0.2-0.8	1.3	0.7-2.6	3.9	2.4-6.3	8.9	6.3-12.5	85.5	81.6-88.8
65+	1,628	1.1	0.7-1.8	1.5	0.9-2.3	6.0	4.4-8.0	7.4	5.9-9.3	84.1	81.4-86.4
Place of Residence:											
Urban	713	0.6	0.2-2.0	1.0	0.5-2.3	2.9	1.5-5.6	6.2	4.2-9.1	89.3	85.6-92.1
Rural	4,463	0.9	0.6-1.3	1.6	1.2-2.1	4.4	3.7-5.3	7.2	6.3-8.2	86.0	84.6-87.2
Education:											
<High School	441	4.2	1.5-11.2	1.7	0.7-3.8	##	##	4.1	2.6-6.6	##	##
High School	1,972	0.7	0.4-1.4	1.6	1.1-2.4	3.8	2.8-5.2	6.6	5.1-8.4	87.2	84.8-89.3
Some College	1,427	0.6	0.3-1.3	1.2	0.5-2.6	3.4	2.3-4.8	5.7	4.1-8.0	89.2	86.4-91.5
College Degree	1,331	0.1	0.0-0.2	1.0	0.4-2.7	1.7	1.0-3.1	8.1	5.4-12.2	89.1	85.0-92.1
Income:											
< \$15,000	470	3.2	1.9-5.6	4.6	2.4-8.7	7.8	5.2-11.4	9.7	6.4-14.7	74.6	68.1-80.2
\$15,000-24,999	887	2.8	1.1-7.1	1.9	0.9-3.8	11.2	6.2-19.4	7.2	5.1-10.2	76.8	69.3-83.0
\$25,000-49,999	1,519	0.4	0.1-1.1	1.7	0.9-3.4	3.2	2.2-4.6	8.9	6.4-12.4	85.8	82.1-88.9
\$50,000-74,999	784	0.2	0.1-1.1	0.7	0.1-3.5	1.7	0.8-3.6	4.8	2.5-9.1	92.6	88.2-95.5
\$75,000+	908	0.1	0.0-0.4	0.2	0.1-0.6	0.6	0.2-2.7	5.0	2.9-8.7	94.1	90.4-96.4
Race/Ethnicity (age-adjusted):											
White, non-Hispanic	4,812	0.6	0.4-0.9	1.3	0.9-2.0	3.6	2.6-5.1	6.2	5.0-7.7	88.3	86.3-90.0
Non-White or Hispanic	349	2.4	0.5-10.6	1.1	0.4-3.3	3.2	1.9-5.3	8.2	4.5-14.3	85.1	78.0-90.3
Marital Status:											
Currently Married	3,241	0.6	0.2-1.4	1.1	0.6-1.8	2.6	1.9-3.4	6.2	4.8-8.1	89.6	87.5-91.3
Previously Married	1,384	2.1	1.1-3.8	2.0	1.3-3.0	6.7	4.9-9.1	8.0	6.0-10.5	81.3	77.8-84.4
Never Married	544	0.3	0.1-1.0	1.7	0.8-3.5	4.8	1.8-12.2	7.3	4.3-12.1	85.9	78.9-90.8
Employment:											
Employed	2,519	0.5	0.1-1.6	0.4	0.2-0.9	2.2	1.6-3.2	5.9	4.3-8.1	91.0	88.6-92.9
Self-employed	581	0.3	0.1-2.4	0.1	0.0-0.5	4.0	1.7-9.1	5.4	3.7-7.7	90.2	85.6-93.4
Unemployed	89	1.1	0.3-3.8	3.2	0.8-11.7	##	##	##	##	##	##
Homemaker	383	0.7	0.2-1.9	0.7	0.2-1.8	##	##	6.2	4.0-9.5	##	##
Student	63	0.0	---	2.9	0.6-13.8	0.3	0.1-2.4	1.7	0.6-4.7	95.1	86.5-98.3
Retired	1,283	1.0	0.6-1.5	1.6	1.0-2.6	5.9	4.3-8.1	8.1	5.9-11.0	83.4	80.1-86.2
Unable to Work	250	6.3	2.9-13.2	15.5	8.5-26.7	8.5	5.2-13.6	10.4	6.2-17.0	##	##
Behavioral Health Region:											
Region 1	512	0.9	0.4-2.2	0.6	0.2-1.5	5.1	2.5-10.0	9.9	6.9-14.1	83.6	78.2-87.8
Region 2	536	0.6	0.2-1.8	2.1	1.1-3.9	3.9	2.4-6.2	7.5	4.6-11.9	85.9	81.2-89.5
Region 3	1,024	1.3	0.7-2.6	2.3	1.2-4.3	4.2	3.1-5.7	7.5	5.6-9.9	84.7	81.6-87.3
Region 4	1,312	1.3	0.8-2.2	0.8	0.5-1.5	5.3	4.0-7.1	6.6	5.3-8.2	85.9	83.6-88.0
Region 5	1,064	0.4	0.1-1.3	0.9	0.6-1.6	3.9	1.6-9.2	7.4	4.7-11.3	87.4	82.2-91.3
Region 6	706	0.6	0.1-2.6	1.3	0.6-2.8	2.6	1.5-4.4	5.5	3.5-8.5	90.0	86.5-92.6

NOTE: "Number" and "Percent" exclude missing, don't know, and refused responses.

- The data are not reported if the confidence interval half width was > 10.

Nebraska 2009 Behavioral Health Consumer Surveys
Summary of Results

DBH
f.w
copy

Methodology

The Department of Health and Human Services' (DHHS) Division of Behavioral Health contracted with the University of Nebraska Medical Center - College of Public Health (UNMC) to conduct the 2009 Behavioral Health Consumer Surveys. ¹ The survey instruments used for the behavioral health consumer surveys were:

- a) the *28-Item Mental Health Statistics Improvement Program (MHSIP) Consumer Satisfaction Survey* (augmented with 11 questions on improved functioning and social connectedness),
- b) the *MHSIP Youth Services Survey (YSS)*, and
- c) the *MHSIP Youth Services Survey for Families (YSS-F)*.

These surveys have been 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.

The sample for the surveys included 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. Magellan Behavioral Health supplied a list of names, addresses and phone numbers of current mental health/substance abuse consumers to UNMC. UNMC conducted the telephone interviews and entered responses from the phone and mail surveys into the survey 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 of Behavioral Health which introduced the survey and explained how the UNMC would be contacting them by phone to solicit their participation in the survey. The phone number of the consumer was included in the introductory letter. The letter was sent to the consumers in the sample, providing them 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 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) conducted 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

¹ Questions regarding the 2009 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@nebraska.gov.

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 8,407 persons in the adult sample, over 2,300 declined to participate. An incorrect or non-working telephone number, or an incorrect address, had been provided for some consumers, so they could not be contacted. In all, 1,090 adult consumer surveys were completed, a 7% increase over 2008. (The confidence interval for the Adult survey was +/- 2.8% at the 95% confidence level.) Of the 928 youth (or parents) in the sample, 135 completed the survey. (The confidence interval for the Youth survey was +/- 7.9% at the 95% confidence level.) Again, incorrect telephone numbers or addresses were issues for the Youth survey.

For the first time, the Department incorporated questions from the Behavioral Health Risk Factor Surveillance System (BRFSS)², a national survey of adults in all 50 states, into the consumer survey. These questions were added to gauge the physical health status of behavioral health consumers.

Survey Results

Adult Survey

Over half (57%) of the adult respondents in 2009 were female. The respondents ranged in age from 19 to 86, with an average age of 42 years. Most were White (89.8%), followed by Black/African American (3.9%), and American Indian (1.8%). About five percent were Hispanic or Latino.

Survey data were analyzed by race, 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):

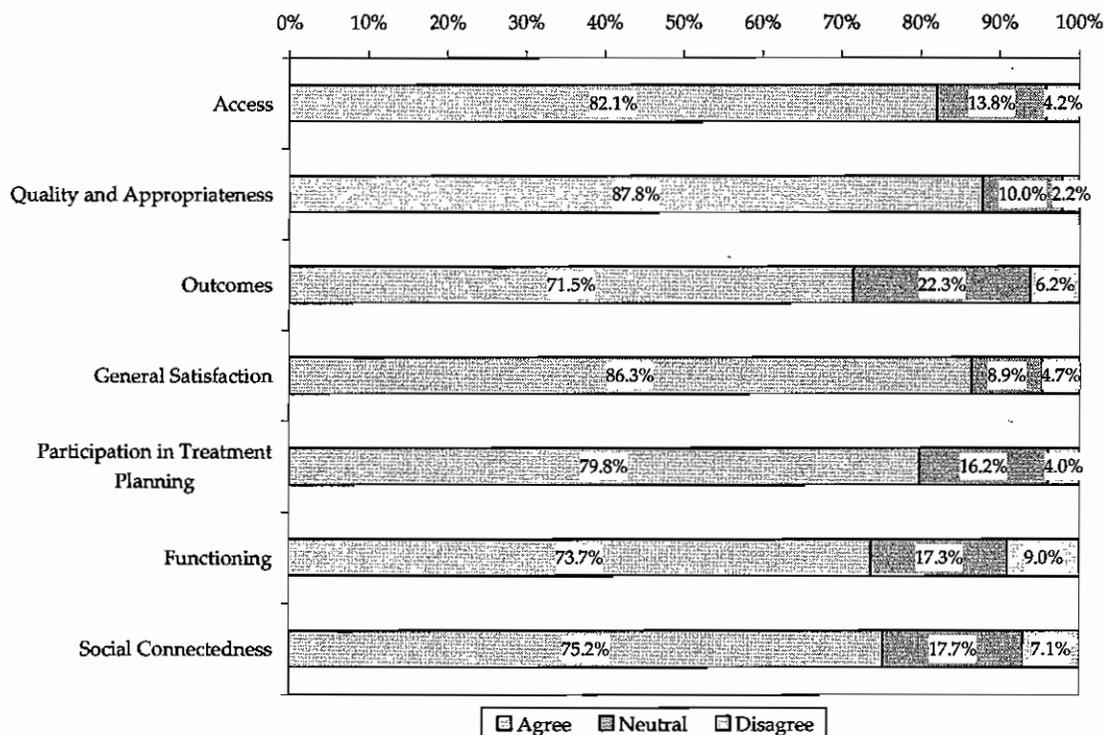
- Access
- Quality and Appropriateness of Services
- Outcomes
- Participation in Treatment Planning
- General Satisfaction
- Functioning
- Social Connectedness

²The Behavioral Risk Factor Surveillance System (BRFSS) is an ongoing telephone health survey of adults ages 18 and over which has collected information on health conditions, health risk behaviors, preventive health practices and health care access in the U.S. since 1984. The BRFSS is used in all 50 states, the District of Columbia, Puerto Rico, Guam and the Virgin Islands. Over 350,000 persons ages 18 and over are interviewed by the BRFSS each year, making it the largest telephone survey in the world.

Summary of Results – Adult Survey

Generally speaking, consumers appeared to be satisfied with the services they received from the mental health and/or substance abuse programs in Nebraska. In the area of **General Satisfaction**, most adult respondents (86.3%) were satisfied with services (Figure 1). About 4.7% percent were dissatisfied with services, and 8.9% were neutral. More than three-fourths (79.8%) were satisfied with their level of involvement in treatment planning. Nearly three-fourths (71.5%) responded positively to questions on the **Outcomes** scale. Most (87.8%) responded positively to the questions related to the **Quality and Appropriateness** of services, and 82.1% thought that the services were **Accessible**.

Figure 1
Statewide Summary – MHSIP Scales – Adults

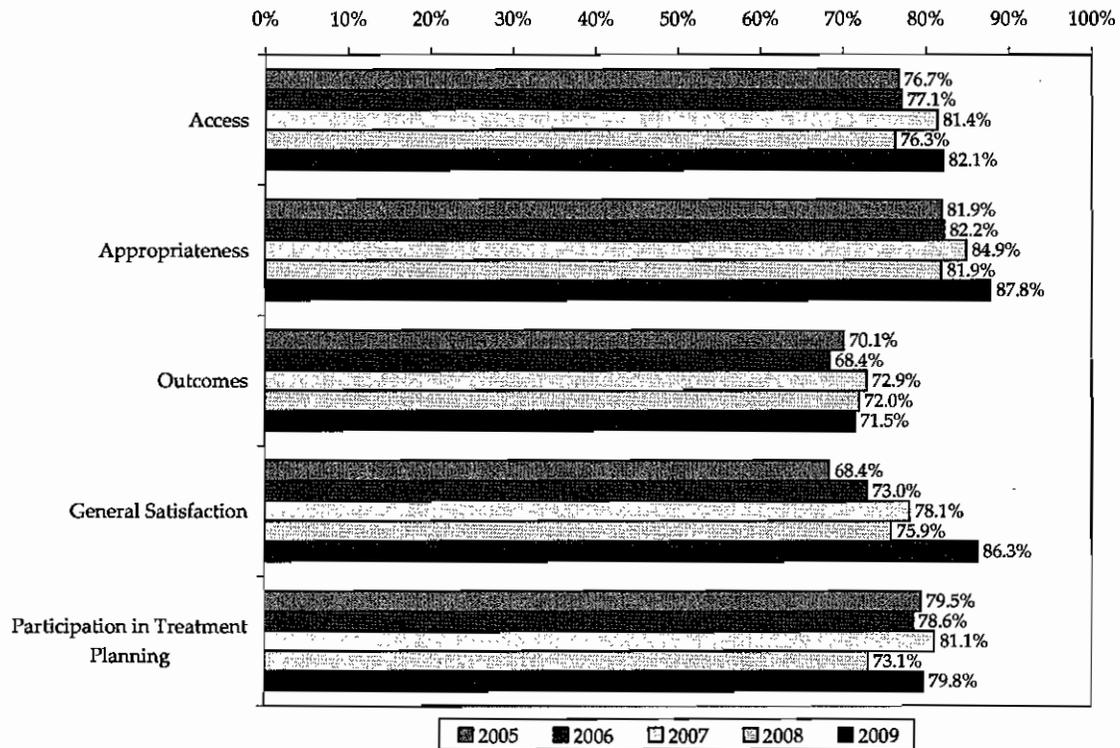


Men responded more positively than women on all seven scales, although none of the differences were statistically significant. There were also no significant differences between responses for White, non Hispanic adults versus non-White or Hispanic adults (see Tables 1 and 2 in Appendix B). Young adults ages 19-24 responded significantly more positively to questions regarding **Social Connectedness** and **Functioning** than did respondents 45-64 years of age. Otherwise, there were no significant differences in scale scores by age.

Persons currently receiving services tended to respond more positively than persons no longer receiving services. In addition, persons who had received services for more than a year tended to respond more positively than persons receiving services for less than a year.

Figure 2 compares the responses from the 2005, 2006, 2007, 2008 and 2009 adult surveys for each of the five primary MHSIP domains. There was an increase in four of the five domains from the 2008 survey to the 2009 survey. The greatest increase was in the *General Satisfaction* domain.

Figure 2
Percent of Respondents Agreeing – 2005 - 2009
By MHSIP Domain



Consumers responded significantly more positively in 2009 than in 2008 to most questions on the survey (see Table 3 in Appendix B for confidence intervals for each survey question). There was one question, however, where consumers responded significantly less positively in 2009 than in 2008: “I feel I belong in my community.”

A summary of the responses to the 28-item MHSIP survey for adults for 2009, plus the eight new questions related to Improved Functioning and Social Connectedness, can be found in Table 4 of Appendix B.

Differences Between Persons Receiving Mental Health versus Substance Abuse Services

The adult consumer survey instrument was originally developed for use by mental health consumers. One question that’s always existed is would persons admitted to a behavioral health program primarily for a mental health problem respond differently on the survey than persons admitted primarily for a substance abuse problem? To answer this question, the consumers

responding to the survey were divided into two groups based upon their "Reason for Admission" to the behavioral health program. More than three-fourths (77.2%) of the persons responding to the survey were admitted primarily for a mental health problem. Less than one-fourth (22.8%) were admitted primarily for a substance abuse problem.

There were some differences between the two groups. First, of the seven scales, the only statistically significant difference between the two groups was on the **Social Connectedness** scale. Persons admitted primarily for a substance abuse problem responded significantly more positively on the **Social Connectedness** scale than did persons admitted primarily for a mental health problem. There were other differences that were statistically significant on individual survey questions. For example, persons admitted for a mental health problem responded significantly more positively to the question: "I like the services that I received here." The opposite was true, however, for other questions. Persons admitted primarily for a substance abuse problem responded significantly more positively than persons admitted for a mental health problem to the following questions:

15. *Staff told me what side effects to watch out for.*

As a result of the services received:

25. *I am getting along better with my family.*

25. *I do better in social situations.*

29. *I do things that are more meaningful to me.*

31. *I am better able to handle things when they go wrong.*

32. *I am better able to do things that I want to do.*

Physical Health Status of Adults in the Survey

It has long been known that there is a connection between a person's mental health and their physical health. To measure the presence of chronic physical health conditions among behavioral health clients, six questions from the Behavioral Health Risk Factor Surveillance System (BRFSS) were included on the consumer survey:

Has a doctor, nurse, or other health professional ever told you that:

a) *you had a heart attack (also called a myocardial infarction)?*

b) *you had angina or coronary heart disease?*

c) *you had a stroke?*

d) *your blood cholesterol was high?*

e) *you had high blood pressure?*

f) *you had diabetes?*

The most common chronic health condition among behavioral health consumers was high blood pressure (40.5% had been told by a doctor, nurse, or other health professional that they had high blood pressure), followed by high cholesterol (36.4%) and diabetes (18.9%). Fewer than one in 14 behavioral health consumers reported having been told by a health care professional that they had angina or coronary heart disease (6.7%), a heart attack (6.4%), or a stroke (4.4%).

When asked whether they smoked cigarettes, most (55.1%) indicated that they did not smoke, 37.9% reported that they smoked every day, and 7.0% reported that they smoked "some days".

When asked to assess their general health, 8.5% rated their general health as "Excellent", 18.9% rated their general health as "Very Good", 37.7% rated their general health as "Good", 25.5% rated their general health as "Fair", and 8.8% rated their general health as "Poor".

Adult consumers were then asked two questions about the number of days in the previous 30 days that their physical or mental health was not good:

- 1) *Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?*
- 2) *Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?*

Respondents reported an average of 8.1 days in the previous 30 days that their physical health was not good, and an average of 9.5 days in the previous 30 days that their mental health was not good.

Consumers were then asked how many days during the past 30 days that poor physical or mental health kept them from doing their usual activities. Over one-third (36.3%) reported that there were no days in the past 30 days when poor physical or mental health kept them from doing their usual activities. The average number of days when poor physical or mental health kept them from doing their usual activities was 9.4 days.

Differences were noted between persons admitted primarily for a mental health problem versus those admitted primarily for a substance abuse problem. Table 1 shows the differences between the two groups for selected questions. Persons admitted primarily for a mental health problem were more likely than persons admitted primarily for a substance abuse problem to have High Blood Cholesterol and Diabetes. Otherwise, the likelihood for having chronic health conditions was about the same for the two groups.

Persons admitted primarily for a substance abuse problem were much more likely to smoke cigarettes every day (55.0% versus 32.7%). Persons admitted primarily for a mental health problem were much more likely to not smoke at all (60.4% versus 35.4%). As far as self-reported general health status, the responses between the two groups were similar.

Persons admitted primarily for a mental health problem reported more days when their physical and mental health were not good, and more days when poor physical or mental health kept them from doing their usual activities. Persons admitted primarily for a mental health problem were more likely than persons admitted primarily for a substance abuse problem to be obese (48.6% vs 31.0%, respectively), and to be underweight, while persons admitted primarily for a substance abuse problem were more likely to be overweight or of normal weight.

Table 1
Differences on BRFSS Questions Between Persons Admitted Primarily
For Mental Health versus Substance Abuse Problems

	Primary Reason for Admission	
	MH	SA
Physical Health Conditions:		
Heart Attack or Myocardial Infarction	6.1%	7.5%
Angina or Coronary Heart Disease	6.7%	6.7%
Stroke	3.9%	5.8%
High Blood Cholesterol	39.3%	26.7%
High Blood Pressure	40.5%	40.8%
Diabetes	21.0%	11.3%
Cigarette Smoking:		
Every Day	32.7%	55.0%
Some Days	6.3%	9.2%
Does Not Smoke	60.4%	35.4%
General Health Status:		
Excellent	8.4%	9.2%
Very Good	18.2%	21.3%
Good	37.0%	40.0%
Fair	27.0%	20.4%
Poor	8.8%	8.8%
In the Past 30 Days:		
Average Days Physical Health Not Good	8.5	6.9
Average Days Mental Health Not Good	10.4	6.5
Average Days Poor Health Prevented Usual Activities	9.9	7.4
Average Days of Binge Drinking	0.5	1.4
Body Mass Index Category:		
Obese	48.6%	31.0%
Overweight	27.1%	37.9%
Normal Weight	22.8%	30.6%
Underweight	1.6%	0.4%

Youth Survey

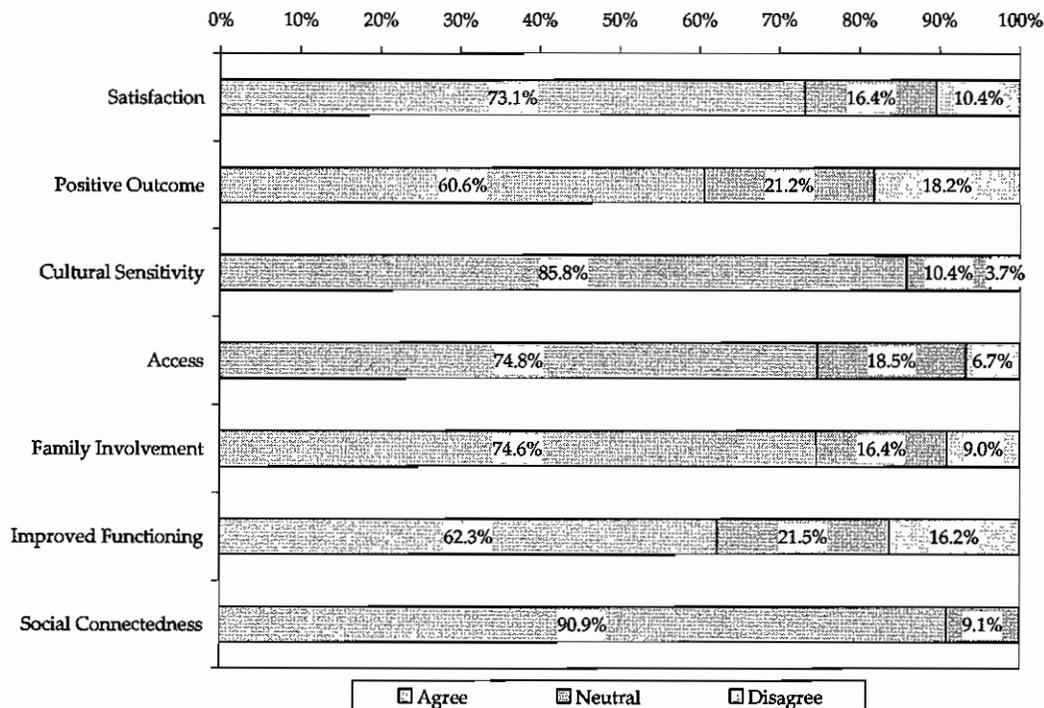
A total of 135 MHSIP youth surveys were completed in 2009, up just slightly over 2008. In most cases, a parent or guardian responded on behalf of the child receiving services. More surveys were completed for boys (61%) than for girls (39%). The youth's ages ranged from 5 years to 19 years, with an average age of 14.1 years. Most of the respondents were White, non Hispanic (78%); 22% were non-White or Hispanic. Half (51%) have Medicaid coverage. Over half (56%) had not received services in the past 12 months; 40% had received community mental health services in the past 12 months, and 4% had received community alcohol or drug abuse services in the past 12 months.

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 Survey³

Most of the respondents (73.1%) indicated that they were satisfied with the services their child received (Figure 3). Ten percent (10.4%) were dissatisfied with the services their child received, and 16.4% were neutral. The most positive responses were in the **Social Connectedness** domain – 90.9% responded positively, and the **Cultural Sensitivity** domain – 85.8% responded positively. This represented a significant increase over 2008 for both scales.

Figure 3
Statewide Summary – MHSIP Scales – Youth



A summary of the responses to the MHSIP survey for youth for 2009 can be found in Table 5, Appendix B.

Health Status of Youth Consumers

The youth were asked some of the same health questions from the BRFSS as the adults. When asked to rate their general health, more than one-third (34.2%) rated their general health as

³ Because of the small sample size, and the large confidence interval (+/-8%), caution should be exercised in interpreting the results of the Youth Survey.

Excellent, 30.8% rated their general health as Very Good, and 28.3% rated their general health as Good. Only 5.8% rated their general health as either Fair or Poor.

The youth reported an average of 1.3 days in the past 30 days that their physical health was not good, 6.7 days when their mental health was not good, and 3.3 days when poor physical or mental health kept them from doing their usual activities. When asked whether the child, in the past 30 days, participated in any physical activity or exercises such as running, sports, swimming, PE or walking for exercise, 88.3% said "yes", 10.8% said "no", and 0.8% weren't sure.

The youth's weight, height and age were used to determine their weight status. Less than two percent were considered underweight, over half (53%) were considered to have healthy weight, 23% were classified as overweight, and 22% were classified as obese.

Survey Sample and Response Rates

Table 2 shows a summary of sample size and response rates for the last six years. For the Adult survey the response rate had gone up each year until 2008, when it dropped to 31%. The response rate for the Adult survey dropped to 29% in 2009. For the Youth survey, the response rate dropped from 42% in 2008 to 32% in 2009.

**Table 2
Survey Sample Size and Response Rates – 2004-2009**

Adult Survey	2004	2005	2006	2007	2008	2009
a. How many Surveys were Attempted (sent out or calls initiated)?	4,412	4,821	3,592	5,198	5,980	8,407
b. How many survey Contacts were made? (surveys to valid phone numbers or addresses)	3,760	1,567	1,471	2,145	3,238	3,748
c. How many surveys were completed? (survey forms returned or calls completed)	657	749	795	1,173	1,019	1,090
d. What was your response rate? (number of Completed surveys divided by number of Contacts)	17%	48%	54%	55%	31%	29%

Youth Survey	2004	2005	2006	2007	2008	2009
a. How many Surveys were Attempted (sent out or calls initiated)?	592	768	1,567	1,037	784	928
b. How many survey Contacts were made? (surveys to valid phone numbers or addresses)	541	497	880	537	306	423
c. How many surveys were completed? (survey forms returned or calls completed)	67	235	465	254	128	135
d. What was your response rate? (number of Completed surveys divided by number of Contacts)	12%	47%	53%	47%	42%	32%

Below is a summary of the data reported by the Division of Behavioral Health 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 2007 through 2009.

For the adult survey the responses in 2009 were more positive than the responses in 2008 for four of the five domains: Access, Quality and Appropriateness, Participation in Treatment Planning, and General Satisfaction. The responses for the fifth domain – Outcomes – were about the same in 2009 as in 2008. For the Youth Survey, improvement from 2008 to 2009 was seen in four of the five domains: General Satisfaction, Outcomes, Participation in Treatment Planning and Cultural Sensitivity.

Table 3
Summary Profile of Client Evaluation of Care/
Nebraska Consumer Survey Results (URS Table 11)

Report Year (Year Survey was Conducted)	2007			2008			2009		
Adult Consumer Survey Results:	Number of Positive Responses	Responses	Percent	Number of Positive Responses	Responses	Percent	Number of Positive Responses	Responses	Percent
1. Percent Reporting Positively About <u>Access</u> .	925	1,137	81.4%	743	974	76.3%	870	1,060	82.1%
2. Percent Reporting Positively About <u>Quality and Appropriateness</u> for Adults.	948	1,117	84.9%	793	968	81.9%	918	1,046	87.8%
3. Percent Reporting Positively About <u>Outcomes</u> .	802	1,100	72.9%	688	955	72.0%	739	1,033	71.5%
4. Percent of Adults Reporting on <u>Participation in Treatment Planning</u> .	801	1,026	78.1%	638	873	73.1%	788	988	79.8%
5. Percent of Adults Reporting Positively about <u>General Satisfaction</u> with Services.	942	1,161	81.1%	767	1,010	75.9%	928	1,075	86.3%
Child/Adolescent Consumer Survey Results:	Number of Positive Responses	Responses	Percent	Number of Positive Responses	Responses	Percent	Number of Positive Responses	Responses	Percent
1. Percent Reporting Positively About <u>Access</u> .	197	253	77.9%	100	128	78.1%	101	135	74.8%
2. Percent Reporting Positively About <u>General Satisfaction</u> for Children.	167	253	66.0%	86	127	67.7%	98	134	73.1%
3. Percent Reporting Positively About <u>Outcomes</u> for Children.	132	251	52.6%	73	125	58.4%	80	132	60.6%
4. Percent of Family Members Reporting on <u>Participation in Treatment Planning</u> For Their Children.	179	252	71.0%	85	127	66.9%	100	134	74.6%
5. Percent of Family Members Reporting High <u>Cultural Sensitivity</u> of Staff. (Optional)	195	252	77.4%	105	128	82.0%	115	134	85.8%

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 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.

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

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 2009 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.

Improved Functioning:

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.

Social Connectedness:

1. I know people who will listen and understand me when I need to talk.
2. I have people that I am comfortable talking with about my child's problems.
3. In a crisis, I have the support I need from family or friends.
4. I have people with whom I can do enjoyable things.

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 1,090 Adult surveys, 30 had more than 1/3rd of the items in the **Access** scale either missing or marked "not applicable". Those 30 surveys were excluded from the calculation of the **Access** scale, leaving 1,060 surveys to be included in the calculation.
2. Average scale scores were calculated for each of the 1,060 surveys
3. Of the 1,060 remaining surveys:
870 had average scores of 2.49 or lower (Agree/Strongly Agree)
146 had average scores between 2.50 and 3.49 (Neutral)
44 had average scores of 3.50 or higher (Disagree/Strongly Disagree)
4. The percent of "positive" responses for the **Access** scale was 870 (from Step 3) divided by 1,060 (from Step 1) = **82.1**

Scale Reliability

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)	.867
Quality and Appropriateness (9)	.911
Outcomes (8)	.934
Participation in Treatment Planning (2)	.627
General Satisfaction (3)	.880

Additional Adult Scales (# of Items)	Alphas
Improved Functioning (5)	.909
Social Connectedness (4)	.876

Youth Scales (# of Items)	Alphas
Satisfaction (6)	.942
Positive Outcome (6)	.950
Cultural Sensitivity (4)	.879
Access (2)	.722
Family Involvement (3)	.824

Additional Youth Scales (# of Items)	Alphas
Improved Functioning (5)	.949
Social Connectedness (4)	.798

Appendix B

Table 1
2009 Adult Survey Scales by Race/Hispanic Origin

Scale	% Agree White Non-Hispanic	% Agree Non-White / Hispanic
Access	82.9%	78.4%
Appropriateness	88.8%	83.0%
Outcomes	72.1%	67.6%
General Satisfaction	86.3%	88.4%
Participation in Treatment Planning	80.9%	73.4%
Functioning	75.5%	73.3%
Social Connectedness	73.1%	76.3%

Table 2
2009 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.	88.6%	88.3%
2. If I had other choices, I would still get services from this agency.	84.0%	81.8%
3. I would recommend this agency to a friend or family member.	88.4%	89.9%
4. The location of services was convenient (parking, public transportation, distance, etc.).	84.7%	83.1%
5. Staff were willing to see me as often as I felt it was necessary.	87.6%	87.0%
6. Staff returned my calls within 24 hours.	83.8%	79.3%
7. Services were available at times that were good for me.	88.9%	85.6%
8. I was able to get all the services I thought I needed.	82.4%	82.0%
9. I was able to see a psychiatrist when I wanted to.	76.7%	73.2%
10. Staff here believe that I can grow, change and recover.	87.9%	77.0%
11. I felt comfortable asking questions about my treatment and medication.	89.0%	85.7%
12. I felt free to complain.	84.2%	75.9%
13. I was given information about my rights.	90.9%	86.9%
14. Staff encouraged me to take responsibility for how I live my life.	88.9%	82.1%
15. Staff told me what side effects to watch out for.	79.6%	77.2%
16. Staff respected my wishes about who and who is not to be given information about my treatment.	92.1%	82.5%
17. I, not staff, decided my treatment goals.	82.3%	78.0%
18. Staff were sensitive to my cultural background (race, religion, language, etc.).	88.2%	85.1%
19. Staff helped me obtain the information that I needed so that I could take charge of managing my illness.	86.6%	83.1%
20. I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.).	80.0%	79.28%
As a result of the services received:		
21. I deal more effectively with daily problems.	82.1%	81.3%
22. I am better able to control my life.	81.3%	81.0%
23. I am better able to deal with crisis.	78.1%	81.2%
24. I am getting along better with my family.	78.1%	74.4%
25. I do better in social situations.	69.6%	66.9%
26. I do better in school and/or work.	68.0%	67.0%
27. My housing situation has improved.	67.6%	67.2%
28. My symptoms are not bothering me as much.	69.5%	65.9%
29. I do things that are more meaningful to me.	77.2%	76.3%
30. I am better able to take care of my needs.	79.3%	84.4%
31. I am better able to handle things when they go wrong.	74.8%	73.5%
32. I am better able to do the things that I want to do.	73.9%	71.9%
33. I am happy with the friendships I have.	78.1%	76.7%
34. I have people with whom I can do enjoyable things.	79.7%	80.7%
35. I feel I belong in my community.	69.2%	73.9%
36. In a crisis, I would have the support I need from family or friends.	83.0%	79.1%

Table 3
2008 and 2009 Adult Consumer Surveys
Confidence Intervals (CI)

1 = Strongly Agree; 5 = Strongly Disagree	2008			2009		
	Mean	SD	95% CI	Mean	SD	95% CI
1. I like the services that I received here.*	2.07	1.094	2.00-2.14	1.71	0.862	1.66-1.76
2. If I had other choices, I would still get services from this agency.*	2.26	1.204	2.18-2.33	1.87	0.965	1.81-1.93
3. I would recommend this agency to a friend or family member.*	2.07	1.136	2.00-2.14	1.73	0.891	1.68-1.78
4. The location of services was convenient.*	2.08	0.997	2.01-2.14	1.84	0.918	1.78-1.90
5. Staff were willing to see me as often as I felt it was necessary.*	2.02	1.038	1.96-2.08	1.76	0.869	1.71-1.81
6. Staff returned my calls within 24 hours.*	2.09	1.034	2.02-2.16	1.90	0.996	1.84-1.96
7. Services were available at times that were good for me.*	2.00	0.961	1.94-2.06	1.77	0.862	1.72-1.82
8. I was able to get all the services I thought I needed.*	2.19	1.120	2.12-2.26	1.90	1.012	1.84-1.96
9. I was able to see a psychiatrist when I wanted to.*	2.34	1.151	2.26-2.42	2.08	1.091	2.01-2.15
10. Staff here believe that I can grow, change and recover.*	1.90	0.940	1.84-1.96	1.77	0.844	1.72-1.82
11. I felt comfortable asking questions about my treatment and medication.*	1.98	1.015	1.91-2.05	1.75	0.890	1.70-1.80
12. I felt free to complain.*	2.15	1.098	2.08-2.22	1.93	0.980	1.87-1.99
13. I was given information about my rights.*	1.92	.0890	1.86-1.98	1.75	0.830	1.70-1.80
14. Staff encouraged me to take responsibility for how I live my life.*	1.89	0.918	1.83-1.95	1.77	0.812	1.72-1.82
15. Staff told me what side effects to watch out for.*	2.15	1.086	2.08-2.22	2.01	0.982	1.95-2.07
16. Staff respected my wishes about who and who is not to be given information about my treatment.*	1.82	0.869	1.77-1.87	1.69	0.827	1.64-1.74
17. I, not staff, decided my treatment goals.*	2.18	1.046	2.11-2.25	1.99	0.924	1.93-2.05
18. Staff were sensitive to my cultural background (race, religion, language, etc.).*	1.91	0.862	1.85-1.97	1.76	0.801	1.71-1.81
19. Staff helped me obtain information that I needed so that I could take charge of managing my illness.*	2.02	0.990	1.96-2.08	1.84	0.881	1.79-1.89
20. I was encouraged to use consumer-run programs (support groups, drop-in clinics, crisis phone line, etc.)	2.09	1.034	2.02-2.16	2.00	0.965	1.94-2.06
As a result of the services received:						
21. I deal more effectively with daily problems.*	2.17	1.031	2.11-2.23	1.93	0.886	1.88-1.98
22. I am better able to control my life.*	2.11	0.999	2.05-2.17	1.96	0.896	1.91-2.01
23. I am better able to deal with crisis.	2.14	0.991	2.08-2.20	2.03	0.931	1.97-2.09
24. I am getting along better with my family.	2.10	0.994	2.04-2.16	2.04	0.986	1.98-2.10
25. I do better in social situations.	2.20	1.005	2.14-2.26	2.22	1.027	2.16-2.28
26. I do better in school and/or work.	2.23	0.999	2.16-2.30	2.21	1.021	2.14-2.28
27. My housing situation has improved.	2.31	1.066	2.24-2.38	2.22	1.020	2.15-2.29
28. My symptoms are not bothering me as much.	2.25	1.080	2.18-2.32	2.28	1.087	2.21-2.35
29. I do things that are more meaningful to me.	2.06	0.922	2.00-2.12	2.06	0.919	2.00-2.12
30. I am better able to take care of my needs.	2.08	0.940	2.02-2.14	1.99	0.878	1.94-2.04
31. I am better able to handle things when they go wrong.	2.14	0.954	2.08-2.20	2.13	0.973	2.07-2.19
32. I am better able to do the things that I want to do.	2.15	0.967	2.09-2.21	2.13	0.958	2.07-2.19
33. I am happy with the friendships I have.	1.96	0.871	1.91-2.01	2.05	0.947	1.99-2.11
34. I have people with whom I can do enjoyable things.	1.91	0.861	1.86-1.96	2.01	0.968	1.95-2.07
35. I feel I belong in my community.**	2.10	0.952	2.04-2.16	2.24	1.069	2.17-2.31
36. In a crisis, I would have the support I need from family or friends.	1.83	.0871	1.78-1.88	1.91	0.991	1.85-1.97

* Consumers responded significantly more positively to this question in 2009 than in 2008.

** Consumers responded significantly less positively to this question in 2009 than in 2008.

Table 4
2009 Adult Consumer Survey
Summary of Results

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Other	% Agree/Strongly Agree
1. I like the services that I received here.*	512	436	81	25	22	14	88.1%
2. If I had other choices, I would still get services from this agency.*	435	454	87	66	25	23	83.3%
3. I would recommend this agency to a friend or family member.*	497	452	62	36	25	18	88.5%
4. The location of services was convenient.*	423	467	82	61	18	39	84.7%
5. Staff were willing to see me as often as I felt it was necessary.*	461	463	68	48	15	35	87.6%
6. Staff returned my calls within 24 hours.*	388	432	69	72	27	102	83.0%
7. Services were available at times that were good for me.*	450	483	62	49	15	31	88.1%
8. I was able to get all the services I thought I needed.*	430	446	84	72	33	25	82.3%
9. I was able to see a psychiatrist when I wanted to.*	319	389	97	89	38	158	76.0%
10. Staff here believe that I can grow, change and recover.*	436	461	96	29	16	52	86.4%
11. I felt comfortable asking questions about my treatment and medication.*	455	451	51	44	21	68	88.6%
12. I felt free to complain.*	383	464	96	65	29	53	81.7%
13. I was given information about my rights.*	441	508	52	32	19	38	90.2%
14. Staff encouraged me to take responsibility for how I live my life.*	424	491	82	32	12	49	87.9%
15. Staff told me what side effects to watch out for.*	315	452	103	75	24	121	79.2%
16. Staff respected my wishes about who and who is not to be given information about my treatment.*	475	459	47	31	17	61	90.8%
17. I, not staff, decided my treatment goals.*	313	522	106	60	24	65	81.5%
18. Staff were sensitive to my cultural background (race, religion, language, etc.).*	403	466	84	26	11	100	87.8%
19. Staff helped me obtain information that I needed so that I could take charge of managing my illness.*	394	503	89	32	25	47	86.0%
20. I was encouraged to use consumer-run programs (support groups, drop-in clinics, crisis phone line, etc.).*	316	468	103	69	24	110	80.0%
As a result of the services received:							
21. I deal more effectively with daily problems.*	349	502	123	49	17	50	81.8%
22. I am better able to control my life.*	332	519	124	59	17	39	81.0%
23. I am better able to deal with crisis.	301	507	138	67	21	56	78.1%
24. I am getting along better with my family.	307	453	123	70	27	110	77.6%
25. I do better in social situations.	253	457	180	102	32	66	69.3%
26. I do better in school and/or work.	200	321	148	81	18	322	67.8%
27. My housing situation has improved.	232	377	183	85	25	188	67.5%
28. My symptoms are not bothering me as much.	241	464	145	129	43	68	69.0%
29. I do things that are more meaningful to me.	282	515	146	74	17	56	77.1%
30. I am better able to take care of my needs.	303	523	142	47	18	57	80.0%
31. I am better able to handle things when they go wrong.	265	510	157	77	30	51	74.6%
32. I am better able to do the things that I want to do.	267	496	166	84	22	55	73.7%
33. I am happy with the friendships I have.	297	512	131	74	23	53	78.0%
34. I have people with whom I can do enjoyable things.	328	506	102	85	23	46	79.9%
35. I feel I belong in my community.**	257	467	158	110	43	55	70.0%
36. In a crisis, I would have the support I need from family or friends.	402	453	89	62	32	52	82.4%

* Consumers responded significantly more positively to this question in 2009 than in 2008.

** Consumers responded significantly less positively to this question in 2009 than in 2008.

Table 5
2009 Youth Consumer Survey
Summary of Results

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Other	% Agree/ Strongly Agree
1. Overall, I am satisfied with the services my child received.	43	61	14	9	7	1	77.6%
2. I helped to choose my child's services.	45	58	14	10	4	4	78.6%
3. I helped to choose my child's treatment goals.	45	57	9	10	10	4	77.9%
4. The people helping my child stuck with us no matter what.	51	57	7	13	4	3	81.8%
5. I felt my child had someone to talk to when he/she was troubled.	44	55	10	16	4	6	76.7%
6. I participated in my child's treatment.	51	66	4	9	4	1	87.3%
7. The services my child and/or family received were right for us.	45	55	17	10	5	3	75.8%
8. The location of services was convenient for us.	59	52	4	10	10	0	82.2%
9. Services were available at times that were convenient for us.	52	62	7	7	7	0	84.4%
10. My family got the help we wanted for my child.	36	58	14	19	6	2	70.7%
11. My family got as much help as we needed for my child.	38	58	14	18	6	1	71.6%
12. Staff treated me with respect.	58	63	4	5	4	1	90.3%
13. Staff respected my family's religious/spiritual beliefs.	57	51	13	1	1	12	87.8%
14. Staff spoke with me in a way that I understood.	59	66	5	2	2	1	93.3%
15. Staff were sensitive to my cultural/ethnic background.	52	58	14	0	2	9	87.3%
As a result of the services my child and/or family received:							
16. My child is better at handling daily life.	31	51	18	21	8	6	63.6%
17. My child gets along better with family members.	26	58	19	17	7	8	66.1%
18. My child gets along better with friends and other people.	27	60	22	14	5	7	68.0%
19. My child is doing better in school and/or work.	26	51	20	19	7	12	62.6%
20. My child is better able to cope when things go wrong.	24	51	24	19	8	9	59.5%
21. I am satisfied with our family life right now.	33	53	18	20	8	3	65.2%
22. My child is better able to do the things he/she wants to do.	25	63	22	13	5	6	66.1%
23. I know people who will listen and understand me when I need to talk.*	44	71	11	5	1	3	87.1%
24. I have people that I am comfortable talking with about my child's problems.	50	75	4	2	1	3	94.7%
25. In a crisis, I have the support I need from family or friends.	52	69	7	4	0	3	91.7%
26. I have people with whom I can do enjoyable things.*	50	75	5	2	0	3	94.7%

* Consumers responded significantly more positively to this question in 2009 than in 2008.

Attachment 10**Harvey, Jim**

From: DiGeronimo, Richard (SAMHSA/CMHS) [Richard.DiGeronimo@samhsa.hhs.gov]
Sent: Saturday, October 31, 2009 5:20 PM
To: Harvey, Jim
Cc: Morrow, John (SAMHSA/CMHS); Berry, Joyce (SAMHSA/CMHS)
Subject: Video Conference
Importance: High

Jim, kudos on the review. It was GREAT! And I was not the only one who thought so. The entire panel, Deborah and Eugene were impressed - and Jim Morrow, who sat in. Nebraska should be proud. Everyone appreciated your thoroughness and your Midwest candor - particularly Scot Adam's. I was proud to be the state's PO. It was interesting and informative - with an appropriate level of humor. Please extend my congrats to your colleagues and my appreciation to you and Scot.

I tried to check on the paperwork that should have been faxed to you for your signature but missed Diann Fahey. (She had already left.) I found a verification copy of the fax indicating your phone was busy - I will check with Diann on Monday in KC. Again, thanks for the review.

11/02/2009

CMHS FY 2010 CONSULTATIVE REGIONAL PEER REVIEW

Summary Checklist

State: NEBRASKA

X The Adult Plan was approved as written.

 The Adult Plan was approved with the following modification(s):

1)

2)

3) N/A

4)

5)

OTHER:

Modifications to State Plans should be addressed by the State within 30 days. Please contact your State's Federal Project Officer before finalizing the modification to your State's Plan to ensure that it is approved.

10/30/2009
Date

Richard diGermino
Signature
Federal Project Officer

James H. Henry
Signature
State Planner

Pat Tabbatt
Signature
Planning Council Chair

CMHS FY 2010 CONSULTATIVE REGIONAL PEER REVIEW

Summary Checklist

State: NEBRASKA

 X The Child Plan was approved as written.

 The Child Plan was approved with the following modification(s):

- 1)
- 2)
- 3)
- 4)
- 5)

OTHER:

Modifications to State Plans should be addressed by the State within 30 days. Please contact your State's Federal Project Officer before finalizing the modification to your State's Plan to ensure that it is approved.

 10/30/2009
Date

 Richard diGeronimo
Signature
Federal Project Officer

 [Signature]
Signature
State Planner

 Pat Selbo
Signature
Planning Council Chair

**COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT**

DRAFT

file copy

IMPLEMENTATION REPORT – NARRATIVE

NEBRASKA DIVISION OF BEHAVIORAL HEALTH

Report to the

MENTAL HEALTH SERVICES ADVISORY COMMITTEE

November 5, 2009

Narrative Content of the Implementation Report

Adult

1. Summary of Areas Previously Identified by State as Needing Improvement

The Division of Behavioral Health analysis of unmet service needs and critical gaps include the following:

GAP #1: CONSUMER INVOLVEMENT

GAP #2: THE PREVALENCE OF MENTAL ILLNESS AND NUMBER OF INDIVIDUALS SERVED BY SYSTEM.

GAP #3: INFORMATION SYSTEM IMPROVEMENT

GAP #4: SHORTAGE OF BEHAVIORAL HEALTH WORKFORCE

GAP #5: MEDICATION ACCESS

GAP #6: CULTURALLY AND LINGUISTICALLY COMPETENT SERVICES

GAP #7: MENTALLY ILL INMATES IN THE STATE CORRECTIONAL SYSTEM

2. Most Significant Events that Impacted the State Mental Health System in the Previous FY

The Division of Behavioral Health moved \$30.1 million from the Regional Centers to Community Services

The Division has redirected \$30 million in permanent funding to community-based services since July 2004, making it possible to close 232 adult beds and 16 adolescent mental health beds at the Regional Centers. These funds are now being used to purchase community based services through the six Regional Behavioral Health Authorities.

Emergency Systems Benchmarks/Diversion Rates (August 28, 2009)

Starting State Fiscal Year 2009, the Nebraska Psychiatric Emergency Systems Team implemented a new process to measure outcomes and emergency system diversion rates across the state. Representatives from the six Regional Behavioral Health Authorities and the Division of Behavioral Health make up the Nebraska Psychiatric Emergency Systems Team. The team formed benchmarks to be used to measure effectiveness of the emergency system. The preliminary data for this report was gathered from five of the six regions for the first three quarters of FY2009 (July 1, 2008 through March 31, 2009). At this time, FY2009 data are not available for the Region 6 area (Omaha metro).

The following is a description of the findings from the first three quarters of FY2009.

From the five reporting Regions, there were 1,010 individuals (duplicated count) placed in Emergency Protective Custody (EPC) during the first three quarters of FY2009.

– A major goal of the Emergency System is to provide services in the community to support consumers rather than utilizing the commitment process whenever possible. Data shows that a reported 65.3% of individuals (n=660) had their EPC status dropped prior to receiving a commitment order.

- Another goal of the Emergency System is to reduce the number of individuals ordered into an inpatient commitment. During the first three quarters of FY2009, only approximately individuals placed under EPC were ordered to complete an inpatient commitment.
- The Emergency System has set another goal that consumers who are placed in EPC will receive the support they need to remain in the community of their choice without the need for legal involvement. This is measured by a low number of individuals receiving repeat EPCs. This is another goal being met with only approximately 12% of consumers receiving more than one EPC in a 12-month period.

Lincoln Regional Center Waiting List

The waiting list for both General Psychiatric and Forensic Mental Health Services has experienced a significant decrease. On December 30, 2008 the Lincoln Regional Center General Psychiatric Waiting List chart was zero (0). Using the same 30 week time period (January to July), the General Psychiatric Waiting List has gone from an average of 18 in 2007 to 3.2 in 2009. There have been two weeks in 2009 (4/14/09 and 7/7/09) where the waiting list for General Psychiatric Services at the Regional Centers was at zero (0). Meanwhile, under Forensic Mental Health Services, the waiting list average for the same 30 week period dropped from an average of 9.1 down to 3.4.

The Nebraska Behavioral Health System did an incredible job of working together to ensure those individuals who needed the Regional Center Level of Care received that service in a timely manner AND those same individuals were transitioned into community when they were ready for discharge. This achievement takes into account that the Lincoln Regional Center is one of the most restrictive and high end levels of care in the system. It shows that individuals move efficiently through this part of the Nebraska system. It reflects the shared vision under Behavioral Health Reform of wanting the consumers to be safe, receive quality services, and move to their community as soon as they were ready.

“LB95” Psychiatric Medications Indigent Drug Reimbursement

The “LB95” Psychiatric Medications Indigent Drug Reimbursement website was updated in October 2008 to help improve access to the program. The detailed eligibility procedures are on the Nebraska Department of Health and Human Services, Division of Behavioral Health web site under Community-Based Services, Psychiatric Medications for the Indigent. <http://www.dhhs.ne.gov/beh/LB95/index.htm>

Network of Care for Behavioral Health

The Division of Behavioral Health signed a contract with Trilogy Integrated Resources, LLC in August 2008. On March 18, 2009, the new Behavioral Health “Network of Care” Web Site was officially launched. Trilogy Integrated Resources LLC of San Rafael, CA created, developed, and maintains the Network of Care for Behavioral Health for the Division of Behavioral Health in the Department of Health and Human Services.

The Behavioral Health “Network of Care” Web Site is an easy-to-use Web Site is a comprehensive, Internet-based community resource for people with mental illness, their

caregivers and service providers. “The Network of Care site is a big step forward in helping people find services and connect and share their stories,” said Scot Adams, Director of the Division of Behavioral Health. “This one-stop information tool lets you access vital information about treatment resources and diagnoses, insurance, and advocacy, and find other pertinent behavioral health Web Sites. Consumers can also choose to communicate directly with others and to organize and store personal health records.”

Benefits of this Network of Care Web site include:

- Helping people find the right services at the right time. Click anywhere on the Nebraska map on the home page to get a comprehensive Service Directory of providers, organized by Behavioral Health Region.
- Giving consumers the option to use the secure Personal Health Record section to organize and store medical and healthcare-related information.
- Having communication tools like message boards and community calendars to help people connect with each other or share information.
- Facilitating providers who want to share challenges and ideas or use the private message boards. Providers can even build their own free Web sites.
- Accessing the easy-to-search libraries; information about specific behavioral health disorders, pending legislation and advocacy; and daily news articles and the latest research about mental health and substance abuse issues from around the world.
- Having a site that is fully ADA-compliant and that offers a text-only version.

The Network of Care for Behavioral Health is on the Nebraska Division of Behavioral Health Web site. <http://www.dhhs.ne.gov/networkofcare/>. This web site is a resource for individuals, families and agencies concerned with behavioral health. It provides information about behavioral health services, laws, and related news, as well as communication tools and other features. The user of this web resource starts by either selecting a county on the map provided or by viewing a text listing of counties.

Regardless of where you begin your search for assistance with behavioral health issues, the Network of Care helps you find what you need - it helps ensure that there is "No Wrong Door" for those who need services. This Web site can greatly assist in our efforts to protect our greatest human asset - our beautiful minds.

The web site can be displayed in 14 different languages, and offers a Service Directory. It can direct you to a number of different service categories including Addiction Recovery, Advocacy and Assistance, Caregiver & Respite Services, Case/Care Management, Children and Families, Crisis and Emergency Services, Developmental Disabilities, Disability Issues/Assistance, Education, Employment, Health Care, Housing and Shelter, Information & Referral Insurance & Benefits, Legal Services, Mental Health Services & Facilities, Military/Veterans' Services, Problem Gambling Services, Residential/Inpatient Care, Self-Help and Support Groups, and Senior Services. The web site includes: COMMUNITY ANNOUNCEMENTS (such as the Alternatives Consumer Conference being held in Omaha October 28 through November 1, 2009), Free Online Consumer Trainings for People Working on Their Recovery, and other resources.

Carol Coussons de Reyes is Director of the Behavioral Health Office of Consumer Affairs

On April 1, 2009, Scot Adams, announced he is appointing Carol Coussons de Reyes, CPS, MS, as Administrator for the Office of Consumer Affairs, effective May 18, 2009. "Carol's personal experience, professional education and unique leadership history make her particularly suited to this position," said Adams. "She will be a valuable addition, and her lived experience with mental illness, wellness, and recovery will add great value to her role. I look forward to benefiting from her experiences and background with advocacy for consumers."

Coussons de Reyes has served as director of the Consumer Relations and Recovery Section in the Georgia Department of Human Services since 2006. Her background includes serving as a Certified Peer Specialist, research coordinator for the Georgia Department of Veterans Affairs Medical Center, research specialist at Emory University, Counselor for South Carolina Vocational Rehabilitation, and psychology technician for the Medical College of Georgia. Coussons de Reyes received a Masters of Psychology at Augusta State University, Augusta, Georgia and a Bachelor's degree in Psychology from Georgia State University.

The Office of Consumer Affairs was created by the Legislature in 2004. The program administrator of the Office must be a consumer or former consumer of behavioral health services and have specialized knowledge, experience or expertise relating to consumer-directed behavioral health services, delivery systems and advocacy on behalf of consumers and their families.

Behavioral Health Workforce Act

LB 603 created the Behavioral Health Workforce Act. LB 603 provided findings regarding the shortage of behavioral health professionals, and the fact this shortage leads to inadequate accessibility and response to behavioral health needs of all Nebraskans. The purpose of this act is to improve community-based behavioral health services and focus on addressing behavioral health issues before they become a crisis through increasing the number of behavioral health professionals and their training. LB 603 creates the Behavioral Health Education Center. This center was created on July 1, 2009 and is administered by the University of Nebraska Medical Center. This center is required to provide funds for additional medical residents in a Nebraska-based psychiatry program, provide psychiatric residency training experiences that serve underserved areas, focus on training of behavioral health professionals in tele-health techniques, analyze the geographic and demographic availability of behavioral health professionals, prioritize the need for additional professionals, establish learning collaborative partnerships and develop interdisciplinary behavioral health training sites. Reporting requirements are provided for this center.

Lincoln Regional Center Received a Perfect Score on Federal Survey

In a press release on December 23, 2008, it was announced that the Lincoln Regional Center (LRC) received a perfect score on a Federal Survey. For more information please go to: <http://www.lhhs.state.ne.us/newsroom/newsreleases/2008/Dec/lrc.htm>

The Lincoln Regional Center (LRC) passed a Center for Medicare and Medicaid Services (CMS) survey of general psychiatric services with no deficiencies. State CMS Surveyors interviewed staff and patients and reviewed all internal investigation reports, all incident/accident reports, all restraint seclusion reports, and 10 patient records. They also reviewed staffing plans for all of Nursing Service and Programming and determined that the plans in place are appropriate. Part of LRC's success is because of the emphasis on trauma-informed care, which focuses on wellness and recovery for trauma survivors, their families and treatment providers.

Justice Grant

The Division of Behavioral Health received a grant from the U.S. Department of Justice – Bureau of Justice Assistance (BJA) Grant - Justice and Mental Health Collaboration Program (CDFA #16.745) which is a CATEGORY II: PLANNING AND IMPLEMENTATION grant. The Award Project Period is from September 1, 2008 through August 31, 2011. The Grant maximum is \$250,000. The Nebraska Theme is: collaborative partnerships to address interagency coordination & communication to implement system improvements for persons with Mental Illness in the Criminal Justice System. The Target Population is young adults 18 to 24 years of age.

The Nebraska Justice Behavioral Health Initiative / Strategic Plan complete report (October 31, 2008) is on the Division of Behavioral Health web site at: Division of Behavioral Health: Community-Based Services Recent Reports
http://www.dhhs.ne.gov/beh/NEJusticeMHStrategicPlan-UN_PPCTFinalReport-Oct31_2008.pdf

In a study released by the Justice Center at the Council of State Governments (June 1, 2009 - New Study Documents High Prevalence of Serious Mental Illnesses among Nation's Jail Populations) researchers found that 14.5 percent of the men and 31 percent of the women interviewed in the jail population, suffered from serious mental illness. They accounted for 16.9 percent of the total jail population. The Division of Behavioral Health is implementing a grant from the US Department of Justice. The Justice and Mental Health Collaboration Program will increase public safety by facilitating collaboration among the criminal justice, juvenile justice, and mental health and substance abuse treatment systems to increase access to services for offenders with mental illness.

Goal 1: Provide consistent statewide training for Nebraska Law Enforcement Officers to improve responses to people with mental illnesses.

Progress: Regions are currently attending Omaha Crisis Intervention Team (CIT) training, and reviewing curriculum to adapt to their regions. Risk assessment training materials are a resource for regions.

Goal 2: Expand or improve access to crisis response services in Nebraska.

Progress: Regional crisis teams working on data collection protocols.

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

Progress: Work team developed recommendations for jail screening protocols which will be submitted to Jail Standards Board.

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

Progress: Invitation issued to regions to submit interest in pilot project. Region 3 Behavioral Health was selected based on review. Justice grant funds will be used to pilot a rural jail mental health diversion program in Buffalo County. The next step involves technical assistance provided to start up rural diversion program in Buffalo County.

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

Progress: Corrections housing team meeting to identify offenders with serious mental illness and develop protocols for transition. Independent Living Plan Team meeting to develop protocols for identifying youth with a Serious Emotional Disturbance and transitioning to housing, employment and mental health treatment.

Criminal Justice Electronic Data Transfer Interagency Agreement

On June 9, 2009, the Nebraska Department of Health and Human Services - Division of Behavioral Health (DHHS-DBH), the Nebraska Department of Correctional Services (DCS) and the Nebraska Commission on Law Enforcement and Criminal Justice (Crime Commission) signed Electronic Data Transfer Interagency Agreements. These agreements require these three state agencies to transfer their data to the Division of Epidemiology, College of Public Health at the University of Nebraska Medical Center in Omaha, NE for the purpose of analysis, compilation and reporting for the mutual benefit of the parties. The initial data covers the time period from January 1, 2005 to December 31, 2008. Before public release, the report(s) produced under these agreements must be acceptable to DHHS, DCS and the Crime Commission. The report(s) remain in draft status until these three agencies approve the document. This requirement is due to the sensitive nature of the content of the report(s) using these data.

Administrative Services Organization (ASO) Contract

The Magellan Behavioral Health contract for Administrative Services Organization (ASO) covering three Divisions in the Department of Health and Human Services-- Division of Behavioral Health, Division of Children & Family Services, and Division of Medicaid & Long Term Care continues to be a significant achievement. This has increased the level of collaboration and coordination between these three Divisions. This contract ends on June 30, 2010. There are annual options for contract renewal for State Fiscal Years 2011, 2012 and 2013. A formalized meeting structure was established to address a variety of issues.

- Monthly meeting with the three divisions to discuss the contract and service delivery plans and issues;

- Monthly meeting with three divisions plus Magellan to discuss the contract and service delivery implications;
- Quarterly meeting with DHHS Division Directors and DHHS Magellan Contract Liaisons to discuss service and contract issues; and
- Network Development meeting with the three divisions and Magellan to identify current projects, address service gaps, contact deliverables and related areas.
- Medicaid and Long Term Care and DBH have held multiple meetings regarding service definitions and regulations.

Transformation Transfer Initiative Grant (TTI)

On November 4, 2008, the State Advisory Committee on Mental Health Services, which serves as the State Mental Health Planning Council under the Federal Community Mental Health Services Block Grant reviewed this proposal. This Committee made the following recommendation: "This Committee recommends support for this proposal. This includes Peer Support for both consumers and the family members. It is timely in the state's transformation."

The Division of Behavioral Health submitted the grant application on November 6, 2008. The Division of Behavioral Health was notified by National Association of State Mental Health Program Directors (NASMHPD) on December 8, 2008 of the grant award. Due to the nature of the grant, a contract needed to be developed between NASMHPD and the Division. That contract was signed on March 26, 2009.

The contract included the following Scope of Work:

- Prepare a Request for Proposal (RFP) in order to select a qualified trainer(s) for Peer Support Training. In preparing the RFP, Regional Consumer Specialists, consumer organizations and other stakeholders will be fully involved.
- Administer a competitive bid process to select a qualified contract(s) to provide Peer Support Training in Nebraska. Regional Consumer Specialists, consumer organizations and other stakeholders will be fully involved in this process.
- Complete an evaluation of the Peer Support Training including but not limited to the development and administration of a strategy involving a pre-test, and post-test of consumers attending the training, data analysis and reporting of results.
- Complete an analysis on what other states are doing in the Peer Support area.
- Schedule to hold between three and six Peer Support Training sessions across the state.
- Schedule to hold one Train the Trainer session with consumers who can teach the curriculum.
- Schedule to hold one statewide meeting on Peer Support.

The State Advisory Committee on Mental Health Services wanted both consumers and the family members to be addressed under the TTI grant. The initial work on the TTI grant addressed both. However, as LB603 moved forward, including the § 71-823 Family Navigator Program, the decision was made to drop the family members from the TTI grant. This was because LB603 expects a peer support type of service, called Family Navigator Program, to be established no later than January 1, 2010. The program will be

administered by the Division of Behavioral Health, and consist of individuals trained and compensated by the Department of Health and Human Services. The Children and Family Behavioral Health Support Act (71-821 to 71-827) was added to the Nebraska Behavioral Health Services Act under LB603, 2009 (operative date May 23, 2009). This law was designed to address the issues raised by the safe haven law.

The overall goal of the TTI Grant is to develop and implement a Peer Support Workforce model. The core discussion involved how to convert the draft Service Definition of Peer Support into something that could be used for a Peer Support Workforce Model. The decision point for this will be in the Request for Proposal (RFP). The RFP for the qualified trainer(s) for Peer Support Training needs to reflect the Peer Support Core Competencies required as part of the Nebraska Behavioral Health System workforce. The RFP was prepared by the University of Nebraska Public Policy Center in consultation with the six Regional Consumer Specialists, the Regional Administrators (or their designee), consumer organizations (National Alliance for the Mentally Ill – Nebraska, Mental Health Association of Nebraska, Partners in Recovery, and the Nebraska Federation of Families) and other stakeholders.

Carol Coussons de Reyes, Office of Consumer Affairs Administrator, is the Project Manager for the TTI Grant.

The Division of Behavioral Health contracted with the University of Nebraska Public Policy Center (UNPPC) to help assist in the implementation of the TTI grant. The Scope of Work includes: Prepare a Request for Proposal (RFP), Administer a Competitive Bid Process, Complete an Evaluation, Prepare a report on What Other States Are Doing, and related tasks.

During the August 13, 2009 review by the State Advisory Committee on Mental Health Services, a committee member indicated she had never heard of anyone talking about a Peer Support Workforce model. Here is the reply to this question:

The Office of Consumer Affairs had the first TTI Steering Committee meeting on July 27, 2009 to determine what model of Peer Support Training would be established. For the TTI Steering Committee, UNPPC tried to keep the Committee focused on competencies for Peer Support Specialists that would be applicable across service delivery models. This is what UNPPC needed to include in the training and the RFP, so the focus was not on models. The first meeting included a wide range of topics such as funding for peer support services, why consumers weren't part of the initial application, peer support models, whether talking about models even makes sense, whether the Division will accept their recommendations, whether national groups will allow Nebraska to use and modify training curriculums, etc. Having the group focus on competencies has been successful in moving the group forward. The review of what other states are doing will include different service delivery models; however the competencies of Peer Support Specialists should be the same across models.

Unmarked Grave Memorial

Dan Powers, Consumer Liaison with the Office of Consumer Affairs in the Division of Behavioral Health, was recognized for his suggestion of an Unmarked Grave Memorial to be established at St. Elizabeth Hospital in Washington D.C. In August 2004, Dan had the idea that the anonymous people buried in unmarked graves on state hospital grounds across the country should have a national memorial. He started talking with others, like Larry Fricks, a man with many national connections. The memorial is not built yet, but the steering committee, representing at least seven national organizations, is raising the more than \$1 million needed. Dan attended the recent dedication ceremony. The story was documented by Nancy Hicks of the Lincoln Journal Star, and can be viewed at: <http://journalstar.com/articles/2009/06/22/news/local/doc4a3eea61111c5272849911.txt>

Collaboration between the Behavioral Health and Developmental Disability Systems

Region 6 Behavioral Healthcare (Omaha) was the recipient of a grant from the NE Planning Council of Developmental Disabilities. One year has been completed, with two years to go. This grant was designed to strengthen collaboration between the behavioral health and developmental disability systems, in the hope that the two systems could work together to help individuals who are dually diagnosed. The term dual diagnosis applies to the co-existence of the symptoms of both intellectual or developmental disabilities and mental health problems. One goal is to raise awareness of the need for specialty care, behavioral health services for people with developmental disabilities, with a focus on behavioral health. It was designed to address issues such as the dually diagnosed population being caught between the two systems with no one wanting to take responsibility for serving them. It also looked at the fact that there are a limited number of mental health practitioners with skills and knowledge to serve persons with developmental disabilities and the struggle to come up with appropriate services for what seems to be an increasing number of dually diagnosed individuals.

It is expected that changes in the business practices within the behavioral health and developmental disability systems will be a long term process. It has been the vision that year one of the grant would focus on organizational activities, year two will focus on planning and year three would move toward operationalizing the system changes. Several key grant activities include:

Project Steering Committee -

- The purpose of this committee was to develop an increased understanding of both the developmental disability (DD) and the behavioral health (BH) systems to identify challenges and help work on the development of strategies toward integrating the two systems at the local level in Omaha, NE.
- The committee membership consist of representatives from Munroe Meyer Institute, Eastern Service Area - Service Coordination, Alegent Medical Center, University of Nebraska Medical Center, a mix of providers from the developmental disability and behavioral health systems, consumers/family members, state representatives, Eastern Nebraska Community Office of Retardation (ENCOR), National

Association for the Dually Diagnosed (NADD), other stakeholders, and staff from Region 6 Behavioral Healthcare.

Consultation Services –

- This is a contract with the National Association for the Dually Diagnosed (NADD). The consultation was provided by Dr. Robert Fletcher, Executive Director of NADD. The service includes personal visits to Omaha, as well as hours of consultation via phone and email.

Case Reviews –

- A joint system case review for persons with a dual diagnosis. For example, during the first year, individuals reviewed were originally at either the Norfolk Regional Center or the Lincoln Regional Center.

Planning Activities -

- Two primary needs have surfaced to date:
 1. Education/training - Education (for individuals working in both systems) was identified as one of the challenges to help improve system collaboration and cooperation. This is education for mental health and developmental disability professionals. Education and training is needed at all levels of both systems. This includes clinical staff, administration and direct care staff.
 2. Psychiatric urgent/crisis care - the challenge of psychiatric urgent/crisis care for the developmentally disabled was identified. This would be some type of crisis component to assist staff when an individual is experiencing a psychiatric crisis.

Revising Service Definitions and Regulations

The Division of Behavioral Health, in partnership with the Division of Medicaid and Long Term Care, has implemented a process to collaboratively review each of the service definitions for the Mental Health waiver and non-waiver services. The Division is proceeding with the development of the Title 206 Rules and Regulations revision process. To date, there have been a number of drafts produced with input from a variety of stakeholders. The package of service definitions will be moved into the draft Title 206 Regulations. As a result, they will undergo another public review through the regulation review process.

The draft for the Service Definitions and the Regulations can be seen on the NE Department of Health and Human Services web site under the Division of Behavioral Health: Community-Based Services section – Quality Improvement Projects - Adult Behavioral Health Service Definitions - Draft Regulations
<http://www.dhhs.ne.gov/beh/behindex.htm>

Child

1. Summary of Areas Previously Identified by State as Needing Improvement

In attempting to identify the prevalence rates of children and youth with severe emotional disturbances (SED) in Nebraska, we look to the number of cases of youth diagnosed with an SED at a specific time. The penetration rate is the number of children/youth with this diagnosis that have received services through the Department of Health and Human Services (DHHS) system which includes the Division of Behavioral Health, the Division of Child and Family Services, the Juvenile Justice Systems, and those receiving service paid thru Medicaid or private insurance. Our current data on this prevalence indicates that 3750 (2008 data) children were served by the Nebraska Division of Behavioral Health. At this time, Nebraska does not have the capacity to determine the penetration rate for all systems for children with severe emotional disturbances because youth often cross systems and gathering an unduplicated count is difficult. However, at the end of this upcoming fiscal year, we expect to be able to identify unduplicated counts between the three Divisions pending the compliance with our Administrative Service Organization. Nonetheless, there is minimal ability to monitor children and youth with SED that are not receiving services but would qualify and should be receiving appropriate care. The Department is anticipating that the utilization of the children's behavioral help line may provide some additional indication of needs as evidenced by parents calling for assistance and the tracking of relevant data. In addition, there is a need for a standard outcome measurement system to more accurately identify youth in multiple systems of behavioral health, child welfare, education and juvenile justice. The Department has been working towards this goal. The challenge is the multiple indicators that may be required from the variety of funding streams, review systems or otherwise and oversight bodies. Services in the public system are targeted to specific groups such as those financially eligible for Medicaid or those in child welfare which includes abuse and neglect, juvenile justice, and/or severe behavioral health disordered youth. Unfortunately, this results in a gap in services between the multiple systems which has grown in the current economic conditions of the state and country. An additional difficulty is identifying which target population the Division should serve amidst the challenges of funding limitations, guidelines and priorities. This fall, DHHS will receive the final results of the 'state ward study,' administered to better identify the prevalence, precursors and implications of youth entering state custody. This study will identify potential gaps in behavioral health services and identify the occurrence of state ward solely to access behavioral health services. This occurrence combined with other issues, has created a high out-of-home placement rate within Nebraska. Currently, around 60% of state wards are in out-of-home care, but at a steady decline and reduction in the last year from 70%. This decrease demonstrates a trend in the right direction. Without an increase in funding, our challenge is to restructure the delivery of services to promote more preventative and early intervention services in order to reduce the number of out of home placements as well as reduce the need for deep end services. Expanding the service array is imperative as are collaborative partnerships with all systems that directly impact the lives of children, youth and families.

There are several special populations that the Division considers a priority due to service capacity barriers. Most specifically, youth in transition and children ages birth to five.

Youth in transition have several barriers that include developmentally appropriate services, payment for services, vocational issues and lack of service providers. There have traditionally been few services that provide the coordinated effort to help youth transition into adulthood besides addressing the more complex needs of mental health disorders. The Division of Behavioral Health has revised the Age Waiver criteria. This waiver addresses youth ages 17-18 that are currently involved in care but will age out and need to transition to adult services. Currently, Nebraska lacks an evidence based practice for this population and is experiencing challenges with identifying appropriate treatment for these youth. Often, these youth are aging out of the child welfare system where placement was secured with treatment in a residential facility. Many adult providers are ill equipped to address the complex needs of this population. Serving these youth effectively will mean more than evidence based treatment, but often habilitating, and the establishment of more informal supports that remained limited while in state care. It is anticipated that the new services being implemented January 1, 2010 and authorized by LB603 will provide some insight into additional system needs. There will be an evaluation of the Help Line, Family Navigator and Post Adoption/Post Guardianship Services to determine not only service effectiveness but also the implications and system barriers/strengths identified by the use of these services. This component will allow DHHS to further review system needs and strategically plan for service implementation.

2. Most Significant Events that Impacted the State Mental Health System in the Previous FY

This year marks the end of the five-year State Infrastructure Grant (SIG). The recommendations made by the Steering Committee for SIG have supported DHHS development of organizational and financial structures, policy changes, needs assessment and strategic planning for children/youth with severe emotional disturbances. A sampling of several pilot projects includes the expansion of a single assessment tool. The Comprehensive Family Assessment, Crisis Response trainings using a Crisis Intervention Team (CIT) model averted for rural youth, Program Evaluations, Evidence Based Practice Consortium, and the strengthening of the family organizations and the Nebraska Federation of Families for Children's Mental Health via technical assistance that enhanced infrastructure allowing agencies to identify sustainable funding. The Division of Behavioral Health and Division of Child and Family Services participate in the Nebraska "*Through the Eyes of the Child*" project. This Juvenile Justice Initiative creates awareness of a child's journey through the juvenile justice system and increases visibility of a child or adolescent's special mental health needs. There also was further distribution of three brochures throughout the state as a response to the complications families and youth endure while addressing their mental health needs. These three learning tools are: the "Children's Service Initiative", which describes how to access mental health and substance abuse services for Nebraska children; the "Your Child and Psychiatric Medications", which aids parents in addressing and inquiring about the potential medications a young person may be prescribed; the "Adolescents and Psychiatric

Medications”, which aids youth on their journey to learn and deal with their potentially prescribed meds. These tools have proven very beneficial and are distributed via paper and web.

The new Help Line and Family Navigator Services, is administered by the Division of Behavioral Health in collaboration with the Division of Children and Family Services. It is considered a valiant success for state funding to be appropriated to family/peer support services. The Department believes in the facilitation of family centered practice, early intervention services and youth/family empowerment in decision making for service planning.

- Children’s Behavioral Health Help Line – a 24/7/365 urgent care line staffed by trained behavioral health professionals supervised by licensed behavioral health professionals aimed at providing crisis response and service referrals to youth and families in need of behavioral health services aimed at reducing morbidity of immediate crisis, improving access and retention as well as reducing police involvement and/or restrictive levels of care;
- Family Navigator Services – a family peer support service aimed at assisting families in navigating the sometimes complex system of behavioral health services designed to empower, encourage and connect families who have called the Help Line, available within 24-72 hours after the call and increasing access to services, retention, social connection and consumer satisfaction. These services will begin January 1, 2010 after a competitive bid process during the fall of 2009. The evaluation of these services will result in indicators to measure the success of the services and the strengths and weaknesses of our system as evidenced by consumer experience. LB603 also provided for the limited existence of a Legislative Oversight Commission who will be monitoring the service implementation and evaluation. In addition to these new services, a significant barrier in data collection has been addressed by SIG. A standardized, statewide information system is crucial for the DHHS Division of Behavioral Health to make informed policy and program decisions regarding children’s behavioral health and to evaluate its Professional Partners Program. Such an information system can be thought of as being comprised of three separate processes: data collection, data entry & storage, and data analysis & reporting. Over time, the individual behavioral health regions have developed separate databases and information systems for data entry and storage. Due to data compatibility issues after the submissions, the process of merging the data took the better part of three months. After the recent submissions, the process took less than three days. As a result, the state’s efforts over the last six months to merge the existing regional databases have been effective and beneficial. One of the most exciting areas of potential for the state is the capacity to couple the newly merged outcome data with the existing financial data to conduct cost-effectiveness studies using techniques such as Data Envelopment Analysis (DEA). The data collected in the regions represent a very rich source of information regarding the Professional Partners Program and its effect on children’s behavioral health in the state. Over the next several months, the state will analyze the data contained in the newly merged statewide database to take advantage of the information that currently

exists piecemeal in each individual region. This achievement will result in the ability to utilize the rich data sources collected across the state and perform data driven decision-making, fulfilling another goal of the DHHS Implementation Plan Pursuant to LB542.

**COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT**

DRAFT

IMPLEMENTATION REPORT – EXPENDITURES

NEBRASKA DIVISION OF BEHAVIORAL HEALTH

Report to the

MENTAL HEALTH SERVICES ADVISORY COMMITTEE

November 5, 2009

Narrative Question:

A report on the purpose for which the block grant monies for State FY were expended, the recipients of grant funds, and a description of activities funded by the grant.

Use of Federal Mental Health Block Grant in FY2009

This is a report on the purposes for which the Federal Community Mental Health Services Block Grant (MH Block Grant) monies for State Fiscal Year 2009 were expended, the recipients of grant funds, and a description of activities funded by the grant.

The Federal Fiscal Year 2009 Award

According to the Notice of Award issued on 05/02/2009 for the program "Block Grants for Community Mental Health Services", the total FY2009 Federal funds approved for Nebraska was **\$1,925,411** during Federal Fiscal Year 2009 (October 1, 2008 through September 30, 2009) with the award period starting 10/01/2008 and ending 09/30/2010.

Expenditures of Community Mental Health Block Grant Funds

The information below shows purpose for which the block grant monies for State FY2009 were expended:

The MH Block Grant 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. These funds need to be used consistent with the restrictions in Federal law and the annual guidance. 59.1% of MH Block Grant Funds were expended on Adult Services, and 40.9% of MH Block Grant Funds were expended on Children's Services.
- (2) The 5% administrative portion was used to support MH Block Grant Adult Goal #2: Empower Consumers. The application for the MH Block Grant provides details on this.
- (3) Funds used to help support the "Independent Peer Review" (per Section 1943 in Attachment A - Community Mental Health Services Block Grant Funding Agreements).
- (4) Beginning with the SFY09, the Department of Health and Human Services-Division of Behavioral Health (DHHS-DBH) altered the source of information used for completion of all grant related reports from the use of self-reported "Actuals" from Regional Behavioral Health Authorities (RBHA) to the use of the State Accounting System, Nebraska Information System (NIS). Prior to this time, a portion of DBH reports were completed using the NIS system, while others were completed using the RBHA self-reported Actuals. This switch enables the Division to consistently complete reports as well as to more accurately reflect expenditures within the State fiscal year rather than expenditures based upon a contract period.

Due to the overlapping nature of contract periods within a state fiscal year and the use of "Actuals" in prior reports, approximately \$200,000 of funds included in this report may have been reported in the prior Implementation Report. It is acknowledged that \$350,630 more is reported on the table on Page 2 of this report than the FY2009 Award.

Funds expended in this Implementation Report are comprised of monies from two Community Mental Health Services Block Grants. This is due to the time differential between State and Federal Fiscal Years, as well as the fluctuations of expenditures submitted by contractors during the reporting period. For the Grand Total \$2,276,041 expenditures indicated, \$1,183,921 of the funds

Adult – Child: Purpose State FY BG Expended – Recipients – Activities Description
DRAFT Implementation Report / October 27, 2009 / Page 2

were from the FFY08 award and \$1,092,120 were from the FY09 award (Total FFY09 award amount = \$1,925,411). To date, not all Federal FY2009 funds have been expended.

In viewing this report, one needs to keep in mind that:

- This report is prepared from the point of view of State Fiscal Year.
- The six Regional Behavioral Health Authorities are under contract with the Department of Health and Human Services (DHHS) Division of Behavioral Health (DBH).
- The Federal Community Mental Health Services Block Grant funds must be obligated and expended within the two-year period.
- There is a lag time for the cash to flow from a Federal Notice of Grant Award, into a contract with Regional Behavioral Health Authorities and ending in a form of payment for services.

Federal Community Mental Health Services Block Grant Funds Expended in State Fiscal Year
2009 - as reported by the Regional Behavioral Health Authorities

Adult	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Total	% of Funds Used
Community Support		101,631	18,617	32,177			152,425	
Day Rehabilitation		63,741				192,976	256,717	
Psych Residential Rehabilitation						240,607	240,607	
Dual Residential Treatment					1,558		1,558	
Day Treatment					52,222		52,222	
Medication Management	6,392		4,216				10,609	
Outpatient Therapy (Ind/Grp/Fam)	21,302		34,211	24,633	159,590	192,454	432,190	
Peer Support			34,008				34,008	
Day Support	33,365		3,366				36,731	
Supported Employment	1,463		25,538	40,916			67,917	
Total Adult Services	\$62,523	\$165,372	\$119,956	\$97,726	\$213,370	\$626,037	\$1,284,983	59.1%
Children	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Total	
Therapeutic Consultation (PL 100-690) Service	37,966	16,125	10,357		69,832		134,280	
Day Treatment (P.L. 102-321) Service			32,937				32,937	
Children's Multi-Systemic Therapy			48,503				48,503	
Professional Partner	78,013		47,030	163,688	153,941	186,073	628,745	
Children's Intensive Outpatient					44,733		44,733	
Total Children Services	\$115,979	\$16,125	\$138,828	\$163,688	\$268,506	\$186,073	\$889,199	40.9%
Grand Total Services Expenditures	\$178,502	\$181,497	\$258,784	\$261,414	\$481,876	\$812,110	\$2,174,182	
Peer Review							5,589	
Administrative							96,270	
Grand Total							\$2,276,041	

Adult – Child: Purpose State FY BG Expended – Recipients – Activities Description
DRAFT Implementation Report / October 27, 2009 / Page 3

-Nebraska Information System, Fiscal Year 2009 Summary of Expenditures; Behavioral Health Administration Program 268 as of June 30, 2009

-Regional Behavioral Health Authority Monthly Billing Documents submitted July, 2008 through June 2009; and verified by payments made through the State Accounting System (Nebraska Information System)

The Recipients of Community Mental Health Block Grant Funds

The six Regional Behavioral Health Authorities were the recipients of the funds. The "Nebraska Behavioral Health Services Act" (Neb. Rev. Stat. §§ 71-801 to 71-818) was passed by the Legislature and signed by the Governor in 2004, with amendments in the years that followed (2005 – 2009). The NBHS Act specifically authorizes "Regional Behavioral Health Authorities" (RBHA) under Neb. Rev. Stat. §§ 71-807 to 71-809. The NBHS Act revised the regional administration of the system. The NBHS Act retained the six geographic "regions" established in 1974. It re-authorized the six regions and renamed them "Regional Behavioral Health Authorities" (RBHA). The RBHA are local units of government organized under the Inter-Local Cooperation Act for the purpose of planning, organizing, staffing, directing, coordinating and reporting of the local service systems of mental health, and substance abuse within assigned geographic areas (regions). Each county participating in the region appoints one county commissioner to the Regional Governing Board to represent that county and to participate in the decision making of the Regional Behavioral Health Authority (RBHA). The RBHA is staffed by the Regional Program Administrator who in turn hires sufficient staff to accomplish the tasks within the region. RBHA contracts with local providers for service delivery.

DESCRIPTION OF ACTIVITIES / ADULT SERVICES

- Community Support – MH - Community Support is a rehabilitative and support service for individuals with primary Axis I diagnosis consistent with a severe and persistent mental illness. Skilled paraprofessionals provide direct rehabilitation and support services to the individual in the community, most generally the individual's home, with the intention of supporting the individual to maintain stable community living, and prevent exacerbation of mental illness and admission to higher levels of care.
- Day Rehabilitation – MH - Day Rehabilitation services are designed to provide individualized treatment and recovery, inclusive of psychiatric rehabilitation and support for clients with a severe and persistent mental illness and/or co-occurring disorders who are in need of a program operating during day hours. The intent of this service is to support the individual in the recovery process so that he/she can be successful in a community living setting of his/her choice.
- Psychiatric Residential Rehabilitation – MH - Psychiatric Residential Rehabilitation is designed to provide individualized treatment and recovery inclusive of psychiatric rehabilitation and support for individuals with a severe and persistent mental illness and/or co-occurring disorder who are in need of recovery and rehabilitation activities within a residential setting. This service is provided by a professional recovery team in a 24-hour staffed residential facility. The intent of the service is to support the individual in the recovery process so that he/she can be successful in a community living setting of his/her choice.
- Dual Residential – This residential treatment service is intended for adults with a primary Axis I diagnosis of substance dependence and a co-occurring severe and persistent mental illness requiring a more restrictive treatment environment to prevent substance use. This service is highly structured, based on acuity, and provides primary, integrated treatment to further stabilize acute symptoms and engage the individual in a program of maintenance, treatment, rehabilitation and recovery.
- Day Treatment – MH - Day Treatment provides a community based, coordinated set of individualized treatment services for individuals with psychiatric disorders who are not able to

function full-time in a normal school, work, and/or home environment and need the additional structured activities of this level of care. This service is less intensive than hospital based day treatment.

- Medication Management – MH - Medication Management is a level of outpatient treatment rendered by a qualified physician that includes evaluation of the individual's need for psychotropic medications, provision of prescriptions, and ongoing medical monitoring of medications. Service expectations include: medical evaluation; medication monitoring; and client education pertaining to the medication and its use.
- Outpatient Therapy (Individual/Group/Family) – Outpatient Individual Therapy is the treatment of psychiatric disorders through scheduled therapeutic visits between the therapist and the individual, and/or the nuclear and/or extended family. The focus of Outpatient Individual Therapy is to improve or alleviate symptoms that may significantly interfere with functioning in at least one life domain (e.g., familial, social, occupational, educational, etc.). The goals, frequency, and duration of Outpatient Individual Therapy will vary according to individual needs and response to therapy. Outpatient Group Therapy is the treatment of psychiatric disorders through scheduled therapeutic visits between the therapist and the consumer in the context of a group setting of at least three, and no more than twelve, participants with a common goal. The focus of Outpatient Group Therapy is to improve or maintain an individual's ability to function as well as alleviate symptoms that may significantly interfere with their interpersonal functioning in at least one life domain (e.g., familial, social, occupational, educational, etc.). Outpatient Group Therapy must provide active treatment for a primary DSM IV diagnosis. The goals, frequency, and duration of Outpatient Group Therapy will vary according to individual needs and response to treatment. Groups that are educational or supportive in nature do not meet the definition of Outpatient Group Therapy. The focus of Outpatient Family Therapy is to alter the family system to increase the functional level of the identified consumer/family through services/interventions on the systems within the family unit.
- Day Support - is designed to provide minimal social support to individuals who currently receive, or have received, behavioral health services and are succeeding in their recovery process. The intent of the service is to support the individual in the recovery process so he/she can experience continued success in the community living setting of his/her choice.
- Peer Support - Peer Support services are designed to promote personal growth, self-esteem, and dignity by developing leadership skills, advocacy skills, and sharing information. Peer Support provides structured scheduled activities that promote socialization, recovery, self-advocacy, self-sufficiency, development of supports, development and maintenance of community living skills. The purpose of Peer Support is to provide an opportunity to teach and support consumers in the acquisition and exercise of skills needed for management of symptoms and for utilization of resources within the community or other treatment settings. Peer Support activities include assistance to consumers in developing service plans and goals; scheduling individual meetings with consumers; facilitating group education classes, facilitating Wellness Recovery Action Planning (WRAP); assisting in accessing work and work-related tools, housing, advocacy, ACT, and self-help groups. Peer Support Specialists serve as a resource on local issues regarding recovery and share that information to help consumers attain recovery; ensure structured activities for consumers to increase self-reliance and resources towards independent living; and advise the regional and state staff about consumers and consumer issues to ensure policies are developed in the most effective relevant, data-driven and consumer-centered manner possible.
- Supported Employment – is designed to provide recovery and rehabilitation services and supports in employment-related activities for consumers with a severe and persistent mental illness and/or a co-occurring substance abuse disorder who express a desire to return to work. A supported employment team provides assistance with all aspects of employment development as requested and

needed by the consumer. The intent of the service is to support the consumer in the recovery process so the consumer's goals can be successfully obtained.

DESCRIPTION OF ACTIVITIES / CHILDREN/YOUTH SERVICES

- Therapeutic Consultation (P.L. 100-690) – 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.
- Day Treatment (P.L. 102-321) – Facility based program serving children and adolescents with Severe Emotional Disturbance. The purpose of Day Treatment is an intensive, non-residential service providing counseling and family services, education, behavior modification and skill building, promoting reintegration back to the child's regular school.
- Children's Multi-Systemic Therapy – Multi-Systemic Therapy (MST) is a family and community-based treatment using an ecological approach for youth with complex clinical, social, and educational problems. MST is short-term in duration (usually 3-5 months), with the MST therapist maintaining a small caseload. Youth referred to MST exhibit a combination of: physical and verbal aggression, school failure and truancy, criminal or delinquent behavior usually associated with contact with delinquent peers, and substance abuse issues. The family, as a whole, will work with a trained MST therapist. The goal of MST is to reduce the frequency and intensity of the youth's referral behavior. The MST therapist will work with the parents assisting them in empowering themselves through gaining the skills and resources needed to address difficulties that will arise while parenting their children. In addition, the youth will learn coping skills to better address family, peer, school, and neighborhood issues
- Professional Partner – Strength-based, family centered approach to working with children with serious emotional disturbances and their families. Provides 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. Professional Partner-School Wraparound is a variation of the Professional Partner Program, through which 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.
- Children's Intensive Outpatient Therapy – Intensive Outpatient Therapy is a specialized mental health treatment program for youth experiencing a wide range of mental health problems that cause moderate and/or acute disruptions in the youth's life. Outpatient treatment programs provide youth, family, or group treatment services, generally on a regularly scheduled basis. The outpatient program provides to each youth served the appropriate assessment and/or diagnosis of the mental health and/or substance abuse problem, as well as effective treatment to change behaviors, modify thought patterns, cope with problems, improve functioning, improve understanding of factors producing problems, identify workable steps to address the problems and/or other related goals. Such programs may include the collateral and/or adjunctive services. Adjunctive services are



designed to link youth with severe persistent mental illness (SPMI) who are participating in the outpatient program to other programs, and coordinating the various services to achieve successful outcomes. Adjunctive services include information gathering and reporting, coordination of services, referral facilitation, and related activities to assure there is coordination between the various programs serving the youth. Adjunctive services are limited to youth who are not currently admitted to a community support program.

History of Mental Health Block Grant Awards and Expenditures

From FFY2004 to FFY2009, the Nebraska allocation has been reduced in the amount of \$180,572, or 8.57%.

	Federal MH Block Award	Cut from FY2004	
		funds cut from Previous Year	percent cut
FFY2004	\$2,105,983		
FFY2005	\$2,086,159	(\$19,824)	-0.90%
FFY2006	\$2,050,210	(\$35,949)	-1.70%
FFY2007	\$2,006,208	(\$44,002)	-2.10%
FFY2008	\$1,973,901	(\$32,307)	-1.61%
FFY2009	\$1,925,411	(\$48,490)	-2.46%

Using the final allocation for FY2009, the Federal Community Mental Health Services Block Grant percentage total of funds for non-Medicaid mental health expenditures is small. State Fiscal Year 08-09 expenditures as reported on the MOE = \$54,560,767. The FY2009 Final Nebraska allocation under the Federal Community Mental Health Services Block Grant = \$1,925,411 (3.5% of the State funds as reported under the MOE.).

The following chart shows the Nebraska State Expenditures for Community Mental Health Services as reported on the Maintenance of Effort (MOE) and the actual Federal Community Mental Health Services Block Grant Award from FY1998 to FY2009.

	State MOE+	Federal MH Block Award
FY1998	\$16,505,943	\$1,300,783
FY1999	\$19,436,770	\$1,367,377
FY 2000	\$18,096,705	\$1,727,251
FY 2001	\$20,483,341	\$2,011,272
FY 2002	\$24,015,746	\$2,042,087
FY 2003	\$29,036,852	\$2,099,881
FY 2004	\$31,207,611	\$2,105,983
FY 2005	\$36,970,889	\$2,086,159

Adult – Child: Purpose State FY BG Expended – Recipients – Activities Description
 DRAFT Implementation Report / October 27, 2009 / Page 7

FY 2006	\$45,342,329	\$2,050,210
FY 2007	\$48,888,467	\$2,006,208
FY2008	\$47,482,195	\$1,973,901
FY2009	\$54,560,767	\$1,925,411
Fund increase FY1998 to 2009	\$38,054,824	\$624,628
percent increase (1998 to 2009)	231%	48%

The State Advisory Committee on Mental Health Services, Nebraska's Mental Health Planning Council, continues to express concerns about the formula used to determine the funding allocation for each state. It appears to penalize states such as Nebraska without considering the unique and costly factor of providing services for such rural settings. The dollar amount Nebraska receives is already substantially smaller than most states. Nebraska has many rural areas with high need for mental health services, that even the smallest of cuts is felt. Receiving cuts year after year is very discouraging to the people of Nebraska that are trying to move forward in providing quality and available mental health services, in response to the immediate need of its consumers.

Nebraska FY 2009 Uniform Reporting System (URS)

Prepared to Meet the Requirements of the

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

PART E: Uniform Data on Public Mental Health System

U.S. Department of Health & Human Services
Substance Abuse & Mental Health Services Administration (SAMHSA)
Center for Mental Health Services (CMHS)

By:

Nebraska Department of Health and Human Services
Division of Behavioral Health

Questions on this report should be directed to:

Jim Harvey
Nebraska Department of Health and Human Services
Division of Behavioral Health
301 Centennial Mall South, Third Floor
PO Box 98925, Lincoln, NE 68509
phone 402-471-7824
email: Jim.Harvey@nebraska.gov

draft as of November 4, 2009

for review by the State Advisory Committee on Mental Health Services on November 5, 2009

Analysis of the data for Tables 2A, 2B, 3, 4, 4a, 5A, 5B, 6, 12, 14A, 14B, 15, portions of 16, 17, 20A, 20B, and 21 are completed by the Epidemiology Department in the College of Public Health at the University of Nebraska Medical Center (UNMC) under contract with the Nebraska Department of Health and Human Services (DHHS) Division of Behavioral Health.

Footnote:

(1) In January 2009, the Division of Behavioral Health cleaned its data system by administratively discharging nearly 18,000 records of admission to program prior to November 2003 and of which had no activity in the last year. This reduced the number of active cases in the system.

(2) The table includes consumers who received only mental health services or who received both mental health and substance abuse services



Table 2A. Profile of Persons Served, All Programs by Age, Gender and Race/Ethnicity

This table provides an aggregate profile of persons in the reporting year. The reporting year should be the latest state fiscal year for which data are available. This profile is based on a client receiving services in programs provided or funded by the state mental health agency. The client profile takes into account all institutional and community services for all such programs. Please provide unduplicated counts if possible.

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Please report the data under the categories listed - "Total" are calculated automatically.

Report Year:	Total		American Indian or Alaska Native			Asian			Black or African American		
	Female	Male	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available
2009											
State Identifier:	NE										
0-12 Years	551	893	15	24		2	4		43	60	
13-17 years	688	903	19	30		10	8		25	42	
18-20 years	766	1,129	23	23		3	9		31	32	
21-64 years	10,707	12,128	252	278		59	59		652	943	
65-74 years	243	191	2	5		6	0		7	6	
75+ years	76	37	1	1		6	1		1	0	
Not Available	4	3	1	1		0	0		1	0	
Total	13,032	15,289	313	362	0	86	81	0	760	1,083	0

Are these numbers unduplicated? Unduplicated Duplicated: between Hospitals and Community Duplicated Among Community Programs
 Duplicated between children and adults Other: describe: _____

Comments on Data (for Age): The age was calculated as follows: [(July 1, 2008 - (Consumer Birth Date)) / 365.25]

Comments on Data (for Gender): If multiple genders listed, the most frequent gender was reported.

Comments on Data (for Race/Ethnicity): For race listed as "Other", reported in "More than one race reported".

Comments on Data (Overall): See General Comments.

DRAFT

Table 2A. Profile of

This table provides a profile of the population that is available. This profile accounts for all institutions and is not intended to represent the entire population.

PLEASE DO NOT

Please report the data for the following:

Table 2.
Report Year:
State Identifier:

	Native Hawaiian or Other Pacific Islander		White		Hispanic (use only if data for Table 2b are not available)	
	Female	Male	Female	Male	Female	Male
0-12 Years	2	2	352	574		
13-17 years	0	1	459	608		
18-20 years	3	0	522	807		
21-64 years	4	4	8,029	8,801		
65-74 years	0	0	194	152		
75+ years	0	0	53	26		
Not Available	0	0	4	1		
Total	9	7	9,613	10,969	0	0

Are these numbers in thousands?

Comments on Data (for Age):
Comments on Data (for Gender):
Comments on Data (for Race/Ethnicity):
Comments on Data (Overall):

DRAFT

Table 2B. Profile of Persons Served, All Programs by Age, Gender and Race/Ethnicity

Of the total persons served, please indicate the age, gender and the number of persons who are Hispanic/Latino or not Hispanic/Latino. Total persons served would be the total as indicated in Table 2A.

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Please report the data under the categories listed - "Total" are calculated automatically.

Report Year:	2009		Hispanic or Latino						Hispanic or Latino Origin			Total			
	State Identifier:	NE	Not Hispanic or Latino			Hispanic or Latino			Not Available			Total			
			Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available	
0 - 12 Years	484	774		47	102		20	17				351	893	0	1,424
13 - 17 years	585	757		82	107		16	39				683	903	0	1,585
18 - 20 years	696	1,002		50	100		20	27				763	1,129	0	1,893
21-64 years	9,812	10,870		706	899		189	359				0	1,248	0	22,533
65-74 years	235	182		4	2		4	7				245	131	0	374
75+ years	73	34		2	1		0	2					3	0	76
Not Available	7	3		0	0		0	5						0	12
Total	17,892	19,622		891	1,211		249	455				13,032	15,289	0	28,321
Comments on Data (for Age):	The age was calculated as follows: [(July 1, 2008 - (Consumer Birth Date)) / 365.25]														
Comments on Data (for Gender):	If multiple genders listed, the most frequent gender was reported.														
Comments on Data (for Race/Ethnicity):															
Comments on Data (Overall):	See General Comments.														

DRAFT

Table 3. Profile of Persons served in the community mental health setting, State Psychiatric Hospitals and Other Settings

This table provides a profile for the clients that received public funded mental health services in community mental health settings, in state psychiatric hospitals, in other psychiatric inpatient programs, and in residential treatment centers for children.

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Table 3. Service Setting	Age 0-17		Age 18-20		Age 21-64		Age 65+	
	Female	Male	Female	Male	Female	Male	Female	Male
Report Year:	2009							
State Identifier:	NE							
Community Mental Health Programs	1,153	1,687	690	992	9,533	10,387	277	166
State Psychiatric Hospitals	0	23	8	25	99	370	5	9
Other Psychiatric Inpatient Residential Treatment Centers	83	85	126	162	1,657	1,975	37	41
Comments on Data (for Age):	5	35	0	2				
Comments on Data (for Gender):								
Comments on Data (Overall):								

Note: Clients can be duplicated between Rows: e.g., The same client may be served in both state psychiatric hospitals and community mental health centers during the same year and thus would be reported in counts for both rows.

Instructions:

- 1 States that have county psychiatric hospitals that serve as surrogate state hospitals should report persons served in such settings as receiving services in state hospitals.
- 2 If forensic hospitals are part of the state mental health agency system include them.
- 3 Persons who receive non-inpatient care in state psychiatric hospitals should be included in the Community MH Program Row
- 4 Persons who receive inpatient psychiatric care through a private provider or medical provider licensed and/or contracted through the SMHA should be counted in the "Other Psychiatric Inpatient" row. Persons who receive Medicaid funded inpatient services through a provider that is not licensed or contracted by the SMHA should not be counted here.
- 5 A person who is served in both community settings and inpatient settings should be included in both rows
- 6 RTC: CMHS has a standardized definition of RTC for Children: "An organization, not licensed as a psychiatric hospital, whose primary purpose is the provision of individually planned programs of mental health treatment services in conjunction with residential care for children and youth primarily 17 years old and younger. It has a clinical program that is directed by a psychiatrist, psychologist, social worker, or psychiatric nurse who has a master's degree or doctorate. The primary reason for the admission of the clients is mental illness that can be classified by DSM-IV codes other than the codes for mental retardation, developmental disorders, and substance-related disorders such as drug abuse and alcoholism (unless these are co-occurring with a mental illness)."

Nebraska Division of Behavioral Health
Table 3. Profile

This table provides information on service settings, in state

PLEASE D

Table 3. Service Setting	Age/Not Available		Total		
	Female	Male	Female	Male	Total
Community Mental Health Program	6	7	111,689	137,239	248,928
State Psychiatric Hospitals			112	477	589
Other Psychiatric Inpatient Residential Treatment Centers	1	0	1,904	2,265	4,169
Comments on Data Age:			5	37	42
Comments on Data Gender):					
Comments on Data (Overall):					

Note: Clients care same year and th

Instructions:

- 1
- 2
- 3
- 4
- 5
- 6

This table describes the status of adults clients served in the report year by the public mental health system in terms of employment status. The focus is on employment for the working age population, recognizing, however, that there are clients who are disabled, retired or who are homemakers, care-givers, etc and not a part of the workforce. These persons should be reported in the "Not in Labor Force" category. This category has two subcategories: retired and other. (The totals of these two categories should equal the number in the row for "Not in Labor Force"). Unemployed refers to persons who are looking for work but have not found employment. Data should be reported for clients in non-institutional settings at time of discharge or last evaluation.

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Table 4.		2009		NE		18-20		21-64		65+		Age Not Available		Total	
Adults Served	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Total
Employed: Competitively Employed Full or Part Time (includes Supported Employment)	305	423	3,613	4,466	22	37	1	0							359
Unemployed	298	476	4,049	4,999	57	44	2	2							390
Not in Labor Force: Retired, Sheltered Employment, Sheltered Workshops, Other (homemaker, student, volunteer, disabled, etc.)	158	223	2,953	2,502	238	147	4	1							25%
Not Available	5	7	92	161	1	0	0	5							1%
Total	666	1,129	10,707	12,138	318	228	3	8	0	0	0	0	0	0	26,291

How Often Does your State Measure Employment Status? All Clients At Admission At Discharge Monthly Quarterly Other: describe:

What populations are included: Only Selected groups; describe: Quarterly Other: describe:

Comments on Data (for Age):

Comments on Data (for Gender):

Comments on Data (Overall):

DRAFT

Table 4a. Optional Profile of Adult Clients by Employment Status: by Primary Diagnosis Reported

The workgroup exploring employment found that the primary diagnosis of consumers results in major differences in employment status. The workgroup has recommended that we explore the ability of states to report employment by primary diagnosis and the impact of diagnosis on employment. The workgroup recommended 5 diagnostic clusters for reporting.

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Table 4a.	Report Year:	2009					
State Identifier:	NE						
Primary Diagnosis	Employed, Compensatively Employed Full or Part Time (includes Supported Employment)	Unemployed	Not in Labor Force: Retired, Sheltered Employment, Sheltered Workshops, Other (includes students, volunteer, disabled, etc)	Employment Status Not Available	Total		
Schizophrenia & Related Disorders (295)	283	957	748	13	2,001	8%	
Bipolar and Mood Disorders (296, 300.4, 301.11, 301.13, 311)	3,259	4,443	2,816	138	10,656	42%	
Other Psychoses (297, 298)	72	213	1,153	62	1,500	6%	
All Other Diagnoses	1,545	1,268	152	5	2,968	17%	
No Dx and Deferred DX (799.9, Y71.09)	3,708	3,048	1,357	55	8,168	32%	
Diagnosis Total	8,867	9,927	6,226	270	25,291		
Comments on Data (for Diagnosis):							

DRAFT

Table 5A. Profile of Clients by Type of Funding Support

This table provides a summary of clients by Medicaid coverage. Since the focus of the reporting is on clients of the public mental health service delivery system, this table focuses on the clientele serviced by public programs that are funded or operated by the State Mental Health Authority. Persons are to be counted in the Medicaid row if they received a service reimbursable through Medicaid.

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Please note that the same person may be served in both Medicaid and Non-Medicaid programs during the same reporting period.

Table 5A		Report Year: 2009		State Identifier: NE				
	Total		American Indian or Alaska Native		Asian		Black or African American	
	Female	Male	Female	Male	Female	Male	Female	Male
Medicaid (only Medicaid)	2,898	2,477	74	63	29	24	270	241
Non-Medicaid Sources (only)	1,908	1,407	42	59	19	9	40	64
Both Medicaid and Non-Medicaid	730	701	13	17	8	3	31	40
Medicaid Status Not Available	7,406	6,832	184	223	30	45	419	738
Total Served	13,092	11,287	313	362	86	81	760	1,083

Data Based on Medicaid Services
 Data Based on Medicaid Eligibility, not Medicaid Paid Services
 People Served by Both* includes people with any Medicaid

Comments on Data (for Age):
Comments on Data (for Gender):
Comments on Data (Overall):

Each row should have a unique (unduplicated) count of clients: (1) Medicaid Only, (2) Non-Medicaid Only, (3) Both Medicaid and Other Sources funded their treatment, and (4) Medicaid Status Not Available. If a state is unable to unduplicate between people whose care is paid for by Medicaid only or Medicaid and other funds, then all data should be reported into the 'People Served by Both Medicaid and Non-Medicaid Sources' and the 'People Served by Both includes people with any Medicaid' check box should be checked.

DRAFT

Table 5A. Profile of

This table provides a focus on the client they received a servi

PLEASE DO N

Please note that the sa

Table 5A Report Year: State Identifier:	Native Hawaiian or Other Pacific Islander			White			Hispanic* Use only if data for Table 5b are not available.			More Than One Race Reported			Race Not Available		
	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available
Medicaid (only Medicaid)	3	4		2,110	1,652					173	122		239	241	
Non-Medicaid Sources (only)	0	0		1,482	1,757					80	96		335	424	
People Served by Both Medicaid and Non-Medicaid	0	0		597	526					23	40		58	75	
Medicaid Status Not Available	6	3		5,424	7,034					526	758		817	1,031	
Total Served	9	7	0	9,613	10,969	0	0	0	0	802	1,016	0	1,419	1,77	0

Comments on Data (for Age):
Comments on Data (for Gender):
Comments on Data (Overall):

Each row should hav and (4) Medicaid Sta if a state is unable tc Served by Both Medi

Table 5B. Profile of Clients by Type of Funding Support

Of the total persons covered by Medicaid, please indicate the gender and number of persons who are Hispanic/Latino or not Hispanic/Latino. Total persons covered by Medicaid would be the total indicated in Table 5A.

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Please note that the same person may be served in both Medicaid and Non-Medicaid programs during the same reporting period.

Table 5B.	2009		Hispanic or Latino						Total					
	Report Year:		Not Hispanic or Latino			Hispanic or Latino			Unknown			Hispanic or Latino Origin		
	State Identifier:		Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available
	NE		2,644	2,132		219	189		35	26		2,098	2,327	
Medicaid Only			1,841	2,241		116	133		41	35		1,998	2,409	
Non-Medicaid Only														
People Served by Both Medicaid and Non-Medicaid Sources			708	670		19	27		3	4		290	701	
Medicaid Status Unknown			6,699	8,579		537	862		170	391		7,406	9,892	
Total Served			11,892	13,622	0	891	1,211	0	249	456	0	13,062	15,289	0
Comments on Data (for Age):														
Comments on Data (for Gender):														
Comments on Data (Overall):														

Each row should have a unique (unduplicated) count of clients: (1) Medicaid Only, (2) Non-Medicaid Only, (3) Both Medicaid and Other Sources funded their treatment, and (4) Medicaid Status Unknown.

DRAFT

Table 6: Profile of Client Turnover

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Table 6.		2009									
Report Year:		NE									
State Identifier:											
Profile of Service Utilization	Total Served at Beginning of Year (unduplicated)	Admissions During the year (duplicated)	Discharges During the year (duplicated)	Length of Stay (in Days) Discharged Patients		For Clients in Facility for Less Than 1 Year: Average Length of Stay (in Days) Residents at end of year		For Clients in Facility More Than 1 Year: Average Length of Stay (in Days) Residents at end of year			
				Average (Mean)	Median	Average (Mean)	Median	Average (Mean)	Median		
State Hospitals	304	307	312								
Children (0 to 17 years)	10	13	9	279	354	202	195	588	607		
Adults (18 yrs and over)	294	294	303	283	104	134	111	1,515	1,081		
Age Not Available											
Other Psychiatric Inpatient	2,000	2,456	2,048								
Children (0 to 17 years)	34	136	122	34	3	128	94	1,078	1,012		
Adults (18 yrs and over)	1,966	2,319	1,925	105	6	147	118	1,159	1,134		
Age Not Available	0	1	1	1	1						
Residential Centers	26	17	28								
Children (0 to 17 years)	24	17	27	289	272	136	129	640	640		
Adults (18 yrs and over)	2	0	2	369	369						
Age Not Available											
Community Programs	1,755	1,629									
Children (0 to 17 years)	1,418	1,620									
Adults (18 yrs and over)	13,326	11,629									
Age Not Available	11	2									
Comments on Data (State Hospital):											
Comments on Data (Other Inpatient):											
Comments on Data (Residential Treatment):											
Comments on Data (Community Programs):											
Comments on Data (Overall):											

DRAFT

Table 8. Profile of Community Mental Health Block Grant Expenditures For Non-Direct Service Activities

This table is used to describe the use of CMHS BG funds for non-direct service activities that are sponsored, or conducted by the State Mental Health Authority

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Table 8	
Report Year:	
State Identifier:	
Profile of Community Mental Health Block Grant Expenditures for Non-Direct Service Activities	
Service	Estimated Total Block Grant
MHA Technical Assistance Activities	
MHA Planning Council Activities	
MHA Administration	\$96,270
MHA Data Collection/Reporting	
MHA Activities Other Than Those Above	\$5,589
Total Non-Direct Services	\$101,859
Comments on Data:	

NOTE: FY2009 Federal funds approved for Nebraska was \$1,925,411 during Federal Fiscal Year 2009 \$1,821,715 was available for allocation to the six Regions in FY2010 Contracts (July 1, 2009 to June 30, 2010).

DRAFT

Table 9: SAMHSA NOMS: SOCIAL CONNECTEDNESS AND IMPROVED FUNCTIONING

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Table 9: NOMS Social Connectedness & Functioning			
Report Year (Year Survey was Conducted): 2009			
State Identifier: Nebraska			
Adult Consumer Survey Results	Number of Positive Responses	Responses	Percent Positive (calculated)
1. Social Connectedness	773	1,028	75%
2. Functioning	769	1,043	73%
Child/Adolescent Consumer Survey Results	Number of Positive Responses	Responses	Percent Positive (calculated)
3. Social Connectedness	120	132	91%
4. Functioning	81	130	62%
Comments on Data:			

Adult Social Connectedness and Functioning Measures

1. Did you use the recommended new Social Connectedness Questions? Yes No Measure used _____

2. Did you use the recommended new Functioning Domain Questions? Yes No Measure used _____

3. Did you collect these as part of your MHSIP Adult Consumer Survey? Yes No

If No, what source did you use? _____

Child/Family Social Connectedness and Functioning Measures

4. Did you use the recommended new Social Connectedness Questions? Yes No Measure used _____

5. Did you use the recommended new Functioning Domain Questions? Yes No Measure used _____

6. Did you collect these as part of your YSS-F Survey? Yes No

If No, what source did you use? _____

DRAFT

Please use the same rules for reporting Social connectedness and Functioning Domain scores as for calculating other Consumer Survey Domain scores for Table 11: E.g.:

1. Recode ratings of "not applicable" as missing values.
2. Exclude respondents with more than 1/3rd of the items in that domain missing.
3. Calculate the mean of the items for each respondent.
4. FOR ADULTS: calculate the percent of scores less than 2.5. (percent agree and strongly agree).
5. FOR YSS-F: calculate the percent of scores greater than 3.5. (percent agree and strongly agree).

Items to Score in the Functioning Domain:

Adult MHSP Functioning Domain:

- 1 I do things that are more meaningful to me.
- 2 I am better able to take care of my needs.
- 3 I am better able to handle things when they go wrong.
- 4 I am better able to do things that I want to do.
- 5 My Symptoms are not bothering me as much (this question already is part of the MHSP Adult Survey)

YSS-F Functioning Domain Items:

- 1 My child is better able to do things he or she wants to do.
- 2 My child is better at handling daily life. (existing YSS-F Survey item)
- 3 My child gets along better with family members. (existing YSS-F Survey item)
- 4 My child gets along better with friends and other people. (existing YSS-F Survey item)
- 5 My child is doing better in school and/or work. (existing YSS-F Survey item)
- 6 My child is better able to cope when things go wrong. (existing YSS-F Survey item)

Items to Score in the Social Connectedness Domain:

Adult MHSP Social Connectedness Domain:

- 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 in my community.
- 4 In a crisis, I would have the support I need from family or friends.

YSS-F Social Connectedness Domain Items:

- 1 I know people who will listen and understand me when I need to talk
- 2 I have people that I am comfortable talking with about my child's problems.
- 3 In a crisis, I would have the support I need from family or friends.
- 4 I have people with whom I can do enjoyable things

Table 10. Profile of Agencies Receiving Block Grant Funds Directly from the State MHA

This table is to be used to provide an inventory of providers/agencies who directly receive Block Grant allocations. Only report those programs that receive MHBG funds to provide services. Do not report planning council member reimbursements or other administrative reimbursements related to running the MHBG Program.

Please use only one row for each program

PLEASE DO NOT ADD, MERGE, DELETE OR MOVE COLUMNS AND/OR CELLS

Table 10				
Report Year:				
State Identifier:				
Agency Name	Address	Name of Director	Phone #	Amount of Block Grant Allocation to Agency
Region 1 Behavioral Health Authority	4110 Avenue D Scottsbluff, NE 69361	Sharyn Wohlers Region 1 Regional Administrator	(308) 635-3171	\$180,619
Region 2 Behavioral Health Authority	110 North Bailey Street P.O. Box 1208 North Platte, NE 69103	Kathy Seacrest Region 2 Regional Administrator	(308) 534-044	\$182,116
Region 3 Behavioral Health Authority	4009 6th Avenue, Suite 65 P.O. Box 2555 Kearney, NE 68848	Beth Baxter, M.S. Region 3 Regional Administrator	(308) 237-511	\$260,092
Region 4 Behavioral Health Authority	206 Monroe Avenue Norfolk, NE 68701	Ingrid Gansebom Region 4 Regional Administrator	(402) 370-3100 x 120	\$264,303
Region 5 Behavioral Health Authority	1645 "N" Street Suite A Lincoln, NE 68508	CJ Johnson Region 5 Regional Administrator	(402) 441-4343	\$425,491
Region 6 Behavioral Health Authority	3801 Harney Street Omaha, NE 68131-3811	Patty Jurjevich Region 6 Regional Administrator	(402) 444-6573	\$557,584
Total FY2008 Allocations				\$1,870,205

* If you need more lines for additional agencies, please add rows or make copies of this table.

NOTE: The amount of allocation to the six Regions for State Fiscal Year 2009 was \$1,870,205. For State Fiscal Year 2010, this allocation was reduced to a total of \$1,821,715 which was a cut of \$48,490.

Table 11: Summary Profile of Client Evaluation of Care

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Table 11.			
Report Year (Year Survey was Conducted): 2009			
State Identifier: Nebraska			
Adult Consumer Survey Results:	Number of Positive Responses	Responses	Confidence Interval
1. Reporting Positively About Access.	870	1,060	3
2. Reporting Positively About Quality and Appropriateness for Adults	918	1,046	3
3. Reporting Positively About Outcomes.	739	1,033	3
4. Adults Reporting on Participation In Treatment Planning.	788	988	3
5. Adults Positively about General Satisfaction with Services.	928	1,075	3
Child/Adolescent Consumer Survey Results:	Number of Positive Responses	Responses	Confidence Interval
1. Reporting Positively About Access.	101	135	8
2. Reporting Positively about General Satisfaction for Children.	98	134	8
3. Reporting Positively about Outcomes for Children.	80	132	8
4. Family Members Reporting on Participation In Treatment Planning for their Children	100	134	8
5. Family Members Reporting High Cultural Sensitivity of Staff.	115	134	8
<i>Please enter the number of persons responding positively to the questions and the number of total responses within each group. Percent positive will be calculated from these data.</i>			
<i>* Please report Confidence Intervals at the 95% level. See directions below regarding the calculation of confidence intervals.</i>			
Comments on Data:			

Adult Consumer Surveys

1. Was the Official 28 Item MHSIP Adult Outpatient Consumer Survey Used? Yes No

- 1.a. If no, which version:
- 1. Original 40 Item Version Yes
 - 2. 21-Item Version Yes
 - 3. State Variation of MHSIP Yes
 - 4. Other Consumer Survey Yes

1.b. If other, please attach instrument used.
 1.c. Did you use any translations of the MHSIP into another language?
 1. Spanish
 2. Other Language: _____

Adult Survey Approach:

2. Populations covered in survey? (Note all surveys should cover all regions of state) 1. All Consumers in State 2. Sample of MH Consumers

2.a. If a sample was used, what sample methodology was used?
 1. Random Sample
 2. Stratified /Random Stratified Sample
 3. Convenience Sample

4. Other Sample: _____

DRAFT

Adult Consumer Surveys (Continued)

2.b Do you survey only people currently in services, or do you also Survey Persons no longer in service?

- 1. Persons Currently Receiving Services
- 2. Persons No Longer Receiving Services

3. Please Describe the populations included in your sample: (e.g., all adults, only adults with SMI, etc.)

- 1. All Adult consumers In state
- 2. Adults with Serious Mental Illness
- 3. Adults who were Medicaid Eligible or in Medicaid Managed Care

3.4 Other: describe: (for example, if you survey anyone served in the last 3 months, describe that here):

4. Methodology of collecting data? (Check all that apply)

	Self-Administered	Interview
Phone	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> Yes
Mail	<input checked="" type="checkbox"/> Yes	
Face-to-face	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Web-Based	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes

4.b. Who administered the Survey? (Check all that apply)

- 1. MH Consumers
 - 2. Family Members
 - 3. Professional Interviewers
 - 4. MH Clinicians
 - 5. Non Direct Treatment Staff
6. Other: describe:

5. Are Responses Anonymous, Confidential and/or Linked to other Patient Databases?

- 1. Responses are Anonymous
- 2. Responses are Confidential
- 3. Responses are Matched to Client databases

6. Sample Size and Response Rate

6a. How many Surveys were Attempted (sent out or calls initiated)?

6b. How many survey Contacts were made? (surveys to valid phone numbers or addresses)

6c. How many surveys were completed? (survey forms returned or calls completed)

6d. What was your response rate? (number of Completed surveys divided by number of Contacts)

6.e. If you receive "blank" surveys back from consumers (surveys with no responses on them), did you count these survey's as "completed" for the calculation of response rates?

8,407
3,748
1,090
29%

Yes No

7. Who Conducted the Survey

7.a. SMHA Conducted or contracted for the Survey (survey done at state level)

Yes No

7.b. Local Mental Health Providers/County mental health providers conducted or contracted for the survey

(survey was done at the local or regional level)

Yes No

7.c. Other: Describe:

* Report Confidence Intervals at the 95% confidence level

Note: The confidence interval is the plus-or-minus figure usually reported in newspaper or television opinion poll results. For example, if you use a confidence interval of 4 and 47% percent of your sample picks an answer you can be "sure" that if you had asked the question of the entire relevant population between 43% (47-4) and 51% (47+4) would have picked that answer.

The confidence level tells you how sure you can be. It is expressed as a percentage and represents how often the true percentage of the population who would pick an answer lies within the confidence interval. The 95% confidence level means you can be 95% certain; the 99% confidence level means you can be 99% certain. Most researchers use the 95% confidence level.

When you put the confidence level and the confidence interval together, you can say that you are 95% sure that the true percentage of the population is between 43% and 51%. (From www.survevsystem.com)

Child/Family Consumer Surveys

1. Was the MHSIP Children/Family Survey (YSS-F) Used? Yes
 If No, what survey did you use? _____
 If no, please attach instrument used.

1.c. Did you use any translations of the Child MHSIP into another language? 1. Spanish
 2. Other Language: _____

Child Survey Approach:

2. Populations covered in survey? (Note all surveys should cover all regions of state)
 1. All Consumers in State
 2. Sample of MH Consumers
 2.a. If a sample was used, what sample methodology was used?
 1. Random Sample 2. Stratified/Random Stratified Sample
 3. Convenience Sample
 4. Other Sample: _____

2.b Do you survey only people currently in services, or do you also Survey Persons no longer in service?
 1. Persons Currently Receiving Services
 2. Persons No Longer Receiving Services
 2a. If yes to 2, please describe how your survey persons no longer receiving services.

3. Please Describe the populations included in your sample: (e.g., all children, only children with SED, etc.)
 1. All Child consumers in state
 2. Children with Serious Emotional Disturbances
 3. Children who were Medicaid Eligible or in Medicaid Managed Care
 3.4 Other: describe: (for example, if you survey anyone served in the last 3 months, describe that here):

4. Methodology of collecting data? (Check all that apply)

	Self-Administered	Interview
Phone	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> Yes
Mail	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> Yes
Face-to-face	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Web-based	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes

4.b. Who administered the Survey? (Check all that apply)

1. MH Consumers
 2. Family Members
 3. Professional Interviewers
 4. MH Clinicians
 5. Non Direct Treatment Staff
 6. Other: describe: _____

5. Are Responses Anonymous, Confidential and/or Linked to other Patient Databases?

1. Responses are Anonymous
 2. Responses are Confidential
 3. Responses are Matched to Client databases

6. Sample Size and Response Rate

6a. How many Surveys were Attempted (sent out or calls Initiated)? 928
 6b How many survey Contacts were made? (surveys to valid phone numbers or addresses) 423
 6.c How many surveys were completed? (survey forms returned or calls completed) 135
 6.d. What was your response rate? (number of Completed surveys divided by number of Contacts) 32%

6.e. If you receive "blank" surveys back from consumers (surveys with no responses on them), did you count these survey's as "completed" for the calculation of response rates?
 Yes No

7. Who Conducted the Survey

7.a. SMHA Conducted or contracted for the Survey (survey done at state level) Yes No
 7.b. Local Mental Health Providers/County mental health providers conducted or contracted for the survey (survey was done at the local or regional level) Yes No

Table 12: State Mental Health Agency Profile

The purpose of this profile is to obtain information that provides a context for the data provided in the tables. This profile covers the populations served, services for which the state mental health agency is responsible, data reporting capacities, especially related to duplication of numbers served as well as certain summary administrative information.

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Table 12	
Report Year:	2009
State Identifier:	NE

Populations Served

1. Which of the following populations receive services operated or funded by the state mental health agency? Please indicate if they are included in the data provided in the tables. (Check all that apply.)

	Populations Covered		Included in Data	
	State Hospitals	Community Programs	State Hospitals	Community Programs
1. Aged 0 to 3	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> Yes
2. Aged 4 to 17	<input checked="" type="checkbox"/> Yes			
3. Adults Aged 18 and over	<input checked="" type="checkbox"/> Yes			
4. Forensics	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> Yes
Comments on Data:	See General Comments.			

2. Do all of the adults and children served through the state mental health agency meet the Federal definitions of serious mental illness and serious emotional disturbances?

- Serious Mental Illness
- Serious Emotional Disturbances

2.a. If no, please indicate the percentage of persons served for the reporting period who met the federal definitions of serious mental illness and serious emotional disturbance?

2.a.1 Percent of adults meeting Federal definition of SMI:	61.7%
2.a.2 Percentage of children/adolescents meeting Federal definition of SED	53.1%

3. Co-Occurring Mental Health and Substance Abuse

3.a. What percentage of persons served by the SMHA for the reporting period have a dual diagnosis of mental illness and substance abuse?

3.a.1 Percentage of adults served by the SMHA who also have a diagnosis of substance abuse problem:	69%
3.a.2 Percentage of children/adolescents served by the SMHA who also have a diagnosis of substance abuse problem:	21%

3.b. What percentage of persons served for the reporting period who met the Federal definitions of adults with SMI and children/adolescents with SED have a dual diagnosis of mental illness and substance abuse.

3.b.1 Percentage of adults meeting Federal definition of SMI who also have a diagnosis of substance abuse problem:	68%
3.b.2 Percentage of children/adolescents meeting the Federal definition of SED who also have a diagnosis of substance abuse problem:	10%

DRAFT

3b.3

Please describe how you calculate and count the number of persons with co-occurring disorders

1) Individuals had Axis diagnostic codes for both mental health and substance abuse disorders. 2) Individuals had services authorized for both mental health and substance abuse 3) Admission reason was a combination of Mental Illness/Substance Abuse 4) Level of care was listed for both mental health and substance abuse

4 State Mental Health Agency Responsibilities

a. Medicaid: Does the State Mental Health Agency have any of the following responsibilities for mental health services provided through Medicaid? (Check All that Apply)

- 1. State Medicaid Operating Agency
- 2. Setting Standards
- 3. Quality Improvement/Program Compliance
- 4. Resolving Consumer Complaints
- 5. Licensing
- 6. Sanctions
- 7. Other

b. Managed Care (Mental Health Managed Care) Are Data for these programs reported on URS Tables?

- 4.b.1 Does the State have a Medicaid Managed Care initiative? Yes No
- 4.b.2 Does the State Mental Health Agency have any responsibilities for mental health services provided through Medicaid Managed Care? Yes No

If yes, please check the responsibilities the SMHA has:

- 4.b.3 Direct contractual responsibility and oversight of the MCOs or BHOs Yes
- 4.b.4 Setting Standards for mental health services Yes
- 4.b.5 Coordination with state health and Medicaid agencies Yes
- 4.b.6 Resolving mental health consumer complaints Yes
- 4.b.7 Input in contract development Yes
- 4.b.8 Performance monitoring Yes
- 4.b.9 Other Yes

5 Data Reporting: Please describe the extent to which your information systems allows the generation of unduplicated client counts between different parts of your mental health system. Please respond in particular for Table 2, which requires unduplicated counts of clients served across your entire mental health system

Are the data reporting in the tables?

- 5.a. **Unduplicated**: counted once even if they were served in both State hospitals and community programs and if they were served in community mental health agencies responsible for different geographic or programmatic areas.
- 5.b. **Duplicated**: across state hospital and community programs
- 5.c. **Duplicated**: within community programs
- 5.d. **Duplicated**: Between Child and Adult Agencies

5.e. **Plans for Unduplication**: If you are not currently able to provide unduplicated client counts across all parts of your mental health system, please describe your plans to get unduplicated client counts by the end of your Data Infrastructure Grant.

6 Summary Administrative Data

6.a. Report Year	2009		
6.b. State Identifier	NE		
<i>Summary Information on Data Submitted by SMHA:</i>			
6.c. Year being reported: From:	07/01/2008	to	06/30/2009
6.d. Person Responsible for Submission	Jim Harvey		
6.e. Contact Phone Number:	402-471-7824		

Table 14A. Profile of Persons with SM/SED served by Age, Gender and Race/Ethnicity

This is a developmental table similar to Table 2A, and 2B. This table requests counts for persons with SMI or SED using the definitions provided by the CMHS, Table 2A, and 2B. Included all clients served by publicly operated or funded programs. This table counts only clients who meet the CMHS definition of SMI or SED. For many states, this table may be the same as Tables 2A, and 2B. For 2007, states should report using the Federal Definitions of SMI and SED if they can report them, if not, please report using your state's definitions of SMI and SED and provide information below describing your state's definition.

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Please report the data under the categories listed - "Total" are calculated automatically.

	Total			American Indian or Alaska Native			Asian			Black or African American			Native Hawaiian or Other Pacific Islander		
	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available
0-12 Years	252	542	0	8	17	1	1	1	21	36	1	1	1	1	1
13-17 years	343	485	0	7	16	5	4	15	15	24	0	0	0	0	0
18-20 years	378	474	0	14	4	3	2	22	20	20	2	0	0	0	0
21-64 years	2,138	2,167	0	143	133	40	37	528	652	3	1	1	1	1	1
65-74 years	20	16	0	2	5	6	0	7	5	0	0	0	0	0	0
75+ years	13	28	0	1	1	6	1	1	1	0	0	0	0	0	0
Not Available	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	3,443	3,778	0	176	176	81	83	584	727	6	6	6	6	6	6
Comments on Data (for Age):															
Comments on Data (for Gender):															
Comments on Data (for Race/Ethnicity):															
Comments on Data (Overall):															

1. State Definitions Match the Federal Definitions:

Adults with SMI, if No describe or attach state definition:

Yes No

Diagnoses included in state SMI definition:

Yes No

Children with SED, if No describe or attach state definition:

Yes No

Diagnoses included in state SED definition:

Yes No

DRAFT

Table 14A. Profile

This is a development of CMHS, Table 2A, & definition of SMI or Definitions of SMI & describing your state

PLEASE DO

Please report the data

Table 14A.
 Report Year:
 State Identifier:

	White		Hispanic/Latino		More Than One Race Reported		Race Not Available	
	Female	Male	Female	Male	Female	Male	Female	Male
0-12 Years	158	347			18	29	50	111
13-17 years	238	333			13	18	68	70
18-20 years	254	344			36	33	47	71
21-64 years	5,419	5,136			531	639	505	509
65-74 years	179	127			7	5	19	19
75+ years	43	18			4	1	8	8
Not Available	0	0			0	0	0	0
Total	6,231	6,905	0	0	606	725	593	679

Comments on Data (for Age):
 Comments on Data (for Gender):
 Comments on Data (for Race/Ethnicity):
 Comments on Data (Overall):

1. State Definitions M

Yes No
 Yes No

Table 14B. Profile of Persons with SMI/SED served by Age, Gender and Race/Ethnicity

Of the total persons served, please indicate the age, gender and the number of persons who meet the Federal definition of SMI and SED and who are Hispanic/Latino or not Hispanic/Latino. The total persons served who meet the Federal definition of SMI or SED should be the total as indicated in Table 14A.

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Please report the data under the categories listed - "Total" are calculated automatically.

Table 14B.	2009		Not Hispanic or Latino						Hispanic or Latino						Total		
	Report Year:	NE	Not Hispanic or Latino			Hispanic or Latino			Not Available			Hispanic or Latino Origin			Male	Female	Not Available
	State Identifier:		Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available	Female	Male	Not Available
0 - 12 Years			231	461		21	73		5	8		259	342		598	0	799
13 - 17 years			298	394		38	50		10	21		396	466		862	0	1,314
18 - 20 years			339	416		26	46		13	12		276	274		552	0	852
21-64 years			6,623	6,517		440	432		106	158		7,169	7,107		14,276	0	27,661
65-74 years			212	158		4	1		4	2		20	161		381	0	542
75+ years			61	27		2	1		0	1		6	29		35	0	64
Not Available			0	0		0	0		0	0		0	0		0	0	0
Total			7,644	7,973	0	531	603	0	138	202	0	8,483	8,778	0	17,261	0	35,521
Comments on Data (for Age):																	
Comments on Data (for Gender):																	
Comments on Data (for Race/Ethnicity):																	
Comments on Data (Overall):																	

DRAFT

Table 15. Living Situation Profile:

Number of Clients in Each Living Situation as Collected by the Most Recent Assessment in the Reporting Period All Mental Health Programs by Age, Gender, and Race/Ethnicity

Please provide unduplicated counts, if possible. This table provides an aggregate profile of persons served in the reporting year. The reporting year should be the latest state fiscal year for which data are available. This profile is based on a client's last known Living Situation.

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Please report the data under the Living Situation categories listed - "Total" are calculated automatically.

Table 15.	2009											
Report Year:	NE											
State Identifier:												
	Private Residence	Foster Home	Residential Care	Crisis Residence	Children's Residential Treatment	Institutional Setting	Jail/Correctional Facility	Homeless/Shelter	Other	NA	Total	
0-17	2777	95	11	1	9	27	45	5	44	16	3080	
18-64	19670	24	755	6	1	405	296	1075	1827	671	24730	
65 +	424	3	37	1	0	26	2	5	33	15	646	
Not Available	6	0	0	0	0	0	0	0	4	5	15	
TOTAL	22877	122	803	8	10	458	343	1085	1908	707	28321	
Female	10910	50	358	3	2	194	93	372	852	198	13032	
Male	11967	72	445	5	8	264	250	713	1056	509	15289	
Not Available											0	
TOTAL	22877	122	803	8	10	458	343	1085	1908	707	28321	
American Indian/Alaska Native	541	5	11	0	1	10	19	34	48	6	675	
Asian	143	1	4	0	0	2	0	4	9	4	167	
Black/African American	1303	18	68	1	1	40	31	138	191	52	1843	
Hawaiian/Pacific Islander	11	1	0	0	0	0	1	2	1	0	16	
White/Caucasian	16863	75	593	5	6	349	246	720	1313	412	20552	
Hispanic *											0	
More than One Race Reported	1204	8	96	1	1	33	20	103	129	223	1818	
Race/Ethnicity Not Available	2812	14	31	1	1	24	26	84	217	10	3220	
TOTAL	22877	122	803	8	10	458	343	1085	1908	707	28321	
Hispanic or Latino Origin	1733	14	35	1	2	15	28	76	174	24	2102	
Non Hispanic or Latino Origin	20831	107	744	6	8	436	284	996	1680	422	26219	
Hispanic or Latino Origin Not Available	313	1	24	1	0	7	31	13	54	261	703	
TOTAL	22877	122	803	8	10	458	343	1085	1908	707	28321	

Comments on Data:

How Often Does your State Measure Living Situation? At Admission At Discharge Monthly Quarterly Other: describe:

* Hispanic: Only use the "Hispanic" row under Race if data for Hispanic as an Ethnic Origin are not available

DRAFT

Table 16: Profile of Adults with Serious Mental Illnesses and Children with Serious Emotional Disturbances Receiving Specific Services:

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Table 16.								
Report Year:		2009						
State Identifier:		NE						
Adults with Serious Mental Illness (SMI)					Children with Serious Emotional Disturbance (SED)			
	n Receiving Supported Housing	n Receiving Supported Employment	n Receiving Assertive Community Treatment	Total unduplicated N - Adults with SMI served	n Receiving Therapeutic Foster Care	n Receiving Multi-Systemic Therapy	n Receiving Family Functional Therapy	Total unduplicated N - Children with SED
Age								
0-12								799
13-17								811
18-20	21	10	0	852				
21-64	801	62	152	14276				
65-74	1	0	4	381				
75+	0	0	0	92				
Not Available		0	0	0				

Gender								
Female	502	43	74	7830				603
Male	321	29	82	7771				1007
Not Available								

Race/Ethnicity								
American Indian/Alaska Native	30	2	0	303				48
Asian	4	0	0	95				11
Black/African American	93	4	19	1235				96
Hawaiian/Pacific Islander	0	0	0	6				2
White	668	51	125	11520				1076
Hispanic*								
More than one race	20	8	12	1256				78
Not Available	8	7	0	1186				299

Hispanic/Latino Origin								
Hispanic/Latino Origin	41	6	5	952				182
Non Hispanic/Latino	754	66	151	14353				1384
Not Available	28	0	0	296				44

Do You monitor fidelity for this service?	Yes / No <input checked="" type="radio"/> <input type="radio"/>	Yes / No <input type="radio"/> <input checked="" type="radio"/>	Yes / No <input checked="" type="radio"/> <input type="radio"/>		Yes / No <input type="radio"/> <input type="radio"/>	Yes / No <input type="radio"/> <input type="radio"/>	Yes / No <input type="radio"/> <input type="radio"/>	
IF YES,								
What fidelity measure do you use?	tool developed by the Division of Behavioral Health							
Who measures fidelity?	State		State					
How often is fidelity measured?	2009		2009					
	Yes / No	Yes / No	Yes / No		Yes / No	Yes / No	Yes / No	
Is the SAMHSA EBP Toolkit used to guide EBP implementation?	<input type="radio"/> <input checked="" type="radio"/>	<input type="radio"/> <input type="radio"/>	<input checked="" type="radio"/> <input type="radio"/>		<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>	
Have staff been specifically trained to implement the EBP?	<input checked="" type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>	<input checked="" type="radio"/> <input type="radio"/>		<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>	

* Hispanic is part of the total served. Yes No

Comments on Data:	Receiving Supported Housing data from only the NE funded Housing Related Assistance program
-------------------	---

* Hispanic: Only use the "Hispanic" row under Race if data for Hispanic as a Ethnic Origin are not available

DRAFT

Table 17: Profile of Adults with Serious Mental Illnesses Receiving Specific Services During The Year:

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Table 17.										
Report Year:		2009								
State Identifier:		NE								
ADULTS WITH SERIOUS MENTAL ILLNESS										
		Receiving Family Psychoeducation	Receiving Integrated Treatment for Co-occurring Disorders (MH/SA)	Receiving Illness Self Management	Receiving Medication Management					
Age										
18-20			189				213			
21-64			3590				4437			
65-74			71				62			
75+			6				16			
Not Available			0				0			
TOTAL			3856				4728			
Gender										
Female			1855				2572			
Male			2001				2156			
Not Available										
Race										
American Indian/ Alaska Native			63				80			
Asian			11				26			
Black/African American			379				332			
Hawaiian/Pacific Islander			1				2			
White			2868				3514			
Hispanic*										
More than one race			443				463			
Unknown			91				311			
Hispanic/Latino Origin										
Hispanic/Latino Origin			206				280			
Non Hispanic/Latino			3637				4407			
Hispanic origin not available			13				41			
Do You monitor fidelity for this service?										
		Yes	No	Yes	No	Yes	No	Yes	No	
		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
IF YES,										
What fidelity measure do you use?										
Who measures fidelity?										
How often is fidelity measured?										
		Yes	No	Yes	No	Yes	No	Yes	No	
Is the SAMHSA EBP Toolkit used to guide EBP Implementation?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Have staff been specifically trained to implement the EBP?		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
* Hispanic is part of the total served. <input type="radio"/> Yes <input type="radio"/> No										
Comments on Data:										

* Hispanic: Only use the "Hispanic" row under Race if data for Hispanic as a Ethnic Origin are not available

DRAFT

Table 20A. Profile of Non-Forensic (Voluntary and Civil-Involuntary) Patients Readmission to Any State Psychiatric Inpatient Hospital Within 30/180 Days of Discharge

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Table 20A.					
Report Year:		2009			
State Identifier:		NE			
	Total number of Discharges in Year	Number of Readmissions to ANY STATE Hospital within		Percent Readmitted	
		30 days	180 days	30 days	180 days
TOTAL	193	5	19	2.59%	9.85%

Age	Total number of Discharges in Year	30 days	180 days	30 days	180 days
0-12	0	0	0		
13-17	1	0	0	0.00%	0.00%
18-20	16	0	2	0.00%	12.50%
21-64	173	5	17	2.89%	9.83%
65-74	3	0	0	0.00%	0.00%
75+	0	0	0		
Not Available					

Gender	Total number of Discharges in Year	30 days	180 days	30 days	180 days
Female	84	1	8	1.19%	9.52%
Male	109	4	11	3.67%	10.09%
Gender Not Available					

Race	Total number of Discharges in Year	30 days	180 days	30 days	180 days
American Indian/ Alaska Native	1	0	0	0.00%	0.00%
Asian	1	0	0	0.00%	0.00%
Black/African American	23	1	4	4.35%	17.39%
Hawaiian/Pacific Islander	0	0	0		
White	139	2	10	1.44%	7.19%
Hispanic*					
More than one race	29	2	5	6.90%	17.24%
Race Not Available	0	0	0		

Hispanic/Latino Origin	Total number of Discharges in Year	30 days	180 days	30 days	180 days
Hispanic/Latino Origin	10	1	4	10.00%	40.00%
Non Hispanic/Latino	157	4	15	2.55%	9.55%
Hispanic/Latino Origin Not Available	26	0	0	0.00%	0.00%

Are Forensic Patients Included? Yes No

Comments on Data: _____

* Hispanic: Only use the "Hispanic" row under Race if data for Hispanic as a Ethnic Origin are not available

DRAFT

Table 20B. Profile of Forensic Patients Readmission to Any State Psychiatric Inpatient Hospital Within 30/180 Days of Discharge

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Table 20B.					
Report Year:		2009			
State Identifier:		NE			
	Total number of Discharges in Year	Number of Readmissions to ANY STATE Hospital within		Percent Readmitted	
		30 days	180 days	30 days	180 days
TOTAL	98	4	12	4.08%	12.24%

Age					
	Total number of Discharges in Year	Number of Readmissions to ANY STATE Hospital within		Percent Readmitted	
		30 days	180 days	30 days	180 days
0-12	0	0	0		
13-17	9	0	0	0.00%	0.00%
18-20	4	0	0	0.00%	0.00%
21-64	82	3	11	3.66%	13.29%
65-74	3	1	1	3.33%	3.33%
75+	0	0	0		
Not Available					

Gender					
	Total number of Discharges in Year	Number of Readmissions to ANY STATE Hospital within		Percent Readmitted	
		30 days	180 days	30 days	180 days
Female	6	0	0	0.00%	0.00%
Male	92	4	12	4.35%	13.04%
Gender Not Available					

Race					
	Total number of Discharges in Year	Number of Readmissions to ANY STATE Hospital within		Percent Readmitted	
		30 days	180 days	30 days	180 days
American Indian/ Alaska Native	2	0	0	0.00%	0.00%
Asian	0	0	0		
Black/African American	14	0	0	0.00%	0.00%
Hawaiian/Pacific Islander	0	0	0		
White	72	4	12	5.56%	16.67%
Hispanic*					
More than one race	10	0	0	0.00%	0.00%
Race Not Available	0	0	0		

Hispanic/Latino Origin					
	Total number of Discharges in Year	Number of Readmissions to ANY STATE Hospital within		Percent Readmitted	
		30 days	180 days	30 days	180 days
Hispanic/Latino Origin	6	0	0	0.00%	0.00%
Non Hispanic/Latino	48	3	4	6.25%	8.33%
Hispanic/Latino Origin Not Available	44	1	8	2.27%	18.18%

Comments on Data:

* Hispanic: Only use the "Hispanic" row under Race if data for Hispanic as a Ethnic Origin are not available

DRAFT

Table 21. Profile of Non-Forensic (Voluntary and Civil-Involuntary Patients) Readmission to Any Psychiatric Inpatient Care Unit (State Operated or Other Psychiatric Inpatient Unit) Within 30/180 Days of Discharge

PLEASE DO NOT ADD, DELETE OR MOVE ROWS, COLUMNS AND/OR CELLS!

Table 21.					
Report Year:		2009			
State Identifier:		NE			
	Total number of Discharges in Year	Number of Readmissions to ANY Psychiatric Inpatient Care Unit Hospital within		Percent Readmitted	
		30 days	180 days	30 days	180 days
TOTAL	252	139	235	63.1%	93.3%

Age					
	Total number of Discharges in Year	30 days	180 days	30 days	180 days
0-12	18	0	0	0.00%	0.00%
13-17	116	5	11	4.31%	9.50%
18-20	252	15	32	5.95%	12.70%
21-64	2079	138	250	6.64%	12.02%
65-74	37	1	2	2.70%	5.41%
75+	18	0	0	0.00%	0.00%
Not Available	1	0	0	0.00%	0.00%

Gender					
	Total number of Discharges in Year	30 days	180 days	30 days	180 days
Female	1158	61	122	5.27%	10.54%
Male	1363	98	173	7.19%	12.69%
Gender Not Available					

Race					
	Total number of Discharges in Year	30 days	180 days	30 days	180 days
American Indian/ Alaska Native	42	6	7	14.29%	16.67%
Asian	12	1	1	8.33%	8.33%
Black/African American	186	5	9	2.69%	4.84%
Hawaiian/Pacific Islander	1	0	0	0.00%	0.00%
White	1689	102	198	6.04%	11.72%
Hispanic*					
More than one race	286	41	71	14.34%	24.83%
Race Not Available	305	4	9	1.31%	2.95%

Hispanic/Latino Origin					
	Total number of Discharges in Year	30 days	180 days	30 days	180 days
Hispanic/Latino Origin	202	10	23	4.95%	11.39%
Non Hispanic/Latino	2235	149	270	6.67%	12.03%
Hispanic/Latino Origin Not Available	84	0	2	0.00%	2.38%

1. Does this table include readmission from state psychiatric hospitals?	<input type="radio"/> Yes	<input type="radio"/> No
2. Are Forensic Patients Included?	<input type="radio"/> Yes	<input type="radio"/> No

Comments on Data:	All non-forensic and psychiatric inpatients patients discharged between 7/1/08 - 6/30/09. See also General Comments.
-------------------	--

* Hispanic: Only use the "Hispanic" row under Race if data for Hispanic as a Ethnic Origin are not available

DRAFT

Please use this table to enter any general comments and/or additional footnotes. This can be used for both footnotes that did not fit in the Footnotes field for a certain table, or it can be used for comments that apply to several tables, or are general comments for a state.

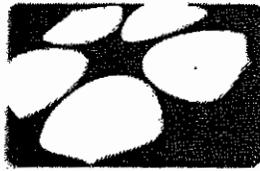
Comment No.	Re. Table No.	Comment
1	All	In January 2009, the Division of Behavioral Health cleaned its data system by administratively discharging nearly 18,000 records of admission to program prior to November 2003 and of which had no activity in the last year. This reduced the number of active cases in the system.
2	All	To obtain unduplicated count of persons served, the Division used social security numbers and dates of birth to identify unique clients in the data system.
3	2A	Data for this table were extracted from the Data Integration Grant (DIG) Database. The DIG Database is a collect of data from several different databases. The databases include in DIG are Magellan 2003, Magellan 2004, Magellan 2009, AIMS, and Avatar. The two Magellan databases hold collections of Community Based Data for Nebraska. The AIMS/Avatar database represents consumers served in one (or more) of the state's three regional centers. The DIG database contains information about Mental Health, Dual Diagnosis, and Substance Abuse consumers. From the DIG database, Records for Mental Health and Dual Diagnosis Consumers are extracted. Mental Health Consumer records are included in this population when they meet one of three criteria: 1) Having a DSM-IV Axis 1 number which complies with a Mental Health Diagnosis or 2) Having a Service Authorization for a Mental Health Treatment Program or 3) Having a final outcome for Mental Health reasons or 4) Having a Mental Health Reason for Admission or the State definition for SMI/SED 5) Meets Consumers only being served for Substance Abuse or Mental Retardation/Developmental Disabilities are EXCLUDED from this population. These are not persons with Dual Diagnosis. They are people with a primary diagnosis are SUBSTANCE ABUSE . The population use for TABLE 2a is an UNDUPLICATED count of persons served in both regional center and community programs. The clients were identified by social security number and date of birth.
4	2B	This is the same population presented in Table 2A distributed by ethnicity.
5	3	Data in this table reflects a population which receives Mental Health Services in one of four settings. This table contains data which are duplicated across rows. Community Mental Health Programs includes clients receiving outpatient services at a State Regional Mental Health Center or clients receiving services at a community provider. State Psychiatric Hospitals include Adults admitted to an inpatient unit and Adolescents admitted to either a sex offender unit or a chemical dependency unit at a State Regional Mental Health Center. Other Psychiatric Inpatients include clients admitted to one of the psychiatric inpatient hospitals within Nebraska, other than a State Regional Mental Health Center. Residential Treatment Center for Children population consists of adolescents admitted to one of the psychiatric units at a State Psychiatric Hospital, otherwise they were classified in State Psychiatric Hospitals if admitted to a sex offender or chemical dependency unit.

		Age was calculated as follows: [(July 1, 2008-- (Consumer Birth Date)] / 365.25]
6	4	This table is a representation of the ADULT population first presented in Table 2a. Employment Status is based on most recent admission data, if more than one. If employment status was listed as unknown or was missing, employment status at discharge, if available, was used.
7	4A	This represents the same population as in Table 4. Primary diagnosis could not be determined, due to the nature of the database (ie several diagnoses at admission, with no clear identification of primary diagnosis). As an alternative, a hierarchal approach was used where the most frequent diagnosis of schizophrenia, bipolar and mood disorders, and other psychiatric diagnostic combinations was applied. Those individuals who did not fall into one of those three categories, were placed in 'all other diagnoses' if other mental health diagnostic codes were listed (Axis codes between 290-316, minus substance abuse codes). The remainder of the population was classified as "No Diagnosis and Deferred" if an appropriate code was listed (799.9 or V71.09) or no diagnosis was given at all.
8	5A	The Population for Table 5a is the same population represented in Table 2A. The distribution of patients was defined as follows: Medicaid Only: persons listed as eligible and receiving payments, without another source of medical insurance. Non-Medicaid Only: persons listed as having a non-Medicaid source of insurance. Both Medicaid and Non-Medicaid: Persons listed as eligible and receiving payments from Medicaid, that have another source of medical insurance. Medicaid Status Not Available: all persons not listed as having Medicaid or another source of medical insurance.
9	5B	This is the same population as presented in Table 5A distributed by ethnicity.
10	6	This table represents the turnover of the clients shown in Table 2A Total Served at Beginning of Year (unduplicated): This population includes clients with admission dates before July 1, 2007 and who were discharged after July 1, 2007, or were not discharged. To unduplicate clients, a hierarchal method was applied so that a person could only be listed in one type of service program on July 1, 2007. Hierarchy structure: (1) State Hospitals (Currently admitted); (2) Residential Treatment Centers for Children (Currently admitted, but not concurrently admitted to a State Hospital); (3) Other Psychiatric Inpatient (Currently admitted, but not concurrently admitted to a State Hospital or RTC for Children); (4) Community Programs (Currently admitted, but concurrently not admitted to any of the above programs). Admissions During the Year (duplicated), the population was limited to records with admission date which occurred between July 1, 2007 and June 30, 2008. Each admission to one of the service types was only counted once, however, a person could be admitted to more than one service type. Discharges During the year (duplicated), the population was limited to records with discharge date which occurred between July 1, 2007 and June 30, 2008. Persons that were discharged and readmitted within 7 days were not considered actual discharges and were not counted (ie Transfers). Each actual discharge from one of the service types was only counted once, however, a person could be discharged from more than one service type. Length of Stay (in Days): Discharged Patients, the population was limited to those persons included in the previous column. Mean and Median number of days was calculated by subtracting the Admission date from the Discharge date of each record.

		<p>For Clients in Facility for Less than 1 Year: Average Length of Stay (in Days): Residents at end of year, the population was limited to persons who were admitted and were not discharged and had been in treatment for less than 365 days (calculated as follows {June 30, 2008-Admission Date}).</p> <p>For Clients in Facility More than 1 Year: Average Length of Stay (in Days): Residents at end of year, the population was limited to persons who were admitted and were not discharged and had been in treatment for more than 365 days (calculated as follows {June 30, 2008-Admission Date}).</p>
11	9, 11, 11a	<p>The Division of Behavioral Health contracts with the NE DHHS Div of Public Health Data Management Unit for annual consumer survey data collection using Federal Mental Health Data Infrastructure Grant funds. Data analysis and reporting completed by DHHS-Operations / Financial Services - Research & Performance Measurement funded by NE DHHS. The data are reported under:</p> <p>Table 9: SAMHSA NOMs: SOCIAL CONNECTEDNESS AND IMPROVED FUNCTIONING</p> <p>Table 11: Summary Profile of Client Evaluation of Care</p> <p>Table 11a: Consumer Evaluation of Care by Consumer Characteristics: (Optional Table by Race/Ethnicity.)</p>
12	12	<p>Line 2.a.1. represents the total number of adults (18 and above) found in Table 14A (SMI population) divided by the total number of adults (18 and above) found in Table 2A (Total MH population served). See Table 14A comments for SMI definitions</p> <p>Line 2.a.2. represents the total number of children/adolescent (less than 18 years old) found in Table 14A (SED population) divided by the total number of children/adolescent (less than 18 years old) found in Table 2A (Total MH population served). See Table 14A comments for SED definitions</p> <p>Line 3.a.1. represents ADULTS (18 years old and greater) in the population served by SMHA who also have a diagnosis of Substance Abuse divided by the total number of Adults in the population.</p> <p>A Person with a Substance Abuse Diagnosis is defined as someone who:</p> <p>(1) Has a DSM-IV Axis 1 number which complies with a Substance Abuse Diagnosis (291.1-292.99 and 303.0-305.99) or</p> <p>(2) Has a Service Authorization for a Substance Abuse Program or</p> <p>(3) Has a Substance Abuse Related "Reason for Admission." or</p> <p>(4) Has a final outcome relating to Substance Abuse or</p> <p>(5) Was seen at a provider that provides care only for Substance Abuse disorders.</p> <p>Line 3.a.2. represents children/adolescents (less than 18 years of age) in the population served by SMHA who also have a diagnosis of Substance Abuse divided by the total number of children/adolescents in the population.</p> <p>Line 3.b.1. represents ADULTS (18 years old and greater) in the population who meet the Federal definition for SMI, who have a diagnosis Substance Abuse problem divided by the total number of ADULTS with SMI in the population (Table 14A).</p> <p>Line 3.b.2. represents children/adolescents (less than 18 years of age) in the population who meet the Federal definition for SED, who have a diagnosed Substance Abuse problem divided by the total number of children/adolescents with SED in the population (Table 14A).</p>
13	14A	<p>This table represents the distribution of the adult SMI and children/adolescent SED population. This population is a subset of the population presented in Table 2A.</p>

		<p>NE State SMI Definition: An Axis diagnosis codes between 295-298.9 AND</p> <p>GAF score= 0-59 OR SSI/SSDI eligible OR Income Source = SSI or SSDI OR were admitted to a Community Mental Health Rehabilitation Based Services: Community Support, Assertive Community Treatment, Psychiatric Residential Rehabilitation, Day Treatment, Day Rehabilitation, Day Support, Vocational Support, or related psychiatric rehabilitation services</p> <p>NE State SED Definition: Age 3-17 AND One of the following Axis diagnosis codes 314.00, 314.01, 314.9, 295.xx, 295.4, 295.7, 297.1, 297.3, 298.8, 298.9,296.0x, 296.4x, 296.5x, 296.6x, 296.7, 296.80, 296.89, 296.90, 301.13, 296.2x, 296.3x, 300.01, 300.21, 300.30, 307.1, 307.51, 309.81, 312.34, 307.23 AND</p> <p>SSI/SSDI eligible OR Income Source = SSI or SSDI OR were admitted to one of the following programs: Professional Partner Services, Special Education Services, Day Treatment</p>
14	14B	This is the same population as presented in Table 14A distributed by ethnicity.
15	15	Living Situation information is based upon Self-Report Data collected at the time of the most recent admission (if more than one). "Children's Residential Treatment, is not recorded in the database. This field was populated by adolescents listed as living in an Institutional Setting that also met the requirements to be considered receiving treatment in a Children's Residential Treatment Center (see Table 3). Living status based on living status at time of most recent admission, if more than one. If living status at admission was unknown, then living status at discharge was used if known.
16	16	<p>Receiving Supported Housing - the data are unduplicated count persons served under the Nebraska Housing Related Assistance Program, using data reported by the six Regional Behavioral Health Authorities.</p> <p>Receiving Supported Employment - reported directly to Nebraska Division of Behavioral Health from the Administrative Services Only Managed Care Contractor, Magellan Health Services as an ad hoc report.</p> <p>Receiving Assertive Community Treatment (ACT) was reported directly to Nebraska Division of Behavioral Health from the Administrative Services Only Managed Care Contractor, Magellan Health Services as an ad hoc report.</p> <p>Adults with SMI served is the same adult population found in Table 14A.</p> <p>Children with SED is the same child/adolescent population found in Table 14a.</p>
17	17	<p>Receiving Integrated Treatment for Co-occurring Disorders (MH/SA) represents individuals listed as receiving treatment in a dual-diagnosis program based on services authorized, admission reason, and level of care.</p> <p>Receiving Medication Management represents individuals listed as receiving medication management in services authorized, or level of care.</p>
18	20A	This table includes all persons discharged from a state psychiatric hospital between 7/1/08-6/30/09, that were not admitted to or discharge from a forensic unit.

		The total number of discharges includes individuals treated at the state psychiatric hospitals only for substance abuse disorders, as well as individuals treated for both substance abuse and mental health disorders and those treated for mental health disorders only.
		Transfers between different state psychiatric hospitals are not counted as discharges. A discharge is counted if the person has been discharged for more than seven days without a readmission, and if the discharge status does not indicate a transfer.
		Readmissions are counted if they occurred greater than seven days after a discharge, and if the discharge status does not indicate a transfer.
19	20B	This table includes all persons discharged from a state psychiatric hospital between 7/1/08-6/30/09, that were admitted to or discharged from a forensic unit.
		Transfers between different state psychiatric hospitals are not counted as discharges. A discharge is counted if the person has been discharged for more than seven days without a readmission, and if the discharge status does not indicate a transfer.
		Readmissions are counted if they occurred greater than seven days after a discharge, and if the discharge status does not indicate a transfer.
20	21	This table includes all persons discharged from a state psychiatric hospital or a psychiatric inpatient hospital between 7/1/08-6/30/09, that were not admitted to or discharged from a forensic unit.
		The total number of discharges includes individuals treated only for substance abuse disorders, as well as individuals treated for both substance abuse and mental health disorders and those treated for mental health disorders only.
		Transfers are not counted as discharges. A discharge is counted if the person has been discharged for more than seven days without a readmission, and if the discharge status does not indicate a transfer.
		Readmissions are counted if they occurred greater than seven days after a discharge, and if the discharge status does not indicate a transfer.



Community Connections

Creating Cultures of Trauma-Informed Care (CCTIC): A Self-Assessment and Planning Protocol

Roger D. Fallot, Ph.D. and Maxine Harris, Ph.D.

July, 2009

Over the past fifteen years, there has been growing acknowledgement of several interrelated facts concerning the prevalence and impact of trauma in the lives of people in contact with various human service systems. We advocate for trauma-informed service approaches for a number of reasons.

- **Trauma is pervasive.** National community-based surveys find that between 55 and 90% of us have experienced at least one traumatic event. And individuals report, on average, that they have experienced nearly five traumatic events in their lifetimes. The experience of trauma is not the rare exception we once considered it. It is part and parcel of our social reality.

- **The impact of trauma is very broad and touches many life domains.** Trauma exposure increases the risk of a tremendous range of vulnerabilities: mental health problems like posttraumatic stress disorder, depression, excessive hostility, and generalized anxiety; substance abuse; physical health problems; interpersonal struggles; eating disorders; and suicidality, among many others. Trauma thus touches many areas of life not obviously or readily connected with the experience of trauma itself. This broad impact makes it particularly important to understand the less evident links between trauma and its sequelae.

- **The impact of trauma is often deep and life-shaping.** Trauma can be fundamentally life-altering, especially for those individuals who have faced repeated and prolonged abuse and especially when the violence is perpetrated by those who were supposed to be caretakers. Physical, sexual, and emotional violence become central realities around which profound neurobiological and psychosocial adaptations occur. Survivors may come to see themselves as fundamentally flawed and to perceive the world as a pervasively dangerous place. Trauma may shape a person's way of being in the world; it can deflate the spirit and trample the soul.

- **Violent trauma is often self-perpetuating.** Individuals who are victims of violence are at increased risk of becoming perpetrators themselves. The intergenerational transmission of violence is well documented. Community violence is often built around cycles of retaliation.

Many of our institutions—criminal justice settings, certainly, but also schools and churches and hospitals—are too frequently places where violent trauma is perpetuated rather than eliminated.

•**Trauma is insidious and preys particularly on the more vulnerable among us.** People who are poor, who are homeless, who have been diagnosed with severe mental health problems, who are addicted to drugs, or who have developmental disabilities—all of these groups are at increased risk of violent victimization.

•**Trauma affects the way people approach potentially helpful relationships.** Not surprisingly, those individuals with histories of abuse are often reluctant to engage in, or quickly drop out of, many human services. Being vigilant and suspicious are often important and thoroughly understandable self-protective mechanisms in coping with trauma exposure. But these same ways of coping may make it more difficult for survivors to feel the safety and trust necessary to helpful relationships.

•**Trauma has often occurred in the service context itself.** Involuntary and physically coercive practices, as well as other activities that trigger trauma-related reactions, are still too common in our centers of help and care.

•**Trauma affects staff members as well as consumers in human services programs.** Stressors deeply affect administrators, clinicians, and support staff working in human services. Not only is “secondary” or “vicarious” traumatization common but direct threats to physical and emotional safety are also frequent concerns. Being asked to do “more and more with less and less” becomes a pervasive theme underlying work experiences that may threaten to overwhelm coping abilities.

Growing awareness of these facts regarding trauma has led to calls for the development of both trauma-informed and trauma-specific services. Human service systems become **trauma-informed** by thoroughly incorporating, in all aspects of service delivery, an understanding of the prevalence and impact of trauma and the complex paths to healing and recovery. Trauma-informed services are designed specifically to avoid retraumatizing those who come seeking assistance as well as staff working in service settings. These services seek “safety first” and commit themselves to “do no harm.” The SAMHSA-funded Women, Co-Occurring Disorders, and Violence Study (1998-2003) has provided evidence that trauma-informed approaches can enhance the effectiveness of mental health and substance abuse services. By contrast, **trauma-specific services** have a more focused primary task: to directly address trauma and its impact and to facilitate trauma recovery. An increasing number of promising and evidence-based practices address PTSD and other consequences of trauma, especially for people who often bring other complicating vulnerabilities (e.g., substance use, severe mental health problems, homelessness, contact with the criminal justice system) to the service setting.

This Self-Assessment and Planning Protocol and its accompanying CCTIC Program Self-Assessment Scale attempt to provide clear, consistent guidelines for agencies or programs interested in facilitating trauma-informed modifications in their service systems. It is a tool for administrators, providers, and survivor-consumers to use in the development, implementation, evaluation, and ongoing monitoring of trauma-informed programs.

Overview of the Change Process, Protocol, and Scale

Culture Change in Human Service Programs

The Creating Cultures of Trauma-Informed Care approach to organizational change is built on five core values of **safety, trustworthiness, choice, collaboration, and empowerment**. If a program can say that its **culture** reflects each of these values in each *contact, physical setting, relationship, and activity* and that this culture is evident in the experiences of staff as well as consumers, then the program's culture is trauma-informed.

We emphasize organizational culture because it represents the most inclusive and general level of an agency or program's fundamental approach to its work. Organizational culture reflects what a program considers important and unimportant, what warrants attention, how it understands the people it serves and the people who serve them, and how it puts these understandings into daily practice. In short, culture expresses the basic values of a program. Culture thus extends well beyond the introduction of new services or the training of a particular subset of staff members; it is pervasive, including all aspects of an agency's functioning.

In order to accomplish this culture change, we strongly recommend several steps:

1) Initial Planning. In this phase, the program considers the importance of, and weighs its commitment to, a trauma-informed change process. The following elements are key to the successful planning of organizational trauma-informed change: a) administrative commitment to and support of the initiative (see Domain 4 below); b) the formation of a trauma initiative workgroup to lead and oversee the change process; c) the full representation of each significant stakeholder group on the workgroup—administrators, supervisors, direct service staff, support staff, and consumers; d) identification of trauma “champions” to keep the initiative alive and “on the front burner;” e) programmatic awareness of the scope (the entire agency and its culture) and timeline (usually up to two years) of the culture shift.

Discussions of trauma-informed program modifications constitute an opportunity to involve all key groups in the review and planning process. In our experience, the more inclusive and fully representative these discussions are, the more effective and substantial the resulting changes.

2) A Kickoff Training Event. Usually two days long, the kickoff training is attended by as many of the staff as practical and includes significant consumer representation; it certainly includes all members of the trauma initiative workgroup. During this event, there are at least three presentations. In the first, central ideas of trauma-informed cultures are presented, emphasizing shifts in both understanding and in practice. Second, the importance of staff support and care is emphasized, ensuring that staff members experience the same values in the organizational culture that consumers need to experience. Finally, a third presentation addresses the importance of trauma in the work of the specific agency (e.g., trauma and substance use, trauma and children or youth, trauma and mental health problems). There is also a great deal of time for the workgroup members and other attendees to discuss the planning process in more detail and to conduct preliminary conversations that will mirror those to be held in the larger

agency after the kickoff. The goal of the kickoff is to motivate and energize the change process while simultaneously providing a beginning sense of direction. The kickoff ends with discussion of next steps in the implementation of this change initiative.

3) Short-term Follow-up. Over the next several months, the agency takes the ideas from the training and applies them in more detail, using this Self-Assessment and Planning Protocol. First, the workgroup develops an Implementation Plan for review by the rest of the administration, staff, and consumers, as well as by outside consultants with experience in facilitating agency change. Community Connections consultants, for example, provide detailed feedback on Implementation Plans; discuss any barriers as they arise; and assist in developing strategies to overcome these obstacles. Simultaneously, two educational events are scheduled for all staff. The first is on “Understanding Trauma” or “Trauma 101.” This training is designed to discuss the prevalence and impact of trauma as well as some of the multiple paths to recovery, emphasizing the ways in which trauma may be seen in the lives of consumers and in the work experience of staff. The second training focuses more directly on “Staff Support and Care,” emphasizing that a culture shift toward a trauma-informed system of care rests on staff members’ experiences of safety, trustworthiness, choice, collaboration, and empowerment. Ideally, these training events are offered by experienced trainers who are also able and willing to encourage and teach staff members to become trainers themselves. In this way, as the program is able, its own trainers become equipped to pass along the important information about trauma to newer or untrained staff.

4) Longer-term Follow-up. After about six-nine months, Community Connections consultants revisit the program site to meet with the workgroup and selected others, in order to review and discuss progress to date. At that time, ongoing processes may be put in place to sustain the initiative to its conclusion. For example, many agencies build trauma-informed questions into their Consumer Satisfaction Survey. Many add the Implementation Plans to the quality assurance or improvement process. Still others, in larger systems, discuss ways to build in consultation to their own and other agencies through a “train the consultant” approach. The most important goal at this phase is to maintain the momentum established after the kickoff training until the culture change is thoroughgoing.