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Nebraska Behavioral Health Needs Assessment

Prepared by

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College of Public Health

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I. Introduction

Executive Summary

Key Findings

One in five Nebraskans have reported experiencing mental illness within the past year, indicating that mental health disorders are relatively widespread, chronic health conditions within the state. The Division of Behavioral Health (DBH) within the Nebraska Department of Health and Human Services is the state's chief behavioral health authority, responsible for providing care and support to adults with serious mental illness and to children with severe emotional disturbance. The DBH fulfills these responsibilities by working with Behavioral Health Region Administrators (RBHAs) and other partners to provide Mental Health Disorder (MHD) and Substance Use Disorder (SUD) services. Annually, about 30,000 people are served through DBH-funded programs across the state.

Some Nebraskans are more affected by mental health disorders and substance use disorders than others. For example, women report poorer mental health status and experience depression more often than men. People with lower incomes and less formal education report poorer mental health status than those with higher incomes and more formal education. In terms of race and ethnicity, the American Indian/Alaska Native population tends to have poorer mental health status compared to people from other racial/ethnic backgrounds. Participants in the community engagement portion of this needs assessment study indicated concerns about the impact of mental illness and substance use disorders on their communities and believe that it is more cost effective to treat these conditions than to deal with their consequences if left untreated.

Nebraska has seen a steady improvement in the psychiatric emergency response system, and this has allowed for a shift in focus to more prevention efforts. For example, data on emergency protective custody (EPC) admissions and Mental Health Board (MHB) commitments showed steady declines between 2011 and 2016. These rates have been at or near the state targets for the first half of 2016. Consumers and stakeholders in the community engagement portion of this needs assessment emphasized steps to prevent or de-escalate crisis situations, including the roles of crisis response teams. Maintaining access to medication and outpatient treatment are two key factors. They recommend establishing more 24/7 drop-in and respite centers to assist with de-escalation of crisis events and to avoid situations that lead to EPC admissions and MHB commitments.

Consumers and stakeholders also emphasized the importance of follow-up care and support after hospital discharge or upon release from incarceration. For example, after discharge, consumers may need access to intermediate care or more support services for a time before being referred to outpatient care only. Providers who participated in the focus groups also expressed concerns about service authorization. They related problems in obtaining authorization for the level of service they see as most appropriate for their patients. Services are also often authorized for short periods of time and require re-authorization to continue services for the length of time needed to support recovery. These concerns may be resolved as the State transitions to a managed care organization structure to pay for behavioral health services.

Although young children can develop mental health disorders and substance use disorders, these disorders become more common during adolescence and young adulthood. In Nebraska, 25% of high school students reported feeling depressed in the last year, and about 15% of high school students reported they considered suicide. In 2015, Nebraska ranked 47th in the nation for binge drinking among adults, showing rates almost twice as high as the lowest ranked state (20% in Nebraska versus 10% in West Virginia). Alcohol use is more common among young adults, with 43% of adults aged 18-25 years reporting binge drinking within the last month. Unfortunately, this age group does not see heavy alcohol use as harmful, and thus prevention efforts should focus on the needs of adolescents and young adults, especially transitional age youths.

Other prevention efforts may include instruction in Mental Health First Aid to increase awareness among the general public about mental illness, as well as targeted efforts to educate parents, teachers, community organization leaders, law enforcement, public health professionals, and others who work with young people. Primary care settings also present an opportunity to provide integrated care and education to help at-risk adolescents and young adults with the support they need. DBH is involved in the Nebraska System of Care (NeSOC), a collaborative effort of public and private agencies, as well as families and youth, who promote coordination of various systems to ensure access to needed care for children. DBH also works with several community coalitions to reduce substance abuse among adolescents and adults.

Building systems that allow access to sharing real-time data and information are key strategies that underlie many of the recommendations in this report. Access to live data on service capacity combined with timely longitudinal data would provide a robust information system, one that would allow DBH and RBHAs to better monitor system performance, including assessing different types and levels of care, and tracking consumer outcomes. Having access to such an information system would also allow providers and administrators to identify available services for consumers at the moment they are needed. Even though collaboration was identified as a strength within the behavioral health system, having an information system providing real-time data would also strengthen existing collaborative efforts between DBH, RBHAs, and service providers across the state. Such a system would also accommodate the need for comprehensive and ongoing needs assessments that could easily be supplemented with community engagement efforts, and such an information system could also support efforts to interpret and apply policies in a more standardized manner statewide.

This needs assessment study also documented the severe shortage in the behavioral health workforce in Nebraska. Health care providers, especially specialists such as psychiatrists, practice mainly in urban settings, leaving rural Nebraska providers with a significant burden. Integrated care and telehealth have been promoted as potential solutions, and indeed they hold great promise for increasing access to behavioral health treatment and more positive outcomes. While there needs to be a continuing effort to recruit and retain behavioral health specialists in rural communities, these new approaches should be implemented broadly in Nebraska. Also, from the perspective of prevention and management of chronic medical conditions, integrated care can help reduce the burden of these illnesses, prolong life expectancy, and improve quality of life for consumers.

Recommendations

Priorities

- There are many ongoing and new efforts to address different aspects of the behavioral health system. While these efforts should not be discontinued, a more focused strategic planning approach should be employed to select a few priority areas and choose those strategies that hold the most promising outcomes and that will improve the allocation of resources.
- Because of limited capacity and outcomes data, it was not possible to conduct a comprehensive assessment in these areas. However, available data indicate a need to address problems associated with the psychiatric emergency response system, and to expand access to treatment for substance-use disorders and co-occurring disorders.
- To decrease the overall burden of behavioral health problems in Nebraska, prevention activities should be expanded. A more focused approach to target specific high-risk populations is needed. It is also recommended that additional efforts be made to reduce exposure to adverse childhood experiences, and to increase screening and early intervention for those who have experienced trauma.

Data-Driven Approach

- In May of 2016, DBH implemented the Centralized Data System, which is expected to reduce duplicate efforts, streamline workflow, and offer dynamic, timely reports for making data-driven decisions and to continuously improve quality and continuity of care for consumers. However, at the time of this report, data to measure quality improvement have not been collected in a consistent or scientifically rigorous manner. Data from all partners and reporting agencies should be collected in a way that allows for valid comparisons across systems and across reporting time periods. Establishing a robust information system that would allow information exchange between providers and across different systems is also needed. Automation of data entry is the ideal solution; however, at minimum, training on quality assurance and strategies to ensure data quality is needed so that providers can enter complete and accurate data in a timely manner. An up-front investment of time and funds to establish a strong information system will have a long-term and strongly positive effect on the behavioral health system.
- A comprehensive needs assessment should be repeated regularly; every three years would be ideal. A smaller-scale assessment should be performed annually to monitor progress in priority areas and for targeted population groups. Performance measures for priority areas should be examined quarterly. In addition, longitudinal data on consumer outcomes should be collected to assess the effects of different interventions and/or initiatives.

Coordination & Standardization

- During the community engagement portion of this needs assessment, stakeholder and consumer participants commented that collaboration and engagement are two major strengths of the current behavioral health system. However, a formal agreement and data sharing protocol are needed to enhance the efficiency of collaborative care.

- Standardization of policies and procedures was also raised as an important issue by stakeholder and consumer participants, especially, standardization of policies across different regions.
- It is important to engage insurance companies and care management organizations to resolve some of the issues related to authorization and credentialing.
- Better education of consumers and families will strengthen their ability to become advocates in accessing the services they need, including providing them with a more holistic approach to their wellness.

Background

Definitions

In this report, the term "behavioral health problems," is used to include both mental health (MH) and substance use (SU) disorders. Behavioral health is defined as mental or emotional well-being and/or actions that affect wellness. Problems include substance use disorders; alcohol and drug addiction; serious psychological distress; suicide; and mental health disorders.[1] Mental illnesses refer to disorders characterized by dysregulation of mood, thought, and/or behavior, as recognized by the Diagnostic and Statistical Manual, 5th edition (DSM-5).[2, 3] DSM-5 uses the term "substance use disorder" to refer to disorders related to the recurrent use of alcohol and/or drugs that cause clinically and functionally significant impairment.[4]

Burden of Mental Health and Substance Use Disorders in the General Population

In a given year, approximately 1 in 5 adults in the U.S. experiences mental illness.[5] In Nebraska, over 17% of adults experience mental illness, which translates to approximately 325,000 adults affected by some type of mental illness in a given year.[6] Mental health issues affect adults and youths. In Nebraska in 2014, 1 in 3 high school students reported feeling depressed in the past year, and about 1 in 5 high school students reported they seriously considered attempting suicide in the past year.[7] Among young adults (18 – 25 years) in Nebraska, about 1 in 5 reported using an illicit drug in the past month.[6]

Although mental health and substance use disorders are very common in the general population, due to a variety of reasons, including stigma associated with these conditions and limited access to care, the use of treatment remains low.[8] Less than half of adults with a mental illness and only about 15% of those aged 12 or older who have a drug use disorder receive treatment in a given year in the U.S. and in Nebraska.[8]

Serious Mental Illness and Serious Emotional Disorders

While mental health disorders are relatively common, the burden of illness is most profound among those who have disability due to serious mental illness (SMI) and serious emotional disturbances (SED). According to the Federal Register (Volume 64, No. 121), SMI among adults (18 years and older) is defined as having, at any time during the previous year, a diagnosable mental, behavioral, or emotional disorder that causes serious functioning impairment that substantially interferes with or limits one or more major life activities. SMIs include major depression, schizophrenia, and bipolar disorder. SMI affects about 4% of the U.S. and Nebraska adult population. SMI is a chronic condition, and without treatment and support, persons with SMIs may experience difficulties living their lives to the fullest capacity.

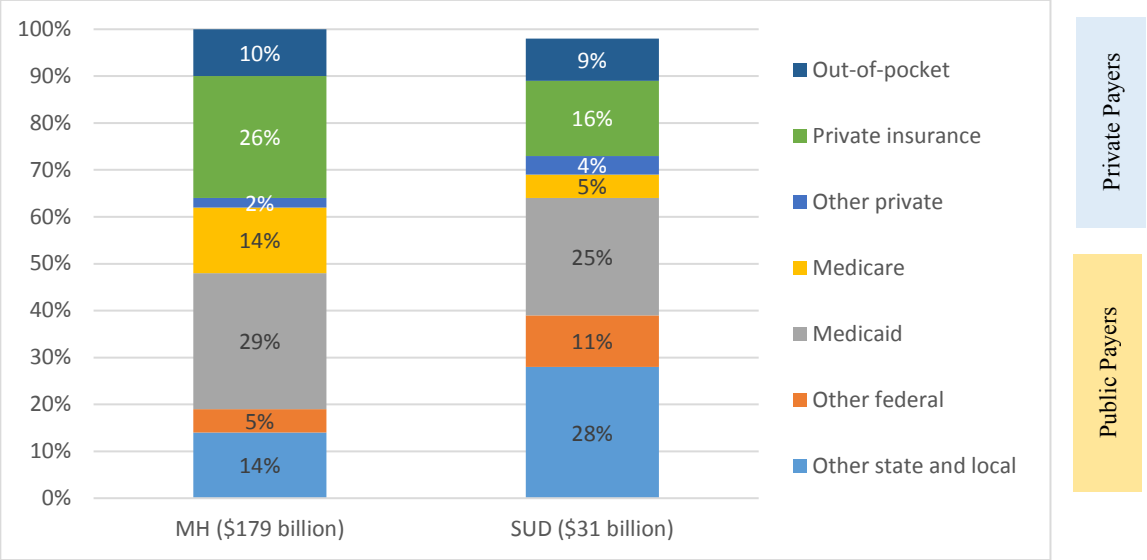
A similar issue exists for children with serious emotional disturbance (SED). At the federal level, SED refers to children and youth who have in the past year had a diagnosable mental, behavioral, or emotional disorder, one that resulted in functional impairment that substantially interfered with or limited the child's role or functioning in family, school, or community activity. There is limited information about estimates for SED because current population surveys do not have an indicator for SED.

Behavioral Health Financing

Behavioral health services in the U.S. are financed through multiple sources including states and counties, the federal-state Medicaid program, the federal Medicare program, federal Block Grants, private insurance coverage, patient out-of-pocket expenditures, and smaller public and private programs. Each service has its own eligibility rules and benefits packages.

Public sources play a large role in financing mental health care, with 62% of behavioral health spending of $179 billion in 2014 covered by public sources, including Medicaid (29%), Medicare (14%), other state and local source (14%), and other federal sources (5%) (**Figure 1.1**).[9] The share of public funded sources is even larger for substance use disorders (69%).

Figure 1.1: 2014 U.S. Distribution of Mental Health (MH) and Substance Use Disorder (SUD) Spending[9]



SAMHSA and State's Mental Health and Substance Abuse Authority

The public behavioral health system supported by states, territories, and counties is considered to be a "safety net" for persons with SMI, SED, and/or SUD who also have financial needs. In most states, behavioral health treatment and service funds flow from the state mental health and substance abuse authority to counties or regions within the state.

The Substance Abuse and Mental Health Services Administration (SAMHSA), an agency within the U.S. Department of Health and Human Services that leads efforts to advance the behavioral health, provides two block grants, the Substance Abuse Prevention and Treatment Block Grant (SABG) and Community Mental Health Services Block Grant (MHBG), to the state mental health and substance abuse authority. The SABG program prioritized the following populations and service areas: pregnant women and women with dependent children; intravenous drug users; tuberculosis services; early intervention services for HIV/AIDS; and primary prevention services. The MHBG program prioritizes adults with SMI and children with SED.

Nebraska's Public Behavioral Health System

The Nebraska Health and Human Services Division of Behavioral Health (DBH) is recognized as the chief authority of the state to administer, oversee and coordinate the state's public behavioral health system, in collaboration with Regional Behavioral Health Authorities and other partners. The DBH is responsible for managing the Substance Abuse Prevention and Treatment Block Grant and Community Mental Health Services Block Grant.

At the state level, the DBH is comprised of three sections: Regional Centers, Community Based Services, and the Office of Consumer Affairs. There are three regional centers, located in Norfolk, Lincoln, and Hastings. The DBH contracts with the six Regional Behavioral Health Authorities to purchase community-based mental health and substance use disorder services using state dollars along with MHBG and SABG funds. Each Regional Behavioral Health Authority is under contract to provide Network Management, Prevention System Coordination, Emergency System Coordination, Youth System Coordination, and Housing Coordination. Each year about 30,000 children and adults in Nebraska receive services through the DBH funded public behavioral health system across the six behavioral health regions.

Challenges Accessing Quality Behavioral Health Care

In 2001, President George W. Bush announced his New Freedom Initiative to promote increased access to educational and employment opportunities for people with disabilities.[10] In 2002, the President identified three obstacles preventing people with mental illness from getting care:

- Stigma that surrounds mental illnesses,
- Unfair treatment limitations and financial requirements placed on mental health benefits in private health insurance, and
- The fragmented mental health service delivery system.

These obstacles continue to prevent people with behavioral health problems from seeking needed care. A recent review study also found that people are reluctant to seek treatment due to a concern about disclosing one's behavioral health problems, particularly for ethnic minorities, youth, men, and those in the military who were much more likely to be deterred by stigma.[11] Also, according to the 2005-2011 U.S. National Surveys on Drug Use and Health, negative views of the community and potential effects on one's job were two commonly cited reasons for not seeking substance use disorder treatment. Inability to afford the cost of care was the most common barrier to treatment for both substance use and mental health disorders.[12] Nationally, the behavioral health delivery system has remained fragmented due to siloed programs and services with varying eligibility criteria and funding sources. Lack of communication and coordination among providers of physical and behavioral health also contributes to fragmentation of care. As a result, access to quality care remains a challenge for persons with behavioral health problems.

Nebraska Behavioral Health Needs Assessment

Purpose and Objectives of Needs Assessment

The purpose of this needs assessment is to provide data to inform the strategic planning for the Division of Behavioral Health (DBH) strengthening Nebraska's public behavioral health system. The specific objectives of the needs assessment were the following:

1. Estimate the burden of behavioral health problems in Nebraska
2. Identify strengths and gaps in Nebraska's public behavioral health system
3. Identify needs of special populations such as persons with developmental disabilities, persons involved in the criminal justice system and the homeless population
4. Describe the current status of behavioral health workforce in Nebraska and identify areas for improvement
5. Discuss national and state-level initiatives for integrated care
6. Engage consumers, families, and stakeholders understanding their perspectives about Nebraska's behavioral health system

Organization of the Report

The report begins with a background to describe the purpose of the needs assessment (Chapter 1) followed by a summary of data sources and methodology of the needs assessment (Chapter 2). Although the needs assessment focuses on the public health behavioral health system funded through DBH, which focuses on services for people with SMI, SED, and SUD, to understand the roles of the public health behavioral health system, it is important to assess the magnitude of mental health and substance use disorders affecting the entire population and as available across payer sources. This report included a chapter to describe the demographic characteristics of the state population (Chapter 3) followed by two chapters on the burden of various behavioral health issues affecting the entire Nebraska population (Chapters 4 and 5). The report then examines services provided through the DBH funded public behavioral health system whose primary focus is on persons with SMI, SED, and SUD (Chapter 6).

Because the population served by the DBH funded public behavioral health system overlaps with populations served by other systems, such as the developmental disabilities program, the criminal justice system, and housing program, one chapter is dedicated to examining the needs of these populations and the existing efforts to address those needs (Chapter 7). This chapter is followed by a discussion of the behavioral health workforce, and summarizes results of the Nebraska workforce analysis study (Chapter 8).

Community engagement was one of the most important components of the needs assessment. Contributions from consumers, families, advocates and collaborators were captured through a series of state-wide focus groups and three surveys; results are reported in Chapter 9. In the final chapter, the report brings readers back to the larger context and to the future of behavioral health care in the U.S. Chapter 10 focuses on a population-based and public health approach to treat the whole person (integrated care), with a focus on the prevention of behavioral and physical health problems.

II. Methods

In order to collect comprehensive information, a literature review was conducted to identify relevant research articles and technical reports. Additional information such as expenditures and service utilization was provided by Nebraska Department of Health and Health and Human Services. Finally, focus groups and surveys were conducted among consumers, stakeholders, and the general public.

Secondary Data Collection and Analysis

Secondary data refers to data that were collected by someone else. Secondary analysis involves the utilization of existing data. For this report, the majority of data were obtained from publicly available databases. The most recently available data were used for each source. When possible, data were broken down by gender, race/ethnicity, age, education, income, poverty status, geographical location, and Behavioral Health Region.

Census and Population-Based Survey Data

- U.S. Census Bureau Data.[13] The Bureau of the Census is a principal agency of the U.S. Federal Statistical System, responsible for producing data about the American people and economy. Examples of data collection activities by the bureau include Decennial Census of Population and Housing, Census of Governments, and Economic Census, American Community Survey (ACS).
    - American Community Survey (ACS).[14] The ACS collects data from January through December. New data is released every year in the form of estimates, in a variety of tables, tools, and analytical reports. The most recently released data were from 2014.
- National Survey on Drug Use and Health (NSDUH), an annual nationwide survey involving interviews with approximately 70,000 randomly selected persons aged 12 and older.[15] These data provide national and state-level estimates on the use of tobacco products, alcohol, illegal drugs and mental health in the United States. NSDUH is sponsored by the Substance Abuse and Mental Health Services Administration.
- Behavioral Risk Factor Surveillance System (BRFSS).[16] This is a health-related telephone survey funded by the Centers for Disease Control and Prevention (CDC), which collects state data on adults 18 years old and older about their behaviors related health risks, chronic health conditions, and use of preventative services. BRFSS completes more than 400,000 randomly selected adult interviews continuously throughout the year. Interviewers use a standardized core questionnaire and optional modules selected by each state.
- Youth Risk Behavior Survey (YRBS).[17] This survey is conducted every two years by states and submitted to the CDC. The survey includes a representative sample of 9th-12th grade students throughout the nation, and results are used to monitor health risk behaviors that contribute to the leading causes of death and disability among youth and adults in the United States.

Other Reports

In addition, information was retrieved from published reports including:

- *Substance Abuse, Mental Illness and Associated Consequences in Nebraska: An Epidemiological Profile* by the Nebraska Department of Health and Human Services (NDHHS)[18]
- *Nebraska's Behavioral Health Workforce-2000 to 2014* by the University of Nebraska Medical Center-College of Public Health (UNMC)[19]
- *Nebraska's Health Disparities Report* by NDHHS[20]
- *Health Status of American Indians in Nebraska Report* by NDHHS[21]

Hospital Discharge Data

To examine the patterns and trends of hospitalization related to mental health and substance use disorders in Nebraska, hospital discharge data were analyzed. De-identified hospital discharge data for the period between 2007 and 2014 were provided by the Nebraska Department of Health and Human Services, Division of Public Health (DPH). There are two types of hospital discharge records—emergency department and inpatient. The DPH receives data from the Nebraska Hospital Association. Hospital discharge records contain information on the date of admission, date of discharge, patient's age, gender, county of residence, and diagnosis codes. Information on hospital discharges is reported from acute care hospitals in Nebraska to the Nebraska Association of Hospitals and Health Systems. The Veterans Affairs, Regional Centers, and Indian Health Service hospitals do not participate, nor do the following hospitals: Lincoln Surgical Hospital (Lincoln), Select Specialty Hospital (Lincoln/Omaha), Douglas County Health Center (Omaha), Midwest Surgical Hospital (Omaha), and Nebraska Spine Hospital (Omaha). In this report, hospital discharge data were used to estimate hospitalization rates related to mental health and substance use disorders.

Primary Data Collection and Analysis

Focus Groups

Focus group participants were invited by each Behavioral Health Region using their existing contact lists. A total of 24 focus groups were organized, with at least one consumer focus group and one stakeholder focus group in each region, for a total of 108 participants for the stakeholder groups and 77 for the consumer groups. To protect consumers' privacy, participants in these groups gave only their first name when signing in to the session. Stakeholders who participated in the sessions were asked to provide both their name and organization. Some of the agencies represented included criminal justice (e.g. law enforcement, probation, corrections), hospitals, public health, service agencies, DHHS, Behavioral Health Regions, Board of Mental Health, and advocacy organizations.

The results of the November 2015 report, *The DHHS Behavioral Health Division's Role in Reducing Service Gaps,* conducted by the Performance Audit Committee of the Nebraska Legislature, served as a starting point to identify topics for inclusion in a semi-structured interview guide.[22] These include:

- disparate authorization periods across systems,
- differences in how services are authorized,
- lack of housing and supports,

- lack of system collaboration,
- access,
- supported employment,
- emergency system access.

As the question guide for the consumer focus group was developed, these topic areas were combined into access to care, available support services, authorization for services from payers, emergency psychiatric services, collaboration between service providers, integrated care, and funding. The first two consumer focus groups revealed that consumers generally do not interact directly with payers when securing authorization for services, so questions in that category were eliminated for the consumer focus groups. Similarly, consumers discussed funding in questions asked about availability of services, so questions about funding were incorporated into availability of services questions for the consumer focus groups. Consumers in the first two focus groups also raised the issue of stigma and misunderstandings related to mental illness and substance use disorders, so that topic was also included in subsequent consumer focus groups.

The semi-structured question guide for the stakeholder focus groups combined the identified topic areas into questions about collaboration among stakeholders, the Behavioral Health Region, and the State; emergency psychiatric services; availability of support services; funding; authorization for services; and integrated care. The topic of stigma was often raised in discussions about support services such as housing or employment, but was not included as a separate topic area for the stakeholder focus groups. The initial stakeholder question guide did not change substantially over the course of the focus groups.

The size of the focus groups ranged from three to 31 participants. Two of the consumer focus groups were conducted at day service programs. At least three of the stakeholder focus groups were conducted in conjunction with a regularly scheduled advisory board meeting for that Region. Although all of the topic areas were covered in each group, questions were not asked in any particular order; rather the facilitator allowed the group to guide the discussion. Focus groups lasted between one and two hours. All focus groups were audio recorded, and with the exception of the last focus group, all were transcribed by an outside contractor (because of time constraints, the last focus group was coded directly from the audio file). The topic areas of each question guide were used to guide the initial coding and to identify sub-categories. The first two transcripts were coded by four researchers and compared for agreement. After determining a high level of agreement between individual coders, subsequent transcripts were coded by the lead researcher for the community engagement portion of this project with the collaboration of one other coder. Transcripts were coded in Microsoft Word and then analyzed using the 'compare documents' feature in Word.

Surveys

Three surveys were developed targeting three types of respondents: 1) consumers and their family members; 2) stakeholders, including those who provide services directly to consumers and those whose work involves interacting with people with serious mental illness and/or substance use disorders; and 3) the general public. To streamline survey distribution, one survey containing all questions was constructed and screening questions were used to direct respondents to the appropriate set of questions. Questions for

surveys were developed first by reviewing the Legislative Performance Audit Committee Report, a report prepared for Region 6 by TriWest,[23] the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Experience of Care and Health Outcomes (ECHO) Survey from the Agency for Healthcare Research and Quality (AHRQ),[24] and the Mental Health Statistics Improvement Program Consumer Survey (MHSIP) from the Substance Abuse and Mental Health Services Administration (SAMHSA).[25] These questions were refined and additional questions added based on preliminary results of the consumer and stakeholder focus groups conducted as part of the community engagement portion of this assessment.

The timeline for the project required using a convenience sampling strategy, one that limits the ability to generalize results. The survey was distributed electronically via a link sent to organizations and agencies to share with their constituents, as well as to listservs and email lists within the domain of the Nebraska Department of Health and Human Services Division of Behavioral Health. Researchers were also notified that some organizations receiving the survey shared the link via their social media accounts. The survey was open from June 1, 2016 to June 17, 2016. A total of 1,692 persons responded to the survey.

Health Profession Tracking Center Survey

For this needs assessment project, the Nebraska Health Profession Tracking Service (HPTS) added questions about integrated care to the annual survey. Due to the wide range of different models and definitions of integrated care, it is difficult to measure the level of integrated primary care implementation within the State of Nebraska. One method is to look at the number and proportion of behavioral health providers in integrated care settings. For this reason, to estimate the true proportion in the state, the HPTS includes a number of items on the 2016 survey that asked behavioral health providers in the state whether they currently practiced in an integrated care setting, if they were interested in working in an integrated care setting, and what they perceived were barriers to integrated care. The behavioral health professionals included in the study were: (1) psychiatrists; (2) advanced practice registered nurses (APRNs) who practice psychiatry; (3) physician assistants (PAs) who practice psychiatry; (4) psychologists; (5) licensed independent mental health practitioners (LIMHPs) and licensed independent mental health practitioners (LIMHPs); (6) licensed mental health practitioners (LMHPs); and (7) licensed alcohol and drug counselors. Surveys were pre-populated with data previously entered into the HPTS database. The data include each professional's demographic information, education, questions specific to behavioral health, practice locations, and practice characteristics.

Criteria for Nebraska licensed professionals surveyed include those practitioners who were: 1) identified as practicing in Nebraska through previous surveys or research; 2) identified with a Nebraska address but HPTS professional status marked as "unknown"; and 3) identified as newly licensed in Nebraska since the time of the last professional survey. Non-respondents to the initial survey mailing are sent a second request. Excluded from the survey are those who were retired, deceased, inactive, disabled, practicing in a new field, and licensed in Nebraska for more than one year and identified with an address outside Nebraska. Updates from the HPTS Survey are entered into the HPTS database, updating professional and facility data.

III. Demographic Profile of the Nebraska General Population

Summary

This chapter presents information about the demographic characteristics of the general Nebraska population. The information included in this chapter is based on U.S. Census data and published reports which used U.S. Census data, Department of Labor data, or related population-based data. Information provided by the Nebraska Department of Health and Human Services was also included.

Chapter Highlights

Nebraska Population Overview and Trends

- In 2015, an estimated 1.9 million people were living in Nebraska
- About 19% of Nebraska population lived in rural counties in 2014
- Between 2000 and 2010, the urban population increased by 13.7% while the rural population decreased by 5.9%
- Between 2000 and 2010, the Hispanic population increased by 77.3%–from 5.5% to 9.2% of the state's population

Nebraska Population Sociodemographic Status

- About 11% of the total Nebraska population did not have health insurance coverage in 2014, a slightly lower percentage compared to the U.S. overall (14%)
- The percentage of people who had at least a high school education in 2014 was higher in Nebraska (90.5%) compared to the U.S. overall (86.3%)
- Nebraska had a lower unemployment rate than the U.S. as a whole in July 2016, with 3.1% of the working population unemployed, compared to 4.9% of the working population in the U.S.
- African Americans and Hispanics have a higher poverty rate in the Omaha Metropolitan Area than the national average and rates have been steadily increasing since 2010

Population Profile of Behavioral Health Regions in Nebraska

- With the exception of Behavioral Health Region 6, all other regions primarily comprise rural counties
- Although Region 6 has the highest percentage of minority populations, the percentage of the Hispanic population was higher in other regions
- In Region 1, one in four children (24%) live in poverty

Nebraska Population Diversity

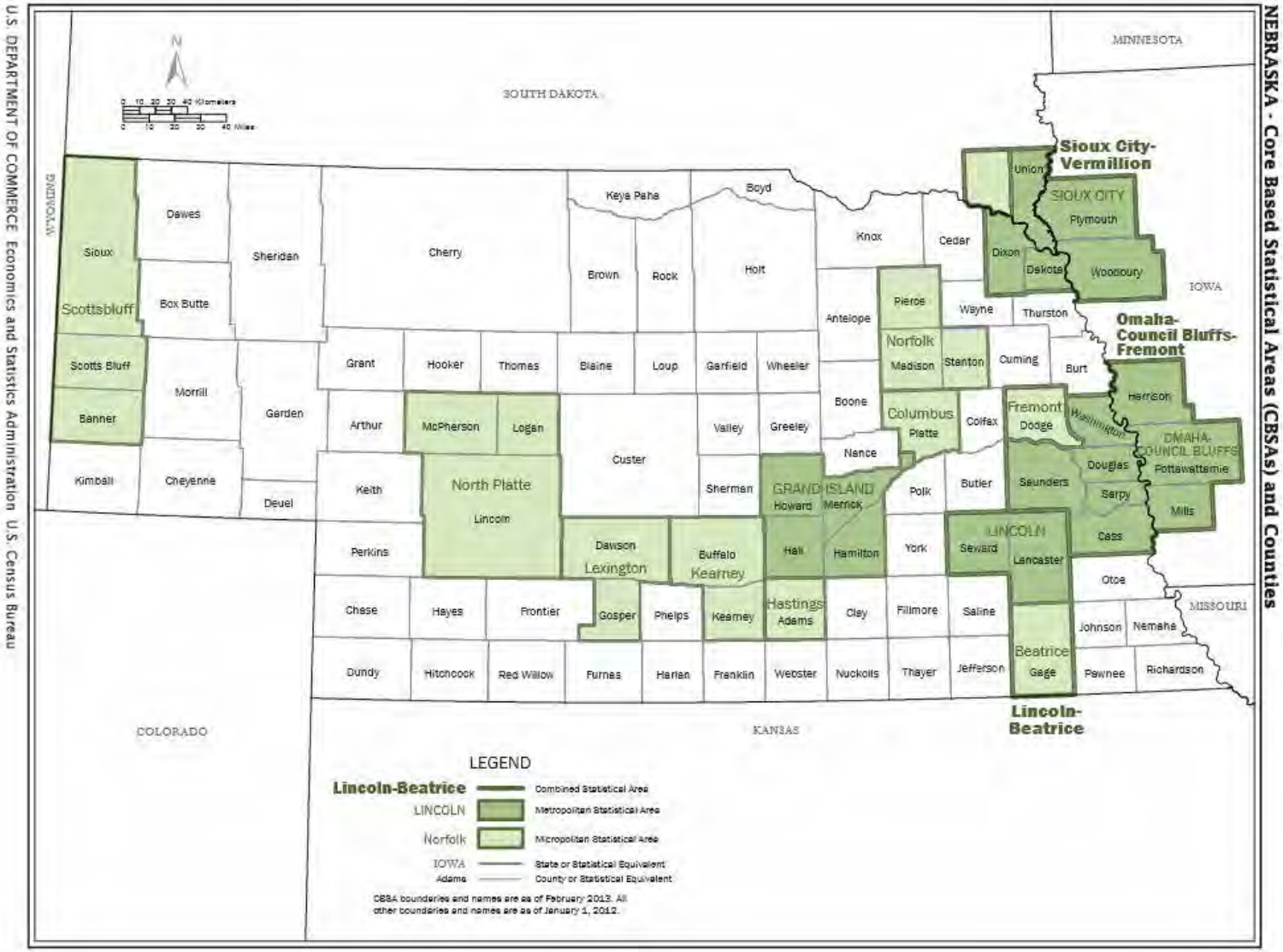
- In 2014, 4.5% of Nebraska's population identified as African American, 1.9% as Asian, 0.7% as American Indian/Alaska Native, and 9.2% as Hispanic/Latino/a origin
- Counties with high concentrations of minority populations include Thurston (60.5%), Dakota (44.6%), Colfax (42.6%), Dawson (36.4%), and Scotts Bluff (24.4%)

Nebraska Population Overview and Trends

Figure 3.1 shows the distribution of the state's population. The U.S. Census Bureau defines a metropolitan county as one that has a city with 50,000 or more residents or is a metropolitan outlying county.[26] A micropolitan county is defined as a county that has a city with 10,000 or more residents.[26] A rural county is defined as a county in which the largest city has less than 10,000 residents.[26] In 2014, 18.6% of Nebraska's population lived in a rural area and 17.6% resided in a micropolitan area. In contrast, only 4.5% of the population in the U.S. lived in a rural area and 8.7% lived in a micropolitan area.[26]

Nebraska's urban population has been steadily increasing: from 2000 to 2010, the population in metropolitan counties in Nebraska increased by 13.7%, compared to a 3.1% rise in micropolitan counties and a 5.9% decrease in rural counties.[27]

Figure 3.1: Metropolitan, Micropolitan, and Rural Areas in Nebraska and Parts of Iowa, 2013[28]



The U.S. Census Bureau collects population information every ten years. To estimate the characteristics of the population between censuses, the Bureau recommends using the American Community Survey (ACS) data.[29] **Table 3.1** summarizes the sociodemographic characteristics of Nebraska's population based on the 2014 ACS data, the most recent available. In 2014, it was estimated that over 1.8 million people lived in Nebraska.[30] Compared to the U.S. population (62.8%), Nebraska had a higher percentage of Non-Hispanic white persons (81.2%). The poverty rate (12.9%) in Nebraska was lower than U.S. rate (15.6%).[29]

About 11% of the total Nebraska population did not have health insurance coverage in 2014, compared to 14% for the U.S. average.[29] People were considered insured if, at the time of the ACS interview, they reported having private or public health insurance coverage. Private insurance was defined as a health insurance plan that was provided through an employer or union, a plan purchased by an individual from a private company, or TRICARE or other military health care. Public health coverage includes the federal programs such as Medicare, Medicaid, Veterans Affair (VA) Health Care (provided through the Department of Veterans Affairs), the Children's Health Insurance Program (CHIP), and individual state health plans. The types of health insurance are not mutually exclusive because people may be covered by more than one plan at the same time. People who had no reported health coverage at the time of the interview, or those whose only health coverage was from the Indian Health Service, were considered uninsured.[14, 31]

Table 3.1: Nebraska and United States Population Characteristics: 2014 Estimates[26, 29]

Characteristic	State of Nebraska		United States	
	N	%	N	%
Total Population	1,855,617	100%	314,107,084	100%
Age				
≤9	261,464	14.1%	40,434,066	12.9%
10-19	255,157	13.7%	42,209,417	13.4%
20-34	383,604	20.7%	64,717,654	20.6%
35-54	471,380	25.4%	84,971,226	27.1%
55-64	226,349	12.2%	38,596,760	12.3%
65-84	218,009	11.8%	37,358,797	11.9%
≥85	39,654	2.1%	5,819,164	1.9%
Gender				
Male	921,597	49.7%	154,515,159	49.2%
Female	934,020	50.3%	159,591,925	50.8%
Race/Ethnicity				
White, NH*	1,506,879	81.2%	197,159,492	62.8%
African American, NH*	83,932	4.5%	38,460,598	12.2%
Asian, NH*	35,325	1.9%	15,536,209	4.9%
Pacific Islander, NH*	1,070	0.1%	493,155	0.2%
American Indian/Alaska Native, NH*	12,907	0.7%	2,082,768	0.7%
Other, NH*	1,409	0.1%	611,881	0.2%
2+ Races, NH*	33,647	1.8%	6,692,885	2.1%
Hispanic**	180,448	9.7%	53,070,096	16.9%
Geography**				
Metropolitan	1,184,351	63.8%	272,667,942	86.8%
Micropolitan	327,205	17.6%	27,242,864	8.7%
Rural	344,061	18.6%	14,196,278	4.5%
Living Below Poverty Level				
Total	231,762	12.9%	47,755,606	15.6%
Children	79,766	17.6%	15,907,395	21.9%
Without Health Insurance				
Total	201,560	11.0%	43,878,131	14.2%
Children	25,986	5.6%	5,217,055	7.1%
Education				
High School Graduation***	--	90.5%	--	86.3%

*NH=Non-Hispanic. Persons of Hispanic origin may be of any race. **Metropolitan=County that has a city with ≥50,000 residents or is a metropolitan outlying county. Micropolitan=County that has a city with ≥10,000 residents. Rural=Largest city in county that has <10,000 residents. ***American Community Survey only provides percentages.

Approximately 1.9 million people were living in Nebraska in 2015.[30] **Table 3.2** shows changes in the population size and the characteristics of the population between 2000 and 2010. The number of persons between 45-64 years of age and those aged 85 years and older increased by 28.5% and 15.8%, respectively.[27] Another notable change between 2000 and 2010 was the growth of the minority population, especially among Hispanic persons. During this period, this population group rose by 77.3% and represented 9.2% of the total population in 2010 as compared to 5.5% in 2000.[27]

Table 3.2: Nebraska Population Characteristics: U.S. Census Bureau 2000 vs. 2010[27]

	2000		2010		% Change in Population
	Population	% of Total	Population	% of Total	
Nebraska Total	1,711,263	100.0%	1,826,341	100.0%	6.7%
Gender					
Female	867,912	50.7%	920,045	50.4%	6.0%
Male	843,351	49.3%	906,296	49.6%	7.5%
Age					
Under 5 years	117,048	6.8%	131,908	7.2%	12.7%
5-14 years	252,379	14.7%	251,634	13.8%	-0.3%
15-24	255,240	14.9%	258,206	14.1%	1.2%
25-44	487,107	28.5%	466,014	25.5%	-4.3%
45-64	367,294	21.5%	471,902	25.8%	28.5%
65-84	198,242	21.5%	207,369	11.4%	4.6%
85 and older	33,953	2.0%	39,308	2.2%	15.8%
Race/Ethnicity					
White, NH*	1,494,494	87.3%	1,499,753	82.1%	0.4%
African American, NH*	67,537	3.9%	80,959	4.4%	19.9%
American Indian/Alaska Native, NH*	13,460	0.8%	14,797	0.8%	9.9%
Asian/PI, NH*	22,324	1.3%	32,885	1.8%	47.3%
Other, NH*	1327	0.1%	2,116	0.1%	59.5%
2+ Races, NH*	17,696	1.0%	28,426	1.6%	60.6%
Hispanic**	94,425	5.5%	167,405	9.2%	77.3%
Minority	216,769	12.7%	326,588	17.9%	50.7%
Urban/Rural Status**					
Metropolitan Counties	942,503	55.1%	1,071,368	58.7%	13.7%
Micropolitan Counties	348,933	20.4%	359,772	19.7%	3.1%
Rural Counties	419,827	24.5%	395,201	21.6%	-5.9%

*NH=Non-Hispanic. Persons of Hispanic origin may be of any race. **Metropolitan=County that has a city with ≥50,000 residents or is a metropolitan outlying county. Micropolitan=County that has a city with ≥10,000 residents. Rural=Largest city in county that has <10,000 residents.

Unemployment and Poverty

In July 2016, Nebraska had a lower unemployment rate than the United States as a whole, with 3.1% of the working population unemployed, compared to 4.9% of the working population in the United States.[32, 33] **Figure 3.2** shows that the unemployment rate in Nebraska has been lower than U.S. unemployment rate between 2006 and 2016.

Figure 3.2: Unemployment Rates in Nebraska and the United States January 2006-July 2016[32, 33]

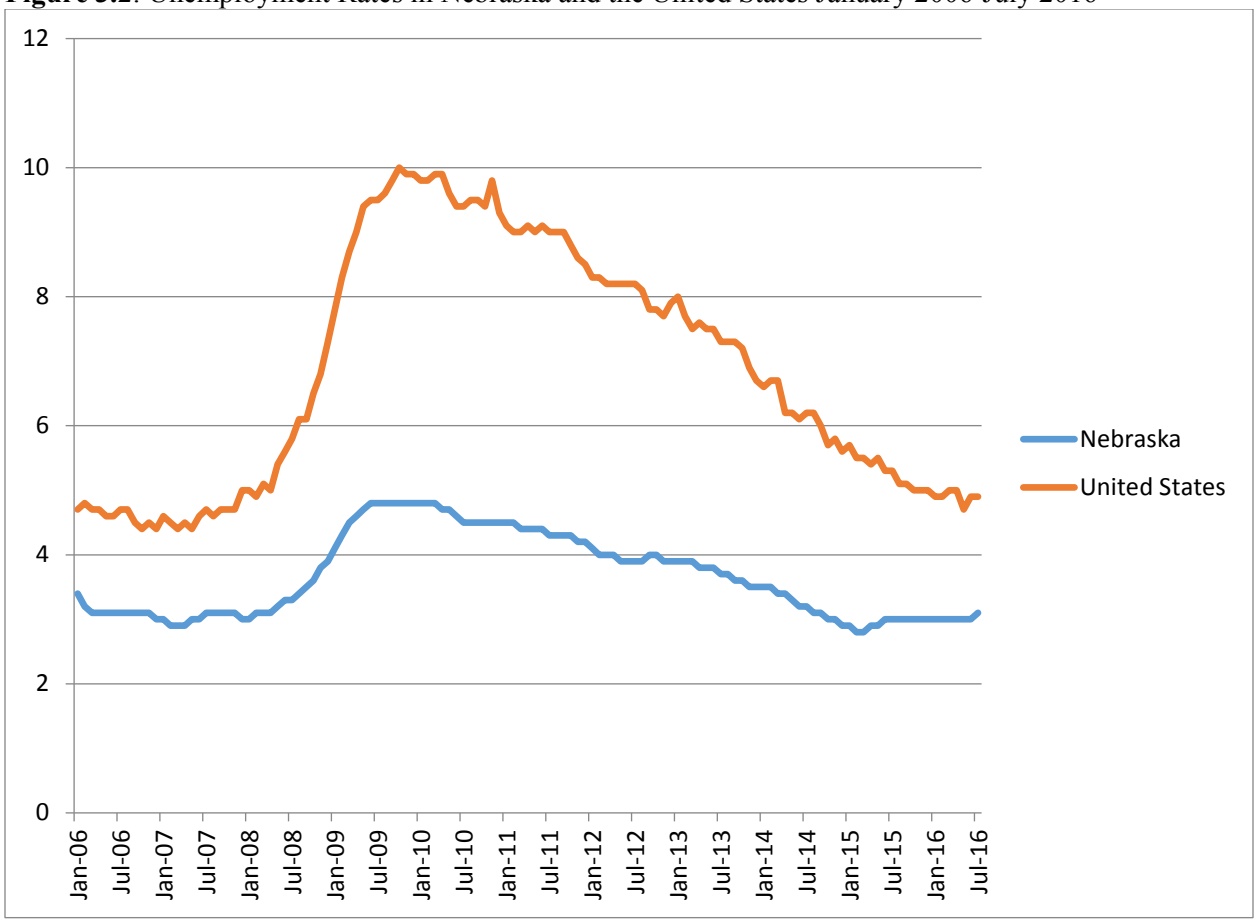
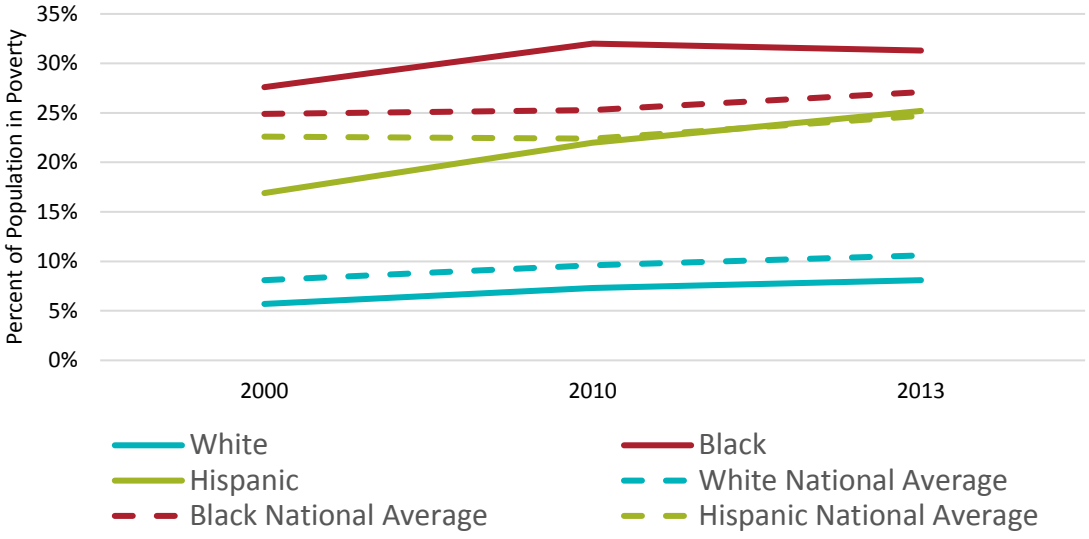


Figure 3.3 compares the poverty rates for the White, Hispanic, and Black population in the Omaha Metropolitan Area with the national average. For African Americans and Hispanics, the poverty rate in the Omaha Metropolitan Area has been higher than the national average and the rates have been steadily increasing since 2010.[34]

Figure 3.3: Poverty Rates in the Omaha Metropolitan Area by Race/Ethnicity (2000-2013) [34]



Population Charateristics by Behavioral Health Regions

In Nebraska, there are six Behavioral Health Regions (see **Figure 3.4**). These regional entities are local governmental units that receive funding from the Division of Behavioral Health to plan for and implement behavioral health care services.[35] In Chapter 6, the major roles of the Behavioral Health Region Authorities and the Division of Behavioral Health are presented.

Figure 3.4: Nebraska Behavioral Health Regions[35]

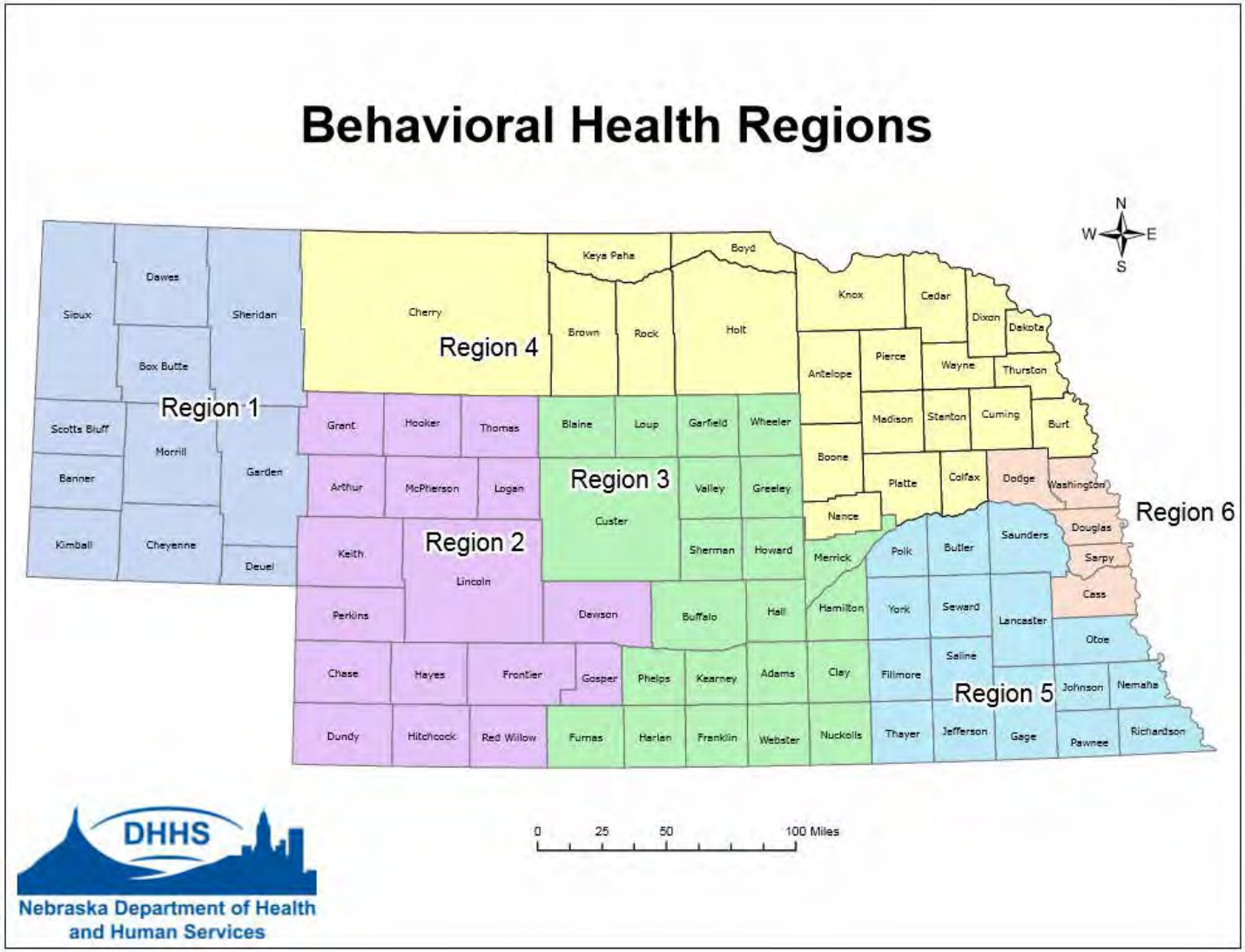


Table 3.3 summarizes the demographic characteristics of the Nebraska population in each Behavioral Health Region. As mentioned previously, the majority of counties in Nebraska are classified as either rural or micropolitan. With the exception of Region 6, all of the other regions primarily comprise rural counties.[28] Although Region 6 has the highest percentage of minority populations, the percentage of Hispanic persons was higher in other regions.[29] In Region 1, one in four children (24%) were living below the poverty level and almost 8% did not have health insurance coverage.[29]

Table 3.3: Nebraska Population Characteristics by Behavioral Health Region (2014)[28, 29]

Characteristic	Nebraska Behavioral Health Region					
	1	2	3	4	5	6
Population	87,314	100,640	228,743	206,834	452,753	779,333
Age (years)						
≤9	13.3%	13.5%	12.9%	13.9%	13.2%	15.0%
10-19	13.4%	13.5%	19.6%	14.3%	13.4%	13.9%
20-34	17.4%	16.7%	17.4%	17.3%	22.5%	22.0%
35-54	23.9%	24.8%	21.9%	24.3%	24.7%	26.5%
55-64	14.0%	13.9%	12.3%	13.1%	12.2%	11.3%
65-84	15.2%	15.2%	13.3%	14.1%	11.8%	9.7%
≥85	2.8%	2.4%	2.6%	3.0%	2.2%	1.6%
Gender						
Male	49.0%	49.8%	49.9%	49.7%	50.1%	49.4%
Female	51.0%	50.2%	50.1%	50.3%	49.9%	50.6%
Race/Ethnicity						
White, NH*	81.6%	84.1%	86.2%	81.9%	86.7%	75.9%
African American, NH*	0.4%	1.4%	1.0%	1.0%	2.6%	8.5%
Asian, NH*	0.8%	0.3%	0.8%	0.6%	2.7%	2.4%
Pacific Islander, NH*	0.2%	0.1%	0.0%	0.0%	0.1%	0.1%
American Indian/Alaska Native, NH*	1.9%	0.3%	0.2%	2.8%	0.4%	0.4%
Other, NH*	0.1%	0.1%	0.0%	0.0%	0.0%	0.1%
2+ Races, NH*	1.6%	1.0%	1.1%	1.1%	1.8%	2.4%
Hispanic**	13.3%	12.6%	10.7%	12.6%	5.7%	10.2%
Geography** (N)						
Metropolitan counties	0	0	4	2	3	4
Micropolitan counties	3	5	3	4	1	1
Rural counties	8	12	15	16	12	0
Living Below Poverty Level						
Total	15.0%	12.4%	12.5%	13.3%	13.5%	12.4%
Children	24.1%	18.8%	16.5%	17.8%	17.1%	17.2%
Without Health Insurance						
Total	13.9%	12.0%	11.4%	12.1%	9.6%	11.0%
Children	7.8%	7.9%	6.1%	8.0%	4.8%	5.2%

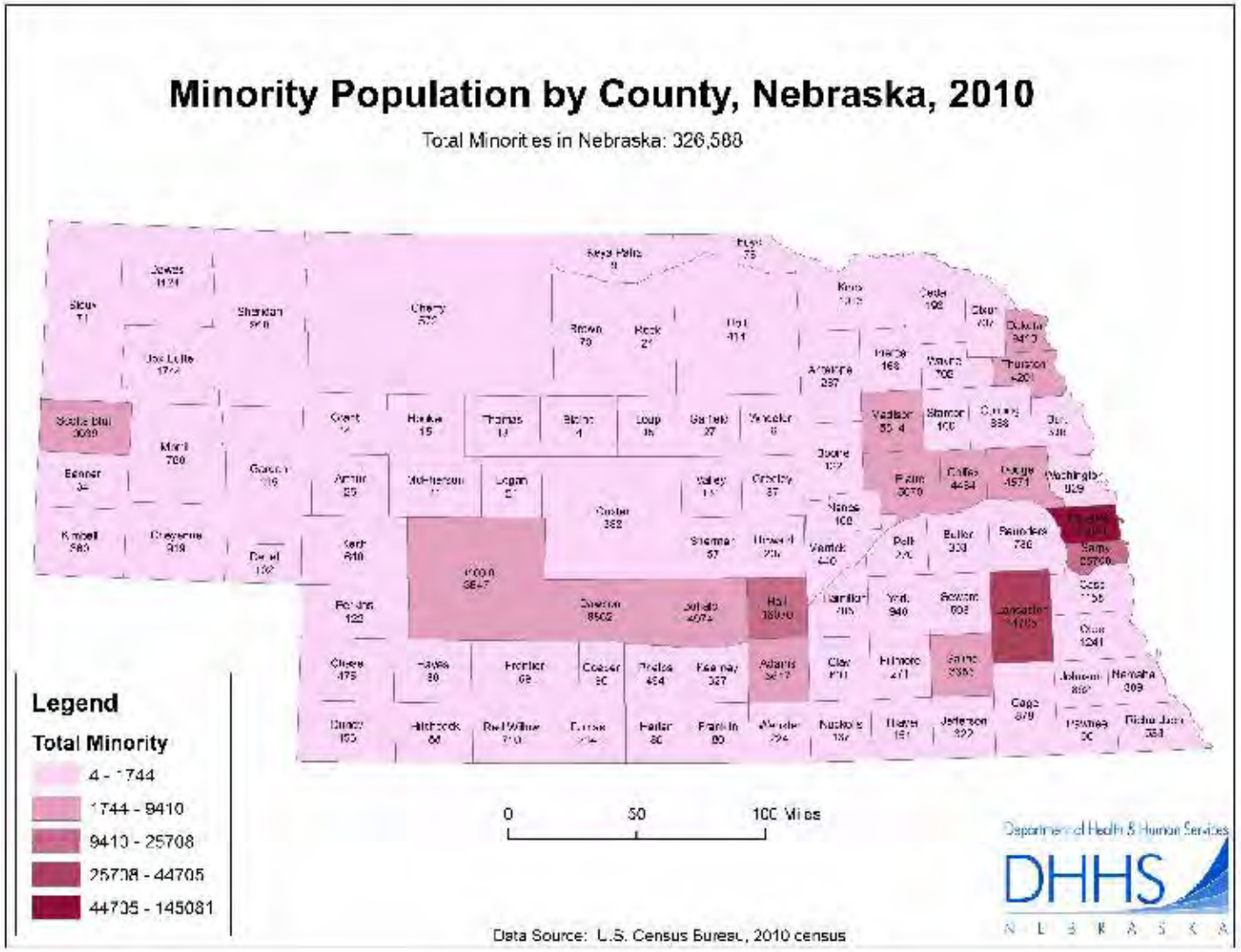
NNH=Non-Hispanic. Persons of Hispanic origin may be of any race. **Metropolitan=County that has a city with ≥50,000 residents or is a metropolitan outlying county. Micropolitan=County that has a city with ≥10,000 residents. Rural=Largest city in county that has <10,000 residents.

Diversity

In comparison with the United States as a whole, Nebraska has a considerably smaller minority population. In 2014, 4.5% of Nebraska's population identified as African American, 1.9% as Asian, 0.7% as American Indian/Alaska Native, and 9.2% as Hispanic/Latino/a origin.[29] In the United States as a whole, it was estimated that 12.2% of the population was African American, 4.9% Asian, and 16.9% Hispanic/Latino origin.[29]

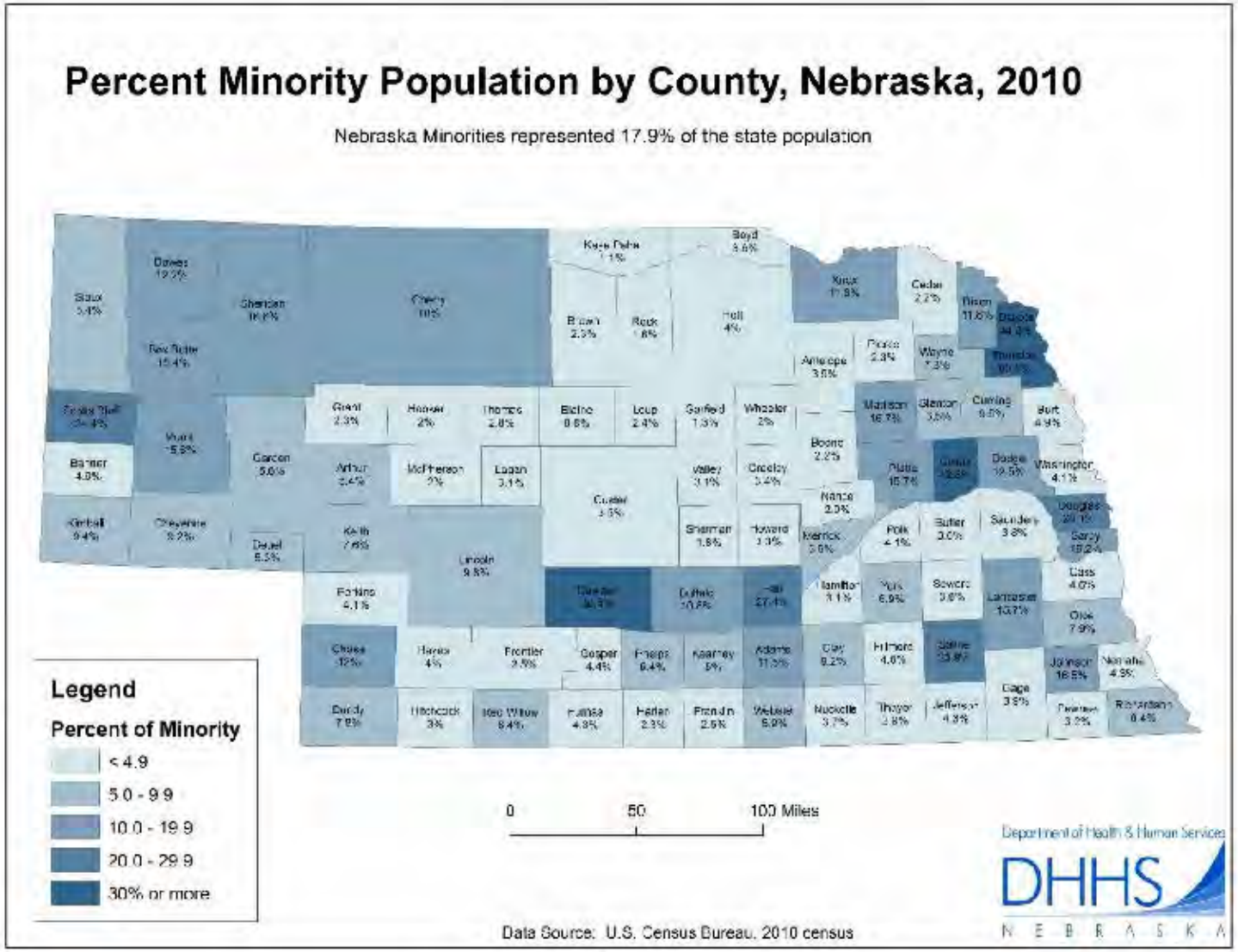
Figure 3.5 shows the number of minority residents by county. According to the 2010 U.S. Census Bureau, there were 326,588 minority residents or about 18% of the population in Nebraska.[27] While the highest number of minority groups were living in urban areas (Douglas, Sarpy, and Lancaster Counties), many micropolitan and rural counties also have a substantial number of minority residents, including Hall (16,070), Scotts Bluff (9,039), Dakota (9,410) and Dawson (8,862) counties.[18] **Figure 3.6** shows the highest concentration of minority residents in northeastern counties such as Thurston (60.5%), Dakota (44.6%), and Colfax (42.6%).[18] A higher percentage of minority residents also lived in Dawson County (36.4%) and in Scotts Bluff County (24.4%).[18] **Figure 3.7** and **Figure 3.8** show the distribution of African American and Hispanic populations.

Figure 3.5: Minority Population by County, Nebraska, 2010[18]



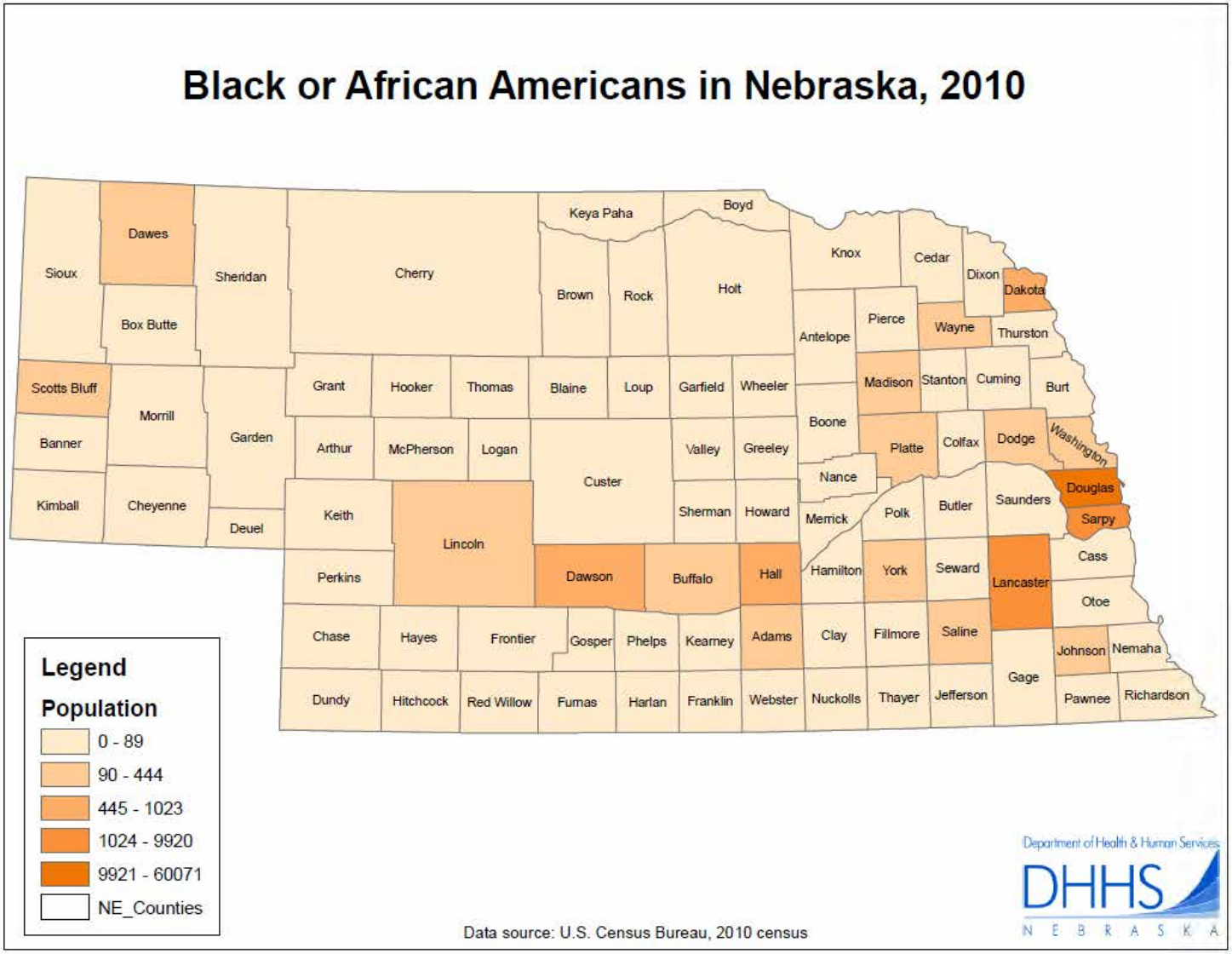
The map was provided by Nebraska Department of Health & Human Services, Office of Health Disparities & Health Equity.

Figure 3.6: Percent Minority Population by County, Nebraska, 2010[18]



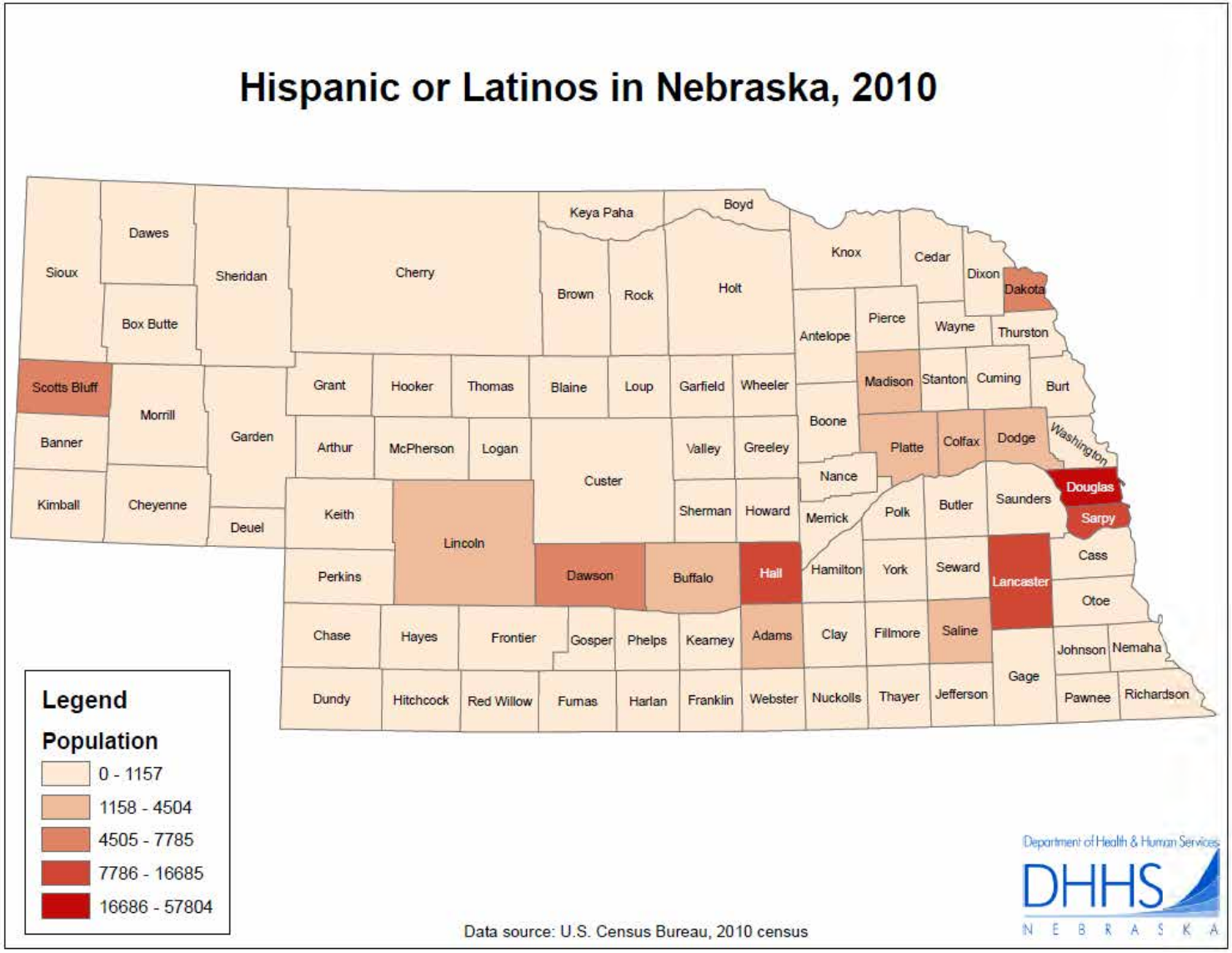
The map was provided by Nebraska Department of Health & Human Services, Office of Health Disparities & Health Equity.

Figure 3.7: Black or African Americans by County, Nebraska, 2010[18]



The map was provided by Nebraska Department of Health & Human Services, Office of Health Disparities & Health Equity.

Figure 3.8: Hispanic or Latino by County, Nebraska, 2010[18]



The map was provided by Nebraska Department of Health & Human Services, Office of Health Disparities & Health Equity.

IV. Behavioral Health Problems in the Nebraska General Population

Summary

This chapter presents information about mental health and substance use disorders affecting the Nebraska population. The information included in this chapter is based on national surveys (e.g., the National Survey on Drug Use and Health, the Behavioral Health Risk Factor Surveillance System, the Youth Risk Behavior Survey), a Nebraska-specific survey (the Nebraska Young Adult Alcohol Opinion Survey), and death certificate data. Information from existing publications and information provided by the Nebraska Department of Health and Human Services have also been used.

Chapter Highlights

Estimates of Mental Health Disorders among Adults in Nebraska

- Mental health illness is a relatively common health problem in Nebraska and in the U.S.: one in five Nebraskans reported any mental illness in the past year.
- The lifetime prevalence of depression is about two times higher among females (22%) compared to males (13%).
- The lifetime prevalence of depression and the prevalence of past-month poor mental health were higher among persons with lower annual incomes and lower educational level.
- American Indians were at high risk of depression and poor mental health.

Estimates of Mental Health Disorders among Adolescents in Nebraska

- One in five high school students (24.1%) reported feeling depressed in the past year and 15% of high school students considered attempting suicide.
- The prevalence of depression and suicide attempts is significantly higher among female students than male students.
- Depression and suicide attempts appears to peak around the 11th grade.
- Depression and suicide attempts are higher among Hispanic students than Non-Hispanic White students.

Estimates of Alcohol Use in Nebraska

- In 2015, Nebraska ranked 47th in the nation, with a 20.3% adult binge drinking prevalence, a striking difference compared to West Virginia (ranked 1st) with a prevalence less than 10%.
- About 40% of young adults (18-25 years) in Nebraska have a binge drinking experience in the past one month, but only 27% of young adults in Nebraska perceive heavy drinking as dangerous.
- The prevalence of alcohol use in the past month among persons 12-20 years of age is the highest in Behavioral Health Region 5.
- Over half (52%) of high school students in Nebraska reported they have ever had an alcoholic drink.

- The prevalence of alcohol use is higher among all female and Hispanic high school students compared to all male or Non-Hispanic White students.

Estimates of Substance Disorders in Nebraska

- The drug-related death rate for Nebraska has been lower than the national average, but there has been a steady increase between 2005 and 2013.
- The rate of drug-related deaths peaks among adults 45-54 years of age.
- About 17% of young adults (18-25 years) reported having used any illicit drugs in the past month and young adults have a higher prevalence of illicit drug use (marijuana, cocaine, non-medical use of pain relievers) than other age groups.
- By the 12th grade, about 20% of students have used marijuana or have taken a prescription drug at least once.
- About 25% of Hispanic high school students compared to 10% of White students used marijuana in the past month.

Estimates of Behavioral Health Treatment Use in Nebraska

- Of those adults in Nebraska with any mental illness, only 47% received treatment.
- Of those adolescents in Nebraska with depression, only 43% received treatment.
- Of those persons 12 years and older in Nebraska with illicit drug dependence or abuse, only 11% received treatment.

Behavioral Health Disparities in Nebraska

- One in three American Indians in Nebraska have anxiety or depression; the percentage of persons reporting serious psychological distress was highest among Hispanics.
- Alcohol-related death rates in Nebraska have been particularly high among American Indians.
- Suicide has disproportionately affected American Indian communities in Nebraska for some time, especially among males.[21]

Adverse Childhood Experiences

- About half of Nebraska adults reported at least one adverse childhood experience.
- The most common adverse childhood experiences in Nebraska included parents divorced or separated (24.9%); lived with a problem drinker (24.6%); lived with somebody who was depressed, mentally ill, or suicidal (18.0%).

Chapter Recommendations

Increase Awareness of Behavioral Health Issues

- Use evidence-based public education and awareness strategies, campaigns, and engagement activities to reduce prejudice and discrimination association with behavioral health problems in settings including schools, workplaces, and faith communities.

- Promote Mental Health First Aid and other evidence-based education programs among persons who have regular contact with high risk populations (teachers, counselors) [see Chapter 10 regarding Mental Health First Aid].

Increase Access To and Use Of Behavioral Health Treatment

- Expand telemental health capacity to increase access to and use of behavioral health service.
- Promote integrated primary and behavioral health care to increase access to and use of behavioral health services in community settings [see Chapter 10 regarding integrated care].

Expand Prevention and Intervention Efforts for High-Risk Population Groups

- Target high school students for prevention, screening, and timely interventions to decrease depression, suicide, and substance-use disorders.
- Expand services for youths (16-24 years) who transition out of state ward or foster care.
- Expand services to prevent, screen, and treat adolescent and adult females at high risk of depression and suicide.
- Establish a plan to advance Culturally and Linguistically Appropriate Services (CLAS) among behavioral health providers.
- Engage and consult with community members and leaders to develop a strategic plan to address behavioral health disparities.

Expand Binge Drinking Prevention, Screening, and Treatment

- Use evidence-based public education and awareness strategies, campaigns, and engagement activities to increase awareness of binge drinking in schools, workplaces, and faith communities.
- Work with health care systems and higher education systems to expand the use of the Screening Brief Intervention Referral and Treatment (SBIRT) in primary care clinics, emergency rooms, and school health clinics.

Expand Services to Prevent and Minimize the Impact of Adverse Childhood Experiences (ACE)

- Use the System of Care approach to increase coordination across different agencies, providers, and systems to prevent and minimize the effect of adverse childhood experiences.
- Expand trauma-informed services to assess ACE and treat persons with ACE.

Estimates of Mental Health Disorders among Adults and Adolescents in Nebraska

Mental Health Indicators: Adults

The National Survey on Drug Use and Health (NSDUH) is an annual nationwide survey of interviews with persons aged 12 and older.[36] This survey was designed to estimate the burden of mental health substance use disorders and treatment use for the U.S. population and for each state.

In this survey, any mental illness (AMI) is defined as any diagnosable mental, behavioral, or emotional disorder other than a substance use disorder. Among adults with AMI, those whose disorder caused significant impairment or interfered with one or more major life activities were defined as having a serious mental illness (SMI).[37, 38]

Table 4.1 shows that mental illness is a relatively common health problem in Nebraska and in the United States. The prevalence of mental illness in Nebraska was comparable to that of the national average: one in five (17.5%) Nebraskans reported AMI in the year preceding the survey, comparable to the national average of 18.1%.[37, 38] Although less common, it is a concern that between 4-7% of Nebraskans had an SMI, serious thoughts of suicide and a major depressive episode in the past year.[37, 38] There were no statistical differences among Behavioral Health Regions or between age groups for all of these indicators.

Table 4.1: Prevalence of Behavioral Health Issues among Persons Aged 18 or Older in Nebraska: Annual Averages Based on 2010, 2011, and 2012 National Survey on Drug and Health Data[6, 37, 38]

	Past Year Any Mental Illness	Past Year Serious Mental Illness	Serious Thoughts of Suicide in the Past Year	At Least One Major Depressive Episode in the Past Year
United States	18.13	3.99	3.78	6.74
Nebraska	17.48	4.44	3.82	6.65
Behavioral Health Region				
Region 1	18.78	4.66	3.85	6.51
Region 2	17.71	5.07	3.83	6.73
Region 3	17.79	4.47	3.87	6.27
Region 4	18.15	4.66	3.74	6.30
Region 5	19.22	4.65	3.99	8.07
Region 6	15.98	4.14	3.71	6.00
Age (years)				
12-17	-	-	-	7.97
18-25	18.70	4.41	6.83	8.57
26+	17.27	4.45	3.29	6.31

The Behavioral Risk Factor Surveillance System (BRFSS) is an annual telephone health survey of adults (18 years and older).[16] The survey is designed to provide the U.S. and state-specific estimates of health-related risk factors, chronic health conditions, and use of preventive services.

The Behavioral Risk Factor Surveillance System (BRFSS) is an annual telephone health survey of adults (18 years and older).[16] The survey is designed to provide the U.S. overall and the state-specific estimates of health-related risk factors, chronic health conditions, and use of preventive services.

Table 4.2 summarizes the 2011-2014 BRFSS data regarding mental health indicators for Nebraska. Lifetime depression was experienced by 17.4% of adults in Nebraska. About one in ten adults reported their mental health was not good for 14 days or more in the past 30 days. In every area, prevalence was significantly higher among females than males. For depression, youngest age group (18-24 years) and two older age groups (65-74; 75+) had significantly lower prevalence of depression compared to those between 25-64 years of age. On the indicator "Mental health was not good ≥14 days in the past 30 days," the prevalence was significantly lower among persons in two oldest groups (65-74; 75+). On the indicator, "Average days mental health was not good in past 30 days," the youngest age group reported 3.7 days, significantly higher than the number reported by the three oldest groups (55-64; 65-74; 75+). On the indicator, "Average days poor physical and/or mental health limited usual activity,"— the three youngest groups (18-24; 25-34; 35-44) had significantly lower numbers of days affected by poor physical and/or mental health compared to older groups. On the indicator, "Poor physical and/or mental health limited usual activities ≥14 days in the past 30 days," those in the two youngest groups (18-24; 25-34) had significantly lower prevalence compared to older groups.

The overall pattern regarding income indicates that persons in higher income groups have better behavioral health status compared to those in lower income groups: 33% of persons in the lowest income group reported that they have had depression, only 12% in the highest income group reported depression. About 23% of persons in the lowest income group reported that their mental health was not good 14 days or more in the past 30 days compared to 4.5% among persons in the highest income group. About 20% of persons in the lowest income group reported that poor physical and/or mental health limited usual activities 14 or more days in the past 30 days compared to 3% of persons in the highest income group did.

A similar pattern was observed with education level. About 21% who had less than high school reported that they had depression, compared to 14% of those with a college degree. About 14% with less than high school education reported their mental health was not good 14 or more days in the past 30 days, compared to 5.3% among college graduates. As to race/ethnicity, in general, Non-Hispanic (NH) Asians had the best behavioral health status, and NH American Indians/Alaska Natives and NHs who indicated multiple race categories had the worst behavioral health status. About 27% of NH American Indians/Alaska Natives and 31% of NHs with multiple race categories reported they had depression, compared to 8.1% of NH Asians.

Table 4.2: Behavioral Health Problem Indicators in Nebraska: Annual Averages Based on 2011-2014 Behavioral Health Risk Factor Surveillance System Data*[39]

	Ever Told They Have Depression (%)	Average Days MH Was Not Good in Past 30 Days	Mental Health Was Not Good ≥14 Days in Past 30 Days (%)	Average Days Poor Physical and/or Mental Health Limited Usual Activity	Poor Physical and/or Mental Health Limited Usual Activities ≥14 Days in Past 30 Days (%)
U.S	17.31 (17.20-17.41)	3.78 (3.75-3.80)	11.71 (11.61-11.81)	2.56 (2.54-2.58)	8.19 (8.11-8.27)
Nebraska	17.38 (16.98-17.80)	3.0	8.81 (8.50-9.13)	1.9	5.97 (5.73-6.22)
Gender					
Male	12.45 (11.91-13.01)	2.43 (2.32-2.54)	7.06 (6.64-7.51)	1.71 (1.61-1.79)	5.30 (4.96-5.66)
Female	22.14 (21.55-22.75)	3.48 (3.37-3.59)	10.49 (10.04-10.96)	2.05 (1.96-2.13)	6.62 (6.28-6.97)
Age					
18-24	15.68 (14.32-17.14)	3.71 (3.43-3.98)	10.07 (8.95-11.32)	1.29 (1.11-1.46)	3.41 (2.70-4.29)
25-34	18.62 (17.47-19.82)	3.34 (3.13-3.54)	9.88 (9.05-10.78)	1.3 (1.28 (1.15-1.42)	3.55 (3.04-4.13)
35-44	18.45 (17.38-19.57)	3.18 (2.96-3.39)	9.38 (8.58-10.24)	1.61 (1.45-1.76)	5.05 (4.45-5.72)
45-54	19.24 (18.30-20.21)	3.23 (3.04-3.43)	10.2 (9.43-10.95)	2.22 (2.05-2.36)	7.20 (6.59-7.87)
55-64	19.51 (18.66-20.38)	2.78 (2.63-2.93)	8.56 (7.97-9.19)	2.43 (2.28-2.58)	8.18 (7.59-8.82)
65-74	15.06 (14.25-15.91)	1.90 (1.75-2.04)	5.53 (5.00-6.12)	2.13 (1.98-2.27)	6.97 (6.43-7.56)
75+	11.21 (10.45-12.01)	1.7 (1.58-1.85)	5.15 (4.66-5.69)	2.5 (2.28-2.64)	8.54 (7.86-9.27)
Income					
< $15,000	33.04 (31.16-34.96)	6.73 (6.27-7.19)	23.31 (21.58-25.14)	5.56 (5.15-5.97)	19.70 (18.13-21.36)
$15,000-$24,999	24.93 (23.62-26.28)	4.53 (4.26-4.80)	14.32 (13.28-15.43)	2.84 (2.65-3.04)	9.31 (8.54-10.14)
$25,000-$34,999	19.49 (18.07-20.99)	3.27 (2.98-3.57)	9.97 (8.90-11.16)	2.05 (1.85-2.26)	6.79 (5.94-7.76)
$35,000-$49,999	16.20 (15.15-17.30)	2.69 (2.51-2.87)	7.66 (6.94-8.46)	1.47 (1.35-1.60)	4.32 (3.83-4.87)
$50,000-$74,999	14.75 (13.74-15.82)	2.36 (2.18-2.55)	6.56 (5.81-7.42)	1.29 (1.14-1.44)	3.76 (3.19-4.44)
$75,000+	11.79 (10.96-12.68)	1.81 (1.65-1.96)	4.53 (3.90-5.26)	0.90 (0.80-0.10)	2.48 (2.02-3.05)
Education					
Less Than High School	20.75 (19.05-22.55)	4.31 (3.92-4.69)	14.16 (12.74-15.70)	3.08 (2.77-3.39)	10.58 (9.40-11.88)
High School/GED	17.67 (16.87-18.50)	3.23 (3.07-3.38)	9.87 (9.25-10.52)	2.00 (1.87-2.12)	6.42 (5.95-6.93)
Some College	19.20 (18.44-19.98)	3.22 (3.07-3.36)	9.64 (9.06-10.25)	1.89 (1.78-1.20)	5.99 (5.56-6.44)
College Graduate	13.85 (13.21-14.52)	2.08 (1.98-2.19)	5.33 (4.87-5.83)	1.22 (1.13-1.30)	3.51 (3.15-3.90)
Race/Ethnicity					
White, NH	17.97 (17.50-18.44)	2.98 (2.89-3.07)	8.74 (8.39-9.11)	1.74 (1.68-1.80)	5.45 (5.19-5.71)
African American, NH	15.16 (13.05-17.54)	3.79 (3.25-4.34)	12.05 (10.10-14.32)	2.98 (2.46-3.50)	10.60 (8.68-12.89)
Asian, NH	8.12 (5.61-11.60)	1.72 (1.26-2.19)	5.36 (3.59-7.94)	1.04 (0.70-1.38)	2.20 (1.20-3.99)
American Indian / Alaska Native, NH	27.14 (22.41-32.46)	5.12 (4.19-6.06)	16.91 (13.17-21.44)	3.45 (2.66-4.24)	12.48 (9.28-16.59)
Other, NH	17.50 (11.07-26.55)	4.75 (2.29-7.21)	15.12 (8.34-25.87)	2.81 (1.08-4.54)	9.38 (4.89-17.25)

Multi-Racial, NH	30.91 (25.94-36.37)	5.55 (4.49-6.60)	17.59 (13.83-22.11)	3.50 (2.61-4.40)	11.54 (8.60-15.32)
Hispanic	14.30 (12.74-16.01)	2.58 (2.26-2.89)	7.68 (6.56-8.98)	1.85 (1.57-2.13)	5.62 (4.67-6.76)
NH=Non-Hispanic. *Numbers in parentheses are 95% Confidence Intervals.					

Mental Health Status Indicators: Adolescents

The Youth Risk Behavior Survey (YRBS) is a biennial survey of health risk and protective behaviors for adolescents, and is a school-based survey of 9-12th graders.[17]

Table 4.3 shows mental health status indicators among high school students. One in five high school students (24.1%) reported feeling depressed in the last year. The proportion of high school students reporting depression in the past year was higher for the U.S. overall (29.9%) compared to Nebraska (24.1%). Similarly, the proportion who reported considering attempting suicide in the past year was higher for the U.S. overall (17.7%) compared to Nebraska (14.6%).[7, 40]

Female students had a significantly higher prevalence of depression (31.4%) compared to male students (17.1%). Female students also had a significantly higher prevalence of considering for a suicide attempt (18.0% vs. 11.3%) and for making a suicide plan (17.0% vs. 9.8%) compared to male students.[7]

Students in the 11th grade had a significantly higher prevalence of depression (29.7%) compared to 9th graders (18.8%) and 12th graders (18.6%), the 11th graders also had a significantly higher prevalence of considering for a suicide attempt (18.2%) than 9th graders (10.3%). Finally, 11th graders had a significantly higher prevalence of suicide attempts that resulted in injury, poisoning, or overdose (6.9%) compared to 9th graders (1.6%).[7]

The prevalence of depression, considering a suicide attempt, making a suicide plan, and attempting suicide at least once in the past year was also significantly higher among Hispanic students compared to Non-Hispanic White students.[7]

Table 4.3: Prevalence of Behavioral Health Issues Among High School Students in Nebraska in 2014 and 2015 in U.S.: Based on Youth Risk Behavior Survey Data[7, 40]

	Feeling Depressed in the Past Year	Seriously Considered Attempting Suicide in Past Year	Made a Suicide Attempt Plan in Past Year	Attempted Suicide One or More Times in Past Year	Attempted Suicide Which Resulted in an Injury, Poisoning, or Overdose in Past Year
United States	29.9*	17.7*	14.6	8.6	2.8
Nebraska	24.1	14.6	13.3	8.9	3.3
Gender					
Male	17.1	11.3	9.8	7.7	3.5
Female	31.4*	18.0*	17.0*	9.4	3.0
Grade					
9th Grade	18.8	10.3	10.3	6.0	1.6
10th Grade	29.2	17.4	14.4	8.2	2.1
11th Grade	29.7*	18.2*	16.9	11.8	6.9*
12th Grade	18.6	11.9	11.2	8.4	2.5
Race/Ethnicity					
White, NH	20.9	12.4	11.6	7.4	2.6
African American, NH	-	-	-	-	-
Other, NH	-	-	-	-	-
Multi-Racial, NH	-	-	-	-	-

Hispanic/Latino	32.7*	20.4*	19.3*	15.9*	5.4
"-" = Fewer than 100 students in this subgroup. NH=Non-Hispanic * Statistically significant at .05					

Estimates of Alcohol Use among Adults and Adolescents in Nebraska

Binge Drinking

Binge drinking is one of the most common patterns of excessive alcohol use in the U.S. The National Institute on Alcohol Abuse and Alcoholism defines binge drinking as "a pattern of drinking alcohol that brings blood alcohol concentration to 0.08 gram percent or above."[41] This pattern corresponds to consuming 5 or more drinks for males and 4 or more drinks for females in about 2 hours.[41]

In 2015, Nebraska ranked 47th in the nation for adult binge drinking, with a prevalence of 20.3%. By contrast, West Virginia was ranked 1st with a prevalence less than 10%.[42] The situation is worse for young adults and teenagers. About 40% of Nebraskans aged 18-25 years had a binge drinking experience in the past month.[43] **Table 4.4** shows the results of an analysis of death certificates data. Although the death rates from chronic liver disease, homicide, and suicide related to drinking were lower in Nebraska than in the U.S. average, the rates increased between 2004 and 2013 in Nebraska.

Table 4.4: Age-Adjusted Alcohol-Related Death Rates per 100,000 in Nebraska and U.S.: 2004-2013 Vital Statistics Data[44]

Indicator	NE Rate (2013)	US Rate (2013)	NE Trend (2004-2013)
Chronic Liver Disease	8.9	10.2	Increasing
Death due to Homicide	4.2	5.2	Increasing
Death due to Suicide	11.6	12.6	Increasing

Table 4.5 shows the prevalence of various types of alcohol use in Nebraska and in the United States. There were no statistical significant differences between U.S. and Nebraska for all of these indicators except for perception of great risk by having 5 or more alcoholic beverages. The percentage reporting this perception was lower among Nebraskans (37.23%) than U.S. overall (42.54%).[38] For alcohol use in the past month among persons aged 12 or older, Region 5 had a significantly higher prevalence (59.38%) than Region 1 (47.40%) or Region 3 (48.40%). For alcohol use in the past month among people aged 12-20, Region 5 had a significantly higher prevalence (32.26%) compared to Region 1 (22.91%), Region 4 (22.63%), and Region 6 (22.43%).[37]

There were some significant differences among age groups. For alcohol use in the past month, persons between 18-25 years of age had a significantly higher prevalence (63.80%) compared to those between 12-17 years (12.25%) and those 26 years and older (56.81%). For binge drinking in the past month, persons between 18-25 years of age had a significantly higher prevalence (43.08%) compared to those between 12-17 years (7.7%) and those 26 years and older (23.37%). For perception of great risk of having 5 or more alcoholic drinks, persons between 18-25 years had a significantly lower prevalence (27.16%) than those who are 12-17 years (39.47%) and those who are 26 years and older (38.73%).[37]

Table 4.5: Estimated Prevalence of Alcohol Use in Nebraska: Annual Averages Based on 2010, 2011, 2012 National Survey on Drug Use and Health Data[6, 37, 38]

	Alcohol Use in the Past Month Among Persons Aged 12 or Older	Alcohol Use in the Past Month Among Persons Aged 12-20	Binge Alcohol Use in the Past Month Among Persons Aged 12 or Older	Binge Alcohol Use in the Past Month Among Persons Aged 12-20	Perceptions of Great Risk of Having 5 or More Alcoholic Beverages Once a Week
United States	51.78	25.04	22.81	15.87	42.54
Nebraska	53.43	25.18	24.53	17.11	37.23*
Behavioral Health Region					
Region 1	47.40	22.91	23.58	17.49	39.82
Region 2	50.70	23.78	23.89	16.63	38.36
Region 3	48.40	24.29	21.94	16.13	37.44
Region 4	48.90	22.63	23.88	17.84	37.39
Region 5	59.38*	32.26*	25.76	21.35*	37.17*
Region 6	53.68	22.43	24.93	14.76	36.71
Age					
12-17	12.25		7.7		39.47
18-25	63.80*		43.08*		27.16*
26+	56.81		23.37		38.73
*Statistically significant at .05					

Figure 4.1 shows the alcohol use by the Behavioral Health Region. The prevalence was the highest in Region 5.[37]

Figure 4.1: Alcohol Use in the Past Month among Persons Aged 12 to 20 in Nebraska, by Behavioral Health Regions: Annual Average of 2010, 2011, 2012 National Survey on Drug Use and Health Data[37]

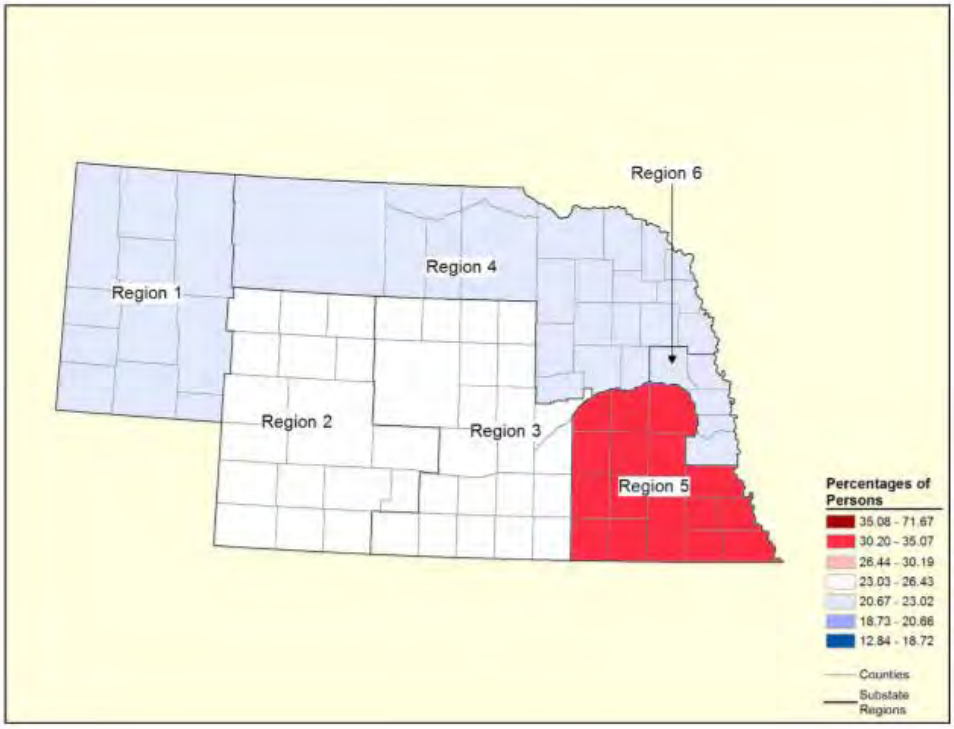


Table 4.6 shows binge drinking and alcohol-impaired driving among young adults in Nebraska. Two thirds of young adults who consume alcohol have had a binge drinking episode in the past month, which translates to about 84,000 persons who have engaged in binge drinking.[43, 44] The percentage of young adults who reported alcohol-impaired driving is higher in Nebraska compared to the national average.[43, 44]

Table 4.6: Binge Drinking and Alcohol-Impaired Driving in Nebraska: 2013 Nebraska Young Adult Alcohol Opinion Survey (NYAAOS) and Behavioral Risk Factor Surveillance System (BRFSS) Data[43, 44]

Indicator	Data Source	Year	NE	Estimated Persons	Trend
Binge Drinking among Adults 19-25	NYAAOS	2013	44.9%	84,000	Stable (2010-2013)
Binge Drinking among Adults who are Past Month Alcohol Users 19-25	NYAAOS	2013	66.3%	84,000	Stable (2010-2013)
Binge Drinking More Than Once in the Past Month among Adults 19-25	NYAAOS	2013	33.0%	62,000	Stable (2010-2013)
Alcohol-Impaired Driving Among Adults	BRFSS	2014	2.5%	35,000	Decreasing (2012-2014)

Alcohol Use among High School Students

Alcohol use and binge drinking are serious public health issues affecting youths in Nebraska and across the United States (**Figure 4.2**). According to the National Survey on Drug Use and Health Data, the percentage of underage binge drinking was higher in Midwestern states compared to the west and southwestern U.S.

Figure 4.2: Underage Binge Alcohol Use in the Past Month among Persons Aged 12-20, by Sub-State Region: Based on Average of 2010, 2011, 2012 National Survey on Drug Use and Health Data*[45]

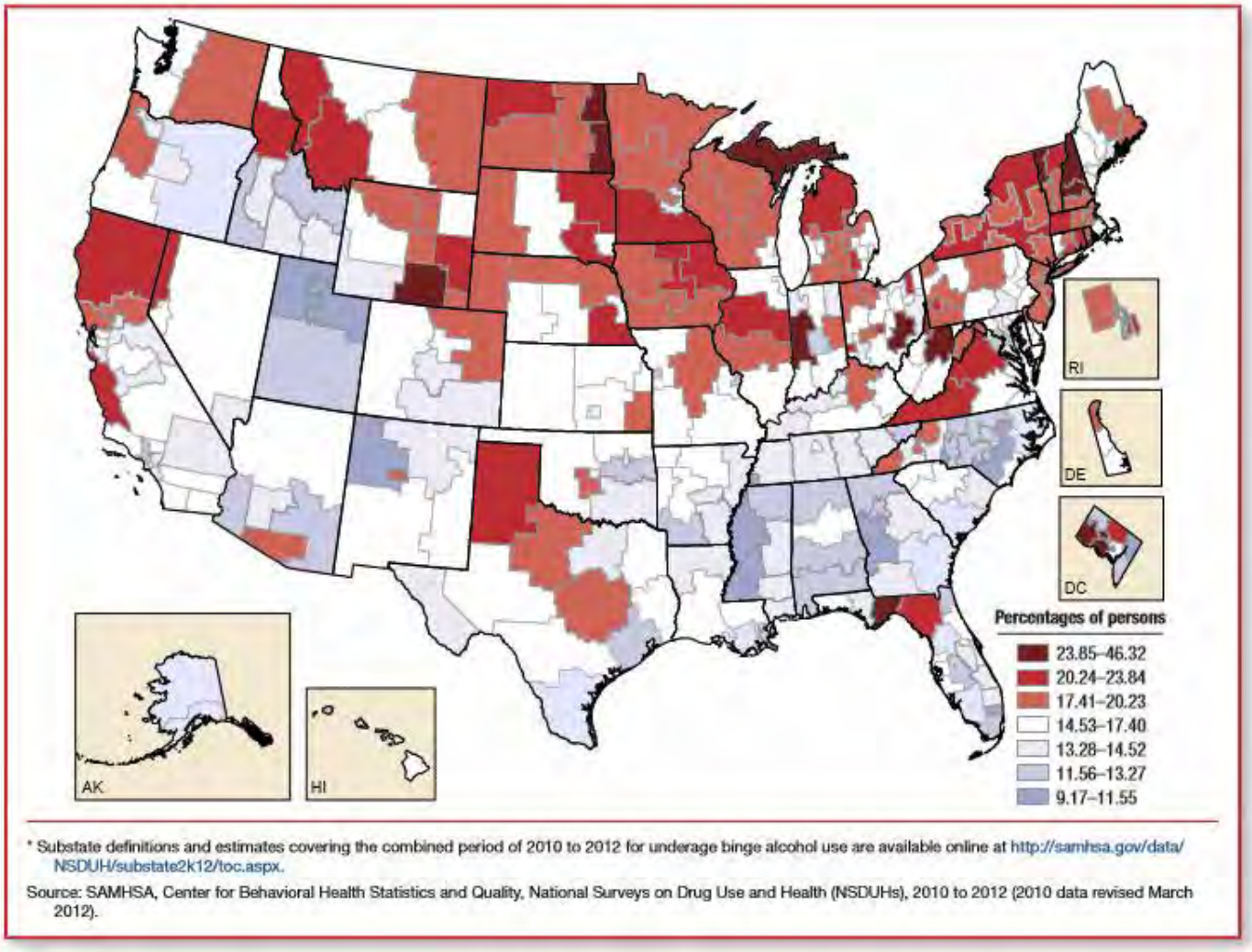


Table 4.7 shows the results of the Youth Risk Behavioral Survey. Compared to the U.S. overall (63.2%), a significantly lower percentage of high school students in Nebraska (51.7%) reported that they ever had an alcoholic drink. Also, a significantly lower percentage of high school students in Nebraska (22.7%) reported that they had at least one alcoholic drink in the past month, compared to the U.S. overall (32.8%).[7, 40]

Students in the 9th grade had a significantly lower prevalence of ever drinking alcohol and or of at least one alcohol drink in the past month compared to those in other grades. Students in the 10th grade had a significantly lower prevalence of having alcohol drink in the past month (20.7%) compared to those in the 12th grade (36.3%). Similar patterns were found for binge drinking. Students in the 9th grade had a significantly lower prevalence than students in other grades; 10th graders had a significantly lower prevalence than 12th graders. Female students had a significantly higher prevalence of ever drinking alcohol (56.5%) compared to male students (46.6%). The prevalence of ever drinking alcohol, having at least one drink in the past month, and binge drinking was significantly higher among Hispanic students than non-Hispanic white students.[7]

Table 4.7: Prevalence of Alcohol Use among High School Students in Nebraska (2014) and the U.S. (2015): Youth Risk Behavior Survey Data[7, 40]

	Ever Had at Least One Drink of Alcohol	Had at Least One Drink of Alcohol in the Past Month	Binge Alcohol Use in the Past Month
United States	63.2*	32.8*	17.1
Nebraska	51.7	22.7	14.3
Gender			
Male	46.6	20.5	14.4
Female	56.5*	24.9	14.4
Grade			
9th Grade	33.8*	7.6*	3.1*
10th Grade	51.3	20.7*	10.1*
11th Grade	58.6	25.8	16.1
12th Grade	63.7	36.3	27.4
Race/Ethnicity			
White, NH	51.5	21.2	12.1
African American, NH	-	-	-
Other, NH	-	-	-
Multi-Racial, NH	-	-	-
Hispanic/Latino	60.0*	30.3*	22.0*

Non-Hispanic. "-" = Fewer than 100 students in this subgroup.
*Statistically significant at .05

Estimates of Substance Use Disorders in Nebraska

Drug Related Deaths

Figure 4.3 shows the time trend in drug-related deaths. For this analysis, Nebraska Department of Health and Human Services Division of Public Health used the following ICD-9 codes to identify deaths caused by substance-related disorders (F11-F16, F18-F19), accidental or intentional poisoning (X40-X44, X60-X64), assaults by drugs, medicaments and biological substances (X85), and drug poisoning of undetermined intent (Y10-Y14). The drug-related death rate for Nebraska has been lower than the national average, but there has been a steady increase between 2005 and 2013.[44, 46] The rate of drug-related deaths peaks among adults 45-54 years of age (**Figure 4.4**).[44, 46]

Figure 4.3: Rate of Drug-Related Deaths, Nebraska vs. U.S.: 2005-2014 Vital Statistics Data[44, 46]

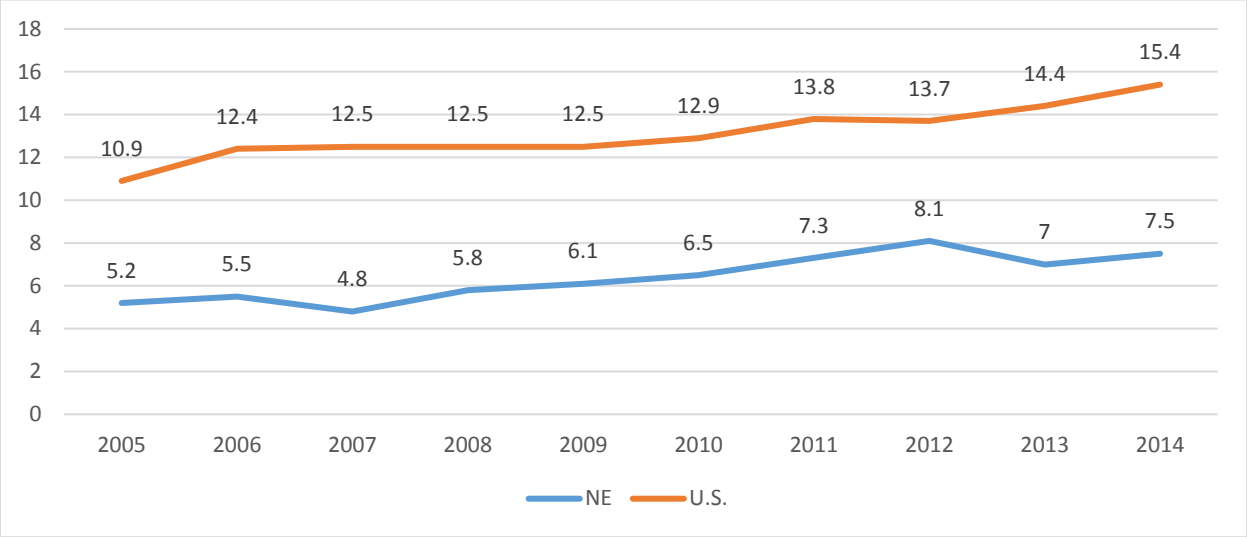
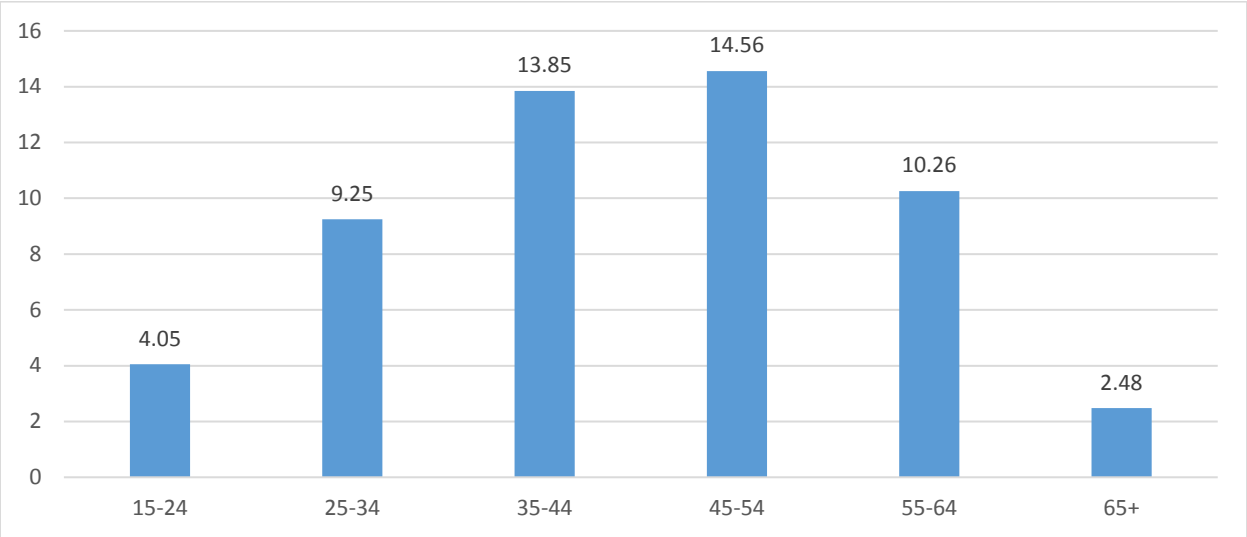


Figure 4.4: Rate of Drug-Related Deaths per 100,000 in Nebraska by Age Group: 2010-2014 Vital Statistics Data[44, 46]



Illicit Drug Use in Nebraska: 12 Years & Older

Table 4.8 shows the prevalence of various illicit drug use among persons aged 12 or older. There were no statistically significant differences between the U.S. and Nebraska for these 5 indicators. Persons in Region 6 had statistically significant higher prevalence of the past month illicit drug use (7.90%) compared to persons in Region 4 (3.92%). Similarly, the prevalence of past month marijuana use was statistically higher in Region 6 (6.71%) compared to Region 4 (3.03%).[37] For all indicators, persons aged 18-25 have a significantly higher prevalence than other age groups. [6]

Table 4.8: Estimated Prevalence of Illicit Drug Use among Persons Aged 12 or Older in Nebraska: Percentages, Annual Averages Based on 2010, 2011, and 2012 National Survey on Drug Use and Health Data[6, 37, 38]

	Illicit Drug Use in the Past Month	Marijuana Use in the Past Month	Illicit Drug Use Other Than Marijuana in the Past Month	Cocaine Use in the Past Year	Non-medical Use of Pain Relievers in the Past Year
United States	8.90	7.01	3.35	1.68	4.63
Nebraska	6.39	5.32	2.49	1.39	3.86
Behavioral Health Region					
Region 1	5.72	4.49	2.33	1.30	4.03
Region 2	4.76	3.96	2.17	1.19	3.51
Region 3	5.44	4.44	2.47	1.14	3.66
Region 4	3.92	3.03	2.15	1.09	3.33
Region 5	5.93	4.91	2.65	1.46	4.33
Region 6	7.90*	6.71*	2.56	1.56	3.82
Age (years)					
12-17	8.4	6.83	3.28	0.90	4.68
18-25	16.55*	14.81*	6.04*	4.25*	8.64*
26+	4.33	3.44	1.77	0.95	2.89
Statistically significant at .05.					

Illicit Drug Use in Nebraska: High School Students

Table 4.9 shows illicit drug use among Nebraska high school students.[7, 40] The prevalence of ever using marijuana and marijuana use in the past month was significantly higher for the U.S. overall compared to Nebraska.[7, 40] For lifetime use of cocaine, 11th graders (7.6%) and 12th graders (6.6%) had a significantly higher prevalence than 9th graders (1.6%). For lifetime inhalant use, 10th graders (10.4%) had a significantly higher prevalence than 9th graders (4.1%). Similarly, heroin, methamphetamines, and marijuana use were significantly higher among 11th and 12th graders than 9th graders. The prevalence of ever using marijuana, cocaine, synthetic marijuana, steroid (pills or shots), and prescription drugs as well as past month use of marijuana was significantly higher among Hispanic students compared to non-Hispanic White students.[7]

Table 4.9: Prevalence of Illicit Drug Use among High School Students in Nebraska (2014) and U.S. (2015): Youth Risk Factor Survey Data[7, 40]

	Smoked Marijuana Least One Time	Used Marijuana One or More Times in the Past Month	Ever Used Cocaine	Ever Used Inhalants[1]	Ever Used Heroin	Ever Used Metham-phetamines	Ever Used Ecstasy	Ever Used Synthetic Marijuana	Ever Taken Steroid Pills or Shots[2]	Ever Taken a Prescription Drug[2]
United States	38.6*	21.7*	5.2	7.0	2.1	3.0	5.0	9.2	3.5	16.8
Nebraska	26.6	13.7	5.3	8.1	2.5	4.2	5.1	7.5	3.5	13.5
Gender										
Male	25.2	12.7	5.2	6.8	2.8	4.1	5.2	6.9	3.3	11.9
Female	27.6	14.4	5.2	9.3	1.9	3.8	5.0	7.6	3.4	14.9
Grade										
9th Grade	10.6	5.0	1.6	4.1	0.3	0.6	0.8	2.6	1.3	5.2
10th Grade	28.7	15.8	4.7	10.4*	1.2	1.9	5.2	6.1	3.4	13.1
11th Grade	28.9	14.5	7.6*	9.7	4.5*	7.6*	5.5	9.0*	4.8	15.3
12th Grade	37.4	18.8	6.6*	7.6	3.6*	6.3*	8.6	11.2*	4.0	19.5
Race/Ethnicity										
White, NH	20.8	10.4	3.5	6.3	1.7	2.9	4.4	5.5	1.9	11.2
African American, NH	-	-	-	-	-	-	-	-	-	-
Other, NH	-	-	-	-	-	-	-	-	-	-
Multi-Racial, NH	-	-	-	-	-	-	-	-	-	-
Hispanic/ Latino	47.0*	25.2*	9.0*	10.7	1.5	4.4	6.9	9.6*	7.4*	18.0*

NH=Non-Hispanic; "-" = Fewer than 100 students in this subgroup or data not available
[1]Inhalants include sniffed glue, breathed the contents of aerosol cans, or inhaled paints or sprays to get high. [2]Without a doctor's prescription
*Statistically significant at .05

Estimates of Behavioral Health Treatment Use in Nebraska

Behavioral Health Treatment Use in Nebraska and U.S.

Table 4.10 and **Figure 4.18** show the treatment use for mental illness, depression, illicit drug dependence/abuse, and alcohol dependence/abuse in Nebraska, compared to the U.S. overall. A large proportion of people who have behavioral health problems do not receive treatment in Nebraska or in the United States. More than half of Nebraskans did not receive treatment for mental illness (53%) or depression (57%). About 90% of people with illicit drug or alcohol dependence/abuse did not receive treatment.[8]

Table 4.10: Treatment Use for Behavioral Health Problems in Nebraska and United States: Annual Averages Based on 2013-2014 National Survey on Drug Use and Health Data[8, 47]

Treatment Use	U.S.	NE
Of Those Adults (18+ yrs) with Any Mental Illness		
Did Not Receive Treatment for Mental Illness in Past Year	57.3%	53.0%
Of Those Adolescents (12-17 yrs) with Depression		
Did Not Receive Treatment for Depression in the Past Year	58.8%	56.8%
Of Those People Aged 12 or Older with Illicit Drug Dependence or Abuse		
Did Not Receive Treatment for Drug Use Disorder in the Past Year	85.9%	88.8%
Of Those People Aged 12 or Older with Alcohol Dependence or Abuse		
Did Not Receive Treatment for Alcohol Dependence or Abuse in the Past Year	92.7%	93.0%

Behavioral Health Disparities

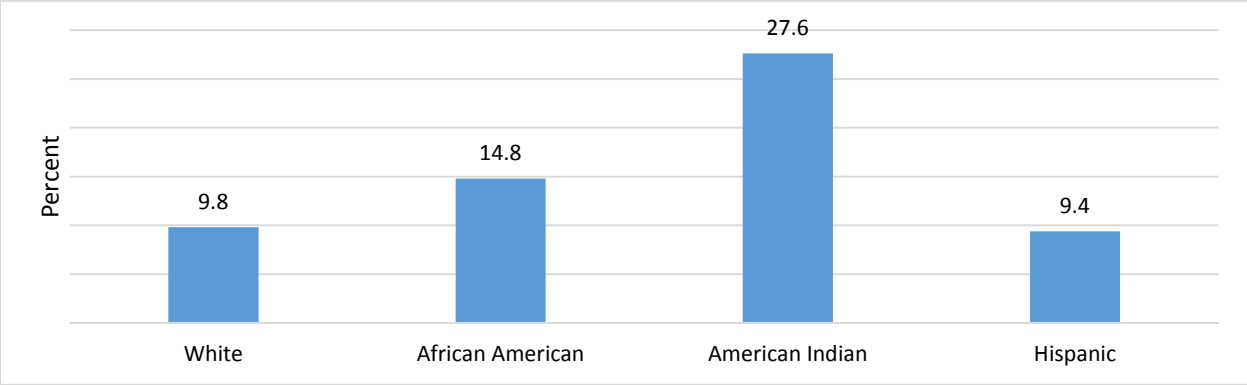
Table 4.11 shows select indicators of mental health among Whites and minority populations in Nebraska.

Table 4.11: Prevalence of Mental Illness by Race/Ethnicity in Nebraska: Annual Averages Based on 2006-2010 Behavioral Risk Factor Surveillance System Data[21]

Race/Ethnicity	Anxiety Disorder	Depressive Disorder	Current Depression	Serious Psychological Distress
White	9.8%	15.8%	6.5%	2.0%
African American	14.8%	13.0%	8.6%	3.4%
American Indian	27.6%	39.4%	29.5%	2.5%
Hispanic	9.4%	13.2%	8.0%	8.2%
Asian category was removed due to insufficient numbers.				

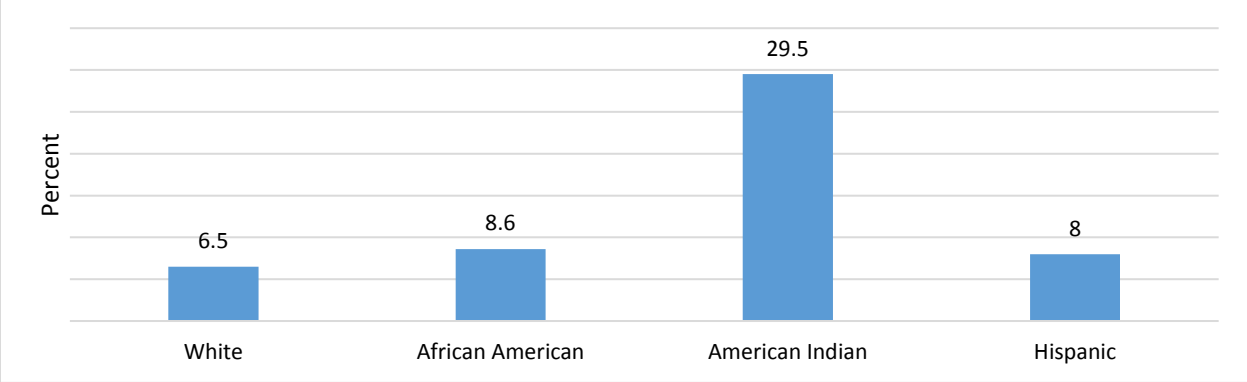
As shown in **Figure 4.5** and **Figure 4.6**, the prevalence of anxiety disorder and depression was particularly high among American Indians, showing as —1 in 3.[21]

Figure 4.5: Prevalence of Anxiety Disorder by Race/Ethnicity in Nebraska: Annual Averages Based on 2006-2010 Behavioral Risk Factor Surveillance System Data[21]



Asian category was removed due to insufficient numbers; data for 2001-2005 was unavailable for all groups.

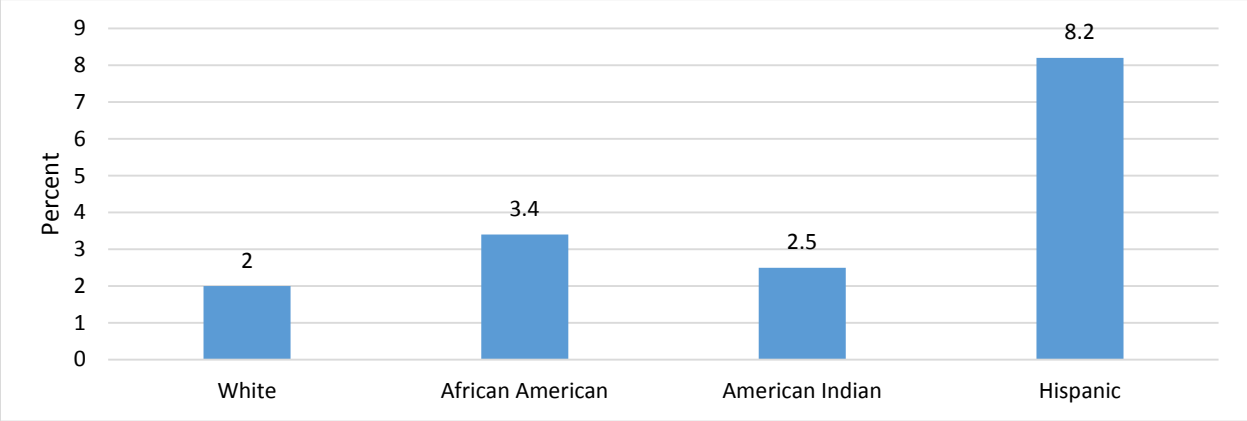
Figure 4.6: Prevalence of Current Depression by Race/Ethnicity in Nebraska: Annual Averages Based on 2006-2010 Behavioral Risk Factor Surveillance System Data[21]



Asian category was removed due to insufficient numbers.

Figure 4.7 shows the percentage of persons reporting serious psychological distress by race/ethnicity. The prevalence was the highest among Hispanics (8.2%) and lowest among Whites (2.0%).[21]

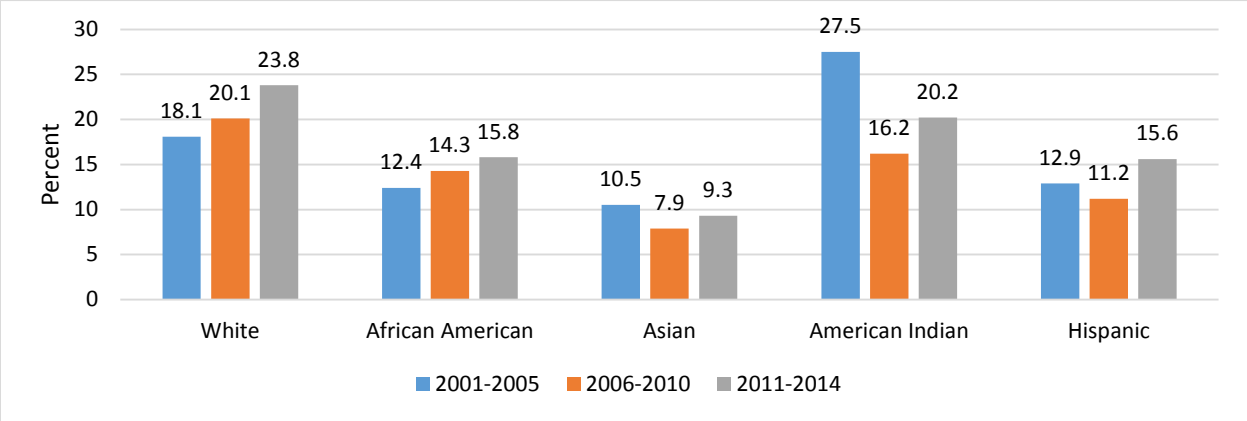
Figure 4.7: Prevalence of Serious Psychological Distress by Race/Ethnicity in Nebraska: Annual Averages Based on 2006-2010 Behavioral Risk Factor Surveillance System Data[21]



Asian category was removed due to insufficient numbers.

Figure 4.8 shows the prevalence of binge drinking by race/ethnicity. Binge drinking has been highest among American Indians during the 2001-2005 period. Although these rates remained relatively high, they dropped below the rate among Whites during the 2006-2010 and 2011-2014 periods.[21, 39]

Figure 4.8: Prevalence of Binge Drinking by Race/Ethnicity in Nebraska: 2001-2014 Behavioral Risk Factor Surveillance Data[21, 39]



Asian category was removed due to insufficient numbers.

Figure 4.9 shows alcohol-related death rates by race/ethnicity. Alcohol-related death rates have been particularly high among American Indians. For example, the age adjusted alcohol-related death rate per 100,000 for American Indians was 86.1 during the 2006-2010 period as compared to 28.2 for Whites and 42.2 for African Americans.[21]

Figure 4.9: Alcohol-Related Death Rates by Race/Ethnicity in Nebraska: 2001-2010 Nebraska Vital Statistics Data[21]

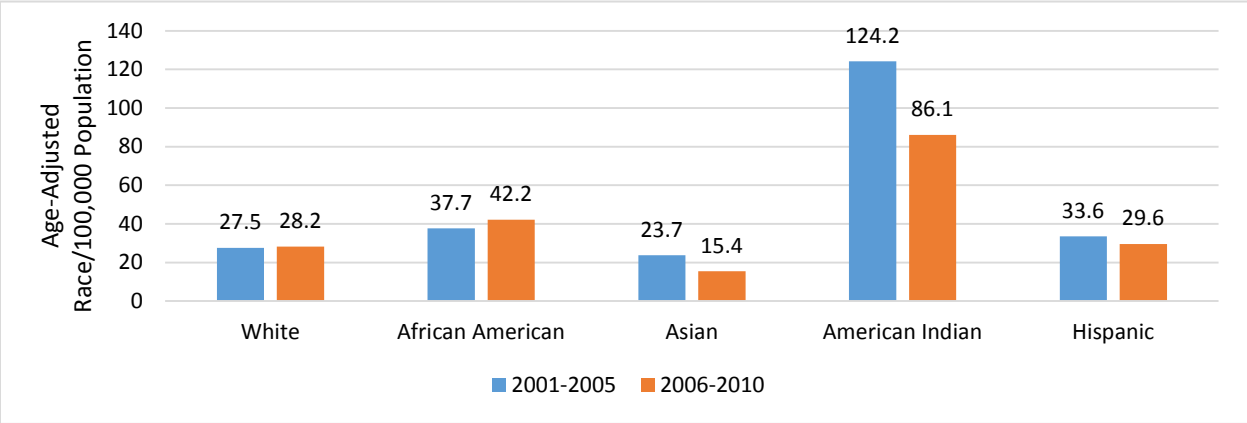


Figure 4.10 shows suicide rates. The suicide rates per 100,000 were higher among American Indians than Whites (12.7 vs. 10.7). For both American Indians and whites, the suicide rate was much higher among males than females (White: 17.8 (male) vs. 3.9 (female); American Indian: 24.7 (male) vs. 1.5 (female)).[21]

Figure 4.10: Suicide Death Rates among American Indians and Whites in Nebraska: 2006-2010 Vital Statistics Data[21]

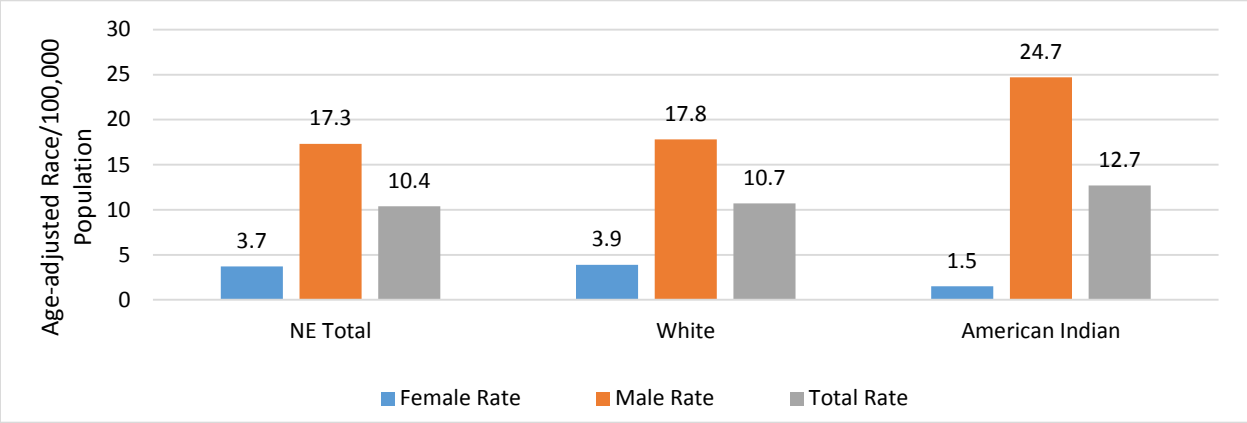
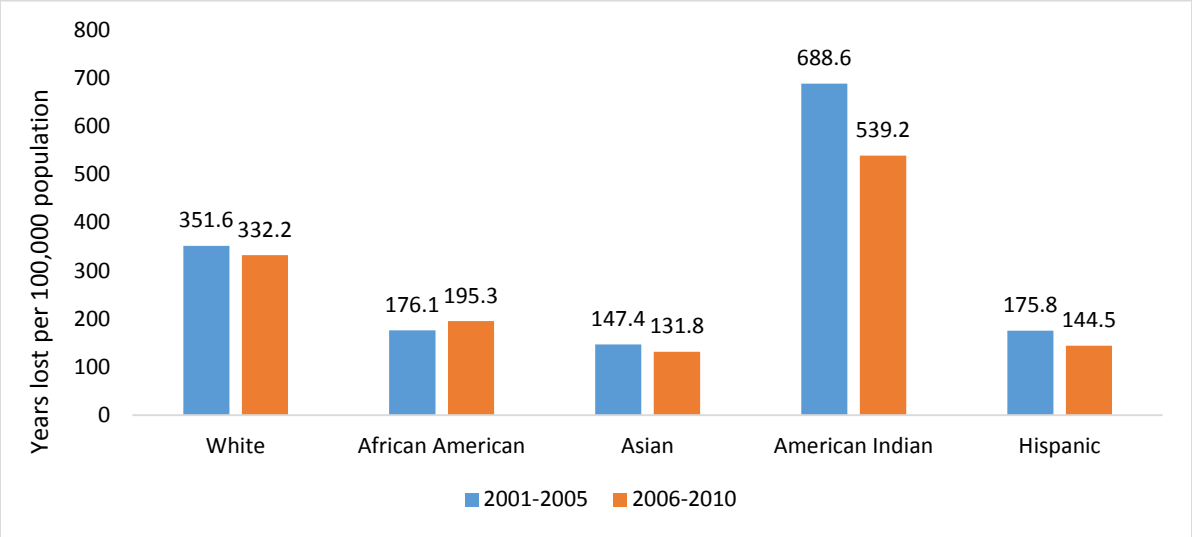


Figure 4.11 shows the number of years lost due to suicide by race/ethnicity.[21] The number was particularly high among American Indians. In total, 539.2 years were lost to suicide among American Indians between 2006 and 2010.

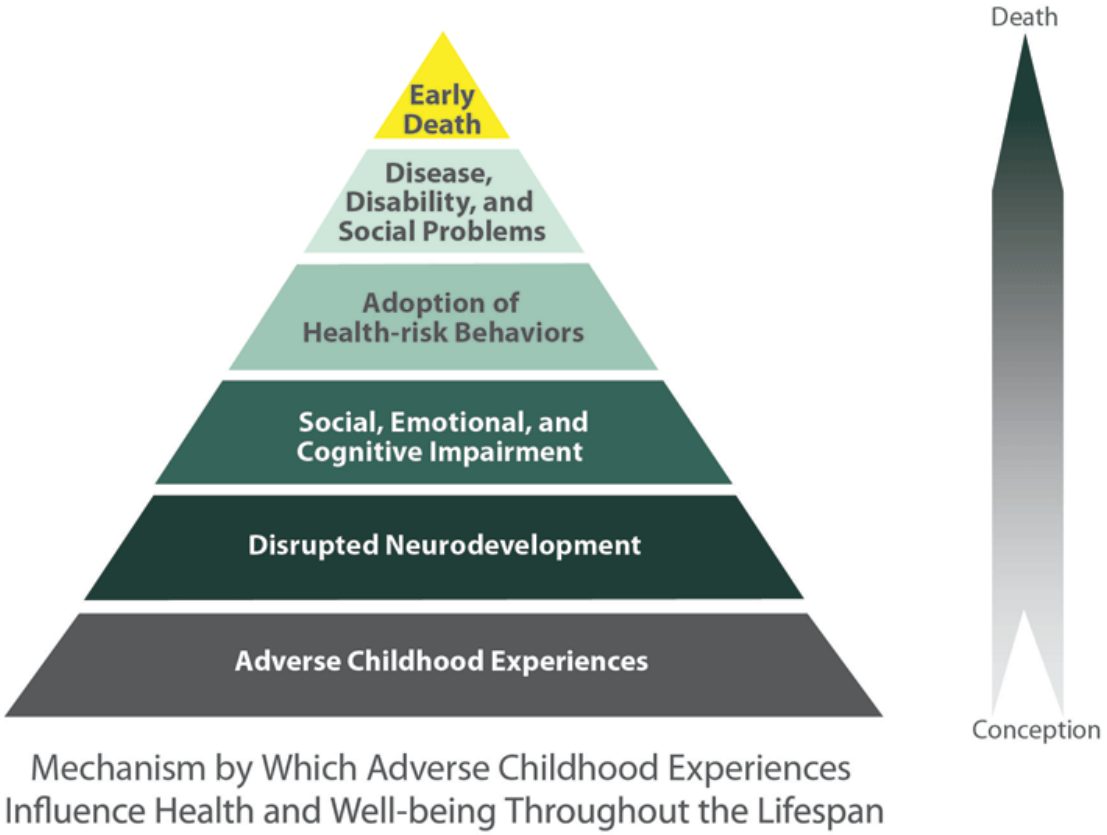
Figure 4.11: Years Lost Due to Suicide by Race/Ethnicity in Nebraska: 2006-2010 Vital Statistics Data[21]



Adverse Childhood Experiences

Past studies have clearly demonstrated that adverse childhood experiences often have a major impact on health throughout the lifespan. For example, the Centers for Disease Control and the Prevention-Kaiser Adverse Childhood Experiences (ACE) Study investigated the impact of childhood abuse and neglect on the health and wellbeing later in life.[48] **Figure 4.12** shows the conceptual framework of the ACE study.

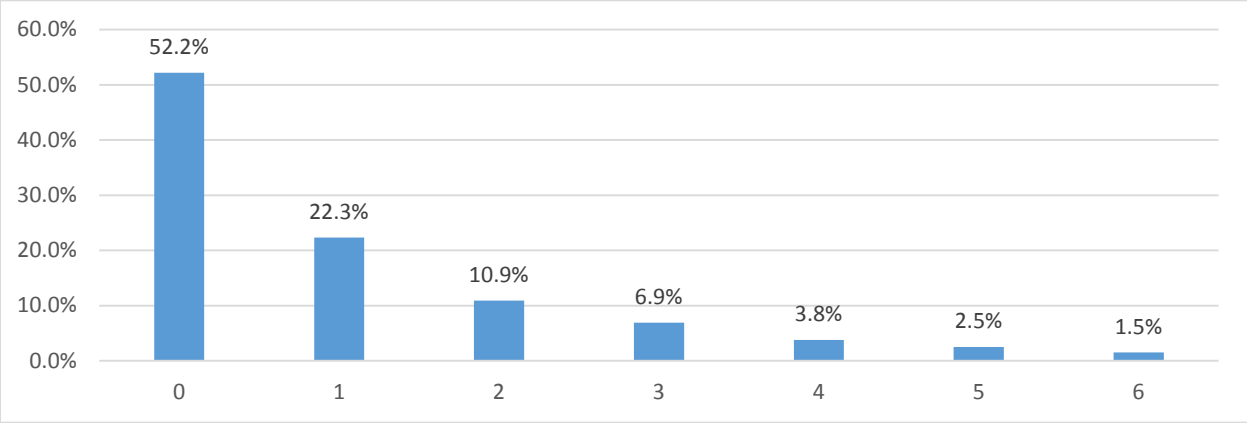
Figure 4.12: The Adverse Childhood Experiences Pyramid[49]



Nebraska and other states are collecting information about ACEs through the Behavioral Risk Factor Surveillance System (BRFSS). The BRFSS ACE Module contains 11 questions that states can include in the BRFSS survey conducted in their states.[50] In Nebraska BRFSS questionnaire, 6 of the 11 questions were included.

Figure 4.13 displays the number of adverse childhood experiences reported by respondents. While just under half of respondents reported at least one adverse childhood experience, over 25% reported two or more.

Figure 4.13: The Number of Adverse Childhood Experiences: 2015 Behavioral Risk Factor Surveillance System



Data for this figure were provided by the Nebraska Department of Health & Human Services.

Table 4.12 shows the proportion of respondents with certain types of adverse childhood experiences. The most common adverse childhood experiences were: parents divorced or separated (24.9%); lived with a problem drinker (24.6%); lived with somebody who was depressed, mentally ill, or suicidal (18.0%).

Table 4.12: The Responses to Adverse Childhood Experiences Questions: 2015 Behavioral Risk Factor Surveillance System

Question	Total	Male	Female
Did you live with anyone who was depressed, mentally ill, or suicidal?	Yes: 18.0%	Yes: 15.6%	Yes: 20.3%
Did you live with anyone who was a problem drinker or alcoholic?	Yes: 24.6%	Yes: 22.2%	Yes: 26.8%
Did you live with anyone who used illegal street drugs or who abused prescription medications?	Yes: 10.8%	Yes: 11.7%	Yes: 10.0%
Did you live with anyone who served time or was sentenced to serve time in a prison, jail, or other correctional facility?	Yes: 8.7%	Yes: 10.0%	Yes: 7.4%
Were you parents separated or divorced?	Yes: 24.9%	Yes: 25.0%	Yes: 24.7%
How often did your parents or adults in your home ever slap, hit, kick, punch, or beat each other up?	At least once: 16.8%	At least once: 16.7%	At least once: 16.9%
	Multiple times: 11.2%	Multiple times: 11.9%	Multiple Times: 10.4%

Data for this table were provided by the Nebraska Department of Health & Human Services.

V. Hospitalization Related to Mental Health Disorders and Substance Related Disorders among General Population in Nebraska

Summary

This chapter presents information about the inpatient and emergency department use related to mental health substance disorders in Nebraska. The information included in this chapter is based on the 2007-2014 Nebraska Hospital Discharge data. A de-identified dataset provided by the Nebraska Department of Health and Human Services, Division of Public Health (DPH) was used to calculate the hospitalizations related to mental health and substance disorders. As a reminder, the Veterans Affairs, Regional Centers and Indian Health Service hospitals do not participate. In addition, the following hospitals do not participate and are therefore, not represented in the data described in this chapter: Lincoln Surgical Hospital (Lincoln), Select Specialty Hospital (Lincoln/Omaha), Douglas County Health Center (Omaha), Midwest Surgical Hospital (Omaha) and Nebraska Spine Hospital (Omaha). U.S. Census data were used for the population denominators.

Chapter Highlights

Hospitalization Related to Mental Health Disorders

- During the 8-year period (2007-2014), there were a total of 85,047 hospitalizations due to mental health disorders in Nebraska.
- Depressive and episodic mood disorders were the most common diagnoses in every age group—52.8% among children (0-9 years), 77.7% among adolescents (10-19 years), 65.6% among adults (20-64 years), 44.5% among older adults (65+ years)
- For the period between 2011-2014, the hospitalization rate due to mental health disorder was highest among adolescents (10-19 years) with 1172 hospitalization per 100,000 population followed by adults aged 20-64 years with 712 per 100,000.
- When comparing the earlier period (2007-2010) and the recent period (2011-2014), it was found that the rate of hospitalization due to mental health disorder increased among adolescents (10-years) by 25% and adults aged 20-64 by 23%.
- When comparing the earlier period (2007-2010) and the recent period (2011-2014), it was found that the rate of hospitalization due to mental health disorder increased in metropolitan counties by 23%.

Hospitalization Related to Substance Use Disorders

- During the 8-year period (2007-2014), there were a total of 9.672 hospitalizations due to substance use disorders in Nebraska.
- About 75% of hospitalizations among adults aged 20-64 years were due to alcohol-related problems. Alcohol-related problems were the primary reasons for hospitalization for 45% of hospitalization among older adults (65+ years) and 20% among adolescents (10-19 years).
- When comparing the earlier period (2007-2010) and the recent period (2011-2014), it was found that the rate of hospitalization due to substance use disorder increased adults aged 20-64 by 45%.

- When comparing the earlier period (2007-2010) and the recent period (2011-2014), it was found that the rate of hospitalization due to substance use disorder increased in metropolitan counties by 43%.

Chapter Recommendations

- Although not all hospitalizations can be avoided, increased access to community-based services may help prevent some of hospitalization due to mental health disorders and/or substance use disorders.
- For example, integrated behavioral health and primary care approach discussed in Chapter 10 may help increase the access to behavioral health services
- Screening Brief Intervention Referral and Treatment (SBIRT) should be implemented in different clinical settings to identify persons who need alcohol and substance-related treatment
- The increasing trend in hospitalization among adults aged 20-64 years and in metropolitan communities warrants a further investigation
- A longitudinal data analysis may be conducted to identify persons who are at high risk for re-current hospitalization due to behavioral health problems.

Hospitalization Related to Mental Health Disorders by Age

During the 8-year period (2007-2014), there were a total of 85,047 hospitalizations due to mental health disorders. **Table 5.1** shows common diagnoses associated with these hospitalizations. Depressive and episodic mood disorders were the most common diagnoses in every age group.

Table 5.1: Hospitalizations Due to Mental Health Disorders by Age Group: 2007-2014 Nebraska Hospital Discharge Data (N=85,047)

Children (0-9 years)	No.	%
Depressive and Episodic mood disorders	1013	52.8
Disturbance of conduct not elsewhere classified	288	15.0
Hyperkinetic syndrome of childhood	253	13.2
Adjustment reaction/Acute reaction to stress	133	6.9
Disturbance of emotions specific to childhood and adolescence	165	8.6
Schizophrenic disorders / delusions/ other nonorganic psychosis	20	1.0
Pervasive developmental disorders	25	1.3
Other	21	1.1
Total	1918	100.0
Adolescents (10-19 years)	No.	%
Depressive and Episodic mood disorders	16679	77.7
Adjustment reaction/Acute Rx to stress	1472	6.9
Schizophrenic disorders/delusions/other nonorganic psychosis	942	4.4
Disturbance of conduct not elsewhere classified	932	4.3
Disturbance of emotions specific to childhood and adolescence	544	2.5
Hyperkinetic syndrome of childhood	379	1.8
Anxiety, dissociative and somatoform disorders	292	1.4
Pervasive developmental disorders	99	0.5
Personality disorders	22	0.1
Other	103	0.5
Total	21464	100.0
Adults (20-64 years)	No.	%
Depressive and Episodic mood disorders	36263	65.6
Schizophrenic disorders/delusions/other nonorganic psychosis	14141	25.6
Adjustment reaction/Acute reaction to stress	2300	4.2
Anxiety, dissociative and somatoform disorders	1234	2.2
Disturbance of conduct not elsewhere classified	380	0.7
Transient/persistent mental disorders due to conditions classified elsewhere	241	0.4
Personality disorders	86	0.2
Specific nonpsychotic mental disorders due to brain damage	68	0.1
Dementias	55	0.1
Physiological malfunction arising from mental factors	61	0.1
Pervasive developmental disorders	42	0.1
Hyperkinetic syndrome of childhood	34	0.1
Other	357	0.6
Total	55262	100.0
Older Adults (65+ years)	No.	%
Depressive and Episodic mood disorders	2849	44.5
Schizophrenic disorders/delusions/other nonorganic psychosis	1307	20.4
Transient/ persistent mental disorders due to conditions classified elsewhere	1177	18.4

Dementias	534	8.3
Anxiety, dissociative and somatoform disorders	248	3.9
Adjustment reaction/Acute reaction to stress	120	1.9
Physiological malfunction arising from mental factors	20	0.3
Specific nonpsychotic mental disorders due to brain damage	75	1.2
Disturbance of conduct not elsewhere classified	27	0.4
Other	46	0.7
Total	6403	100.0

Figure 5.1: Common Mental Disorder Diagnoses Related to Hospitalizations among Children (0-9 years) in Nebraska: 2007-2014 Hospital Discharge Data

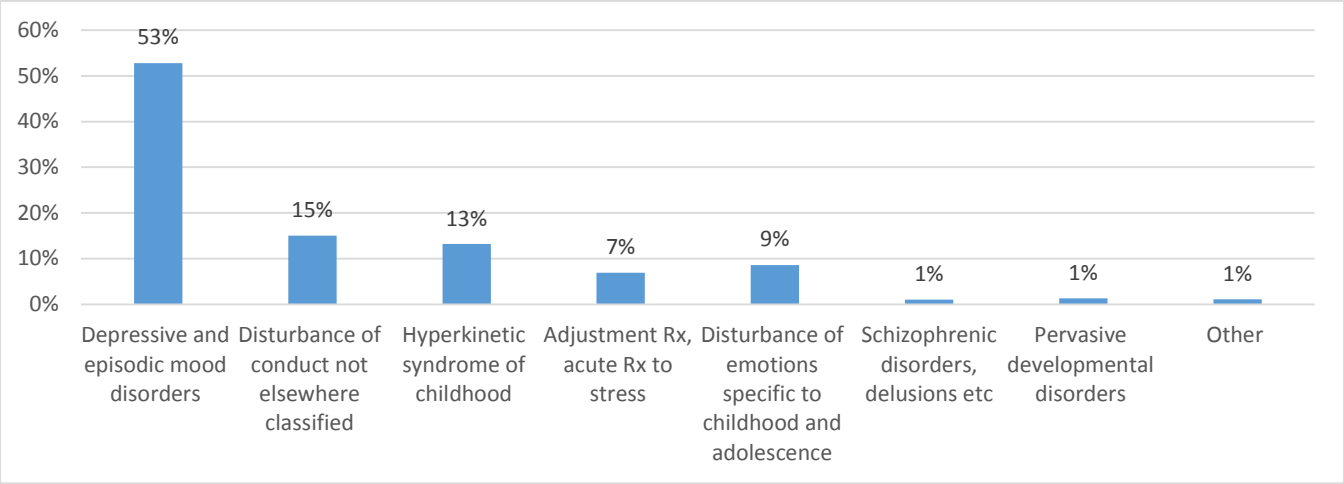


Figure 5.2: Common Mental Disorder Diagnoses Related to Hospitalizations among Adolescents in Nebraska: 2006-2013 (10-19 years)

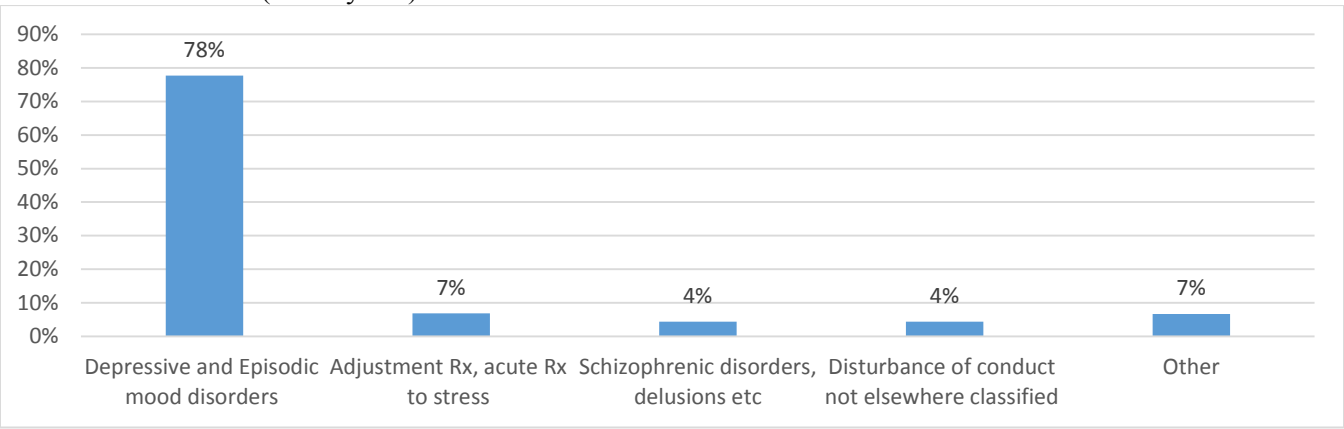


Figure 5.3: Most Common Mental Disorder Diagnosis Related to Hospitalizations among Adults (20-64 years) in Nebraska: 2007-2014 Hospital Discharge Data

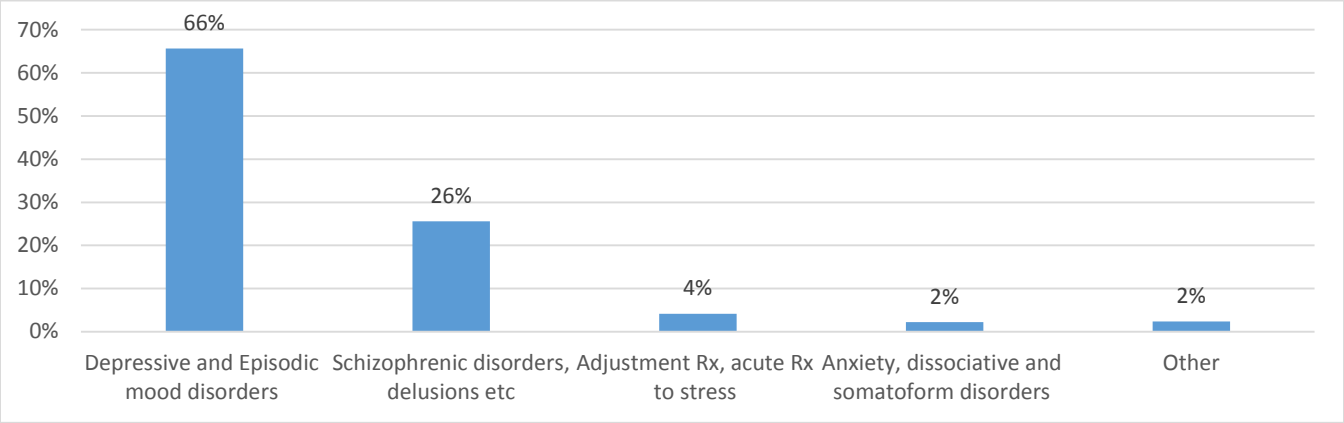
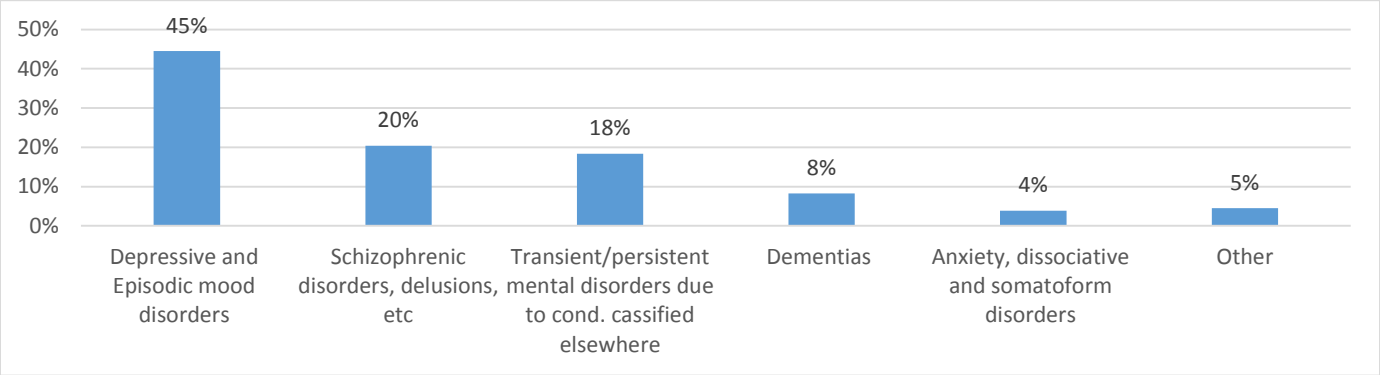


Figure 5.4: Common Mental Disorder Diagnoses Related to Hospitalizations among Older Adults (65+ years) In Nebraska: 2007-2014 Hospital Discharge Data



Hospitalization Related to Substance Disorders by Age

Table 5.2 shows diagnoses related to substance-related disorder hospitalizations. A total of 9,672 hospitalizations occurred due to substance disorders between 2007 and 2014.

Table 5.2: Hospitalizations Due to Substance Use Disorders by Age Group: 2007-2014 Nebraska Hospital Discharge Data (N=9,672)

Adolescents (10-19 years)	Number	%
Nondependent abuse of drugs	105	30.3
Drug-induced mental disorders	120	34.6
Drug dependence	59	17.0
Alcohol dependence syndrome	32	9.2
Alcohol-induced mental disorders	31	8.9
Total	347	100.0
Adults (20-64 years)	Number	%
Alcohol-induced mental disorders	3797	45.6
Alcohol dependence syndrome	2255	27.1
Drug-induced mental disorders	1212	14.6
Nondependent abuse of drugs	748	9.0
Drug dependence	316	3.8
Total	8328	100.0
Older Adults (65+ years)	Number	%
Drug-induced mental disorders	501	50.3
Alcohol-induced mental disorders	276	27.7
Alcohol dependence syndrome	169	17.0
Nondependent abuse of drugs	47	4.7
Other	4	0.4
Total	997	100.0

Time Trends of Hospitalization Related to Mental Health and Substance Disorders

Between 2007-2010 and 2011-2014, the rate of hospitalization for mental health disorders increased substantially for adolescents and adults but decreased for children and the elderly. As for substance use disorders, the rate of hospitalization during these periods increased for adults but decreased for adolescents and the elderly (**Table 5.3, Figure 5.5** and **Figure 5.6**).

Hospitalization rates related to both mental health and substance use disorders increased in all geographic areas from the period 2007-2010 to 2011-2014 (**Table 5.4**, **Figure 5.5**, and **Figure 5.6**). The most notable increases ware in the metropolitan area.

Table 5.3: Crude Rates* per 100,000 of Hospital Discharge with Primary Diagnosis of Mental Health and Substance Use Disorders by Age Group: 2007-2010 vs. 2011-2014 Nebraska Hospital Discharge Data

	2007-2010		2011-2014		Rate Ratio	
	Number	Rate	Number	Rate	RR	95% CI
Mental Health Disorders						
All	38283	530.06	46764	627.86	1.18	1.16, 1.20
Children	1016	99.35	902	85.84	0.86	0.79, 0.94
Adolescents	9509	938.16	11955	1171.7	1.25	1.22, 1.28
Adults	24410	578.94	30852	711.65	1.23	1.21, 1.25
Elderly	3348	345.23	3055	293.25	0.85	0.81, 0.89
Substance Use Disorders						
All	4068	56.33	5604	75.24	1.34	1.31, 1.38
Adolescents	194	19.14	153	15	0.78	0.63, 0.96
Adults	3350	79.45	4978	114.82	1.45	1.39, 1.52
Elderly	524	54.03	473	45.4	0.84	0.74, 0.95

*Rate per 100,000. Rate ratio calculations=(rate 2011-2014)/(rate 2007-2010)=RR
Rate ratio CI calculations= exp{LN of RR ± [sqrt of (1/(2011-2014 cases))+ 1/(1/(2007-2010 cases))]*1.96}

Figure 5.5: Crude Rates per 100,000 of Hospital Discharge with Primary Diagnosis of Mental Health Disorders by Age Group: 2007-2010 vs. 2011-2014 Nebraska Hospital Discharge Data

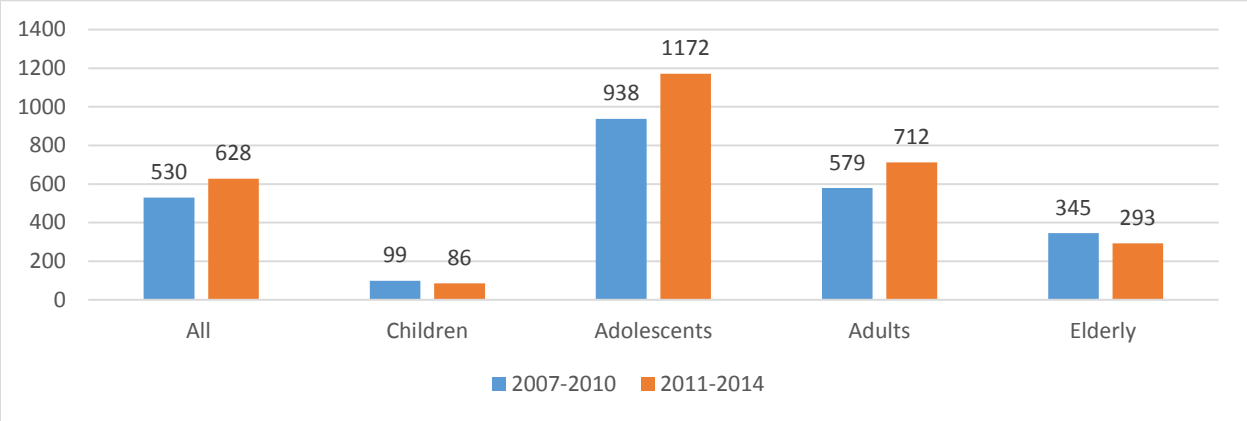


Figure 5.6: Crude Rates per 100,000 of Hospital Discharge with Primary Diagnosis of Substance Use Disorder by Age Group: 2007-2010 vs. 2011-2014 Nebraska Hospital Discharge Data

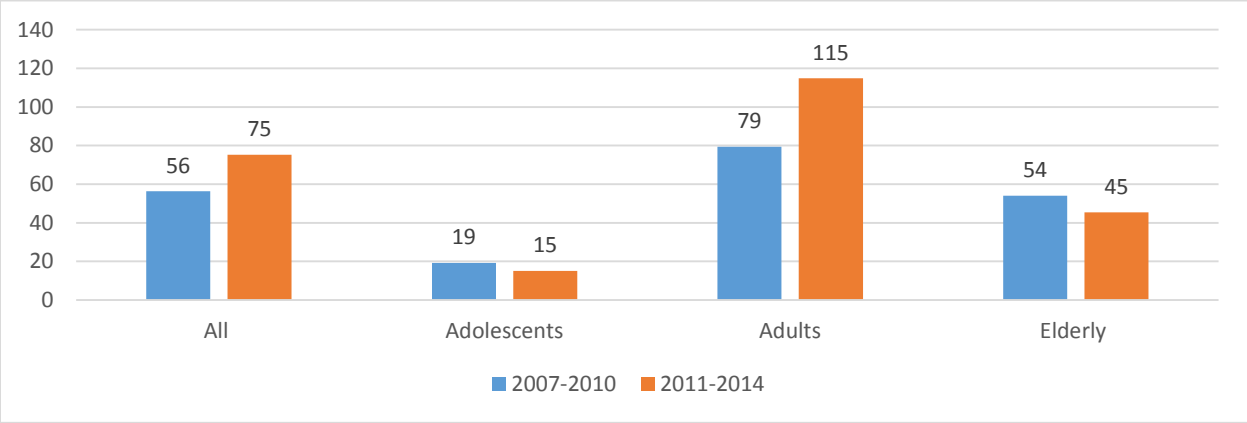


Table 5.4: Crude Rates per 100,000 of Hospital Diagnosis of Mental Health and Substance Use Disorders by Residence Location: 2007-2010 vs. 2011-2014 Nebraska Hospital Discharge Data

	2007-2010		2011-2014		Rate Ratio	
	Number	Rate	Number	Rate	RR	95% CI
Mental Health Disorders						
All	38283	530.06	46764	627.86	1.18	1.16, 1.20
Metropolitan	26183	577.34	33762	708.53	1.23	1.21, 1.25
Rural	7329	564.18	7767	592.9	1.05	1.02, 1.08
Remote	4771	343.69	5235	381.25	1.11	1.07, 1.15
Substance Use Disorders						
All	4068	56.33	5604	75.24	1.34	1.42, 1.55
Metropolitan	2604	57.42	3921	82.29	1.43	1.55, 1.72
Rural	920	70.82	1081	82.52	1.17	1.08, 1.29
Remote	544	39.19	602	43.84	1.12	1.03, 1.31
Those with on identifiable county were removed from the analysis by location. Because of this there were 123 mental illness diagnoses removed and 109 substance use disorder diagnoses removed.						

Figure 5.7: Crude Rates per 100,000 of Hospital Discharge with Primary Diagnosis of Mental Health Disorders by Residential Location: 2007-2010 vs. 2011-2014 Nebraska Hospital Discharge Data

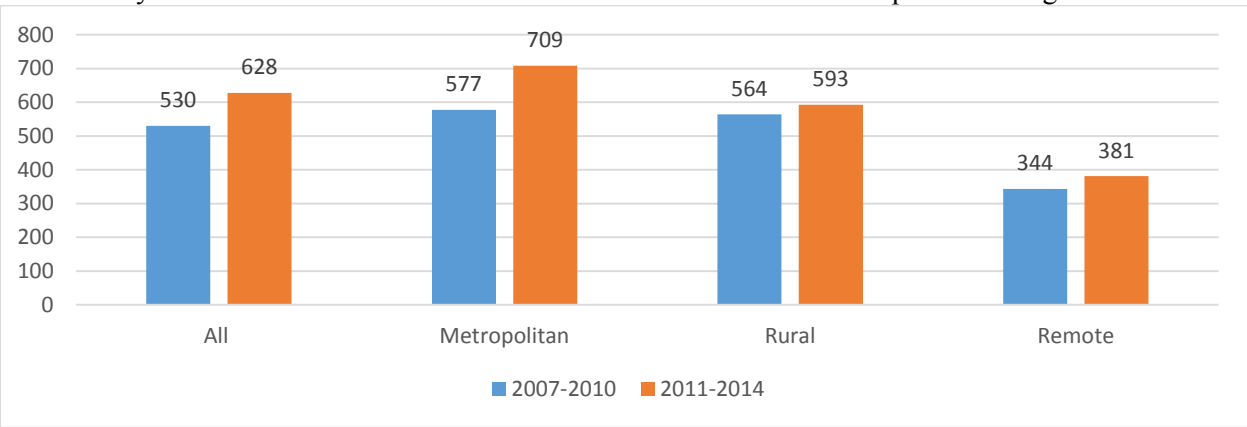
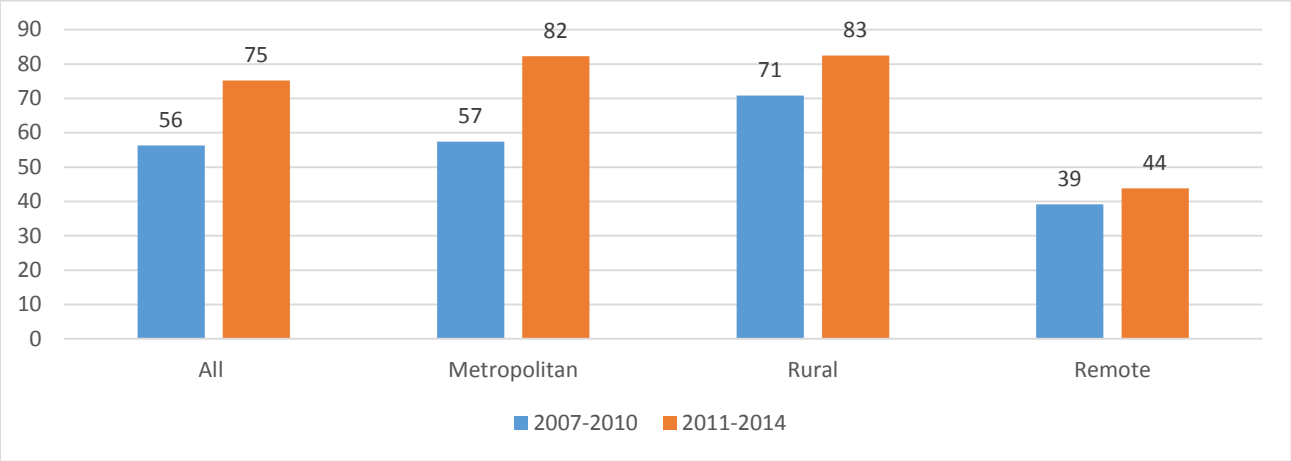


Figure 5.8: Crude Rates per 100,000 of Hospital Discharge with Primary Diagnosis of Substance Use Disorder by Residential Location: 2007-2010 vs. 2011-2014 Nebraska Hospital Discharge Data



Hospital Length of Stay Related to Mental Health and Substance Use Disorders

Tables 6.5 and **Table 6.6** show the mean length of stay for different age groups and by residential location. The average length of stay for mental health disorders declined for all of the population groups between the periods 2007-2010 and 2011-2014, but elderly average remained considerably higher than the other groups. The mean length of stay dropped in all of the geographic areas for both mental health and substance use disorders.

Table 5.5: Mean Length of Stay (Days) of Hospital Discharge with Mental Health Disorders and Substance Use Disorders by Age Group: 2007-2010 vs. 2011-2014 Nebraska Hospital Discharge Data

	2007-2010			2011-2014			p-value
	Number	Mean	SD	Number	Mean	SD	
Mental Health Disorders							
All	38283	7.54	10	46764	6.12	8.76	<.0001*
Children	1016	7.49	10.05	902	5.24	5.53	<.0001*
Adolescents	9509	7.29	10.08	11955	5.38	10.62	<.0001*
Adults	24410	7.29	9.84	30852	6.11	7.73	<.0001*
Elderly	3348	10.03	10.57	3055	9.34	10.4	0.0087
Substance Use Disorders							
All	4068	4.37	5.61	5604	4.14	4.95	0.0382*
Adolescents	194	5.98	7.52	153	5.48	6.7	0.523
Adults	3350	4.16	5.3	4978	4.07	4.97	0.4342*
Elderly	524	5.09	6.46	473	4.42	3.92	0.0475*
*Unequal variance							

Table 5.6: Mean Length of Stay (Days) of Hospital Discharge with Primary Diagnosis of Mental Health and Substance Use Disorders by Residence Location: 2007-2010 vs. 2011-2014 Nebraska Hospital Discharge Data

	2007-2010			2011-2014			p-value
	Number	Mean	SD	Number	Mean	SD	
Mental Health Disorders							
All	38283	7.54	10	46764	6.12	8.76	<0.0001*
Metropolitan	26183	7.69	10.17	33762	6.21	9.07	<0.0001*
Rural	7329	7.29	9.69	7767	6.15	8.57	<0.0001*
Remote	4771	7.12	9.49	5235	5.54	6.75	<0.0001*
Substance Use Disorders							
All	4068	4.37	5.61	5604	4.14	4.95	0.0382*
Metropolitan	2604	4.46	5.28	3921	4.22	4.92	0.0672*
Rural	920	4.43	6.68	1081	4.09	5.46	0.2187*
Remote	544	3.85	5.09	602	3.73	4.1	0.6571*
*Unequal variance							

VI. The Nebraska Public Behavioral Health System

Summary

In this report, a public behavioral health system is defined as a system which administers publicly funded behavioral health services. The public behavioral health system is typically administered by the state government and funded by federal, state, and local governments. In this report, the main focuses are the programs and services funded by the Nebraska Department of Health Division of Behavioral Health. The information included in this chapter is based on reports and data provided by the Nebraska Department of Health and Human Services, the Division of Behavioral Health. In addition, information obtained through the literature review is included.

Chapter Highlights

Organizational Structure and Expenditure

- Division of Behavioral Health (DBH) is the chief behavioral health authority of the State. The DBH administers, oversees, and coordinates the state's public behavioral health system to address the prevention and treatment of mental health and substance use disorders.
- The DBH is responsible for managing state funding budgeted to DBH and also for federal funding, including the Community Mental Health Services Block Grant and the Substance Abuse Prevention and Treatment Block Grant funded by the Substance Abuse Mental Health Services Administration.
- At the state level, the DBH is comprised of three sections: Regional Centers (public psychiatric hospitals), Community Based Services, and the Office of Consumer Affairs. There are three regional centers located in Norfolk, Lincoln, and Hastings. Lincoln Regional Center also includes Whitehall, a psychiatric residential treatment facility that serves adolescent males who have sexually harmed others.
- The DBH contracts with the six Regional Behavioral Health Authorities for community-based mental health and substance use disorder services. In addition, the DBH contracts with other entities for prevention, treatment, and recovery and support services.
- In 2016, the expenditure for the DBH funded public behavioral system in Nebraska was over $94,000,000 for mental health and substance use disorder services combined.
- About 32,000 consumers are served annually through Division of Behavioral Health (DBH) services. Of these, 8% are consumers 18 years or younger and 17% are adults aged 19-24.

Wait List and Capacity Assessment

- Block Grant funding requires that states have a waiting list management system to report waiting times and use of interim services for those identified as meeting Federal Substance Use Disorder priority populations (Pregnant & Injecting Drug Users, Pregnant Substance Users, and Injecting Drug Users).
- In FY2016, wait times for community-based services ranged from 0-134 days, with an average wait of 19.5 days. Over 60% of waits were for short-term residential services. For substance use

disorder (SUD) treatment for priority populations, the average wait day was longest for outpatient substance use disorder service (37.3 days) followed by therapeutic community service admission (37.1 days), and then halfway house (31.7 days). The average wait day was the longest for women with dependent children (24.7 days). Within this group, the wait was particularly long for therapeutic community service (41.9 days) and for outpatient service (37.3 days).

- With an exception of secure residential services, in FY2015, all bed-based services were near or above capacity at both agency and region levels. Psychiatric residential capacity at the region level has been between 126% and 162% during the last 3 fiscal years. Also at the region level, halfway house, intermediate residential and short-term residential services for substance use disorders have been near or slightly above 100% in the past 3 fiscal years.

Emergency Response System

- Emergency Protective Custody (EPC) admissions declined steadily from 744 during the third quarter of 2011 to 683 during the second quarter in 2016. Similarly, Mental Health Board commitments declined from 174 to 97 during the same time period.
- According to Magellan extract data, 9% of adult consumers had at least one EPC admission in each of FY 2013, 2014, and 2015. In FY2015, the percentage of EPC admission was highest among adults 65 years and older. In FY2015, Region 1 had the highest percentage of EPC admissions (19%) followed by Region 4 (16%), while Regions 5 (6%) and 6 (8%) had a relatively lower percentage of consumers with an EPC admission.
- The DBH hired a consultant to assist with emergency mapping. Two priorities identified were: (1) track performance more consistently and thoroughly over time; and (2) identify opportunities for improvement related to key 'pressure points' within the system. It was proposed to collect more robust indicators of the following key outcomes: (a) reduced repeated EPC readmission and (b) timely access to appropriate treatment (timely completion of crisis evaluations, timely completion of MHB commitment hearings, and timely engagement with for subacute treatment).

Co-Occurring Disorder Services and Trauma Informed Care

- Persons with co-occurring disorders are best served through integrated treatment where providers can address mental and substance use disorders at the same time. This approach often resulted in better outcomes and lower costs.
- In 2013 and 2015, the DBH implemented assessment of co-occurring disorder services using the Compass-EZ, a tool that allows behavioral health programs to create baseline measures describing their ability to deliver services to persons with co-occurring disorders. The assessment scores improved from 2013 to 2015 in every domain. The following areas were identified as some of opportunities for improvement: 1) quality Improvement and data; 2) integrated treatment and recovery programming; and 3) integrated discharge and transition planning.

- In FY2015 67% of consumers reported emotional abuse. Among those who reported trauma, over 50% reported experiencing physical abuse (56.7%) and traumatic loss of a loved one (54.5%). Across the Behavioral Health Regions, female consumers reported higher prevalence of trauma compared to male consumers.
- DBH retains a consultant to assess trauma-informed services. A total of 73 agency programs participated in 2013 and 86 agency programs participated in the assessment in 2015. The scores for all domains improved between 2013 and 2015. Screening, program policies and procedures were identified as the top strengths while administrative support, human resources, and staff training were identified as opportunities for improvement.

Mental Health National Outcome Measures

- National Outcome Measures (NOMs) were developed by Substance Abuse Mental Health Services Administration (SAMHSA) in collaboration with states. *It is important to note that Nebraska's data on NOMs as provided by the DBH only include data from those consumers or patients who received services funded through the DBH and do not include counts from Medicaid Long-Term Care funding or other funding sources.*
- In FY 2015, the overall Mental Health Disorder (MHD)/Dual Services penetration rate was lower for Nebraska with 10.3 per 1,000 population compared to 23.5 for Midwest and 23.1 for the U.S. overall. The penetration rate was notably lower in Nebraska compared to the national average for children (0-17 years) and for community mental health programs.
- Overall, the employment rate for consumers in MHD/Dual Services and SUD Services was higher in Nebraska compared to the U.S.
- The percentage of children and adults served through MHD/Dual Services living in private residents was higher in Nebraska than in the U.S. overall. The percentage of adults served through SUD services who have stable housing was comparable between Nebraska and the U.S. overall.
- A higher proportion of SUD consumers in Nebraska used self-help programs compared to the U.S. average.

Consumer Satisfaction Survey

- Adult and youth consumers and their families indicated that they were satisfied with most aspects of the services they received.
- About 75% of mental health consumers are obese or overweight.
- Nearly 50% of mental health consumers and 66% of substance consumers are smokers compared to 17% of the general population.
- About half of youth consumers were obese or overweight.

Organizational Structure of Nebraska Public Behavioral System

Public Behavioral Health System

In this report, a public behavioral health system is defined as a system which administers publicly funded behavioral health services. The public behavioral health system is typically administered by the state government and funded by federal, state, and local governments. In this report, the main focuses are the programs and services funded by the Nebraska Department of Health Division of Behavioral Health.

Role of the Division of Behavioral Health

The Nebraska Behavioral Health Services Act designates the Division of Behavioral Health (DBH) as the chief behavioral health authority of the State [§71-806(1)]. The DBH administers, oversees, and coordinates the state's public behavioral health system to address the prevention and treatment of mental health and substance use disorders. The DBH is responsible for managing state funding budgeted to DBH and also federal funding which includes the Community Mental Health Services Block Grant and the Substance Abuse Prevention and Treatment Block Grant funded by the Substance Abuse Mental Health Services Administration.[51]

Public Behavioral Health System Organization

At the state level, the DBH comprises three sections: Regional Centers (public psychiatric hospitals), Community Based Services, and the Office of Consumer Affairs. There are three regional centers located in Norfolk, Lincoln, and Hastings. The Norfolk Regional Center is a Sex Offender Treatment Center Phase I service, designed to reduce danger from and risk of re-offense by patients. The Lincoln Regional Center (LRC) provides three types of services: psychiatric services for people with severe and persistent mental illness; forensic services to provide evaluation, assessment, and treatment for persons as ordered by the Nebraska legal system; and Phase II and III sex offender treatment. LRC also includes Whitehall, a psychiatric residential treatment facility that serves adolescent males who have sexually harmed others. The Hastings Juvenile Chemical Dependency Program, a Psychiatric Residential Treatment Facility, provides a residential substance use disorder treatment for young men.[51]

Community-Based Services

The DBH contracts with the six Regional Behavioral Health Authorities for community-based mental health and substance use disorder services. In addition, the DBH contracts with other entities for prevention, treatment, and recovery and support services. Examples include Trilogy Integrated Services to provide a web portal for consumer access; Father Flanagan's Boys Town, which operates the Nebraska Family Helpline; and four federally recognized Native American Tribes for the provision of culturally appropriate mental health and substance use disorder treatment services and relapse prevention activities.[51]

Office of Consumer Affairs

The Office of Consumer Affairs (OCA) conducts activities to promote consumer involvement in the service system and recovery process. Consumers are defined as persons receiving mental health or substance disorder services. These activities include facilitation of community forums for consumers to

give feedback on the quality of service and to identify gaps in these services. The OCA also implements training for Peer Support and Wellness Specialists and training for members of the various mental health boards across the state responsible for the civil commitment of persons who are mentally ill and dangerous. The OCA's People's Council is designed to advise the DBH around consumer involvement in all aspects of service planning and delivery.[51] The Council is a subcommittee to the DBH Joint (Mental Health and Substance Use Disorder) Advisory Committee.

Regional Organization

The DBH contracts with six Regional Behavioral Health Authorities (RBHAs) (**Figure 6.1, Table 6.1**) and authorizes them to purchase services using state general funds, funds received under the Community Mental Health Services Block Grant and the Substance Abuse Prevention Treatment Block Grant, and other discretionary federal grants. Each RBHA is under contract to provide Network Management, Consumer System Coordination, Prevention System Coordination, Emergency System Coordination, Youth System Coordination, and Housing Coordination.[51]

Figure 6.1: Nebraska Behavioral Health Regions Map[35]

Table 6.1: Region Behavioral Health Office, Number of Counties, Population and Percentage of Population[51]

Behavioral Health Region	RBHA Office	Counties	Population	% of Population
1 (Panhandle/Western)	Scottsbluff	11	87,104	4.7%
2 (South Western)	North Platte	17	100,642	5.4%
3 (South Central)	Kearney	22	229,646	12.3%
4 (Northeast & North Central)	Norfolk	22	206,304	11.0%
5 (Southeast)	Lincoln	16	456,138	24.4%
6 (Eastern)	Omaha	5	788,682	42.2%
Total		93	1,868,516	100.0%

Partnerships

Effective collaborative partnerships among public and private systems, as well as with individual consumers, families, agencies, and communities, are important components of the systems of care for treating persons with mental health and substance use disorders. Publicly funded services are administered by different agencies including the Division of Behavioral Health, the Division of Medicaid and Long-Term Care, the Division of Public Health, and the Division of Children and Family Services. In addition, other state and federal agencies (e.g., State Probation through the Nebraska Supreme Court, the Nebraska Department of Correctional Services, the Nebraska Department of Education Vocational Rehabilitation, and the Veterans' Administration) fund and/or collaborate on behavioral health services and supports.[51]

Core Services, Network Management, and System Expectations

This section summarizes the required core services, network management, and system expectations as outlined in the Fiscal Year 2017 Region Budget Plan Guidelines released by the Department of Health and Human Services Division of Behavioral Health (DBH).[52]

Core Services

Core services are defined as essential services that are to be represented in each regional network of services (**Table 6.2**). The behavioral health services funded by the DBH include inpatient and outpatient treatment services, residential and outpatient rehabilitative services, and support services including services provided by peers.

Table 6.2: Core Services Offered by Nebraska Division of Behavioral Health[52]

Mental Health	Substance Use	Dual
Community Support	Community Support	Dual Residential
Flex Fund	Flex Fund	Emergency Community Support
Day Rehabilitation	Intensive Outpatient	
Outpatient Counseling (Adult/Youth)	Outpatient Counseling (Adult/Youth)	
Emergency Protective Custody	Short Term Residential	
Acute Hospital Inpatient	Prevention Services	
Crisis Response		
Sub-Acute Hospital		
Medication Management		
Professional Partner		
Supported Employment		
Housing Related Assistance		

Network Management and System Expectations

The Behavioral Health Regions annually submit a plan for service provision and finance to DBH for approval. The plan covers the expectations related to network management and various system expectations.

- Network Management
- Quality Improvement Coordination
- Prevention System Coordination
- Youth System Coordination
    - Wraparound services for youth (Professional Partner Program)
- Housing Coordination
- Consumer System Coordination
- Emergency System Coordination

Evidence-Based Practice

The Division of Behavioral Health (DBH) provides guidelines for evidence-based practice (EBPs) in the fiscal budget plan guidelines to the Regional Behavioral Health Authorities (RBHAs).[52]

EPBs are defined by DBH as a set of preventive, treatment and support activities that evaluation research has shown to be effective and that has been included in one or more of three categories:

- Included in Federal registries of evidence-based interventions;
- Reported (with positive effects on the primary targeted outcome) in peer-reviewed journals; or
- Documented effectiveness supported by other sources of information and the consensus of informed experts.

In 2016, the DBH conducted a survey to assess the use of EBPs by the agencies funded by DBH (**Table 6.3**). Twenty-five agencies provided information about EBPs for adult mental disorders. Most commonly used EBPs are Seeking Safety, Dialectical Behavioral Therapy, Wellness Recovery Action Plan, Trauma-Focused Cognitive Behavioral Therapy, Eye Movement Desensitization, and Reprocessing and Cognitive Behavioral Social Skills Training.

Table 6.3: The Use of Evidence-Based Practices by Funded Agencies Participated in the Survey: Adult Mental Health Disorders in the State of Nebraska, 2016 (N=25)

Number of Programs Reporting Use of EBPs	Age Groups Participating in EBP with Agency		
	18-25	26-54	55+
Acceptance and Commitment Therapy	3	3	3
Acceptance-Based Behavioral Therapy for Generalized Anxiety Disorder	1	1	1
Celebrating Families!	1	1	0
Cognitive Behavioral Social Skills Training	8	8	7
Cognitive Behavioral Therapy for Adolescent Depression	6	1	1
Acceptance and Commitment Therapy	3	3	3
Acceptance-Based Behavioral Therapy for Generalized Anxiety Disorder	1	1	1
Celebrating Families!	1	1	0
Cognitive Behavioral Social Skills Training	8	8	7
Cognitive Behavioral Therapy for Adolescent Depression	6	1	1
Cognitive Behavioral Therapy for Late-Life Depression	1	1	6
Cognitive Enhancement Therapy	1	1	1
Critical Time Intervention	1	1	1
Depression Prevention (Managing Your Mood)	5	5	5
Dialetical Behavior Therapy	10	10	10
Eye Movement Desensitization and Reprocessing	9	9	9
Family Behavior Therapy	7	7	6
ICCD Clubhouse Model	1	1	1
Incredible Years	1	1	0
Interactive Journaling	2	2	2
Mindfulness-Based Cognitive Therapy	3	3	2
Mindfulness-Based Stress Reduction	3	3	2
Modified Therapeutic Community for Persons with Co-Occurring Disorders	1	1	1
National Alliance on Mental Illness (NAMI) Family-to Family Education Program	1	1	1

Nurturing Parenting Programs	2	2	1
OQ-Analyst	1	1	1
Panic Control Treatment (PCT)	1	1	1
Partners for Change Outcome Management System: The Heart and Soul of Change Project	1	1	1
Pathway's Housing First Program	1	1	1
Program of All-Inclusive Care for the Elderly (PACE)	1	1	1
Psychiatric Rehabilitation Process Model	2	2	2
Psychoeducational Multifamily Groups	1	1	0
Relationship-Based Care	7	7	6
Seeking Safety	12	13	12
Six Core Strategies to Prevent Conflict and Violence: Reducing the Use of Seclusion and Restraint	1	1	1
Systems Training for Emotional Predictability and Problem Solving	2	2	2
Telemedicine-Based Collaborative Care	5	5	5
Trauma Affect Regulation: Guide for Education and Therapy (TARGET)	1	1	1
Trauma Recovery and Empowerment Model	2	2	2
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)	8	7	6
Traumatic Incident Reduction	1	1	1
Wellness Recovery Action Plan (WRAP)	8	9	9

Data in this table were provided by the Nebraska Department of Health & Human Services Division of Behavioral Health

Table 6.4 shows the results on EBPs for adult substance use disorders reported by 25 agencies. Motivational Interview, Seeking Safety, Relapse Prevention Therapy, and Twelve-Step Facilitation Therapy are some of most commonly used practices.

Table 6.4: The Use of Evidence-Based Practices by Funded Agencies Participated in the Survey: Adult Substance Use Disorders in the State of Nebraska, 2016 (N=25)

Number of Programs Reporting Use of EBPs	Age Groups Participating in EBP with Agency		
	18-25	26-54	55+
A Woman's Path to Recovery	3	3	3
Alcohol Behavioral Couple Therapy	1	1	1
Behavioral Couples Therapy for Alcoholism and Drug Abuse	4	4	4
Brief Marijuana Dependence Counseling	3	3	3
Brief Strengths-Based Case Management for Substance Abuse	5	5	4
Broad Spectrum Treatment (BST) and Naltrexone for Alcohol Dependence	2	2	2
Cocaine-Specific Coping Skills Training	1	1	1
Contracts Prompts and Reinforcement of Substance Use Disorder Continuing Care (CPR)	1	1	1
Customized Employment Supports	3	3	3
Family Behavior Therapy	5	5	5
Functional Family Therapy for Adolescent Alcohol and Drug Abuse	1	1	1
Interactive Journaling	3	4	4
Interim Methadone Maintenance	1	1	1
Living in Balance	1	1	1
Matrix Model	5	5	5
Modified Therapeutic Community for Persons with Co-Occurring Disorders	1	1	1
Motivational Enhancement Therapy	7	7	7
Motivational Interviewing	17	17	17

Network Therapy	1	1	1
OQ-Analyst	1	1	1
Pathways' Housing First Program	1	1	1
Prize Incentives Contingency Management for Substance Abuse	1	1	0
Recovery Training and Self-Help	4	4	4
Relapse Prevention Therapy (RPT)	9	9	9
Seeking Safety	11	11	10
Service Outreach and Recovery	1	1	1
Solution-Focused Group Therapy	6	6	6
Supportive-Expressive Psychotherapy	1	1	1
Trauma Recovery and Empowerment Model (TREM)	3	3	3
Twelve Step Facilitation Therapy	8	8	8

Data in this table were provided by the Nebraska Department of Health & Human Services Division of Behavioral Health

A total of 13 agencies provided the information about EBPs for youth mental health disorders (**Table 6.5**). Unlike the EBPs for adults, there was no specific EBP that was more commonly used except Trauma-Focused Cognitive Behavioral Therapy which was used by 3-6 agencies (depending on the age groups).

Table 6.5: The Use of Evidence-Based Practices by Funded Agencies Participating in the Survey: Youth Mental Health Disorders in the State of Nebraska, 2016 (N=13)

Number of Programs Reporting Use of EBPs	Age Groups Participating in EBP with Agency		
	0-5	6-12	13-17
Brief Strategic Family Therapy	0	0	3
Family Behavior Therapy	1	3	4
Family Support Network	0	0	1
Attachment Based Family Therapy	1	2	2
Brief Strategic Family Therapy	1	2	3
Cognitive Behavioral Therapy for Adolescent Depression	1	5	6
Celebrating Families	2	2	2
Child and Family Traumatic Stress Intervention	3	2	3
Coping Cat	1	1	1
Child-Parent Psychotherapy	2	2	2
Cognitive Processing Therapy for Posttraumatic Stress Disorder	1	3	4
Adolescent Coping with Depression	0	1	2
Family Behavior Therapy	1	3	4
Grief and Trauma Intervention for Children	1	1	1
HeartMath	2	2	2
Incredible Years	1	1	0
Interpersonal Psychotherapy for Depressed Adolescents	1	1	1
Multisystematic Therapy for Juvenile Offenders	0	1	1
Mindfulness-Based Stress Reduction	0	1	2
Multi-Family Psychoeducational Psychotherapy	1	1	1
Multisystematic Therapy for Youth with Problem Sexual Behaviors	1	1	1
Multisystematic Therapy with Psychiatric Supports	1	1	2
Nurturing Parenting Problems	2	2	1
Parent-Child Interaction Therapy	2	3	1
Parenting with Love and Limits	1	1	1

Preschool PTSD Treatment	1	0	0
Real Life Heroes	1	1	1
Seeking Safety	0	1	4
Trauma-Focused Cognitive Behavioral Therapy	3	6	6
Trauma Focused Coping (Multimodality Trauma Treatment)	1	1	1

Data in this table were provided by the Nebraska Department of Health & Human Services, the Division of Behavioral Health.

Number of Consumers Served through DBH Funded Programs

Annual Number of Consumers Served

Table 6.6 shows the unduplicated number of consumers served through the Division of Behavioral Health (DBH) funded programs in Fiscal Years (FYs) 2013, 2014, and 2015. In FY 2013 and FY 2014, close to 32,000 consumers were served. DBH improved reporting accuracy in its data system by administratively discharging nearly 30,000 records of admission which had no activity for over one year thus reducing the overall number of active cases in the data system for persons receiving services. In subsequent review of FY 2014 data, it was determined that this administrative discharge accounts for what appears to be, the decreasing number of persons served in FY 2015 (N=28,116).

In FY 2015, 8.1% (n=2,289) consumers were 18 years or younger and 16.5% (n=4,651) were young adults aged 19-24. Persons 55 and older were 10.7% of the consumer population. The remaining 64.7% were persons aged 25-54. A little over half (55.7%) of the consumers were male. The majority (74.2%) of consumers were Non-Hispanic whites, 8.2% were Non-Hispanic African Americans, 9.1% were Hispanics of any race, and 2.3% were Non-Hispanic American Indians/Alaska Natives. Behavioral Health Region 6 had the highest percentage of consumers (33%, n=9,289), followed by Region 5 (28.7%, n=8,058), Region 3 (17.3%, n=4,864), Region 4 (10.7%, n=3,015), Region 2 (5.5%, n=1,559), and Region 1 (3.8%, n=1,059).

Table 6.6: Unduplicated Number of Consumers Served in Division of Behavioral Health Funded Programs in FY2013, 2014 and 2015

	FY2013	FY2014	FY2015
Total	31,974	31,994	28,116
Age			
0-18 years	2,482	2,745	2,289
19-24 years	5,081	4,923	4,651
25-34 years	8,526	8,474	7,797
35-44 years	6,293	6,292	5,411
45-54 years	6,102	5,947	4,969
55-64 years	2,928	3,017	2,547
65+ years	555	593	452
Unknown	7	3	0
Gender			
Female	14,470	14,395	12,445
Male	17,504	17,599	15,671
Race/Ethnicity			
NH White	24,010	23,917	20,856
NH Black/African American	2,657	2,653	2,294
NH Native American/Alaska Native	957	845	653
NH Asian	205	223	202
NH Native Hawaiian/Other Pacific Islander	101	101	80

NH Multiracial	240	265	206
Hispanic (any race)	2,453	2,617	2,557
Unknown	1,351	1,373	1,268
Region of Residence			
1	1,586	1,314	1,059
2	1,933	1,923	1,559
3	5,112	5,387	4,864
4	3,045	3,479	3,015
5	8,945	8,966	8,058
6	10,927	10,564	9,289
Out of State or Unknown	426	361	272
NH=Non-Hispanic			

This table was provided by Nebraska Department of Health & Human Services Division of Behavioral Health

Table 6.7 shows the number of consumers receiving services on March 31 in 2014, 2015, and 2016. These are snap-shots from March 31 of DBH funded consumers. On March 31, 2014, there were a total of 9,939 unduplicated consumers who received mental health or dual services, while 3,272 unique consumers received services substance use or dual services. These numbers increased over time between 2014 and 2016. On March 31 of 2016, there were a total of 12,540 consumers receiving mental health or mental health dual services while 3,938 consumers were receiving substance use and substance use dual services.

Table 6.7: Annual Review of Unduplicated in MH and Dual / SU and Dual Service Counts of Division of Behavioral Health Funded Consumers on March 31st by Region and Statewide: 2014-2016

Region of Residence*	2014 March 31		2015 March 31		2016 March 31	
	MH and Dual	SU and Dual	MH and Dual	SU and Dual	MH and Dual	SU and Dual
Region 1	398	91	403	85	383	108
Region 2	722	169	750	196	940	283
Region 3	1,817	725	1,906	711	2,493	813
Region 4	1,271	428	1,397	561	1,666	618
Region 5	2,346	835	2,452	904	3,275	973
Region 6	3,266	978	3,206	899	3,687	1,095
Out of state / Unknown	172	65	182	72	226	68
State*	9,939	3,272	10,229	3,414	12,540	3,938

MH=Mental Health. SU=Substance Use.
These counts are point in time count and do not represent all in serviced during the given year.
*All numbers are unduplicated totals so the statewide total will not match the sum of the individual regions.

This table was provided by Nebraska Department of Health & Human Services Division of Behavioral Health.

Table 6.8 presents the number of Medicaid-only consumers in Medicaid Rehabilitation Option (MRO) and Substance Abuse Waiver services on March 31 in 2014, 2015, and 2016. Again, the number of

consumers receiving mental health and substance use services through Medicaid increased from 2014 to 2016.

Table 6.8: Annual Review of Unduplicated in Medicaid Rehabilitation Option and Substance Abuse Waiver Services Count of Medicaid Only Consumers on March 31st by Region and Statewide: 2014-2016

Region of Residence*	2014 March 31		2015 March 31		2016 March 31	
	MH	SU	MH	SU	MH	SU
Region 1	71	6	85	6	83	7
Region 2	113	23	99	16	77	11
Region 3	211	20	215	20	170	13
Region 4	140	35	158	36	138	41
Region 5	450	45	516	46	500	47
Region 6	647	52	726	46	726	51
Out of state / Unknown	43	5	33	4	15	3
State*	1675	186	1832	174	1709	173

MH=Mental Health. SU=Substance Use.
These counts are point in time count and do not represent all in serviced during the given year.
*All numbers are unduplicated totals so the statewide total will not match the sum of the individual regions.

This table was provided by Nebraska Department of Health & Human Services Division of Behavioral Health.

Public Behavioral Health System Expenditures

Nebraska Expenditures

The expenditures for mental health and substance use disorders for the previous three years are reflected in **Table 6.9**. These funds include state and federal revenues supporting community based treatment, recovery, and prevention initiatives in Nebraska as well as work force training and development activities. In 2016, the expenditure for the Division of Behavioral Health (DBH) funded public behavioral system in Nebraska was over $94,000,000 for mental health and substance use disorder services combined (**Table 6.9**). This was a considerable increase compared to the 2014 expenditure of about $86,000,000.

Table 6.9: Nebraska's Mental Health & Substance Use Disorder Program Expenditures: FY 2014-2016

Service	2014	2015	2016
Mental Health	55,760,743.04	56,632,592.15	60,383,501.62
Substance Use	30,127.033.76	32,161,577.78	33,737,609.80
Total	85,887,746.80	88,794,169.93	94,121,111.42

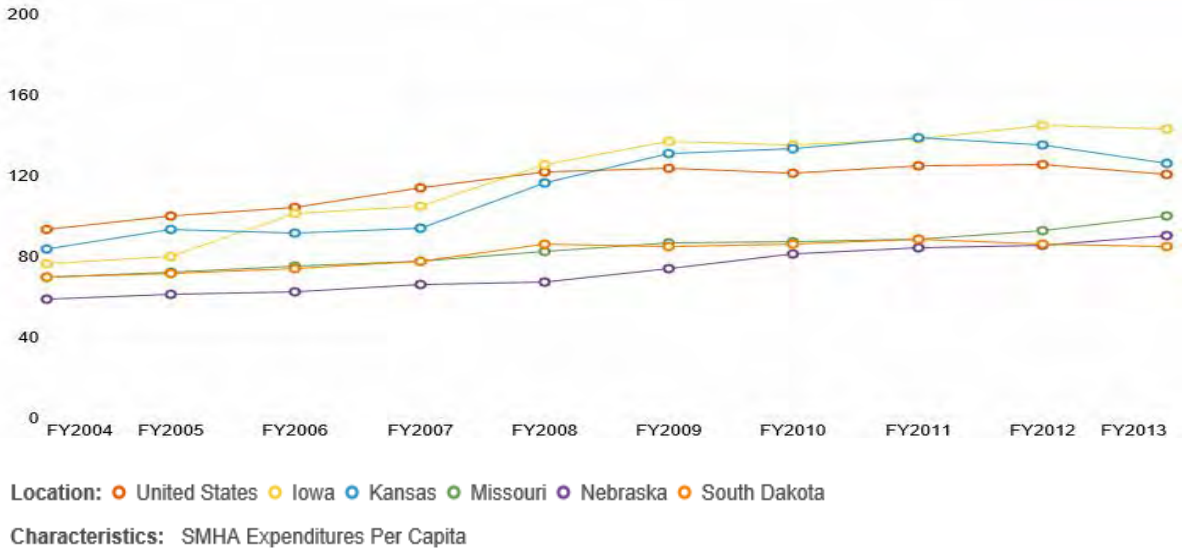
Data for this table were provided by the Nebraska Department of Health & Human Services Division of Behavioral Health.

National Trends on Expenditures

The National Association of State Mental Health Program Directors Research Institute, Inc. (NRI) collects and analyzes data on state mental health programs.

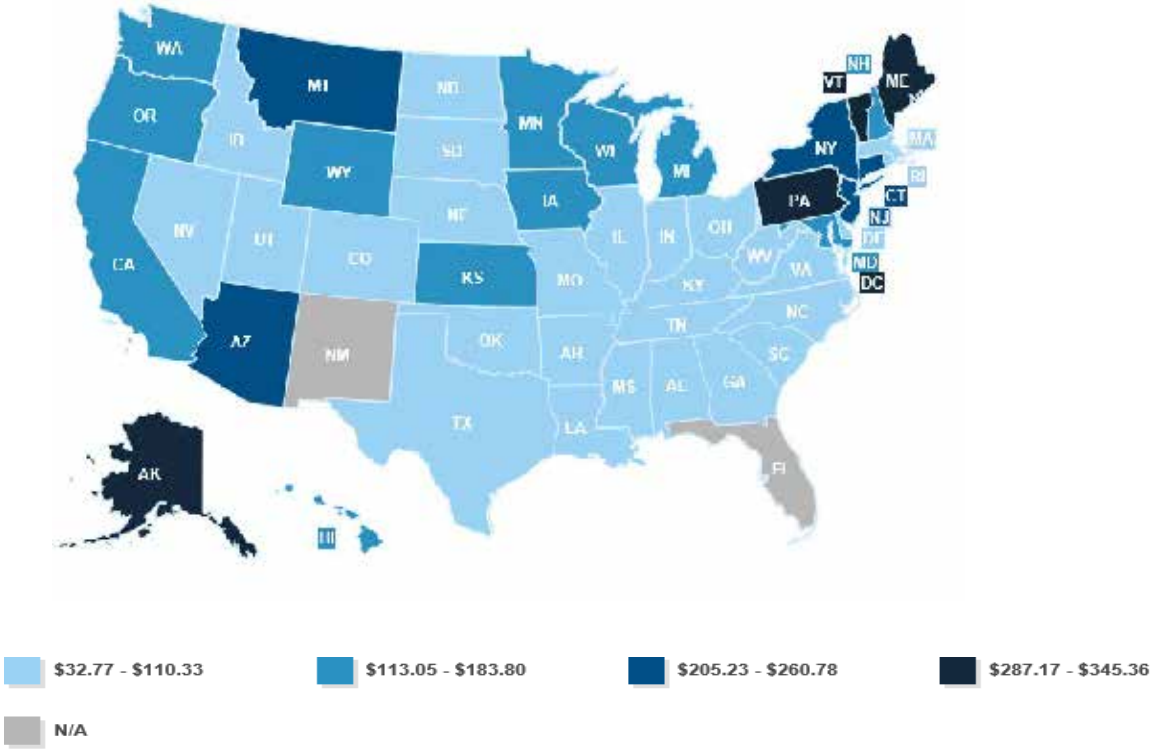
Figure 6.2 shows the state mental health agency per capita expenditures from Fiscal Years 2004 to 2013 in Nebraska, other Midwest states, and the national average. In alignment with the national and regional trend, Nebraska's per capita expenditure increased during this period, although it still ranks well below the national average and below other Midwestern states except South Dakota.[53]

Figure 6.2: State Mental Health Agency Per Capita Mental Health Services Expenditures in Millions, FY 2004-2013[53]



Mental health services expenditures vary considerably across the United States (**Figure 6.3**). [53]

Figure 6.3: State Mental Health Agency Per Capita Mental Health Services Expenditures in Millions, FY 2013[53]



Between FY 2001 and FY 2013, expenditure increased by 92.1% nationwide from $81.00 to $119.62 per million. During the same period, the expenditure for Nebraska increased by 77.3% from $56.00 to $77.30 per million (**Table 6.10**).[53]

Table 6.10: FY 2001, FY 2012, FY 2013 State Mental Health Agency-Controlled Mental Health Expenditures Per Capita[53]

State	State Psychiatric Hospital-Inpatient FY'01	FY'12	FY'13	% Change FY'01-13	Community MH FY'01	FY'12	FY'13	% Change FY'01-13	Total SMHA-Controlled FY'01	FY'12	FY'13	% Change FY'01-13	Notes
Alabama	$23.3	$27.6	$20.6	-11.6%	$32.0	$46.9	$50.4	57.4%	$55.3	$76.3	$72.5	27.6%	
Alaska	$27.9	$45.4	$44.5	59.6%	$50.7	$287.9	$287.7	467.5%	$83.7	$335.4	$341.1	307.3%	
Arizona	$6.6	$10.7	$10.4	18.3%	$78.7	$185.0	$192.1	144.2%	$85.5	$209.4	$205.2	139.4%	
Arkansas	$6.7	$18.8	$17.8	166.1%	$18.9	$29.0	$25.7	40.1%	$25.2	$45.1	$43.6	61.5%	a
California	$16.6	$46.0	$43.9	165.1%	$74.1	$133.7	$126.5	70.4%	$90.5	$169.6	$160.5	75.2%	b
Colorado	$19.0	$21.1	$21.8	15.0%	$44.8	$73.9	$76.0	69.8%	$64.1	$95.0	$98.8	54.1%	ab
Connecticut	$51.6	$69.7	$65.7	26.9%	$78.1	$144.8	$151.3	93.6%	$128.4	$214.4	$216.8	68.8%	ac
Delaware	$79.6	$42.5	$37.2	-53.3%	$31.2	$85.0	$56.7	81.8%	$92.9	$100.0	$98.5	5.8%	c
District of Columbia	$179.0	$158.0	$129.6	-27.9%	$214.8	$125.4	$112.0	-47.9%	$394.7	$305.4	$305.9	-22.5%	
Florida	$20.1	$21.0	NR		$19.1	$19.6	NR		$35.5	$37.3	NR		
Georgia	$20.6	$27.9	$28.3	36.0%	$22.1	$35.3	$36.1	72.3%	$45.5	$58.1	$59.3	30.2%	b
Hawaii	$36.2	$55.5	$57.0	49.2%	$129.8	$79.9	$81.9	-38.8%	$181.9	$131.2	$131.8	-27.5%	
Idaho	$16.7	$16.6	$16.4	-2.3%	$28.4	$14.3	$14.7	-48.2%	$45.0	$32.5	$32.8	-28.6%	
Illinois	$24.6	$27.3	$24.2	-1.6%	$37.3	$52.1	$52.2	40.1%	$63.3	$74.9	$72.1	14.5%	
Indiana	$24.0	$23.5	$23.3	-2.7%	$42.7	$46.[illegible]	$46.5	9.0%	$67.3	$70.6	$70.7	5.0%	
Iowa	$12.3	$12.0	$13.[illegible]	8.4%	$38.5	$130.2	$127.8	223.1%	$52.0	$143.8	$142.1	173.7%	
Kansas	$21.4	$32.6	$45.1	110.6%	$38.0	$101.4	$91.5	140.7%	$60.3	$134.5	$125.5	108.1%	
Kentucky	$33.0	$34.2	$34.6	4.9%	$22.9	$28.5	$26.0	13.8%	$45.7	$55.1	$55.1	13.1%	
Louisiana	$26.2	$27.2	$23.6	-9.8%	$18.2	$29.0	$27.7	52.3%	$45.2	$65.5	$55.5	22.7%	
Maine	$12.1	$48.0	$44.0	**	$69.8	$293.[illegible]	$301.3	**	$107.4	$338.2	$345.1	**	b
Maryland	$36.1	$39.2	$40.7	6.7%	$83.2	$140.2	$132.9	59.7%	$127.0	$184.6	$178.9	40.9%	b
Massachusetts	$19.2	$13.8	$13.7	-28.4%	$84.1	$92.7	$93.5	11.2%	$108.5	$108.6	$110.3	3.5%	a
Michigan	$29.5	$23.4	$25.3	-14.2%	$64.0	$95.[illegible]	$124.1	92.9%	$84.4	$120.1	$130.1	54.1%	
Minnesota	$31.1	$20.8	$21.9	-29.6%	$72.2	$146.2	$151.6	111.0%	$101.0	$168.1	$177.9	71.1%	
Mississippi	$51.9	$45.1	$39.8	-23.2%	$34.1	$60.3	$58.1	70.4%	$67.3	$106.6	$99.3	74.1%	
Missouri	$30.1	$37.7	$40.8	36.3%	$28.8	$59.9	$55.2	105.0%	$69.8	$92.2	$89.4	86.3%	
Montana	$26.7	$27.1	$29.5	2.8%	$96.0	$168.7	$175.4	79.9%	$123.9	$197.9	$209.3	68.2%	
Nebraska	$32.1	$33.5	$32.2	0.6%	$17.8	$58.3	$64.2	265.1%	$50.8	$84.8	$89.7	77.3%	
Nevada	$20.6	$23.8	$23.8	14.2%	$36.2	$53.9	$63.3	74.7%	$57.8	$59.4	$69.4	55.2%	
New Hampshire	$33.6	$40.7	$61.4	66.8%	$78.7	$83.9	$98.1	25.2%	$111.8	$138.1	$138.4	23.8%	
New Jersey	$35.0	$60.5	$80.4	129.6%	$52.4	$140.0	$144.0	169.9%	$89.9	$210.6	$209.9	132.3%	
New Mexico	$12.1	$15.8	NR		$20.2	$119.7	NR		$32.5	$131.4	NR		d
New York	$52.1	$66.4	$61.9	18.9%	$119.0	$191.0	$197.5	61.7%	$174.9	$205.6	$260.9	49.2%	b
North Carolina	$37.0	$28.7	$32.8	-11.3%	$17.2	$103.8	$63.0	266.3%	$54.8	$134.8	$97.1	77.8%	
North Dakota	$35.0	$18.6	$18.0	-49.5%	$42.0	$67.4	$70.4	65.9%	$78.3	$86.2	$88.5	11.7%	
Ohio	$22.8	$18.3	$18.6	18.1%	$41.3	$72.0	$78.1	89.3%	$65.8	$92.8	$100.3	54.9%	a
Oklahoma	$11.6	$13.9	$14.2	19.9%	$25.4	$39.5	$39.4	54.9%	$39.6	$54.2	$53.9	35.9%	
Oregon	$23.3	$56.6	$76.8	228.6%	$53.4	$123.5	$121.6	264.1%	$85.2	$177.8	$183.8	215.9%	
Pennsylvania	$42.5	$35.6	$34.7	-18.3%	$117.9	$200.[illegible]	$250.0	119.7%	$151.4	$295.1	$287.2	89.6%	a
Rhode Island	$29.4	$44.3	$45.4	54.6%	$58.3	$69.0	$58.3	8.1%	$87.7	$108.3	$105.1	21.6%	***
South Carolina	$27.0	$20.3	$20.7	-23.2%	$43.3	$23.7	$34.7	-19.8%	$74.4	$57.1	$59.4	-21.5%	
South Dakota	$40.8	$51.5	$51.3	26.7%	$18.0	$32.2	$32.1	83.5%	$60.8	$83.6	$84.1	38.1%	
Tennessee	$22.1	$23.6	$19.4	-12.2%	$44.9	$69.0	$65.9	46.7%	$66.9	$88.6	$87.0	27.0%	
Texas	$14.4	$13.8	$14.7	2.0%	$21.8	$23.9	$24.7	13.4%	$37.6	$38.1	$40.5	8.2%	b
Utah	$18.1	$18.2	$18.2	2.3%	$51.1	$45.8	$52.0	1.8%	$69.7	$64.4	$70.3	1.7%	b
Vermont	$20.5	$37.5	$22.1	7.4%	$110.9	$213.0	$253.6	127.5%	$130.2	$253.3	$291.7	124.0%	
Virginia	$39.4	$40.8	$41.7	5.8%	$23.1	$49.0	$47.4	105.0%	$62.5	$92.5	$92.0	39.0%	b
Washington	$28.3	$31.6	$31.6	11.6%	$56.2	$70.3	$80.0	37.4%	$85.5	$113.0	$113.7	28.4%	
West Virginia	$26.3	$34.6	$38.6	46.8%	$27.0	$58.[illegible]	$63.5	135.5%	$49.5	$83.9	$94.4	94.9%	a
Wisconsin	$20.3	$35.3	$35.1	72.7%	$54.3	$67.5	$77.8	43.3%	$75.0	$102.9	$113.1	50.8%	b
Wyoming	$26.7	NA	$82.7	194.8%	$33.1	$52.3	$54.2	63.7%	$61.9	$111.5	$118.8	95.2%	a
Total	$26.6	$32.6	$30.6	17.5%	$53.3	$63.9	$60.5	62.3%	$87.0	$126.2	$121.2	92.1%	
Average(Mean)	$31.3	$34.7	$35.9	23.4%	$52.8	$83.4	$86.1	80.0%	$84.4	$120.4	$132.8	50.1%	
Median	$26.7	$30.7	$32.2	6.7%	$42.6	$69.0	$70.4	69.6%	$68.9	$106.3	$100.3	49.2%	
State Reporting	51	51	0	51	51	51	0	51	51	51	0	51	
State Increasing				32				45				45	
State Decreasing				17				4				4	

N=Expenditures reported but inter-jurisdictional comparisons are not feasible

NR = Not Reported

a = Medicaid Revenues for Community Programs are not included in SMHA Controlled Expenditures

b = SMHA Controlled Expenditures include funds for mental health services in jails or prisons

c = Children's Mental Health Expenditures are not included in SMHA Controlled Expenditures

d = The New Mexico State system withdrew since FY07, and as a result they reported a significant increase in mental health funding compared with prior years. This is an artifact of the state reorganization and not any significant increase in mental health.

** In FY2002 Maine instituted a more comprehensive methodology to calculate revenues and expenditures. This methodology change accounts for the large increase in expenditures between FY2001 and current reporting. For that reason, change in expenditures between FY2001 and present are not reported.

*** Rhode Island does not have a state psychiatric hospital. Reported figures are expenditures expended for psychiatric services at a state-run hospital (Eleanor Slater Hospital).

Services Capacity and Wait Times

Review of Community-Based Services Wait List

The Division of Behavioral Health (DBH) annually contracts with the six Regional Behavioral Health Authorities (RBHAs) to develop and manage a comprehensive, continuous and integrated system of care and services for mental health and substance use disorder treatment, prevention, rehabilitative and support services with sufficient capacity for their designated geographic area. RBHAs ensure that persons on the "Waiting List" are admitted into treatment at the earliest possible time, to the most appropriate level of care, and within a reasonable geographic area that is acceptable to the consumer. RBHAs also ensure that their provider network is able to provide the federally mandated substance use prevention services and substance use treatment services to meet federally required timeframes for priority populations. Wait list and capacity information collected from providers also assists DBH and RBHAs to be effective stewards of public funding, since both inform network decision making regarding services purchased.

Background on Wait List Reporting

Per Block Grant funding requirements, states are required to have a waiting list management system to report waiting times and use of interim services for those identified as meeting Federal Substance Use Disorder priority populations (Pregnant & Injecting Drug Users, Pregnant Substance Users, and Injecting Drug Users).

In Nebraska, DBH funded behavioral health providers are required to submit weekly waitlist reports on these Federally identified Substance Use Disorder priority populations waiting for services along with current region capacity and for the agency overall. Additionally in Nebraska, priority is given to and data reported by providers for Women with Dependent Children and persons with a Mental Health Commitment waiting for treatment.

While current weekly report submissions are focused primarily on these priority populations, wait list and capacity considerations were included in the development of the DBH's Centralized Data System (CDS) to create a process that allows providers to easily capture wait information for all populations waiting for treatment across all behavioral health service types. Until waitlist function is fully activated, it should be noted that waitlist times are most available and reliable for describing priority populations waiting for treatment into substance use disorder services and that capacity is most reliably captured for bed-based services.

Community-Based Substance Use Disorder Services

As shown in **Table 6.11**, in FY 2016, there were 488 unique waits for service and 427 unique persons waited for service (some people were counted more than once because they were waiting for multiple services or they waited at different times for services). Wait times ranged from 0-134 days with an average wait of 19.5 days. Range and average wait days were calculated using only cases that had a wait list removal date (n=436). 62.5% of waits were for Short-Term Residential Services.

Table 6.11: Count of Unique Waits and Average Wait Days by Region, FY2016

Behavioral Health Region	N (includes all unique waits)	Average Wait Days
1	0	0.0
2	21	21.6
3	67	14.9
4	108	21.5
5	231	17.6
6	61	28.8
Grand Total	488	19.5

Average wait days calculation includes only cases with a wait list removal.

This table was provided by Nebraska Department of Health & Human Services Division of Behavioral Health

Table 6.13 shows the average wait days by substance use disorder service and priority population for FY 2016. The average wait day was longest for outpatient service (37.3 days) followed by therapeutic community service (37.1 days), and then halfway house (31.7 days). The average wait day was the longest for women with dependent children (24.7 days). Within this group, the wait was particularly long for therapeutic community service (41.9 days) and for outpatient service (37.3 days).

Table 6.12: Average Wait Days by Substance Use Disorder Service and Priority Population, FY2016

Substance Use Disorder Service	Priority Population					
	1 (P/IV)	2 (P)	3 (IV)	4 (WW/DC)	5 (MHBC)	Average Wait Days by Service
Community Support	-	-	-	20.0 (n=20)	-	20.0
Dual Disorder Residential	-	17.0 (n=1)	21.3 (n=17)	3.0 (n=1)	14.6 (n=16)	18.0
Halfway House	-	-	31.7 (n=39)	-	-	31.7
Intensive Outpatient	-	-	6.8 (n=4)	9.1 (n=11)	-	8.1
Intermediate Residential	-	-	15.6 (n=5)	4.0 (n=1)	6.0 (n=1)	12.6
Outpatient	-	-	-	37.3 (n=10)	-	37.3
Short-Term Residential	8.0 (n=2)	9.7 (n=11)	14.5 (n=151)	18.8 (n=92)	6.8 (n=27)	15.0
Therapeutic Community	-	-	24.8 (n=20)	41.9 (n=37)	21.0 (n=2)	37.1
Average Wait Days by Priority Population	8.0	10.3	18.6	24.7	10.1	19.5

P/IV=Pregnant IV user. P=Pregnant. IV=IV user. WW/DC=Women With Dependent Child. MHBC=Mental Health Board Commitment.
Some clients were in more than one priority population.

This table was provided by Nebraska Department of Health & Human Services Division of Behavioral Health

Capacity reporting is included in weekly reports from providers and is currently under review by DBH to ensure accuracy, given that this functionality and reporting capability is further developed for use in the CDS across all services. Current reporting on capacity is most accurate and reliable for bed-based services. Agency Capacity describes the annual average of the percent of overall agency beds being used. Region Capacity describes the annual average of the percent of beds being used by Regions of those originally budgeted and allocated for Region use, meaning the percent can exceed 100% as bed availability exists at the agency level.

Table 6.13 shows the agency and region capacity for bed-based services from FY2014 to FY2016. With the exception of secure residential services in FY2015, all bed-based services were at near or above capacity at both agency and region levels. Psychiatric residential capacity at the regional level has been between 126% and 162% during the last 3 fiscal years. Also at the regional level, halfway house, intermediate residential and short-term residential services for substance use disorders has been near or slightly above 100% in the past 3 fiscal years.

Table 6.13: Agency and Region Capacity for Mental Health and substance Use Disorder Bed-Based Services

	FY2014		FY2015		FY2016	
Mental Health Services	Agency Capacity*	Region Capacity**	Agency Capacity*	Region Capacity**	Agency Capacity*	Region Capacity**
Psychiatric Residential Rehab	91.6%	149.1%	86.5%	125.7%	93.7%	162.2%
Secure Residential	99.5%	36.3%	96.1%	51.5%	92.9%	126.2%
Substance Use Disorder Services	Agency Capacity	Region Capacity	Agency Capacity	Region Capacity	Agency Capacity	Region Capacity
Dual Disorder Residential	96.5%	90.8%	96.0%	95.4%	90.3%	87.8%
Halfway House	93.2%	100.0%	93.2%	102.8%	90.6%	100.9%
Intermediate Residential	88.3%	90.3%	90.9%	130.3%	84.1%	103.7%
Short-Term Residential	73.2%	98.0%	72.4%	105.8%	71.5%	105.9%
Therapeutic Community	83.8%	86.1%	89.1%	102.8%	91.2%	85.6%

Data source is weekly waitlist and capacity from provider/region reports.
*Agency Capacity describes the annual average of the percent of overall agency beds being used.
** Region Capacity describes the annual average of the percent of beds being used by Regions of those originally budgeted and allocated for Region use, meaning the percent can exceed 100% as bed availability exists at the agency level.

This table was provided by Nebraska Department of Health & Human Services Division of Behavioral Health

Review of Court-Ordered Competency Restoration

In 2014, at the Lincoln Regional Center there were a total of 47 admissions under court-ordered competency restoration **(Table 6.14).** The average restore time, defined as the time between admission and a letter generated stating the opinion about whether the individual is competent or not restorable, was 96.6 days, and the average hearing time, defined as the time between the letter being sent and discharge

after the resulting order was received, was 33.6 days. Note that calculation of the average hearing time includes only cases in which the letter has been sent and the patient has been discharged. The average length of stay, defined as the time between discharge date and admission date, was 128.2 days. Note the calculation of the average length of stay included only cases which were discharged. The 2016 data through 8/4/16 indicates that there was an improvement for all three indicators: average restoration time, average hearing time, and average length of stay all decreased compared to the calendar 2014 data.

Table 6.14: Average Timeframes (in Days) for All Admissions into Lincoln Regional Center Under Court-Ordered Competency Restoration

Calendar Year of Admission	Number of Admissions	Average Days from Order to Admission	Average Restore Time[1]	Average Hearing Time[2]	Average Length of Stay[3]
2014	47	33.4	96.6	33.6	128.2
2015	56	47.8	121.5	34.3	153.8
2016 (through 8/4/16)	43	33.2	88.6	16.4	103.0

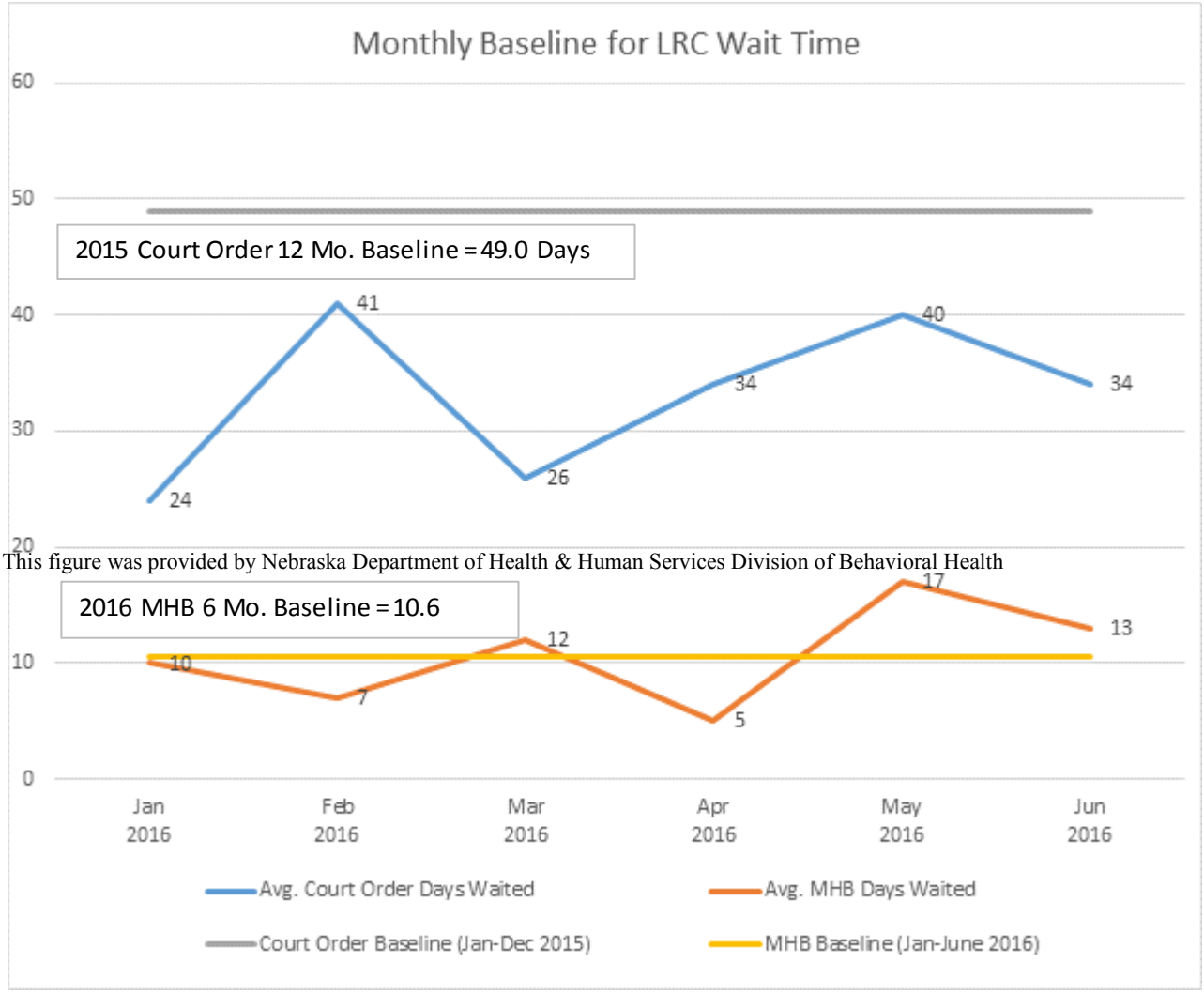
[1]Time between admission and letter being sent with the opinion the individual is competent/not restorable.
[2]Time between letter being sent and the discharge data after order was received. Includes only cases in which letter has been sent and individual has been discharged (i.e., have a discharge data).
[3]Time between discharge date and admission date. Calculation includes only cases which have been discharged (i.e., have a discharge date). All cases in 2014 and 2015 have been discharged and are, therefore, all included in the Length of Stay calculation. However, of the 43 admissions, only 18 have been discharged as of 8/4/16 and are included in the Average Length of Stay calculation.

This table was provided by Nebraska Department of Health & Human Services Division of Behavioral Health

Review of Wait Times for Admission into Lincoln Regional Center (LRC)

Since January 2016, 8 Mental Health Board (MHB) Committed people in community based hospitals came to LRC on an emergency basis. The average time to admission was 0.875 days (less than 1 day). **Figure 6.4** shows that the average wait times for those with a MHB Commitment typically are below 14 days before admission into LRC. Collection of wait days in the LRC data system for MHB Committed people did not begin until late 2015, thus the first six months of data in 2016 for MHB Committed people has been used to establish a baseline average of 10.6 waiting days (**Table 6.15**). Average wait times in 2016 for those Court Ordered are consistently below the 49.0 day wait average from 2015 for Court Ordered admission into LRC.

Figure 6.4: Monthly Baseline for Lincoln Regional Center Wait Time



This figure was provided by Nebraska Department of Health & Human Services Division of Behavioral Health

Table 6.15: Court Order and Mental Health Board Days Waited January-June 2016

	Jan 2016	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016
Avg. Court Order Days Waited	**24**	**41**	**26**	**34**	**40**	**34**
Number Court Ordered Admitted	5	6	10	5	8	11
Number Admitted < or = 21 days	2	0	2	1	1	3
Number Admitted < or = 14 days	2	0	2	1	1	1
Number Admitted < or = 7 days	1	0	2	0	1	1
Number Admitted < or = 3 days	1	0	2	0	1	0
Number Admitted < or = 1 day	0	0	1	0	1	0
Avg. MHB Days Waited	**10**	**7**	**12**	**5**	**17**	**13**
Number MHB Admitted	12	8	11	5	5	6
Number Admitted < or = 21 days	9	8	10	5	3	5
Number Admitted < or = 14 days	8	7	7	4	2	4
Number Admitted < or = 7 days	7	5	7	3	1	4
Number Admitted < or = 3 days	5	4	5	3	1	2
Number Admitted < or = 1 day	4	2	3	2	1	2

This table was provided by Nebraska Department of Health & Human Services Division of Behavioral Health

Emergency System Coordination

Emergency system coordination is one of the core functions of the state behavioral health system, and provides support for consumers experiencing an acute behavioral health crisis.

Within each behavioral health region, the Emergency System Coordinator is responsible for providing emergency system coordination through contracts and partnerships with various entities including crisis centers, law enforcement, mental health boards, providers, psychiatric hospitals, and state-inpatient psychiatric facilities.

Statewide Coordination

The Division of Behavioral Health (DBH) manages the statewide emergency system through ongoing contact with each of the emergency system coordinators. DBH organizes and conducts a minimum of two conference calls per month with the Regional Emergency Systems Coordinators and with the staff of the residentially based Lincoln Regional Center (LRC) to maintain relevancy with crisis centered activities within each Region and at LRC, and to insure that consumers are receiving treatment in accordance with their abilities and needs. These calls allow for opportunities for individual case reviews, brainstorming remedies for difficult cases, identification of strengths and needs in statewide treatment options, and sharing of local developments within Regional/LRC partner networks. In addition to routine phone conferences, the DBH holds quarterly in-person meetings at various locations throughout the state. These day-long meetings allow for more robust conversations about emergency systems topic, result in recommendations for change if indicated.

Regional Efforts

Regional Coordinators work via variety of efforts to manage effective "flow-through" for consumers who enter the emergency system. Across the state, communities have implemented a variety of services and trainings to improve crisis response, which include, but are not limited to, emergency coordination focused on complex cases, expansion of crisis response programs for both adult and youth response, Behavioral Health Threat Assessment (BHeTA) and Crisis Intervention Training (CIT) for law enforcement. These two trainings, in particular, help officers to better assess and manage crisis situations involving persons with behavioral health problems. All activities and supports are designed to promote system flow-through. **Table 6.16** summarizes the emergency response services provided regionally.

Table 6.16: Examples of Emergency Response Services Provided in Different Behavioral Health Regions

Emergency Response	Behavioral Health Region and Providers
Emergency Psychiatric Observations	Region 1 (Box Butte General Hospital)
Crisis Stabilization - EPC	Region 3 (Mid Plains Center)
Crisis Assessment	Region 1 (Human Service, Inc.); Region 2 (Great Plains Regional Medical Center); Region 5 (CMHC); Region 6 (Catholic Charities)
Emergency Protective Custody Crisis Stabilization	Region 5 (Crisis Center)
Emergency Protective Custody	Region 1 (Regional West); Region 2 (Great Plains); Region 3 (Richard Young, Mary Lanning), Region 4 (Faith Regional); Region 6 (Catholic

	Health Initiatives, Douglas County Community Mental Health Center, Fremont Medical Center)
24-Hour Crisis Line:	Region 1 (Panhandle Mental Health Clinic); Region 2 (Region 2); Region 3 (Richard Young, Mary Lanning); Region 4 (Behavioral Health Specialists, Heartland Counseling Services, Rainbow Center); Region 5 (Blue Valley Behavioral Health, Center Pointe); Region 6 (Lasting Hope, Safe Harbor)
Mental Health Respite	Region 3 (South Central Behavioral Services); Region 4 (Liberty Centre); Region 5 (The Bridge); Region 6 (Salvation Army)
Emergency Community Support	Region 1 (Region 1, CrossRoads, WCHR); Region 2 (Region 2); Region 3 (Mary Lanning, Region 3, Goodwill Industries, South Central Behavioral Services); Region 4 (Liberty Centre, Rainbow Center); Region 5 (Lutheran Family Services, TASC); Region 6 (Salvation Army)
Crisis Response	Region 1 (Region 1, Box Butte General Hospital, CrossRoads, Southern Tier); Region 2 (Region 2); Region 3 (South Central Behavioral Services); Region 4 (Behavioral Health Specialists, Heartland Counseling Services, Rainbow Center); Region 5 (TASC); Region 6 (Heartland Family Services, Lutheran Family Services)
Outpatient Psychotherapy-Urgent Access	Region 2 (Region 2); Region 6 (Lutheran Family Services)
Hospital Diversion	Region 5 (Mental Health Association); Region 6 (Community Alliance)

This table was provided by Nebraska Department of Health & Human Services Division of Behavioral Health

Emergency Protective Custody and Mental Health Board Trends

What are EPC and MHB?

The Nebraska Mental Health Commitment Act describes the purpose and procedures related to emergency protective custody (EPC) admissions and mental health board (MHB) commitments.[54] The purpose of the Act is provided in Section 71-902. The Act recognizes that persons with mental illnesses should be encouraged to obtain voluntary treatment in lieu of any type of involuntary treatment. If voluntary treatment is not obtained, the individual may be subjected to EPC under limited conditions and for a limited period of time. As described in Section 71-915, the presiding judge in each judicial district court must create at least one, but not more than three, Mental Health Board(s) (MHBs) in each such district.[54]

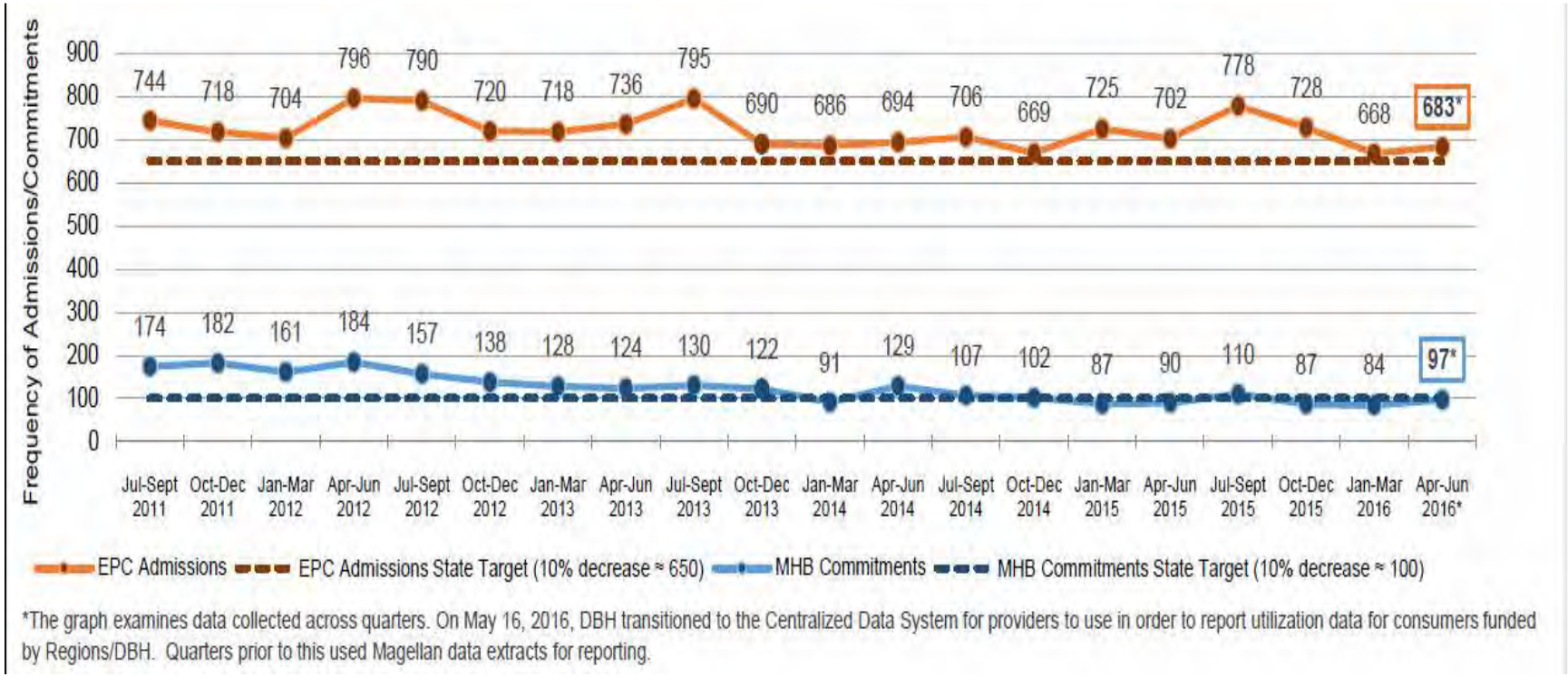
DBH is responsible for the MHB training process, which it also uses as an opportunity to increase awareness about Emergency Protective Custody (EPC) and Mental Health Board (MHB) commitments. Review of and updates to the MHB training manual and overall process for training of MHB members help to ensure that persons are committed when necessary, and that commitments occur through consistent processes across the state. Providing training on the commitment process to other groups, such as law enforcement and county officials, helps to ensure commitments are made and closed as intended for individual and public safety. A Mental Health Commitment Webinar training hosted by DBH is being conducted in September, 2016, for Mental Health Board members, county clerks, attorneys and judges, State Patrol, emergency coordinators from each of the 6 Regional Behavioral Health Authorities, law enforcement, community and regional center hospital staff, and others interested in learning more about the Mental Health Commitment process.

EPC and MHB Trends

EPC data are under review to identify factors contributing to counts and training opportunities for system partners so as to ensure consistency and accuracy in reporting. DBH has updated the MHB committee member training manual and process to improve consistency in practice and understanding of the Mental Health commitment process. Trainings on Mental Health First Aid are also being used across the state to help increase awareness on behavioral health treatment needs and options for care in community settings. Coordination between crisis response teams and law enforcement helps to identify alternative methods of care and support for persons in crisis.

Figure 6.8 illustrates the time trends of EPC admissions and MHB commitments between 2011 and 2016. EPC admissions declined steadily from 744 during the third quarter of 2011 to 683 during the second quarter in 2016. Similarly, MHB commitments declined from 174 to 97 during the same time period. Note that on May 16, 2016, DBH transitioned to the Centralized Data System for providers to use in order to report utilization data for consumers funded by Regions/DBH. Quarters prior to this used Magellan data extracts for reporting.

Figure 6.5: Frequency of Emergency Protective Custody (EPC) Admissions and Mental Health Board (MHB) Commitments in Nebraska: 2011-2016

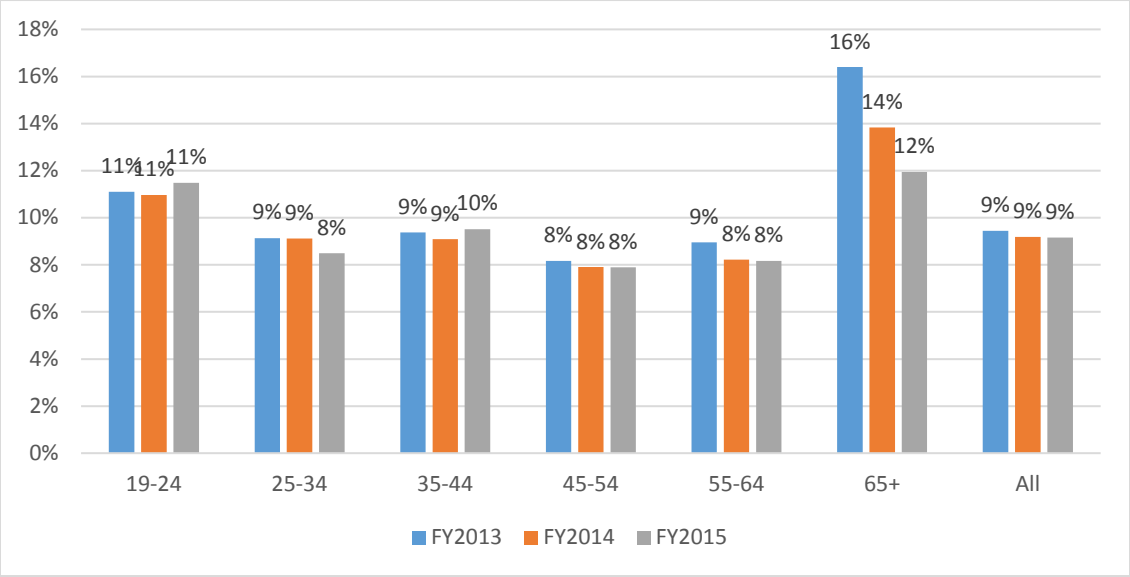


*The graph examines data collected across quarters. On May 16, 2016, DBH transitioned to the Centralized Data System for providers to use in order to report utilization data for consumers funded by Regions/DBH. Quarters prior to this used Magellan data extracts for reporting.

This table was provided by Nebraska Department of Health & Human Services Division of Behavioral Health

Figure 6.6 and **Figure 6.7** are based on Magellan extract data. As shown in **Figure 6.6**, of all age groups combined, 9% of adult consumers had at least one emergency protective custody (EPC) admission in each of FY 2013, 2014, and 2015. The percentage of EPC admission was highest among adults 65 years and older but the rate for this population also decreased between FY 2013 (16%) to FY 2015 (12%).

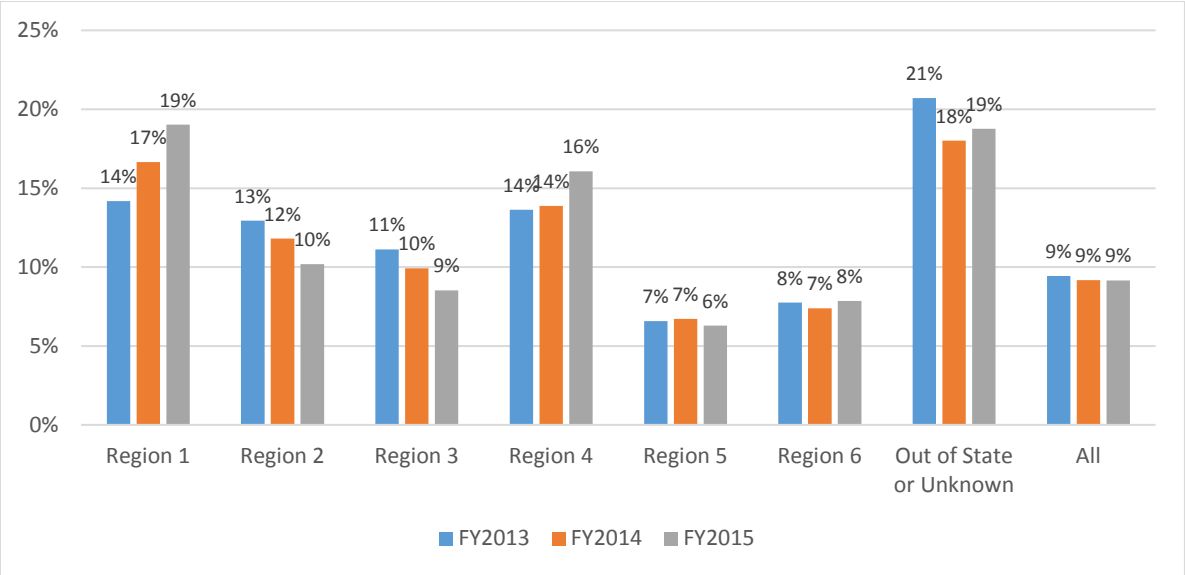
Figure 6.6: Adult Consumers with At Least One EPC in Given Year by Age Group



Data for this chart were provided by the Nebraska Department of Health & Human Services Division of Behavioral Health.

Figure 6.7 shows that the EPC admission varied across Behavioral Health Regions. The percentage was the highest among those out of state or at an unknown address (18% to 21%). Based on the FY 2015 data, Region 1 had the highest percentage of EPC admissions (19%) followed by Region 4 (16%). During the FY 2015, Region 5 had the lowest percent (6%), followed by Region 6 (8%).

Figure 6.7: Adult Consumers with At Least One EPC in Given Year by Behavioral Health Region



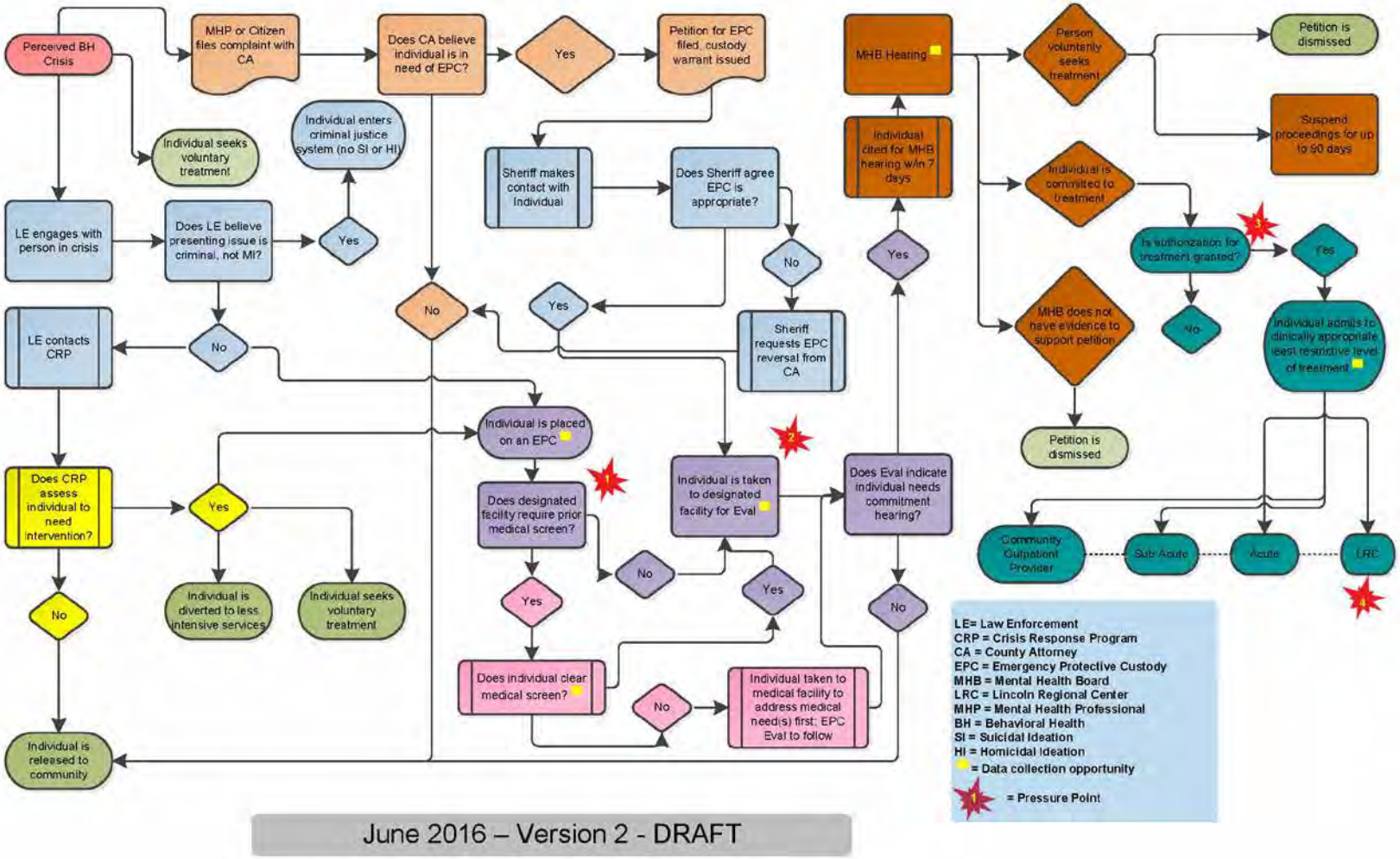
Data for this chart were provided by the Nebraska Department of Health & Human Services Division of Behavioral Health.

Division of Behavioral Health Emergency System Mapping Workgroup

The general public and stakeholders of the Nebraska public behavioral system perceive significant gaps in the emergency response system. The DBH hired a consultant to assist with emergency mapping. On June 27, 2016 the Regional Emergency Coordinators and central DBH staff met to discuss opportunities for optimizing performance of the Nebraska Behavioral Health Emergency Service System. Two priorities were identified: (1) track performance more consistently and thoroughly over time; and (2) identify opportunities for improvement related to key "pressure points" within the system. It was proposed to collect more robust indicators of the following key outcomes: (a) reduced repeated EPC readmission; and (b) timely access to appropriate treatment (timely completion of crisis evaluations, timely completion of MHB commitment hearings, and timely engagement with subacute treatment).

Figure 6.8 represents a complex picture of emergency system coordination. The map helps to identify opportunities for data collection and intervention to improve the coordination. The workgroup is in the process of refining the data collection process for these outcomes and of reviewing preliminary reports based on this data set. The result will be standardized data reporting across regions which can be used to analyze trends in system operations across regions, and implement changes for improving outcomes.

Figure 6.8: Nebraska Emergency System Mapping Draft



This figure was provided by Nebraska Department of Health & Human Services Division of Behavioral Health

Co-Occurring Disorder Services

What are Co-Occurring Disorders?

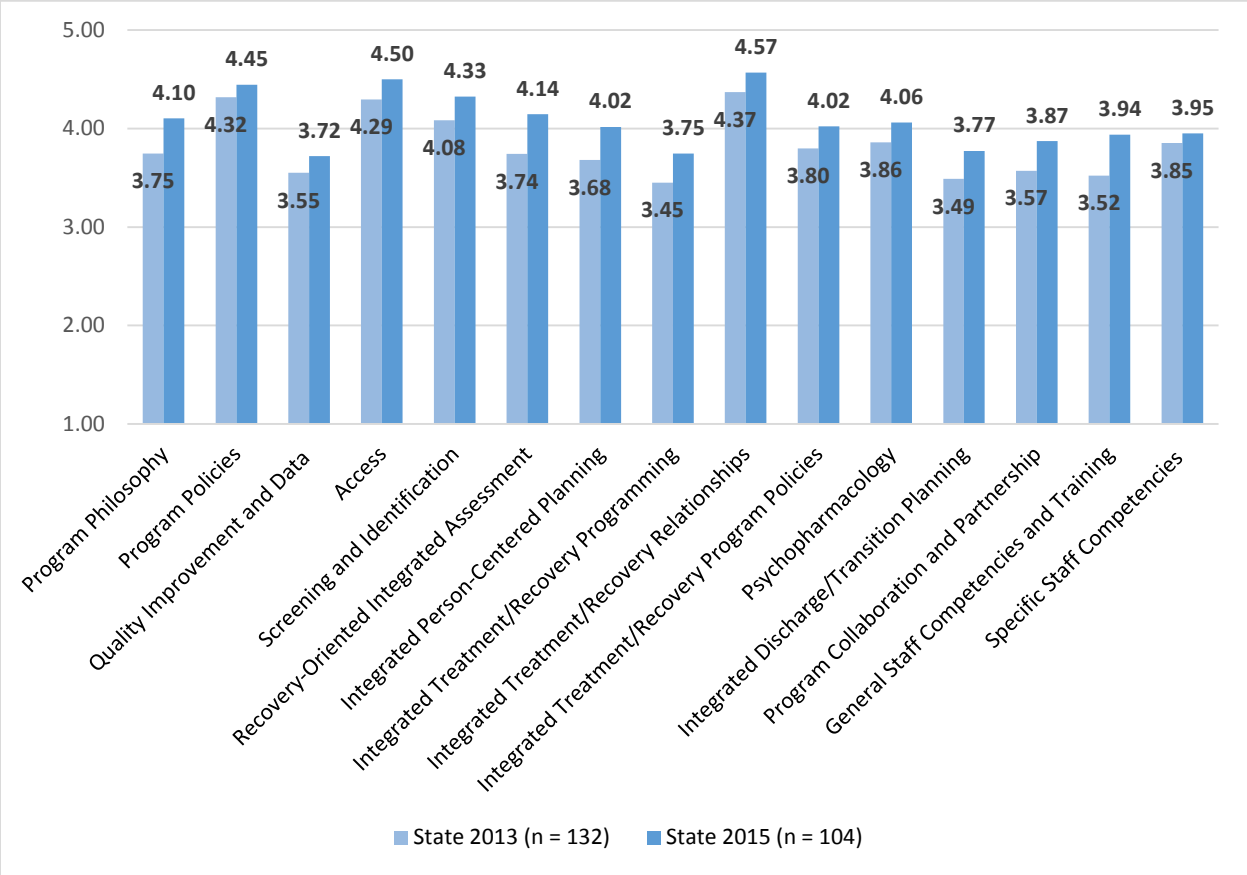
Persons who have substance use disorders as well as mental health disorders are diagnosed as having "co-occurring disorders." People with mental health disorders are more likely to experience an alcohol or substance use disorder compared to those without mental health disorders. Co-occurring disorders can be difficult to diagnose due to the complexity of symptoms stemming from these two groups of disorders. Persons with co-occurring disorders are best served through integrated treatment, where providers can address mental and substance use disorders at once. This approach often results in better outcomes for patients and lower costs to the delivery system.[55]

Assessment of Co-Occurring Disorder Services

In 2013 and 2015, the Division of Behavioral Health (DBH) implemented an assessment of co-occurring disorder services using the Compass-EZ. The Compass-EZ by Zia Partners, and allows behavioral health programs to create baseline measures to describe their ability to deliver services to persons with co-occurring disorders. Behavioral health agencies contracted with a Behavioral Health Region completed self-assessments using the tool in 2013 and again in 2015. Each of the 15 domains included in the assessment was scored on a 1-5 scale (Not at All=1; Slightly = 2; Somewhat=3; Mostly=4; Completely=5).

Using COMPASS-EZ, providers assessed their own ability to provide services for persons with co-occurring disorders. The resulting data were used to conduct a system-wide assessment. As shown in **Figure 6.9**, 132 agency programs participated in 2013 and 104 agency programs participated in 2015. The assessment scores improved from 2013 to 2015 in every domain.

Figure 6.9: Agencies' Assessment of Domains of Co-Occurring Disorder Service: 2013 vs. 2015



This figure was provided by Nebraska Department of Health and Human Services, Division of Behavioral Health.

Table 6.17 ranks the domains at the state level and for each Region, with 1 being the lowest ranked domain (indicating room for improvement), and 15 being the highest ranked domain (indicating an area of strength). It should be noted that some agencies provide services to more than one Behavioral Health Region and thus would have been included for each Region with which it contracts for services. Additionally, some agencies submitted individual assessments for multiple programs they offer across various services.

Table 6.17: Ranking of Self-Assessment Scores of Co-Occurring Disorder Services for the Entire State and for Behavioral Health Regions: 2015 Data

Domains	State (N=104)	Region 1 (n=14)	Region 2 (n=12)	Region 3 (n=16)	Region 4 (n=12)	Region 5 (n=24)	Region 6 (n=26)
Quality improvement and data	1	5	3	3	1	5	2
Integrated treatment / recovery programming	2	4	1	5	3	3	3
Integrated discharge / transition planning	3	6	2	1	8	2	6
Program collaboration and partnership	4	2	14	4	4	8	4
General staff competencies and training	5	3	8	2	2	7	11
Specific staff competencies	6	9	5	6	5	6	5
Integrated person-centered planning	7	8	9	7	9	4	7
Integrated treatment / recovery program policies	8	7	4	9	10	1	9
Psychopharmacology	9	1	13	14	12	10	1
Program philosophy	10	10	6	8	7	9	10
Recovery-oriented integrated assessment	11	12	7	10	6	11	8
Screening and identification	12	13	10	12	11	12	12
Program policies	13	15	12	11	13	13	13
Access	14	14	11	13	15	14	14
Integrated treatment / recovery relationships	15	11	15	15	14	15	15

Need improvement Strength

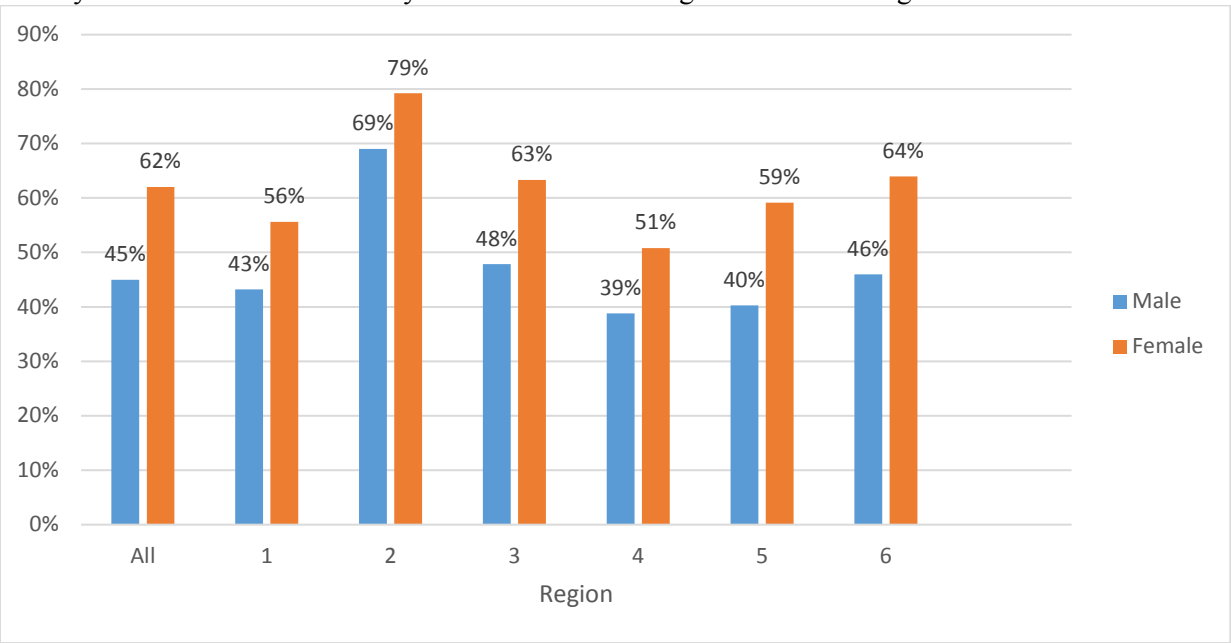
The data in this table were provided by the Nebraska Department of Health and Human Services, Division of Behavioral Health.

Trauma-Informed Services

Prevalence of Trauma History

As discussed in Chapter 3, trauma experienced in childhood and adulthood can have a significant psychological and physiological impact throughout one's life. History of trauma has been assessed among consumers served by the public behavioral system. **Figure 6.10** shows the percentage of consumers in the Division of Behavioral Health funded programs who reported history of trauma. The figure is from admission data for 7/1/14-6/30/15. Across the Behavioral Health Regions, female consumers had higher prevalence of trauma compared to male consumers. Consumers in Region 2 had the highest prevalence of trauma (79% for females and 69% of males).

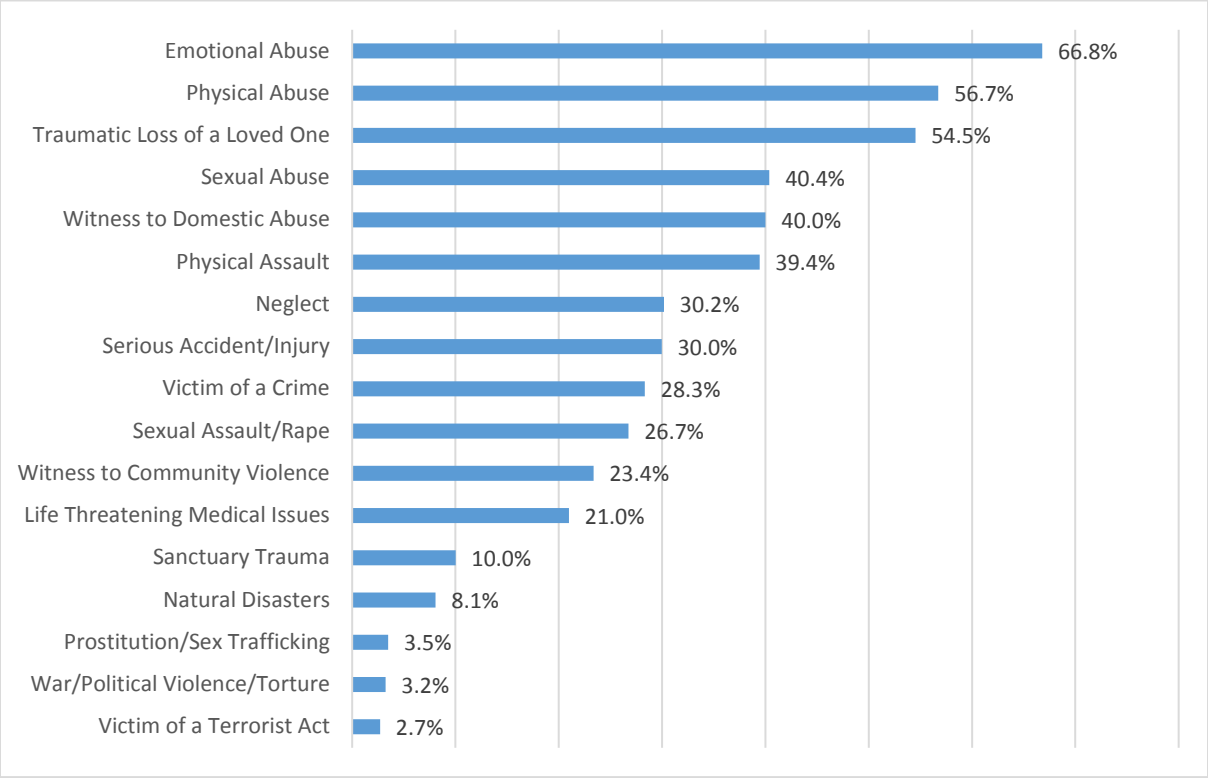
Figure 6.10. Percentage of Consumers in Division of Behavioral Health Funded Programs Reported History of Trauma at Admission by Behavioral Health Region: FY 2015 Magellan Data



Data for this figure were provided by Nebraska Department of Health & Human Services Division of Behavioral Health.

Figure 6.11 shows the types of trauma indicated by those with a history of trauma. At admission, 67% of consumers reported emotional abuse. Over 50% of consumers reported experiencing physical abuse (56.7%) and traumatic loss of a loved one (54.5%).

Figure 6.11: Types of Trauma Indicated for Those with a History of Trauma as Reported by Consumers in Division of Behavioral Health Funded Programs at Admission: FY 2015

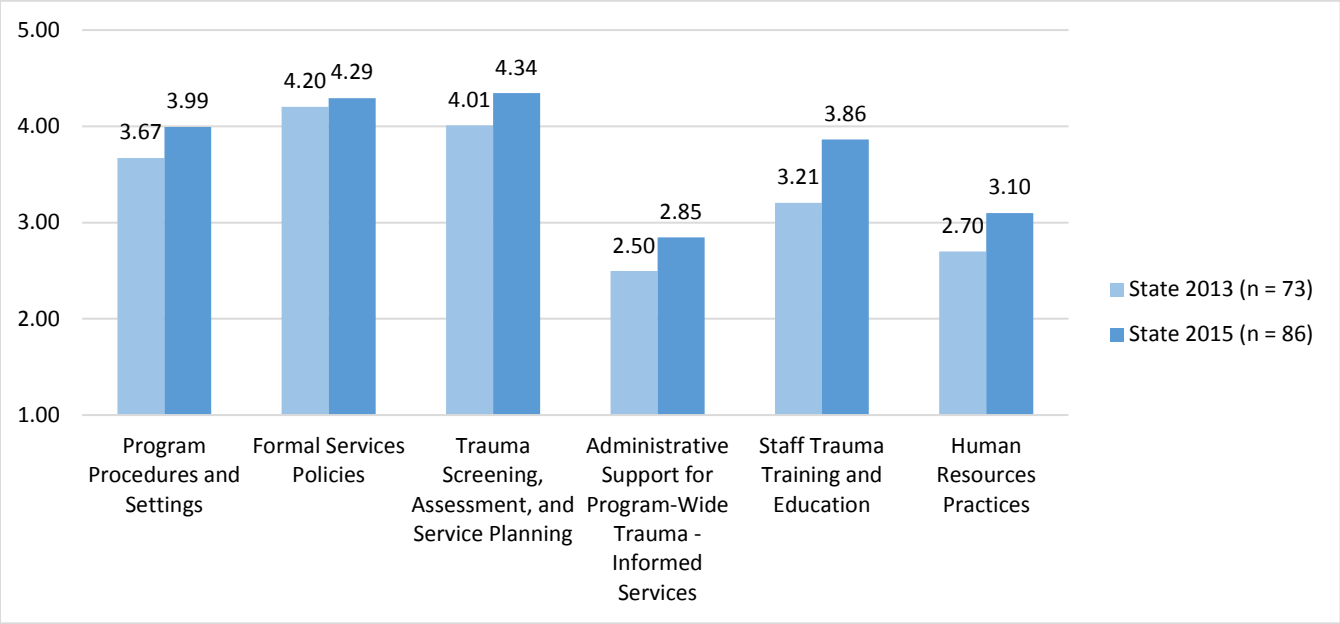


Data for this figure were provided by Nebraska Department of Health & Human Services Division of Behavioral Health.

Trauma-Informed Services

The Division of Behavioral Health (DBH) retains a consultant to assess trauma-informed services. A total of 73 agency programs participated in 2013, and 86 agency programs participated in the assessment in 2015 (**Figure 6.12**). The scores for all domains improved between 2013 and 2015. Screening, program policies, and procedures were identified as the top strengths while administrative support, human resources, and staff training were identified as opportunities for improvement (**Table 6.18**).

Figure 6.12: Agencies' Assessment of Domains of Trauma-Informed Service: 2013 vs. 2015



This figure was provided by Nebraska Department of Health & Human Services Division of Behavioral Health.

Table 6.18: Trauma Informed Services Strengths and Opportunities for Improvement Assessed by Agencies: 2015

Top 3 Strengths	Score
Trauma Screening, Assessment, and Service Planning	4.34
Formal Services Policies	4.29
Program Procedures and Settings	3.99
Top 3 Opportunities for Improvement	**Score**
Administrative Support for Program-Wide Trauma -Informed Services	2.85
Human Resources Practices	3.10
Staff Trauma Training and Education	3.86

This data in this table were provided by Nebraska Department of Health and Human Services, Division of Behavioral Health.

Supported Employment

Supported Employment (SE) is an evidence-based service designed to promote rehabilitation and return to productive employment for persons age 19 and older who have behavioral health disorders. The service employs a team approach for treatment with the employment specialist responsible for carrying out all vocational services from intake through follow-along. Job placements are: community-based (i.e., not sheltered workshops, not onsite at SE or other treatment agency offices, or employment in enclaves or prevocational training), competitive (i.e., jobs are not exclusively reserved for SE consumers but open to the public), in normal settings, and using multiple employers. The team is assertive in engaging and retaining consumers in treatment, especially in employing face-to-face community visits, rather than phone or email contacts. The SE team consults and works with family and significant others as appropriate. SE services are coordinated with Vocational Rehabilitation. Funding is braided between Vocational Rehabilitation and DBH and based on an outcome and/or milestone payment.[56]

In December 2015, a symposium was held to identify strengths and weaknesses of supported employment programs and to make recommendations to improve these programs.

Strengths:

- Collaborative partnerships between DBH, Vocational Rehabilitation, Medicaid, Behavioral Health Regions, Regional Providers
- Six providers located across the state (showing varying degrees of implementation and fidelity to the IPS model)
- Benefits planning and counseling for consumers
- An accountable system with focus on consumers' outcomes

Challenges:

- Overcoming the misconception that persons with behavioral health issues cannot work; convincing consumers themselves that they can work (providing hope); and assuring consumers that benefits counseling will assist them in keeping their benefits
- Turnover in trained staff, particularly those working with persons with behavioral health and other complex needs
- Stigma among consumers of term "job coach"
- Need to increase the number of providers to improve access

Goal(s) identified as a result of attending the symposium

- Increase the number of persons receiving supported employment services
- Expand workforce to work with population and increase number of persons involved
- Coordinate education of consumers, community members, schools, behavioral health providers, and professionals working with supported employment on the benefits for consumers as well as the business community

- Address the misconception that persons with behavioral health disorders cannot work; educate about and advertise success of employers and consumers (tell the stories of successes and have employers with success vouch for the program)
- Change language to decrease stigma related to “job coach”; use business language in the employment setting

Prevention Services

One of the Division of Behavioral Health's (DBH's) priorities is to develop a sustainable and effective prevention system designed to reduce substance use disorders and their related consequences, one that supports the promotion of mental health. Each Behavioral Health Region has a Preventive System Coordinator, known as a Regional Prevention Coordinator, who provides training and technical assistance to community partners regarding prevention needs and solutions.

Strategic Planning

The state's *Five-Year Prevention Statewide Strategic Plan* identified the reduction of substance use behaviors including: Underage drinking, binge drinking, prescription drug abuse, marijuana use, and illegal sale of tobacco products to minors.

The guiding principles for the prevention taskforce include:

- All prevention activities will be culturally relevant;
- Substance abuse prevention policy, quality improvement, and agency participation will be shaped through cross-agency advisory groups;
- DBH will coordinate and support the work of the State's substance abuse prevention advisory council, and will actively recruit and educate partners who can contribute to the work;
- Each Region will identify its highest risk subpopulations and will develop a plan to enhance or build community responses; and
- Each community coalition will create a plan to maximize and sustain outcomes, and will choose strategies that can be sustained for at least five years.

Workforce Training

While the prevention workforce is largely voluntary, the DBH requires that all paid prevention staff in both regional and community coalitions complete 12 hours of continuing education about Professional Core competencies. In addition, any paid prevention staff must complete the Substance Abuse Prevention Skills Training (SAPST) within the first year of hire. SAPST was developed under the Substance Abuse Mental Health Services Administration's Center for the Application of Prevention Technologies contract, and provides an introduction to the fundamentals of substance abuse prevention based on current knowledge and practice in the field. This training is designed to prepare practitioners, reduce the likelihood of substance use disorders, and promote well-being among individual consumers and within families, workplaces, schools, and communities. SAPST training is endorsed by the International Certification and Reciprocity Consortium.

Workforce Survey

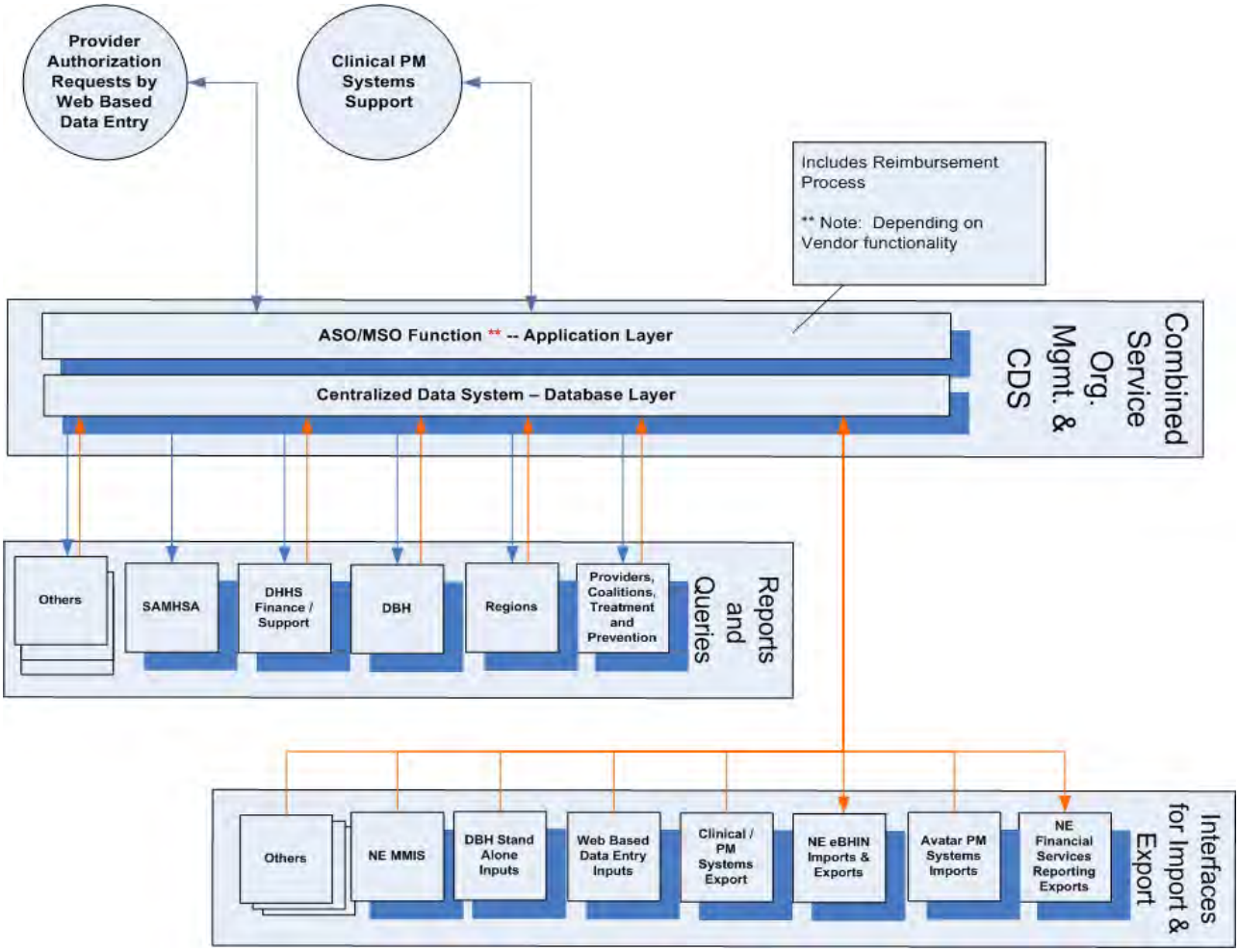
The DBH recently conducted a survey of the workforce to assess its training needs in response to the competencies and overachieving initiatives outlined in the strategic plan document. The survey results will be used for the next behavioral health comprehensive strategic planning for 2017-2020.

Information System

In May of 2016, the Division of Behavioral Health (DBH) implemented a customized, DHHS-owned Centralized Data System (CDS). The CDS securely collects data from a variety of sources, allowing for increased analysis and reporting on behavioral health service use and capacity information. The CDS allows DBH and Regional Behavioral Health Authorities (RBHAs) to review, monitor, and report on programmatic, administrative, and fiscal accountability functions with all behavioral health providers contracted with DBH and RBHAs. The system also provides increased automation in the authorization of services funded by the DBH and Behavioral Health Regions. The CDS is expected to reduce duplicate efforts, streamline workflow, and offer dynamic and timely reports for data-driven decisions that will continuously improve the quality and continuity of care for consumers.

The CDS was built with the vision of consolidating IT platforms and software from a variety of data sources to improve sharing and reporting data across multiple agencies and divisions, a function not currently available within DHHS (**Figure 6.14**). The CDS Interface Layer electronically transmits data across agency systems, in real time or on a batch schedule, providing a comprehensive means for system analysis and reporting. An electronic billing system (EBS) is also under development for DBH. The CDS Interface Layer will enable data sharing and allow for coordinated reporting between these two DBH data systems. The EBS is expected to be in use beginning July, 2017.

Figure 6.13: Centralized Data System Layout



This figure was provided by the Nebraska Department of Health & Human Services Division of Behavioral Health

Mental Health National Outcome Measures

What Are National Outcome Measures (NOMs)?

National Outcome Measures (NOMs) were developed by the Substance Abuse Mental Health Services Administration (SAMHSA) in collaboration with states. They consist of ten domains aimed at tracking and reporting outcomes for people receiving behavioral health services. The ten domains include: Reduced Morbidity (includes abstinence from drugs and alcohol and decreased mental illness symptomology); Employment/Education; Crime and Criminal Justice Involvement; Stability in Housing; Social Connectedness; Access and Capacity (to services); Retention (includes increased retention in treatment for Substance Use Disorders and reduced use of psychiatric inpatient beds); Perception of Care; Cost Effectiveness; and Use of Evidence-Based Practices.

Interpretation of NOMs

It is important to note that Nebraska's data on NOMs as provided by the Division of Behavioral Health (DBH) only include data from those consumers or patients who received services funded through the DBH and do not include counts from Medicaid Long-Term Care funding or other funding sources. This may or may not be true of the surrounding states frequently used for comparison. National averages comprise states which have varied degrees of Medicaid funding included in their reported data. This distinction is important to understand when reviewing and drawing conclusions about any differences noted in average comparisons.

Reports which include national or multistate comparisons are typically available for two to three years following actual data collection. Some measurement tools used to collect information are only conducted every two or three years. More current Nebraska data are sometimes available, and collection has been included for particular areas to further describe counts for Nebraska; however, comparisons may not yet be available or are considered only preliminary results that will be updated as analysis and national reports are finalized. While data measures and data sources cited vary depending on questions asked and timing of report publication, all data within this report can be considered "current available" data.

FY2015 Nebraska NOMs for Mental Health and Dual Services

In this section, NOMs reported for the Uniform Reporting System on mental health and dual services are summarized.[57] Note other states' data may include Medicaid-served consumers whereas Nebraska data presented here include consumers served through the Division of Behavioral Health funded services.

Table 6.19 presents demographic characteristics of persons served by the Nebraska state mental health authority compared to the U.S. and the Midwest. There are some differences in demographic characteristics between Nebraska and the U.S. Only 9.3% of Nebraska consumers were aged 0-17 years compared to 27.8% for the U.S.; 86.1% of Nebraska consumers were White compared to 61.6% for the U.S. overall. The overall penetration rate was lower for Nebraska with 10.3 per 1,000 population compared to 23.5 for Midwest and 23.1 for the U.S. overall. The penetration rate was notably lower for children: 2.5 per 1,000 for aged 0-12 in Nebraska compared to 23.1 for the U.S.; 7.8 per 1,000 for aged 13-17 in Nebraska compared to 41.9 for the U.S.

Table 6.19: Access Domain – Demographics of Persons Served by the State Mental Health Authority, FY 2015[57]

Demographics	Total Served				Penetration Rate (per 1,000 population)			States Reporting
	Nebraska		US					
	n	%	n	%	Nebraska	Midwest	US	
Total	19,441	100.0%	7,448,380	100.0%	10.3	23.5	23.1	58
Age								
0-12	839	4.3%	1,190,211	16.0%	2.5	24.4	22.6	58
13-17	981	5.0%	875,802	11.8%	7.8	44.6	41.9	58
18-20	928	4.8%	324,105	4.4%	11.3	25.5	25.0	58
21-24	1,795	9.2%	431,757	5.8%	16.4	25.0	23.3	58
25-44	8,640	44.4%	2,274,325	30.5%	18.1	29.0	27.1	58
45-64	5,880	30.2%	1,982,464	26.6%	12.4	21.8	23.7	58
65-74	315	1.6%	240,502	3.2%	2.2	7.3	9.1	57
75 and over	63	0.3%	121,440	1.6%	0.5	3.6	6.1	55
Age Not Available	-	-	7,774	0.1%	-	-	-	28
Gender								
Female	9,802	50.4%	3,862,676	51.9%	10.4	24.1	23.5	58
Male	9,636	49.6%	3,576,125	48.0%	10.3	22.8	22.5	58
Gender Not Available	3	0.0%	9,579	0.1%	-	-	-	36
Race/Ethnicity								
American Indian/Alaskan Native	485	2.5%	89,822	1.2%	18.9	39.6	22.7	52
Asian	145	0.7%	92,867	1.2%	3.5	6.7	5.4	54
Black/African American	1,669	8.6%	1,443,784	19.4%	18.1	37.3	34.2	52
Native Hawaiian/Pacific Islander	128	0.7%	16,829	0.2%	57.3	50.1	23.0	54
White	16,736	86.1%	4,588,378	61.6%	9.9	19.5	18.6	55
Hispanic or Latino Race	2	0.0%	68,501	0.9%	0.0	-	3.6	11
Multi-Racial	244	1.3%	189,933	2.5%	6.4	36.1	24.8	51
Race Not Available	32	0.2%	958,266	12.9%	-	-	-	54
Hispanic or Latino Ethnicity	1,632	8.4%	1,029,735	14.4%	8.5	13.7	18.7	52
Not Hispanic or Latino Ethnicity	17,165	88.3%	5,537,361	77.2%	10.2	21.0	21.5	57
Ethnicity Not Available	644	3.3%	605,941	8.4%	-	-	-	48

Table 6.20 and **Table 6.21** report two other indicators for access domain: persons served in community mental health programs and state psychiatric hospitals by age and gender. The penetration rates for the use of state psychiatric hospitals were similar between Nebraska and the U.S. However, the penetration rates for the community mental health programs were notably lower in Nebraska. For example, the total penetration rate for the community mental health programs for Nebraska was 9.4 per 1,000 compared to 22.6 per 1,000 for U.S. Also, for the age 0-17, Nebraska's penetration rate was much lower (3.7 per 1,000) compared to the U.S. (27.7 per 1,000).

Note data from other states may include Medicaid-served consumers, whereas Nebraska data presented here include consumers whose services were funded through the Division of Behavioral Health.

Table 6.20: Access Domain – Persons Served in Community Mental Health Programs by Age and Gender, FY 2015[57]

	Served in Community				Penetration Rates (Rates per 1,000 population)		States Reporting
	Nebraska		US				
	n	%	n	%	Nebraska	US	
Age 0-17	1,713	9.7%	2,041,716	28.0%	3.7	27.7	57
Age 18-20	776	4.4%	315,260	4.3%	9.4	24.3	57
Age 21-64	14,796	84.0%	4,577,072	62.8%	13.9	24.6	57
Age 65+	323	1.8%	348,338	4.8%	1.2	6.9	56
Age Not Available	-	-	6,228	0.1%	-	-	28
Age Total	17,608	100.0%	7,288,614	100.0%	9.4	22.6	57
Female	9,116	51.8%	3,795,963	52.1%	9.7	23.1	57
Male	8,489	48.2%	3,483,198	47.8%	9.1	21.9	57
Gender Not Available	3	0.0%	9,453	0.1%	-	-	35
Female	9,116	51.8%	3,795,963	52.1%	9.7	23.1	57

Table 6.21: Access Domain – Persons Served in State Psychiatric Hospitals* by Age and Gender, FY 2015[57]

	Served in State Psychiatric Hospitals				Penetration Rates (Rates per 1,000 population)		States Reporting
	Nebraska		US				
	n	%	n	%	Nebraska	US	
Age 0-17	-	-	10,183	7.4%	0.0	0.2	36
Age 18-20	13	3.4%	5,684	4.1%	0.2	0.5	51
Age 21-64	343	89.8%	114,398	82.9%	0.3	0.6	51
Age 65+	26	6.8%	7,688	5.6%	0.1	0.2	51
Age Not Available	-	-	3	0.0%	-	-	3
Age Total	382	100.0%	137,956	100.0%	0.2	0.4	51
Female	59	15.4%	46,304	33.6%	0.1	0.3	51
Male	323	84.6%	91,607	66.4%	0.3	0.6	51
Gender Not Available	-	-	45	0.0%	-	-	12
Total	382	100.0%	137,956	100.0%	0.2	0.4	51

*Include regional centers and associated youth programs they offer.

Table 6.22 and **Table 6.23** report the information specific to adults with serious mental illness (SMI) and children with severe emotional disturbance (SED). Again, the penetration rates for state psychiatric hospitals were similar between Nebraska and the U.S. overall, while the penetration rates for community programs were much lower in Nebraska compared to the U.S. Among children (0-17 years) with SED, the community program penetration rate for Nebraska was 2.7 per 1,000 compared to 19.5 per 1,000 for the U.S. overall. The community program penetration rate for adults (aged 21-64) with SMI was also much lower in Nebraska (9.2 per1,000) compared to the U.S. (17.3 per 1,000).

Note data from other states may include Medicaid-served consumers, whereas Nebraska data presented here include consumers whose services were funded through the Division of Behavioral Health.

Table 6.22: Access Domain – Adults with SMI and Children with SED Served in Community Mental Health Programs by Age and Gender, FY 2015[57]

	Served in Community				Penetration Rates (Rates per 1,000 population)		States Reporting
	Nebraska		U.S.				
	n	%	n	%	Nebraska	U.S.	
Age 0-17	1,281	11.0%	1,375,911	28.2%	2.7	19.5	54
Age 18-20	377	3.2%	179,028	3.7%	4.6	14.4	55
Age 21-64	9,746	83.9%	3,097,919	63.4%	9.2	17.3	55
Age 65+	217	1.9%	230,764	4.7%	0.8	4.8	53
Age Not Available	-	-	1,141	0.0%	-	-	17
Age Total	11,621	100.0%	4,884,763	100.0%	6.2	15.7	56
Female	6,139	52.8%	2,544,276	52.1%	6.5	16.1	56
Male	5,481	47.2%	2,337,384	47.9%	5.9	15.3	56
Gender Not Available	1	0.0%	3,103	0.1%	-	-	26
Total	11,621	100.0%	4,884,763	100.0%	6.2	15.7	56

Table 6.23: Access Domain – Adults with SMI and Children with SED Served in State Psychiatric Hospitals by Age and Gender, FY 2015[57]

	Served in State Psychiatric Hospitals				Penetration Rates (Rates per 1,000 population)		States Reporting
	Nebraska		U.S.				
	n	%	n	%	Nebraska	U.S.	
Age 0-17	-	-	7,909	8.5%	0.0	0.2	31
Age 18-20	7	4.1%	11,673	12.5%	0.1	1.0	46
Age 21-64	152	89.9%	69,201	74.0%	0.1	0.4	46
Age 65+	10	5.9%	4,773	5.1%	0.0	0.1	44
Age Not Available	-	-	3	0.0%	-	-	1
Age Total	169	100.0%	93,559	100.0%	0.1	0.3	46
Female	50	29.6%	31,664	33.8%	0.1	0.2	46
Male	119	70.4%	61,876	66.1%	0.1	0.4	46
Gender Not Available	-	-	19	0.0%	-	-	9
Total	169	100.0%	93,559	100.0%	0.1	0.3	46

Table 6.24 shows appropriateness domains; i.e., the percentages of consumers meeting the federal definition for certain disorders. These indicators reflect the extent to which the state mental health authority's (SMHA) programs serve the intended populations of behavioral health consumers. Per Block Grant funding requirements, states are required to have a waiting list management system to report waiting times and use of interim services for persons identified as meeting Federal Substance Use Disorder priority populations (Pregnant & Injecting Drug Users, Pregnant Substance Users, Injecting Drug Users).

The U.S. average percentage of adults served through the SMHA who meet the federal definition for SMI is 71.5% which is higher than the percentage for Nebraska (64.6%). The percent of children served through the SMHA who meet the federal definition for SED is similar between Nebraska (74.2%) and U.S. (72.1%). For the consumers with co-occurring disorder, the percent of adults served through the SMHA who had a co-occurring mental health and alcohol and other disorder was higher in Nebraska (32.5%) compared to U.S. average (22.7%) while the percent of children served through the SMHA who had a co-occurring mental health and alcohol and other disorder was lower in Nebraska (3.5%) than the U.S. average (6.2%), but similar to the U.S. median (3.0%).

Note these percentages are calculated based on only those consumers whose services were funded by the Division of Behavioral Health; therefore, a much higher percentage is represented compared to penetration (which uses population figures) because it does not include Medicaid for Nebraska. Therefore, Nebraska's statistics appear lower compared to U.S. averages.

Table 6.24: Appropriateness Domain – Percent of Adults and Children Served Who Meet the Federal Definition for SMI/SED and Percent of Adults and Children Served Who Have Co-Occurring MH/Alcohol and Other Drug (AOD) Disorders, FY 2015[57]

Nebraska Adults and Children who meet the Federal Definition of SMI/SED	Nebraska	U.S. Average	U.S. Median	States Reporting
Percent of Adults served through the state mental health authority who meet the federal definition for SMI	64.6%	71.5%	72.0%	54
Percent of Children served through the state mental health authority who meet the federal definition for SED	74.2%	72.1%	76.0%	55
Co-occurring MH and Substance Abuse Consumers	**Nebraska**	**U.S. Average**	**U.S. Median**	**States Reporting**
Percent of Adults served through the state mental health authority who had a co-occurring MH and AOD disorder	32.5%	22.7%	19.0%	53
Percent of Children served through the state mental health authority who had a co-occurring MH and AOD disorder	3.5%	6.7%	3.0%	52
Percent of Adults served through the state mental health authority who met the Federal definitions of SMI who also have a substance abuse diagnosis	20.1%	20.5%	18.5%	52
Percent of Children served through the state mental health authority who met the Federal definitions of SED who also have a substance abuse diagnosis	1.7%	6.2%	3.0%	51

Table 6.25 presents information on admission to state psychiatric hospitals, other inpatient hospitals, residential treatment centers, and community programs. In FY 2015, in Nebraska 382 all of adult persons received service at state psychiatric hospitals and 2,613 others (78 children and 2,535 adults) received service at other inpatient hospitals. During the same period, 75 persons (50 children and 25 adults) received service at residential treatment centers and 17,608 persons (1,713 children and 15,895 adults) received service in community programs. The admission rate for residential treatment for children was considerably lower in Nebraska (0.56) compared to the U.S. average (3.07). Similarly, the admission rate for community programs for children was lower in Nebraska (0.75) compared to the U.S. average (4.00).

Note other states' data may include Medicaid-served consumers whereas Nebraska data presented here include consumers whose services were funded through the Division of Behavioral Health.

Table 6.25: Appropriateness Domain – Number of Admissions during the Year to State Hospital Inpatient and Community-Based Programs, FY 2015[57]

Setting	Demographic	Nebraska			U.S.			Admission Rate		State Report-ing
		Admissions During Year	Total Served At Start of Year	Total Served During Year	Admissions During Year	Total Served At Start of Year	Total Served During Year	Nebraska	U.S.	
State Psychiatric Hospitals	Total	99	291	382	113,158	39,165	136,244	0.26	0.83	51
	Children	-	-	-	9,454	1,322	9,929	-	0.95	31
	Adults	99	291	382	103,703	37,841	126,134	0.26	0.82	51
	Age NA	-	-	-	1	2	1	-	1.00	1
Other Inpatient	Total	3,083	388	2,613	459,065	39,137	313,432	1.18	1.46	35
	Children	84	1	78	76,166	2,445	41,213	1.08	1.85	29
	Adults	2,999	387	2,535	382,787	36,591	271,768	1.18	1.41	35
	Age NA	-	-	-	112	101	157	-	0.71	6
Residential Treatment Centers	Total	36	39	75	66,378	10,969	38,260	0.48	1.73	37
	Children	28	22	50	46,200	4,930	15,035	0.56	3.07	36
	Adults	8	17	25	20,136	6,033	20,763	0.32	0.97	27
	Age NA	-	-	-	42	6	36	-	1.17	2
Community Programs	Total	18,781	9,523	17,608	18,221,792	3,735,705	6,580,114	1.07	2.77	49
	Children	1,278	764	1,713	7,382,437	954,254	1,845,495	0.75	4.00	49
	Adults	17,503	8,759	15,895	10,824,986	2,778,279	4,728,407	1.10	2.29	49
	Age NA	-	-	-	14,369	3,172	5,867	-	2.45	16

Hospital Includes all persons admitted to a State Regional Mental Health Center (forensic and non-forensic).
Other Inpatient Includes clients admitted to one of the psychiatric inpatient hospitals within Nebraska, other than a State Regional Mental Health Centers.
Residential Adolescents included here were admitted to one of the adolescent psychiatric units at a state psychiatric hospital.
Community Includes clients receiving outpatient services at a State Regional Mental Health Center or clients receiving services at a community provider.
Overall For clients without a discharge date, length of stay was calculated using June 30, 2015 as a 'discharge date'. N/A means no clients fell into this category.

Table 6.26 shows the length of stay at hospitals and residential treatment centers. Overall, the median length of stay was longer in Nebraska than for the U.S. For example, in Nebraska, among those who stayed in state hospitals one year or less, the median length of stay was 251 days compared to 76 days for the U.S. overall. The median length of stay for those who stayed in state hospitals more than one year was similar between Nebraska (1,022 days) and the U.S. overall (1,030 days). The median length of stay for other inpatient hospitals for children was longer in Nebraska (94 days) than the U.S. (32 days). The median length of stay for adults who stayed one year or less in other inpatient hospitals was also longer in Nebraska (80 days) compared to the U.S. (32 days).

Note other states' data may include Medicaid-served consumers, whereas Nebraska data presented here include consumers whose services were funded through the Division of Behavioral Health.

Table 6.26: Appropriateness Domain – Length of Stays in State Psychiatric Hospitals, Other Psychiatric Inpatient and Residential Treatment Centers for Children Settings, FY 2015[57]

Settings	Demographic	Nebraska						U.S.						
		Length of Stay (Days)						Length of Stay (Days)						
		Discharged Clients		Resident Clients in Facility 1 year or less		Resident Clients in Facility more than 1 year		Discharged Clients		Resident Clients in Facility 1 year or less		Resident Clients in Facility more than 1 year		States Reporting
		Average	Median	Average	Median	Average	Median	Average	Median	Average	Median	Average	Media	
State Hospitals	All	-	-	-	-	-	-	157	58	101	74	1,219	815	15
	Children	-	-	-	-	-	-	79	64	72	62	526	524	26
	Adults	486	151	264	251	1,543	1,022	244	75	100	76	1,928	1,030	49
	Age NA	-	-	-	-	-	-	10	8	17	8	-	-	1
Other Inpatient	All	-	-	-	-	-	-	125	310	56	45	1,325	669	5
	Children	4	3	94	94	-	-	23	19	43	32	609	554	22
	Adults	44	4	111	80	1,106	452	96	80	44	32	979	709	32
	Age NA	-	-	-	-	-	-	9	4	37	25	1	1	4
Residential Treatment Centers	All	-	-	-	-	-	-	118	126	108	103	551	503	4
	Children	185	130	243	238	415	401	145	118	113	103	572	532	30
	Adults	120	102	193	220	515	515	272	211	127	117	1,024	810	18
	Age NA	-	-	-	-	-	-	181	178	22	4	-	-	1

Hospital Includes all persons admitted to a State Regional Mental Health Center (forensic and non-forensic).
Other Inpatient Includes clients admitted to one of the psychiatric inpatient hospitals within Nebraska, other than a State Regional Mental Health Centers.
Residential Adolescents included here were admitted to one of the adolescent psychiatric units at a state psychiatric hospital.
Community Includes clients receiving outpatient services at a State Regional Mental Health Center or clients receiving services at a community provider.
Overall For clients without a discharge date, length of stay was calculated using June 30, 2015 as a 'discharge date'. N/A means no clients fell into this category.

Table 6.27 shows the use of several of those evidence-based practices (EBPs). The percentage of adult consumers who receive EBPs was about two times higher in Nebraska compared to the U.S. except for dual diagnosis treatment. About half of Nebraska adult consumers (54.1%) received medication management, compared to only 21.5% for the U.S. average. For children, of the three EBPs listed, Nebraska used multi-systemic therapy and had a lower percentage of use (0.9%) than the U.S. average (4.6%). However, it is important to note, there are many other EBPs used in Nebraska for both adult and child consumers which were not shown in this table. Fidelity measurement of EBPs is not consistent across states. Only 1 to 20 states reported fidelity of the EBPs listed in the table. Nebraska measured fidelity of supported housing, supported employment, assertive community treatment and multi-systemic therapy.

Note that Nebraska data are only for the Division of Behavioral Health (DBH) funded services. Services funded by the DBH focus on priority populations, while data from other states data include Medicaid services (which may but do not necessarily include priority populations).

Table 6.27: Appropriateness Domain – Evidence-Based Practices Reported by SMHAs, FY 2015[57]

Adult EBP Services	Nebraska		U.S.		Penetration Rate: % of Consumers Receiving EBP/Estimated SMI		Measuring Fidelity		States Reporting
	EBP N	SMI N	EBP N	SMI N	Ne	U.S.	Nebraska	U.S.	
Supported Housing	801	11,387	71,533	3,356,732	7.0%	2.6%	Yes	6	33
Supported Employment	605	11,387	62,500	3,356,732	5.3%	2.0%	Yes	14	41
Assertive Community Treatment	115	11,387	61,215	3,356,732	1.0%	1.9%	Yes	20	36
Family Psychoeducation	-		27,706	3,356,732	-	1.8%	-	1	14
Dual Diagnosis Treatment	519	11,387	208,811	3,356,732	4.6%	10.5%	No	11	24
Illness Self Management	-		273,289	3,356,732	-	17.3%	-	5	21
Medication Management	6,163	11,387	367,769	3,356,732	54.1%	21.5%	No	3	19
Child/Adolescent EBP Services	**Nebraska**		**U.S.**		**Penetration Rate: % of Consumers Receiving EBP/Estimated SMI**		**Measuring Fidelity**		**States Reporting**
	EBP N	SMI N	EBP N	SMI N	Nebraska	U.S.	Nebraska	U.S.	
Therapeutic Foster Care	-	-	11,586	1,266,691	-	1.3%	-	7	24
Multi-Systemic Therapy	17	1,797	29,938	1,266,691	0.9%	4.6%	Yes	10	18
Family Functional Therapy	-	-	26,949	1,266,691	-	4.8%	-	6	13

Table 6.28 shows information related to employment status, one of the outcome indicators. In every aspect, the percentage of consumers employed was higher in Nebraska than the U.S. average. In Nebraska, 62% of consumers in the labor force were employed compared to 34.5% for the U.S. average. The percentage of employed was higher in Nebraska than the U.S. average for every age group.

Note that data from other states data may include consumers served by Medicaid, whereas Nebraska data presented here include consumers whose services were funded through the Division of Behavioral Health.

Table 6.28: Outcomes Domain – Employment Status of Adult Mental Health Consumers Served in the Community by Age and Gender, FY 2015[57]

Demographics	Nebraska				Employed as Percent of those in Labor Force		Employed as Percent of Known Employment Status		States Reporting
	Employed	Unemployed	In Labor Force*	With Known Employment Status	Nebraska	U.S.	Nebraska	U.S.	
Age 18 to 20	282	188	470	762	60%	48%	37.0%	19.8%	57
Age 21 to 64	4,917	3,012	7,929	14,129	62%	46%	34.8%	22.7%	57
Age 65 and over	38	14	52	274	73%	39%	13.9%	9.4%	56
Age Not Available	-	-	-	-	-	55%	-	21.4%	8
Age TOTAL	5,237	3,214	8,451	15,165	62%	45%	34.5%	21.7%	57
Female	2,838	1,544	4,382	8,045	65%	48%	35.3%	22.8%	57
Male	2,398	1,670	4,068	7,119	59%	42%	33.7%	20.3%	57
Gender Not Available	1	-	1	1	100%	39%	100.0%	18.2%	31
Gender TOTAL	5,237	3,214	8,451	15,165	62%	45%	34.5%	21.7%	57

*In Labor Force is the sum of consumers employed and unemployed.
**With Known Employment Status is the sum of consumer employed, unemployed and not in labor force.
Consumers employed as a % of those in labor force uses adults employed and unemployed as the denominator. Consumers employed as % of known employment status uses the sum of persons employed, unemployed and not in labor force as the denominator.

Table 6.29 summarizes the information related to living situation of consumers who were served through the state mental health authority. Among children (0-17 years), a higher percentage of consumers in Nebraska was living in private residents (88.2%) than the U.S. average (57.8%). Similarly, among adults (18 years and over), a higher percentage of consumers in Nebraska (66.5%) were living in private residents than the U.S. overall (58.7%). The percentage of adult consumers living in homeless or living in shelters was higher in Nebraska (6.9%) than for the U.S. overall (3.5%).

Note other states' data may include Medicaid-served consumers whereas Nebraska data presented here include consumers served through the Division of Behavioral Health funded services.

Table 6.29: Appropriateness Domain – Living Situation of Consumers Served by State Mental Health Agency Systems, FY 2015[57]

Age Group	Setting	Nebraska			U.S.			State Reporting
		Living Situation	Percent in Living Situation	Percent with Known Living Situation	Living Situation	Percent in Living Situation	Percent with Known Living Situation	
All Persons Served	Private Residence	13,316	68.5%	75.3%	4,120,639	58.4%	76.2%	58
	Foster Home	32	0.2%	0.2%	69,697	1.0%	1.3%	49
	Residential Care	485	2.5%	2.7%	188,558	2.7%	3.5%	52
	Crisis Residence	11	0.1%	0.1%	6,936	0.1%	0.1%	32
	Residential Treatment Center	21	0.1%	0.1%	10,871	0.2%	0.2%	34
	Institutional Setting	189	1.0%	1.1%	76,632	1.1%	1.4%	51
	Jail (Correctional Facility)	419	2.2%	2.4%	77,670	1.1%	1.4%	53
	Homeless (Shelter)	1,211	6.2%	6.8%	184,710	2.6%	3.4%	54
	Other	2,011	10.3%	11.4%	674,892	9.6%	12.5%	47
	Not Available	1,746	9.0%	-	1,641,492	23.3%	-	47
	Total	19,441	100.0%	100.0%	7,052,097	100.0%	100.0%	58
Children Under Age 18	Private Residence	1,606	88.2%	94.1%	1,123,535	57.8%	78.6%	57
	Foster Home	17	0.9%	1.0%	44,058	2.3%	3.1%	49
	Residential Care	16	0.9%	0.9%	16,709	0.9%	1.2%	46
	Crisis Residence	1	0.1%	0.1%	1,384	0.1%	0.1%	27
	Residential Treatment Center	18	1.0%	1.1%	7,992	0.4%	0.6%	33
	Institutional Setting	16	0.9%	0.9%	5,601	0.3%	0.4%	45
	Jail (Correctional Facility)	13	0.7%	0.8%	9,349	0.5%	0.7%	48
	Homeless (Shelter)	3	0.2%	0.2%	5,660	0.3%	0.4%	50
	Other	17	0.9%	1.0%	215,212	11.1%	15.1%	43
	Not Available	113	6.2%	-	515,672	26.5%	-	46
	Total	1,820	100.0%	100.0%	1,945,172	100.0%	100.0%	57
Adults over Age 18	Private Residence	11,710	66.5%	73.2%	2,995,188	58.7%	75.3%	58
	Foster Home	15	0.1%	0.1%	25,600	0.5%	0.6%	48
	Residential Care	469	2.7%	2.9%	171,661	3.4%	4.3%	51
	Crisis Residence	10	0.1%	0.1%	5,552	0.1%	0.1%	31
	Residential Treatment Center	3	0.0%	0.0%	2,876	0.1%	0.1%	23
	Institutional Setting	173	1.0%	1.1%	70,874	1.4%	1.8%	51
	Jail (Correctional Facility)	406	2.3%	2.5%	68,180	1.3%	1.7%	53
	Homeless (Shelter)	1,208	6.9%	7.6%	178,886	3.5%	4.5%	54
	Other	1,994	11.3%	12.5%	459,468	9.0%	11.5%	47
	Not Available	1,633	9.3%	-	1,122,491	22.0%	-	47
	Total	17,621	100.0%	100.0%	5,100,776	100.0%	100.0%	58

Table 6.30 reports the demographic characteristics of homeless consumers. In Nebraska, 98.8% of consumers who were homeless or living in shelters were adults aged 18-64 years, which is slightly higher than that for the U.S. overall (94.7%). For both Nebraska and the U.S. overall, about 60% of consumers who were homeless or living in shelters were males. A higher percentage of Nebraska homeless consumers were American Indian/Alaska Native (4.1%) than the U.S. average (1.6%).

Note that data from other states data may include consumers served by Medicaid, whereas Nebraska data presented here include consumers whose services were funded through the Division of Behavioral Health.

Table 6.30: Appropriateness Domain – Persons Who Were Homeless by Age, Gender, Race, and Ethnicity, FY 2015[57]

	Homeless or Living in Shelters				Percent of Total with Known Living Situation		States Reporting
	Nebraska		U.S.		Nebraska	U.S.	
	%	N	%	%	%	%	
Age 0 to 17	3	0.2%	5,660	3.1%	0.2%	0.4%	50
Age 18 to 64	1,196	98.8%	174,837	94.7%	7.6%	4.7%	54
Age 65+	12	1.0%	4,049	2.2%	3.9%	1.4%	52
Age Not Available	-	-	164	0.1%	-	5.8%	8
Age Total	1,211	100.0%	184,710	100.0%	6.8%	3.4%	54
Female	451	37.2%	71,631	38.8%	5.0%	2.5%	53
Male	760	62.8%	112,829	61.1%	8.7%	4.3%	54
Gender Not Available	-	-	250	0.1%	-	4.6%	21
Gender Total	1,211	100.0%	184,710	100.0%	6.8%	3.4%	54
American Indian or Alaska Native	50	4.1%	2,987	1.6%	11.6%	4.3%	47
Asian	6	0.5%	1,406	0.8%	4.7%	2.0%	44
Black or African American	174	14.4%	56,822	30.8%	11.5%	5.3%	51
Native Hawaiian or Other Pacific Islander	9	0.7%	392	0.2%	7.6%	3.7%	35
White	953	78.7%	97,327	52.7%	6.2%	2.9%	51
Hispanic or Latino	*	*	1,122	0.6%	*	1.9%	9
More Than One Race	19	1.6%	5,803	3.1%	8.7%	3.6%	42
Race Not Available	-	-	18,851	10.2%	-	3.3%	45
Race Total	1,211	100.0%	184,710	100.0%	6.8%	3.4%	54
Hispanic or Latino	65	5.4%	33,515	18.1%	4.3%	3.2%	48
Not Hispanic or Latino	1,122	92.7%	137,384	74.4%	7.1%	3.4%	52
Not Available	24	2.0%	13,811	7.5%	4.9%	3.8%	40
Ethnicity Total	1,211	100.0%	184,710	100.0%	6.8%	3.4%	54

CY2014 Nebraska NOMs for Substance Use Disorder Services

This section presents national outcome measures (NOMs) for substance use disorder (SUD) services. As shown in **Table 6.31,** 10.3% of consumers served by substance use disorder (SUD) programs funded through the Division of Behavioral Health (DBH) were employed or were students at discharge from a short-term facility, compared to 22.0% for the U.S. average. The percentage of consumers employed or students at discharge was much higher for other types of facilities in Nebraska. For instance, 54.2% of people were employed or were students when they were discharged from an outpatient facility in Nebraska, much higher than the U.S. average of 36.0%.

Table 6.31: Employment/Education Status – Clients Employed or Student (Full-time and Part-time) (Prior 30 days) at Admission vs. Discharge: CY 2014 Nebraska and CY 2014 U.S.[58]

Indicator	Nebraska		U.S.
	At Admission	At Discharge	At Discharge
Short-Term			
Number of clients employed or student (full-time or part-time) [numerator]	126	107	
Total number of clients with non-missing values on employment status [denominator]	1034	1034	
Percent clients employed or student (full-time and part-time)	12.2%	10.3%	22.0%
Long-Term			
Number of clients employed or student (full-time or part-time) [numerator]	77	255	
Total number of clients with non-missing values on employment status [denominator]	558	588	
Percent clients employed or student (full-time and part-time)	13.8%	45.7%	16.0%
Outpatient			
Number of clients employed or student (full-time or part-time) [numerator]	1320	1484	
Total number of clients with non-missing values on employment status [denominator]	2736	2736	
Percent clients employed or student (full-time and part-time)	48.2%	54.2%	36.0%
Intensive Outpatient			
Number of clients employed or student (full-time or part-time) [numerator]	180	215	
Total number of clients with non-missing values on employment status [denominator]	428	428	
Percent clients employed or student (full-time and part-time)	42.1%	50.2%	27.0%
Exclude detox, hospital inpatient, opioid replacement clients; deaths; and incarcerated.			

Table 6.32 shows the living situations of consumers served in SUD treatment programs funded by the DBH. In Nebraska 80.8% to 96.9% of consumers discharged from SUD treatment facilities were in a stable living situation 30 days prior, which is comparable to that of the U.S. average.

Table 6.32: Stability of Housing – Clients Reporting Being a Stable Living Situation (Prior 30 Days) at Admission vs. Discharge: CY 2014 Nebraska and CY 2012 U.S.[58]

Indicator	Nebraska		US
	At Admission	At Discharge	At Discharge
Short-term residential			
Number of clients in a stable living situation [numerator]	627	715	
Total number of clients with non-missing values on living arrangements [denominator]	858	858	
Percent clients in stable living situation	73.1%	83.3%	88.8%
Long-term residential			
Number of clients in a stable living situation [numerator]	325	344	
Total number of clients with non-missing values on living arrangements [denominator]	426	426	
Percent clients in stable living situation	76.3%	80.8%	84.0%
Outpatient			
Number of clients in a stable living situation [numerator]	2237	2272	
Total number of clients with non-missing values on living arrangements [denominator]	2427	2427	
Percent clients in stable living situation	92.2%	93.6%	95.5%
Intensive Outpatient			
Number of clients in a stable living situation [numerator]	375	378	
Total number of clients with non-missing values on living arrangements [denominator]	390	390	
Percent clients in stable living situation	96.2%	96.9%	94.4%
Exclude detox, hospital inpatient, opioid replacement clients; deaths; and incarcerated.			

Table 6.33 shows the percentage of consumers with an arrest record. Overall, Nebraska arrest statistics are similar to that of the U.S. average, except for consumers in intensive outpatient treatment: the percentage of people with any arrest 30 days prior to discharge was lower in Nebraska (84.3%) compared to the U.S. average (94.0%).

Table 6.33: Clients without Arrests (Any Charge) (Prior to 30 Days) at Admission vs. Discharge: CY 2014 Nebraska and CY 2012 U.S.[58]

Indicator	Nebraska		US
	At Admission	At Discharge	At Discharge
Short-term residential			
Number of clients without arrests [numerator]	932	1014	
Total number of Admission and Discharge clients with non-missing values on arrests [denominator]	1038	1038	
Percent clients without arrests (full-time and part-time)	89.8%	97.7%	95.0%
Long-term residential			
Number of clients without arrests [numerator]	551	553	
Total number of Admission and Discharge clients with non-missing values on arrests [denominator]	580	580	
Percent clients without arrests (full-time and part-time)	95.0%	95.3%	96.0%
Outpatient			
Number of clients without arrests [numerator]	2633	2610	
Total number of Admission and Discharge clients with non-missing values on arrests [denominator]	2822	2822	
Percent clients without arrests (full-time and part-time)	93.3%	92.5%	95.0%
Intensive outpatient			
Number of clients without arrests [numerator]	409	375	
Total number of Admission and Discharge clients with non-missing values on arrests [denominator]	445	445	
Percent clients without arrests (full-time and part-time)	91.9%	84.3%	94.0%
Exclude detox, hospital inpatient, opioid replacement clients; deaths; and incarcerated.			

Table 6.34 shows alcohol abstinence rates at admission and at discharge among consumers (regardless of primary problem) served through SUD treatment facilities funded by the DBH. There was an improvement in the abstinent rate for short-term residential (37.3% to 76.5%), long-term residential (61.9% to 75.3%), and intensive outpatient (63.0% to 77.5%) programs.

Table 6.34: Alcohol Abstinence – Clients with No Alcohol Use at Admission vs. Discharge (Regardless of Primary Problem): CY 2014 Nebraska[58]

Indicator	Nebraska		US
	At Admission	At Discharge	At Discharge
Short-term residential			
Number of clients abstinent from alcohol [numerator]	374	767	
All clients with non-missing values on at least one substance/frequency of use [denominator]	1003	1003	
Percent of clients abstinent from alcohol	37.3%	76.5%	NA
Long-term residential			
Number of clients abstinent from alcohol [numerator]	348	423	
All clients with non-missing values on at least one substance/frequency of use [denominator]	562	562	
Percent of clients abstinent from alcohol	61.9%	75.3%	NA
Outpatient			
Number of clients abstinent from alcohol [numerator]	1496	1592	
All clients with non-missing values on at least one substance/frequency of use [denominator]	2090	2090	
Percent of clients abstinent from alcohol	71.6%	76.2%	NA
Intensive outpatient			
Number of clients abstinent from alcohol [numerator]	283	293	
All clients with non-missing values on at least one substance/frequency of use [denominator]	378	378	
Percent of clients abstinent from alcohol	63.0%	77.5%	NA

Table 6.35 shows alcohol abstinence rates at admission and at discharge among consumers who were alcohol users at admission to treatment facilities funded by the DBH. Discharge alcohol abstinence rate was lower among these consumers compared to all consumers combined shown in **Table 6.34**. The discharge abstinent rate ranged from 26.8% (outpatient) to 77.5% (intensive outpatient) among alcohol users, while discharge abstinent rates among all consumers combined were well above 80% regardless of the level of care.

Table 6.35: Alcohol Abstinence at Discharge, Among Alcohol Users at Admission: CY 2014 Nebraska[58]

	Nebraska		US
	At Admission	At Discharge	At Discharge
Short-term residential			
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		399	
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge) [denominator]	629		
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission		63.4%	NA
Long-term residential			
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		87	
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge) [denominator]	214		
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission		40.7%	NA
Outpatient			
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		159	
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge) [denominator]	594		
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission		26.8%	NA
Intensive outpatient			
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		67	
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge) [denominator]	140		
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission		47.9%	NA

Table 6.36 shows that alcohol abstinence rate remains high among consumers who were abstinent from alcohol at admission. Over 95% of consumers who were abstinent from alcohol at admission to a treatment program were still abstinent from alcohol at discharge.

Table 6.36: Alcohol Abstinence at Discharge, Among Alcohol Abstinent at Admission: CY 2014 Nebraska[58]

	Nebraska		US
	At Admission	At Discharge	At Discharge
Short-term residential			
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		368	
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [numerator]	374		
Percent of clients from alcohol at discharge among clients abstinent from alcohol at admission		98.4%	NA
Long-term residential			
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		336	
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [numerator]	348		
Percent of clients from alcohol at discharge among clients abstinent from alcohol at admission		96.6%	NA
Outpatient			
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		1433	
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [numerator]	1496		
Percent of clients from alcohol at discharge among clients abstinent from alcohol at admission		95.8%	NA
Intensive outpatient			
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		226	
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [numerator]	238		
Percent of clients from alcohol at discharge among clients abstinent from alcohol at admission		95.0%	NA
Exclude detox, hospital inpatient, opioid replacement clients; deaths; and incarcerated.			

Table 6.37 shows that among all consumers treated at SUD programs funded by DBH (regardless of primary problem), 72.4% to 72.8% were abstinent from drugs at discharge.

Table 6.37: Drug Abstinence—Clients with No Drug Use at Admission vs. Discharge (Regardless of Primary Problem): CY 2014 Nebraska[58]

Indicator	Nebraska		US
	At Admission	At Discharge	At Discharge
Short-term residential			
Number of clients abstinent from drug [numerator]	371	726	
All clients with non-missing values on at least one substance/frequency of use [denominator]	1003	1003	
Percent of clients abstinent from drug	37.0%	72.4%	NA
Long-term residential			
Number of clients abstinent from drug [numerator]	374	428	
All clients with non-missing values on at least one substance/frequency of use [denominator]	562	562	
Percent of clients abstinent from drug	66.5%	76.2%	NA
Outpatient			
Number of clients abstinent from drug [numerator]	1627	1697	
All clients with non-missing values on at least one substance/frequency of use [denominator]	2090	2090	
Percent of clients abstinent from drug	77.8%	81.2%	NA
Intensive outpatient			
Number of clients abstinent from drug [numerator]	279	313	
All clients with non-missing values on at least one substance/frequency of use [denominator]	378	378	
Percent of clients abstinent from drug	73.8%	82.8%	NA

Table 6.38 shows discharge drug abstinence rates among drug users. The abstinence rate ranged from 27.4% for outpatient to 57.4% for short-term residential treatment.

Table 6.38: Drug Abstinence at Discharge, Among Drug Users at Admission: CY 2014 Nebraska[58]

Indicator	Nebraska		US
	At Admission	At Discharge	At Discharge
Short-term residential			
Number of clients abstinent from drug at discharge among clients using drug at admission [numerator]		363	
Number of clients using drug at admission (records with at least one substance/frequency of use at admission and discharge) [denominator]	632		
Percent of clients abstinent from drug at discharge among clients using drug ad admission		57.4%	NA
Long-term residential			
Number of clients abstinent from drug at discharge among clients using drug at admission [numerator]		65	
Number of clients using drug at admission (records with at least one substance/frequency of use at admission and discharge) [denominator]	188		
Percent of clients abstinent from drug at discharge among clients using drug ad admission		34.6%	NA
Outpatient			
Number of clients abstinent from drug at discharge among clients using drug at admission [numerator]		127	
Number of clients using drug at admission (records with at least one substance/frequency of use at admission and discharge) [denominator]	463		
Percent of clients abstinent from drug at discharge among clients using drug ad admission		27.4%	NA
Intensive outpatient			
Number of clients abstinent from drug at discharge among clients using drug at admission [numerator]		47	
Number of clients using drug at admission (records with at least one substance/frequency of use at admission and discharge) [denominator]	99		
Percent of clients abstinent from drug at discharge among clients using drug ad admission		47.5%	NA

Similar to alcohol users (**Table 6.36**), the discharge drug abstinence rates were high among consumers abstinent from drugs at admission (over 95%) (**Table 6.39**).

Table 6.39: Drug Abstinence at Discharge, Among Drug Abstinent at Admission: CY 2014 Nebraska[58]

Indicator	Nebraska		US
	At Admission	At Discharge	At Discharge
Short-term residential			
Number of clients abstinent from drug at discharge among clients abstinent from drug at admission [numerator]		363	
Number of clients abstinent from drug at admission (records with at least one substance/frequency of use at admission and discharge [numerator]	371		
Percent of clients from drug at discharge among clients abstinent from drug at admission		97.8%	NA
Long-term residential			
Number of clients abstinent from drug at discharge among clients abstinent from drug at admission [numerator]		363	
Number of clients abstinent from drug at admission (records with at least one substance/frequency of use at admission and discharge [numerator]	374		
Percent of clients from drug at discharge among clients abstinent from drug at admission		97.1%	NA
Outpatient			
Number of clients abstinent from drug at discharge among clients abstinent from drug at admission [numerator]		1570	
Number of clients abstinent from drug at admission (records with at least one substance/frequency of use at admission and discharge [numerator]	1627		
Percent of clients from drug at discharge among clients abstinent from drug at admission		96.5%	NA
Intensive outpatient			
Number of clients abstinent from drug at discharge among clients abstinent from drug at admission [numerator]		266	
Number of clients abstinent from drug at admission (records with at least one substance/frequency of use at admission and discharge [numerator]	279		
Percent of clients from drug at discharge among clients abstinent from drug at admission		95.3%	NA
Exclude detox, hospital inpatient, opioid replacement clients; deaths; and incarcerated.			

Compared to the U.S. overall, participation was high in self-help programs such as Alcoholic Anonymous and Narcotics Anonymous, and this was true across different levels of treatment for Nebraska consumers (**Table 6.40**).

Table 6.40: Social Support of Recovery – Clients Attending Self-help Programs (e.g., AA, NA, etc.) (Prior 30 Days) at Admission vs. Discharge: CY 2014 Nebraska and CY 2012 U.S.[58]

Indicator	Nebraska		US
	At Admission	At Discharge	At Discharge
Short-term residential			
Number of clients attending self-help program [numerator]	366	965	
Total number of clients with non-missing values on self-help attendance [denominator]	1028	1028	
Percent clients attending self-help programs	35.6%	93.9%	66.0%
Long-term residential			
Number of clients attending self-help program [numerator]	395	548	
Total number of clients with non-missing values on self-help attendance [denominator]	568	568	
Percent clients attending self-help programs	69.5%	96.5%	69.0%
Outpatient			
Number of clients attending self-help program [numerator]	924	1050	
Total number of clients with non-missing values on self-help attendance [denominator]	2819	2819	
Percent clients attending self-help programs	32.8%	37.2%	27.0%
Intensive outpatient			
Number of clients attending self-help program [numerator]	183	264	
Total number of clients with non-missing values on self-help attendance [denominator]	440	440	
Percent clients attending self-help programs	41.6%	60.0%	44.0%
Exclude detox, hospital inpatient, opioid replacement clients; deaths; and incarcerated.			

Table 6.41 shows the median length of stay (LOS) among Nebraska consumers served at SUD treatment programs funded by DBH. In Nebraska, the median LOS for rehabilitation/residential programs was 29 days for short-term and 74 days for long-term programs. The median LOS for ambulatory (outpatient) programs was 51 days for intensive outpatient, 85 days for outpatient, and 331 for detoxification. Finally, the median LOS for opioid replacement therapy was 55 days.

Table 6.41: Retention – Length of Stay (in Days) of Clients Completing Treatment: CY 2014 Nebraska and CY 2012 U.S.[58]

Level of Care	Nebraska				US
	Average (Mean)	25th Percentile	50th percentile	75th percentile	Median
Detoxification (24-hour care)					
Hospital inpatient	0	0	0	0	
Free-standing residential	2	1	1	2	4
Rehabilitation/Residential					
Hospital inpatient	0	0	0	0	
Short-term (up to 30 days)	28	21	29	36	21
Long-term (over 30 days)	94	28	74	136	54
Ambulatory (Outpatient)					
Outpatient	114	28	85	144	90
Intensive outpatient	62	35	51	79	56
Detoxification	331	331	331	331	
Opioid Replacement Therapy					
Opioid replacement therapy	104	5	55	168	201
ORT outpatient	85	20	56	98	6

The Division of Behavioral Health Consumer Satisfaction Survey Results

The Division of Behavioral Health (DBH) conducts the annual Behavioral Health Consumer Survey to solicit feedback from adult and youth consumers who mental health and/or substance use disorder services from the DBH publicly funded, community-based behavioral health system. This section reports the results of the 2015 survey on consumer satisfaction, and on health issues such as obesity and smoking.

A total of 1,497 adults (30% response rate) and 340 youth caregivers (33% response rate) completed the 2015 survey. **Table 6.42** shows the results of the adult consumer survey.[59] In general, Nebraska's results are similar to that of the U.S. average. For almost all indicators, at least 70% of consumers in Nebraska responded positively, indicating their overall satisfaction with services they receive. One exception was "Social Connectedness," which received the lowest percentage of positive responses among all indicators in this table for both Nebraska (68%) and the U.S. overall (69%). [57, 59]

Table 6.42: Adult Consumers Positively Responded to Measures: 2012-2015 Nebraska vs. 2015 U.S. Average[57, 59]

Indicator	Nebraska				U.S.
	2012	2013	2014	2015	2015
Access	81%	82%	81%	83%	85%
Quality/Appropriateness	86%	86%	85%	87%	89%
Outcomes	74%	70%	72%	73%	70%
General Satisfaction	84%	85%	79%	87%	89%
Participation in Treatment Planning	77%	79%	84%	79%	80%
Functioning	76%	71%	74%	73%	70%
Social Connectedness	75%	69%	71%	68%	69%

Table 6.43 shows the breakdown of the 2015 survey results by Behavioral Health Region. There were some statistical differences between regions.[59] For example, a significantly higher percentage of consumers in Region 2 responded positively to the access question, whereas a significantly lower percentage of consumers in Region 4 responded positively to this question. Regarding the quality/appropriateness question, a significantly higher percentage of consumers in Region 2 positively responded to this question compared to other regions.

Table 6.43: Adult Consumers Positively Responded to Measures 2015 Nebraska: By Region[59]

Region	Access	Quality/ Appropriate-ness	Outcomes	Participant Treatment Planning	General Satisfaction	Functioning	Social Connected-ness
Region 1	86%	89%	72%	84%	88.1%	71%	64%
Region 2	87%	93%*	78%	82%	90.4%	76%	65%
Region 3	89%**	89%	76%	80%	89.9%	76%	69%
Region 4	78%**	83%	74%	78%	83.0%	71%	71%
Region 5	84%	85%	71%	76%	85.7%	75%	69%
Region 6	82%	90%	70%	81%	86.5%	72%	68%
*Significant difference at .05. **Significant difference at .01.							

There were some questions about health status and health risk factors included in the consumer survey. **Table 6.44** shows the health status of adult consumers and the Nebraska general population. The

prevalence of diabetes was high among mental health disorder consumers compared to substance use disorder consumers in the general population of Nebraska (17.1%, 5.3%, and 9.2%, respectively). About 75% of mental health consumers are obese or overweight, compared to 67% of the general population. The general health status among mental health and substance use disorder consumers was also poorer than the general population. Almost 50% of mental health consumers and 66% of substance use disorder consumers were smokers compared to 17% of the general population.[59]

Table 6.44: Differences on BRFSS Questions between Consumers Receiving Mental Health versus Substance Use Disorder Services and the General Adult Population in Nebraska[59]

Indicators	(Consumer Survey) 2015 Primary Reason for Admission		(BRFSS) 2014 Nebraska General Pop.
	MHD	SUD	
Physical Health Conditions			
Heart Attack or Myocardial Infarction	5.3%	2.8%	3.8%
Angina or Coronary Heart Disease	4.5%	1.9%	3.9%
Stroke	4.0%	2.8%	2.6%
Diabetes	17.1%	5.3%	9.2%
Body Mass Index Category			
Obese	47.5%	23.7%	30.2%
Overweight	27.8%	34.9%	36.5%
Normal Weight	22.7%	39.1%	31.7%
Underweight	1.9%	2.3%	1.6%
Cigarette Smoking			
Every Day	36.8%	51.2%	11.8%
Some Day	8.5%	14.5%	5.0%
Does Not Smoke	54.7%	34.3%	80.1%
General Health Status			
Excellent	6.8%	9.3%	19.2%
Very Good	19.2%	26.9%	36.4%
Good	37.9%	41.4%	31.1%
Fair	26.2%	16.7%	9.9%
Poor	9.6%	5.6%	3.3%
In the Past 30 Days			
Average Days Physical Health Not Good	8.1	4.9	3.0
Average Days Mental Health Not Good	11.4	7.5	2.8
Average Days Poor Health Prevented Usual Activities	7.8	5.0	1.8
Average Days of Binge Drinking	1.2	1.5	--

Table 6.45 shows the results of Nebraska youth/family survey and the U.S. average data. Compared to other measures, the percentage that positively responded to “Outcomes” and “Functioning” has been lower. In 2015, only 60.8% of those who participated in the youth/family survey indicated a positive response to the outcome indicator.[59]

Table 6.45: Youth/Family Positively Responded to Measures: 2012-2015 Nebraska vs. 2015 U.S. Average[59]

Indicator	Nebraska				U.S.
	2012	2013	2014	2015	2015
Access	87.4%	85.3%	84.2%	82.1%	86%
General Satisfaction	79.0%	76.6%	77.9%	76.1%	86%
Outcomes	63.8%	67.1%	61.6%	60.8%	68%
Family Involvement	86.3%	89.3%	88.2%	89.8%	88%
Cultural Sensitivity	91.9%	94.0%	92.8%	95.1%	94%
Functioning	63.4%	66.7%	62.7%	62.4%	70%
Social Connectedness	81.0%	83.6%	84.3%	77.3%	86%

Table 6.46 shows the health outcomes from the youth survey. It is important to note that 33% of youth consumers are obese, and an additional 20% are overweight. There are various reasons why youths with behavioral health issues are at higher risk of obesity and other health problems, and these include the effects of certain psychotropic medications. A comprehensive measure to prevent and manage chronic disease risk factors such as diet and physical activity is also warranted for youths and adults with behavioral health issues.[59]

Table 6.46: BRFSS Questions for Youth Consumers[59]

Indicator	Youth
Body Mass Index Category	
Obese	32.7%
Overweight	19.4%
Normal Weight	42.7%
Underweight	5.2%
General Health Status	
Excellent	24.8%
Very Good	38.2%
Good	29.4%
Fair	7.0%
Poor	0.6%
In the Past 30 Days	
Average Days Physical Health Not Good	1.8
Average Days Mental Health Not Good	8.7
Average Days Poor Health Prevented Usual Activities	3.6

VII. Special Populations: Issues and Needs

Summary

This chapter presents information about some of most vulnerable population groups including populations with intellectual and developmental disabilities, the criminal justice system population, Veterans, and the homeless population. Because of limited time and resources, other at-risk populations, such as transitional age youths and the lesbian/gay/bi-sexual/transgender (LGBT) population were not included in the present report. Transitional age youths and LGBT are at increased risk of experiencing behavioral health problems and face a number of barriers to access needed treatment, and a separate needs assessment that focuses on both of these populations should be conducted in the near future.

The information in this chapter was obtained from the Nebraska Department of Health and Human Services. Literature reviews were also conducted to collect additional information.

Chapter Highlights

Population with Intellectual and Developmental Disabilities (IDDs)

- According to the literature, persons with intellectual and developmental disabilities (IDDs) may be at higher risk of developing mental health and substance use disorders. However, there are limited resources available due to lack of provider training and evidence-based practices specifically tailored to the IDD population.
- In Nebraska, an estimated 9.4% of children and 46.4% of adults served in community-based programs administered by Division of Developmental Health have been diagnosed with a mental disorder and/or substance use disorder.
- In Nebraska, an estimated 63% of adults in state-operated services administered by the Division of Developmental Health have been diagnosed with a mental disorder and/or substance use disorder.
- Nebraska Developmental Disabilities created a 5-year strategic plan for 2017-2021, which aims to facilitate self-advocacy by people with IDDs, to examine and identify causes of service disparities, and to increase collaboration within the state's developmental disability network.

Criminal Justice System Population

- The number of incarcerated continues to increase in Nebraska and across the United States.
- It is estimated that 50-60% of inmates have mental health or substance related disorders.
- Inmates with mental health or substance related disorders are higher risk of recidivism.
- In Nebraska and across the United States, efforts to divert persons from the criminal justice system have been accomplished using CIT and mental health/drug courts.
- In 2003, the Justice Behavioral Health Committee was created to help improve communication and collaboration between the criminal justice system and the behavioral health treatment systems in Nebraska.

- A study by the Council of State Governments Justice Center found that the Nebraska Department of Correctional Services uses several state-of-the art risk reduction programs, but that the people who need to participate in the program(s) do not enter them as soon as they should. The study recommended to increase access to evidence-based community programs for populations involved in the criminal justice system and to provide incentives to service providers so as to create a continuum of care in the community coordinated with models of prison programming.

Veterans

- An estimated 22 million veterans were living in the U.S. in 2013; of these, 5.2 million veterans live in rural communities.
- In 2015, over 47,000 veterans were homeless. While homelessness among veterans has decreased annually since 2010, veterans are overrepresented among the homeless population.
- In 2012, about 8% of inmates in state and federal prisons or local jails were veterans. About half of incarcerated veterans were told they had a mental disorder by a mental health provider.
- The lifetime post-traumatic stress disorder (PTSD) incidence among service members is two to three times of that in the general population, with the prevalence estimate range from 13%-20%.
- One in ten returning combat veterans who served in Operation Enduring Freedom/Operation Iraqi Freedom seen by Veterans Affairs health care have a problem with alcohol or other drugs.
- One in four women receiving care at the VA and 1 in 100 men report they experienced military sexual trauma (MST). Persons who experienced MST are 9 times more likely to develop PTSD and they experience higher prevalence of depression, anxiety, and other mood disorders.
- About 77% of veterans who committed suicide had never received behavioral health treatment or connected with VA.
- Over 137,000 veterans live in Nebraska, and close to half of them (46%) are 65 years or older.
- Many veterans living in rural Nebraska have disabilities and/or live in poverty.

Homeless Population and Housing Programs

- About half of the chronically homeless have mental health problems.
- In rural communities, homelessness may be more of a burden because of limited resources and housing options.
- About 11% of adult homeless persons are veterans at a higher risk of a variety of mental health problems, including PTSD, depression, and substance use disorders.
- Often housing is not affordable for those on disability and public assistance.
- A collaborative program between the Department of Housing and Urban Development (HUD) and Veterans Affairs (VA) for finding and sustaining permanent housing combines HUD housing vouchers with VA supportive services to veterans and their families.
- The Division of Behavioral Health contracts with Regional Behavioral Health Authorities to deliver housing assistance (Housing Related Assistance [HRA]). HRA funds are designed to cover housing and related costs. Persons in the HRA program also receive services and support to maintain or secure independent living in community settings.

Chapter Recommendations

For Persons with Intellectual and Developmental Disabilities (IDDs)

- Expand the training and education opportunities for persons with IDDs who are served by the Division of Developmental Disabilities (DDD) for self-advocacy to improves and maintains health.
- Conduct a study to assess access to and use of evidence-based behavioral health services among persons with IDDs served by the DDD.
- Develop a strategic plan to improve the behavioral health status of persons with IDDs served by the DDD.

For Persons in the Criminal Justice System

- Follow the recommendation from the study by the Council of State Governments Justice Center to increase access to evidence-based community programs for persons involved in the justice system, and to provide incentives to service providers that will create a continuum of care in the community and is coordinated with models of prisons programming.
- Provide training and services to expand and strengthen the behavioral health workforce for the criminal justice system.

For Veterans

- Develop a strategic plan to improve the coordination of civilian, military, and veteran service systems to increase access to and use of behavioral health services, housing, and social support programs.
- Facilitate development and/or expansion of suicide prevention programs for veterans and military families.

For Homeless Persons and Housing Programs

- As described in this chapter and Chapter 9, persons with behavioral health issues who live in rural communities have limited housing resources and options. Educate and provide incentives to rental property owners, and increase support for consumers to secure and maintain permanent housing in rural communities.
- Assess the housing need of transitional age youths with behavioral health problems; they are likely to have tremendous barriers to obtaining stable and safe housing.

Population with Intellectual and Developmental Disabilities (IDDs)

Definitions and Prevalence of IDDs

Intellectual and developmental disabilities (IDDs) are defined as "disorders that are usually present at birth and that negatively affect the trajectory of the individual's physical, intellectual, and/or emotional development".[60] An intellectual disability can start any time before a child turns 18 and is characterized by "significant limitations in cognitive functioning and adaptive behaviors that relate to everyday social and practical skills."[61]

The term "developmental disabilities" is a broader category and can be intellectual, physical, or both. The major types of developmental disabilities include: Autism spectrum disorder, cerebral palsy, hearing loss, intellectual disability, and vision impairment.[60]

In the U.S. about 14% of children aged 3-17 years have a developmental disability.[62] The prevalence ranges from 0.13% for blindness to 7% for attention deficit hyperactive disorder (ADHD) and 8% for learning disabilities. The prevalence of developmental disabilities is nearly twofold higher among children insured by Medicaid compared to children insured by private insurance.[62]

Mental Health and Substance Related Disorders among Persons with IDDs

The prevalence of mental health disorders may vary among different types of IDDs, but the general consensus is that persons with IDDs may be at a higher risk for psychiatric disorders due to genetic, family, and social factors that are shared by these disorders.[63-65] The prevalence of mental health disorders among persons with IDDs ranges from 15%[66] to 30%[67] and 41%.[68]

According to Chapman et al., the seven to eight million people in the United States who have intellectual disabilities have a disproportionately increased risk for a co-occurring substance abuse disorder.[61] When compared to persons with substance abuse disorders who do not have intellectual disabilities, those with IDDs are less likely to receive substance use disorder treatment or remain in treatment.[61]

Mental Health and Substance Use Disorder Treatment

The following challenges in treatment of mental health substance related disorders among persons with IDDs have been identified in (**Table 7.1**).[61, 69]

Table 7.1: Challenges with Treatment of Mental Health and Substance Disorders among Persons with IDDs[61, 69]

Socioeconomic Issues
Among all mental health disorders, those with intellectual disabilities and mental illness are the least socially accepted. These groups face health, housing, and employment disparities.
Persons who have intellectual disabilities are more likely to face poverty and insurance coverage issues.
Medicaid coverage which varies by state, has been the most common payer for this population, but often does not cover private substance use disorder treatment.
Misperception about and Issues with Treatment
There is a misperception that existing treatment programs are not effective for the IDD population. This may result in the IDD population less likely to initiate the substance use disorder treatment than those without IDDs.
Some persons with IDDs may not fully comprehend treatment plans and are stigmatized and excluded from the rest of the treatment group.
Provider Training Needs
Many behavioral health providers do not have the adequate training to assess, treat, or manage the complexity of comorbid IDDs and mental health substance disorders.
Counselors may confuse the lack or insufficiency of participation in treatment programs due to IDD limitations with non-compliance.
Lack of Evidence-Based Programs
Partly because of complexities with intellectual and developmental disabilities and barriers to conduct research with the IDD population, data are lacking to establish evidence-based treatment programs for the IDD population.

Developmental Disabilities Services and Support in Nebraska

The Division of Developmental Disabilities (DDD) of the Nebraska Department of Health & Human Services (DHHS) provides funding and oversight for community-based services and operates sites providing services for persons with developmental disabilities. The Division is responsible for: 1) determining eligibility for developmental disabilities (DD) services, 2) providing service coordination for eligible persons, 3) determining eligibility for DD Medicaid waivers services, 4) regulating and paying providers for community-based DD services, 5) providing training and technical assistance, and 6) investigating complaints.

Community-Based Services

An assigned service coordinator from DHHS assists the individual consumer and the family in accessing needed services. Eligible persons can choose what types of services they want to receive. Specialized services are provided by certified agencies; non-specialized services are flexible with supports provided by agencies or community members (other than family members within the consumer's household). For non-specialized services, there is no formalized certification process, but there is a process in place for approval by field staff to meet specific regulations.

State-Operated Services

Nebraska administers the Beatrice State Developmental Center (BSDC) and Bridges. BSDC comprises separate intermediate care facilities for those with intellectual disabilities, and a vocational and recreational team that operates independently of the intermediate care facilities on the campus. Bridges is

licensed as a Center for Developmental Disabilities, administered by a program manager, and overseen by the leadership of the BSDC. The Bridges program is staffed by qualified employees who address the safety and behavioral challenges of consumers living at Bridges.

Other Related Assistance

In addition, the DDD helps eligible persons with access to varied resources, including Supplemental Security Income (SSI) benefits, Medicaid, long-term care services, and other economic assistance.

Demographic Characteristics of Persons Served in Nebraska DDD Programs

In FY 2015 (7/1/14-6/30/15), the DDD served 3,953 persons in the community-based programs and 125 in state-operated programs (**Table 7.2)**. Six in 10 (59%) were males. The majority (80%) were adults aged between 21 and 60 years. Close to 90% were Non-Hispanic Whites. An estimated 9.4% of children and 46.4% of adults in community-based services have been diagnosed with a mental disorder and/or substance use disorder. An estimated 63% of adults in state-operated services have been diagnosed with a mental disorder and/or substance use disorder.

Table 7.2: Demographic Characteristics of Persons Served in Programs Administered by Nebraska Division of Developmental Disabilities in FY 2015

Demographic Characteristics	Community-Based Services		State-Operated Services	
	Number	%	Number	%
TOTAL	3953	100.0	125	100.0
Gender	3953	100.0	125	100.0
Male	2331	59.0	75	60.0
Female	1616	40.9	50	40.0
Missing	6	0.2	0	0.0
Age (years)				
≤10	46	1.2	0	0.0
11-20	336	8.5	0	0.0
21-30	1284	32.5	8	6.4
31-40	895	22.6	10	8.0
41-50	577	14.6	13	10.0
51-60	463	11.7	52	41.6
61-70	255	6.5	33	26.4
71-80	78	2.0	5	4.0
81-90	19	0.5	4	3.2
Race/Ethnicity				
Non-Hispanic White	3434	86.87	111	88.80
Non-Hispanic African American	230	5.81	1	0.80
Non-Hispanic Other	127	3.21	4	3.20
Hispanic (of any race)	138	3.49	1	0.80
Missing	24	.60	9	7.2

Information in this table was provided by Nebraska DHHS Division of Developmental Disabilities.

5-Year State Plan by Nebraska Planning Council on Developmental Disabilities

The Administration on Intellectual and Developmental Disabilities (AIDD) is a federal agency responsible for the implementation and administration of the Developmental Assistance and Bill of Rights Act of 2000 and the disability provisions of the Help America Vote Act.[70] Each state's developmental

disabilities council submits a 5-year plan to the AIDD outlining the intended use of federal funding. Three goals identified in the draft 2017-2021 plan are the following (**Table 7.3**):

Table 7.3: Goals under 5-Year State Plan

Self-Advocacy
Support to a statewide self-advocacy organization
Facilitating people with developmental disabilities by providing leadership training to their peers
Activities to promote the participation of people with disabilities in cross-disability and culturally diverse leadership coalitions
Targeted Disparity
Examination of disparities in services based on a minority status or other factors
Identification of causes of service disparities and strategies to address such disparities
Collaboration
Strategic activities to show collaborations where the entire DD Network (Disability Rights Nebraska, Munroe-Meyer Institute University Center for Excellence in Developmental Disabilities, and the Nebraska Planning Council on Developmental Disabilities)

Information for this table was provided by the Nebraska Department of Health & Human Services Division of Behavioral Health

Criminal Justice System Populations

Incarceration Trends

Since the 1970s, the number of people incarcerated has grown at the federal, state and local levels of government (**Figure 7.1**).[71] Nebraska statistics mirror this trend as well (**Figure 7.2**),[72] with a 19% increase in the Nebraska imprisonment rate between 2006 and 2014 (**Figure 7.3**).[73]

Figure 7.1: Number of People Incarcerated per 100,000 Population by Level of Government, 1925-2012[71]

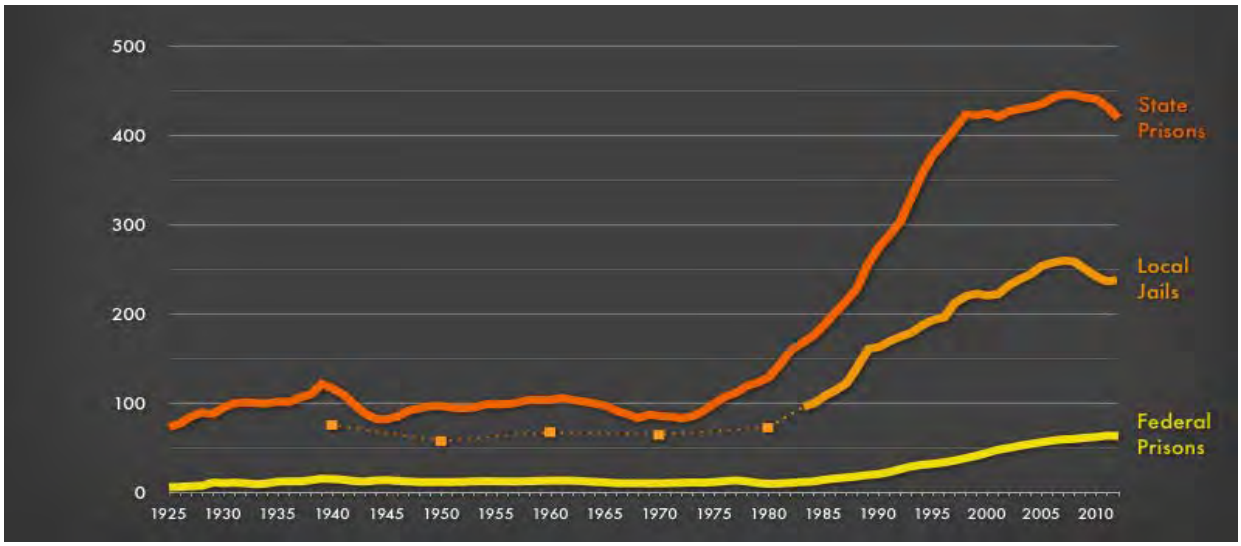


Figure 7.2: State Prison Population in Nebraska, 1978-2011[72]

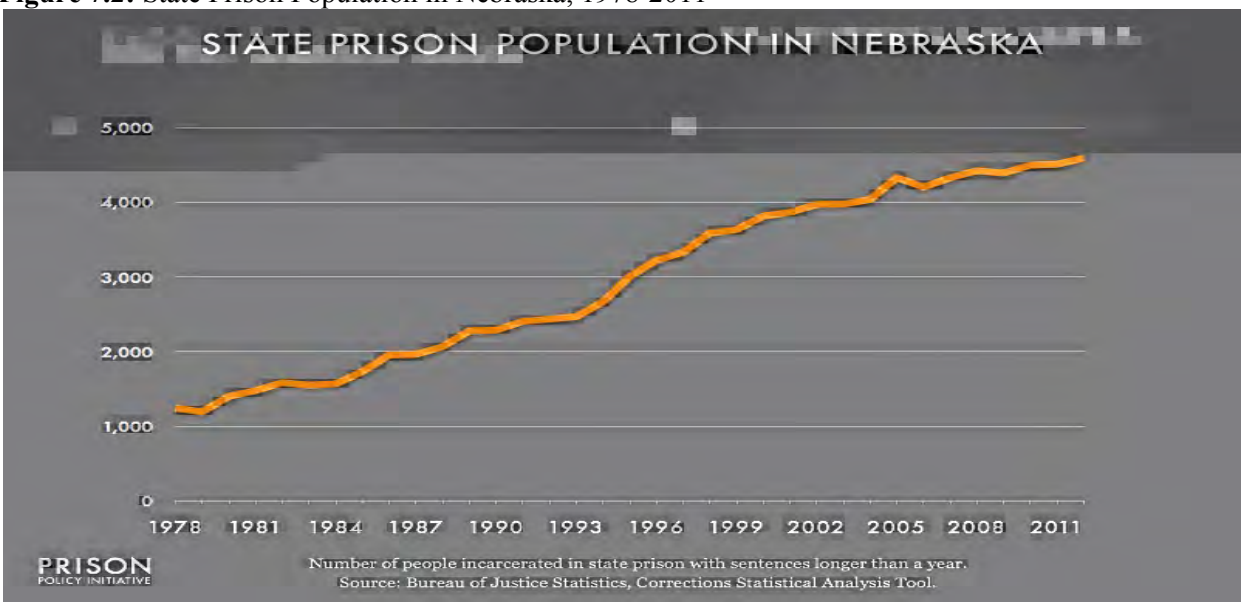
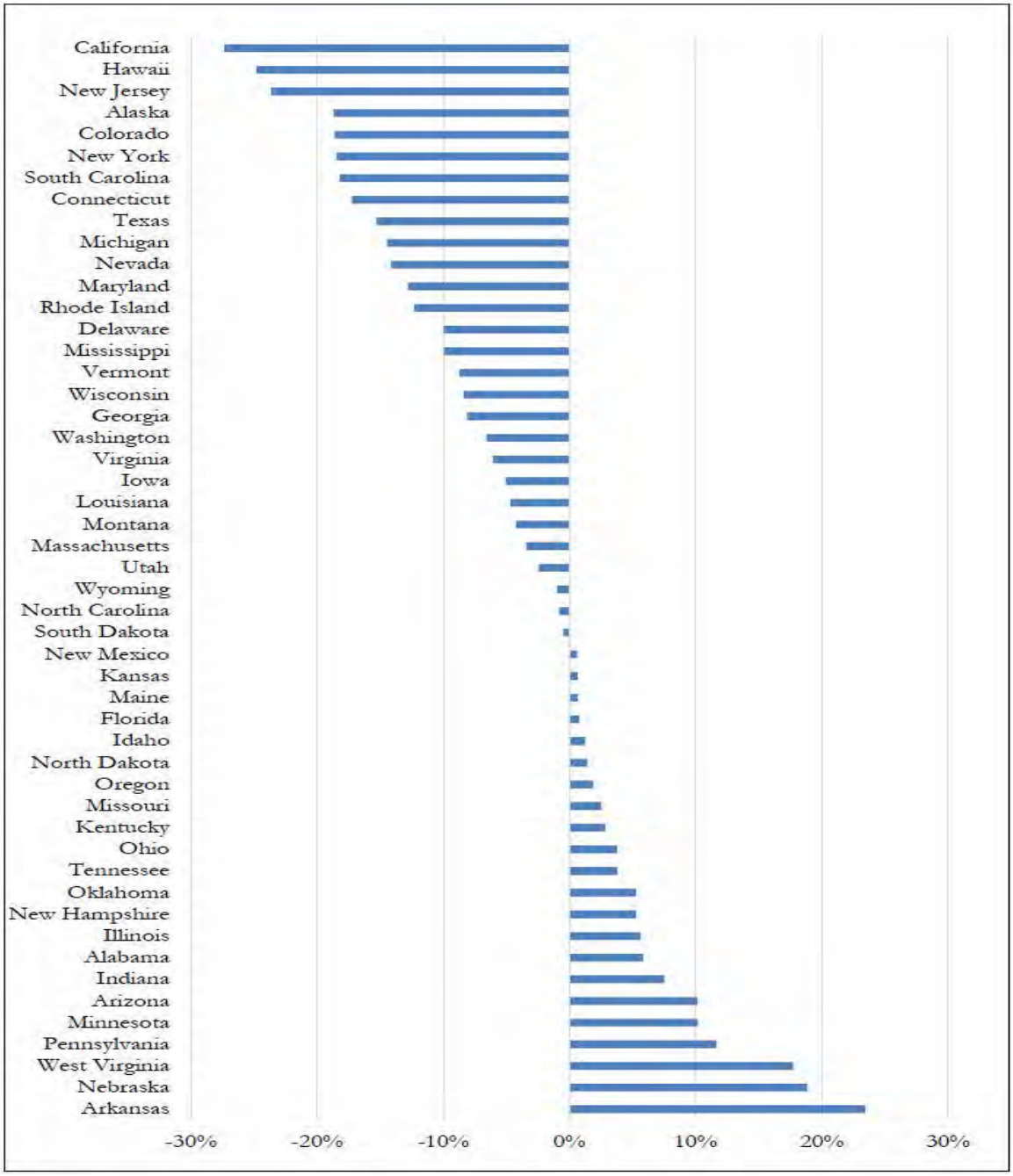


Figure 7.3: Change in Imprisonment Rates by State, 2006-2014[73]



Impact of Deinstitutionalization

Prior to the deinstitutionalization movement in the 1960s and 1970s, most people with chronic and severe mental illnesses were living in institutional settings. As people with serious mental illnesses were released from institutional settings to community-based care, "criminalization" of people with mental illnesses began to emerge.[74]

Because of poor symptom control in the fragmented network of community supports, people with mental illnesses continued to experienced "revolving door" hospital admissions, incarceration, and homelessness. Over time, jails and prisons became "de-facto psychiatric care facilities" as more people with mental illnesses were found there.[74]

About 15% of men and 25% of women in jails have a serious mental illness. People with mental illness may remain incarcerated longer compared to those who do not.[75] However, contrary to common belief, most violent crimes are not committed by people with mental health disorders. In fact, people with mental illnesses are more likely than the general population to become the victims of violent crimes, including assault, rape, and mugging.[76]

Behavioral Health Problems among Inmates

Because of the lack of data specific to Nebraska, this report does not contain information specific to its population. Nevertheless, national statistics shown in this section may help to understand the extent of behavioral health issues affecting inmates.

Many people in the criminal justice system have a mental illness and/or substance use disorder. Due to lack of recent published data, a 2006 Bureau of Justice Statistic is used here to illustrate this point.[77] The study used a modified structured interview for the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV). **Table 7.4** shows that about 75% of state prisoners and jail inmates met the criteria for a mental health disorder (mental disorder and/or substance use disorder). Over 40% of state prisoners and 49% of local jail inmates met the criteria for both a mental health and substance use disorder.

Table 7.4: Mental Health and Substance Disorders among Prison and Local Jail Inmates: 2006 Bureau of Justice Report[77]

	State Prison	Federal Prison	Local Jail
Both mental health and substance disorders	42%	29%	49%
Substance disorder only	24%	28%	19%
Mental disorder only	15%	16%	15%
Any mental disorder	56%	45%	64%
Recent history of mental health disorders	24%	14%	21%
Told had disorder by mental health professionals	9%	5%	21%
Had overnight hospital stay	5%	2%	11%
Used prescribed medication	18%	10%	5%
Had professional mental health therapy	15%	8%	14%
Symptoms of any mental disorder	49%	40%	60%
Major depressive disorder	24%	16%	30%
Mania disorder	43%	35%	54%
Psychotic disorder	15%	10%	24%

Table 7.5 compares the characteristics of those with and without a mental disorder. Substance related disorders and drug use were more common among those with a mental disorder. Inmates with mental health disorders are more likely to be homeless, experienced past physical or sexual abuse, have parents who abused alcohol or drugs, and tended to have a family member who had been incarcerated.

Table 7.5: Characteristics of Prison and Local Jail Inmates with and without Mental Health Problems: 2006 Bureau of Justice Report[77]

Characteristics	State Prison		Local Jail	
	With Mental Disorder	Without Mental Disorder	With Mental Disorder	Without Mental Disorder
Substance related disorder	74%	56%	76%	53%
Drug use in month before arrest	63%	49%	62%	42%
Family background				
Homeless in year before arrest	13%	6%	17%	9%
Past physical or sexual abuse	27%	10%	24%	8%
Parents abused alcohol/drugs	39%	25%	37%	19%
Family members ever incarcerated	52%	42%	52%	36%
Mother	7%	4%	9%	3%
Father	20%	13%	22%	13%
Brother	36%	30%	35%	26%
Sister	7%	5%	11%	5%

As shown in **Table 7.6** inmates with mental health disorders tended to use drugs and alcohol at a high level compared to those without mental health disorders.

Table 7.6: Drug and Alcohol Use among Prison and Local Jail Inmates with and without Mental Health Problems: 2006 Bureau of Justice Report[77]

Characteristics	State Prison		Local Jail	
	With Mental Disorder	Without Mental Disorder	With Mental Disorder	Without Mental Disorder
Drugs				
Regular use	76%	61%	78%	58%
In month before offense	63%	49%	62%	42%
At time of offense	38%	26%	34%	20%
Alcohol				
Regular use	68%	58%	73%	62%
In month before offense	62%	53%	81%	74%
At time of offense	34%	28%	35%	30%
Binge drinking	44%	30%	48%	30%

According to a more recent study, about half of female offenders had a lifetime post-traumatic stress disorder (PTSD) diagnosis and over 80% of them had lifetime substance disorder diagnosis (**Table 7.7**).[78]

Table 7.7: Prevalence of Lifetime and 12-Month Serious Mental Illness, PTSD and Substance Use Disorders among Female Offenders: A Multi-Site Study by Lynch et al.[78]

Disorder	Lifetime	12 month
Serious mental illness	43%	32%
PTSD	53%	28%
Substance use disorders	82%	53%

Behavioral Health Problems in Juvenile Justice System

In recent years there has also been a lack of published data for the juvenile justice system. However, a 2006 report by the National Center for Mental Health and Juvenile Justice (NCMHJJ) found that 70.4% of youth in the juvenile justice system met criteria for at least one mental disorder (**Figure 7.4**).[79] The most common mental health disorders are disruptive disorders (e.g., conduct disorder), substance use disorder, and anxiety disorder. Over 60% of youth with a mental disorder diagnosis met criteria for substance use disorder. **Figure 7.5** shows that girls are more likely to have any mental disorder and greater prevalence of specific types of disorders compared to boys.

Figure 7.4: Mental Health Prevalence in Juvenile System: NCMHJJ Study[79]

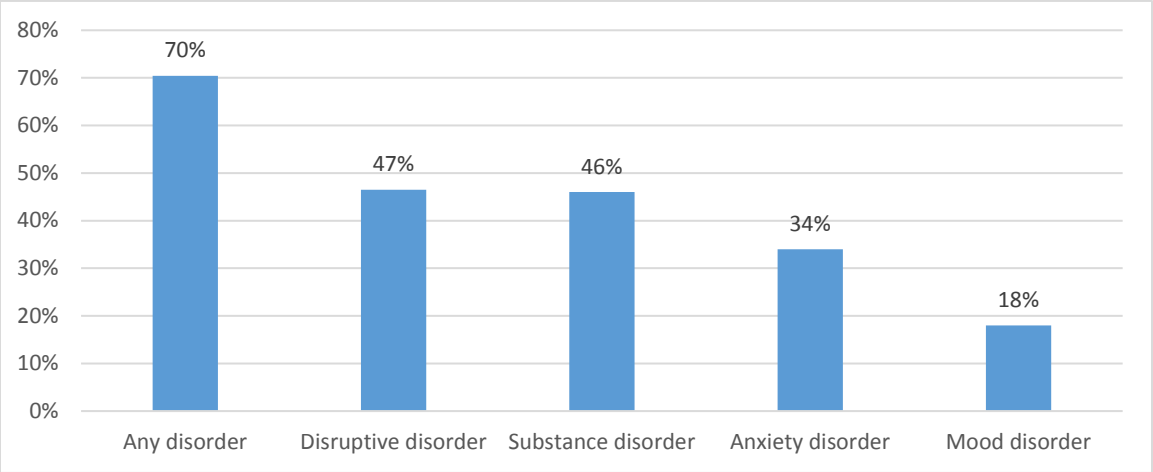
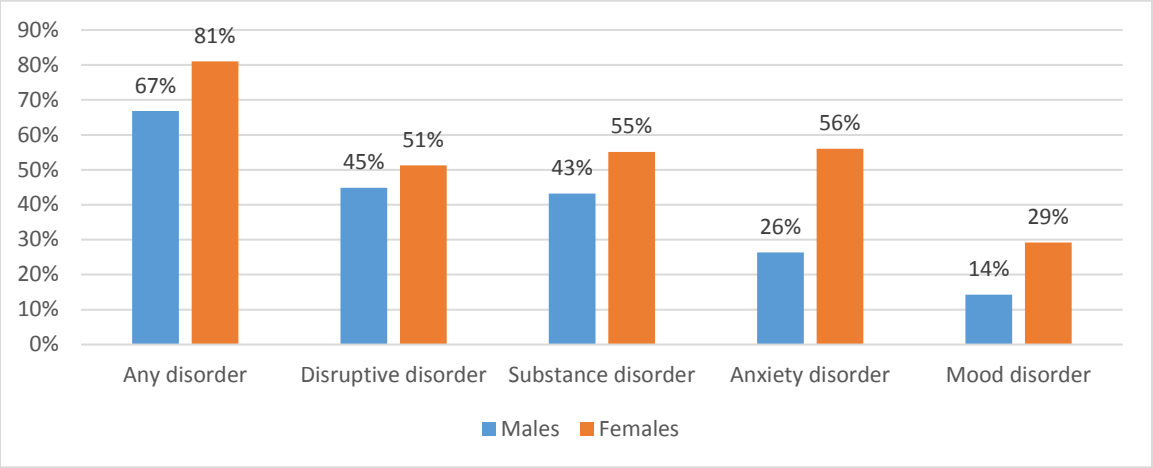


Figure 7.5: Mental Health Prevalence in Juvenile System by Gender: NCMHJJ Study[79]



Treatment Needs

It is often very difficult for those arrested and who enter the criminal justice system to get needed treatment. The Office of National Drug Control Policy and the Department of Federal Corrections provided the following statistics:[80]

Only 4 in 10 prisoners reported getting some substance use disorder treatment services while incarcerated.

- Only 25% of men and 15% of women reported participating in a formal substance use disorder treatment program while incarcerated.
- To address the treatment access issues, mental health and drug abuse programs were expanded, but the data from the Bureau of Prisons indicated that at the end of fiscal year 2014, more than 12,300 people were waiting for drug abuse treatment.

Upon release, attaining benefits and receiving needed health and social services may take a long time. Therefore, many people fall through the cracks and experience relapse of psychiatric episodes and substance use problems, which in turns increases their risk of again being arrested and incarcerated.

SAMHSA Strategic Initiatives

Criminal & Juvenile Justice Goals and Objectives

In its strategic plan "Leading Change 2.0: Advancing the Behavioral Health of the Nation 2015-2018," the Substance Abuse and Mental Health Services Administration (SAMHSA) identified goals and objectives to reduce the impact of mental illness and substance use disorders on the U.S. population.[81] One of the goals included in the strategic plan is to "create capacity and systems change in the behavioral health and justice systems" and included the following five objectives:

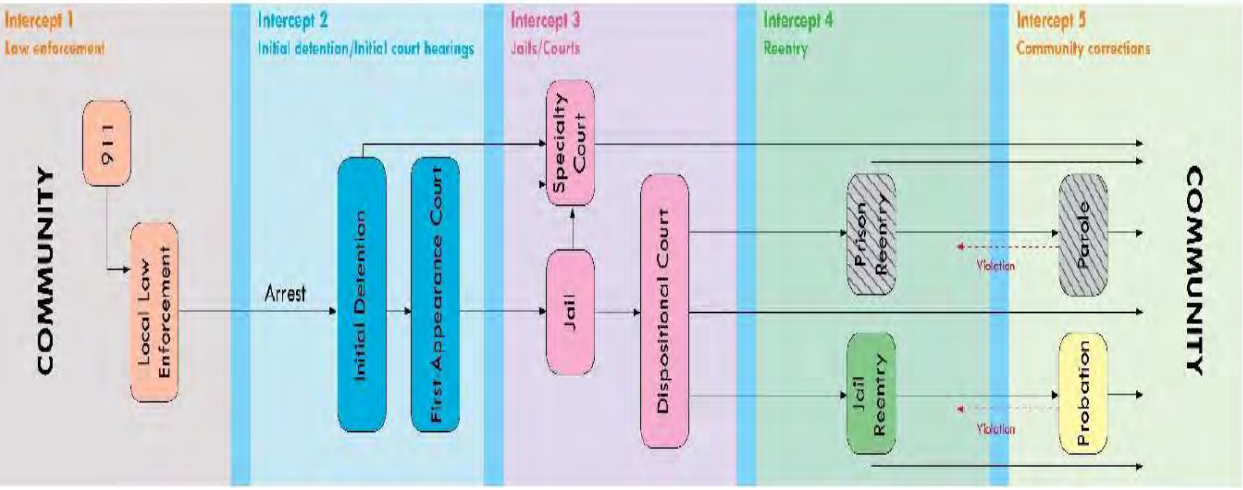
- Provide comprehensive treatment and recovery services in the community to prevent entry into or deeper involvement in the criminal or juvenile justice systems
- Develop and implement treatment and related recovery support models for early diversion from the criminal and juvenile justice systems

- Provide tools, trainings, and technical assistance for effective screening and assessments for behavioral health, trauma, and criminogenic risk, as well as strategies for connecting people to appropriate community-based services
- Provide models for effective reintegration into communities that support public and individual safety and recovery
- Provide training and technical assistance on approaches that ensure the criminal and juvenile justice population have behavioral health coverage to help divert them from jail, prison, or detention centers, or that help them to avoid re-incarceration after release.

Sequential Intercept Model

The Sequential Intercept Model provides a conceptual framework for communities to evaluate appropriate interventions. It outlines a series of points of interception where an intervention can prevent vulnerable persons from entering or going deeper into the criminal justice system (**Figure 7.6**). Using this model, a community can develop targeted strategies to reduce the number of those who enter or re-enter the criminal justice system.[82]

Figure 7.6: Sequential Intercept Model[82]



SAMHSA Example Programs

Table 7.8 provides some concrete examples for capacity building and collaboration at various interception points.[82]

Table 7.8: SAMHSA Program Examples by Intercept[82]

Intercept 1: Community and Law Enforcement	
Early Diversion Programs	• Aims to divert people with mental health and/or substance use from the criminal justice system and into community services without the leverage of the court. • Focuses on the role of law enforcement officers working collaboratively with community behavioral providers to prevent arrest and adjudication.
Teen Court Programs	• Focuses on preventing juvenile crime by diverting youth with substance use treatment needs from deeper immersion in the traditional juvenile justice system to teen courts. • Provides substance use treatment services and related recovery support.
Intercept 2: Arrest and Initial Detention / Court Hearings	
Adult Behavioral Health Treatment Court Collaborative	• Aims to allow local courts more flexibility in collaborating with multiple criminal justice system components and local community treatment and recovery providers to address the behavioral health needs of adults involved in the criminal justice system. • Allows eligible persons to receive treatment and recovery support services regardless of what court they enter. • Focuses on connecting with persons early in their involvement in the criminal justice system and prioritizing the participation of municipal and misdemeanor courts in the collaborative.
Intercept 3: Jails / Specialty Courts	
Adult Treatment Drug Courts	• Expands and/or enhances substance use disorder treatment services in existing adult and family "problem solving" courts, which use the treatment drug court model. • Includes drug courts serving adults, tribal healing-to-wellness courts, driving-while-intoxicated / driving-under-the influence courts, co-occurring drug and mental health courts, veterans' courts, and municipal courts that use the problem-solving model. • Provides coordinated, multi-system approach designed to combine the sanction power of treatment drug courts with effective treatment services to break the cycle of criminal behavior, alcohol and/or drug use, and incarceration or other penalties.
Adult Tribal Healing to Wellness Courts Program	• Provides resources for tribal courts to divert American Indians and Alaska Natives with substance use and co-occurring mental health disorders away from the criminal justice system and into behavioral health treatment.
Juvenile Treatment Drug Court Program	• Diverts young people from juvenile detention to community-based behavioral health treatment, with the goal of treatment and recovery and prevention of deeper involvement in juvenile and criminal justice systems.
Intercept 4: Reentry from Jails and Prisons to the Community	
Offender Reentry Program	• Expands and enhances substance use and mental health treatment services for persons reintegrating into communities after being released from correctional facilities.

Nebraska Behavioral Health & Criminal Justice Joint Statistics Brief

In 2009 the Nebraska Department of Health and Human Services formed agreements with the Nebraska Commission on Law Enforcement and Criminal Justice and the Nebraska Department of Correctional Services to use data from respective systems for analysis and reporting. The statistics included in this section are based on 5-year (January 1, 2005 – December 31, 2009) data from these three organizations.[83]

During the 5-year study period, a total of 25,564 adults received behavioral health services in community settings. **Figure 7.7** shows that 50% of these consumers have been to jail or prison at least once during this period.

Figure 7.7: Adults in Community-Based Behavioral Health Program Who Have Been to Jail or Prison At Least Once in 5-Year Period (2005-2009)[83]

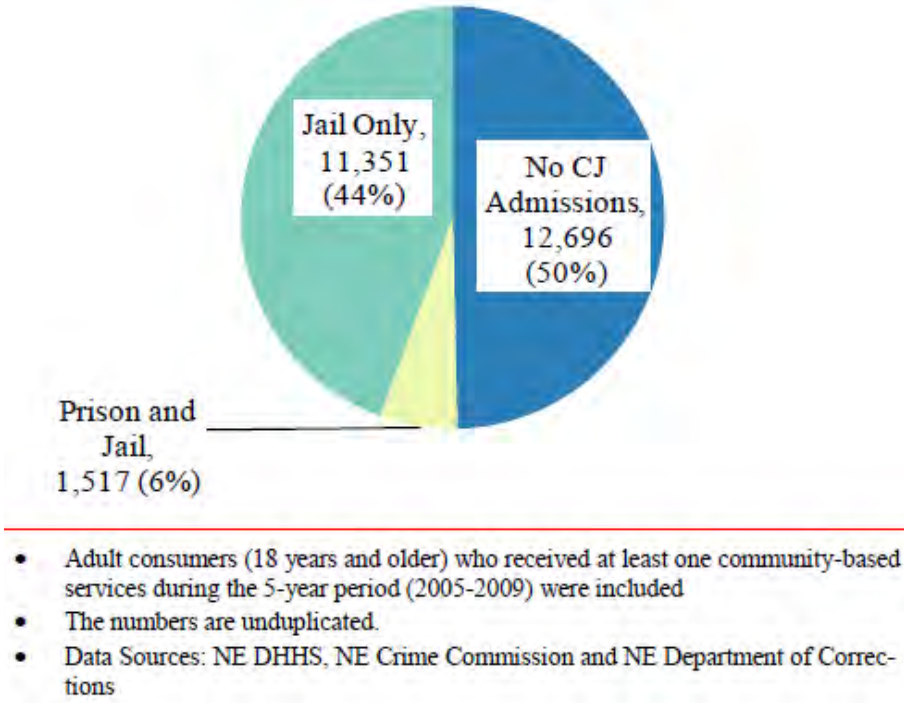
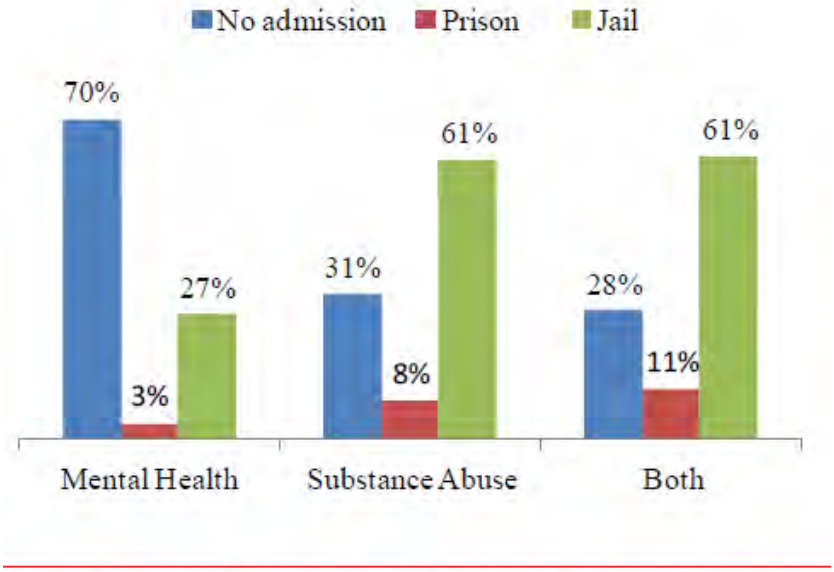


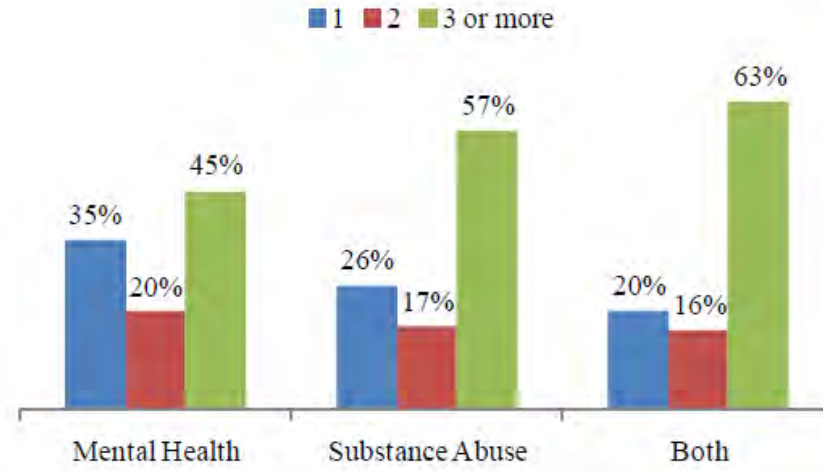
Figure 7.8 shows that patterns of prison admissions vary across service type. For example, 61% of people in substance use disorder programs or in substance use disorder and mental health programs had at least one jail admission in 5 years. Only 27% of people in mental health programs had a jail admission. As shown in **Figure 7.9** among persons who had at least one jail admission, those receiving treatment in substance use disorder programs and those in substance use disorder and mental health programs had a higher number of jail and prison admissions. Sixty-three percent (63%) of persons who received both types of services had 3 or more jail and/or prison admissions.

Figure 7.8: Adults in Community-Based Behavioral Health Program with No Admission, Prison Admission, and Jail Admission by Type of Services in 5-Year Period (2005-2009)[83]



- Adult consumers (18 years and older) who received at least one community-based services during the 5-year period (2005-2009) were included
- The numbers are unduplicated.
- Data Sources: NE DHHS, NE Crime Commission and NE Department of Corrections

Figure 7.9: Among Adults Who Had At Least One Jail Admission, the Number of Jail and/or Prison Admissions in 5-Year Period (2005-2009)[83]



- Adult consumers (18 years and older) who received at least one community-based services during the 5-year period (2005-2009) were included
- The numbers are unduplicated.
- Data Sources: NE DHHS, NE Crime Commission and NE Department of Corrections

Nebraska's Efforts and Initiatives

Justice Behavioral Health Committee

In 2003, the Justice Behavioral Health Committee (JBHC) was created to help improve communication and collaboration between the criminal justice system and behavioral health treatment systems in Nebraska. The JBHC consists of 32 members representing the Executive and Judicial branches as well as the behavioral health treatment administration, providers, and consumers.

The JBHC conducts four ongoing workgroups: data, curriculum, sex offenders, and provider subcommittees to assist in fulfilling its mission, "to ensure integration, cooperation, and active communication between the criminal justice system and treatment systems, substance use, and mental health." JBHC creates, reviews, and facilitates implementation of standards for substance use evaluations and treatment, and standards for mental health evaluation and treatment as shown in **Table 7.9**.

Table 7.9: The Justice Behavioral Health Committee Work Groups' Activities

Data Workgroup
• Implementation of justice data system (data) • Minimum standards for registered providers • Standardization of data elements • Data sharing for specific projects
Curriculum Workgroup
• Identify skills, knowledge, and capacities needed by justice officials and practitioners to provide criminal justice BH services. • Training standards to complete evaluations for various professions with substance use scope of practice, continuing education requirements, dissemination of documents and coordination with training, educational institutions, and various licensing boards. • This includes best practices and criminogenic needs. • The rubrics are reviewed annually with the group as to how implemented across their agencies/division.
Sex Offenders Workgroup
• Minimum standards and best practices for the provision of sex offender treatment services
Provider Workgroup
• Recommendations of evidence-based practices to justice committee • Recommendations of treatment plan standards for agency/individual practice

Assessment and Treatment of Mental Health and Substance Use Disorders for Corrections Population

The Nebraska Department of Correctional Services requested that the Council of State Governments Justice Center conduct an assessment of institutional programs. After a 6-month review, a number of recommendations were made to reduce recidivism. NDCS uses several state-of-the-art risk reduction programs, including one for substance use treatment. However, the consumers who need the program(s) do not enter them in a timely manner. **Figure 7.10** compares the current and recommended processes to deliver programs efficiently. In addition, the Justice Center recommended:

- Access to evidence-based community programs for justice-involved populations and
- Provide incentives to service providers to create a continuum of care in the community coordinated with models of prisons programming.

Figure 7.10: Current and Proposed system

Current System for Assessment and Referral

High substance use need — Wait list — In Substance Use Disorder Program

High antisocial attitudes — (Need is yet to be identified) — Wait list — In CBI Program

0 — 6 MO — 12 MO — 18 MO — 24 MO — 30 MO — 36+ MO

Admission

Proposed System for Assessment and Referral: Concurrent Programming

High substance use need — Wait list — In Substance Use Disorder Program

High antisocial attitudes — Wait list — In CBI Program

In this example, moderate- and high-risk individuals are immediately placed into programming to address criminal thinking. Participation in substance use disorder treatment occurs simultaneously.

0 — 6 MO — 12 MO — 18 MO — 24 MO — 30 MO — 36+ MO

Admission

Veterans Population

Demographic Characteristics of Veterans

According to the U.S. Department of Veterans Affairs, in 2013, there were over 22 million veterans living in the U.S.[84] Roughly 55% of all veterans are 60 years and older.[84] About 9% of veterans are women, who are also the fastest growing segment of the veteran population.[84] According to the 2015 Office of Rural Health Annual Report, 5.2 million veterans live in rural communities across the United States.[85] About half (51.4%) are reported as married in 2014.[86] Over 1.1 million Americans are providing care to military injured or disabled who served since 9/11—including spouses, parents, and friends. These caregivers have little to no formal support network and they often care for veterans with a behavioral health problem.[87] These caregivers are at increased risk of depression.

In 2015, it was estimated that 47,725 veterans were homeless. While homelessness among veterans has decreased annually since 2010, veterans are overrepresented among the homeless population, estimated at 11% of the total. An alarming trend is that the number of OIF/OEF/Operation New Dawn (OND) veterans who are homeless is increasing.[88]

In 2012, about 8% of inmates in state/federal prisons or local jails were veterans. About half of incarcerated veterans were told they had a mental disorder by a mental health provider. Close to 80% of incarcerated veterans had an honorable or under honorable conditions discharge.[89]

Behavioral Health Problems Affecting Veterans

PTSD and TBI

Veterans experience a number of behavioral health issues. The lifetime incidence of post-traumatic stress disorder (PTSD) in service members is two to three times of that in the general population, with a prevalence estimate range of 13% to 20%.[90] The high prevalence of PTD is associated with longer deployment, multiple deployments, and greater time away from base camp. PTSD is linked to an increased risk for suicidal behavior.[90] Veterans may experience delayed symptoms of PTSD, and these may occur years after traumatic experience.[90]

More than 20% of Operation Enduring Freedom (OEF) / Operation Iraqi Freedom (OIF) sustain brain injuries.[91] Traumatic brain injuries (TBIs) exist at three levels of acuteness based on initial symptoms; "mild" accounts for about 80% of TBIs and is very difficult to diagnose.[91] TBIs often co-occur with PTSD and [91] increases the risk for suicide.[92]

Co-Occurring Conditions

One in ten returning OEF/OF veterans seen at Veterans Affairs have a problem with alcohol or other drugs.[93] Alcohol misuse and prescription drug misuse are more prevalent among service members than civilians. Also, alcohol and drug use disorders are co-morbid with PTSD.[93]

Many veterans also experience co-occurring conditions. For example, psychiatric conditions (PTSD, depression, substance misuse) may be found with medical conditions such as chronic pain and TBI may be experienced.[90] Psychosocial problems, including relationship problems, intimate partner violence,

unemployment, homelessness, and incarceration are also not uncommon among veterans with co-occurring conditions. The prevalence of substance use disorder and serious mental health disorders is high among homeless veterans.[90]

Sexual Trauma

Military sexual trauma (MST) is the term used by the Department of Veterans Affairs to refer to experiences of sexual assault or repeated, threatening sexual harassment experienced during his or her military service.[94] Among veterans, one in four women receiving care at the VA and 1 in 100 men report they experienced military sexual trauma (MST). Persons who experience MST are 9 times more likely to develop PTSD and they experience higher prevalence of depression, anxiety and other mood disorders.

Suicide among Veterans

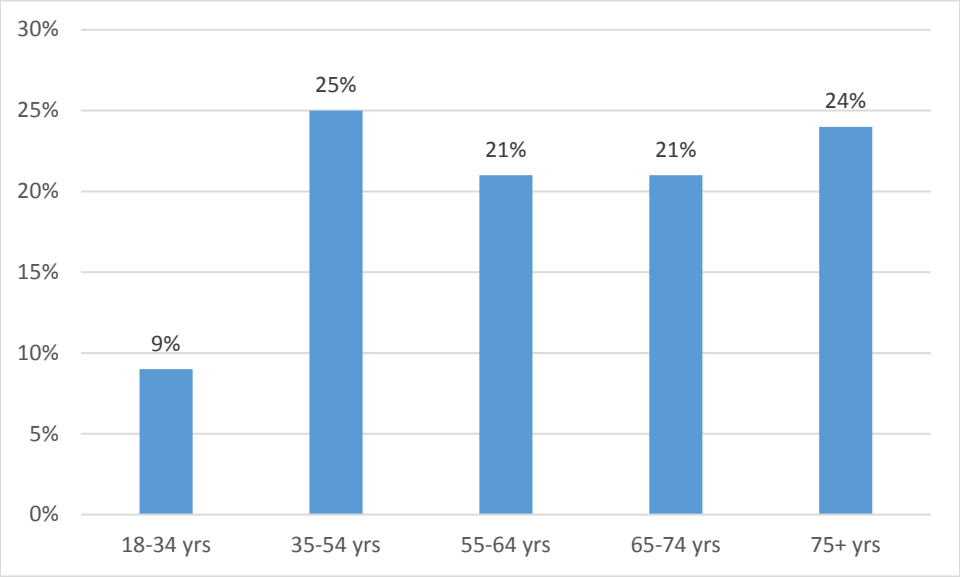
On average, 22 veterans die each day by suicide. Of those who committed suicide, 77% never received behavioral health treatment or connected with VA. About 70% of veterans completing suicide were 50 years or older. [40] Also, suicide rates among female veterans are increasing more rapidly compared to male veterans. These statistics suggest that female veterans and Vietnam era veterans urgently need culturally appropriate interventions.[95]

Veterans in Nebraska

According to the 2010-2014 US Census Bureau American Community Survey estimates, there are 137,392 veterans in Nebraska. About 92% of Nebraska veterans are men.

About 21% of veterans are 65-74 years of age and 24% are 75 years or older (**Figure 7.11**).[96]

Figure 7.11: Age Distribution of Nebraska Veterans: 2010-2014 U.S. Census Bureau American Community Survey[96]



As shown in **Figure 7.12**, 37% of veterans in Nebraska had some college or an Associate's degree and 25% of them have a Bachelor's degree or higher.

Figure 7.12: Educational Attainment of Nebraska Veterans: 2010-2014 US Census Bureau American Community Survey[96]

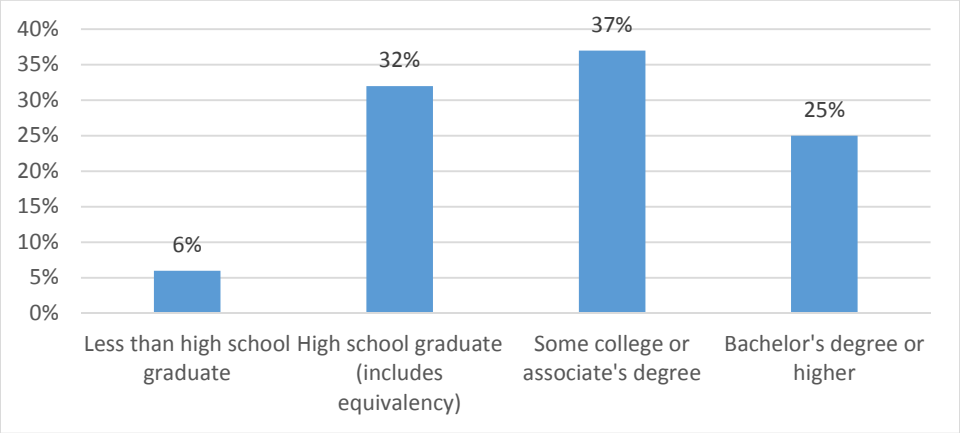


Figure 7.13 shows counties with higher number of veterans, including Scottsbluff, Lincoln, Dawson, Buffalo, Hall, Adams, Stanton, Lancaster, Dakota, and Douglas Counties.

Figure 7.13: The Number of Veterans by County[96]

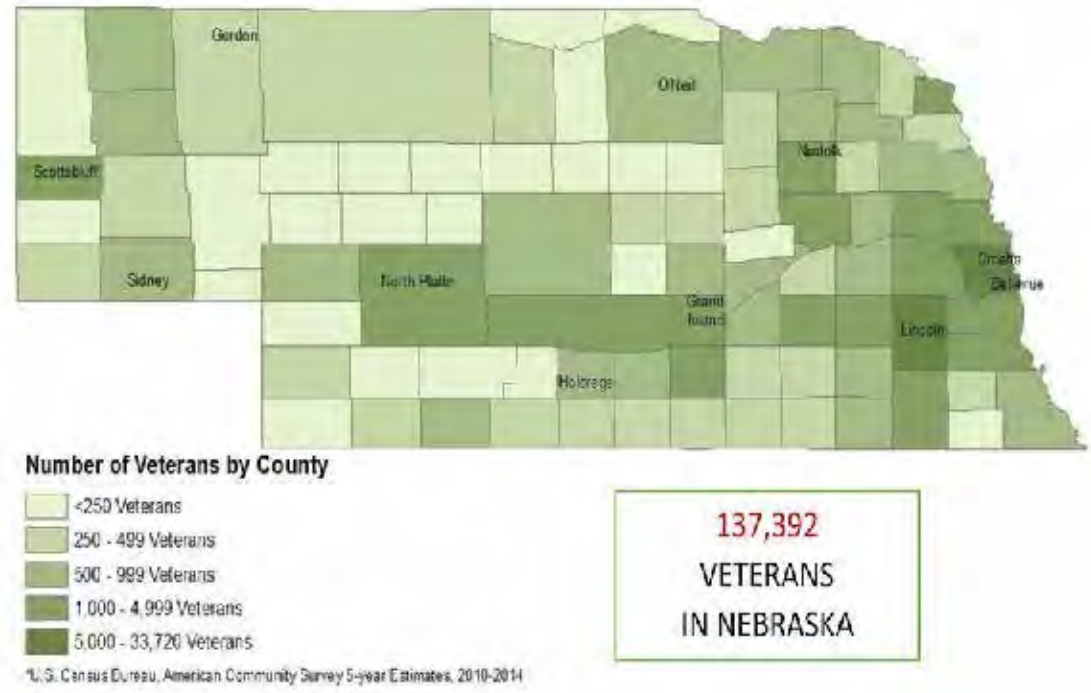


Figure 7.14 shows the percentage of Veterans with disability by county. This map looks similar to the previous map (**Figure 7.13**) except that the urban counties such as Lancaster and Douglas have lower percent of veterans with disability compared to rural counties.

Figure 7.14: The Percent of Veteran with Any Disability[96]

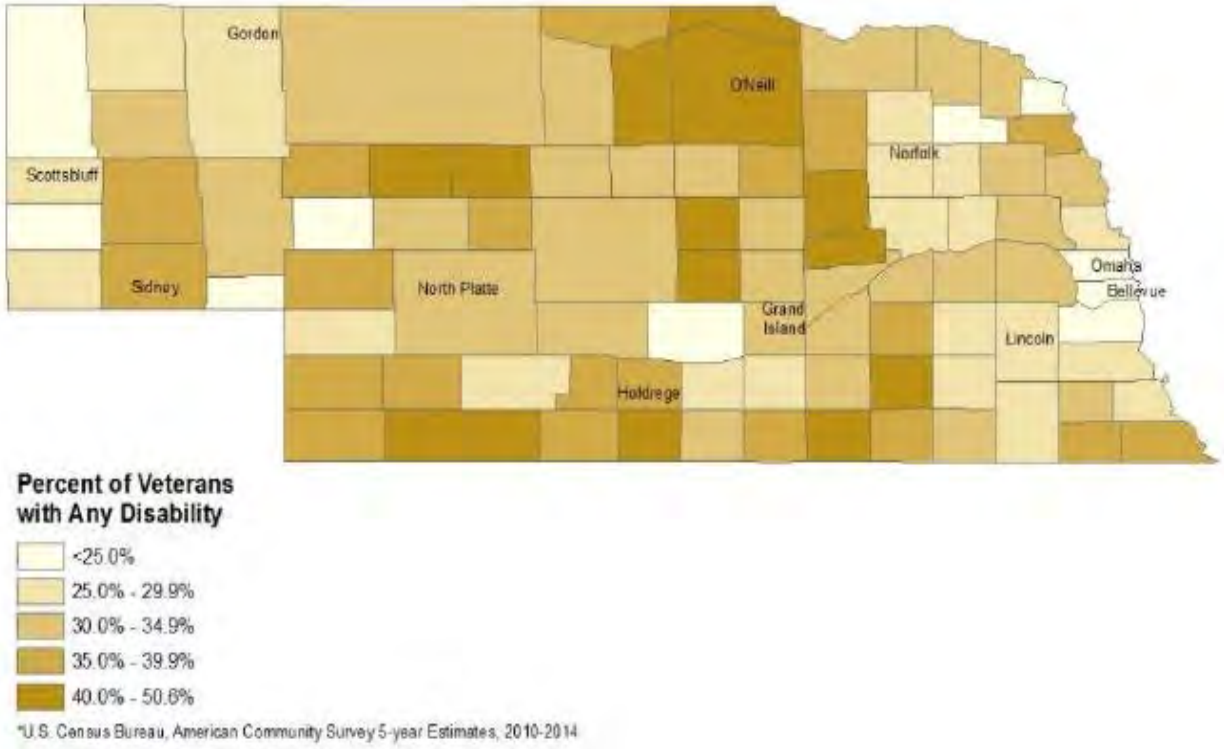
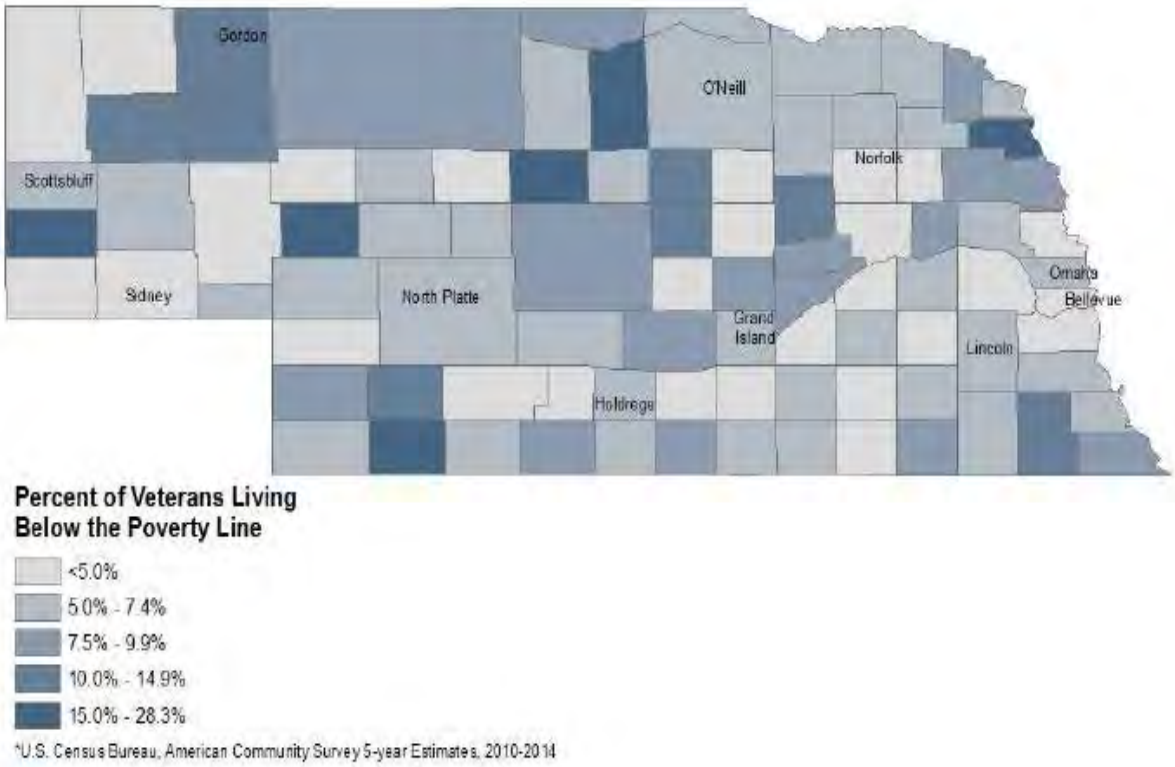


Figure 7.15 shows the percentage of Veterans who are living below the poverty level. Counties with a higher percent of Veterans living below poverty level include Banner, Box Butte, Sheridan, Arthur, Hitchcock, Blaine, Rock, and Dakota.

Figure 7.15: The Percent of Veterans Living Below Poverty Level[96]



*U.S. Census Bureau, American Community Survey 5-year Estimates, 2010-2014

Homeless Population

Background

Homelessness in the U.S.

According to the Department of Housing and Urban Development (HUD) 2013 Annual Homeless Assessment Report (AHAR), in January 2015 a total of more than half a million were homeless on a given night.[88] About 70% of these were staying in residential programs for the homeless and 30% had no shelter. Almost 25% of homeless were children.[97] About 11% of homeless adults were veterans.[88]

Mental Health and Substance Use Disorders among Homeless People

Permanent Supportive Housing (PSH) is one of components of Continuum of Care programs which will be discussed later in this chapter. PSH is designed to serve people who are homeless and who have disabilities. Unlike people using emergency shelter and transitional housing programs, people in PSH are in housing and not considered homeless. According to the 2014 AHAR, mental health difficulties were the most common disability among persons in PSH, with 56% of adults in the program having either a mental health condition or a dual diagnosis that included both mental health and substance use disorders (**Table 7.10**).[98] Among Veterans living in PSH, 59% had a mental health condition or dual diagnosis and 13% had only a substance use disorder.[98]

Table 7.10: All Adults and Veterans Living in PSH in the U.S., 2014[98]

Disability Type	All Adults	Veterans
Any Type of Disability	82.7%	82.9%
Dual Diagnosis	22.2%	28.6%
Mental Health	34.3%	30.0%
Substance Use	9.9%	13.1%
Physical Disability	21.1%	37.9%
HIV/AIDS	5.9%	4.5%
Developmental Disability	4.5%	3.6%

The term "chronic homelessness" is used to describe a situation in which a person spends more than a year in a state of homelessness or has experienced a minimum of four episodes of homelessness over a three-year period. In 2015, of those who were homeless on a single night, about 15% were chronically homeless.[97]

Even though chronic homelessness represents a small portion of the overall homeless population, they use more than half of available services.[99, 99] About 30% of the chronically homeless also have a serious mental illness and about two-thirds have a primary substance use disorder or other chronic health condition that interferes with getting and maintaining stable, affordable housing.[99]

Rural Homeless Issues

Homelessness is not just a problem in urban areas, but there is little data and research on rural communities, where a limited number of shelters and other homeless assistance programs are available. In these communities, people are more likely to live in a car or camper or with relatives in overcrowded housing. People experiencing homelessness in rural communities are also more likely to be white, female,

married, and currently working. Also, homelessness among American Indians/Alaska Natives and migrant workers is more common in rural communities. Studies conducted in California and Montana indicate that the prevalence of mental health and substance use disorders may be higher among rural homeless people compared to the urban homeless.[100]

Homeless Veterans and Housing and Urban Development (HUD)/Veterans Affairs Program

An estimated 11% of the adult homeless population are veterans.[88] The majority of homeless veterans are single, live in urban areas, and have mental illness and/or substance use disorders. African Americans account for 10.4% and Hispanics 3.4% of the veteran population in general; however, roughly 45% of all homeless veterans are African American or Hispanic.[101] HUD-VASH is a collaborative program between Housing and Urban Development (HUD) and the Department of Veterans Administration (VA), which combines HUD housing vouchers with VA supportive services to veterans and their families to find and sustain permanent housing. HUD provides rental assistance vouchers to homeless veterans who are eligible for VA health care services. VA case managers may connect veterans with support services such as health care, mental health, and substance use treatment to help in their recovery process and with the ability to maintain housing. As of September 2015, HUD allocated more than 78,000 vouchers to veterans.[101]

Nebraska Homeless Population and Housing Programs

Nebraska Housing Affordability Gap

In Nebraska, a single person with a disability receives supplemental security income (SSI) benefits equal to $726 per month (**Table 7.11**). Statewide, this income was equal to 18.9% of the area median income, which means that this person would have to pay 61% of their monthly income to rent a HUD efficiency unit and 76% for a HUD one-bedroom unit. The cost of a one-bedroom rental unit ranged from a low of 65% of monthly income in Seward County to a high of 88% in the Omaha/Council Bluffs area.[102, 103]

Table 7.11: Priced Out in 2014 Data for Nebraska[102, 103]

HUD Housing Market Area	SSI Monthly Payment	SSI as % of Median Income	% SSI for 1-Bedroom	% SSI for Efficiency
Lincoln	$726	18.3%	73%	57%
Omaha/Council Bluffs	$726	17.0%	88%	66%
Sanders County	$726	16.9%	73%	50%
Seward County	$726	16.3%	65%	50%
Sioux City*	$726	20.8%	76%	58%
Non-Metropolitan Areas	$726	20.7%	66%	57%
Statewide	$726	18.9%	76%	61%
*Indicates that this housing market area crosses state boundaries				

SSI payments for a single person in Nebraska constitute the equivalent of an hourly wage of $3.60-$4.19 less than the federal minimum wage (**Table 7.12**). In 2014, on average a person had to earn $10.72 per hour to be able to afford a one-bedroom rental unit, based on HUD's financial management regulation (FMR) (referred to by the National Low Income Housing Coalition as the Housing Wage).

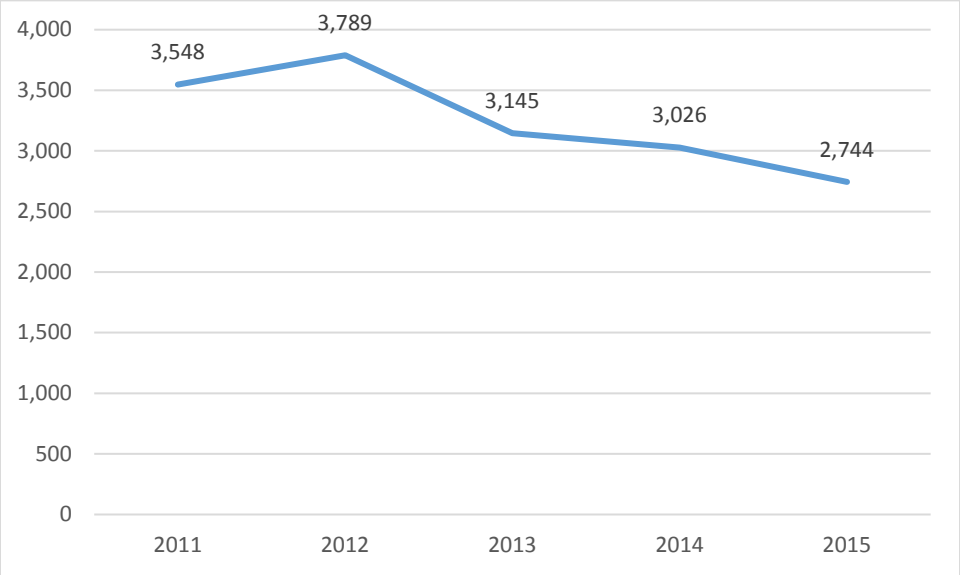
Table 7.12: SSI Payments as Hourly Wage – Nebraska[102, 103]

HUD Housing Market Area	SSI as Hourly Wage	NLIHC Housing Wage
Lincoln	$4.19	$10.19
Omaha/Council Bluffs	$4.19	$12.35
Sanders County	$4.19	$10.42
Seward County	$4.19	$9.10
Sioux City*	$4.19	$10.58
Non-Metropolitan Areas	$4.19	$9.25
Statewide	$4.19	$10.72
NLIHC=National Low Income Housing Coalition		

Nebraska Homeless Population Trends

According to the HUD data, the Nebraska homeless population has been steadily declining since 2012 from 3,789 to 2,744 (**Figure 7.16**).[102]

Figure 7.16: Nebraska Total Homeless Population, 2011-2015[102]



As shown in **Table 7.13**, there were a total of 2,001 homeless households and 2,744 homeless people in Nebraska in 2015. Of the 2,744 total homeless people, over half (54%) were in emergency shelters.[102, 104]

Table 7.13: Nebraska Homeless Population, 2015[102, 104]

	Sheltered			
Indicator	Emergency Shelter	Transitional Housing*	Unsheltered	Total
Household information				
0 children[1]	976	563	115	1,654
≥ 1 adult and 1 child[2]	152	152	0	327
Only children[3]	15	5	0	20
Total homeless households	1,143	743	115	2,001
People in households without children[1]				
People in households without children[1]	991	579	123	1,693
People in households with ≥ 1 adult and 1 child[2]	481	543	0	1,024
People in households with only children[3]	21	6	0	27
Total homeless people	1,493	1,128	123	2,744

* Safe Haven programs are included in the Transitional Housing category.
** These numbers include unduplicated counts.
[1]This category includes single adults, adult couples with no children, and groups of adults.
[2]This category includes households with one adult and at least one child under age 18.
[3]This category includes persons under age 18, including children in one -child households, adolescent parents and their children, adolescent siblings, or other household configurations composed only of children.

Population Characteristics by Continuum of Care in Nebraska

In 1987, Congress enacted the McKinney-Vento Homeless Assistance Act to address homelessness in the United States. Through this act, the Continuum of Care (CoC) was established to promote comprehensive systems to help the homeless by providing frameworks within communities to organize and deliver housing and other services. The two main purposes of CoC are to develop a long-term strategic plan while managing a year-round planning effort, and to apply for McKinney-Vento Homeless Act competitive grants. These goals include providing services for the homeless and identifying gaps in community needs for outreach, emergency shelter facilities, and transitional and permanent housing. There are three Continuum of Care planning groups in Nebraska, one for outstate Nebraska, one for Omaha/Council Bluffs and one for Lincoln.[102, 104] The CoC in outstate Nebraska is called "Nebraska Balance of State."

As shown in **Table 7.14**, characteristics of the homeless population varied by region

- In the Lincoln and Omaha CoC areas, 60 to 70% of the population were males compared to 59% in the remaining regions.
- The proportion of children (<18 years) was the highest in outside of Lincoln/Omaha area (33%), followed by the Lincoln CoC (24%).
- About 30% of the Omaha CoC population were African Americans.
- The proportion of Hispanics was highest outside of Lincoln/Omaha area (21%).
- The proportion of chronically homeless persons, those with serious mental illness and those with substance use was very high in the Omaha CoC (18%, 20%, 27%, respectively).
- One in 5 homeless persons in the Lincoln CoC was a victim of domestic violence.

Table 7.14: Characteristics of Homeless Population by CoC, 2015[102, 104]

(U.S. Department of Housing and Urban Development) Characteristics	Lincoln	Omaha	Nebraska Balance of State
Gender			
Female	38.5%	31.0%	50.6%
Male	61.2%	68.5%	49.4%
Transgender	0.3%	0.5%	0.0%
Age			
<18	23.8%	19.2%	33.0%
18-24	14.3%	8.8%	10.9%
>24	61.9%	72.0%	56.1%
Race			
Black/African-American	18.2%	29.2%	4.2%
White	63.0%	61.0%	86.9%
Asian	1.4%	0.9%	0.4%
American Indian/Alaska Native	6.3%	3.7%	3.5%
Native Hawaiian/Other Pacific Islanders	0.7%	0.7%	0.0%
Multiple Races	10.4%	4.4%	5.1%
Hispanic/Latino			
Hispanic/Latino	10.2%	14.0%	21.1%
Non-Hispanic/Non-Latino	89.8%	86.0%	78.9%
Other Characteristics			
Chronically Homeless	6.6%	17.7%	2.4%
Severely Mentally Ill	16.1%	20.0%	5.6%
Chronic Substance Abuse	17.5%	27.2%	5.5%
Veterans	11.3%	10.1%	2.9%
Victims of Domestic Violence	23.5%	15.4%	7.7%
Unaccompanied Youth	13.0%	7.2%	7.1%

Housing Programs in Nebraska

The Department of Housing and Urban Development (HUD) provides resources to states, local governments and nonprofit housing agencies to provide access to or develop affordable housing. These resources include[102, 103]

- Federal Public Housing Units
- Home Investments Partnership Program
- Community Development Block Grant (CDBG) Program
- Section 811 Supportive Housing for Persons with Disabilities Program
- Section 202 Supportive Housing for the Elderly Program
- Continuum of Care Program
- Emergency Solutions Grants (ESG) Program

- Housing Opportunities for Persons with AIDS (HOPWA) Program
- Housing Choice Vouchers (HCV)

(Note these programs are offered to all eligible Nebraskans and are not specific to behavioral health consumers.)

Each year, Congress allocates billions of dollars to all states and communities approved to receive federal funds from HUD. To receive these federal funds, these states and communities must have a HUD-approved Consolidated Plan (ConPlan) which outlines strategies for the following four federal housing funds: Community Development Block Grant (CDBG), HOME Investment Partnerships Program (HOME), Housing Opportunities for Persons with AIDS (HOPWA) and Emergency Solution Grant (ESG).[102, 103]

The Community Development Block Grant is one of the largest and longest continuously run programs at HUD. It addresses critical needs for housing rehabilitation, public facilities, infrastructure, economic development, public services, and other identified situations. Every year, 95% of funds are invested in services for low-to-moderate-income persons. The money provided in each grant is based on the state's or community's poverty level, population, housing overcrowding, and age of housing.[102, 103] Other than simply providing aide to poorer individuals, CDBG funds are used to eliminate slums, operate homeless shelters, and financially support those with special needs and disabilities.[102, 103] **Table 7.15** shows planned allocations for Nebraska in Fiscal Year 2016.

Table 7.15: FY 2016 Plan Allocations for Nebraska[102, 103]

Location	CDBG	HOME	ESG	HOPWA	Total
Bellevue	$298,768	$0	$0	$0	$298,768
Lincoln	$1,701,414	$830,622	$144,736	$0	$2,676,772
Omaha	$4,231,548	$1,586,615	$386,724	$0	$6,204,886
State of Nebraska	$9,944,180	$3,023,348	$941,814	$370,412	$14,279,754
Total	$16,524,837	$5,440,584	$1,473,274	$370,412	$23,809,107

Housing Voucher Utilization Rates

Nationwide, the use of housing vouchers is low. As indicated in **Table 7.16**, the rate of use of vouchers by non-elderly disabled persons in Nebraska overall was slightly higher than the national rate (23% vs. 20%). Regional variations were also observed. For example, the Lincoln Housing Authority had the highest use rate of 81%, followed by Columbus Housing Authority (38%) and Douglas County (37%) among non-elderly persons with disabilities.

Table 7.16: Housing Choice Voucher Utilization Rates[102, 103]

PHA	Nonelderly persons with disabilities	Elderly persons with disabilities	Elderly persons without an identified disability
Alliance HA	22%	18%	10%
Beatrice HA	35%	13%	2%
Bellevue HA	20%	8%	7%

PHA	Nonelderly persons with disabilities	Elderly persons with disabilities	Elderly persons without an identified disability
Central Nebraska HA	25%	9%	21%
Chadron HA	17%	15%	7%
Columbus HA	38%	8%	6%
Cozad HA	29%	6%	9%
Crete HA	35%	0%	18%
Douglas County	37%	11%	5%
Fremont HA	35%	11%	16%
Goldenrod HA	21%	20%	23%
Gothenburg HA	33%	28%	0%
Hall County HA	18%	13%	18%
Hastings HA	24%	12%	16%
Kearney HA	31%	9%	14%
Lexington HA	11%	8%	46%
Lincoln HA	81%	6%	0%
McCook HA	30%	11%	20%
Norfolk HA	31%	6%	6%
Northeast Nebraska HA	26%	4%	3%
Omaha HA	17%	9%	2%
Scotts Bluff County HA	28%	21%	11%
South Sioux City HA	16%	22%	3%
West Central Nebraska	34%	19%	19%
York HA	15%	7%	21%
State Average	23%	11%	7%
National Average	20%	15%	7%

For Nebraska, the use of public housing units occupied by non-elderly persons with disabilities was slightly higher than the national use rate (19% vs. 17%) (**Table 7.17**). Again, large regional variations are observed across housing authorities.[102, 103]

Table 7.17: Public Housing Unit Utilization Rates[102, 103]

PHA	Non-elderly persons with disabilities	Elderly persons with disabilities	Elderly persons without an identified disability
Ainsworth HA	30%	17%	47%
Albion HA	8%	10%	52%
Alliance HA	0%	4%	2%
Alma HA	7%	21%	57%
Ansley HA	33%	6%	39%
Auburn HA	12%	10%	54%
Aurora HA	24%	32%	39%
Bassett HA	6%	24%	35%
Bayard HA	16%	21%	58%
Beemer HA	6%	0%	38%

PHA	Non-elderly persons with disabilities	Elderly persons with disabilities	Elderly persons without an identified disability
Bellevue HA	2%	5%	0%
Benkelman HA	8%	3%	38%
Blair HA	17%	12%	40%
Blue Hill HA	9%	3%	51%
Bridgeport HA	29%	6%	53%
Broken Bow HA	13%	9%	16%
Burwell HA	8%	7%	30%
Cairo HA	19%	0%	25%
Cambridge HA	14%	7%	21%
Chappell HA	14%	21%	32%
Clarkson HA	9%	5%	36%
Clay Center HA	22%	4%	17%
Coleridge HA	14%	7%	43%
Columbus HA	17%	20%	63%
Cozad HA	30%	12%	28%
Creighton HA	12%	9%	75%
Crete HA	28%	21%	44%
Curtis HA	25%	10%	20%
David City HA	15%	13%	48%
Deshler HA	10%	7%	14%
Douglas County HA	33%	14%	4%
Edgar HA	0%	11%	58%
Emerson HA	17%	6%	28%
Fairbury HA	22%	9%	26%
Fairmont HA	6%	0%	50%
Falls City HA	16%	8%	47%
Fremont HA	31%	13%	35%
Friend HA	7%	18%	57%
Genoa HA	20%	5%	55%
Gibbon HA	17%	17%	31%
Gordon HA	4%	8%	52%
Gothenburg HA	6%	9%	38%
Grant HA	19%	19%	44%
Greeley HA	23%	0%	23%
Gresham HA	25%	8%	17%
Hall County HA	7%	14%	13%
Harvard HA	36%	0%	7%
Hay Springs HA	0%	224%	71%
Hemingford HA	13%	13%	60%
Henderson HA	6%	12%	35%
Hooper HA	3%	8%	29%
Humboldt HA	30%	9%	9%
Imperial HA	10%	5%	75%
Indianola HA	9%	4%	39%
Kearney HA	26%	21%	23%
Lexington HA	13%	7%	8%
Lincoln HA	No data available		
Loup City HA	12%	12%	55%
Lynch HA	14%	0%	86%
Lyons HA	15%	0%	69%
McCook HA	27%	13%	33%
Minden HA	43%	18%	29%

PHA	Non-elderly persons with disabilities	Elderly persons with disabilities	Elderly persons without an identified disability
Nebraska City HA	18%	4%	51%
Neligh HA	20%	27%	50%
Nelson HA	14%	21%	29%
Newman Grove HA	13%	0%	53%
Niobrara HA	12%	0%	41%
North Loup HA	0%	6%	78%
North Platte HA	5%	12%	23%
Oakland HA	11%	17%	50%
Omaha HA	20%	10%	3%
Ord HA	19%	4%	29%
Oshkosh HA	6%	28%	61%
Oxford HA	25%	25%	35%
Pawnee City HA	25%	11%	33%
Plattsmouth HA	28%	19%	43%
Ravenna HA	26%	21%	32%
Red Cloud HA	11%	9%	30%
Sargent HA	20%	10%	60%
Schuyler HA	6%	0%	10%
Scotts Bluff County HA	24%	16%	9%
Shelton HA	40%	7%	13%
St. Edward HA	7%	13%	40%
St. Paul HA	13%	10%	56%
Stanton HA	11%	4%	79%
Stromsburg HA	5%	20%	35%
Sutherland HA	10%	20%	55%
Syracuse HA	33%	0%	67%
Tecumseh HA	4%	9%	87%
Tekamah HA	22%	0%	78%
Tilden HA	24%	18%	29%
Verdigre HA	0%	0%	87%
Wayne HA	15%	12%	41%
Weeping Water HA	39%	17%	28%
Wilber HA	4%	4%	74%
Wood River HA	6%	18%	35%
Wymore HA	8%	12%	76%
York HA	45%	15%	20%
State Average	19%	11%	22%
National Average	17%	15%	15%

Other Programs

Table 7.18 shows the number of beds and units designated to serve homeless families and persons from 2013 to 2015. This includes Emergency Shelter (ES), Transitional Housing (TH), Permanent Supportive Housing (PSH), Rapid Re-Housing (RRH), and Other Public Housing (Other PH). The length of stay allowed by these programs varies. For example, the TH program allows people to stay for up to 24 months. **Table 7.19** illustrates that from 2013 to 2015, there was a 16% decrease in families and 3% decrease in persons using the Emergency Shelter program, while there was a 35% decrease in families and 23% decrease in persons using Transitional Housing. There was an 11% decrease in families and 6% increase in persons using Permanent Supportive Housing. From 2014 to 2015, there was a 334% increase

in families and 142% increase in persons using Rapid Re-Housing and a 107% increase in families and 560% increase in persons using Other Public Housing.[102, 104]

Table 7.18: Beds Available for Homeless People[102, 104]

Type	2013		2014		2015		Change 2013-2015	
	Families	Persons	Families	Persons	Families	Persons	Families	Persons
ES	711	946	734	944	594	921	-16%	-3%
TH	1,142	847	865	813	744	648	-35%	-23%
PSH	431	613	425	608	382	642	-11%	+6%
RRH*			29	52	291	126	+334%	+142%
Other PH**			54	10	115	66	+107%	+560%

*The provider program type "Rapid Re-Housing" was added in 2014.
**Other PH consists of PH-Housing with Services and PH-Housing Only, as identified in the 2014 HMIS Data Standards.

Division of Behavioral Health Housing Related Assistance (HRA) Program

The lack of safe and affordable housing is one of the barriers to recovery from mental health and/or substance use disorders. Many adults with a serious mental illness live on Supplemental Security Income (SSI), a federal cash benefit program for those either 65 or older, blind, or disabled, and who have limited incomes. SSI provides a limited amount of cash; therefore, persons relying on SSI may have difficulty finding an affordable home.

As authorized under Neb. Rev. Stat.71-812(3), the state of Nebraska provides housing assistance to very low income adults with serious mental illness. The Division of Behavioral Health contracts with Regional Behavioral Health Authorities (RHBAs) to deliver the housing assistance. The rental assistance program serves as a bridge to other housing sources such as the Federal Housing Choice Voucher Programs (commonly known as "Section 8") or living in independent housing without rental assistance. These Housing Related Assistance (HRA) funds are designed to cover rent, utility costs, security deposits, and the like. In addition, persons in the HRA program receive services and support to maintain or secure independent living in community settings.

The HRA program provides Supported Housing capacity in each of the six RHBAs, promoting housing stability through rental assistance and housing coordination services and supports. Housing expenditures include housing costs such as rent, utility costs, and security deposits. Housing coordination includes pre-tenancy and tenancy services to promote housing success and to foster community integration and inclusion. **Table 7.19** shows HRA program expenditures by Behavioral Health Region for FY 2013-2015. The expenditure for HRA increased between FY 2013 and FY 2015 in each region.

Table 7.19: Division of Behavioral Health HRA Program Expenditures by Region and Fiscal Year

Division of Behavioral Health HRA Program Expenditures by Region by Fiscal Year						
FY13	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
Total HRA Designated Dollars	$ 118,913.00	$ 132,278.00	$ 276,471.00	$ 274,717.00	$ 508,062.00	$ 1,020,752.00
Total HRA Housing Expenditures	85,557	132,278	176,911	203,787	465,712	946,587
Total HRA Housing Coordination	33,356	-	99,560	70,930	42,350	74,165
FY14	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
Total HRA Designated Dollars	$ 94,309.00	$ 150,136.00	$ 294,745.00	$ 315,774.00	$ 583,984.00	$ 906,250.00
Total HRA Housing Expenditures	58,528	144,788	174,383	240,449	496,290	788,436
Total HRA Housing Coordination	35,781	5,348	120,362	75,325	87,694	117,814
FY15	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
Total HRA Designated Dollars	$ 135,009.00	$ 150,762.00	$ 324,478.00	$ 321,676.00	$ 668,738.00	$ 1,106,456.00
Total HRA Housing Expenditures	101,155	150,762	190,621	246,817	560,924	1,009,188
Total HRA Housing Coordination	33,854	-	133,857	74,859	107,814	97,268

The RBHAs administer the Nebraska DHHS Division of Behavioral Health Housing Assistance Program in their service area. **Table 7.20** shows the funding sources for the housing program expenditure for FY 2015. Program funding sources include the Nebraska State Housing Related Assistance Program and general state funds. The Housing Assistance Program supports rental assistance and one-time cost assistance supporting household formation (reported as Housing Voucher Expenditures) and housing coordination activities (reported as Housing Coordination Expenditures) based on the identified needs in the RBHA service area.

Table 7.20: Division of Behavioral Health Housing Program Expenditures (Actual) for FY2015

DBH Housing Program Expenditures for FY15 by Region						
Total Housing Services	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
All funds (HRA, State MH funds, State SA funds)	$ 191,127.00	$ 179,412.00	$ 324,479.00	$ 322,039.00	$ 769,222.00	$ 1,198,594.00
Housing Voucher Expenditures	$ 151,330.00	$ 150,762.00	$ 190,621.00	$ 246,818.00	$ 661,408.00	$ 1,101,326.00
HRA Funds	101,155	150,762	190,621	246,817	560,924	1,009,188
State MH Funds Housing Assistance	12,610	-	-	-	-	92,138
State SA Funds Housing Assistance	37,564	-	-	-	100,484	-
Housing Coordination Expenditures	$ 39,797.00	$ 28,650.00	$ 133,858.00	$ 75,221.00	$ 107,814.00	$ 97,268.00
Region Housing Coordination - HRA Funds	33,854.31	-	133,857.24	74,859.37	107,813.74	97,268.00
Region Housing Coordination - State MH Funds	5,942.36	24,101.01	-	361.22	-	-
Region Housing Coordination - State SA Funds	-	4,548.07	-	-	-	-
Total HRA Designated Dollars	$ 135,010.00	$ 150,762.00	$ 324,478.00	$ 321,677.00	$ 668,738.00	$ 1,106,456.00
Total HRA Housing Voucher Expenditures	101,155.22	150,761.99	190,620.75	246,817.03	560,923.91	1,009,187.83
Total HRA Housing Coordination Expenditures	33,854.31	-	133,857.24	74,859.37	107,813.74	97,268.00
Note: Numbers may not sum due to rounding.						

VIII. Behavioral Health Workforce

Summary

This chapter describes the results of Nebraska behavioral health workforce analysis and summarizes the efforts to improve the availability of the behavioral health workforce in the state. The information included in this chapter is based on data obtained from the Health Profession Tracking Service. In addition, information was collected through literature reviews and by informant interviews.

Chapter Highlights

Behavioral Health Profession Shortage

- There is a general shortage of any type of behavioral health workforce, especially in rural communities.
- Parity and health reform legislation has increased the demand for behavioral health services.
- In 2014, 79 counties were state-designated as shortage areas for psychiatrists and mental health practitioners in Nebraska
- In 2014, only 12 Nebraska counties had psychiatrists; between 2010 and 2014, there was a decrease in the number of psychiatrists
- Positive trends in the behavioral health workforce between 2010 and 2014 include an increase in the number of advanced practice registered nurses (APRN) who practice psychiatry, psychologists, and licensed mental health practitioners (LMHPs).
- Many psychiatrists and APRNs practicing psychiatry in Nebraska are nearing retirement age. Over 60% of psychiatrists and APRNs practicing psychiatry are 51 years and older.
- Lack of diversity in the racial/ethnic backgrounds of providers is an issue

Rural Behavioral Health Workforce Recruitment and Retention Issues

- According to a study conducted among behavioral health providers and administrators in rural Nebraska, there are a number of factors affecting recruitment and retention of behavioral health workforce
- There is a nationwide shortage of psychiatrists and other types of behavioral health providers; the need for competitive pay was emphasized
- Delays in processing licensing applications at the state level and credentialing with health maintenance organizations are problems when trying to hire providers
- After the provider's education requirements have been met, trainees in rural locations have difficulty obtaining the supervision required for licensure
- Low reimbursement rates and excessive paperwork are huge deterrents for providers and health care facilities, especially small-scale practices in rural communities

Peer Support Workforce

- Nebraska Division of Behavioral Health Office of Consumer Affairs conducted a peer-support workforce survey in 2015-2016

- Both currently employed and unemployed peer support specialists indicated they would be interested in more education opportunities. Areas of interest include: building the capacity of peer organizations for personal and professional development; peer rights; trauma-informed care; system navigation and accessing benefits; public speaking and giving effective testimony; cultural sensitivity training; wellness and recovery planning; behavioral health promotion; crisis support; and prevention education.
- About 40% of specialized peer support who were employed at the time of the survey indicated they were working for non-profit organizations, 30% for a peer run organization and 16% for governmental agencies.

Unlicensed Workforce

- About 70-80% of current behavioral health providers are unlicensed; they largely provide day-to-day care, playing a vital role in the behavioral health system.
- The turnover among unlicensed behavioral health providers has been of great concern, with a reported turnover rate ranging from 19% to 72%.
- Because of the dearth of research to understand reasons for difficulties retaining unlicensed workforce, there have been no effective remedial strategies identified in the literature.

Chapter Recommendations

Psychiatric Prescriber Shortage

- One of the important roles of psychiatrists is medication assessment and management. To some extent, a shortage of psychiatrists may be addressed through the use of other prescribers, such as primary care providers, physician assistants, APRNs, and pharmacists. However, many of these alternative providers lack training in psychiatric care. Courses and seminars to provide training should become more available in communities and/or as distance education.
- As described in Chapter 10, many rural communities in Nebraska are using telemental health for medication management, which can be one of the solutions to increase access to prescribers in rural communities. Investment in strengthening telemedicine in general can be one of many long-term solutions to address the health workforce shortage.

Training Need Related to Integrated Care and Telemedicine

- As described in Chapter 10, integrated behavioral health and primary care models can increase access to behavioral health services in rural settings. Although not all complex cases can be handled in primary care settings, having behavioral health specialists on site, or virtually through telehealth, can improve the outcomes of patients and can save on costs.
- Currently, however, there is a lack of training to make effective, collaborative practice feasible. There is also lack of training in the use of telemedicine, among both primary care providers and behavioral health specialists. Therefore, a state-wide provision of integrated care and telemedicine training is strongly recommended.

Peer Support Training Need

- As described in this chapter and in Chapter 9, consumers have expressed a strong desire to expand the role of peer support specialists and to receive comprehensive peer specialist training
- The Division of Behavioral Health Office of Consumer Affairs (OCA) peer support survey received national recognition as a model practice. OCA should continue its effort to obtain contributions from peer support specialists and consumers in general to strengthen and expand its training program.

Long-standing and Emerging Issues in Behavioral Health Workforce

Long-standing Issues

An adequate supply of a well-trained workforce in behavioral health services is essential for delivery of preventive care and treatment. Workforce issues have been recognized for decades. In its 2006 report, the Institute of Medicine chronicles efforts beginning in the 1970s that attempted to deal with behavioral health workforce issues.[105] Shortage of qualified professionals, recruitment and retention difficulties, and an aging workforce have been well documented.[106] As described in Chapter 4 Behavioral Health Problems in Nebraska General Population, there is a high prevalence of behavioral health problems in the U.S. and many people who need treatment are not getting services. As described in this chapter, there is a general shortage of any type of behavioral health workforce, especially in rural communities in Nebraska. Also, due to socioeconomic issues and a lack of adequate health insurance coverage, underserved populations in urban communities have limited access to the behavioral health workforce. A more diverse workforce in terms of cultural backgrounds needs to be developed.[107] Although co-occurring disorders (having both mental health and substance use disorders) are fairly common, there is a lack of substance-abuse treatment specialists and behavioral health providers who are adequately trained to address the co-occurring diagnosis.[108]

Emerging Issues

In addition to these longstanding issues, the changing landscape has resulted in additional challenges for behavioral health workforce development.[109] Enactment of the parity and health reform legislation has increased the demand for behavioral health services. Advancements in research have increased attention to the evidence-based and outcome-oriented approaches. A movement to promote empowerment of people with mental health and substance use disorders has created demands for active participation and engagement of consumers and families in community settings. There has been a push for a model of care that is recovery-oriented, person-centered, and integrated. Finally, behavioral health has moved to a chronic care and public health model that recognizes the importance of prevention and early detection of behavioral health issues in the general population, as well as management of medical illnesses among people with chronic mental illnesses. These new movements mean that there is an increased demand for well-trained professionals who are equipped to work in an inter-professional team environment.[109] Similarly, the Substance Abuse and Mental Health Services Administration has identified children and adolescents, geriatric persons, and persons residing in rural areas as the most vulnerable populations in need of behavioral health interventions.[109]

Types of Behavioral Health Professions

There are many different types of behavioral health professions. Some professions require a license to practice and others do not. Briefly, the following are the major types of behavioral health professions.[110] It is important to note that regulations for behavioral health professions vary across different states.

Prescribers

Prescribing and managing medication is an important part of behavioral health treatment. Examples of professionals who can prescribe psychotropic medications are the following: (Regulations for prescribing power vary across different states)

- Primary care physicians
- Pharmacists
- Psychiatrists
- Advanced Practice Registered Nurse practicing psychiatry
- Physician assistants (in some states)

Independent Mental Health Professionals

Mental health professionals who can assess, diagnose, and independently treat behavioral health problems. These professionals include:

- Psychologists – services may include psychological testing and the evaluation or assessment of personal characteristics such as intelligence, personality, abilities, interests, aptitudes, and psychophysiological and neuropsychological functioning; counseling, psychoanalysis, psychotherapy, hypnosis, biofeedback, and behavior analysis and therapy; diagnosis and treatment of mental and emotional disorders, alcoholism and substance abuse, disorders of habit or conduct, and the psychological aspects of physical illness, accident, injury, or disability; psycho-educational evaluation, therapy, remediation, and consultation; and supervision of qualified persons performing services specified in 172 NAC 155.2
- Licensed Independent Mental Health Practitioners (LIMHPs)–services include providing treatment, assessment, psychotherapy, counseling, or equivalent activities for behavioral, cognitive, social, mental, or emotional disorders, including interpersonal or personal situations with or without consultation with a qualified physician or licensed psychologist.

Other Licensed Mental Health Professions

- Licensed Mental Health Practitioners (LMHPs) provide treatment, assessment, psychotherapy, counseling, or equivalent activities for behavioral, cognitive, social, mental, or emotional disorders, including interpersonal or personal situations; and initial assessment of organic mental or emotional disorders for the purpose of referral or consultation.
- Addiction Counselors

  Licensed Alcohol and Drug Counselors (LADCs) scope of practice includes the application of general counseling theories and treatment methods adapted to specific addiction theory and research for the express purpose of treating any alcohol or drug abuse, dependence, or disorders.

  Certified Compulsive Gambling Counselor (CCGC) provide services under clinical supervision to compulsive gambling clients for remuneration. For purposes of this report, practitioners dual licensed as LADCs and CCGCs were included. Practitioners licensed only as a CCGC were not included. (Note: CCGC certification has changed to Certified Disordered Gambling Counselor (CDGC).

Unlicensed Mental Health Professionals

Unlicensed mental health practitioners include but not limited to the following:

- Pastoral counselors
- Peer support specialists
- Social workers (BSW level)
- Direct care mental health staff (Behavioral technicians.)

Nebraska Behavioral Health Workforce Analysis

Introduction

The passage of LB 603 in 2009 established the Behavioral Health Education Center (BHECN) at the University of Nebraska Medical Center to support an increase in the recruitment, retention, and competency of the state's behavioral health workforce. One of the strategies of BHECN is to "facilitate the collection, analysis, and dissemination of behavioral health workforce data and the prioritization of training and recruitment of behavioral health professionals by type and region." The BHECN workforce analysis uses data collected by the Health Professions Tracking Service (HPTS).[111]

The HPTS maintains a database of Nebraska's licensed healthcare professionals, including behavioral health professionals. Using Nebraska licensure data as the foundation, the HPTS conducts annual surveys of healthcare and behavioral health professionals practicing in Nebraska, those located in Nebraska with an "unknown" status, and those newly licensed in Nebraska (regardless of location).

The most recent workforce analysis was conducted in 2015 using 2010-2014 HPTS data. Behavioral health professionals reported here include: psychiatrists, psychologists, advanced practice registered nurses (APRNs), physician assistants (PAs), licensed independent mental health practitioners (LIMHPs), licensed mental health practitioners (LMHPs), and licensed alcohol and drug counselors (LADCs). (**Figure 8.1**, **Table 8.1**). Professionals listed in this report hold an active license to practice in Nebraska and have a primary and/or satellite practice location in Nebraska. Behavioral health professionals who practice in the federal and state institutions are not included in this report.

Figure 8.1: Behavioral Health Professionals Included in the Nebraska Workforce Analysis

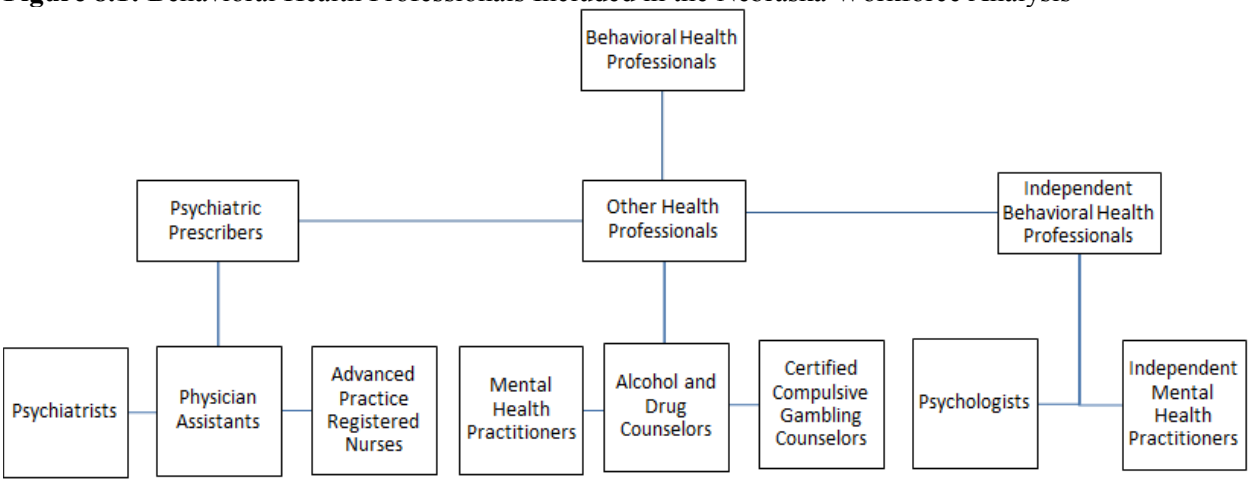


Table 8.1: Description of Behavioral Health Professions Examined in the Nebraska Workforce Analysis

Profession	Description
Psychiatrists	Board-certified by the American –Allopathic Board of Neurology and Psychiatry or by the American Osteopathic Board of Neurology and Psychiatry and board-eligible (i.e., has successfully completed an accredited program of graduate medical or osteopathic education in psychiatry or child psychiatry) allopathic or osteopathic physicians specialized in psychiatry. Residents and house officers were excluded from the analysis.
APRNs practicing psychiatry	Self-identified psychiatry as their primary or secondary practice specialty. APRNs practicing psychiatry included both those who were and were not board-certified in psychiatry. APRNs that were board-certified in psychiatry held a national board certification from the American Nurses Association.
PAs practicing psychiatry	Self-identified psychiatry as their primary or secondary practice specialty.
Psychologists	Held a license to practice psychology and were actively practicing psychology.
LIMHPs	Licensed and actively practicing as an independent mental health practitioner. A variety of services to persons, couples, families, and/or groups could be provided with or without consultation from a qualified physician or licensed psychologist.
LMHPs	Licensed and actively practicing as a mental health practitioner. Had a limited scope of service compared to LMHPs.
LADCs	Licensed and actively practicing as an alcohol and drug counselor. Could have a dual license to include LADC and Certified Compulsive Gambling Counselor (CCGC) certificate. Note CCGC certification has changed to Certified Disordered Gambling Counselor (CDGC). Persons with solely CCGC licenses were excluded.

Health Professional Shortage Areas

An area is designated as a state mental health professional shortage area if the service area population-to-psychiatrist ratio is greater than or equal to 10,000:1. **Figure 8.2** shows that only five counties (Douglas, Lancaster, Sarpy, Thurston, and Fillmore) were not considered state designated mental health professional shortage areas. The areas within a 25-mile radius of the cities of Omaha and Lincoln were also classified as non-shortage areas. Therefore, the counties of Butler, Cass, Dodge, Gage, Otoe, Saunders, Saline, Seward, and Washington were classified as partial shortage areas. Nebraska's other 79 counties were state-designated as shortage areas for psychiatrists and mental health practitioners.

Figure 8.2: State-Designated Shortage Areas: Psychiatry & Mental Health[19]

Source: Rural Health Advisory Commission
DHHS - Nebraska Office of Rural Health
Statewide Review: 2013
Last Updated: July 2013

Cartography: Clark Sintek | Community & Regional Planning Intern | DHHS
For: Marlene Janssen | Exec. Director, Rural Health Advisory Commission
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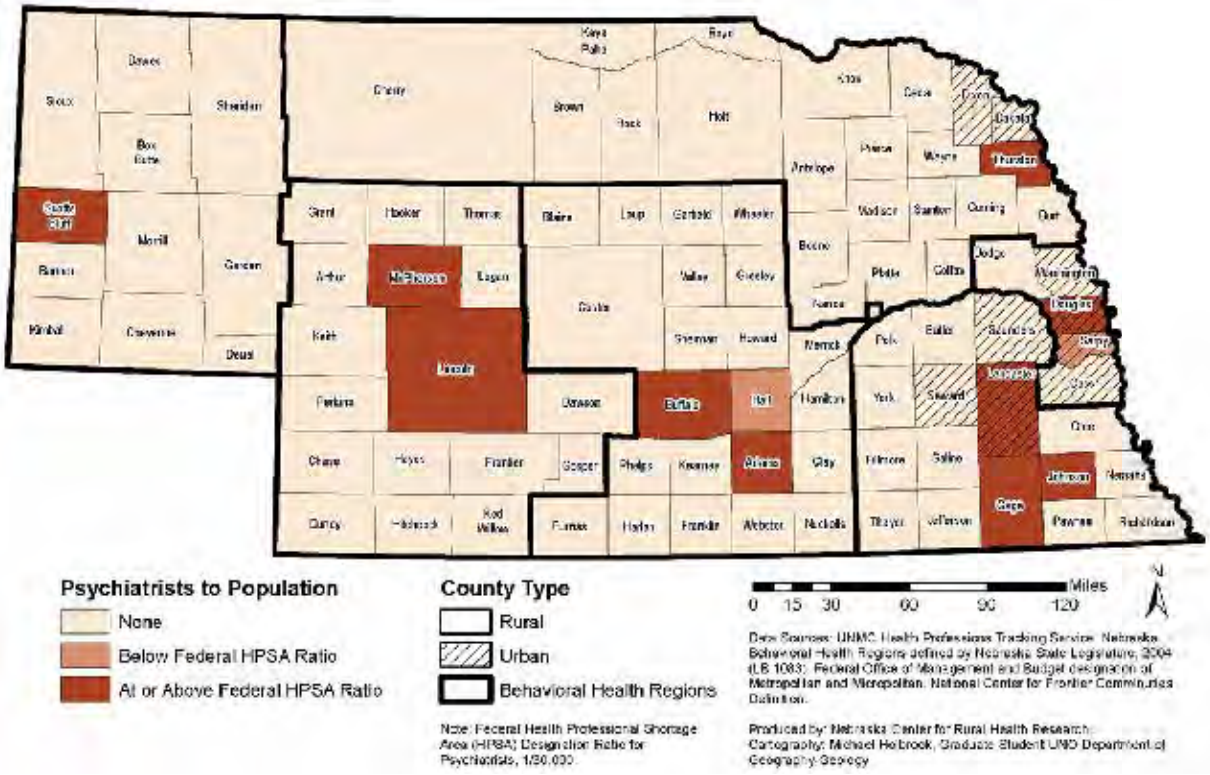
As shown in **Figure 8.3,** only 12 counties had psychiatrists, including two counties with psychiatrists below the Federal Health Professional Shortage Areas (HPSAs) ratio.[19]

Figure 8.3: Geographic Distribution of Psychiatrists: 2014[19]



Nebraska Counties with High Needs for Mental Health Services

According to the Substance Abuse and Mental Health Services Administration, determination of "unusually high needs for mental health services" is based on the following criteria: (1) 20% of the population (or of all households) in the area had incomes below the poverty level; (2) the ratio of the number of children under 18 to the number of adults of ages 18 to 64 (youth ratio) exceeded 0.6; and (3) the ratio of the number of persons aged 65 and over to the number of adults of ages 18 to 64 (elderly ratio) exceeded 0.25.[19]

In **Table 8.2**, counties were identified as having unusually high needs for mental health services using the above criteria.

Table 8.2: Counties with Unusually High Needs for Mental Health Services, Nebraska 2014[19]

Region I	Region II	Region III	Region IV	Region V	Region VI
Box Butte	Arthur[2]	Adams	Antelope	Butler	Dodge
Cheyenne	Chase[2]	Blaine[2]	Boone	Fillmore	
Dawes[2]	Dundy[2]	Clay	Boyd[2]	Gage	
Deuel[2]	Frontier[2]	Custer[2]	Brown[2]	Jefferson	
Garden[2]	Gosper[2]	Franklin[2]	Burt	Johnson	
Kimball[2]	Grant[2]	Furnas[2]	Cedar	Nemaha	
Morrill[2]	Hayes[2]	Garfield[2]	Cherry[2]	Otoe	
Scotts Bluff	Hitchcock[2]	Greeley[2]	Cuming	Pawnee[2]	
Sheridan[2]	Hooker[2]	Hamilton	Dixon[1]	Polk	
Sioux[2]	Keith	Harlan[2]	Holt[2]	Richardson	
	Lincoln	Howard	Keya Paha[2]	Saunders[1]	
	Logan[2]	Kearney	Knox	Seward[1]	
	McPherson[2]	Loup[2]	Nance	Thayer	
	Perkins[2]	Merrick	Pierce	York	
	Red Willow	Nuckolls	Platte		
	Thomas[2]	Phelps	Rock[2]		
		Sherman[2]	Thurston		
		Valley			
		Webster[2]			
		Wheeler[2]			

Source: U.S. Census Bureau, 2009-2013 5-Year American Community Survey
Note: An area was considered to have unusually high needs for mental health services if one of the following criteria was met: (a) 20 percent or more of the population (or of all households) in the area had incomes below the poverty level; (b) the youth ratio, defined as the ratio of the number of children under 18 to the number of adults of ages 18 to 64, exceeded 0.6; and (c) the elderly ratio, defined as the ratio of the number of persons aged 65 and over to the number of adults of ages 18 to 64, exceeded 0.25 (Health Resources and Services Administration, n.d.).
[1] Metropolitan county. Federal Office of Management and Budget designation, 2009.
[2] Frontier county (< 7 persons/square mile). National Center for Frontier Communities definition, U.S. Census Bureau 2010 Intercensal Estimates.

Nebraska Behavioral Health Workforce Trends

Table 8.3 shows the trend of behavioral health workforce supply trends between 2010 and 2014. During this period, there was a decrease in the number of psychiatrists and mental health practitioners, while a large increase was observed for PAs (43.7%), IMHPs (38.2%), and APRNs (25.6%).[19]

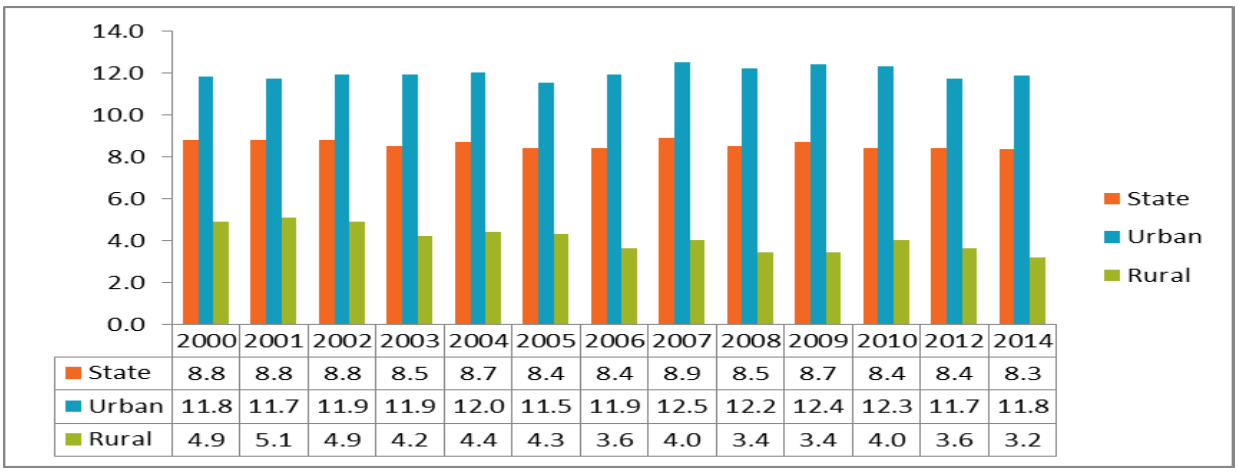
Table 8.3: Supply of Actively Practicing Behavioral Health Professionals by Work Status, Nebraska 2010, 2012 and 2014[19]

	2010			2012			2014			% Change 2010-2014
Profession Type	Full-Time	Part-Time	Total	Full-Time	Part-Time	Total	Full-Time	Part-Time	Total	
Psychiatric Prescribers										
Psychiatrists[1]	123	38	161	125	31	156	121	35	156	-3.1
APRNs Practicing Psychiatry[2]	61	17	78	56	19	75	71	27	98	+25.6
PAs Practicing Psychiatry[3]	6	3	9	9	3	12	11	5	16	+43.7
Subtotal	190	58	248	190	53	243	203	67	270	+8.9
Independent Behavioral Health Professionals										
Psychologists[4]	237	81	318	256	79	335	282	84	366	+15.1
LMHPs[4]	451	138	589	524	179	703	602	212	814	+38.2
Other Behavioral Health Professionals										
Mental Health Practitioners[4]	679	312	991	684	347	1,031	609	309	918	-7.3
Addiction Counselors[5]	111	27	138	130	26	156	114	29	143	+3.6
Total[6]	1,668	616	2,284	1,784	684	2,468	1,810	768	2,511	+9.9

Source: Health Professions Tracking Service, University of Nebraska Medical Center 2014
APRNs=Advanced Practice Registered Nurses; PAs=Physician Assistants; LMHPs=Licensed Mental Health Practitioners.
[1]Includes allopathic and osteopathic physicians. Excludes residents.
[2]Includes Advanced Practice Registered Nurses who identified psychiatry as their primary or secondary practice specialty.
[3]Includes physician assistants who identified psychiatry as their primary or secondary practice specialty.
[4]A practitioner may have held more than one license type. Persons were counted only once in this table in the highest level category.
[5]Addiction counselors included licensed as alcohol & drug counselors (LADCs).
[6]Includes only unduplicated counts of all professionals, although some professionals may have held more than one license type. Persons were counted only once in this table in the highest level category.

Figures 8.4-8.6 show the ratio of population to providers per 100,000 between 2000 and 2014 for prescribers. The ratio was stable for psychiatrists at the state and urban levels with a slight decrease at the rural level, while there was an increase in the ratio of population to providers for APRNs and PAs at all levels. The ratio in rural areas for APRNs and PAs was compatible to that of urban areas each year when compared to that of psychiatrists, for which the ratio in rural areas lagged behind that of urban areas.[19]

Figure 8.4. Ratio of Population to Providers (per 100,000): Psychiatrists by Geographic Location, Nebraska 2000-2014[19]



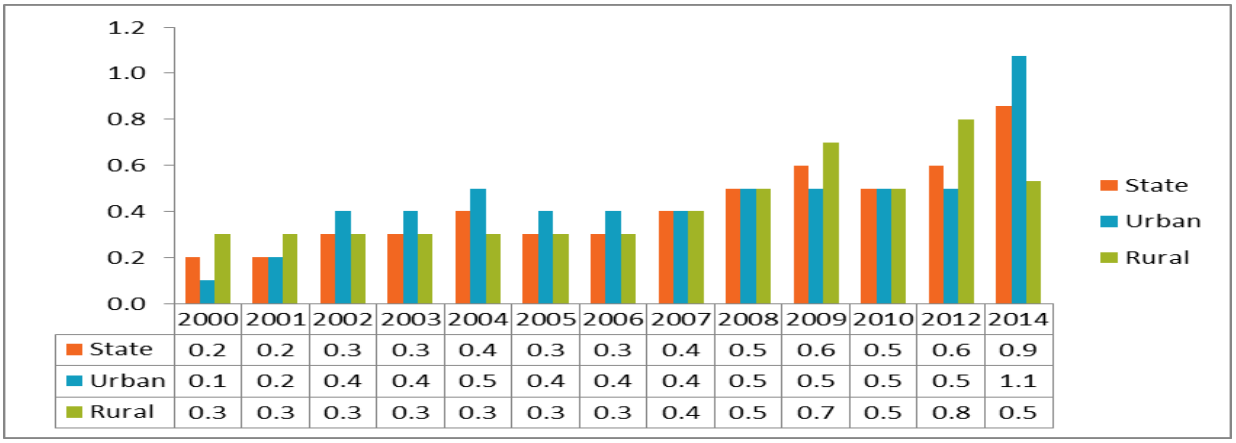
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2012	2014
State	8.8	8.8	8.8	8.5	8.7	8.4	8.4	8.9	8.5	8.7	8.4	8.4	8.3
Urban	11.8	11.7	11.9	11.9	12.0	11.5	11.9	12.5	12.2	12.4	12.3	11.7	11.8
Rural	4.9	5.1	4.9	4.2	4.4	4.3	3.6	4.0	3.4	3.4	4.0	3.6	3.2

Figure 8.5: Ratio of Population to Providers (per 100,000): Advanced Practice Registered Nurses Practicing Psychiatry by Geographic Location, Nebraska 2000-2014[19]

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2012	2014
State	0.9	1.1	1.4	1.5	1.7	1.8	2.3	2.7	3.7	4.0	4.3	4.0	5.2
Urban	1.3	1.5	1.9	1.6	1.7	2.1	2.4	3.1	4.3	4.6	4.7	4.2	6.2
Rural	0.4	0.7	0.9	1.3	1.6	1.5	2.3	2.2	2.8	3.6	3.7	3.8	3.8

Figure 8.6: Ratio of Population to Providers (per 100,000): Physician Assistants Specialized in Psychiatry by Geographic Location, Nebraska 2000-2014[1919]

19

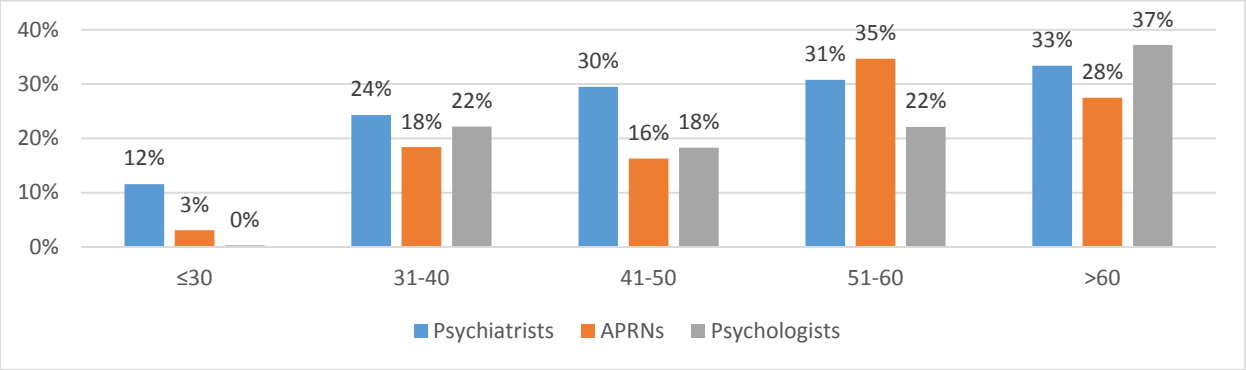


	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2012	2014
State	0.2	0.2	0.3	0.3	0.4	0.3	0.3	0.4	0.5	0.6	0.5	0.6	0.9
Urban	0.1	0.2	0.4	0.4	0.5	0.4	0.4	0.4	0.5	0.5	0.5	0.5	1.1
Rural	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.4	0.5	0.7	0.5	0.8	0.5

Recruitment & Retention Issues

Figure 8.7 shows the age distribution of psychiatrists, advanced practice registered nurses (APRNs), and psychologists.[19] A large proportion of these providers are nearly the retirement age. For example, 31% of psychiatrists are between 51 and 60 years of age and 33% of them are over 60 years of age. Similarly, 35% of APRNS are between 51 and 60 years of age and 28% of them are over 60 years of age.

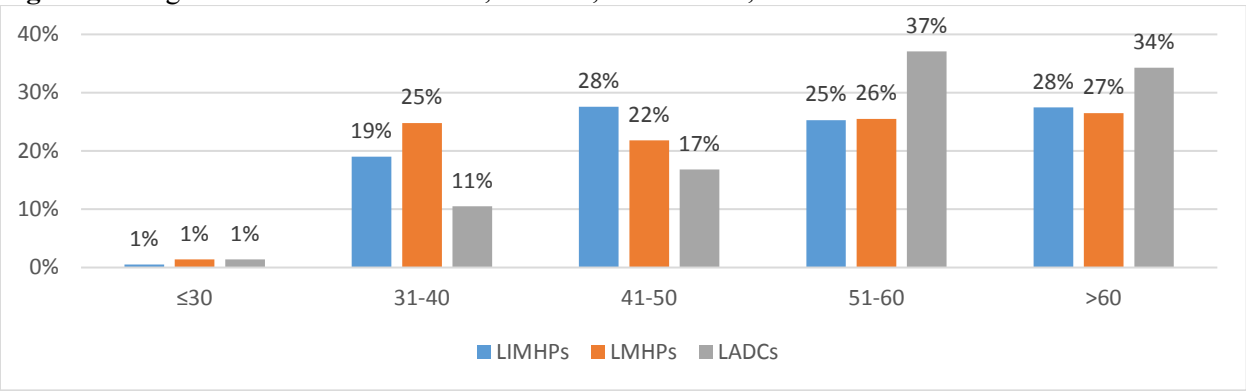
Figure 8.7: Age Distribution of Psychiatrists, APRNs, and Psychologists, Nebraska 2014[19]



APRNs=Advanced Practice Registered Nurses

Figure 8.8 shows the age distribution of licensed independent mental health practitioners (LIMHP), licensed mental health practitioners (LMHPs) and licensed alcohol and drug counselors (LADCs).[19] A larger proportion of LADCs are in older age categories (51-60 and >60 years) than LIMHPs and LMHPs. For example, 37% of LADCs are 51-60 years of age and 34% of them are 60 years and older.

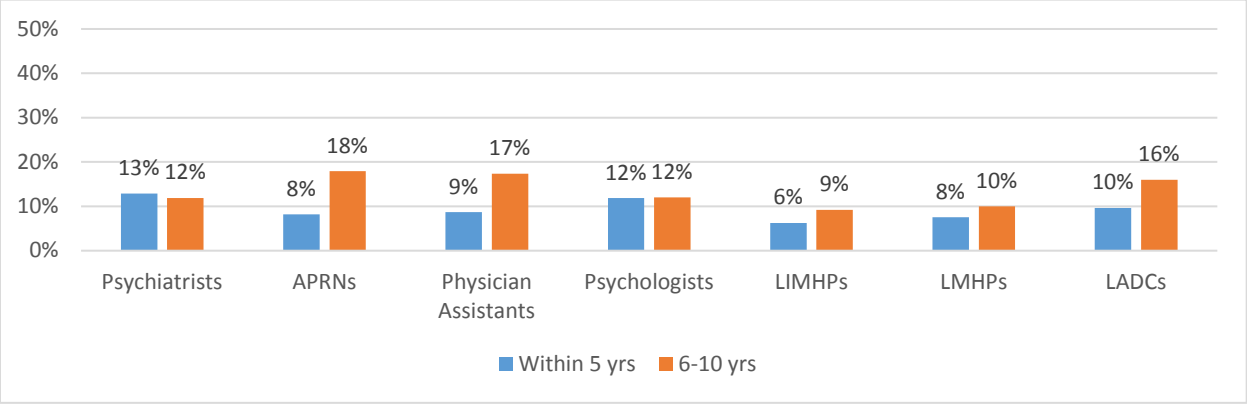
Figure 8.8: Age Distribution of LIMHPs, LMHPs, and LADCs, Nebraska 2014[19]



LIMHPs=Licensed Independent Mental Health Practitioners; LMHPs=Licensed Mental Health Practitioners; LADCs=Licensed Alcohol and Drug Counselors.

Figure 8.9 shows information about the intention to retire among behavioral health providers. One in 5 psychiatrists, advanced practice registered nurses (APRNs), physician assistants, psychologists, and licensed alcohol and drug counselors (LADCs) indicated their intention to retire within 10 years.

Figure 8.9: Behavioral Health Providers' Intentions to Retire or Discontinue Practice, Nebraska 2014[19]



APRNs=Advanced Practice Registered Nurses; LIMHPs=Licensed Independent Mental Health Practitioners; LMHPs=Licensed Mental Health Practitioners; LADCs=Licensed Alcohol and Drug Counselors.

In order to understand factors affecting the recruitment and retention of behavioral health providers, in 2012 and 2013, a focus group study was conducted among behavioral health providers and administrators in rural communities in Nebraska.[112]

Tables 8.4 summarize the factors affecting recruitment and retention.[112] National and local competition was identified as one reason with difficulty recruiting and retain psychiatrists and advanced practice registered nurses. Low Medicaid reimbursement and a cumbersome process for authorization created a hardship for providers of all types. The need for competitive pay to attract and retain providers was also mentioned. A long delay in licensing and credential created a difficulty for both providers and agencies that hire the providers. Rural communities have a limited number of providers who can supervise provisionally licensed providers. Rural communities have limited choices and access to education and training of providers. Because of a shortage of providers, the workload for providers in rural agencies can be overwhelming and the professional and social isolation are also mentioned as a deterrent.

Table 8.4: Factors Affecting Recruitment & Retention Perceived by Providers and Administrators in Rural Nebraska[112]

Theme	Description
National and local competitions	Competition for psychiatrist applicants is high due to short supply nationwide, high salaries offered in more desirable places, draw of private practice, and hiring competition among local agencies. A few areas reported having had a psychiatrist position open for several years or longer even when using a recruitment agency. Difficult to hire psychiatric APRNs due to applicants having many other options including local competition.
Medicaid	Medicaid's requirement for prior authorization for medications is a strain on providers and a barrier to recruitment and retention. Low Medicaid reimbursement.
Pay	The need for competitive pay was emphasized in all provider groups. Cutting revenue dollars according to per capita allowance differentially affects rural agencies due to having less money available for basic programming and infrastructure.

	Lack of funding affects hiring of behavioral health providers not required to be licensed (e.g., technicians, residential workers, community support workers). Some agencies reported that they cannot compete with retail stores in their area that often pay workers more.
Licensing & credentialing application	Delay in processing licensing applications at the state level as well as credentialing with health maintenance organizations are problematic in trying to hire most provider types. While waiting for credentialing to be completed, a provider is unable to see patients, so agencies cannot bill and they cannot be reimbursed. Provisionally licensed mental health practitioners sometimes experience long delays after submitting their applications for full licensure. Delays can create financial difficulty for the agencies wanting to hire these providers as they are unable to bill for providers' services.
Supervision	After provider's educational requirements have been met, trainees in rural locations have difficulty obtaining the supervision required for licensure. Concern for supervisors regarding professional liability for the supervisee's actions. For psychiatrists, lack of local supervising psychiatrists and the need for medical authorizations are problematic.
Education & training	Difficulty to obtaining necessary coursework or supervised experience required for licensed alcohol / drug counselors. Cost of education / training. Lack of health care facilities that offer training in rural settings.
Workload & resources for complex cases	The burden of not having others with whom to share the patient load, and consequently having little downtime. Too few professional resources and agencies to which they can refer complex patients.
Isolation	Social and geographic isolation in rural areas. Professional isolation reported by psychiatrists. In a rural community, there are only one or two psychiatrists in the area.

Table 8.5 summarize the potential solutions proposed by the providers and administrators participate in the focus group study.[112] Financial incentives such as increase in pay and perks as well as expansion of loan repayment programs have been suggested. The participants also emphasized the importance of residency and internships tailored for rural settings. Extending the medical staff privilege among psychologists in rural hospitals was thought as a way to encourage the practice. Participants saw the need for financial incentive and resource allocation to strengthen the telehealth infrastructure. Finally, it was suggested to combine resources to promote rural communities and facilities and to emphasize the unique strengths of the communities.

Table 8.5: Potential Solutions to Address Recruitment and Retention Issues Suggested by Providers and Administrators in Rural Nebraska[112]

Theme	Description
Pay & perks	Offer a long-term contract and a guaranteed salary. Make pay competitive compared to metropolitan areas. Offer housing allowance.
Rural residency	Develop rural residency programs for psychiatrists. Include family members to be integrated into the community. Offer a longer residency program (e.g., 1 year).
Internship & supervision	Create a rural psychology internship site that would provide supervision to pre-doctoral interns and postdoctoral provisionally licensed psychologists.
Loan repayment	Expand loan repayment program to recruit different professionals, not just psychiatrists.
Training & education	Bring advanced education and training to rural sites. Increase opportunities for social work training.

Medical staff privilege	Grant psychologists medical staff privileges in more rural hospitals.
Telehealth	Provisional non-prescribing providers could be supervised via telemedicine. Provide therapy via telemedicine so that LMHPs can get experience required for full licensure faster when hired. Streamline processes and regulations regarding telemedicine to make it easier for providers and health care facilities to adopt telemedicine. Provide financial incentives and technical assistance to set up and maintain telemedicine.
Combine resources to afford a position	Rural areas may combine resources to fund a psychiatrist position in a variety of settings and offer a fixed schedule, relief from weekend or holiday call, and time off.
Market strengths and benfits	Create a video specific to the area that would highlight the community, including key providers and resources in the area.

Peer Support Workforce

Peer Support

According to Substance Abuse and Mental Health Services Administration, "peer support services are delivered by persons who have common life experience with the people they are serving."[113] A peer provider also known as peer specialist is an individual who uses his or her lived experience of recovery from mental health and/or substance use disorder, plus skills learned in formal training, to deliver services in behavioral health settings to promote mind-body recovery and resiliency.[114] Peers provide assistance that promote a sense of belonging within the community and development of self-efficacy through role modeling.[113]

Nebraska Peer Support Workforce Survey

In 2015-2016, Nebraska Division of Behavioral Health (DBH) Office of Consumer Affairs (OCA) conducted a peer support survey.[115] The sample for this survey was a convenience sample identified through postings on the OCA's Certified Peer Support and Wellness Specialist listserv and the National Peer Support Facebook Group. In addition information about the survey was sent out to a wide range of partner organizations. An estimate on the sample size of people receiving the link is about 600 persons. The original request for participation was delivered on December 8, 2015 and the data collection ended in January 11, 2016. There were a total of 106 completed or partially completed surveys.

Peer Support Employment Status

A little over three-fifths of survey respondents were currently employed in paid positions as peer support providers (63%) while 13% indicated that they are currently employed in volunteer positions (n=13). About 9% indicated that they are not currently employed as a peer support provider, but have worked as one in the past. An additional 9% indicated that they are currently not employed as a peer support provider, but are seeking a position. The remaining 5% had never been employed as a peer support provider and were not looking for a position.

Training, Certification, and Education Opportunities

Among respondents who are not employed as peer support specialists, 87% of respondents have completed 40 hours of specialized peer support training (87%), 12% have not completed the training, but plan to do so in the future. Only one respondent indicated that she/he does not wish to pursue specialized training at this time. The most commonly earned certification was the Certified Peer Support and Wellness Specialist (CPSWS) offered through the National Federation for Parent Support Providers. Other certificates earned by respondents included the Depression and Bipolar Support Alliance Peer Specialist Training, Whole Health and Wellness, Middle Management Training, Voice Healers, Emotional CPR, Wellness Recovery Plan, and Individual Placement and Support.

Both currently employed and not currently employed survey respondents (N=106) indicated that they would be interested in more educational opportunities. The results were fairly consistent among opportunities: building capacity of peer organizations (n=50), personal and professional development (n=47), peer rights (n=44), trauma informed care (n=43), system navigation and accessing benefits

(n=41), public speaking/giving effective testimony (n=40), cultural sensitivity training (n=38), wellness and recovery action planning (n=38), behavioral health promotion (n=36), crisis support (n=36), prevention education (n=33), boundaries and ethics (n=32), and other types (n=12).

Peer Support Provider Employment Characteristics

Respondents were asked how many years they worked as a paid or volunteer peer support provider with the current organization. A quarter (25%) of respondents indicated they worked less than a year. After removing the respondents who reported working less than 1 year, the average length of working at the current organization as a peer support provider was 5.2 years. Hours worked by respondents varied, with 69% working 40 or more hours, 14% working 20-39 hours, and 17% working less than 20 hours per week. The average hourly wage was $16.72/hour and the median was $16.00. Forty-two percent (42%) respondents earned between $10-14.99, 31% earned $15-19.99 and 27% earned $20.00 or more hourly.

When describing the type of organization they work for, 39% of respondents indicated that they work for a non-profit organization, 30% for a peer run organization, and 16% for a local, state, or federal government agency. Other organization types included independent contractor, faith-based organization, hospital, and law enforcement. When asked about their primary role within their current paid or volunteer position, 56% selected direct service provider, 12% selected program manager, 7% selected Agency Director, 6% selected Systems Transformation Advocate, 4% selected education training provider, and 1% selected administrative support.

Survey respondents were asked to identify which types of support services they provide in their current position. The most frequently selected option was advocacy (84%), followed by recovery support (81%), and mentoring (80%). Other options selected included support services (72%), health/behavioral education (69%), crisis intervention (63%) and support groups (61%).

Respondents' demographic characteristics were available for those who are currently employed (n=70). More than half (63%) of respondents were female. A half (52%) of the respondents were between 45 and 64 years of age, 28% were between 35-44 years of age, 13% were between 25-34 years of age, 4% were between 18-24 years of age, and the remaining 3% were 65 years or older. The majority (84%) of respondents were whites, 6% were African Americans, 3% American Indian/Alaska Native, 1% Asian, and the remaining 6% of respondents selected "other" race/ethnicity background option. Forty-one percent (41%) of respondents indicated having completed at least an associate's degree; 21% indicated that their highest level of education was bachelor's degree and 20% reported a graduate or professional degree. Thirty-one percent (31%) responded their highest level of education was some college, 3% reported high school, and 4% reported some high school. Twenty-one percent (21%) of the respondents indicated that they have served on active duty in the U.S. Armed Forces or the Armed Forces of another country.

Unlicensed Workforce

Currently, there is no accurate estimate of the number of unlicensed behavioral health workers employed in Nebraska. However, according to information provided by behavioral health agencies, about 70-80% of the current behavioral health workers are unlicensed. These persons provide day-to-day care and play a vital role in the behavioral health system.

The turnover among unlicensed behavioral health workers has been a great concern,[116, 117] According to the Bureau of Labor, the annual turnover rate in 2015 was 23.6% for all industries combined and 19.9% for the education and health services sector.[33] For behavioral health workers, the annual turnover rate has been reported to range from 19% to 72%.[118] Although the bulk of day-to-day care is provided by community behavioral health workers who are mostly unlicensed, the majority of the behavioral health workforce studies in the past have focused on licensed professionals such as psychiatrists, nurse practitioners with psychiatry specialty, psychologists, and licensed independent behavioral health providers.[119, 120] Because there is a dearth of research to understand reasons for difficulties with retention of unlicensed behavioral health workers, it is difficult to identify potential interventions to decrease the turnover rate.

Workforce Development Efforts

Ambassador Program

In 2012, the Ambassador Program was created to recruit high school and college students to behavioral health as a career. In 2013 and 2014, BHECN held a Career Day, which included one hour sessions for students interested in behavioral health. There were 505 students who participated in 2013 and 488 in 2014. In 2014 and 2015, BHECN held an Ambassador Conference for high school students, which resulted in 130 students participating during these years, and a BHECN College Conference, where 67 college students attended. In October 2014, it was shown that 32 out of 43 high school students that graduated from one of the Ambassador Conferences were enrolled in a Nebraska college or university. There were 64 college students who graduated since attending the BHECN College Conference and 20 have enrolled at UNMC in a variety of health care professions since then.[121]

Virtual Mentorship Program

The Virtual Mentorship Program allows high school and college students to use internet-based technology to participate in behavioral health career mentorship sessions with persons working within the behavioral health workforce. This two-year educational pilot program has connected 40 students with 2 psychiatry residents and 2 doctoral psychology trainees, in which 6 live online sessions are conducted and students are given access to a secure online blog site. After the first year, 92.9% of students indicated that they would recommend this program to their peers.[121]

Graduate Level Training

At the graduate level, BHECN has encouraged students to remain in the Nebraska behavioral health workforce in order to serve those with behavioral health needs. During the academic years 2013/2014 and 2014/2015, there were 1,519 students (i.e., medical, PA, nursing) who trained at Lasting Hope Recovery Center and Community Alliance in Omaha. BHECN has encouraged psychiatric training among UNMC and Creighton University residents and has supported about 4 residents annually, with 7 out of 11 residents remaining in Nebraska in 2015. Ten psychiatric residents spent one month at rural psychiatric facilities during the 2014/2015 academic year. It was shown that 9.7% of UNMC and 7.1% of Creighton 4th year medical students chose psychiatry for residency that year.[121]

During this time, BHECN and the Munroe-Meyer Institute granted doctoral internship support via stipends for 5 trainees in the rural primary care setting where they were given 10,000 hours of supervised training by licensed psychologists. These trainees provided 3,500 additional patient visits to youth and adults in rural areas. Sixteen master's degree students from the University of Nebraska-Omaha, Chadron State, and other areas were trained through internships and practicums in the behavioral health setting. Seven Applied Behavior Analysis students were given supervision and intensive training at the Munroe-Meyer Institute for children with autism spectrum disorders. These master's level students received 3,000 hours of supervised training and provided 12,000 hours of services to youth and adults. It has been shown that 76% of graduates have remained in Nebraska and have pursued behavioral health-related careers.[121]

Continuing Education & Training

BHECN provides free training to all behavioral health organizations in Nebraska. From July 1, 2013, to June 30, 2015, BHECN trained 3,207 members of the behavioral health workforce, including 2,126 rural members and 1,081 urban members. One of the programs offered was Seeking Safety, which is evidence-based and counsels people on safety from trauma and substance use. Mental Health First Aid is an educational program for adults and youth that aims to identify, understand and respond to signs of mental illness and substance use disorders. There were custom trainings on trauma, psychopharmacology, and self-care. The trauma-informed approach and specific interventions provide an understanding of trauma in persons and organizations and how to heal from it. Compassion Fatigue provided trainees with the tools to understand trauma and burn out, along with signs and symptoms, and how to become resilient and care for themselves when this occurs.[121]

Other Initiatives

In addition, there are a variety of initiatives that BHECN has established to improve behavioral health in Nebraska. From July 1, 2013, to June 30, 2015, a total of 207 persons attended a live broadcast webinar and 118 watched a webinar recording. These webinars included information such as attention deficit hyperactivity disorder (ADHD) screening and diagnosis and how to best conduct behavioral telehealth service delivery. BHECN helped establish a job website in 2015 (i.e., NebraskaBehavioralHealthJobs.com) for employers and potential employees, which has resulted in 5,724 site visits. In June 2014, BHECN hosted the Integrating Behavioral Health into Primary Care conference, in which 170 participants attended. In June 2015, BHECN collaborated with 10 community partners (e.g., Building Healthy Futures, CHI Health, etc.), which educated 270 participants on mental health screening and evidence-based interventions. There were 64 persons in 2013 and 130 persons in 2014 who attended the annual BHECN-sponsored certified peer support conference, in which services and support are provided by those who have similar life experiences with the people they are serving. BHECN conducted a Compassion Fatigue workshop and presented the posters “Growing Your Own Behavioral Health Workforce” and “Success with Your State Senators” at the 2015 National Council for Behavioral Health Conference.[121]

Other BHECN initiatives include a partnership with the Munroe-Meyer Institute, which has screened 4,095 children over 22 months in its pilot program for early detection of behavioral disorders such as ADHD, anxiety/depression, oppositional disorder, learning problems, and conduct disorders. These screenings in Omaha, Columbus, Chadron, Alliance, and Valentine have been used to assess children’s behavioral health needs as indicators for future treatment. BHECN has also partnered with the Educational Service Units in the Panhandle and Northeast Nebraska to train school staff on student behavioral health needs and it plans to extend this training to other areas. Furthermore, BHECN has reached out to rural Community Health Workers in the Latino community, known as Promotoras, who have not worked in traditional behavioral healthcare settings. BHECN is currently in the process of utilizing local organizations to train the Promotoras to work effectively in behavioral health. BHECN also participated in legislative studies LR 592 in 2014 and LR 185 in 2015 to highlight the needs of the Nebraska behavioral health workforce.[121]

IX. Community Engagement

Summary

This chapter presents results from community engagement focus groups and surveys done as part of the needs assessment to collect input from consumers and their family members, stakeholders, and the general public. The data collection activities took place in May-June 2016. It should be noted that the focus groups and surveys discussed in this chapter are different from the annual consumer surveys conducted through the Division of Behavioral Health described in Chapter 6. Data collection and analysis methods are presented in the following section of this chapter.

Chapter Highlights on Surveys Findings

A total of 1,692 responded surveys—299 respondents to the consumer and family survey, 1159 respondents to the stakeholder survey, and 234 respondents to the general public survey. In the section below, major findings from these three surveys are summarized.

Perception of Access to and Availability of Behavioral Health Treatment

- The level of awareness about availability of services for serious mental illness (SMI) and psychiatric emergency was relatively high among consumer respondents—68% indicated that they knew how to access care for serious mental illness and 73% indicated that they knew where to go in case of a psychiatric emergency.
- The majority of stakeholder respondents indicated that access to behavioral health care is limited or difficult in their communities. For example, only 20% indicated that consumers can easily get SMI treatment in a timely manner and 32% indicated that consumers with SUD have access to medication they need.
- The general public respondents held a different perception of behavioral health treatment availability from that of consumers or stakeholders. Less than 10% of general population survey respondents thought that SMI or SUD treatment availability in Nebraska was adequate and only 3-4% thought that the current SMI or SUD funding in Nebraska was adequate.
- Slightly less than half (45%) of general population survey respondents indicated that they knew how to access SMI or SUD services (other than through their local ER) and 39% felt confident about being able to help someone at risk of harming themselves or others during an SMI or SUD emergency.
- Treatment cost was one of deterrents for accessing needed care—64% of consumer respondents indicated that there was a time they were not able to pay their co-pay for behavioral health treatment.
- Wait times for treatment varies depending on the type of service needed. Approximately 60% of consumer respondents indicate they were able to receive counseling or therapy appointments with two weeks and 51% were able to receive medication management appointments with two weeks; however, only 40% were able to receive appointments SUD treatment within two weeks.

- The majority of consumer respondents reported traveling less than 60 miles for appointments (Counseling/Therapy 97%; Medication Management 95%; SUD Treatment 93%).

Awareness and Reported Use of Support Services

- The majority of consumer respondents (80%) indicated that peer-to-peer recovery support was available to them
- A slight majority (51%) of consumer respondents indicated that housing support was available to them.
- While awareness of Wellness and Recovery Action Plan (WRAP) tool is low (30%); however, of those consumer respondents who were told about it, 55% indicated they had developed and used a WRAP.
- A slight majority (53%) of consumer respondents were told about self-help groups, and of those that were told 58% attended.
- 57% of consumer respondents report they can always or most of the time get day services placement when needed, 51% report the same for case management services, and 52% for community support services.

Consumer Report on General Medical Health Care

- Chronic medical conditions were common among consumers. About 43% of consumer respondents reported that they have been diagnosed with a chronic medical condition. The most common condition was high blood pressure (49%).
- Of consumer respondents who reported being diagnosed with a chronic condition, 54% reported being able to see a medical doctor for their chronic case 2-4 times a year.
- Access to general health care is high with 89% of consumer respondents reporting they had seen a medical doctor for their general health within the last year, 69% had seen a dentist, and 57% had seen an eye doctor.
- 90% of consumer respondents reported they can always or most of the time get an appointment with a medical doctor when needed with a majority (83%) getting an appointment with two weeks and 91% traveling less than 30 miles.
- About 32% of consumers reported that they are smokers. Of consumer respondents that smoke, 56% of smokers had a discussion about smoking cessation with a provider.

Chapter Highlights on Focus Groups Findings

A total of 77 consumers and 108 stakeholders from six Behavioral Health Regions participated in 18 focus groups. Stakeholders were from the criminal justice system, hospitals, public health agencies, behavioral health agencies, and governmental agencies. Focus groups generated a large amount of information on a variety of topics. In the following sections, major themes and potential action steps based on input from the focus group participants are summarized.

Assumptions about Mental Illness and Substance Use

- Consumers emphasize the importance of being seen as a whole person and not limited to their mental illness.
- Consumers stated that being diagnosed with a mental illness should not automatically limit them to a life of poverty and reliance on government assistance.
- Stakeholders and consumers indicated the need for sustained education and awareness building about SMI/SUD; perhaps modeled after the efforts related to tobacco cessation.

Collaboration and Engagement

- Stakeholders perceive strong collaborative networks (within BHRs, between BHRs, and with DHB) as an asset to Nebraska's behavioral health system
- All Behavioral Health Regions have teams that meet regularly to discuss issues and resolve problems. The team meetings lead to building networks that are used informally to find appropriate services
- Although the informal network is important to build trust and increase coordination, a formal system of information exchange is needed to improve the continuity of care and minimize psychiatric emergency.
- Collaboration should be extended to include Medicaid and managed care organizations' (MCO) representatives. They should be invited to meetings to encourage open discussions to resolve some of issues beyond the purview of DBH that are identified in this report (e.g., service authorization, credentialing).
- The Behavioral Health Region's community advisory boards include consumers. Regions and other behavioral health service providers employ peer specialists. Consumers collaborate with one another through coalitions developed by and for consumers.
- Consumers participated in the focus groups expressed a strong desire to take a more active part of decision making in the behavioral health system. The Office of Consumer Affairs initiates efforts to work across Division of Behavioral Health Care/Medicaid/MCO to increase consumer involvement.

Emergency Psychiatric Services

- Even when officers are compassionate and helpful, involvement of law enforcement in the process of hospitalization can be quite traumatic for consumers and their families.
- Stakeholders reported that limited psychiatric inpatient capacity especially in rural areas mean long wait which can result in escalation of the person's behavior and/or law enforcement resources used to transport the consumer for a long distance for hospitalization.
- Stakeholders perceive lack of emergency psychiatric services for juveniles.
- Resources, such as the 24/7 crisis line, that are available to help de-escalate consumers need to be more widely promoted.
- Drop-in and respite centers could be an alternative for people who do not meet EPC criteria but that still need some supervision and support for hours to few days. This can help consumers

stabilize, reduce the burden on law enforcement and hospitals, and reduce the likelihood of illegal activities. Also, this helps consumers and families stay within their communities to receive needed to support.

Post-care Follow Up

- Stakeholders reported that many times consumers are given responsibility for setting up appointments for follow-up care; however, they either do not call the provider or wait until it is too late after medication is gone.
- There should be an information system set up to maintain the continuity of care while maintaining confidentiality of sensitive personal and health information of consumers. The information sharing for the post-follow up care should include systems such as probation and parole.
- Peer support program may be expanded to assign a peer navigator (under the supervision of case manager as appropriate) in order to help consumers being discharged from emergency treatment understand how to access follow up care.

Maintenance of Level of Care and Need for Intermediate Levels of Care

- Stakeholders (providers) reported challenges in getting authorization for appropriate levels of care and inconsistencies in how authorization criteria are applied. They recommended changing the current authorization criteria to include a maintenance level of care so consumers can continue to receive coverage for medications and therapy they need to remain stable.
- Stakeholders also recommended developing authorization criteria that recognize SMI/SUD as a chronic condition like diabetes or heart disease and provide ongoing services accordingly.
- Stakeholders indicated that transition from one level of care can be abrupt when a consumer is deemed to no longer need or be eligible for services. Consumers and stakeholders advocated for four levels of care: emergency inpatient treatment, intermediate care (e.g., group homes), outpatient treatment, and maintenance level of care.

Support Services

- Consumers expressed optimism toward service availability. They reported there are more services and shorter wait times for programs like day rehab services or community support.
- It was recommended to keep 'network of care' information updated and provide resource directories that are updated on a regular basis. Also, information should be disseminated in a variety of ways including through print materials that can be distributed at places that consumers go.

Transportation and Housing

- Rural communities do not have many options for transportation and the public transportation system such as busses can be difficult for consumers to use.

- Although there are transportation services (funded by Medicaid) specifically for persons with behavioral issues, having to book rides in advance does not allow for emergency needs. Also, consumers reported that some transportation services are not reliable (e.g., no show/late show).
- Working in collaboration with Medicaid or others that provide/fund transportation services, quality control measures for the existing transportation contractors should be implemented and other transportation options which allow 24/7 access should be developed.
- Stakeholders and consumers report housing shortages and indicate that the process for accessing subsidized or support housing can be difficult to navigate.
- Consumers reported lack of temporary housing and some areas of the state do not have homeless shelters.
- Recommendations about housing included education of landlords in order to reduce stigma of SMI/SUD and incentivizing development of housing for people with SMI/SUD through property tax rebates.

Focus Group Study Participants and Framework

Focus Group Study Participants

The focus group participants were invited by Behavioral Health Region Administrators using their existing contact lists. A total of 24 focus groups were scheduled with at least one consumer focus group and one stakeholder focus group in each region; there were a total of 108 participants for the stakeholder groups and 77 for the consumer groups (**Table 9.1**).

Table9.1: Number of Focus Group Study Stakeholder and Consumer Participants by Behavioral Health Region

Behavioral Health Region	Number of Stakeholder Participants	Number of Consumer Participants
1	20	5
2	16	31
3	11	11
4	26	11
5	28	10
6	7	9
TOTAL	108	77

In order to protect consumers' privacy, participants in these groups gave only their first name when signing in to the session. Stakeholders were asked to provide both their name and organization. The types of agencies represented included: criminal justice, (e.g. law enforcement, probation, corrections); hospitals; public health; service agencies; DHHS; Region staff; Board of Mental Health; and advocacy organizations (**Table 9.2**).

Table 9.2: Number of Focus Group Participants by Agency Type

Agency Type	Number of Participants
Criminal Justice System	24
Hospitals	15
Public Health	2
Behavioral Health Service Agency	27
Nebraska Department of Health & Human Services	9
Behavioral Health Regions	23
Other	8

The size of the focus groups ranged from three to 31 participants. Two of the consumer focus groups were conducted at day service programs. At least three of the stakeholder focus groups were conducted in conjunction with a regularly scheduled advisory board meeting for that Region.

Framework

The results of the November 2015 report *The DHHS Behavioral Health Division's Role in Reducing Service Gaps* conducted by the Performance Audit Committee of the Nebraska Legislature served as a

starting point in identifying topics to include in a semi-structured interview guide covering the following topics: 1) access to care, 2) available support services, 3) authorization for services from insurers, 4) emergency psychiatric services, 5) collaboration between service providers, 6) integrated care, and 7) funding.[122]

After the first two consumer focus groups the "funding" category was eliminated because consumers generally do not interact directly with insurers in securing authorization for services and consumers discussed funding within the context of service availability. The topic of stigma was often raised in discussions about support services such as housing or employment but was not included as a separate topic area for the stakeholder focus groups. The initial stakeholder question guide did not change substantially over the course of the focus groups.

The topic areas of each question guide were used to guide the initial coding and sub-categories were identified (**Table 9.3**).

Table 9.3: Coding Categories with Descriptions

Coding Category	Description
Authorization	Statements about the process for getting services authorized by the consumer's insurance provider
Maintenance Level of Care	Statements about authorization for on-going supportive care once consumer is stabilized
Funding	Statements about funding for various programs to address SMI/SUD
Workforce Shortages	Statements about workforce shortage impacting delivery of care or services
Collaboration	Statements about how various entities involved in dealing with SMI/SUD coordinate with one another
Post-care Follow Up	Statements dealing with follow-up with consumers who have been released from in-patient or residential treatment programs
Information Flow	Statements dealing with the flow of information between stakeholder entities
Emergency Psychiatric Services	Statements dealing with the process of getting a consumer into immediate care
Access	Statements about accessing services including wait times, insurance coverage, and transportation to appointments
Integrated Care	Statements about coordination of care between providers treating consumers with co-occurring conditions such as SMI and diabetes, etc.
Support Services	Statements about services needed to help the consumer meet their needs including housing, transportation, or employment
Assumptions about SMI/SUD	Statements that reflect assumptions, stigma, or lack of understanding about SMI/SUD
SMI=serious mental illness; SUD=substance use disorder.	

Focus Group Results

Important Considerations

This chapter presents results from community engagement focus groups and surveys conducted in May-June 2016 by the University of Nebraska College of Public Health researchers. It should be noted that the focus groups and surveys discussed in this chapter are different from the annual consumer surveys conducted through the Division of Behavioral Health (DBH) described in Chapter 6.

The DBH Consumer Survey uses the list of consumers who received services through the community-based behavioral care funded by the Division as a sampling frame. The focus groups and surveys discussed in this chapter went beyond to capture a broader audience. Therefore, the results described in this chapter cannot be directly compared to the results of the Division of Behavioral Health Consumer Survey described in Chapter 6.

It is also important to note that focus group participants and survey respondents included in the focus groups and surveys tended to see services they receive from the Department of Health and Human Services as a system and did not distinguish between the various divisions within DHHS that offer those services. For example, even though the Medicaid program is a separate division from the DBH, respondents, particularly consumers, did not make that distinction in their responses to questions about behavioral health services.

There are limitations relevant to both the focus groups and surveys. Convenience sampling was used for both activities. For the focus groups, this sampling approach resulted in over representation of consumer specialists employed by the Behavioral Health Regions or other service providers and over representation of consumers who were attending day programs. The time-frame for conducting the focus groups also meant that scheduling of the groups may have presented a barrier to consumer participation. For the survey, this sampling approach means that respondents were more likely to have an interest in the topic and were more motivated to respond. This sampling approach introduces bias into the results and caution should be exercised when extrapolating the data to the larger audience of consumers, their families, stakeholders, or the general public. Both the focus groups and survey gathered perceptions about behavioral health services and, as such, may not necessarily align with the quantitative data. Gaps between what the data show and what the perceptions are provide opportunities for further exploration. Nonetheless, the results of the focus groups and surveys provide valuable information that can be used to make inferences about the perspectives of consumers, their family members, stakeholders, and the general public.

Collaboration

Overall stakeholders appeared to be more satisfied with the current levels of collaboration within the behavioral health system and across different systems than did consumers, including collaboration between the state and local entities. Stakeholders identified multiple ways they collaborate with one another both formally and informally. On a formal level, all Regions have teams that meet regularly to discuss issues and resolve problems. These teams include law enforcement, corrections, probation, hospitals, psychiatrists, therapists, and the various behavioral health service agencies. The team meetings also lead to building networks that are used informally, often described by stakeholders as 'picking up the phone' in order to find appropriate services for a consumer or to resolve a problem. Collaboration is also evident in developing new programs for consumers and training personnel. Many of the stakeholders attending the focus groups indicated that they have been in their position or discipline for more than a decade. These strong networks are an asset to Nebraska's behavioral health system.

Many stakeholders indicated that collaboration could be improved when developing policies and procedures. Although a majority of the collaboration experiences are beneficial, there are times when working together is negatively influenced by providers protecting their territory and/or funds. A stakeholder mentioned "Instead of competing for dollars, let's work together with the dollars…" It was also mentioned that representatives from Medicaid and the new MCO's should be included in the meetings to encourage more successful collaboration between these representatives and the professionals who work in the field.

Consumers interpreted collaboration as having the opportunity to provide input about the behavioral health system in general and the programs or activities of each Region specifically. The Regions' community advisory boards include consumers, and the Regions and other behavioral health service providers employed peer specialists. These consumers in advisory or peer specialist roles speak for other consumers as they liaise with Region staff and other service providers during collaborative efforts. In addition, consumers collaborate with one another through coalitions developed by and for consumers.

A common theme among all consumer focus groups was the need for and desire to have consumers be a more active part of decision making in the behavioral health system. One consumer focus group suggested that in the future needs assessment and planning efforts that consumers and stakeholders come together to discuss issues and make decisions. Comments about collaboration were often offered as part of a discussion about stigma and ways to reduce the misperceptions about people who are mentally ill.

Table 9.4: Collaboration Theme Summary Table

Stakeholders Perspectives	Consumers Perspectives
• Strong networks are an asset to Nebraska's behavioral health system. • See collaboration between agencies as a prevention tool that allows people to obtain services before they reach a crisis situation • All Regions have teams that meet regularly to discuss issues and resolve problems. • The team meetings lead to building networks that are used informally to find appropriate services for a consumer or to resolve a problem. • Collaboration could be improved when developing policies and procedures. • "Instead of competing for dollars, let's work together with the dollars…"	• Interpreted collaboration as having the opportunity to provide input about the BH system and the programs or activities in each Region • The Regions' community advisory boards include consumers; Regions and other behavioral health service providers employed peer specialists. • Consumers in advisory or peer specialist roles speak for other consumers as they liaise with Region staff and other service providers during collaborative efforts • Consumers collaborate with one another through coalitions developed by and for consumers. • The need for and desire to have consumers be a more active part of decision making in the behavioral health system primarily as a way to address stigma and misconceptions about SMI/SUD even among those providing services to the SMI/SUD population.
Conclusions and Recommendations	
• Seek opportunities for active consumer involvement on advisory committees, special committees, etc., including new MCO's. • Bring consumers and providers together in future planning efforts so that both groups have the opportunity to generate ideas and strategies that address issues from both perspectives simultaneously. • Consumers that are well into recovery see their input from lived experience as a valuable source of information that can be used to guide decision making and, ultimately, lead to realistic sustainable solutions. • Representatives from Medicaid and new MCO's should be included in meetings to encourage more successful collaboration between these representatives and the professionals who work in the field. • Support the Office of Consumer Affairs efforts to work across DBH/Medicaid/MCO's to increase consumer involvement.	

Information Flow

Information sharing was a common concern among the larger category of collaboration with both consumer and stakeholder focus groups. Although participants expressed a need to share information, any consideration to do so must be done within the context of balancing privacy with the need to know. One focus group mentioned that having a single database in all pharmacies could help record when a prescription is given to a unique identifier. Sharing information is also important in preventing consumers from reaching a crisis level. For example, stakeholders would be able to know if a consumer was out of compliance with his or her treatment or not attending appointments which would serve as a type of 'early

warning' that consumer might need extra help in staying on track with their recovery. A lack of an integrated way to share information also impacts the communication between hospitals. A consumer taken to the hospital receives that establishment's assessment. If this consumer must be transported to another hospital, he or she has a good chance of having another similar assessment and/or lab work because information from the first hospital is not always shared.

Consumers talked about how communication flow impacts the services they receive and their recovery. The information flow also impacts post-care follow up. They recognized that consistency in information sharing may be difficult because there are multiple entry points into the system and it's difficult to track everyone who accesses services at different points. There was also a sense that follow-up care after a crisis situation may also be affected by the workforce shortage with limited resources available at the Region level.

Consumers indicated concerns about whether the therapy they receive is addressing the same symptoms or problems that the medication they're taking is intended to address and they saw this as an information sharing problem.

Both consumer and stakeholder groups did see ways to streamline the system by allowing more information sharing between agencies and service providers. Both groups saw this as an issue that could be addressed through legislation. Several consumer focus group participants mentioned using a streamlined consent process with perhaps one consent form that covered all service providers and all service providers using the same consent form. Both groups discussed using existing systems as a possible solution and cited the electronic medical record systems that hospitals use and the Nebraska Criminal Justice Information System (NCJIS) as possible options in solving the information sharing problems.

Stakeholders also reported that county attorneys in the western part of the state appear to interpret the Emergency Protective Custody (EPC) laws differently than county attorneys in the eastern part of the state. These stakeholders identified these differing interpretations as something that needs to be addressed in order to have a state-wide system that functions smoothly county-to-county within Regions and across Regions. Several stakeholders recommended holding training sessions to help distribute information and get everyone on the same page. This would be beneficial to many entities, but the EPC process and Child Protective Service system were specifically highlighted. Concerns were raised about consumer privacy and HIPAA issues in sharing information but overall both groups felt the benefit of being able to share information outweighed any potential risk.

Table 9.5: Information Theme Summary Table

Stakeholders Perspectives	Consumers Perspectives
• Having systems in place could help the stakeholders monitor the persons who go 'doctor shopping.' • Having a single database in all pharmacies could help record when a prescription is given to a unique identifier	• Communication flow impacts the services they receive as well as their recovery. • The information flow also impacts post-care follow up. • Consistency in information sharing may be difficult because there are multiple entry

- Sharing information is also important in preventing consumers from reaching a crisis level.
- A lack of an integrated way to share information impacts the communication between hospitals.

points into the system and it's difficult to track everyone who accesses services at different points.

- Follow-up care after a crisis situation may also be affected by the workforce shortage with limited resources available at the Region level.
- Concern about lack of communication between prescriber and therapist
- Providers should bear the primary responsibility for sharing information with one another about a patient because providers are the experts.

Conclusions and Recommendations

- DHHS/DBH should support ways to be more efficient and effective in sharing pertinent treatment and referral information between agencies and providers, including building upon interfaces between systems while complying with HIPAA and 42 CFR.
- Differing interpretations of the Emergency Protective Custody (EPC) laws as something that needs to be addressed in order to have a state-wide system that functions smoothly county-to-county within Regions and across Regions.

Post-care Follow Up

Stakeholders discussed post-care follow up within the context of collaboration and information sharing. They appeared to associate post-care follow up more closely with emergency psychiatric commitments and board of mental health hearings than did consumers. Their comments largely reflected the need to continue to follow someone who had been under a commitment order or had a board of mental health order. Some stakeholders mentioned that there are reports sent regarding instances of non-compliance among consumers, but at times it is not taken one step further to do something about the reporting. These stakeholders believed that being able to follow up with consumers under a board of mental health order would allow them to better help those consumers progress toward recovery and stability.

Stakeholders identified information sharing as a major factor in providing post-care follow up to ensure that a consumer is being directed toward needed services. There have been issues when persons try to follow up with a consumer's treatment. Someone will try following up with a provider, but the consumer has never been to that office. Many times consumers are given responsibility for setting up an appointment; however, they either do not call the provider or wait until it is too late after their medications are gone. This could cause consumers to take significant steps backward in their treatment.

Table 9.6: Post Care Follow Up Summary Table

Stakeholders Perspectives

- Many times consumers are given responsibility for setting up an appointment; however, they either do not call the provider or wait until it is too late after their medications are gone.

Conclusions & Recommendations

- Identify methods that comply with HIPAA and 42 CFR to improve post-follow up care, including communication with ancillary systems such as probation, parole, etc.
- Expanding the peer support program would allow everyone receiving emergency treatment for SMI/SUD to be assigned a peer navigator (perhaps under the supervision of a case manager) in order to help consumers being discharged from emergency treatment understand how to access follow up care.
- Provide education on reporting of non-compliance to all service provider organizations within the system.

Emergency Psychiatric Services

Stakeholders and consumers both discussed emergency psychiatric services within the context of collaboration perhaps because these emergency services often involve both law enforcement and healthcare facilities working together to help the person in crisis. Across the state, wait times can be long for people seeking emergency mental health treatment through hospital emergency departments. Waiting typically occurs in either the emergency departments or the police stations. In addition, the hospital emergency departments are often the only local place in rural communities to seek immediate services. Consumers pointed out that having to wait often exacerbated their situation.

Stakeholders, particularly law enforcement, noted that having to wait either led to escalation of the person's behavior or they 'calmed down' enough that they no longer met EPC criteria. This is problematic in that law enforcement cannot leave a person they are trying to EPC alone in the hospital waiting room. In effect, a law enforcement officer is taken away from other public safety duties to sit with a person who needs treatment. Law enforcement officers participating in the focus groups were clear that they did not see providing this type of service as the best use of limited law enforcement resources, especially those from rural areas that may have only one or two officers to cover a large area. Especially in rural areas, if there is no room in the local psychiatric unit consumers have to travel significant distances to receive emergency care. In many cases that transportation is provided by law enforcement and the patient being transported is handcuffed in the back of a law enforcement vehicle. This type of transport often adds to the trauma the person is experiencing. In rural areas, this situation also requires a law enforcement officer to be away from regular duty for several hours which is a hardship in counties that may have only two or three officers to cover the entire area. One focus group mentioned currently having access to a transport company, but it is difficult to contact that service during the night hours.

The issue of emergency psychiatric services for juveniles was raised by stakeholders in all sessions. Although the context of the discussion differed from group to group, several stakeholders mentioned the lack of emergency psychiatric services for juveniles. Many establishments will either not accept youth or may not always have the capability to accommodate youth due to the characteristics of patients (eg., sex offenders).

There was some discussion during the focus groups about different areas interpreting statutes differently. One recommendation that was mentioned multiple times is implementing a standardized process and

distributing this information across the state, possibly through trainings. A few stakeholders mentioned a disconnect between healthcare professionals and law enforcement, specifically involving an individual who meets the criteria for placement under EPC and the roles of each party during an EPC.

Consumers also felt that mental health emergencies were not taken as seriously as physical health emergencies when they went to the hospital emergency department for help. They attributed this lack of urgency to the fact that mental health emergencies do not necessarily present with overt physical symptoms. Overall, consumers agreed that difficulty in accessing emergency psychiatric services included the perceived attitudes of first responders and hospital personnel that exacerbated the consumer's mental health emergency.

Many consumers had encounters with law enforcement while they were experiencing a mental health or substance use disorder emergency. In general consumers reported that police officers often recognize when the person they're dealing with is experiencing a mental health crisis and respond accordingly. Such responses often include calling in a therapist from a crisis response team. At the same time, consumers discussed how traumatizing it is for a person experiencing a mental health crisis to deal with law enforcement. Having experienced this trauma in the past may lead to reluctance to call for help when it is needed.

Consumers recognized that emergency psychiatric services were complicated by a general lack of interim options. Typically, emergency situations are handled either through hospitalization or being detained by law enforcement. Consumers were clear that more options are needed because not everyone experiencing a mental health crisis should be hospitalized or detained by law enforcement for safety reasons. Some stakeholders also mentioned about a lack of services after the emergency situation. Many consumers are being sent back to their homes too soon. In addition, when consumers are able to receive outpatient treatment, the facilities may not have the resources to provide the appropriate level of care.

Several consumers also discussed their use of the 24/7 crisis line that is available. In general, they felt that the service was helpful and that the people answering the line are well trained. Respite care was seen as another part of emergency psychiatric services and there was discussion of gaps in the availability of these types of services.

Table 9.7: Emergency Psychiatric Services Summary Table

Stakeholders Perspectives	Consumers Perspectives
• Having to wait either led to escalation of the person's behavior or they 'calmed down' enough that they no longer met EPC criteria. • Especially in rural areas, if there is no room in the local psychiatric unit consumers have to travel significant distances to receive emergency care. • In rural areas, this situation also requires a law enforcement officer to be away from regular duty for several hours which is a hardship in counties that may have only two or three officers to cover the entire area. • Currently having access to a transport company, but it is difficult to contact that service during the night hours. • Lack of emergency psychiatric services for juveniles. Many establishments will either not accept youth or may not always have the capability to accommodate youth due to the characteristics of patients who are currently admitted, for example sex offenders.	• Traumatizing for a person experiencing a mental health crisis to deal with law enforcement, even when the officers involved are compassionate and helpful. • Having experienced this trauma in the past may lead to reluctance to call for help when it is needed. • Typically, emergency situations are handled either through hospitalization or being detained by law enforcement. • In many cases that transportation is provided by law enforcement and the patient being transported is handcuffed in the back of a law enforcement vehicle.
Conclusions and Recommendations	
• More advertising to let people know about the 24/7 crisis line and crisis response teams available in each region to help de-escalate consumer problems. • Peer-run drop-in centers could be an alternative for people who do not meet EPC criteria but that still need some supervision for a short period of time. • Having respite centers where a consumer could stay for a few days until they stabilized would reduce the burden on law enforcement and hospitals. • Drop-in centers and respite centers could help stabilize someone in crisis and, thus, reduce the number of people who ended up engaging in illegal activity resulting in detention. • Provide training for primary medical care on behavioral health including that mental health treatment is essential to good general health. • Provide training for mental health board members on relevant statutes and processes.	

Authorization for payment / payment for services

Stakeholders and consumers alike expressed concern that decision makers, especially those involved in authorizing payment for services, do not understand the chronic nature of serious mental illness and substance use disorder. It was clear that consumers do not necessarily see all of the components of the behavioral health system as separate entities rather, from the consumers' perspective, all of the components of the behavioral health system are interconnected and what happens in one part of the system has a ripple effect on other parts of their interactions with the system.

Stakeholders identified difficulties in getting a consumer authorized for appropriate levels of care as a major issue within the existing system. It is difficult to get authorization for services at the level a

consumer needs or for the length of time a consumer needs. Participants at all stakeholder groups indicated that they often end up providing services on a pro bono basis just to help consumers get what they need in order to remain stable in their recovery. Stakeholders also discussed how authorization issues leads to a vicious cycle where loss of services negatively impacts a consumer's recovery. This negative impact often leads to repeated hospitalizations for the consumer. Stakeholders identified that each time a consumer goes through this cycle they fall further behind and, thus, have a harder time getting back to the level of recovery or stabilization that they were at before the hospitalization. This vicious cycle was viewed by stakeholders in terms of service to the consumers and as a fiscal management issue.

Stakeholders have mentioned the difficulty of receiving authorization, as well as the inconsistency of what gets approved. They also discussed that the amount of work medical professionals have to do to get services authorized takes valuable time away from working with patients. When the authorization process is difficult, it also deters providers from serving that client. Stakeholders have mentioned that services that were once authorized may be taken away and require a re-authorization or reduced because they worked "too well." Stakeholders were aware of the utilization guidelines that present the criteria for authorization approval for DBH, however it appeared that consumers were not. This is an area where making a distinction between what is handled by DBH and what is handled by Medicaid or other DHHS divisions may be influencing perceptions about authorization for services.

Stakeholders also discussed the pending changes in payment for behavioral health services in Nebraska. Much of the discussion focused on comparing the difficulty of processing paperwork and authorization for services in the current system to what they expect the new system to be like. They expressed concerns about the amount of time spent handling paperwork now and that the new system would increase that workload. Consumers were also aware of the pending changes and had suggestions to help ease the paperwork burden on the providers.

Both consumers and stakeholders noted that fewer medical providers are accepting Medicaid in part because of the amount of paperwork required and the lower negotiated payment rates. A stakeholder focus group recognized the importance of consumers being able to choose providers who they bond with, rather than from a specific shortened list. This capability benefits the consumers' treatment.

Insurance coverage was also discussed as a factor in consumers' ability to access care. Most of the consumers attending the focus groups discussed payment for their mental health or substance use disorder treatment in terms of state funding either through Magellan, Medicaid, or Medicare. Only two of the participants reported having private insurance through an employer. Consumers report that they've lost Medicaid coverage without notification and that some have lost coverage multiple times. It's important to note that although these consumers may have indeed been notified, the notification either did not reach them or they did not understand the notification so, from their perspective, they were not notified. Several consumers also reported being required to buy supplemental insurance in order to lower their income enough to continue to be eligible for Medicaid. It appears that they may be talking about the Excess Income program, which clearly is not well understood.

Table 9.8: Authorization Summary Table

Stakeholders Perspectives	Consumers Perspectives
• Challenges in getting authorization for appropriate levels of care. • Inconsistency in how authorization criteria is applied • Often end up providing services on a pro bono basis just to help consumers get what they need in order to remain stable in their recovery. • When the authorization process is difficult, it deters providers from serving that client.	• Report that they've lost Medicaid coverage without notification (or did not understand reasons for cancelation) and that some have lost coverage multiple times. • Lack of transition services to support continuity of care when treatment plan is achieved • Excess Income program is not well understood.

Conclusions and Recommendations
• Change current authorization criteria to include a maintenance level of care so consumers can continue to receive coverage for medications and therapy they need to remain stable. • Clarify authorization criteria by educating consumers and stakeholders on utilization guidelines that present the criteria for authorization approval for DBH. • Educate consumers about the provisions for ongoing services accordingly. • Employ consumer specialists to assist with processing paperwork (perhaps under the supervision of a case manager). • Educate consumers on Excess Income program, employment impacts on Medicaid status, and other factors that may impact their access to services. • Conduct or continue cost and rate studies to assess equitable rates for service coverage

Levels of Care

Stakeholders and consumers both reported two perspectives when transitioning from one level of care to another. Some pointed out that transitioning from one level of care can be abrupt when a consumer is deemed to no longer need or to be no longer eligible for services. In the majority of focus groups participants discussed the consequences of authorization of services being denied because the consumer had been accessing services "too long" or of having "gotten too well". Others discussed the need for more intermediate levels of care between emergency services like inpatient treatment and outpatient services. Income eligibility requirements make it difficult for consumers to become self-sufficient. All of the focus groups discussed the need for more levels of care that reflect the reality of the consumers 'journey' in moving from crisis to self-sufficiency. Specifically, they identified four levels: emergency inpatient treatment, intermediate care such as group homes as a step after inpatient treatment; outpatient treatment; and then a maintenance level where the consumer could keep the services that were vital to them remaining stable such as payment for medication and therapy.

Table 9.9: Levels of Care Summary Table

Stakeholders Perspectives	Consumers Perspectives
• Transitioning from one level of care can be abrupt when a consumer is deemed to no longer need or no longer be eligible for services. • Need for more intermediate levels of care between emergency services like inpatient treatment and outpatient services.	• Income eligibility requirements for various services (e.g. Medicaid, SNAP) make it difficult for consumers to become self-sufficient. • Need four levels of care: emergency inpatient treatment, intermediate care such as group homes as a step after inpatient treatment; outpatient treatment; and then a maintenance level where the consumer could keep the services that were vital to them remaining stable such as payment for medication and therapy.
Conclusions and Recommendations	
• Implement policies across various DHHS divisions providing services to this population that make the transition from relying on assistance to self-sufficiency more smooth, for example using the four levels of care identified by consumers. • Specifically develop policies that make the reduction in services more gradual and focus on services needed to remain stable and not income as the primary criteria for assigning resources. • Educate consumers and providers about which division within DHHS provides which services so there is a better understanding of the service system and its various components. • Develop communication strategies within the treatment plan to make sure the consumer understands what constitutes discharge and provide guidance in identifying 'next steps'.	

Funding and Workforce Shortage

Consumers clearly recognized a relationship between funding for programs and the shortage of qualified professionals working in behavioral health, especially in rural areas. Turnover among service provider staff also has an impact on consumers and is seen by consumers as another component of funding issues. Many consumers are uncomfortable with change and expressed a sense of being traumatized by having to go back and repeat their story to a new therapist or case worker. High turnover means that seasoned staff leave and are replaced with inexperienced staff. That inexperience is evident to consumers and has an impact on programing from a consumer perspective. From a stakeholder perspective, organizations have to start all over and train the new staff members which adds to their operating costs. Consumers expressed strong appreciation for being able to work with staff that had similar experiences; in most cases peer specialists.

As opposed to turnover, stakeholders also see overall workforce shortage as an issue. Providers may have the ability to accept more patients, but they simply do not have the capacity to do so. A stakeholder mentioned that the existing shortage is exasperated by using the current staff to complete necessary tasks like authorization paperwork. The amount of time it takes to get providers credentialed was also raised as an issue. Many providers have to wait several months until they receive their credentials. Even though credentialing does not fall within the purview of DBH, this discussion again highlighted the interconnected nature of the various divisions with DHHS and the fact that those receiving or providing

services do not see each division as a distinct entity within the overall system. Stakeholders discussed some ideas to help attract and retain workforce.

Stakeholders described funding as a challenge, especially when it is siloed. Several persons recommended allowing funds to follow the client as well as flexible funding. Some stakeholders believe that flexible funding would allow consumers a better opportunity to receive the right level of care. Many stakeholders expressed the wish to control funds locally to allow funds to be directed to need in that specific area. They also discussed the need for fund distribution to consider several factors and not solely population. Rural areas have a greater need for transportation services (and thus possibly more transportation funding) than urban areas typically do.

Stakeholders believe that more funding is needed. They have seen other agencies (as well as their own) be very conscientious with their money, but more money would definitely benefit the system. The costs of providers and administrative personal have increased, but the funding has not. In addition, reimbursement rates do not always match the cost of the service and/or cover many required tasks.

Although there is a shortage of psychiatrists in rural areas, there are more physicians that are willing to manage psychotropic meds thus making it easier for consumers to get the medication management that they need. Consumers discussed the shortage of psychiatrists in rural areas and noted that medication management is frequently handled by nurse practitioners, especially in rural areas.

Consumers understood the practical realities of attracting and retaining mental health professionals to rural areas. Some consumers mentioned the use of TeleHealth or TeleMed as a means to address the workforce shortage however the perceptions about accessing care using remote technologies were mixed. One stakeholder mentioned that these services are not ideal in all areas, especially those with poor Internet speed. Consumers also provided ideas on how technology could be made more acceptable, for example by having a nurse in the room or by having every third or fourth visit be in person.

Table 9.10: Funding and Workforce Shortage Summary Table

Stakeholders Perspectives	Consumers Perspectives
• Organizations have to start all over and train the new staff members which adds to their operating costs. • Providers may have the ability to accept more patients, but they simply do not have the staff to do so. • Existing shortage is exasperated by using the current staff to complete necessary tasks like authorization paperwork. • The amount of time it takes to get providers credentialed was also raised as an issue.	• Uncomfortable with change and expressed a sense of being traumatized by having to go back and repeat their story to a new therapist or case worker. • High turnover means that seasoned staff leave and are replaced with inexperienced staff; that inexperience is evident to consumers and has an impact on programing from a consumer perspective. • Consumers expressed strong appreciation for being able to work with staff that had similar experiences; in most cases peer specialists
Conclusions and Recommendations	

- Provide strategies and incentives for primary care physicians to participate in medication management for SMI/SUD patients perhaps by improving information flow between behavioral health professionals and primary care physicians, especially in rural areas.
- Increase the use of technology with a focus on making the interactions more acceptable to consumers, for example by having a nurse in the room or by having every third or fourth visit with the psychiatrist or therapist be in person.

Access to Care

Medication management is a concern across the state, especially when someone is discharged from the hospital or other in-patient facility. Typically, the consumer is given medication to last a few days to two weeks, but they may have to wait four to six weeks to get an appointment with a psychiatrist that can write a prescription for their medications. When an appointment is cancelled or missed the consumer must often wait for a new appointment. Consumers report that even though the delay may be small, it is still stressful. Consumers also described accessing care as needing to fail first before care would be available rather than receiving care in order to avoid failing. Division of Behavioral Health and BHRAs determined the medication management as an area to begin measuring access and have goals around medication management appointments offered in a timely manner for those discharging from inpatient levels of care.

Recognizing that SMI/SUD affects the whole family was another point frequently raised in the consumer focus groups. These conversations often highlighted the need to offer services to the whole family not just the person with the SMI/SUD diagnosis. Stakeholders also highlighted the importance of being able to have family around while the consumer is going through treatment. They mentioned that transports, in particular, are difficult for the consumer and his or her family. The family may not always be able to travel to visit the consumer or to be a part of the treatment. The consumer is also taken away from the community that is familiar to him or her.

There were mixed reviews from stakeholders regarding the variety of services that are offered. A few stakeholders believed that there was a wide array of services while others discussed a gap in the assortment of services available to be accessed. Stakeholders mentioned several services that are missing for all age groups.

Stakeholders mentioned that there is a concern regarding consumers taking up beds in treatment facilities who may not need that level of care the facility provides, but they have no other place to go. This denies access to these services for consumers who need that level of care.

Table 9.11: Access to Care Summary Table

Stakeholders Perspectives	Consumers Perspectives
• Not enough medication is given at discharge to carry the consumer from discharge to first medication management appointment. • The importance of being able to have family around while the consumer is going through treatment.	• Access to a level of care that would help the consumer succeed in their recovery is often not immediately available. Consumers feel they must 'fail' at a lower level of care before they can access a sufficiently higher level of care. • SMI/SUD affects the whole family

- The family may not always be able to travel to visit the consumer or to be a part of the treatment.
- The consumer is also taken away from the community that is familiar to him or her.

Conclusions and Recommendations

- Provide strategies and incentives for primary care physicians to participate in medication management for SMI/SUD patients perhaps by improving information flow between psychiatrists and primary care physicians, especially in rural areas.

Transportation

Transportation is an issue across the state. The Medicaid contracted transportation service provider is reported to be unreliable with a scheduled ride not showing up, rides cancelled on very short notice, and difficulty in accessing the scheduling system either by phone or online. Consumers often have cell phone plans with limited minutes so having to be on hold for an extended time waiting to schedule a ride creates a financial hardship for them. The phone reservation service is only staffed during normal business hours. Likewise, many consumers do not have easy access to a computer so going online to schedule rides is difficult as well. In addition, having to book rides in advance, typically three days, doesn't allow for emergency needs such as needing to see a medical doctor when a consumer is ill. In rural areas there may be only one transportation provider covering a large geographic area. In rural areas there is either no or limited public transportation and the public transportation system, like busses, can be difficult for consumers to use. Consumers had several creative ideas on how to address transportation problems including expanding options for ride sharing, implementing quality control measures with existing transportation contractors, and reducing the barriers-to-entry for other transportation companies that want to compete in the marketplace.

Table 9.12: Transportation Summary Table

Stakeholders Perspectives	Consumers Perspectives
• The public transportation system, like busses, can be difficult for consumers to use.	• The Medicaid contracted transportation service provider is reported to be unreliable with a scheduled ride not showing up, rides cancelled on very short notice, and difficulty in accessing the scheduling system either by phone or online. • Having to book rides in advance, typically three days, doesn't allow for emergency needs such as needing to see a medical doctor when a consumer is ill. • In rural areas there may be only one transportation provider covering a large geographic area.
Conclusions and Recommendations	
• Implement quality control measures for the existing transportation contractor and tie those measures to payment, (e.g. no show/late show results in a penalty).	

- Expand options for ride sharing, perhaps an Uber type model with drivers specifically trained on SMI/SUD; volunteers from churches or organizations working with retired volunteers (e.g., AARP) were mentioned as an option for implementing this kind of program.
- Reduce barriers to entry for other transportation providers that want to compete in this market.

Time and Resource Management Skills

Access to care is also influenced by the consumers' skills in managing their time and resources. Consumers discussed the need to plan their time and budget carefully in order to make good choices in terms of managing their situation. They pointed out that many consumers have not learned those skills and, in fact, not having skills that support good decision making may have been a contributing factor to the consumer ending up in crisis in the first place. The lack of time management and budgeting skills also lead to a cycle where consumers may go several days without medication and begin to experience setbacks in their recovery because they are not being compliant with their medication regimen.

Table 9.13: Time Management Summary Table

Stakeholders Perspectives	Consumers Perspectives
• Many consumers have not learned time management skills; not having skills that support good decision making may have been a contributing factor to the consumer ending up in crisis in the first place. • The lack of time management and budgeting skills also lead to a cycle where consumers may go several days without medication and begin to experience set-backs in their recovery because they are not being compliant with their medication regimen.	• The need to plan their time and budget carefully in order to make good choices in terms of managing their situation.
Conclusions and Recommendations	
• Expand the peer specialist program and use peer specialists to improve time and resource management skills in two ways: 1) one-on-one coaching and, 2) develop and deliver classes on topics like budgeting and keeping a calendar with curriculum developed using adult learning best practices.	

Integrated Care

When asked about co-occurring conditions consumers indicated that mental illness and substance use usually occur together because people are using alcohol or drugs, whether prescription or illegal, to self-medicate in order to cope with what they are going through. They also felt that chronic illnesses were common. Consumers defined integrated care as treating the whole person; mentally, physically, and emotionally. Consumers that had been in recovery longer discussed the importance of healthy habits to maintaining their recovery.

A common thread throughout the consumer focus groups was the need for those working in health care and behavioral health to treat those diagnosed with severe mental illness and substance use disorder from a holistic perspective. Too often the medical professional focuses on the diagnosis and in doing so inadvertently invalidates what the consumer is experiencing. Consumers consistently discussed the importance of finding ways to educate health care and mental health professionals on the consumers' perspective as a key step in developing a more holistic way to treat severe mental illness and substance use disorder.

Providers have recognized there are more and more persons with a dual diagnosis. Many stakeholders understand that there is a challenge in receiving services when a consumer has a dual diagnosis or a single diagnosis that touches on multiple areas of the healthcare system. They recognize that integrated care is important, and that healthcare is switching to a more integrated approach. Some stakeholders described their current programs that are following this approach and appearing to be successful.

Table 9.14: Integrated Care Summary Table

Stakeholders Perspectives	Consumers Perspectives
• More and more persons with a dual diagnosis. • There is a challenge in receiving services when a consumer has a dual diagnosis or a single diagnosis that touches on multiple areas of the healthcare system. • Integrated care is important and healthcare is switching to a more integrated approach. • Some stakeholders described their current programs that are following this approach and appearing to be successful.	• Mental illness and substance use usually occur together because people are using alcohol or drugs, whether prescription or illegal, to self-medicate in order to cope with what they are going through. • Too many clients manage psychiatric illness with bad health practices such as smoking. • Felt that chronic illnesses were common. • Defined integrated care as treating the whole person; mentally, physically, and emotionally. • Consumers that had been in recovery longer discussed the importance of healthy habits to maintaining their recovery. Consumers need to know that recovery means healthy living. • The importance of finding ways to educate health care and mental health professionals on the consumers' perspective as a key step in developing a more holistic way to treat severe mental illness and substance use disorder.
Conclusions and Recommendations	
• Improving information flow between various types of providers would help address issues with co-occurring conditions. • There is a need to educate professionals that provide behavioral health services at all levels on the importance of recognizing and treating the whole person. Focus on the consumer's experience of illness and ability to function, not just diagnosis. • Consumers consistently reiterated that they are more than their SMI/SUD diagnosis. Train providers and practitioners to validate the experiences of their patients.	

- Consumers identified nutrition and exercise counseling (not just informational brochures) as a helpful resource in addressing their integrated care needs.
- Consumers suggested classes on healthy eating on a budget, yoga, and meditation but, again, developed and taught using adult learning best practices.

Support Services

Across the state consumers expressed optimism in terms of the services available. Consumers report that there are more services than there have been in the past resulting in shorter or no waitlists for programs like day rehab services or community support. They discussed that if a consumer is determined to get help, they are able to find the resources they need. Consumers were clear, however, that it often takes determination on the part of the person needing services to find the kind of help they need. The need for the consumer to exhibit this determination comes at a time when they likely do not have the emotional or mental energy to advocate for themselves. Along with the increase in services, consumers discussed efforts underway to train various stakeholders to recognize when someone dealing with serious mental illness or substance use disorder is struggling and needs to access resources. They also identified peer run drop-in centers as a way to help consumers find the services they need.

Consumers also recognized the role of advocacy and the people within the behavioral health system focused on advocating for improvement of the system within Nebraska. They specifically mentioned efforts to maintain or increase funding for behavioral health services as well as collaboration between various service organizations focused on making the system run smoothly. These efforts on consumers' behalf were seen as important strengths within the current system.

The increase in services brings with it the problem of knowing what is available or accessing information about the various resources available. Consumers also discussed the difficulty of keeping directories of available services up-to-date because of staff turnover within behavioral health service provider agencies as well as addition and deletion of programs and service providers over time.

Relying on websites to disseminate information about available services is also problematic because not all consumers have easy access to the internet. There can be considerable constraints for those consumers that rely on accessing computers at the public library or at day service facilities. Consumers recommended disseminating information in a variety of ways including through print materials that can be distributed at the places that consumers go.

Table 9.15: Support Services Summary Table

Consumers Perspectives
• Optimistic about service availability; more services and shorter wait times for programs like day rehab services or community support. • Consumer self-advocacy is needed but can be difficult because advocacy is most needed at a time when the consumer may be least likely to have the emotional or mental energy to advocate for themselves. • Efforts underway to train various stakeholders to recognize when someone dealing with serious mental illness or substance use disorder is struggling and needs to access resources.

- They also identified peer run drop-in centers as a way to help consumers find the services they need.

Conclusions and Recommendations
• Establishing a type of statewide clearinghouse that could be used as a resource to locate services and programs across the State. • Having a single hub would make it easier to keep information up-to-date. • Keep 'network of care' information updated and provide resource directories that are updated on a regular basis. • Peer run drop-in centers as a way to help consumers find the services they need. • Disseminate information in a variety of ways including through print materials that can be distributed at the places that consumers go such as drop in centers or community centers.

Housing

Consumers and stakeholders both agree that safe, affordable housing is a problem especially in rural areas. Division of Behavioral Health and BHRAs determined that supported housing is another area of focus for measuring access that they will be moving forward with.

Several consumers mentioned the assisted living facilities that were initiated when various residential regional centers across the state were closed a few years ago. Across the board these facilities were seen as sub-standard in terms of the physical facilities and of the locations that further isolate the residents. Consumers recognized that the isolation, lack of access to resources, and sub-optimal living conditions do nothing to help those dealing with severe mental illness and substance use disorder in their recovery. Consumers also discussed the lack of temporary housing; some areas of the State have no homeless shelters while in other areas the shelters are often overcrowded. Stakeholders agreed with this observation. The result is that consumers will 'couch surf' or live on the streets; and, because they have no stable housing, they have difficulty keeping appointments for therapy or medication management and become non-compliant in their treatment regimen.

Not only is there a shortage of housing but the process for accessing subsidized or support housing can be difficult to navigate. The participants in these consumer focus groups did not seem to feel that the process for accessing housing aligned with their needs. They also pointed out that having housing vouchers in and of themselves didn't really address the problem if there is no housing capacity for those with SMI/SUD within a community.

Table 9.16: Housing Summary Table

Stakeholders Perspectives	Consumers Perspectives
• Not only is there a shortage of housing but the process for accessing subsidized or support housing can be difficult to navigate. • Assisted living facilities were seen as sub-standard in terms of the physical facilities and in terms of the locations that further isolate the residents.	• Affordable housing is a problem especially in rural areas. • Lack of temporary housing; some areas of the state have no homeless shelters while in other areas the shelters are often overcrowded. • Having housing vouchers in and of themselves didn't really address the

problem if there is no housing capacity for those with SMI/SUD within a community.

Conclusions and Recommendations
• Across the state, focus group participants expressed a desire to see better alternatives than the existing assisted living facilities currently in use. • Recommendations included quality control measures to make sure that housing is not substandard and requiring that these facilities be located in towns that are big enough to provide amenities such as access to libraries, day programs, easier access to therapy and support groups, and better transportation options. • Other suggestions to improve the housing situation for people with SMI/SUD included educating landlords in order to reduce the stigma and myths that may make landlords reluctant to rent to consumers. • The idea of providing incentives perhaps in the form of property tax rebates be implemented to encourage development of more housing for people with SMI/SUD.

Other Services

Availability of day programs was an important benefit for many consumers because it gives them something to do and reduces the social isolation that can lead to a 'relapse'. The stability within day programs was mentioned specifically with several consumers sharing that they had been attending their current day program for a long time. Stakeholders also mentioned that supported employment programs are beneficial for consumers as well as a service that organizes persons to periodically check-in on the consumers who live more independently. Division of Behavioral Health and BHRAs have identified supported employment as a focus area where they will measure access.

Additional supports that would be beneficial but are not available across the state include group therapy for PTSD or sexual abuse. Stakeholders also believed that legal aid for consumers is an important service to have and is underfunded. In discussing services for families, consumers noted that people with children need help with daycare while they are at therapy or medication management appointments. These kind of support services were also presented by consumers within the context of treating the whole person.

Table 9.17: Other Services Summary Table

Stakeholders Perspectives	Consumers Perspectives
• Supported employment programs are beneficial for consumers as well as a service that organizes persons to periodically check-in on the consumers who live more independently. • Additional supports that would be beneficial but are not available across the state include group therapy for PTSD or sexual abuse. • Legal aid for consumers is an important service to have and is underfunded.	• Availability of day programs was an important benefit for many consumers because it gives them something to do and reduces the social isolation that can lead to a 'relapse'. • In discussing services for families, consumers noted that people with children need help with daycare while they are at therapy or medication management appointments. These kind of support services were also presented by consumers within the context of treating the whole person.

Conclusions and Recommendations
• Although participants had ideas about the kinds of additional services that would be beneficial, they recognized the need for funding in order to implement their ideas. • Therefore, the most frequent recommendation for providing services was to increase funding or find funding support for these types of services.

Consumer Specialists

Community support workers and peer support / consumer specialists are highly regarded and having these workers available is seen as particularly valuable. Peer specialists are seen as a vital link to access other services and navigate the system. These services are seen as important for both adults and youth and their families. Consumer focus group participants noted that there were different job titles associated with different roles that consumer specialists or peers have within the existing system but there is confusion about the roles. For example, the distinction between consumer specialist providing peer support and a consumer providing peer support skills to enhance services was unclear. Consumers recommended that consistency be established between regions in terms of the function or role of a peer specialist and their job description.

The majority of the consumers attending focus groups held in other than day program settings either were currently working as consumer specialists or were in training to become consumer specialists These participants stressed their capacity to take on more responsibilities. They also emphasized their unique abilities to connect with consumers because of their shared experiences. All of these participants identified the role of consumer specialists or peer specialists as a vital component in the behavioral health system and recognized the value added to the system because of these workers. These participants also all discussed how expanding the role of peers could address some funding issues, for example by having a lower-paid peer specialist take on duties, such as filing paperwork, that would free a higher paid professional such as a nurse to perform more clinical duties. Overall they seemed to feel that consumer specialists or peer specialists needed to be seen as an integral part of the behavioral health services team.

Table 9.18: Consumer Specialist Summary Table

Consumers Perspectives
• Community support workers and peer support / consumer specialists are highly regarded and the consumer specialist program is seen as particularly valuable. • Peer specialists are seen as a vital link to access other services and navigate the system. These services are seen as important for both adults and youth and their families. • Day program settings either were currently working as consumer specialists or were in training to become consumer specialists • The role of consumer specialists or peer specialists as a vital component in the behavioral health system and recognized the value added to the system because of these workers. • Consumer specialists or peer specialists needed to be seen as an integral part of the behavioral health services team.
Conclusions and Recommendations
• Identify areas in which peer specialists can supplement or support existing services • Use peers in a variety of settings in order to provide a number of service supports

Assumptions about Mental Illness/Substance Use

When participants in the focus groups discussed stigma, they tended to blend SMI and SUD together in that the stigma is that people suffering from SMI or SUD are 'less than' people who do not suffer from these conditions. Multiple participants in the consumer and stakeholder focus groups discussed the concept of burning one's bridges as a barrier to accessing care. From the consumers' perspective this barrier appears to be tied to a paternalistic attitude that if a consumer does not behave in what is deemed an acceptable manner, then the consumer is punished by being denied services. There is also a sense of shame over acting-out behavior that they've engaged in during a time of frustration. These perceptions highlight the fact that those suffering from mental illness or substance use disorder and who are not stabilized may lack the skills to verbalize their frustration or express their needs in appropriate ways.

Consumers expressed concern that when workers within the behavioral health system make a mistake, whether that be when someone who is processing paperwork mistakenly checks the wrong box or a transportation worker simply doesn't show up with a ride, to the person making the mistake the error may seem like a small thing but the consequences to the consumer can be significant. Consumers discussed how instability within the system impacts recovery, for example of having and then losing services, housing insecurity, and turn-over in staff among service providers. In every focus group, consumers talked about the importance of being seen as a whole person and not limited to their mental illness. They equated being seen as a whole person with better understanding on the part of behavioral health service providers and that better understanding would translate into better care.

Consumers also talked about how the stigma associated with mental illness and substance use disorder makes it more difficult to ask for help when it's needed. The stakeholder focus groups had similar comments as well. Consumers repeatedly mentioned that recovery and maintaining recovery requires constant effort and it is important to ask for help when needed.

A theme expressed through all of the topics discussed with consumers was how the stigma of mental illness creates misperceptions and impacts the interactions between the consumers and those providing services. Consumers consistently introduced the importance of trauma informed care and how people providing services have inadvertently made things worse for the consumer by stereotyping or buying into myths about mental illness. Stakeholders also touched on the topic. They highlighted that behavioral health is more of a subjective diagnosis as opposed to an objective diagnosis like cancer or heart disease. One stakeholder focus group discussed the belief that some people focus too much on the diagnosis and not enough on the symptoms. Several stakeholders believed the stigma that occurs is a training and education issue. Stigma and perceptions about mental health issues also differs across cultures.

In discussing the impact of stigma, consumers identified how the label 'mental illness' resulted in devaluing their abilities even though they may have been successful in life before they experienced a mental health crisis or became addicted to drugs. Consumers were particularly adamant that being diagnosed with a mental illness should not automatically limit them to a life of poverty and reliance on government assistance. They appeared to feel however that the behavioral health system is set up to keep

them dependent, that they are set up to fail because once they reach a point where they need only a little help to maintain their recovery then they lose all services and are thrown back into crisis again. Consistently throughout the consumer focus groups participants emphasized that they are more than their diagnosis and that once they are stable and in recovery they are capable of being productive citizens.

Table 9.19: Assumptions Summary Table

Consumers Perspectives
• The importance of being seen as a whole person and not limited to their mental illness. • The importance of trauma informed care • Being diagnosed with a mental illness should not automatically limit them to a life of poverty and reliance on government assistance.
Conclusions and Recommendations
• There is a need for sustained education and awareness about SMI/SUD and ways in which people suffering from these conditions can become active, engaged members of society • Consumers and stakeholders alike indicated that there is a need for sustained education and awareness building about SMI/SUD; perhaps modeled after the sustained efforts related to tobacco cessation.

Survey Methods

Three surveys were developed targeting three types of respondents: 1) consumers and their family members; 2) stakeholders including those who provide services directly to consumers and those whose work involves interacting with people with serious mental illness and/or substance use disorder; and 3) the general public. In order to streamline survey distribution to meet the time constraints presented by this project, one survey containing all questions was constructed and screening questions were used to direct respondents to the appropriate set of questions. Questions for surveys were developed first by reviewing The DHHS Behavioral Health Division's Role in Reducing Service Gaps,[122] TriWest Health and Human Service Evaluation and Consulting,[23] the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Experience of Care and Health Outcomes (ECHO) Survey from the Agency for Healthcare Research and Quality (AHRQ),[24] and the Mental Health Statistics Improvement Program Consumer Survey (MHSIP) from the Substance Abuse and Mental Health Services Administration (SAMHSA).[25] These questions were refined and additional questions added based on preliminary results of the consumer and stakeholder focus groups conducted as part of the community engagement portion of this statewide needs assessment.

The timeline for the project necessitated using a convenience sampling strategy which limits the generalizability of the results. The survey was distributed electronically via a link sent to relevant organizations and agencies to share with their constituents as well as to listservs and email lists within the domain of the Nebraska DHHS DBH. In addition, the researchers were notified that some organizations receiving the survey shared the link via their social media accounts. The survey was open from June 1, 2016 to June 17, 2016. This method of distribution precluded the ability to send reminder emails to prompt potential respondents to complete the survey.

Consumer Survey Results

Important Considerations

It is important to remember that the needs assessment consumer survey discussed in this section is different from the Division of Behavioral Health (DBH) Consumer Survey which was sent to consumers who received services through the Division's community-based programs. The needs assessment consumer survey was advertised and promoted broadly throughout the state to capture input among persons with mental or substance use disorders living in Nebraska. Therefore, the results of the needs assessment consumer survey should not be directly compared with the results of the Division's Consumer Survey. The Division's survey focused on consumers in community-based behavioral health programs funded by the Division while the needs assessment consumer survey was most likely to capture perceptions and opinions of a wider audience.

It is also important to note that the needs assessment survey questions included respondents' perceptions about issues that are beyond the purview of the DBH. Those receiving services for SMI/SUD and some stakeholders see services from the DHHS as a system and do not distinguish between the various divisions within DHHS that offer those services.

The needs assessment survey gathered information on perceptions so there may be gaps between what the data included in other parts of this report shows. In addition, because the focus was on gathering perceptions the survey did not define terms such as 'available', 'affordable', or 'timely'. The convenience sampling strategy used to accommodate the project timeline is a limitation of the needs assessment survey.

Respondent Characteristics

A total of 299 respondents completed the consumer and family survey (**Table 9.20**). The majority (68.9%) of respondents were from urban counties. Slightly more than half of all respondents (59.2%) identified as female. Distribution by age was fairly even with most respondents reported their age between 20 and 59. The majority of consumers (95.0%) were white, non-Hispanic. When compared to the US Census Bureau population estimates for 2015, this response rate demonstrates an underrepresentation of Black/African American, Asian, and Hispanic Nebraskans (making up 5.0%, 2.3%, and 10.4% of the state respectively). As racial minorities are known to face significant disparities in mental health services, care should be taken in assuming that these results can be generalized to all of Nebraska's diverse communities.

Approximately half of all respondents (51.0%) reported being covered by private insurance, either through their employer or through the Nebraska insurance exchange. Public insurance (Medicaid or Medicare) coverage was identified by 23.2% of respondents. A higher proportion of rural respondents reported to have public insurance (25.0% vs. 22.3%) and have no insurance or self-pay (22.8% vs. 11.2%) compared to urban respondents.

The majority (51%) of respondents reported living with family and the second largest group (34.8%) reported living independently. A higher proportion of urban respondents reported living independently

than rural respondents (37.9% vs. 28.0%) while a higher proportion of rural respondents reported living with their family than urban respondents (55.9% vs. 44.8%).

Almost half of the respondents were employed full-time (more than 30 hours a week; 47.8%) while many of consumers (38.5%) were not employed at all.

Table 9.20: Characteristics of Consumer/Family Survey Participants by Rurality

	Urban	Rural	Total
Total Respondents	**206 (68.9%)**	**93 (31.1%)**	**299 (100%)**
Gender			
Male	79 (38.3%)	43 (46.2%)	122 (40.8%)
Female	127 (61.7%)	50 (53.8%)	177 (59.2%)
Age (years)			
≤ 19	15 (7.3%)	8 (8.6%)	23 (7.7%)
20-9	45 (21.8%)	15 (16.1%)	60 (20.1%)
30-39	41 (19.9%)	19 (20.4%)	60 (20.1%)
40-49	45 (21.8%)	17 (18.3%)	62 (20.7%)
50-59	31 (15.0%)	19 (20.4%)	50 (16.7%)
60-69	26 (12.6%)	11 (11.8%)	37 (12.4%)
≥70	3 (1.5%)	4 (4.3%)	7 (2.3%)
Race			
White	193 (93.7%)	91 (97.8%)	284 (95.0%)
Black / African-American	12 (5.8%)	0 (0%)	12 (4.0%)
American Indian / Alaskan Native	5 (2.4%)	2 (2.2%)	7 (2.3%)
Other*	4 (1.9%)	0 (0%)	4 (1.3%)
Ethnicity			
Hispanic	9 (4.4%)	1 (1.1%)	10 (3.4%)
Non-Hispanic	197 (95.6%)	91 (98.9%)	288 (96.6%)
Primary Language			
English	204 (99.0%)	93 (100%)	297 (99.3%)
Other	2 (1.0%)	0 (0%)	2 (0.7%)
Primary Payer for Behavioral Health Services			
Public Insurance (Medicaid or Medicare)	46 (22.3%)	23 (25.0%)	69 (23.2%)
Private Insurance	114 (55.3%)	38 (41.3%)	152 (51.0%)
No Insurance / Self-Pay	23 (11.2%)	21 (22.8%)	44 (14.8%)
Don't Know / Other †	23 (11.2%)	10 (10.9%)	33 (11.1%)
Living Arrangements			
I live independently by myself.	77 (37.9%)	26 (28.0%)	103 (34.8%)
I live by myself but have a community support worker.	7 (3.4%)	3 (3.2%)	10 (3.4%)
I live with my family.	99 (48.8%)	52 (55.9%)	151 (51.0%)
I live in a group home or assisted living facility.	4 (2.0%)	5 (5.4%)	9 (3.0%)
Other †	16 (7.9%)	7 (7.5%)	23 (7.8%)
Current Employment Status			
Full-time (more than 30 hours a week)	101 (49.0%)	42 (45.2%)	143 (47.8%)
Part-time (less than 30 hours a week)	26 (12.6%)	15 (16.1%)	41 (13.7%)
Not currently employed	79 (38.3%)	36 (38.7%)	115 (38.5%)

* Other races included one Asian American and persons who identified as a combination of the listed racial options.
† Two respondents reported using probation vouchers to pay for services. No other specific payers or living arrangements were disclosed on the survey.

Consumer Perceptions of Access to and Availability of Behavioral Health Treatment

Table 9.22 shows the distribution of consumer perceptions of access and availability to treatment services. A slight majority (53.5%) of urban respondents believe there are a variety of behavioral health treatment providers in their area, but rural respondents do not share that belief. However, a majority of both urban (71.4%) and rural (61.5%) respondents indicated they know how to access the behavioral health system for help with serious mental illness. Both urban (71.6%) and rural (77.2%) respondents also indicated they know where to go to get professional help in a behavioral health emergency. Urban respondents were more likely to believe they can get mental health care from their local hospital compared to rural respondents, but both groups appear to see their local hospital as a source of mental health care (64.3% and 54.5% respectively). Neither group saw their local hospital as a place to receive substance abuse care.

A majority of the respondents indicated that they did not receive inpatient treatment in the past year, which means these respondents were likely further along in their recovery and, thus more stable. Of the respondents who did receive inpatient treatment in the past year, those in both urban and rural areas indicated they experienced problems receiving community-based services such as day programs, in-home visits, or outpatient therapy (40% and 46.2% respectively). A majority of both urban and rural respondents indicated that they needed immediate counseling in the past year (66.1% and 64.3% respectively) but experienced difficulty in receiving that counseling when they needed it primarily because there were no appointments available.

Table 9.21: Consumer Perceptions of Access to Treatment Services for Behavioral Health Treatment Services by Rurality

	Urban	Rural	Total
There are a variety of behavioral health treatment providers available in my area.			
Yes	107 (53.5%)	27 (29.3%)	134 (45.9%)
No / Not Sure	93 (46.5%)	65 (70.7%)	158 (54.1%)
I know how to access behavioral health system for help with serious mental illness.			
Yes	142 (71.4%)	56 (61.5%)	198 (68.3%)
No / Not Sure	57 (28.6%)	35 (38.5%)	92 (31.7%)
In case of behavioral health emergency, I know where to go to get professional help.			
Yes	144 (71.6%)	71 (77.2%)	215 (73.4%)
No / Not Sure	57 (28.4%)	21 (22.8%)	78 (26.6%)
I can go to my local hospital to get mental health care.			
Yes	126 (64.3%)	49 (54.4%)	175 (61.2%)
No / Not Sure	70 (35.7%)	41 (45.6%)	111 (38.8%)
I can go to my local hospital to get substance abuse care.			
Yes	52 (33.8%)	21 (26.6%)	73 (31.3%)
No / Not Sure	102 (66.2%)	58 (73.4%)	160 (68.7%)
In the past year, were you discharged from inpatient treatment unit?			
Yes	41 (24.0%)	13 (16.9%)	54 (21.8%)
No / Not Sure	130 (76.0%)	64 (83.1%)	194 (78.2%)
In the past year if you were discharged from an inpatient treatment unit, were you able to get intensive community based services needed to continue in your recovery (day program or in-home visits, outpatient therapy/counseling)?			
Yes	16 (40.0%)	6 (46.2%)	22 (41.5%)
No / Not Sure	24 (60.0%)	7 (53.8%)	31 (58.5%)

In the past year, did you need counseling right away?			
Yes	117 (66.1%)	54 (64.3%)	171 (65.5%)
No / Not Sure	60 (33.9%)	30 (35.7%)	90 (34.5%)
In the past year if you needed counseling right away, were you able to see the therapist right away when you needed?			
Yes	52 (45.2%)	22 (40.7%)	74 (43.8%)
No / Not Sure	63 (54.8%)	32 (59.3%)	95 (56.2%)
In the past year, if you needed counseling right away but were not able to see a therapist right away, why not? (Select all that apply)			
No appointments were available.	42 (66.7%)	22 (68.8%)	64 (67.4%)
Insufficient money to pay for appointment	17 (27.0%)	14 (43.8%)	31 (32.6%)
Inadequate transportation or excessive distance	7 (11.1%)	16 (50.0%)	23 (24.2%)
Lack of adequate insurance coverage	6 (9.5%)	4 (12.5%)	10 (10.5%)
Other*	12 (19.0%)	3 (9.4%)	15 (15.8%)
* Other reported reasons included difficulty locating appropriate services, stigma, non-adherence, infrequent availability of providers, or that they felt services were not needed.			

Respondents' reports of their ability to get appointments when needed for behavioral health treatment categorized by rurality is provided in **Table 9.22**. Overall, the response was similar between urban and rural respondents. It appears that for both urban and rural respondents appointments with therapists are more readily available than those with psychiatrists. Approximately 73% of all respondents report they are able to get an appointment with a therapist 'always' or 'most of the time' compared to only 60% for appointments with a psychiatrist and 60% for inpatient treatment. Overall, this indicates that respondents are generally able to get the appointments they need for behavioral health treatment.

Table 9.22: Consumer Reports of Their Ability to Get Appointments for Behavioral Health Treatment When Needed by Rurality

	Urban	Rural	Total
Therapist:			
Always	33 (19.8%)	9 (12.9%)	42 (17.7%)
Most of the time	96 (57.5%)	37 (52.9%)	133 (56.1%)
Rarely	30 (18.0%)	20 (28.6%)	50 (21.1%)
Never	8 (4.8%)	4 (5.7%)	12 (5.1%)
Psychiatrist			
Always	19 (12.4%)	9 (15.8%)	28 (13.3%)
Most of the time	73 (47.7%)	25 (43.9%)	98 (46.7%)
Rarely	40 (26.1%)	15 (26.3%)	55 (26.2%)
Never	21 (13.7%)	8 (14.0%)	29 (13.8%)
Inpatient			
Always	19 (27.1%)	7 (20.0%)	26 (24.8%)
Most of the time	25 (35.7%)	12 (34.3%)	37 (35.2%)
Rarely	16 (22.9%)	10 (28.6%)	26 (24.8%)
Never	10 (14.3%)	6 (17.1%)	16 (15.2%)

Consumer reports of wait times and travel distances are provided in **Table 9.23.** It appears that rural respondents experienced shorter wait times for counseling or therapy appointments (appointment within 2 weeks: 68.8% for rural versus 58.5% for urban) but traveled further to receive those services (traveling less than 30 miles: 57.1% for rural versus 91.4% for urban). Nonetheless, the majority (91.6%) of rural respondents were able to access counseling or therapy appointments within 60 miles. Wait times for appointments for medication management were also shorter for rural respondents (appointment within 2 weeks 51.5% for rural versus 49.1% for urban). Although rural respondents had to travel further to receive those services, the majority (89.4%) were able to access medication management services within 60 miles. Treatment for substance abuse disorder was less accessible with both a majority of both urban (62.7%) and rural (59.4%) reporting wait times of more than 3 weeks for appointments. Distances traveled for appointments for both urban and rural respondents for substance use disorder treatment was similar to distances travelled for counseling and medication management.

Table 9.23: Consumer Reports of Wait Time for and Distance to Services by Rurality

	Urban	Rural	Total
Counseling / Therapy			
Wait time for appointment			
Less than 1 week	40 (21.9%)	20 (25.0%)	60 (22.8%)
1-2 weeks	67 (36.6%)	35 (43.8%)	102 (38.8%)
3-4 weeks	58 (31.7%)	16 (20.0%)	74 (28.1%)
5 weeks or longer	18 (9.8%)	9 (11.3%)	27 (10.3%)
Distance traveled for appointment			
Less than 30 miles	171 (91.4%)	48 (57.1%)	219 (80.8%)
30-60 miles	15 (8.0%)	29 (34.5%)	44 (16.2%)
61-120 miles	1 (0.5%)	5 (6.0%)	6 (2.2%)
121 miles +	0 (0.0%)	2 (2.4%)	2 (0.7%)
Medication Management			
Wait time for appointment			
Less than 1 week	33 (18.6%)	16 (24.2%)	49 (20.2%)
1-2 weeks	54 (30.5%)	22 (33.3%)	76 (31.3%)
3-4 weeks	49 (27.7%)	19 (28.8%)	68 (28.0%)
5 weeks or longer	41 (23.2%)	9 (13.6%)	50 (20.6%)
Distance traveled for appointment			
Less than 30 miles	159 (90.3%)	41 (54.7%)	200 (79.7%)
30-60 miles	13 (7.4%)	26 (34.7%)	39 (15.5%)
61-120 miles	4 (2.3%)	6 (8.0%)	10 (4.0%)
121 miles +	0 (0.0%)	2 (2.7%)	2 (0.8%)
Substance Use Disorder Treatment			
Wait time for appointment			
Less than 1 week	8 (13.6%)	3 (9.4%)	11 (12.1%)
1-2 weeks	14 (23.7%)	12 (37.5%)	26 (28.6%)
3-4 weeks	15 (25.4%)	15 (46.9%)	30 (33.0%)
5 weeks or longer	22 (37.3%)	2 (6.3%)	24 (26.4%)
Distance traveled for appointment			
Less than 30 miles	65 (90.3%)	24 (58.5%)	89 (78.8%)
30-60 miles	3 (4.2%)	13 (31.7%)	16 (14.2%)
61-120 miles	3 (4.2%)	3 (7.3%)	6 (5.3%)
121 miles +	1 (1.4%)	1 (2.4%)	2 (1.8%)

Table 9.24 summarizes the financial barriers reported by respondents. The majority (74.3%) of all respondents felt treatment for serious mental illness (SMI) was not affordable. A majority (61.5%) of respondents indicated that co-pays for medication for SMI were not affordable. Many (65.6%) respondents indicated that they pay a co-pay for treatment for SMI or SUD and 63.9% had experienced a time when they were unable to afford that co-pay.

Table 9.24: Consumer Reports of Financial Barriers to Serious Mental Illness or Substance Use Disorder Treatment by Rurality

	Urban	Rural	Total
Treatment for serious mental illness is affordable?			
Yes	51 (27.0%)	20 (23.0%)	71 (25.7%)
No / Not Sure	138 (73.0%)	67 (77.0%)	205 (74.3%)
Co-pays for medication to treat serious mental illness are affordable?			
Yes	64 (35.8%)	37 (44.6%)	101 (38.5%)
No / Not Sure	115 (64.2%)	46 (55.4%)	161 (61.5%)
Pay a co-pay for treatment for serious mental Illness or substance use disorder treatment?			
Yes	123 (68.3%)	47 (59.5%)	170 (65.6%)
No / Not Sure	57 (31.7%)	32 (40.5%)	89 (34.4%)
Ever unable to pay co-pay for serious mental illness or substance use disorder treatment?			
Yes	73 (60.3%)	33 (71.7%)	106 (63.9%)
No / Not Sure	48 (39.7%)	13 (28.3%)	60 (36.1%)

Consumer Perceptions of Access to and Availability of Support Services

Consumer perceptions of access to and availability of support services are broken down by rurality in **Table 9.25.** Perceptions about the availability of support services were mixed, however it appears that when respondents were aware of options such as self-help groups or Wellness Recovery Action Plans they benefit from these resources. A majority of urban (84%) and rural (68.2%) respondents indicated they were aware of peer-to-peer recovery support services. Housing support was seen as available by over half (52.4%) of urban respondents but only 46.6% of rural respondents. Among those who were told about availability of self-help groups (57.3% of urban respondents and 42.0% of rural respondents) 56.7% of urban respondents and 61.8% of rural respondents attended self-help meetings. The most common (70.9%) reason given for not attending self-help groups was that the meetings were not helpful. Respondents were less knowledgeable Wellness Recovery Action Plans (WRAP) with 67.9% of urban and 65.9% of rural respondents indicating they had not been told about this recovery tool. Of those that did know about WRAP (32.1% urban and 34.1% rural) 52.5% of urban respondents and 61.5% of rural respondents indicated that they had developed and used a WRAP. Among all respondents 83.3% indicated that they wanted to work in the last two years and 26.6% of those respondents reported receiving assistance in finding work. Among all respondents 46.8% indicated that they wanted to attend school in the last two years and 35.1% of those respondents reported receiving assistance in attending school.

Table 9.25: Consumer Perceptions of Access to and Availability of Support Services by Rurality

	Urban	Rural	Total
Availability of peer-to-peer recovery support?			
Yes	163 (84.0%)	60 (68.2%)	223 (79.1%)
No / Not Sure	31 (16.0%)	28 (31.8%)	59 (20.9%)
Availability of housing support?			
Yes	97 (52.4%)	41 (46.6%)	138 (50.5%)
No / Not Sure	88 (47.6%)	47 (53.4%)	135 (49.5%)
Told about self-help group in the past 12 months?			
Yes	102 (57.3%)	34 (42.0%)	136 (52.5%)
No / Not Sure	76 (42.7%)	47 (58.0%)	123 (47.5%)
Attended self-help group (if told)?			
Yes	55 (56.7%)	21 (61.8%)	76 (58.0%)
No / Not Sure	42 (43.3%)	13 (38.2%)	55 (42.0%)
Reasons why self-help groups were not attended (if told):			
Meeting did not work or was not helpful.	29 (69.0%)	10 (76.9%)	39 (70.9%)
Didn't want to share with other consumers.	18 (42.9%)	3 (23.1%)	21 (38.2%)
Insufficient Transportation or excessive distance.	10 (23.8%)	3 (23.1%)	13 (23.6%)
Other	11 (26.2%)	4 (30.8%)	15 (27.3%)
Told about Wellness Recovery Action Plan (WRAP)?			
Yes	62 (32.1%)	30 (34.1%)	92 (32.7%)
No / Not Sure	131 (67.9%)	58 (65.9%)	189 (67.3%)
Developed and used WRAP (if told)?			
Yes	32 (52.5%)	16 (61.5%)	48 (55.2%)
No / Not Sure	29 (47.5%)	10 (38.5%)	39 (44.8%)
Wanted to work in the past two years?			
Yes	137 (87.3%)	53 (74.6%)	190 (83.3%)
No / Not Sure	20 (12.7%)	18 (25.4%)	38 (16.7%)
Received help finding employment in the past two years?			
Yes	26 (23.2%)	16 (34.8%)	42 (26.6%)
No / Not Sure	86 (76.8%)	30 (65.2%)	116 (73.4%)
Wanted to attend school in the past two years?			
Yes	73 (51.4%)	29 (38.2%)	102 (46.8%)
No / Not Sure	69 (48.6%)	47 (61.8%)	116 (53.2%)
Received help with attending school in the past two years?			
Yes	23 (33.3%)	11 (39.3%)	34 (35.1%)
No / Not Sure	46 (66.7%)	17 (60.7%)	63 (64.9%)

Respondents' reports of their ability to access support services are shown in **Table 9.26.** Overall access to these services is inconsistent. Both urban and rural respondents indicate day services placements are readily available (57.5%). It should be noted that day services are provided by organizations other than DBH, such as the Salvation Army, and thus these services may be more readily available. However only a small majority of both groups indicated 'always' or 'most of the time' receiving case management services (53.2%) and community support services (52%).

Table 9.26: Consumer Reports of Their Ability to Get Support Services When Needed by Rurality

	Urban	Rural	Total
Day Services Placement			
Always	9 (20.5%)	8 (27.6%)	17 (23.3%)
Most of the time	15 (34.1%)	10 (34.5%)	25 (34.2%)
Rarely	9 (20.5%)	6 (20.7%)	15 (20.5%)
Never	11 (25.0%)	5 (17.2%)	16 (21.9%)
Case Management			
Always	15 (22.7%)	9 (20.9%)	24 (22.0%)
Most of the time	20 (30.3%)	14 (32.6%)	34 (31.2%)
Rarely	12 (18.2%)	8 (18.6%)	20 (18.3%)
Never	19 (28.8%)	12 (27.9%)	31 (28.4%)
Community Support Services			
Always	15 (19.2%)	10 (22.2%)	25 (20.3%)
Most of the time	25 (32.1%)	14 (31.1%)	39 (31.7%)
Rarely	23 (29.5%)	8 (17.8%)	31 (25.2%)
Never	15 (19.2%)	13 (28.9%)	28 (22.8%)

Physical Health among Consumers of Behavioral Health Services

Data on consumer reports of general medical care availability and health behaviors are presented in **Table 9.27.** A majority (76%) of respondents indicated that physical health is very important or somewhat important to their recovery. A majority (68.9%) indicated they eat the recommended 5 servings of fruits and vegetables a day, however only 23.8% of respondents indicated they get the recommended 150 minutes of moderate exercise per week. Over half (51%) of respondents indicated they get less than 60 minutes of moderate exercise per week. It appears that respondents are more likely to equate physical health with healthy eating rather than appropriate levels of exercise. A majority (68.2%) of respondents indicated that they do not use tobacco. Among those that do use tobacco however, 56.3% indicated that their health care provider had talked to them about quitting which indicates that consumers are likely aware of the dangers of tobacco use. When asked about accessing medical care other than treatment for SMI or SUD, 89.6% of all respondents indicated they are able to get an appointment with a medical doctor when needed. A majority (82.8%) indicated they are able to get an appointment within two weeks. Not unexpectedly, a majority (95.9%) of urban respondents indicate they travel less than 30 miles to see a medical doctor however a majority (94.1%) of rural respondents indicate they travel less than 60 miles.

Table 9.27: Consumer Reports of Health Behaviors and General Medical Health Care Availability by Rurality

	Urban	Rural	Total
How important is physical health to your treatment for SMI or SUD?			
Very important	101 (49.3%)	49 (52.7%)	150 (50.3%)
Somewhat important	56 (27.3%)	21 (22.6%)	77 (25.8%)
Not sure	39 (19.0%)	19 (20.4%)	58 (19.5%)
Somewhat unimportant	4 (2.0%)	2 (2.2%)	6 (2.0%)
Not at all important	5 (2.4%)	2 (2.2%)	7 (2.3%)
Frequency of adequate daily consumption of fruits or vegetables (5 servings)?			
Never	73 (35.4%)	21 (22.6%)	94 (31.4%)
1-2 days a week	72 (35.0%)	40 (43.0%)	112 (37.5%)
3-4 days a week	38 (18.4%)	18 (19.4%)	56 (18.7%)
5 or more days a week	23 (11.2%)	14 (15.1%)	37 (12.4%)
Amount of moderate exercise per week?			
<0.5 hours per week	74 (36.1%)	34 (36.6%)	108 (36.2%)
0.5 - 1 hour per week	29 (14.1%)	15 (16.1%)	44 (14.8%)
1 - 1.5 hours per week	30 (14.6%)	13 (14.0%)	43 (14.4%)
1.5 -2 hours per week	21 (10.2%)	11 (11.8%)	32 (10.7%)
2+ hours per week	51 (24.9%)	20 (21.5%)	71 (23.8%)
Tobacco use?			
Yes	58 (30.4%)	31 (34.8%)	89 (31.8%)
No / Not Sure	133 (69.6%)	58 (65.2%)	191 (68.2%)
If yes, has provider discussed tobacco cessation?			
Yes	33 (58.9%)	16 (51.6%)	49 (56.3%)
No / Not Sure	23 (41.1%)	15 (48.4%)	38 (43.7%)
Able to get an appointment with a medical doctor when necessary?			
Always	65 (34.8%)	32 (39.5%)	97 (36.2%)
Most of the time	104 (55.6%)	39 (48.1%)	143 (53.4%)
Rarely	15 (8.0%)	9 (11.1%)	24 (9.0%)
Never	3 (1.6%)	1 (1.2%)	4 (1.5%)
Wait time for medical care?			
Less than 1 week	85 (44.7%)	46 (54.8%)	131 (47.8%)
1-2 weeks	71 (37.4%)	25 (29.8%)	96 (35.0%)
3-4 weeks	22 (11.6%)	11 (13.1%)	33 (12.0%)
5 weeks or longer	12 (6.3%)	2 (2.4%)	14 (5.1%)
Distance traveled for medical care?			
Less than 30 miles	189 (95.9%)	69 (81.2%)	258 (91.5%)
30-60 miles	6 (3.0%)	11 (12.9%)	17 (6.0%)
61-120 miles	1 (0.5%)	3 (3.5%)	4 (1.4%)
121 miles or further	1 (0.5%)	2 (2.4%)	3 (1.1%)

Time since last appointment for general health, dentistry, and eye care is presented in **Table 9.28.** Consumers were asked about the time since last visit to physical health providers as a measure of assessing their access to routine physical health care. A majority of respondents had seen a medical doctor (89.0%), dentist (68.6%), and eye doctor (57.2%) within the last year.

Table 9.28: Consumer Reports of Time since Last Visit to Physical Health Providers

	Urban	Rural	Total
Medical Doctor (for General Health)			
Within the last year	182 (88.3%)	84 (90.3%)	266 (89.0%)
Two years ago	12 (5.8%)	4 (4.3%)	16 (5.4%)
More than two years ago	12 (5.8%)	5 (5.4%)	17 (5.7%)
Dentist			
Within the last year	145 (70.4%)	60 (64.5%)	205 (68.6%)
Two years ago	28 (13.6%)	13 (14.0%)	41 (13.7%)
More than two years ago	33 (16.0%)	20 (21.5%)	53 (17.7%)
Eye Doctor			
Within the last year	119 (57.8%)	52 (55.9%)	171 (57.2%)
Two years ago	39 (18.9%)	20 (21.5%)	59 (19.7%)
More than two years ago	39 (18.9%)	18 (19.4%)	57 (19.1%)
Never been	9 (4.4%)	3 (3.2%)	12 (4.0%)

A description of behavioral health consumers with chronic conditions is available in **Table 9.29.** Almost half (42.5%) of all respondents reported being diagnosed as having a chronic medical condition by a medical professional with high blood pressure (48.8%), diabetes (30.6%), asthma (26.4%), and arthritis (21.5%) as the most commonly reported conditions. Around half (53.9%) of respondents with chronic medical conditions reported seeing a medical doctor for their chronic condition between 2 and 4 times a year and 28.7% indicated they saw a medical doctor 5 times or more a year.

Table 9.29: Consumer Reports of Chronic Medical Conditions by Rurality

	Urban	Rural	Total
Diagnosed with a chronic medical condition?			
Yes	81 (41.5%)	40 (44.4%)	121 (42.5%)
No / Not Sure	114 (58.5%)	50 (55.6%)	164 (57.5%)
If so, which chronic condition? †			
Cancer	5 (6.2%)	2 (5.0%)	7 (5.8%)
Heart Disease	5 (6.2%)	3 (7.5%)	8 (6.6%)
High Blood Pressure	37 (45.7%)	22 (55.0%)	59 (48.8%)
Diabetes	23 (28.4%)	14 (35.0%)	37 (30.6%)
Chronic Obstructive Pulmonary Disease (COPD)	4 (4.9%)	2 (5.0%)	6 (5.0%)
Asthma	22 (27.2%)	10 (25.0%)	32 (26.4%)
Arthritis	18 (22.2%)	8 (20.0%)	26 (21.5%)
Other *	39 (48.1%)	11 (27.5%)	50 (41.3%)
How often do you see medical doctor for chronic condition?			
Less than once a year	13 (16.9%)	7 (18.4%)	20 (17.4%)
2-4 times a year	42 (54.5%)	20 (52.6%)	62 (53.9%)
5-6 times a year	10 (13.0%)	8 (21.1%)	18 (15.7%)
More than 6 times a year	12 (15.6%)	3 (7.9%)	15 (13.0%)

† Totals may not add up to 100% as respondents were able to select all applicable chronic conditions.

* The most commonly listed other conditions included mental illnesses, conditions associated with obesity, chronic pain, neurological conditions, and conditions closely related to those listed.

Service Utilization

Consumers reported on their yearly use of a number of different services including hospital emergency departments (ED), crisis stabilization units, residential programs, outpatient therapy / counseling, and self-help / support groups (**Table 9.30**). The respondents' answers to the questions about service utilization may reflect selection bias in that the consumers who chose to participate in this survey were well into recovery and stable enough that they do not need these services. The majority of respondents indicated they did not use hospital emergency department (74.8%), crisis stabilization unit (86.9%), or residential program (88.3%) during the last year. Many (67.9%) respondents indicate that they did use outpatient therapy or counseling once or more in the last year. A majority of the respondents (68.6%) did not use self-help or support groups in the last year.

Table 9.30: Consumer Reports of Service Utilization by Rurality

	Urban	Rural	Total
Hospital Emergency Department			
Did not use service in the last year	150 (73.2%)	73 (78.5%)	223 (74.8%)
Used service once or more in the last year	55 (26.8%)	20 (21.5%)	75 (25.2%)
Mean yearly uses (among users)	1.7	2.1	1.8
Crisis Stabilization Unit			
Did not use service in the last year	182 (88.3%)	77 (83.7%)	259 (86.9%)
Used service once or more in the last year	24 (11.7%)	15 (16.3%)	39 (13.1%)
Mean yearly uses (among users)	1.7	1.5	1.6
Residential Program			
Did not use service in the last year	187 (90.8%)	77 (82.8%)	264 (88.3%)
Used service once or more in the last year	19 (9.2%)	16 (17.2%)	35 (11.7%)
Mean yearly uses (among users)*	2.4	4.8	3.5
Median yearly uses (among users)	1	1	1
Outpatient Therapy / Counseling			
Did not use service in the last year	64 (31.1%)	32 (34.4%)	96 (32.1%)
Used service once or more in the last year	142 (68.9%)	61 (65.6%)	203 (67.9%)
Mean yearly uses (among users)*	11.4	10.1	11.0
Self-Help / Support Group			
Did not use service in the last year	139 (67.5%)	66 (71.0%)	205 (68.6%)
Used service once or more in the last year	67 (32.5%)	27 (29.0%)	94 (31.4%)
Mean yearly uses (among users)*	11.5	11.3	11.5

* Means were calculated with consumers who selected the maximum option (20+ uses) for data collection assigned a value of 20 uses, therefore the true mean is likely to exceed that reported in this table.

Stakeholder Survey

Respondent Characteristics

A total of 1159 stakeholders submitted responses to the survey across the six regions of Nebraska. Respondents were asked to describe the organizations they represented (**Table 9.31**). The majority (73.4%) of respondents represented provider agencies (24.9%), educational organizations (13.5%), probation (12.5%), the behavioral health regional administrations (11.3%), and state agencies (11.2%).

This survey gathered information on perceptions so there may be gaps between what the data included in other parts of this report shows. The convenience sampling strategy used to accommodate the project timeline is a limitation of the study in that not all Regions are equally represented, and there may be selection bias in that stakeholders who feel more strongly may have been more likely to respond.

Table 9.31: Distribution of Stakeholder Respondents by Region and Organization Type by Region

	Region 1	Region 2	Region 2	Region 4	Region 5	Region 6	Total
Organization Type							
Advocacy Organization	11 (6.4%)	3 (4.3%)	2 (1.4%)	4 (2.8%)	3 (1.4%)	6 (2.1%)	29 (2.8%)
Behavioral Health Region	16 (9.2%)	15 (21.7%)	14 (9.9%)	27 (19.1%)	16 (7.3%)	29 (9.9%)	117 (11.3%)
Child & Family Services	5 (2.9%)	5 (7.2%)	4 (2.8%)	6 (4.3%)	7 (3.2%)	9 (3.1%)	36 (3.5%)
Community Coalition	0 (0.0%)	1 (1.4%)	2 (1.4%)	2 (1.4%)	3 (1.4%)	2 (0.7%)	10 (1.0%)
Education	27 (15.6%)	6 (8.7%)	18 (12.8%)	10 (7.1%)	17 (7.8%)	62 (21.2%)	140 (13.5%)
Faith-based Organization	3 (1.7%)	1 (1.4%)	4 (2.8%)	0 (0.0%)	7 (3.2%)	12 (4.1%)	27 (2.6%)
Judiciary	3 (1.7%)	1 (1.4%)	1 (.7%)	2 (1.4%)	11 (5.0%)	13 (4.5%)	31 (3.0%)
Law Enforcement and Corrections	1 (.6%)	2 (2.9%)	3 (2.1%)	17 (12.1%)	7 (3.2%)	14 (4.8%)	44 (4.3%)
Peer Services Support Organization	1 (.6%)	2 (2.9%)	1 (.7%)	2 (1.4%)	6 (2.8%)	8 (2.7%)	20 (1.9%)
Probation	13 (7.5%)	10 (14.5%)	25 (17.7%)	23 (16.3%)	23 (10.6%)	35 (12.0%)	129 (12.5%)
Provider Agency	36 (20.8%)	14 (20.3%)	45 (31.9%)	42 (29.8%)	52 (23.9%)	68 (23.3%)	257 (24.9%)
Public Health	7 (4.0%)	2 (2.9%)	5 (3.5%)	2 (1.4%)	25 (11.5%)	11 (3.8%)	52 (5.0%)
State Agency	42 (24.3%)	4 (5.8%)	14 (9.9%)	3 (2.1%)	37 (17.0%)	16 (5.5%)	116 (11.2%)
Other*	8 (4.6%)	3 (4.3%)	3 (2.1%)	1 (.7%)	4 (1.8%)	7 (2.4%)	26 (2.5%)
Total†	173 (16.7%)	69 (6.7%)	141 (13.6%)	141 (13.6%)	218 (21.1%)	292 (28.2%)	1034 (100%)

*Others include services for the elderly, non-state government agencies, philanthropic organizations, housing support, private businesses, professional associations, and other support organizations as well as persons with multiple roles.
† 125 respondents did not answer this question.

Table 9.32 shows the distribution of respondent roles by region. Respondents filled a wide range of roles within their organizations. Respondents indicated roles that were categorized as Behavioral Health Specialists (24.0%), support staff (23.0%) which includes case managers and community health workers. Law and order roles were also well represented with 17.7% of respondents indicating they held roles in law enforcement, probation, corrections, or attorneys. There were also a large number who reported being none of the above or some other role (30.8%). More than half of all stakeholders (62.6%) had been working in their field for 10 years or longer which is a strength of the behavioral health system in Nebraska. Distribution of the duration of time stakeholders report working in their field is provided in **Table 9.33.**

Table 9.32: Distribution of Stakeholder Roles by Region

	Region 1	Region 2	Region 2	Region 4	Region 5	Region 6	Total
General Healthcare Providers*	**9 (5.2%)**	**2 (2.9%)**	**8 (5.7%)**	**4 (2.8%)**	**15 (6.9%)**	**9 (3.1%)**	**47 (4.5%)**
APRN	1 (0.6%)	0 (0%)	2 (1.4%)	1 (.7%)	3 (1.4%)	4 (1.4%)	11 (1.1%)
Nurses	3 (1.7%)	2 (2.9%)	4 (2.8%)	2 (1.4%)	11 (5.0%)	4 (1.4%)	26 (2.5%)
PA	2 (1.2%)	0 (0%)	1 (0.7%)	0 (0%)	0 (0%)	0 (0%)	3 (0.3%)
Pediatrician	0 (0%)	0 (0%)	1 (0.7%)	0 (0%)	0 (0%)	0 (0%)	1 (0.1%)
Primary care physician	0 (0%)	0 (0%)	0 (0%)	1 (.7%)	0 (0%)	1 (.3%)	2 (0.2%)
Pharmacist	3 (1.7%)	0 (0%)	0 (0%)	0 (0%)	1 (0.5%)	0 (0%)	4 (0.4%)
Behavioral Health Specialists*	**44 (25.4%)**	**12 (17.4%)**	**31 (22.0%)**	**26 (18.4%)**	**48 (22.0%)**	**87 (29.8%)**	**248 (24.0%)**
LIMHP	7 (4.0%)	7 (10.1%)	12 (8.5%)	10 (7.1%)	23 (10.6%)	26 (8.9%)	85 (8.2%)
LMHP	14 (8.1%)	3 (4.3%)	10 (7.1%)	6 (4.3%)	13 (6.0%)	37 (12.7%)	83 (8.0%)
Psychologist	8 (4.6%)	0 (0%)	1 (0.7%)	1 (.7%)	4 (1.8%)	10 (3.4%)	24 (2.3%)
Psychiatric Nurses and Mid-Levels	4 (2.3%)	1 (1.4%)	5 (3.5%)	5 (3.5%)	1 (.5%)	6 (2.1%)	22 (2.1%)
Psychiatrist	1 (.6%)	0 (0%)	0 (0%)	0 (0%)	2 (0.9%)	1 (0.3%)	4 (0.4%)
Substance Use Disorder Counselor	7 (4.0%)	0 (0%)	3 (2.1%)	2 (1.4%)	3 (1.4%)	4 (1.4%)	19 (1.8%)
Support Staff*	**39 (22.5%)**	**18 (26.1%)**	**27 (19.1%)**	**31 (22.0%)**	**62 (28.4%)**	**61 (20.9%)**	**238 (23.0%)**
Community Health Worker	8 (4.6%)	0 (0%)	1 (0.7%)	2 (1.4%)	6 (2.8%)	6 (2.1%)	23 (2.2%)
Community Support Staff	12 (6.9%)	8 (11.6%)	6 (4.3%)	11 (7.8%)	23 (10.6%)	12 (4.1%)	72 (7.0%)
Direct care worker	6 (3.5%)	3 (4.3%)	3 (2.1%)	5 (3.5%)	10 (4.6%)	10 (3.4%)	37 (3.6%)
Recovery Support Worker (Peer counselor)	3 (1.7%)	0 (0%)	0 (0%)	2 (1.4%)	7 (3.2%)	15 (5.1%)	27 (2.6%)
Service Coordination / Case Management / Social Work	8 (4.6%)	4 (5.8%)	11 (7.8%)	7 (5.0%)	9 (4.1%)	16 (5.5%)	55 (5.3%)
Law and Order*	**18 (10.4%)**	**12 (17.4%)**	**26 (18.4%)**	**41 (29.1%)**	**35 (16.1%)**	**51 (17.5%)**	**183 (17.7%)**
Attorney	3 (1.7%)	0 (0%)	0 (0%)	0 (0%)	3 (1.4%)	4 (1.4%)	10 (1.0%)
Corrections Officer	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	2 (0.7%)	2 (0.2%)
Law Enforcement Officer	1 (0.6%)	2 (2.9%)	2 (1.4%)	16 (11.3%)	4 (1.8%)	5 (1.7%)	30 (2.9%)
Probation Worker	8 (4.6%)	10 (14.5%)	22 (15.6%)	23 (16.3%)	21 (9.6%)	36 (12.3%)	120 (11.6%)
Other*	**63 (36.4%)**	**25 (36.2%)**	**49 (34.8%)**	**39 (27.7%)**	**58 (26.6%)**	**84 (28.8%)**	**318 (30.8%)**
Teachers and Other School Personnel	17 (9.8%)	4 (5.8%)	9 (6.4%)	4 (2.8%)	9 (4.1%)	23 (7.9%)	66 (6.4%)
Administration and Management	18 (10.4%)	6 (8.7%)	13 (9.2%)	11 (7.8%)	7 (3.2%)	19 (6.5%)	74 (7.2%)
Child Welfare Worker	0 (0%)	0 (0%)	1 (0.7%)	2 (1.4%)	0 (0%)	0 (0%)	3 (0.3%)
Total	**173**	**69**	**141**	**141**	**218**	**292**	**1034**

* Category totals include all of the specific roles within the category as well as those within the category who do not fall under a specific role.

Table 9.33: Distribution of The Duration of Stakeholder's Time Working in Their Field by Region

Duration	Region 1		Region 2		Region 2		Region 4		Region 5		Region 6		Total	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%
< 1 year	6	3.5%	2	2.9%	5	3.5%	5	3.5%	5	2.3%	6	2.1%	29	2.8%
1-4 years	30	17.3%	15	21.7%	26	18.4%	29	20.6%	42	19.3%	45	15.4%	187	18.1%
5-9 years	27	15.6%	9	13.0%	22	15.6%	30	21.3%	33	15.1%	50	17.1%	171	16.5%
>=10 years	110	63.6%	43	62.3%	88	62.4%	77	54.6%	138	63.3%	191	65.4%	647	62.6%
Total	**173**		**69**		**141**		**141**		**218**		**292**		**1034**	

Stakeholders were also asked about the services provided by their organizations (**Table 9.34**). Respondents were asked to identify all of the services they provide and 91.2% reported providing services related to SUD, 77.5% reported providing services related to SMI. A minority (33.8%) of respondents indicated that they contract with others to provide these services, and 19.2% of respondents reported providing none of these services.

Table 9.34: Distribution of Respondent Reports of Services Provided by Region

	Region 1		Region 2		Region 3		Region 4		Region 5		Region 6		Total	
Services Provided	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Substance Use Disorder Prevention	29	16.8%	23	33.3%	24	17.0%	43	30.5%	50	22.9%	59	20.2%	228	22.1%
Substance Use Disorder Clinical Treatment	41	23.7%	24	34.8%	33	23.4%	27	19.1%	51	23.4%	57	19.5%	233	22.5%
Substance Use Disorder Intervention Services	30	17.3%	19	27.5%	28	19.9%	35	24.8%	37	17.0%	54	18.5%	203	19.6%
Substance Use Disorder Recovery Support	34	19.7%	19	27.5%	26	18.4%	37	26.2%	50	22.9%	61	20.9%	227	22.0%
Detoxification Services	17	9.8%	2	2.9%	9	6.4%	7	5.0%	6	2.8%	11	3.8%	52	5.0%
Severe Mental Health Treatment	47	27.2%	22	31.9%	33	23.4%	35	24.8%	65	29.8%	94	32.2%	296	28.6%
Severe Mental Health Rehabilitation	30	17.3%	13	18.8%	15	10.6%	24	17.0%	37	17.0%	57	19.5%	176	17.0%
Severe Mental Health Support	56	32.4%	27	39.1%	47	33.3%	42	29.8%	66	30.3%	92	31.5%	330	31.9%
Contracts with Others for These Types of Services	58	33.5%	31	44.9%	50	35.5%	52	36.9%	69	31.7%	89	30.5%	349	33.8%
Does not Provide These Types of Services at All	32	18.5%	14	20.3%	28	19.9%	27	19.1%	40	18.3%	58	19.9%	199	19.2%
Other *	26	15.0%	2	2.9%	15	10.6%	20	14.2%	20	9.2%	34	11.6%	117	11.3%
Total Number of Organizations †	**173**		**69**		**141**		**141**		**218**		**292**		**1034**	

* Others primarily fell within crisis/emergency management, case management, referral to other organizations, support services, education, faith-based/spiritual support, medication/prescription management, services for persons with intellectual / developmental disabilities, school-based behavioral health services, temporary treatment until referrals are possible, evaluation, and advocacy. Some respondents reported a desire to offer referral services but expressed difficulty in obtaining services for their clients.
† Totals may not add up as respondents were able to select all applicable services.

The stakeholder survey respondents serve a wide range of different populations and communities across the state of Nebraska (**Table 9.35**). Adults were the most commonly served age group (74.5% of all organizations); however, a majority of respondents indicated that they serve children (54.5%), adolescents (61.7%), transitional aged youth (15-17 years) (56.1%), and older adults (≥59 years) (54%). A number of respondents also reported providing services to special populations including pregnant women (46.4%), women with dependent children (47.6%), and the homeless or inadequately housed (48.5). More than half (51.7%) of respondents also indicated that their organization offered services to those involved with the criminal justice system, and a significant minority (43.2%) offered services to those in the juvenile justice system. Based on these responses it appears that a broad spectrum of the population is served by these organizations.

Table 9.35: Distribution of Stakeholder Reports of the Populations They Serve by Region

	Region 1		Region 2		Region 3		Region 4		Region 5		Region 6		Total	
Age Groups	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Children	98	56.6%	51	73.9%	83	58.9%	82	58.2%	105	48.2%	145	49.7%	564	54.5%
Adolescents	105	60.7%	53	76.8%	98	69.5%	91	64.5%	117	53.7%	174	59.6%	638	61.7%
Transition Age (15-17)	105	60.7%	50	72.5%	90	63.8%	88	62.4%	98	45.0%	149	51.0%	580	56.1%
Adults	120	69.4%	59	85.5%	103	73.0%	120	85.1%	174	79.8%	194	66.4%	770	74.5%
Older Adults (59+)	91	52.6%	46	66.7%	72	51.1%	90	63.8%	115	52.8%	148	50.7%	562	54.4%
Special Populations														
Pregnant Women	78	45.1%	44	63.8%	64	45.4%	79	56.0%	88	40.4%	127	43.5%	480	46.4%
Women with Dependent Children	77	44.5%	47	68.1%	69	48.9%	81	57.4%	95	43.6%	123	42.1%	492	47.6%
People Living with HIV/AIDS	57	32.9%	37	53.6%	43	30.5%	53	37.6%	55	25.2%	99	33.9%	344	33.3%
The Homeless or Inadequately Housed	86	49.7%	45	65.2%	63	44.7%	76	53.9%	94	43.1%	137	46.9%	501	48.5%
Intravenous Drug Users	71	41.0%	37	53.6%	52	36.9%	66	46.8%	69	31.7%	100	34.2%	395	38.2%
Criminal Justice and Corrections														
Persons Involved with the Criminal Justice System	84	48.6%	52	75.4%	75	53.2%	84	59.6%	109	50.0%	131	44.9%	535	51.7%
Persons Involved with the Juvenile Justice System	79	45.7%	47	68.1%	80	56.7%	68	48.2%	70	32.1%	103	35.3%	447	43.2%
Persons Involved with the Corrections System	78	45.1%	40	58.0%	53	37.6%	67	47.5%	76	34.9%	108	37.0%	422	40.8%
Other*	11	6.4%	0	0.0%	5	3.5%	5	3.5%	15	6.9%	8	2.7%	44	4.3%
Total Number of Stakeholders†	**173**		**69**		**141**		**141**		**218**		**292**		**1034**	

* The overwhelmingly most common other populations reported were persons with developmental / intellectual disabilities and organizations reporting that they serve everyone. Additional groups mentioned were refugees, racial minorities, those with economic need, veterans, victims of abuse, children and their families, or those mandated by the courts or other government agencies

† Totals may not add up as respondents were able to select all applicable populations

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Access to Behavioral Health and Substance Use Disorder Services

As reported in **Table 9.36**, stakeholders perceptions about access to SMI services is less optimistic. It is important to note that for purposes of this perception survey terms such as 'timely manner' or 'wait too long' were not defined, but were left open to interpretation by the respondent. The perceptions reported here may not align with objective data in other sections of this report. Respondents felt that it was difficult to get mental health assessments (58.8%), difficult to get SMI treatment in a timely manner (67.1%), and wait times for SMI treatment were too long (63.8%). Stakeholder respondents agreed with urban consumer respondents that consumers are able to choose from a variety of behavioral health treatment providers. Stakeholder respondents also agreed with all consumer respondents that behavioral health treatment services can be accessed at a local hospital emergency room. Stakeholder respondents' perceptions about access to medication for SMI treatment were mixed with 41.4% reporting that people with SMI do have access and 40.2% reporting that they do not.

Table 9.37 shows perceived access to SUD services which were more mixed than perceptions about access to SMI services. Stakeholder perceptions were fairly evenly divided between agreeing and disagreeing about most questions they were asked about access to SUD services with one exception. Over half (53.2%) felt people with SUD have to wait too long to receive treatment.

Table 9.36: Stakeholder's Perceived Access to Mental Disorder Services by Region

	Region 1		Region 2		Region 3		Region 4		Region 5		Region 6		Total	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%
It is easy to get mental health assessments in a timely manner in my area.														
Yes	36	20.8%	29	42.0%	46	32.6%	51	36.2%	65	29.8%	67	22.9%	294	28.4%
No	104	60.1%	38	55.1%	75	53.2%	74	52.5%	124	56.9%	193	66.1%	608	58.8%
Not Sure	33	19.1%	2	2.9%	20	14.2%	16	11.3%	29	13.3%	32	11.0%	132	12.8%
It is easy to get treatment for serious mental illness in a timely manner in my area.														
Yes	24	13.9%	20	29.0%	33	23.4%	37	26.2%	46	21.1%	52	17.9%	212	20.5%
No	119	68.8%	45	65.2%	87	61.7%	86	61.0%	146	67.0%	210	72.2%	693	67.1%
Not Sure	30	17.3%	4	5.8%	21	14.9%	18	12.8%	26	11.9%	29	10.0%	128	12.4%
People with serious mental illness in my area have access to medication they need.														
Yes	65	37.6%	43	62.3%	65	46.1%	66	46.8%	89	40.8%	100	34.2%	428	41.4%
No	63	36.4%	16	23.2%	49	34.8%	52	36.9%	95	43.6%	141	48.3%	416	40.2%
Not Sure	45	26.0%	10	14.5%	27	19.1%	23	16.3%	34	15.6%	51	17.5%	190	18.4%
People with serious mental illness in my area often have to wait too long to receive treatment.														
Yes	110	63.6%	45	65.2%	82	58.2%	76	53.9%	146	67.3%	200	68.5%	659	63.8%
No	34	19.7%	19	27.5%	34	24.1%	46	32.6%	45	20.7%	52	17.8%	230	22.3%
Not Sure	29	16.8%	5	7.2%	25	17.7%	19	13.5%	26	12.0%	40	13.7%	144	13.9%
Services are available for family members of behavioral health consumers (serious mental illness/substance use disorder) in my area.														
Yes	79	45.7%	35	50.7%	59	41.8%	55	39.0%	85	39.2%	134	45.9%	447	43.3%
No	49	28.3%	19	27.5%	51	36.2%	53	37.6%	64	29.5%	86	29.5%	322	31.2%
Not Sure	45	26.0%	15	21.7%	31	22.0%	33	23.4%	68	31.3%	72	24.7%	264	25.6%
Consumers are able to choose from a variety of behavioral health treatment providers in my area.														
Yes	58	33.5%	26	37.7%	39	27.7%	52	37.1%	96	44.0%	136	46.6%	407	39.4%
No	100	57.8%	35	50.7%	88	62.4%	79	56.4%	94	43.1%	128	43.8%	524	50.7%
Not Sure	15	8.7%	8	11.6%	14	9.9%	9	6.4%	28	12.8%	28	9.6%	102	9.9%
Consumers can go to a local hospital emergency room in my area and get behavioral health treatment services.														
Yes	84	48.6%	37	53.6%	54	38.3%	70	50.0%	120	55.0%	163	55.8%	528	51.1%
No	47	27.2%	21	30.4%	54	38.3%	55	39.3%	62	28.4%	80	27.4%	319	30.9%

Not Sure	42	24.3%	11	15.9%	33	23.4%	15	10.7%	36	16.5%	49	16.8%	186	18.0%
People on probation or parole are able to get the behavioral health treatment services they need in my area.														
Yes	58	33.5%	36	52.2%	58	41.1%	70	50.0%	93	42.7%	111	38.0%	426	41.2%
No	55	31.8%	18	26.1%	39	27.7%	33	23.6%	44	20.2%	93	31.8%	282	27.3%
Not Sure	60	34.7%	15	21.7%	44	31.2%	37	26.4%	81	37.2%	88	30.1%	325	31.5%
Total	**173**		**69**		**141**		**140**		**218**		**292**		**1033**	

Table 9.37: Stakeholder's Perceived Access to Substance Use Disorder Services by Region

	Region 1		**Region 2**		**Region 3**		**Region 4**		**Region 5**		**Region 6**		**Total**	
	#	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**
It is easy to get substance use disorder assessments in my area.														
Yes	51	29.5%	32	46.4%	55	39.0%	67	47.9%	89	40.8%	104	35.7%	398	38.6%
No / Not Sure	67	38.7%	30	43.5%	55	39.0%	43	30.7%	64	29.4%	122	41.9%	381	36.9%
It is easy to get substance use disorder treatment in my area.														
Yes	46	26.6%	17	24.6%	38	27.0%	55	39.3%	75	34.4%	88	30.1%	319	30.9%
No / Not Sure	79	45.7%	47	68.1%	76	53.9%	59	42.1%	80	36.7%	138	47.3%	479	46.4%
People with substance use disorder in my area have access to medication they need.														
Yes	56	32.4%	27	39.1%	44	31.2%	62	44.3%	64	29.4%	74	25.3%	327	31.7%
No / Not Sure	49	28.3%	23	33.3%	47	33.3%	40	28.6%	68	31.2%	113	38.7%	340	32.9%
People with substance use disorder in my area often have to wait too long to receive treatment.														
Yes	91	52.6%	42	61.8%	76	53.9%	67	48.2%	115	52.8%	158	54.1%	549	53.2%
No / Not Sure	34	19.7%	17	25.0%	33	23.4%	42	30.2%	40	18.3%	57	19.5%	223	21.6%
Services are available for family members of substance use disorder consumers in my area.														
Yes	59	34.1%	30	43.5%	44	31.2%	57	40.7%	69	31.7%	108	37.0%	367	35.5%
No / Not Sure	50	28.9%	20	29.0%	50	35.5%	41	29.3%	55	25.2%	84	28.8%	300	29.0%
Consumers are able to choose from a variety of substance use disorder treatment providers in my area.														
Yes	40	23.1%	19	27.5%	30	21.3%	42	30.2%	82	37.6%	113	38.7%	326	31.6%
No / Not Sure	91	52.6%	42	60.9%	78	55.3%	75	54.0%	78	35.8%	107	36.6%	471	45.6%
Consumers can go to a local hospital in my area and get substance use disorder care.														
Yes	44	25.4%	23	33.3%	34	24.1%	49	35.3%	73	33.5%	82	28.2%	305	29.6%

No / Not Sure	66	38.2%	28	40.6%	57	40.4%	57	41.0%	72	33.0%	113	38.8%	393	38.1%
People on probation are able to get the substance use disorder services they need in my area.														
Yes	57	32.9%	28	40.6%	52	36.9%	65	46.8%	92	42.2%	118	40.5%	412	40.0%
No / Not Sure	47	27.2%	23	33.3%	46	32.6%	32	23.0%	39	17.9%	75	25.8%	262	25.4%
Total	**173**		**69**		**141**		**140**		**218**		**292**		**1033**	

Stakeholders also reported on the need for additional services targeting specific underserved or disparate populations (**Table 9.38**). Stakeholder respondents in all Regions identified people with comorbid conditions (70.6%) and parents/children family treatment (52.6%) as populations requiring additional services. Regions 4 (49.7%), 5 (50.9%) and 6 (51%) also identified non-English speaking populations as needing additional services.

Table 9.38: Stakeholder's Perceptions of Disparate Populations Requiring Additional Services by Region

Population	Region 1		Region 2		Region 3		Region 4		Region 5		Region 6		Total	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%
African Americans	51	29.5%	8	11.6%	16	11.4%	19	13.5%	47	21.6%	93	31.9%	234	22.6%
Hispanic Americans	66	38.2%	16	23.2%	49	34.8%	52	36.9%	72	33.0%	108	37.0%	363	35.1%
Native Americans	67	38.7%	8	11.6%	21	14.9%	37	26.2%	59	27.1%	89	30.5%	281	27.2%
Non-English Speaking	76	43.9%	31	44.9%	64	45.4%	70	49.7%	111	50.9%	149	51.0%	501	48.5%
Older Adults	65	37.6%	14	20.3%	40	28.4%	42	29.8%	66	30.3%	77	26.4%	304	29.4%
Parents and Children / Family Treatment	105	60.7%	29	42.0%	66	46.8%	75	53.2%	115	52.8%	154	52.7%	544	52.6%
The LGBT Community	70	40.5%	13	18.8%	34	24.1%	32	22.7%	66	30.3%	124	42.5%	339	32.8%
Deaf & Hard of Hearing	57	33.0%	16	23.2%	23	16.3%	35	24.8%	63	28.9%	86	29.5%	280	27.1%
People w/Comorbid Conditions	135	78.0%	48	69.6%	96	68.1%	94	66.7%	144	66.1%	213	73.0%	730	70.6%
Veterans	77	44.5%	21	30.4%	47	33.3%	57	40.4%	73	33.5%	108	37.0%	383	37.0%
Other *	13	7.5%	5	7.3%	11	7.8%	11	7.8%	30	13.8%	27	9.3%	97	9.4%
Total †	**173**		**69**		**141**		**141**		**218**		**292**		**1034**	

* The overwhelmingly most common other populations requiring additional services reported were persons with developmental / intellectual disabilities, children, and adolescents. Additional groups included refugees and those with economic need.
† Totals may not add up as respondents were able to select all applicable populations.

Stakeholders identified the top social concerns in their communities from a list of options (**Table 9.39**). The two most frequent social concerns cited by stakeholder respondents were mental illness (76.0%) and substance use disorders (69.2%). Other social concerns included affordable services (58.1%), family problems (55.2%), poverty (55.2%), and transportation (49.1%). It is worth noting that treatment for mental illness and substance use disorders are exacerbated by affordability of services, family problems, poverty, and transportation issues.

Table 9.39: Stakeholder Reports of Top Social Concerns in Their Community by Region

Social Concern	Region 1		Region 2		Region 3		Region 4		Region 5		Region 6		Total	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Mental Illness	136	78.6%	52	75.4%	101	71.6%	105	74.5%	161	73.9%	231	79.1%	786	76.0%
Substance Use Disorder	120	69.4%	54	78.3%	102	72.3%	106	75.2%	135	61.9%	199	68.2%	716	69.2%
Affordable Services	108	62.4%	37	53.6%	81	57.5%	84	59.6%	118	54.1%	173	59.3%	601	58.1%
Family Problems	113	34.7%	37	46.4%	83	41.1%	85	39.7%	118	45.9%	161	44.9%	597	57.7%
Poverty	102	59.0%	36	52.2%	78	55.3%	63	44.7%	118	54.1%	174	59.6%	571	55.2%
Transportation	87	50.3%	40	58.0%	76	53.9%	69	48.9%	94	43.1%	142	48.6%	508	49.1%
Homelessness	79	45.7%	22	31.9%	36	25.5%	41	29.1%	83	38.1%	111	38.0%	372	36.0%
Unemployment	55	31.8%	24	34.8%	39	27.7%	39	27.7%	62	28.4%	95	32.5%	314	30.4%
Suicide	51	29.5%	8	11.6%	24	17.0%	36	25.5%	50	22.9%	74	25.3%	243	23.5%
Crime / Violence	43	24.9%	10	14.5%	15	10.6%	12	8.5%	33	15.1%	123	42.1%	236	22.8%
Total †	**173**		**69**		**141**		**141**		**218**		**292**		**1034**	

† Totals may not add up as respondents were able to select multiple social concerns.

General Population Survey Results

Respondent Characteristics

A total of 234 Nebraskans completed the general population survey. Survey respondents represented Nebraskans in both urban (59%) and rural (41%) locations. The respondents were predominantly white (89.7%) and a majority (74.8%) were female. A small number of respondents reported being black or African American (3.0%), American Indian or Alaskan Native (3.0%), or Hispanic, Latino/a, or of Spanish origin (4.7%). As with the consumer survey, when compared to the U.S. Census Bureau population estimates for 2015, the general population survey underrepresents Black/African American, Asian, and Hispanic Nebraskans. The majority (89%) were between 30 and 70 years of age. The perceptions represented in these survey results are primarily those of white, middle aged females.

This survey gathered information on perceptions, so there may be gaps between what the data included in other parts of this report shows. The convenience sampling strategy used to accommodate the project timeline is a limitation of the study.

Table 9.40: Breakdown of Respondent Characteristics on the General Population Survey by Rurality

Characteristics	Urban		Rural		Total	
	No.	%	No.	%	No.	%
Total	**138**	**59.0%**	**96**	**41.0%**	**234**	**100%**
Gender						
Male	34	24.6%	25	26.0%	59	25.2%
Female	104	75.4%	71	74.0%	175	74.8%
Age (years)						
20-29	7	5.1%	6	6.3%	13	5.6%
30-39	24	17.5%	5	5.2%	29	12.4%
40-49	27	19.7%	25	26.0%	52	22.3%
50-59	35	25.5%	28	29.2%	63	27.0%
60-69	36	26.3%	28	29.2%	64	27.5%
≥70	8	5.8%	4	4.2%	12	5.2%
Race†						
White	121	87.7%	89	92.7%	210	89.7%
Black / African American	7	5.1%	0	0.0%	7	3.0%
American Indian or Alaska Native	4	2.9%	3	3.1%	7	3.0%
Other*	7	5.1%	5	5.2%	12	5.1%
Ethnicity						
Hispanic	5	3.6%	6	6.3%	11	4.7%
Non-Hispanic	133	96.4%	90	93.8%	223	95.3%

† Totals may not add up as respondents were able to select all applicable races.
* Other included primarily those with multiple racial identities and those who took objection to racial definition.

Perceived Need and Access to Mental Health Services

Table 9.41 represents general public respondents' perceptions about the burden of serious mental illness (SMI) and access to SMI treatment services as well as societal responsibilities and impacts. A majority of respondents understand the burden of SMI to both the person with mental illness and society including the contribution to homelessness (82.1% agree), incarceration (82.5% agree), and unemployment (86.3% agree. A majority of respondents (82.5%) understand that SMI is a chronic condition that needs lifelong treatment and believe that by providing ongoing support to persons with SMI we can allow them to be productive members of society (92.3%). Furthermore, the majority of respondents (84.6%) agreed that society has a responsibility to help care for people with SMI, and that it is more cost effective to treat SMI (88.0% agree) than to pay for the consequences if left untreated. Although this survey used convenience sampling strategies that limit generalizability to the larger population, the results may suggest that Nebraskan's feel both an ethical and financial mandate to provide SMI services.

Although, as described above, the majority of respondents recognized the importance of mental health services, there were differences in services actually available in their communities. Only 6.8% of general public respondents indicated that there are adequate treatment services for Nebraskans with SMI. A significant minority (45.3%) did indicate that they knew how to access SMI services other than the local hospital emergency department which means they know how to access the services that are available. A majority (92.3%) saw financial or insurance issues as barriers to SMI treatment.

Table 9.41: General Population Perceptions of Mental Health Burden, Need, and Access to Services in Nebraska by Rurality

(Respondents reporting "Yes")	Urban		Rural		Total	
	#	%	#	%	#	%
Perceived Burden of Serious Mental Illness (SMI):						
Untreated or undertreated mental illness is commonly associated with suicide.	104	75.4%	79	82.3%	183	78.2%
SMI is often associated with other health disorders.	95	68.8%	65	67.7%	160	68.4%
People with SMI have a shorter lifespan than the general population.	98	71.0%	49	51.0%	147	62.8%
SMI is a contributing factor to a person being homeless.	122	88.4%	70	72.9%	192	82.1%
SMI is a contributing factor to a person being incarcerated.	120	87.0%	73	76.0%	193	82.5%
People with SMI are more likely to live in poverty.	113	81.9%	67	69.8%	180	76.9%
People with SMI are more likely to be unemployed.	121	87.7%	81	84.4%	202	86.3%
SMI is a chronic condition that needs life-long treatment.	115	83.3%	78	81.3%	193	82.5%
Society has a responsibility to help care for people with SMI.	125	90.6%	73	76.0%	198	84.6%
It is more cost effective to treat SMI than pay for consequences if untreated.	124	89.9%	82	85.4%	206	88.0%
Providing on-going support to persons with SMI allows them to be productive members of society.	130	94.2%	86	89.6%	216	92.3%
Access to Serious Mental Illness (SMI) Services in Nebraska:						
There adequate services for Nebraskans with serious mental illness.	5	3.6%	11	11.5%	16	6.8%
I know how to access services for SMI other than emergency room.	58	42.0%	48	50.0%	106	45.3%
I am confident helping someone at risk of harming themselves or others.	51	37.0%	40	41.7%	91	38.9%
People with SMI face financial and/or insurance barriers to care.	126	91.3%	90	93.8%	216	92.3%
People with SMI usually have social support to get needed help.	7	5.1%	4	4.2%	11	4.7%
People with SMI are able to get prescriptions filled when needed.	6	4.3%	1	1.0%	7	3.0%
There are some treatment programs in Nebraska that are available for free.	31	22.5%	25	26.0%	56	23.9%
Current funding for treatment of SMI is adequate to meet the needs in Nebraska.	6	4.3%	1	1.0%	7	3.0%
Total Number of Respondents (n):	**138**		**96**		**234**	

Perceived Need and Access to Substance Use Disorder Services

Table 9.42 shows general public respondents' perceptions about substance use disorder (SUD). Both urban and rural respondents saw drug use as a significant problem, including alcohol use (85.5%), prescription drug use (83.3%) and illegal drug use (86.8%). Over half (56.4%) of respondents also believe that drug related hospitalizations are increasing in Nebraskans. As with SMI, a majority of respondents (90.2%) believe it is more cost effective to provide treatment for SUD than to pay for the consequences if left untreated.

As with mental health services, general public respondents painted a somewhat different picture of the services actually available in their communities. Only 8.5% of general public respondents indicated that there are adequate treatment services for Nebraskans with SUD. A significant minority (43.6%) did indicate that they knew how to access SUD services other than the local hospital emergency department which means they know how to access the services that are available. And a majority (78.6%) see financial or insurance issues as barriers to SUD treatment.

Although this survey used convenience sampling strategies that limit generalizability to the larger population, the results may suggest that Nebraskan's feel both an ethical and financial mandate to provide SUD services.

Table 9.42: General Population Perceptions of Substance Use Disorder Burden, Need, and Access to Services in Nebraska by Rurality

(Respondents reporting "Yes")	Urban		Rural		Total	
	#	%	#	%	#	%
Perceived Burden of Substance Use Disorders (SUDs):						
Alcohol abuse is a problem in Nebraska.	119	86.2%	81	84.4%	200	85.5%
Prescription drug abuse is a problem in Nebraska.	115	83.3%	80	83.3%	195	83.3%
Illegal drug abuse is a problem in Nebraska.	115	83.3%	88	91.7%	203	86.8%
The number of hospitalizations in Nebraska linked to the abuse of drugs is increasing.	76	55.1%	56	58.3%	132	56.4%
It is more cost effective to treat substance abuse than it is to pay for its consequences if left untreated.	128	92.8%	83	86.5%	211	90.2%
Perceived Access to Substance Use Disorder Treatment Services:						
There are adequate treatment services available in Nebraska for people with SUD.	12	8.7%	8	8.3%	20	8.5%
I know how to access substance use disorder services (not including emergency room.)	54	39.1%	48	50.0%	102	43.6%
I am confident helping someone who is experiencing an overdose or other SUD emergency.	42	30.4%	30	31.3%	72	30.8%
People with substance use issues face significant financial and/or insurance barriers in paying for their care.	110	79.7%	74	77.1%	184	78.6%
People with substance use issues usually have the social support to get the help they need.	10	7.2%	8	8.3%	18	7.7%
There are some substance use disorder treatment programs in Nebraska that are available for free.	30	21.7%	19	19.8%	49	20.9%
Current funding for treatment of substance use disorders is adequate to meet the need in Nebraska.	8	5.8%	2	2.1%	10	4.3%
Total Number of Respondents (n):	**138**		**96**		**234**	

Top Social Concerns, Service Payers, and other comments.

Table 9.43 represents general public respondents' beliefs about top social concerns relative to SMI and SUD. There is no clear consensus among either urban or rural respondents. Among all respondents 24.8% identified problems accessing care as a top social concern and 19.2% indicated affordable treatment services was a top concern.

Table 9.43: General Population Ratings of Top Social Concern Relative to Substance Use and Mental Health by Rurality

Top Social Concern:	Urban		Rural		Total	
	#	%	#	%	#	%
Family problems	17	12.3%	16	16.7%	33	14.1%
Problems accessing care	31	22.5%	27	28.1%	58	24.8%
Crime/violence	18	13.0%	6	6.3%	24	10.3%
Poverty	11	8.0%	10	10.4%	21	9.0%
Homelessness	6	4.3%	1	1.0%	7	3.0%
Unemployment	3	2.2%	2	2.1%	5	2.1%
Substance use	6	4.3%	12	12.5%	18	7.7%

Transportation	2	1.4%	0	0.0%	2	0.9%
Suicide	2	1.4%	2	2.1%	4	1.7%
Affordable treatment services	30	21.7%	15	15.6%	45	19.2%
Mental illness	8	5.8%	4	4.2%	12	5.1%
Other*	4	2.9%	1	1.0%	5	2.1%
Total	**138**		**96**		**234**	

* Others included services for those with developmental disabilities, coordination of existing services, and combinations of multiple listed concerns.

Respondents were asked about which payer organizations offered coverage for mental health and SUD services (**Table 9.44**). A majority of respondents believed that the patient pays out of pocket (76.9%), Medicaid (70.9%), private insurance (60.7%), Veterans Affairs (59.4%) and insurance through an employer (57.7%) were primary sources of payment for SMI or SUD services. This may indicate that respondents recognize the complex payment system that consumers and providers alike must navigate.

Table 9.44: Nebraskans Perceptions of Organization Paying for Mental Health and Substance Use Services by Rurality

Organizations Paying for SUD and SMI Services:	**Urban**		**Rural**		**Total**	
	#	**%**	**#**	**%**	**#**	**%**
Medicaid	101	73.2%	65	67.7%	166	70.9%
Medicare	67	48.6%	45	46.9%	112	47.9%
Veterans Affairs	92	66.7%	47	49.0%	139	59.4%
Private Insurance	85	61.6%	57	59.4%	142	60.7%
Insurance through an Employer	81	58.7%	54	56.3%	135	57.7%
The Patient / Out-of-Pocket	110	79.7%	70	72.9%	180	76.9%
Nebraska Office of Probation Administration vouchers	37	26.8%	27	28.1%	64	27.4%
Other *	11	8.0%	7	7.3%	18	7.7%
Total Number of Respondents (n): †	**138**		**96**		**234**	

† Totals may not add up as respondents were able to select all applicable payers.
* Other payers identified included the states taxpayers as a whole, non-profit organizations, providers, and in some cases a complete absence of payers for these services.

Open-Ended Responses

Respondents were provided space at the end of the survey and encouraged to provide any additional comments. These open-ended responses were treated as qualitative data and coded for themes. One of the most prevalent themes was difficulty in accessing services. These difficulties were perceived as an insufficient number of providers, prohibitively high costs of treatment, and long wait times to receive treatment.

Many of those surveyed identified specific areas of services that they felt did not meet existing need including acute and long-term inpatient (residential) placements, community support services, services in schools, services for co-occurring substance use and mental health disorders, services for those with developmental disabilities, and crisis intervention services. A large number of respondents expressed their belief that services need to address a range of issues related to SMI and SUD such as homelessness, poverty, inadequate transportation, and adequate access to nutritious foods. Some respondents suggested that lack of integrated efforts to address SMI and SUD on multiple levels may lead to existing treatments not being as effective as they could be. Also commonly mentioned was the detrimental role of stigma towards people who seek mental health and substance use services. Many of these issues lie outside the purview of the Division of Behavioral Health (DBH) but are included here to emphasize the respondents' belief in the importance of integrated solutions to address SMI and SUD.

Perhaps the most striking theme encountered was the feeling of learned helplessness experienced by many respondents. Learned helplessness, in psychology, is a mental state in which one tolerates adverse circumstances because they have learned through repeated exposure that those stimuli are unavoidable.[123] Within the context of survey respondents, this sense of learned helplessness came from repeated attempts to access the SMI/SUD resources they needed to be successful in their efforts to become mentally stable or recover from SUD. A number of respondents told personal anecdotes of needing services for themselves or their loved ones and struggling to access those services within the behavioral health system or being denied services because they did not meet criteria for receiving those services. Respondents described the pain of considering foster care for their children in order to get them the services they need or debating leaving the state entirely in order to get the services they need. These respondents felt powerless in their attempts to navigate the complexities of the behavioral health system. This sense of powerlessness extended beyond consumers and family members personal experience to stakeholders who expressed doubt that this survey would result in any meaningful changes by citing the lack of action following past data collection on the topic and political gridlock.

X. Public and Population-Based Approach to Increase Access and Use of Behavioral Health Services

Summary

In this chapter, some public health and population health initiatives concepts and approaches relevant to behavioral health were discussed. The information included in this chapter is based on data obtained from the Nebraska Department of Health and Human Services. In addition, literature reviews and informant interviews were conducted to provide a more complete picture of integration in Nebraska.

Chapter Highlights and Recommendations

Why Integrated Care Now?

- People with mental health disorders have the high prevalence of chronic health problems including obesity, high blood pressure, cardiovascular disease, diabetes and chronic obstructive disease, which is linked to premature deaths in this population group.
- Barriers to accessing primary care services have been a major obstacle for early detection and treatment of chronic health problems.
- There is a need to promote behavioral health in the general population in order to prevent or treat behavioral health problems in early stages and to demystify and destigmatize behavioral health illnesses and treatments.
- Integration of behavioral health in the primary care settings can increase access to medical care services among people with mental health and substance use disorders. Integration can also expand the use of behavioral health screening and treatment among people in the general population.

Integrated Care in Nebraska

- As described in Chapter 9, the consumers and stakeholders who participated in the focus group interviews and surveys expressed a strong desire for a more integrated and whole person approach to improve both their behavioral and physical health.
- An integrated care model has been used in different healthcare systems in Nebraska. According to a recent state-wide survey, there is a high level of interest among providers to practice in integrated care settings.
- The Division of Medicaid and Long Term Care recently signed contracts with three managed care organizations. Beginning on January 1, 2017, the MCOs will receive a single capitated per member per month fee to address both the behavioral and physical health needs of Medicaid beneficiaries.
- This change has the potential to enhance care coordination, reduce the fragmentation of services, and improve information sharing. In addition to integrating physical and behavioral health needs, the MCOs are required to screen all beneficiaries for unfavorable social conditions such as poor housing and food insecurity.

Other Initiatives

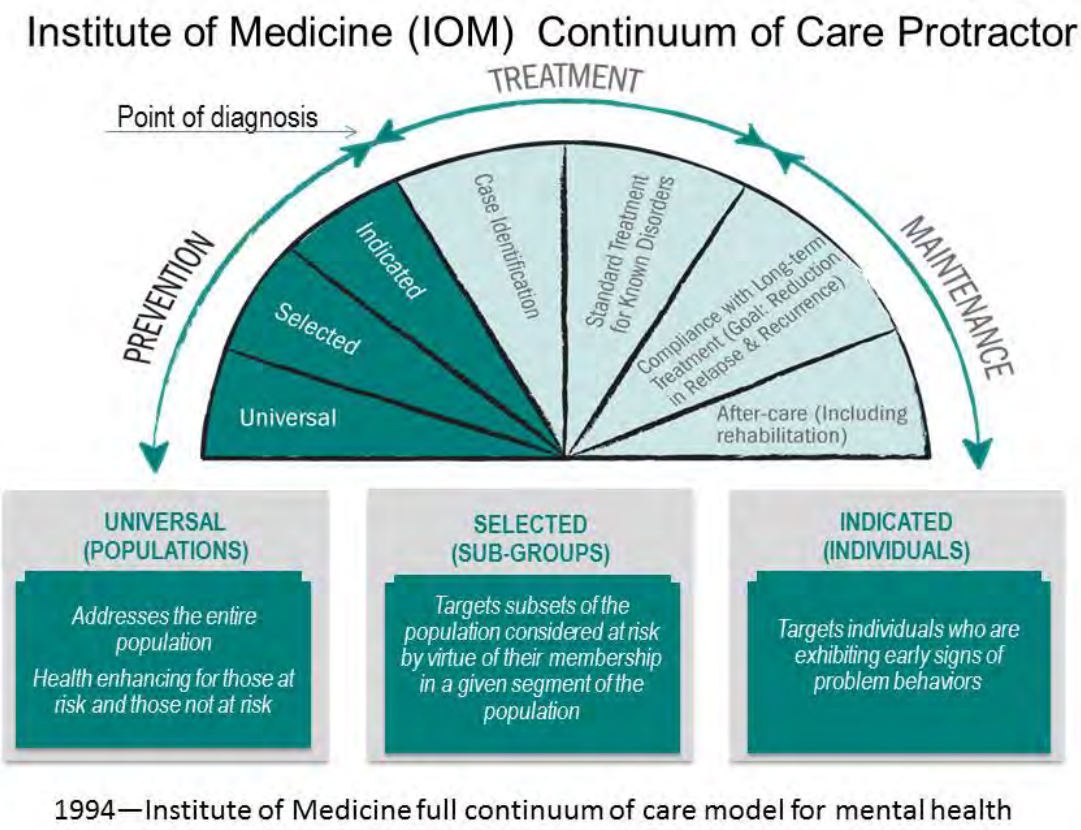
- Integration efforts can be enhanced by implementing the mental health first aid program widely across the state and using telehealth more extensively.
- Mental Health First Aid is a public education program to promote early detection and intervention of behavioral health problems. In 2015, a total of 1,026 people throughout Nebraska were trained.
- Although there are many different ways telehealth can be used, the primary use in Nebraska has been medication management. Other states such as Massachusetts, North Carolina, and South Carolina as well as the Veterans Health Administration have used telehealth extensively and demonstrated success in improving access to care, treatment outcomes, and cost saving.
- Mental Health First Aid, telehealth and other population-based initiatives are relatively new and need to be implemented in a more systematic manner. It is also critical to evaluate these initiatives over the long-term to determine their impact on health outcomes.

Relevant Public Health Concepts

Continuum of Care

Prevention is one of principles of public health which emphasizes the importance of risk reduction. In an Institute of Medicine report, a conceptual model for continuum of care which includes prevention is presented in **Figure 10.1**.[124] The prevention activities are aimed at the entire population groups or settings such as schools ("Universal"), whereas treatment is targeted toward subgroups or communities with a higher prevalence of mental health problems ("Selected") or persons with early detectable signs of mental health stress ("Indicated"). Universal interventions are offered to an entire population because their benefits outweigh the costs and risks. Selective interventions target at risk groups only (e.g., low-income groups with mental health disorders). In this case, a moderate cost is justified because the interventions will decrease the risk of illness and reduce the avoidable cost associated with treating that illness. Finally, indicated interventions are provided only to high-risk persons.[125]

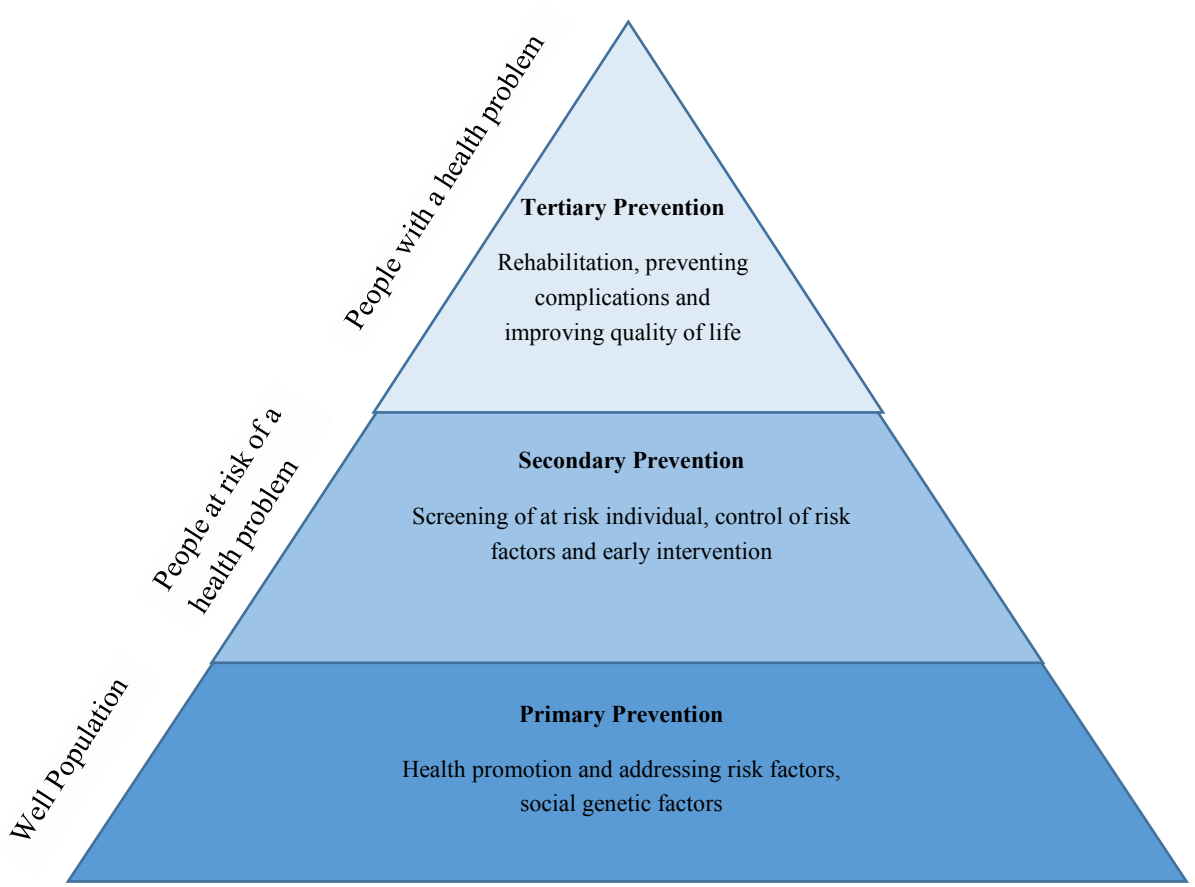
Figure 10.1: Institute of Medicine Continuum of Care Protractor[124]



Primary, Secondary and Tertiary Prevention

Figure 10.2 depicts primary, secondary and tertiary prevention approaches. Primary prevention is designed to prevent a disease or health condition from occurring in the first place. It covers people without a disease or health condition of interest. For example, immunization programs prevent people from contracting certain diseases or evidence-based bully programs in schools are considered primary prevention programs. Secondary prevention attempts to identify the disease or the condition at its earliest stage so that prompt and appropriate management can be initiated. This prevention approach is designed for people at risk for a health problem (e.g., colon cancer screening programs for all people over 50 or behavioral health assessment of refugees who were exposed to physical and psychological stress). Finally, tertiary prevention focuses on reducing consequences of the disease and maintaining a high quality of life. This approach targets people who have already developed the disease. In this case, it is important to ensure that access to care is maintained.

Figure 10.2: Primary, Secondary and Tertiary Preventions



What is Integrated Care and Why Integrated Care Now?

Premature Deaths among People with Mental Health and Substance Use Disorders

People with mental health and substance use disorders tend to die decades earlier than people without these conditions.[126] A large cohort study (N=1,138,853) found that adults with schizophrenia are 3.5 times more likely to die at an earlier age than the general population.[127] Cardiovascular disease, lung cancer, chronic obstructive pulmonary disease, influenza, and pneumonia were some of the major causes of death. Accidental deaths accounted for more than twice as many deaths as suicidal and non-suicidal substance-induced deaths, which was another leading cause of death among adults with schizophrenia. The cause of death is mostly from untreated and preventable chronic illnesses such as obesity, hypertension, diabetes, and cardiovascular disease, that are aggravated by poor health habits such as smoking, inadequate physical activity, poor nutrition, and substance use disorders.[128-131]

Barriers to primary care have been a major obstacle for early detection and treatment of chronic illnesses and lifestyle modifications. Integration of behavioral health in the primary care setting can increase access to medical care services among people with mental health and substance use disorders. Integration can also expand the use of behavioral health screening and treatment among people in the general population.

Health Care Coverage Expansion for Mental Health and Substance Use Disorder Services

The Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 and Affordable Care Act (ACA) offer opportunities to improve and integrate behavioral and medical care. MHPAEA supplements prior provisions under the Mental Health Parity Act of 1996, which required parity regarding aggregate lifetime and annual dollar limits.[132] Mental health parity refers to the notion insurance plans should provide the same or equal coverage for the treatment of mental health and substance use conditions as they do for treatments available under the more conventional medical conditions. Historically, insurance plans have covered treatment of mental health and substance use conditions differently, often "requiring a higher cost-sharing structure, more restrictive limits on the number of inpatient days and outpatient visits allowed, separate annual and lifetime caps on coverage, and different prior authorization requirements than coverage for other medical care".[133] MHPAEA requires group health plans and health insurers to ensure that financial requirements, including co-pays, deductibles, and treatment limitations (e.g., visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to medical/surgical benefits.[134] Because of MHPAEA, the benefits must be offered "on par" with medical/surgical benefits and cannot be subject to quantitative and non-quantitative limitations that are less favorable than those applied to medical services.

The Affordable Care Act (ACA) of 2010 requires that most individual and small employer health insurance plans, including all plans offered through the Health Insurance Marketplace, cover mental health and substance use disorder services.[135] The insurance plans must cover essential health benefits, which include 10 categories of benefits for mental health and substance use disorder services. In addition, rehabilitative and habilitative services that can help support people with behavioral health challenges are required to be covered. Because of the ACA, most health plans now cover preventive services such as depression screening for adults and behavioral assessment for children at no cost. As of 2014, most plans

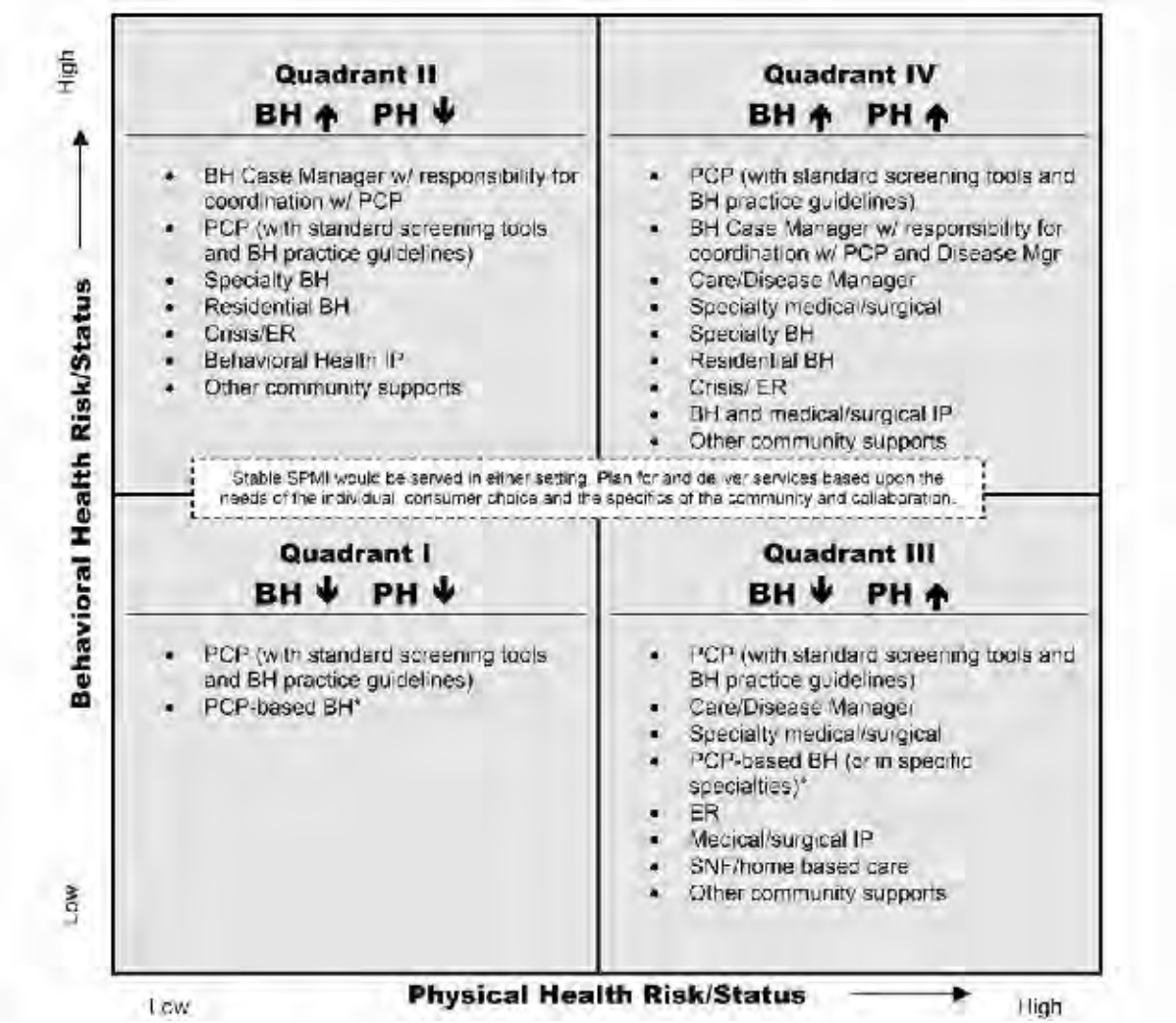
cannot deny the coverage or charge the insurance beneficiaries ~~more~~ due to pre-existing health conditions, including mental health.[135]

Definitions and Models

There are many definitions of integrated care. One broad definition of integration is "Whole person care that focuses on overall health; creates partnerships across all aspects of health; and is facilitated by a variety of clinical, structural, and financial arrangements, and community supports that remove barriers between physical and behavioral healthcare".[136] More clinically oriented definitions are offered by the Substance Abuse and Mental Health Services Administration (SAMHSA) and The Agency for Healthcare Research and Quality (AHRQ). SAMHSA defines integrated care as "the systematic coordination of general and behavioral health".[137] AHRQ's definition which was adapted by the Patient-Centered Primary Care Collaborative, is "care resulting from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population".[138]

In 2003, the National Council for Community Behavioral Healthcare issued the background paper on behavioral health/primary care integration models.[139] The Four Quadrant Clinical Integration Model shown in **Figure 10.3** provides a useful framework to understand the level of collaboration between mental health (MH), substance use (SU) disorders and primary care providers: In Quadrant I the patient has Low MH (e.g., uncomplicated mood disorders and some risky behaviors such as tobacco use), which could be treated in a primary care setting. Patients in Quadrant II have High MH (e.g., serious mental illness), Low SU, and low physical health needs. In this case, these patients would be best served by providers in the MH system who have SU competency). In Quadrant III patients have Low MH, High SU, and high physical health needs. Patients in this quadrant should be treated in the SU system by providers who have MH competency. In Quadrant IV patients with High MH and High SU should be served by a fully integrated MH/SU program.

Figure 10.3: The Four Quadrant Clinical Integration Model[139]



SAMHSA also classifies integrated care according to the level of coordination and cooperation among providers and systems. **Table 10.1** summarizes six distinct levels that are included the following three categories: Coordinated Care, Co-Located Care, and Integrated Care.[140]

Table 10.1: The Six Levels of Integrated Care (SAMHSA Standard Framework)[140]

Coordinated Care	
Level 1: Minimal Collaboration	BHPs and PCPs work in separate locations using separate systems.
	Providers communicate infrequently and usually based on the need for specific information about a specific mutual patient.
Level 2: Basic Collaboration at a Distance	BHPs and PCPs work in separate locations using separate systems.
	Providers communicate periodically about shared patients but generally behavioral health is still viewed as a separate specialty care.
Co-Located Care	
	BHPs and PCPs are co-located but may not necessarily use the same space.

Level 3: Basic Collaboration Onsite	Providers communicate regularly by phone, e-mail, and occasionally in person to discuss shared patients.
	Providers still work primarily through referrals and individual providers are independently responsible for most treatment decisions.
Level 4: Close Collaboration with Some System Integration	BHPs and PCPs collaborate closely and share the same practice space.
	Providers have an understanding of each other's roles and work together through personal communication to meet the needs of complex patients.
	Providers share some systems such as using common electronic medical records or having a single front desk schedule for both behavioral and primary care appointments.
Integrated Care	
Level 5: Close Collaboration approaching an Integrated Practice	BHPs and PCPs work closely together as a true team with frequent personal communication.
	The team actively implements system level solutions to apply integrated care for a broad range of patients.
	Some systems, such as fully accessible medical records or billing systems, may still be separate.
Level 6: Full Collaboration in a Transformed/Merged Practice	BHPs and PCPs work together seamlessly as a single transdisciplinary team.
	Both providers and patients view care as a one-stop shop treating the whole person.
	Integrated care is applied to all patients, not just those with complex needs or at a higher risk.
BHP=behavioral health provider. PCP=primary care provider.	

Once patients are categorized by quadrant, it is possible to match the patient needs and settings with the level of collaboration and integration. For example, patients that are at high risk for mental health and substance use disorders as well as multiple physical health conditions probably need at least co-located care and perhaps integrated care. Patients with highly complex conditions would ideally receive treatment in an integrated setting where there would be a common patient record and joint treatment plans. For those patients that are at low risk for complex behavioral health conditions might be best served in a coordinated primary care and mental health practices where collaboration is facilitated by a care manager. In rural areas where there are fewer resources, there may be a great reliance on care managers and telehealth services.

Why Integrated Primary Care?

In the past, behavioral health and physical health services have usually been provided by multiple providers in separate settings with little coordination. However, this lack of coordination and integration has led to poor health outcomes, particularly for those persons and families that have difficulty accessing care. There are also many other reasons why it is important to consider integrating behavioral health and primary care services, including:

- Primary care clinics are often the gateway to recognition and treatment of mental health and substance use disorders.
- Most people turn to primary care providers, not specialty mental health providers, with their emotional problems.

- Offering behavioral health services in nontraditional settings encourages people wanting to avoid the stigma surrounding mental health to seek help.
- Patients may be more likely to follow up on treatment if the service is given in house rather than referred out to mental health specialty clinics.
- Patients like the convenience of "one-stop" shopping at a primary care clinic.
- Integrated care produces significant positive results, including decreases in depression levels, improvement in quality of life, decreased stress, and lower rates of psychiatric hospitalization.
- Integrated care may lead to a reduction of inappropriate use of medical services and save costs in emergency room visits and hospitalizations.
- The primary care network serves minority populations and culturally diverse communities.
- Integrated care can reduce racial disparities in mental health access and utilization.
- Incorporating primary care providers into behavioral health services may help increase access for Hispanic patients partly because of its beneficial effects on reducing the high levels of mental health stigma among Latinos.

From Medical Homes to Health Homes

There are several new health delivery models which have the potential of improving the coordination of behavioral health and medical care as well as placing a greater focus on prevention. For example, a medical home model, which is also known as a person-centered medical home or patient-centered medical home (PCMH), is a care model that involves the coordinated care of an individual's overall health care needs.[141] A health home model is similar to a PCMH, but its main focus is to offer coordinated care to persons with two or more chronic health conditions, including mental health and substance use disorders. Health home providers are required to operate under a "whole-person" philosophy by integrating and coordinating all primary, acute, behavioral health, and long-term services to support and treat the whole person. Another important aspect of health homes is the central role provided by case managers.[141] The health home develops linkages to community programs and resources, as well as improves coordination and integration of primary and behavioral health care. Health homes were created under Section 2703 of the ACA as an optional Medicaid State Plan benefit for states to establish and coordinate care for Medicaid beneficiaries with chronic conditions.[142] Thus far, the Nebraska Medicaid program has not established a health home model although 19 other states, including Kansas, Iowa, and Missouri have implemented this.

Barriers to Integrated Care

Bachrach, et al., reviewed the literature and interviewed consumers, providers, payers, and policymakers to identify challenges faced by different states in the implementation of integrated physical and behavioral health services.[143] These challenges are summarized under administrative, purchasing, regulatory, and information technology.

Administrative Issues

- In most states, the responsibility for Medicaid physical health, mental health, and substance use disorder services is vested across two or more separate agencies. The fragmented administration

may lead to misaligned purchasing strategies and conflicting and redundant regulation of physical and behavioral health providers.

- It is extremely challenging to consolidate physical and behavioral health services within one agency. Thus, it is a common practice for states to consolidate behavioral health purchasing, contracting, and rate-setting in a single Medicaid agency and retain licensing and clinical policy in separate behavioral health agencies.

Purchasing Issues

- While Medicaid-managed care is the preferred delivery model in most states, few states offer integrated benefits in managed care. Most states carve out or create separate reimbursement streaming for some behavioral health services. These carve-out arrangements create barriers to care coordination and information-sharing.

Regulatory Issues

- State regulations governing licensure and certification, billing, and health information exchange can prevent the efficient delivery of integrated care. Often, the regulations on physical and behavioral services vested across different agencies are redundant and lack cohesiveness.
- Nontraditional providers such as community health workers and peer counselors increasingly play a role in integrated care models. There is need for licensing rules and credentialing programs for these professionals.

Information Technology Issues

- The rate of information technology adoption has been slow among behavioral health providers.
- State and federal constraints on sharing behavioral health data can hinder integrated care delivery.

Nebraska appears to have overcome some of these barriers. For example, the Division of Medicaid and Long term Care has recently signed contracts with three managed care organizations (MCOs). Beginning on January 1, 2017, the MCOs will receive a single capitated per member per month fee to address both the behavioral and physical health needs of Medicaid beneficiaries. In the past, one MCO was responsible for meeting the behavioral health needs of the beneficiaries and a separate MCOs was responsible to treat the physical health needs. This change has the potential to enhance care coordination, reduce the fragmentation of services, and improve information sharing. In addition to integrating physical and behavioral health needs, the MCOs are required to screen all beneficiaries for unfavorable social conditions such as poor housing and food insecurity.

However, Nebraska still faces some major challenges in integrating behavioral health and primary care services. For example, the ability to share information between practices is limited. While the number of community health workers and peer specialists is expanding across the state, their roles and responsibilities may vary considerably across the state. Of course, these and other issues are magnified by the shortages of health professional throughout the state.

Integrated Primary Care in Nebraska

Health Profession Survey Results

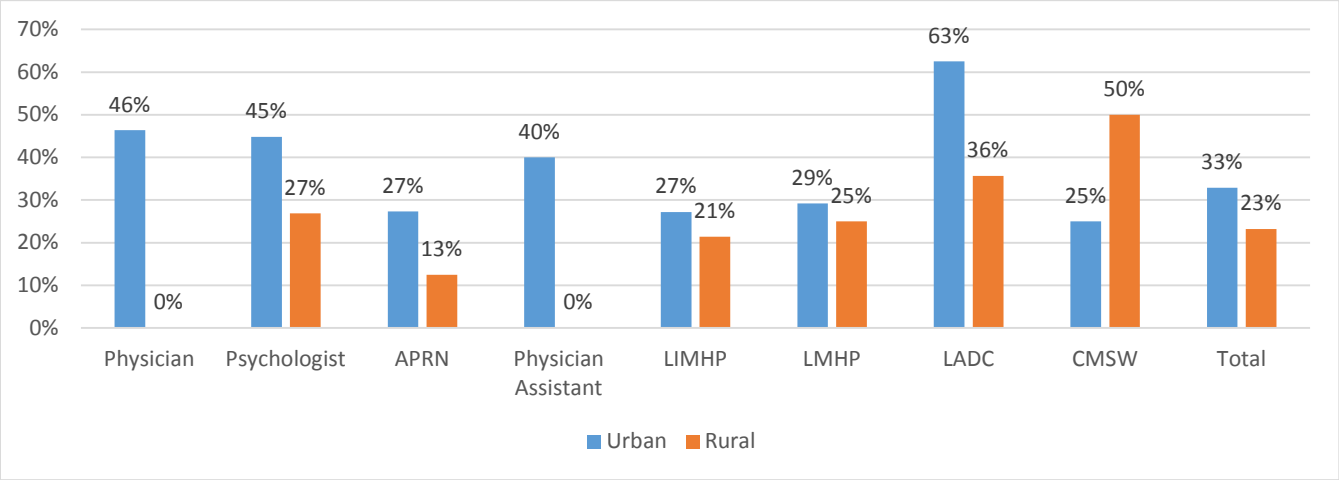
Due to the wide range of different models and definitions of integrated care, it is difficult to measure the level of integrated primary care implementation in Nebraska. One method of measuring integration is to examine the number and proportion of behavioral health providers who practice in integrated care settings. For this reason, the Health Profession Tracking Service (HPTS) expanded their 2016 survey by asking behavioral health providers in the state whether they were currently practicing in an integrated care setting, if they were interested in working in an integrated care setting, and if they perceived barriers to integrated care in the state. The behavioral health professionals included in the study were: (1) psychiatrists, (2) advanced practice registered nurses (APRNs) practicing psychiatry, (3) physician assistants (PAs) practicing psychiatry, (4) psychologists, (5) licensed independent mental health practitioners (LIMHPs), (6) licensed mental health practitioners (LMHPs) and (7) licensed alcohol and drug counselors (LADCs). The surveys were pre-populated with data previously entered into the HPTS database.[144]

Table 10.2 and **Figure 10.4** show the percentages of behavioral health providers who are practicing integrated care in Nebraska. Overall, 33% of urban and 23% of rural behavioral health providers who responded to this question indicated that they were practicing integrated care. Within urban areas, the practice of integrated care was most common among LADCs (63%), physicians (46%), and psychologists (45%). In rural areas, the practice was most common among Certified Master Social Workers (CMSWs) (50%), LADCs (36%), and psychologists (27%).

Table 10.2: Percentage of Behavioral Health Providers Practicing Integrated Care in Nebraska[144]

	Urban (n=596)	Rural (n=228)	Total (N=824)
ALL	32.9%	23.2%	30.2%
Physician	46.4%	0.0%	39.4%
Psychologist	44.8%	26.9%	41.2%
APRN	27.3%	12.5%	23.3%
Physician Assistant	40.0%	0.0%	28.6%
LIMHP	27.2%	21.4%	25.4%
LMHP	29.2%	25.0%	28.1%
LADC	62.5%	35.7%	50.0%
CMSW	25.0%	50.0%	33.3%
Response among providers currently practicing integrated care.			

Figure 10.4: Percentage of Behavioral Health Providers Practicing Integrated Care in Nebraska[144]



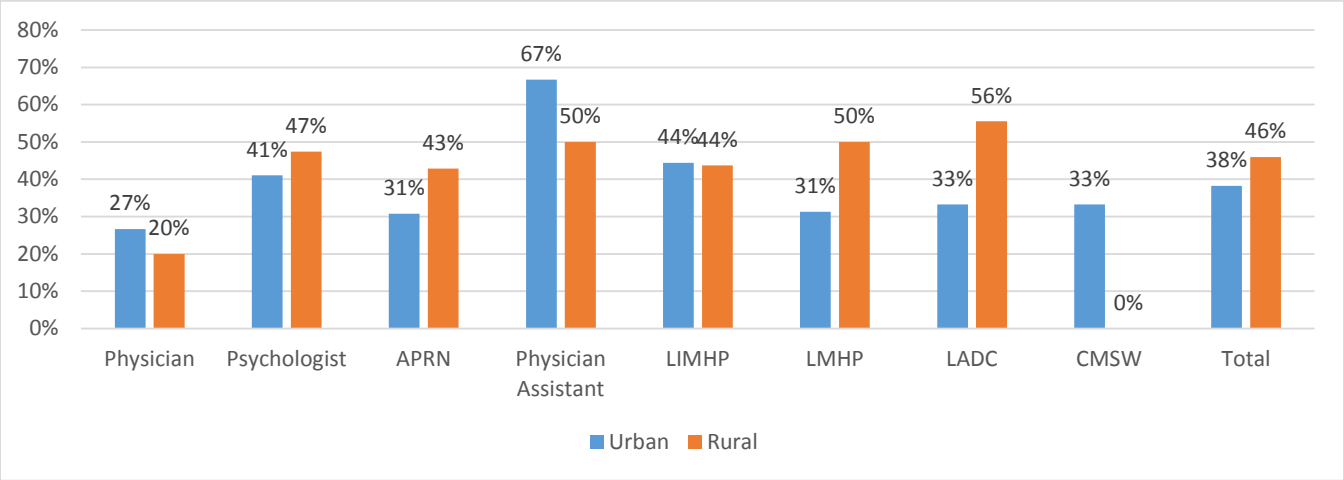
Response among providers currently practicing integrated care.

Table 10.3 and **Figure 10.5** show the percentages of behavioral health providers who were not practicing integrated care but were interested in practicing. Overall, 38% of urban and 46% of rural providers indicated they were interested in integrated care. Within urban areas, the highest level of interest was reported by physician assistants (67%), LIMHPs (44%), and psychologists (41%). Within rural areas, LADCs (56%), LMHPs (50%) and PAs (50%) indicated the highest level of interest.[144]

Table 10.3: Percentage of Behavioral Health Providers in Nebraska Interested in Integrated Care[144]

	Urban (n=380)	Rural (n=163)	Total (N=543)
ALL	38.2%	46.0%	40.5%
Physician	26.7%	20.0%	25.0%
Psychologist	41.1%	47.4%	42.7%
APRN	30.8%	42.9%	35.0%
Physician Assistant	66.7%	50.0%	60.0%
LIMHP	44.4%	43.7%	44.2%
LMHP	31.3%	50.0%	36.5%
LADC	33.3%	55.6%	46.7%
CMSW	33.3%	0%	33.3%
Response among providers not currently practicing integrated care.			

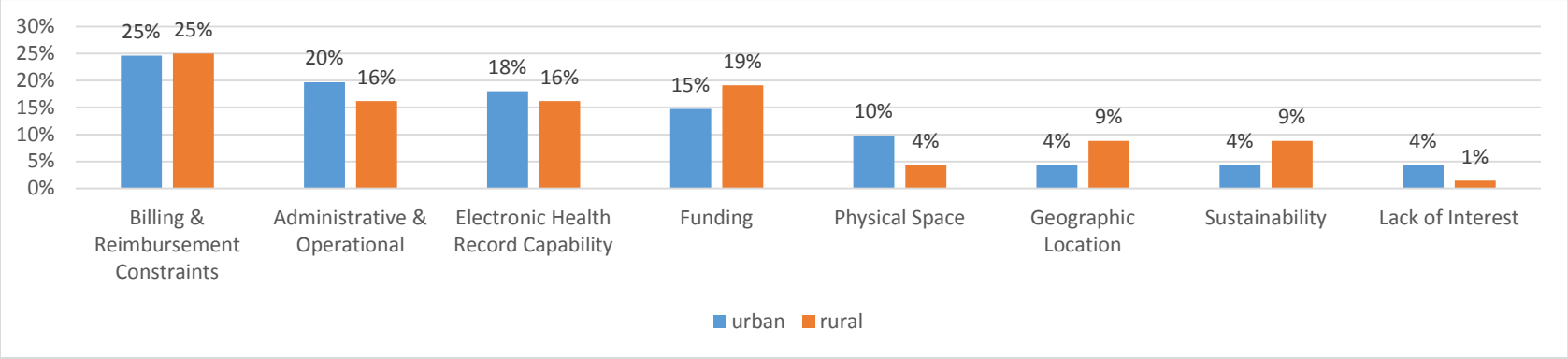
Figure 10.5: Percentage of Behavioral Health Providers in Nebraska Interested in Integrated Care[144]



Response among providers not currently practicing integrated care.

Figure 10.6 shows the most common barriers that were identified by urban and rural behavioral health providers were "Billing & Reimbursement Constraints," "Administrative & Operational," "Electronic Health Record Capability" and "Funding". **Table 10.4** shows the ranking of perceived barriers by profession. Overall, billing and reimbursement was ranked as the barrier at 25%, followed by administration and operations at 19%, electronic health record capability at 18%, funding at 16%, physical space at 8%, geographic location at 6%, lack of interest at 4%, and sustainability at 4%. Half of CMSWs and 43% of APRNs indicated billing and reimbursement constraint as a barrier to integrated care. Half of the physician assistants ranked administration and operations as a barrier. Lack of an electronic health record capability was reported as a barrier by 50% of PAs and CMSWs and 43% of APRNs.[144]

Figure. 10.6: Barriers to Integration Reported by Behavioral Health Providers in Nebraska: Urban vs. Rural[144]



Response among providers currently practicing integrated care.

Table 10.4: Ranking of Barriers to Integration Reported by Behavioral Health Providers in Nebraska by Professional Type[144]

Profession	1	2	3	4	5	6	7	8
ALL	Billing & Reimb (25%)	Adm & Operat (19%)	EHR Capability (18%)	Funding (16%)	Physical Space (8%)	Geographic Location (6%)	Lack of Interest (4%)	Susta6nability (4%)
Physician	EHR Capability (23%)	Physical Space (15%)	Billing & Reimb (8%)	Funding (8%)	Geographic Location (8%)	Lack of Interest (8%)	--	--
Psychologist	Billing & Reimb (30%)	Adm & Operat (24%)	EHR Capability (19%)	Physical Space (15%)	Funding (11%)	Geographic Location (6%)	Lack of Interest (4%)	Sustainability (4%)
APRN	Billing & Reimb (43%)	EHR Capability (43%)	Adm & Operat (29%)	Physical Space (29%)	Funding (14%)	Geographic Location (14%)	Sustainabilit y (14%)	--
Physician Assistant	Adm & Operat (50%)	EHR Capability (50%)	--	--	--	--	--	--
LIMHP	Billing & Reimb (22%)	Adm & Operat (17%)	Funding (17%)	EHR Capability (16%)	Geographic Location (5%)	Physical Space (5%)	Lack of Interest (4%)	Sustainability (8%)
LMHP	Billing & Reimb (30%)	Funding (22%)	Adm & Operat (21%)	EHR Capability (15%)	Physical Space (5%)	Geographic Location (4%)	Lack of Interest (3%)	Sustainability (5%)
LADC	Adm & Operat (13%)	EHR Capability (13%)	Geographic Location (13%)	Billing & Reimb (7%)	Funding (7%)	Lack of Interest (7%)	Physical Space (7%)	--
CMSW	Billing & Reimb (50%)	EHR Capability (50%)	Funding (50%)	--	--	--	--	--

Multiple responses were allowed for this question about the barrier.

Mental Health First Aid

What is Mental Health First Aid?

In 2008, Mental Health First Aid was introduced in the U.S. by the National Council for Behavioral Health. Mental Health First Aid is a public education program to promote early detection and intervention.[145] It is an 8-hour course that educates participants about risk factors and warning signs of mental health problems, builds understanding of their impact, and provides an overview of resources that are available to treat mental illness. The course uses a 5-step action plan to help a person in crisis connect with professional, peer, social, and self-help care. Mental Health First Aid is appropriate for a variety of professionals and can help those who regularly engage with persons who may experience mental health challenges.[146]

Mental Health First Aid can be adapted to different audiences. In rural communities which suffer chronic shortages of behavioral health providers, this program may help to increase mental health literacy among key community members.[146] Mental Health First Aid materials have also been designed to be used by bilingual and bicultural instructors to train the Spanish-speaking population.[146]

Nebraska Mental Health First Aid Training

In 2014, new legislation (LB 931) created the Nebraska Mental Health First Aid Training Act.[147] According to the 2015 Status Report, a total of 1,026 people were trained.[148] About 25% of the trainees were associated with schools, universities, or colleges (**Table 10.5**). About 47% of the communities participated in the training were from non-metro areas. As shown in **Table 10.6**, the participants rated the program very high across the state.[148] For example, the statewide evaluation question averages ranged from a low of 96.1% to 98.0% (**Table 10.6**).

Table 10.5: Nebraska Mental Health First Aid Training Participant Characteristics[148]

	Trainee Demographics	Reg 1 (N=47)*	Reg 2 (N=101)*	Reg 3 (N=146)*	Reg 4 (N=51)*	Reg 5 (N=256)*	Reg 6 (N=425)*	State Average (N=1,026)*
Trainee Agency Type	School/University/College	6.4%	15.4%	87.5%	0.0%	8.5%	20.0%	25.1%
	State Department of Education	0.0%	0.0%	0.0%	0.0%	0.6%	0.7%	0.4%
	Department of Veterans' Affairs	0.0%	0.0%	0.0%	0.0%	0.0%	0.5%	0.2%
	Law Enforcement	4.3%	24.2%	0.0%	0.0%	11.9%	8.8%	8.5%
	Local Health Department	21.3%	9.9%	4.2%	0.0%	1.1%	2.6%	3.9%
	Other	68.1%	50.5%	8.3%	100.0%	78.0%	67.5%	61.9%
Community Type	Metro (Omaha, Lincoln, Grand Island)	0.0%	0.0%	2.8%	0.0%	98.9%	79.4%	53.3%
	Non-metro (All Other NE Areas)	100.0%	100.0%	97.2%	100.0%	1.1%	20.6%	46.7%
Gender	Male	18.2%	18.9%	12.7%	19.6%	36.6%	18.3%	22.1%
	Female	81.8%	81.1%	87.3%	80.4%	63.4%	81.7%	77.9%
Race/Ethnicity	American Indian/Alaskan Native	4.3%	1.0%	2.2%	0.0%	2.3%	2.1%	2.1%
	Asian	0.0%	0.0%	2.2%	0.0%	2.0%	1.4%	1.4%
	Black or African American	0.0%	1.0%	2.2%	0.0%	3.1%	9.6%	5.2%
	Hispanic or Latino Origin	8.5%	6.9%	12.3%	3.9%	3.1%	9.6%	7.8%
	Native Hawaiian or Other Pacific Islander	2.1%	1.0%	0.7%	0.0%	0.4%	0.0%	0.4%
	Caucasian or White	80.9%	83.2%	79.7%	88.2%	80.5%	72.2%	77.6%
	Other/Missing	4.2%	6.9%	0.7%	7.9%	8.6%	5.1%	5.5%
Age	Less Than 16	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	16-24	7.0%	7.4%	69.9%	10.2%	7.8%	9.0%	16.8%
	25-44	46.5%	42.1%	18.0%	57.1%	46.5%	52.2%	45.1%
	45-60	41.9%	36.8%	9.8%	26.5%	30.0%	29.1%	27.9%
	61-80	4.7%	13.7%	2.3%	6.1%	13.6%	9.7%	9.6%
	81 and Older	0.0%	0.0%	0.0%	0.0%	2.1%	0.0%	0.5%
Household Income	Less than $24,999	8.5%	13.3%	38.4%	18.1%	20.4%	12.7%	17.6%
	$25,000 to $49,999	38.3%	32.2%	34.8%	43.4%	29.3%	35.1%	34.6%
	$50,000 to $99,999	44.7%	38.9%	21.4%	28.9%	42.5%	35.8%	35.4%
	$100,000 to $149,999	8.5%	8.9%	1.8%	9.6%	6.0%	11.1%	8.5%
	$150,000 to $199,999	0.0%	3.3%	3.6%	0.0%	1.8%	3.8%	2.8%
	$200,000 or more	0.0%	3.3%	0.0%	0.0%	0.0%	1.4%	1.0%

*The (N=) in the Region heading rows represents the total number of persons who attended trainings in each Region and the aggregated count for the Statewide total. Some questions were not answered by all respondents, so valid percentages have been reported

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Table 10.6: Nebraska Mental Health First Aid Training Participant Evaluation[148]

"As a result of this training, I feel more confident that I can…"

Evaluation Outcomes	Regi 1 (N=47)*	Reg 2 (N=101)*	Reg 3 (N=146)*	Reg 4 (N=51)*	Reg 5 (N=256)*	Reg 6 (N=425)*	State Average (N=1,026)*
Recognize the signs that someone may be dealing with a mental health problem or crisis.	97.9%	96.0%	100.0%	92.0%	96.8%	99.3%	98.0%
Reach out to someone who may be dealing with a mental health problem or crisis.	100.0%	96.0%	100.0%	92.0%	95.6%	98.6%	97.5%
Ask a person whether s/he is considering killing her/himself.	97.8%	97.0%	98.6%	90.0%	95.5%	95.9%	96.1%
Actively and compassionately listen to someone in distress.	100.0%	98.0%	99.3%	92.0%	96.7%	98.8%	98.0%
Offer a distressed person basic "first aid" level information and reassurance about mental health problems.	97.8%	98.0%	98.5%	90.0%	96.8%	98.1%	97.4%
Assist a person who may be dealing with a mental health problem or crisis to seek professional help.	100.0%	95.0%	99.3%	92.0%	97.2%	98.1%	97.5%
Assist a person who may be dealing with a mental health problem or crisis to connect with community, peer, and personal supports.	97.8%	96.0%	99.3%	92.0%	96.8%	97.6%	97.2%
Be aware of my own views and feelings about mental health problems and disorders.	100.0%	95.0%	98.5%	92.0%	96.3%	97.1%	96.8%
Recognize and correct misconceptions about mental health and mental illness as I encounter them.	100.0%	97.0%	99.3%	92.0%	96.8%	97.6%	97.3%

*The (N=) in the Region heading rows represents the total number of persons who attended trainings in each Region and the aggregated count for the Statewide total. Some questions were not answered by all respondents, so valid percentages have been reported

Telehealth for Behavioral Health Care

Even with the implementation of the Mental Health Parity and Addiction Equity Act of 2008 and the Affordable Care Act of 2010, the coverage and cost of mental health care remain a challenging issue. Given the gaps in access to, and provision of, mental health services, telemedicine is considered as a viable alternative to help bridge the existing care gap. As described in Chapter 4 "Behavioral Health Problems in the General Population" there is a large proportion of people with mental health and substance use disorders who are not accessing treatment in the U.S. and Nebraska. Also, as described in Chapter 9 "Behavioral Health Workforce," there is a huge maldistribution of behavioral health professionals resulting in a serious shortage of psychiatrists, licensed alcohol and addiction counselors, and other behavioral health specialists in rural areas. Stigma and financial cost are also associated with mental health and substance use disorders and discourage people from seeking needed help.

One of the first documented uses of telemedicine for behavioral health care was in Nebraska. In 1955, Nebraska psychiatrists used closed-circuit television to provide consults.[149] In 2013, 52% of hospitals were using telehealth and another 10% were beginning the process of implementing it.[150] Consumer interest, acceptance, and confidence in telemedicine has also been growing. About 74% of U.S. consumers stated they would use telehealth services and 70% of patients are comfortable communicating with their health care providers via text, e-mail, or video.[151, 152] More recently, the number of states have passed telemedicine parity laws that require private insurers to cover telemedicine-provided services that are comparable to in-person services.[153] Medicaid agencies are promoting the use of telemedicine in their payment and delivery reforms to increase the coverage for telemedicine-provided services.[154]

What is Telebehavioral Health?

Telehealth is the broad term for health care at a distance. Telehealth has also been called telemedicine, e-health, m-health (mobile health), connected health, and health telematics.[155] Telehealth utilizes electronic information and telecommunications technologies to bring patients and health professionals together for clinical care, education, public health, health administration, administrative meetings, provider training, and continuing medical education. Technologies include videoconferencing, the internet, electronic health records, store-and-forward imaging, streaming media, and terrestrial and wireless communications.[156]

Essentially, telehealth uses technology to reduce geographical and transportation barriers to health care and health education.[155] Telehealth can be especially valuable for patients who live in rural areas, where there may be limited access to board-certified specialists. These patients may have to travel a great distance to reach a medical facility to visit specialist. Utilizing telehealth services can save both time and money without reducing the quality of care. In addition, telehealth can be helpful for those who simply lack adequate transportation to visit the doctor's office, either in a rural or an urban setting.[157]

The area of telehealth specific to behavioral health has often been called telemental health, telebehavioral health, e-counseling, e-therapy, online therapy, cybercounseling, or online counseling. This often involves mental health and substance use disorder services provided from a distance, usually utilizing real-time videoconferencing sessions.[158]

Benefits of Telebehavioral Health

A report from SAMHSA described benefits of telebehavioral health as shown in **Table 10.7**.[159]

Table 10.7: Benefits of Telebehavioral Health[159]

Improved care delivery	• The Patient Centered Medical Home model of care recognizes the value of care coordination supported by technology. • Telebehavioral health can encourage collaborative and integrated approaches by strengthening relationships within teams and across agencies. • Technology can also provide clinicians with ready access to patient health data.
Expanded staff capacity	• Telehealth can give providers more mobility to deliver health care in different venues. • Telehealth can be used to tap into staff working part-time for multiple locations.
Cost savings	• Telehealth can reduce the cost of care delivery. • Patient relapse events may be lowered if telehealth enables a provider to deliver services quickly. • Telehealth can save on travel time for both patients and providers.

Coverage and Payment

Coverage for telehealth services and adequate reimbursement for hospitals and other health care providers for telehealth services varies greatly by state.[158] Many states have developed "parity" laws, which require health insurers to cover and pay for telehealth services the same way they would for the same services provided in-person.[158] Other states have adopted partial parity laws, which require coverage of and reimbursement for telehealth services; however certain technology, provider, or geographic restrictions may exist.[158] Some states including Nebraska do not have parity laws for telehealth coverage and reimbursement.

Over the past four years, the number of states that have developed parity laws has doubled.[154] To date, 29 states have adopted telehealth parity laws for private insurance. Twenty-two of these states (and D.C.) have parity laws authorizing state-wide coverage of telehealth services, without any provider or technology restrictions. In addition, Nebraska and 47 other state Medicaid programs have some form of coverage for telehealth services. Medicaid telehealth coverage in Nebraska includes store-and-forward, remote patient monitoring, home health services, occupational therapy, physical therapy, speech and audiology, podiatry and optometric services. Nebraska also requires coverage of autism treatment via telehealth in private insurance and state-employee plans.[154]

For mental health and substance use disorder services, mental health assessments, individual therapy, psychiatric diagnostic interview exams, and medication management are generally the most covered telehealth services between states.[154] Forty-eight states, including Nebraska, have some form of coverage and reimbursement for mental health services provided via videoconferencing.

Challenges with Provision of Telebehavioral Health

Although telebehavioral health holds considerable promise, there are a number of obstacles.[160]

Concerns from Providers

- It is sometimes more difficult to establish rapport and build good relationships with patients which in turn makes it more challenging for patients to comply with treatment plans.
- It may affect their clinical workflow processes.
- It may require the adoption of new procedures which may distract the current practice.
- It can be costly for providers in small clinics.

Legal and Regulatory Issues

- As practicing physicians, psychiatrists must comply with all of the obligations that apply to physicians practicing telehealth.
- In Delaware, a provider practicing telepsychology must conduct a risk-benefit analysis and document the findings. For example, the risk-benefit analysis must assess whether a patient's presenting problems and conditions are consistent with the use of telepsychology to the patient's benefit.
- In South Dakota, marriage and family therapists are required to evaluate whether electronic therapy is appropriate for persons and inform them of the potential risks and benefits with electronic therapy.

Examples of Telebehavioral Health from Other States

The Veterans Health Administration (VHA) has a long history of using telemental health. In 2010, the VHA established a National Treatment Center and by 2013, the VHA delivered close to 280,000 patient encounters to more than 91,000 patients from 150 VA Medical Centers and 729 community based outpatient clinics. In addition, in 2013, chronic disease management services were provided via telehealth to support over 7,000 patients with chronic mental health conditions at home.[160]

One of the most-studied models of telepsychiatry is the Massachusetts Child Psychiatry Access Project (MCPAP). Initially piloted as the Targeted Child Psychiatric Services program, MCPAP is intended to provide easy collaboration between primary care providers (PCPs) and child psychiatrists and to strengthen the ability of PCPs to address behavioral health needs. MCPAP provides real-time telephone consultation from 8 a.m. to 5 p.m. Monday-Friday to pediatricians in Massachusetts. The PCPs call into a central phone number and receive a call back consultation from a participating psychiatric provider within an hour. For more complex cases, patients can be referred for a direct evaluation by the psychiatric providers.[161-163] According to the National Network of Child Psychiatry Access Programs (NNCPAP), similar child psychiatry access programs have been implemented in 28 states and Washington D.C.

Across North Carolina, 28 counties do not have a psychiatrist, leading many people to seek treatment in their local hospital emergency department (ED). As a result, a statewide telepsychiatry system was launched in January 2014 and was administered by East Carolina University's Center for Telepsychiatry

and e-Behavioral Health. This was modeled after South Carolina's telepsychiatry system, which decreased ED wait times from 48-72 hours to less than 6 hours in only 3 years. It also contained costs by reducing the number of people admitted to state institutions from hospital EDs. So far, the telepsychiatry system in North Carolina is showing similar results. Patients spend less time waiting in hospital EDs and have a lower likelihood of returning to the emergency room for treatment. They are also finding fewer involuntary commitments to state psychiatric hospitals and higher satisfaction for inpatients using telepsychiatry.[158]

Nearby, the South Carolina Hospital Association and the South Carolina Department of Mental Health established a statewide telepsychiatry network that allows patients, emergency department physicians, and psychiatrists to communicate via video-based wireless communications. The program has resulted in an estimated cost savings of nearly 30 million dollars.[154]

Another potential application of behavioral telehealth is in the criminal justice system. A meta-analysis of studies looking at the use of telepsychology among justice-involved adult clients found that telehealth was at least comparable to in-person outcomes.[164] Others have highlighted the usefulness of telepsychiatry in juvenile justice settings.[165]

Telebehavioral Health in Different Regions of Nebraska

Region 1

Telehealth has been conducted by the following providers including: the Panhandle Health Group, NEPSA, WCHR, and Cirrus House.

Region 2

Region 2 Behavioral Health Services employs one APRN and two therapists who work from Lincoln to provide services through telehealth. The APRN sees clients in Ogallala, McCook, Lexington and North Platte. One therapist sees clients in North Platte and the other sees clients in Ogallala. All of them work in the Heartland Clinics in those communities which are administered by the Region.

Region 3

Region 3 Behavioral Health Services contracts with medication management providers who use telehealth services. Richard Young Behavioral Health in Kearney has a psychiatrist and APRNs who are onsite. Richard Young offers medication management through telehealth to inmates at the Buffalo County Jail in Kearney. Encounter Telehealth uses telehealth for all of its medication management services.

Region 4

Region 4 Behavioral Health provides medication management services at the following sites: Heartland Counseling (South Sioux City and O'Neill), Behavioral Health Specialist (Norfolk), and Rainbow Center (Columbus). In addition to the medication management, the following sites utilize telehealth for therapy and other services: Heartland Counseling (South Sioux City and O'Neill) and Oasis Counseling (Norfolk).

Region 5

Region 5 Behavioral Health Services has one provider, Blue Valley Behavioral Health, which consistently uses web-based telehealth in its rural offices. It was estimated that 40% of the medication management services are conducted through telehealth and approximately 10-15% of their outpatient mental health and substance use services are conducted via telehealth. In order to expedite response times to law enforcement, the Region's crisis response team is also in the process of implementing telehealth between Mary Lanning, an acute/subacute provider, and the Lancaster County Mental Health Board.

Region 6

Telehealth is implemented by many providers, including CHI and Telecare Corp.

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