



# **Nebraska Justice Mental Health Initiative**

## **Needs Assessment**

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UNIVERSITY OF  
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## EXECUTIVE SUMMARY

- It is estimated that 40,168 individuals in Nebraska have a serious mental illness and are below 200% of the poverty level; this is the population likely to require publicly funded mental health services. Of these individuals, 6,958 or about 18%, fall between the ages of 18-24.
- Older adolescents and young adults are disproportionately represented in the justice population. For example, 56% of individuals on probation are ages 16-29.
- Nebraska has 80 jails and juvenile detention facilities with capacity for 4,599 inmates. There is no information regarding how many of these inmates have mental health disorders.
- Of inmates at state correctional facilities, 31.4% have a mental health diagnosis and 87.7% have a substance abuse diagnosis. The proportion of state inmates with mental health diagnoses is substantially higher than national rates (16-18%).
- Challenges in serving individuals with mental health problems in justice settings include the following:
  - Law enforcement officers and others (e.g., jail personnel, probation officers often do not have the skills to work effectively with individuals with behavioral health disorders.
  - Mental health providers often do not have the skills to effectively address the needs of justice involved individuals
  - Mental health services are not always coordinated with justice
  - Diversion services are not available in many parts of the state
  - Local jails have difficulty identifying the behavioral health needs of inmates and there currently is no standardized assessment process.
  - Local jails often send persons with mental health disorders to state correctional facilities as “safekeepers” (1365 over the last eight years). Annual cost to serve safekeepers is estimated at \$1.32 million, not including medical costs.
  - A subpopulation of individuals tends to cycle through correctional and psychiatric facilities. These consumers have higher prevalence of severe mental illness, substance related disorders, and personality disorders.
  - It is estimated that 20% of individuals with mental health disorders released from prison are homeless
- Solutions recommended by work teams include the following:
  - Develop collaborative partnerships for interagency coordination and communication to implement system improvements for persons with persons with mental illness in the criminal justice system
  - Provide mental health training including CIT for law enforcement, probation, parole, jail personnel, and community corrections staff
  - Improve access to crisis stabilization services and other mental health services with improved coordination with law enforcement
  - Implement standardized behavioral health screening in jails
  - Dedicate resources to community mental health for diversion services
  - Enhance affordable supportive housing for justice involved youth transitioning to adulthood

# **NEBRASKA'S JUSTICE MENTAL HEALTH PROJECT**

## **NEEDS ASSESSMENT**

The purpose of Nebraska's Justice Mental Health Project is to build collaborative partnerships to address interagency coordination and communication in order to implement system improvements for persons with mental illness in the Nebraska criminal justice system. Nebraska envisions a comprehensive approach to screening, assessing, and treating the mental health needs of individuals involved in the juvenile and criminal justice systems. To work toward this system, the project has undertaken a needs assessment to identify strengths and challenges in the identification and treatment of justice involved persons with mental health and substance abuse needs. This report summarizes the need from three sources: 1) statistical information primarily from state agencies, 2) documentation of current successful programs in Nebraska, and 3) needs identified through working groups of the Justice Mental Health Initiative.

### **Nebraska Population Demographics**

Nebraska has a population of about 1.7 million, and almost half (811,425) live in six metropolitan counties. The balance of the population is scattered across the state in 87 other micropolitan, rural and frontier counties. Nebraska is diverse geographically and demographically. As one of the nation's refugee resettlement states, Nebraska is experiencing an increase in Sudanese and Somali refugees. Additionally, Nebraska has one of the highest growth rates of Hispanic/Latino populations. Nebraska is also home to four federally recognized Native American Tribes. Between the 1990 and 2000 censuses, the overall percentage of Whites declined from 94% to 90% while the number of

Hispanic/Latinos increased 255% to 5.5% of the total population. Each race and culture brings uniqueness and varying perspectives on mental health and justice issues.

Low socioeconomic status is a critical barrier to financial accessibility. Approximately 900,000 individuals in Nebraska (53% of the State's population of 1.7 million) are considered poor, falling 300% under the national poverty level (Holzer & Press, 2001). According to recent data, seven of the nation's 12 poorest counties were in Nebraska (citation?). Racial minority populations are especially impacted. For instance, according to the 2000 Census, Native Americans have the highest rate of poverty at 33% followed by African Americans at 27.4%, Hispanics at 21.4%, and Whites at 9.9%.

### **Justice Involved Individuals and Issues of Behavioral Health**

It is estimated that 40,168 individuals in Nebraska have a serious mental illness and are below 200% of the poverty level (WICHE, 2007); this is the population likely to require publicly funded mental health services. Of these individuals, 6,958 or about 18%, fall between the ages of 18-24 – the target population for this project. Service utilization data indicate this age group is underserved in comparison to other age groups (44% compared to 65% for all age groups (WICHE 2001). In addition, older adolescents and young adults are over represented in the justice system. For example, 56% of individuals on probation in Nebraska (10,483 of 18,563) are ages 16-29.

According to the Nebraska Crime Commission, Nebraska jails and juvenile detention facilities have the capacity to house approximately 4,599 offenders. Statewide the jail and juvenile detention centers are about 80% full or housing approximately 3,679 individuals. There is no information currently available regarding the numbers of jail inmates who have behavioral health disorders. Data collected by the Nebraska

Department of Correctional Services (DCS) between July 1, 2006 and June 30, 2007, reveal that 31.4% of inmates who completed evaluations at intake had a DSM IV mental health diagnosis and 87.7% had a substance abuse diagnosis. As of June 2006, 19.7% (858 inmates) of Nebraska's total inmate population was prescribed psychiatric medication. Among the adult correctional population, 22 percent of males were diagnosed with a mental illness and 34 percent of females were diagnosed with a mental illness. Gender trends among juvenile offenders parallel that of adult populations, with mental illness/medical symptoms prevalence (32% vs. 14%) reported higher among females than males, respectively (Herz, 2000). The percentage of inmates with mental health diagnoses has increased in recent years, and the rate of mental illness found in the Nebraska prison population exceeds national prevalence estimates – 31.4% percent in Nebraska versus 16 to 18 percent nationally (U.S. Dept. of Justice, National Institute of Corrections, 2004).

### **Service Area Challenges**

*Law Enforcement.* There are unique challenges in addressing the needs of young adults with mental illness who come in contact with the justice system. In the Omaha metropolitan area, approximately 10% of law enforcement officers have been trained in CIT, which has led to significantly improved interactions between law enforcement and persons with mental illnesses. However, in other parts of the state this training has been lacking for law enforcement, and throughout the state there is a lack of mental health training for probation and parole officers. Even when law enforcement is trained in interacting with persons with mental illnesses, often there is a lack of coordination between law enforcement and mental health services.

*Mental Health Services.* One reason for the lack of coordination between law enforcement and mental health services is due to the significant deficiency of mental health services available for justice involved individuals. According to current estimates, approximately 2000 mental health professionals are available in Nebraska, and only 16% of these professionals are licensed clinical psychologists. Furthermore, according to the Nebraska Psychiatric Society, there are only 191 psychiatrists in the state and only nine psychiatrists were located in the western half of Nebraska. The U.S. Department of Health and Human Services has designated over 70% of Nebraska's counties as mental health shortage areas, and 86 of Nebraska's 93 counties are psychiatric shortage areas. There is also a shortage of licensed alcohol/drug abuse counselors (LADC), with a current ratio of 1 LADC to every 3,068 residents. The implications of the shortage of mental health and substance abuse professionals is that for the behavioral health system to be effective, it must work in coordination with other systems such as law enforcement, corrections, probation/parole, housing, and employment.

In addition to the limitations related to service professionals, there also appears to be a lack of crisis resources. The number of reported individuals in Emergency Protective Custody (EPC) has decreased from FY02 to FY07, while the number of days individuals remain in emergency rooms in hospitals has increased since 2005. In addition, hospital beds in Hasting, Norfolk, and Douglas County have decreased for people in need of EPC,. As a result, local, county and state law enforcement officers report having difficulty accessing crisis beds in hospitals under contract with behavioral health regions for Emergency Protective Custody (EPC) care. Law enforcement officials often must contact multiple facilities to find an available bed and transport individuals long

distances. In Nebraska, the responsibility for crisis beds has been shifting from state operated psychiatric hospitals to community based services including private hospitals; more than 200 state psychiatric beds have closed since 2003. Private beds for people needing EPCs, have also decreased in some Nebraska communities (Policy Research Associates, 2008 Attachment 12). In response to the lack of crisis services, several solutions have been developed including adding more community beds (Norfolk, LRC, Richard Young Hospital, Lasting Hope Recovering Center in Omaha) developing crisis respite beds (CRB), Crisis Response Teams (CRT), and Intensive Case Management (ICM).

*Correctional Facilities.* One issue challenging Nebraska's correctional system is the transfer of "safekeepers" (inmates transferred from local jails to state facilities for safekeeping) from jails across Nebraska to state correctional facilities because the local facilities cannot adequately address their mental health or medical needs. Over the last eight years 1365 safekeepers has been sent to the Department of Correctional Services, an average of 170 per year. Currently, the charge for safekeepers is \$75.78 per day, plus additional medical charges that could be added for mental health and medical services in DCS and external to DCS. Annual costs to serve safekeepers are estimated to be \$1.32 million not including medical expenses. The largest age group for safekeepers is 19 to 25 year olds. About 95% of safekeepers are sent from rural jails reflecting challenges managing behavior in local jails, difficulty accessing behavioral health resources and challenges in coordination between justice and mental health in rural and frontier communities.

Another issue concerns high need individuals who cycle between mental health and correctional facilities. Data from the Nebraska Department of Correctional Services between January 1, 2005 and June 30, 2007 provide information on 38 consumers who had been in a state psychiatric facility and a state correctional facility. Of these, 95% were found to have had multiple arrests, with number of prior arrests ranging from 1-53. As such, the number of readmissions was related to the existence of three factors. Consumers who had two or more readmissions reported higher prevalence of severe mental illness, substance related disorders, and personality disorders, compared to consumers who had not readmitted or who readmitted once (48.8%, 35.7%, and 34.1%), respectively (Watanabe-Galloway, 2008).

*Community Re-entry.* There is a gap in the State Behavioral Health System regarding mentally ill inmates who discharge from the Nebraska state prison system into the community. Discharging inmates who are mentally ill represent a relatively large, but generally unrecognized population. These former inmates require access to behavioral health services including psychiatric, mental health, substance abuse, and dual diagnosis treatment to address their needs. Individuals with mental illness discharged from jails and prisons often face challenges in finding adequate housing and sustainable employment. Many face homelessness and move in and out of shelters. Individuals with a serious mental illness and who are homeless have been shown to have higher recidivism rates, higher numbers of incarcerations and higher number of days spent in jail (Myers, 2007). In Lincoln, between July of 2006 and June 2007, a total of 1,974 people were homeless at some point, and between 2005-2006, Nebraska experienced a 67 percent increase of homeless veterans (National Alliance to End Homelessness). Little is

known about homeless transitioning youth in Nebraska. Nationwide, it is estimated that 10% of people who leave jail are homeless, with a much higher percentage, 20%, observed among individuals with mental illness (BJA, 2006). Affordable and sustainable housing is thus important to decrease recidivism and provide the necessary supports for people with mental illness, particularly among transitioning youth. Compared to housed youth, the rate of mental illness is disproportionately higher for homeless youth (Greenbalt & Robertson, 1993). While most of the literature on homeless individuals has been conducted on adults and runaway teens, few studies have examined the needs of transitioning young adults. In a study of homeless youth between the ages of 13 and 23, the majority of participants recruited on the street and agencies were in the age group of 19-21 and experienced a high prevalence of depression (Unger, Kipke, Simon, Montgomery, & Johnson, 1997).

For individuals who have been released from correctional facilities, shelter use is highly associated with increased reentry (Metraux & Culhane, 2003) while supportive housing has been associated with reduced involvement in criminal justice system and reduction in both jail and prison incarceration rates, 30 and 47 percent respectively (Culhane et al, 2002). Data collected in Nebraska indicates the cost of homelessness services exceeds that of supportive housing by 71% (Chicoine, 2007). Data from 2005-2006 indicate that 27 homeless individuals utilized emergency services in Lincoln; an annual cost of \$25,943 per person living on the street. In comparison, the annual cost for a person to live in an efficiency apartment is estimated at \$7,344, an annual cost savings of \$18,600 per person (Chicoine, 2007). Compared to cost of homelessness and further cost of release and re-incarceration, supportive housing is a comprehensive approach to

address the needs of individuals transitioning to adulthood. Strategies for supportive housing include the use of Forensic Case Managers to provide support, providing Rent-Wise education for renters, having discharge planners utilize websites to assist with housing plans and developing an affordable housing website.

### **Nebraska Programs**

Nebraska has a number of programs and initiatives upon which to build the system of care for justice-involved individuals with mental health and substance abuse needs.

***Diversion Programs.*** Existing adult diversion programs in Nebraska include the Douglas County Mental Health Diversion program and the Lancaster County Jail Diversion Project. These programs are aimed to divert persons with a serious mental illness and/or a substance use disorder from entering the criminal justice system. These programs have demonstrated successful outcomes over time including lower use of emergency rooms for both mental/emotional and physical complaints; diminished cognitive difficulties over time (i.e. concentration, worry, attentional focus), diminished frequency experiencing affective symptoms (i.e. frustration, fear, tension), diminished frequency of reported depressive symptoms over time; diminished paranoid like perspective over time (i.e. paranoia, suspiciousness); and increased report of perceived control of life. These findings indicate an improvement of symptoms, attitude, and usage of services for individuals involved in diversion programs (Parker, 2008).

***Crisis Intervention Training.*** Research indicates that Crisis Intervention Training for law enforcement officers can be successful in avoiding arrests and incarceration for persons with mental illness and in improving access to behavioral health

services. In Nebraska, the city of Omaha has been the first to implement this training, with up to 150 law enforcement and correction officers reportedly trained since 2006 (The Reader Omaha, 2008).

**Housing Assistance Program.** One of the goals of the mental health block grant is to creating more flexible admission criteria to meet changing consumer needs and permit better integration with other recovery-oriented services such as housing assistance and supported employment. Services to to address this need are currently supported by PATH Funds: The PATH programs will provide outreach, screening and diagnostic treatment services, case management, referral, some temporary housing assistance, and other appropriate services to individuals who are suffering from serious mental illness or are suffering from serious mental illness and from substance abuse, and are homeless or at imminent risk of becoming homeless.

**Regional Consumer Specialists.** The Division of Behavioral Health's Office of Consumer Affairs contracted with each of the six Regional Behavioral Health Authorities to hire Regional Consumer Specialists. By May 15, 2007, all six Regions had hired their Regional Consumer Specialists. These Consumer Specialists provide an opportunity to improve consumer-centered practice in services and systems including approaches for justice involved individuals.

**Expansion of Crisis Beds.** Faith Regional Health Services in Norfolk expanded their inpatient crisis /inpatient unit from 13 to 20 beds. In Omaha, the Lasting Hope Recovery Center opened at the end of 2007. Key components of Lasting Hope include the following:

- A crisis center with 24-hour call-in support. The center will offer assessments, triage and referral services to ensure that the immediate needs of patients are met efficiently. As a result, families will have a single place to turn when seeking help for mentally ill relatives.
- Sixty-four beds dedicated to acute and sub-acute care. These settings will be designed based on the philosophy of the center, to help patients transition through the continuum of care and successfully re-enter the community. There will be 16 beds for people in immediate crisis, 16 beds for those needing a week or less of treatment and 32 beds for those who require three to six weeks of inpatient care before they are ready for outpatient programs.
- There will be urgent outpatient care, emergency community support and peer driven services.
- The center also will provide education and research opportunities for behavioral health professionals
- Provide a base for consultations over a "telehealth" network that links sites across the state.

### **Addressing the Needs**

Nebraska has conducted a broad-based strategic planning process designed to develop a comprehensive system of screening, assessment, treatment and support services for individuals with mental illness involved in the justice system. Strategies developed through this planning process follow the Sequential Intercept Model and are intended to provide mental health intervention across the phases of justice involvement – contact with law enforcement, initial detention and court hearing, involvement in with courts and

in jail or prison, reentry to the community, and parole/probation. A strategic planning workshop was held December 5-6, 2007 in Lincoln, Nebraska. The purpose of the workshop was to 1) understand the characteristics and service needs of the target population, 2) use the Sequential Intercept Model as a framework to design and prioritize interventions, 3) assess gaps and strengths in areas of services and programs, agency coordination and collaboration and policy and legislation, and 4) prioritize gaps and develop a plan of action. Fifty nine stakeholders from across the state attended the workshop. These stakeholders represented mental health consumers, Regional Behavioral Health staff, law enforcement, mental health service providers, the Legislature, and state agencies (the Division of Behavioral Health, Division of Children and Family Services, Protection and Safety Administrators, Nebraska Homeless Assistance Program, Department of Correctional Services, Community Corrections Council, Office of Probation Administration, Crime Commission, and Division of Vocational Rehabilitation). Participants worked in six regional groups to plan for local needs, while a state level work team developed a strategic plan for state level issues. The output of the strategic planning process was a vision reached through consensus to have a seamless system to identify, support, and treat children and adults with mental and emotional disorders involved across the justice system. Policy Research Associates facilitated the planning and developed the report which included 14 recommendations. For the full report, see: [http://www.hhs.state.ne.us/beh/NE\\_CriminalJusticeMHReport&Attachmts-Jan28\\_2008.pdf](http://www.hhs.state.ne.us/beh/NE_CriminalJusticeMHReport&Attachmts-Jan28_2008.pdf). As first steps in achieving this vision, five priority areas were developed from the strategic planning session and ongoing meetings of these work teams. These priority areas and associated strategies are as follows:

**Strategy 1: Provide statewide Crisis Intervention Team (CIT) training for Law Enforcement officers and make clear linkages with local crisis response teams.** CIT training has been adopted in parts of the state, particularly the Omaha metropolitan areas; however, CIT training is lacking in many parts of the state and often law enforcement officers are not linked to community services. The whole community benefits when there are trained law enforcement officers who understand the signs and symptoms of mental illness and know how to make referrals and involve local community providers for the purpose of diversion. In addition, other juvenile justice personnel such as probation, parole officers, and jail personnel benefit from CIT training. This strategy is to train 20 law enforcement officers, 50 probation officers, and 50 parole officers in the initial training.

**Strategy 2: Expand or improve access to crisis stabilization services with improved coordination with law enforcement officers.** There are crisis services available in each of the six behavioral health regions; however, often law enforcement is not aware of which facilities have beds available causing problems for persons with mental illness in crisis. At this time, it falls on the law enforcement officials to search for a bed, which takes valuable patrol time and can be very disruptive for consumers in crisis. When law enforcement cannot locate an inpatient bed, jails can become a default placement if there is a chargeable offense. Centralized coordination of local crisis response duties among law enforcement, Crisis Response Teams, and Emergency Inpatient Facilities can ensure timely transport, effective utilization of crisis beds and each Regional Health Authority can develop a strategy to track bed availability and capacity issues.

**Strategy 3: Implement standardized mental health and substance abuse screening instruments in the jails that prompt referrals for services.** Many of Nebraska jails are utilizing some form of screening, but clear identification of mental health risk and needs is not consistently being done nor are there clear linkages to services. Implementation of this strategy would result in the standardized screening will be provided to every inmate in all 80 Nebraska jails and detention centers.

**Strategy 4: Dedicate resources to community mental health to provide diversion services through the use of Forensic Intensive Case Management.** Forensic Intensive Case Management services are appropriate along the entire Sequential Intercept Model. Forensic case management and diversion programs as key components in the community mental health system can prevent people with mental illness from entering the justice system. Forensic case management is essential to help broker the multiple service systems that may be part of an individual's reentry plan. In addition, close coordination with probation and parole is required so the service and supervision is coordinated.

**Strategy 5: Enhance affordable supportive housing for justice involved youth transitioning to adulthood.** Affordable and sustainable housing is important to decrease recidivism and provide the necessary supports for people with mental illness. Data collected in Nebraska indicates supported housing is a cost effective intervention and can prevent more costly crisis and shelter services. Strategies to help ensure housing for persons with mental illness include the use of Forensic Case Managers to coordinate support, provide Rent-Wise education for renters, have discharge planners utilize websites to assist with housing plans, develop an affordable housing website, and link the statewide effort with Omaha's continuum on homelessness 10 year plan. The Nebraska

Housing Related Assistance program is designed to address the housing cost burden for adults who are extremely low income with a serious mental illness. Nebraska proposes to expand its training and coordination effort resulting in lower homeless rates for persons with mental illness.

These strategies incorporate a process to provide standardized screening across Nebraska's 80 local jails and correctional facilities using a screening instrument validated through the GAINS center. The Jail Standards Division is represented on the Steering Committee for this initiative and has the authority to make regulatory changes and provide technical assistance in implementation. The project will develop a process for connecting individuals with mental health disorders to appropriate mental health services including crisis response teams and mental health diversion programs. One of the features of these programs is intensive forensic case management, which helps connect consumers to both formal services and informal supports offered through faith based and community organizations and helps coordinate other benefits for which the consumer is eligible. The project will establish a process for transition planning from correctional facilities to community re-entry focusing on linkages to behavioral health programs, including services for individuals with co-occurring disorders, and support services including supported housing and employment. The project will also focus on providing CIT training for law enforcement officers, probation and parole officers, and jail personnel, which will allow justice professionals to understand, identify and appropriately respond to the needs of persons with mental health disorders. The following diagram provides a logic model depicting the linkages among project vision, needs, strategies, and anticipated outcomes of the initiative.