I. Open Meeting
Call to Order/Welcome – Danielle Smith, Chair of the State Advisory Committee on Mental Health Services called the meeting to order at 9:06 a.m. Chair Smith welcomed attendees to the meeting and introduced Chair of the State Advisory Committee on Substance Abuse Services, Beau Boryca. Chair Boryca welcomed all attendees as well. John Trouba, Division of Behavioral Health (DBH) Federal Aid Administrator, informed attendees that the joint meeting follows the Open Meeting Act, which was posted near the meeting room entrance, and can be found on the DBH website identified on the agenda. Attendees were reminded that there would be two allotted time periods for public comment, one in the morning and one in the afternoon.

Quorum for Committees
Roll call was conducted, and a quorum was determined to exist for the State Advisory Committee on Substance Abuse Services (Substance Abuse Committee). Roll call was conducted but quorum was not met for the State Advisory Committee on Mental Health Services (Mental Health Committee). Due to no quorum for the Mental Health Committee, several items on the Membership Business agenda could not be addressed.

State Advisory Committee on Substance Abuse Services
Members in Attendance: Ashley Berg, Heather Bird, Beau Boryca, Heather Crawford, Diana Meadors, Kelli Means, Michael Sheridan, Mike Tefft.

State Advisory Committee on Mental Health Services
Members in Attendance: Margaret Damme, Lindy Foley, Timothy Heller, Tracy Jordan, Kristen Larsen, Jennifer Reyna, Carisa Schweitzer Masek, Danielle Smith.

DHHS Staff
In Attendance: Karen Harker, Jeri Keller-Heuke, Michelle Nunemaker, John Trouba, Betty Jean Usher-Tate, Linda Wittmuss.

II. Membership Business
Introduction of New Members—
Due to the presence of newer committee members for both the Mental Health Committee and the Substance Abuse Committee, all attendees present introduced themselves.

Meeting Minutes from April 14, 2022 (Both committees)—
Substance Abuse Committee Chair Boryca presented the April 14, 2022 meeting minutes for review. Chair Boryca asked if there were any corrections or comments. Hearing none, Chair Boryca asked the Substance Abuse Committee for a motion to accept the April 14, 2022 meeting minutes as written. Motion was made and seconded by Substance Abuse committee members to accept the April 14, 2022 minutes as written. Motion was carried unanimously by vocal vote.

Mental Health Chair Smith tabled the vote due to no quorum present for the Mental Health Committee.

Meeting Minutes from November 4, 2021 (MH committee)—
Mental Health Chair Smith tabled the vote due to no quorum present for the Mental Health Committee.
Member Term of Appointment Reminder—
John Trouba reminded committee members that terms are three (3) years in length, with a limit of two (2) terms that can be served consecutively. If a member’s term expires, they may apply for a different vacant seat, if one exists.

Mental Health Committee Election—
Chair Smith tabled the nominations and election of officers for the Mental Health Committee due to no quorum being present. Danielle Smith will remain as Chairperson until elections can be held.

III. Integrated Health Partnership
Dr. Todd Stull and Will Schmeckle from the Nebraska Medical Association presented the “2022 Nebraska Integrated Healthcare Needs Assessment Survey Results”. The goal of this project is to expand integrated healthcare practices in Nebraska and provide start-up funding for clinics to add behavioral health professionals.

Dr. Stull gave the current status of the Opioid Settlement Remediation Advisory Committee. Nebraska anticipates receiving up to $110 million from settlement funds over a period of up to 18 years. At least 50% of these funds will go to all geographic regions of the state, with the remaining funds still undetermined at this time. Exhibit E of the Distributor Settlement Agreement lists the acceptable uses for these funds, which will be managed by DHHS. The application criteria and process are still in progress. Information on the Opioid Settlement can be found at https://dhhs.ne.gov/Pages/Opioid-Settlement-Workgroup.aspx.

IV. Break

V. 988 and the National Suicide Prevention Lifeline Update
Michelle Nunemaker, DBH System of Care Administrator, discussed the rollout and operation of the 988 Suicide and Crisis Hotline. The soft launch of 988 took place on July 16, 2022, as crisis calls transition from 1-800-273-TALK. Over 600 calls were answered in July, and an estimate of 1500 calls will be answered in August. Of the calls received so far, four in Lincoln and Omaha resulted in Mobile Crisis Response activation. In addition to traditional phone calls, text and chat contacts are also available. This hotline operates through Boys Town National Hotline in Omaha and is staffed 24/7 by trained crisis counselors. Information on the 988 Suicide and Crisis Hotline can be found at https://dhhs.ne.gov/Pages/988.aspx.

VI. Public Comments
There were no public comments received during the morning Public Comment opportunity.

VII. 2022 SAMHSA Block Grant “Mini” Application
Betty Jean Usher-Tate, DBH Data & QI Administrator, and Karen Harker, DBH Deputy Director of Finance, reviewed the Substance Abuse and Mental Health Services Administration (SAMHSA) Mini Application and Priority Area Review for FY2022-FY2023. There are currently seven (7) priority areas for FY22/23. Current data supporting each priority area was reviewed, with some data being noted as preliminary only. Second-year target measures are on track. Recent Medicaid expansion in Nebraska has resulted in lower numbers of populations served by DBH, as compared to previous years. Expenditures are broken down by Mental Health Block Grant funding and Substance Abuse Block Grant funding. No recommendations were suggested by either committee. These slides will be posted on the DBH website as part of this meeting’s materials.

VIII. Lunch—Lunch & Learn Presentation
Brad Meurren from Disability Rights Nebraska presented “Housing & Behavioral Health—How They Interact”.

IX. Director’s Updates
Linda Wittmuss, Deputy Director of the Department of Health and Human Services Division of Behavioral Health (DBH), thanked members of the committees for attending today’s meeting.
Contracts – With the new fiscal year, new contracts with service providers are in place. These include the rate increases for FY23.

Opioid Settlement Remediation Advisory Committee – This monthly workgroup is currently reviewing DBH’s needs assessments to gain insight on gaps and needs across the state. Information can be found on the DHHS website at https://dhhs.ne.gov/Pages/Opioid-Settlement-Workgroup.aspx.

DBH Strategic Plan – The DHHS Behavioral Health Strategic Plan 2022-2024 is now six months into its first year, with 54% of year one tasks either on track or completed. Areas of strength include the behavioral health collaborative on service array, definitions, evidence-based practices, and prevention. The plan is on the DHHS website at https://dhhs.ne.gov/Behavioral%20Health%20Documents/DBH%20Strategic%20Plan%202022-2024.pdf.

Service Definitions – DBH is currently reviewing service definitions, waitlist, and capacity management with Medicaid Long Term Care.

Mental Health Board Commitment Manual – DBH is currently conducting the biennial review of this manual in conjunction with DHHS Legal and medical directors. Input has been received from stakeholders, including board members, court clerks and Lincoln Regional Center psychiatric students.

Nebraska Hospital Association and Nebraska Health Care Association – DBH has initiated meetings with Nebraska Hospital Association and Nebraska Health Care Association to address access to services, behavioral health in-reach, bed registry, and waitlist and capacity management.

Outpatient Competency Restoration – Legislation passed last year provided for DHHS to contract with outside providers to offer Outpatient Competency Restoration (OCR) as an alternative to placement at a state hospital. OCR includes counseling, case management and medication management in the service offering. There are currently five contracted providers, with three more pending approval. These providers cover four of the six behavioral health regions. So far, there are eight active cases, three potential cases, three successful restorations and four discharged/rescreened to patient cases. A coordinator has also been hired.

Office of Consumer Affairs (OCA) – The Recovery Friendly Workplace Initiative (RFWI) is being formed as a resource for employers to better support their employees who are in recovery. This workgroup is in the early stages of determining criteria for employers to be designated as Recovery Friendly. The RFWI will be discussed at the next meeting.

X. Public Comments:
There were no public comments received during the afternoon Public Comment opportunity.

XI. Meeting Wrap Up
The next Joint Advisory Committee meeting will be Thursday, November 17, 2022 at the Lancaster County Extension Office, 444 Cherrycreek Road, Lincoln, NE.

XII. Adjourn
The meeting agenda having been completed, Chairs Boryca and Smith declared the meeting adjourned at 1:42 p.m.
A SURVEY OF A PRIMARY CARE PHYSICIANS IN NEBRASKA ON THEIR COLLABORATION WITH BEHAVIORAL HEALTH PROVIDERS AND EFFORTS TO INTEGRATE BEHAVIORAL HEALTH SERVICES INTO THEIR CLINICAL SETTING.
NMA Project on Integrated Healthcare

- Purpose: expand integrated healthcare practices in Nebraska.
- Definition of integrated healthcare: co-location and coordination of care across primary and behavioral health.
- In the process of expanding our project through BHECN’s ARPA funding.
  - Start-up funds for clinics to hire a behavioral health professional
  - Development of a telehealth network for psychiatry
Nebraska is in the bottom tier of states in terms of the percentage of primary care physicians co-located with behavioral health providers.
Needs Assessment Survey

- Online survey administered in March – April 2022

- Sent to 1,582 Nebraska primary care physicians

- 107 responded (7% response rate)
Response Bias

- 63% of respondents indicated that a behavioral health provider is available within their clinic either in-person or through telehealth.
- Statewide data indicate that less than one-third or primary care physicians in Nebraska have a behavioral health provider co-located in their practice.
- Response bias =
  - Unreliable data in terms of how many primary care physicians are working closely with behavioral health providers
  - Reliable data in terms of barriers to integrated care practices
Respondents

- **Family medicine**: 38%
- **Pediatrics**: 23%
- **Obstetrics & Gynecology**: 6%
- **Hospitalist**: 5%
- **Other**: 11%
- **Internal medicine**: 17%
Location of practice

- Large urban area: 68%
- Small urban area: 21%
- Rural area: 11%
90% conduct at least one type of BH screening tool (note response bias)

Conduct a behavioral health screening tool of any type

- Depression: 85%
- Anxiety: 62%
- Substance Use: 39%
- Other: 13%
The top barriers to conducting BH screening are time and lack of referral options.
Almost all reported that they make referrals for BH services (note response bias)

- Making referrals for any type of BH service: 96%
- Making referrals for BH services WITHIN the provider's clinical site (including tele-health): 75%
- Making referrals for BH services OUTSIDE of the provider's clinical site: 89%
Just over half of respondents agree or strongly agree that they have adequate knowledge of the BH resources in their community.

- Strongly disagree: 4%
- Disagree: 24%
- Neither agree nor disagree: 16%
- Agree: 43%
- Strongly agree: 13%
Communication with BH providers improves drastically when the BH provider is available in the clinic

- Rare or infrequent communication
- Semi-frequent communication (less than monthly)
- Regular communication (monthly or more)

BH providers WITHIN clinic*
- 18% Rare or infrequent communication
- 60% Regular communication
- 22% Semi-frequent communication

BH providers OUTSIDE of clinic
- 66% Rare or infrequent communication
- 29% Semi-frequent communication
- 5% Regular communication

*“WITHIN clinic” includes telehealth.
The main barrier to making referrals for BH services is a shortage of providers.

<table>
<thead>
<tr>
<th>NO BARRIERS</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providers exist in my area, but their schedules are full</td>
<td>7%</td>
</tr>
<tr>
<td>Lack of providers in my area</td>
<td>68%</td>
</tr>
<tr>
<td>Patients do not follow-up on referrals</td>
<td>55%</td>
</tr>
<tr>
<td>Lack of communication from the behavioral health...</td>
<td>46%</td>
</tr>
<tr>
<td>Lack of quality services in my area</td>
<td>44%</td>
</tr>
<tr>
<td>Lack of awareness of what services are available in my area</td>
<td>28%</td>
</tr>
<tr>
<td>Lack of providers able to see patients within my clinical site</td>
<td>25%</td>
</tr>
<tr>
<td>Other</td>
<td>18%</td>
</tr>
</tbody>
</table>

Other 6%
63% have therapists or psychologists available at their clinic or through tele-health (note response bias)

<table>
<thead>
<tr>
<th>Professional</th>
<th>Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health therapists or psychologists</td>
<td>63%</td>
</tr>
<tr>
<td>Social workers</td>
<td>45%</td>
</tr>
<tr>
<td>Care coordinators</td>
<td>43%</td>
</tr>
<tr>
<td>Psychiatrists or Psychiatric APRNs</td>
<td>32%</td>
</tr>
<tr>
<td>Nutrition and wellness coaches</td>
<td>26%</td>
</tr>
<tr>
<td>Addiction counseling</td>
<td>21%</td>
</tr>
<tr>
<td>Medication management aide</td>
<td>7%</td>
</tr>
<tr>
<td>One or more of the above</td>
<td>81%</td>
</tr>
</tbody>
</table>
Psychiatry and mental health are the most needed professionals to add or expand at the clinical site

<table>
<thead>
<tr>
<th>Professional</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO CURRENT NEED OR INTEREST</td>
<td>13%</td>
</tr>
<tr>
<td>Psychiatrists or Psychiatric APRNs</td>
<td>52%</td>
</tr>
<tr>
<td>Mental health therapists or psychologists</td>
<td>51%</td>
</tr>
<tr>
<td>Addiction counseling</td>
<td>29%</td>
</tr>
<tr>
<td>Social workers</td>
<td>27%</td>
</tr>
<tr>
<td>Nutrition and wellness coaches</td>
<td>26%</td>
</tr>
<tr>
<td>Care coordinators</td>
<td>25%</td>
</tr>
<tr>
<td>Medication management aide</td>
<td>19%</td>
</tr>
<tr>
<td>Other</td>
<td>4%</td>
</tr>
</tbody>
</table>
Cost and a lack of available providers are the top two barriers to adding mental health therapists (LMPH) on site.

<table>
<thead>
<tr>
<th>Challenge</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up-front cost of hiring a provider</td>
<td>65%</td>
</tr>
<tr>
<td>Finding available and qualified providers</td>
<td>65%</td>
</tr>
<tr>
<td>Billing for the mental health therapist's services</td>
<td>42%</td>
</tr>
<tr>
<td>Financial risk associated with hiring a mental health therapist on site</td>
<td>33%</td>
</tr>
<tr>
<td>Finding independently licensed providers</td>
<td>23%</td>
</tr>
<tr>
<td>Difficulty in predicting the need for providers on a given day</td>
<td>18%</td>
</tr>
<tr>
<td>Credentialing the provider with insurance</td>
<td>16%</td>
</tr>
<tr>
<td>Uncertainty about ability to fill appointments</td>
<td>15%</td>
</tr>
<tr>
<td>Staff time to hire and train a provider</td>
<td>11%</td>
</tr>
<tr>
<td>Developing a system for offering these services</td>
<td>11%</td>
</tr>
<tr>
<td>Collaborating care between the therapist, primary care provider, and others</td>
<td>4%</td>
</tr>
<tr>
<td>Other</td>
<td>8%</td>
</tr>
</tbody>
</table>
Most respondents are at least potentially interested in being part of a pilot project to expand integrated practices at their site.

- 40% Not currently interested
- 42% Maybe
- 18% Yes
"We are a private practice pediatric group in Lincoln Nebraska with 16 pediatricians and 6 psychologists practicing out of 4 clinic sites. We are very proud of the program we have grown over the last 10+ years. Having in house psychology for our patients is a game changer, allowing our physicians to feel much more confident managing and helping our patients with behavioral health needs. Our only problem is we need more providers--they are all full. I would love to figure out how we could incorporate LMHPs to help manage the patient load but the cost of adding compared to reimbursement makes it difficult. I feel that our psychologists are underpaid when compared to the work they do and their training--even though they are paid competitively."
A few more quotes...

“We need more providers to handle the load. Also, health care reimbursement needs to be improved as these professionals are not supported enough from the insurance companies.”

“I work for the state, and it can sometimes be hard for us to find providers who wish to work in rural areas.”

“I would also be interested in opportunities for reverse integrated healthcare models - integrating primary care in behavioral health locations particularly for higher risk patients such as those with severe disorders such as psychosis.”
Nebraska 988

Joint Advisory Committee Meeting
August 18, 2022
On July 16, 2022, 1-800-273-TALK transitioned to 988.
On July 16, 2022, the soft launch of 988 took place with the transition from 1-800-273-TALK to 988

**Short-term goal**
A strengthened and expanded Lifeline infrastructure to respond to crisis calls, texts, and chats anytime

**Long-term vision**
A system that provides more opportunities for crisis services
Someone to Call

- The call center in Nebraska is located at Boys Town National Hotline in Omaha.
- 988 is staffed 24/7 by trained Crisis Counselors who will:
  - Triage and safety plan
  - Provide referrals and resources
  - Activate Mobile Crisis Response when appropriate

<table>
<thead>
<tr>
<th>Month</th>
<th>Calls Presented</th>
<th>Calls Answered</th>
<th>Adj. Ans Rate</th>
<th>ASA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jun</td>
<td>1080</td>
<td>999</td>
<td>95.70%</td>
<td>0:13</td>
</tr>
<tr>
<td>Jul</td>
<td>1240</td>
<td>1126</td>
<td>95.10%</td>
<td>0:11</td>
</tr>
<tr>
<td>Aug (MTD)</td>
<td>675</td>
<td>616</td>
<td>95.10%</td>
<td>0:11</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Offered Contacts*</th>
<th>Answered Contacts</th>
<th>Answer Rate*</th>
<th>Staffed Hours</th>
<th>Volume</th>
</tr>
</thead>
<tbody>
<tr>
<td>177</td>
<td>142</td>
<td>80.2%</td>
<td>331.5/336: 98.5%</td>
<td>Approximately: .5 contacts/hour</td>
</tr>
</tbody>
</table>
Vibrant Health’s Technology and Process

988 is not exactly like 911

988 calls are routed first through Vibrant Health’s system and not directly to a person.

People who call 988 are given three options:
- Press 1 to connect with the Veterans Crisis Line
- Press 2 to connect with the Spanish Subnetwork
- Remain on the line and be connected to a local crisis center; if local crisis center is unable to answer, the caller is routed to a national backup center
Someone to Respond

- Person with Lived Experience on the team
- Standardized training and expectations
- Post crisis follow-up
- Referrals for Services

<table>
<thead>
<tr>
<th>MCR Referrals</th>
<th>MCR Declines</th>
<th>MCR Activations</th>
</tr>
</thead>
<tbody>
<tr>
<td>24</td>
<td>19</td>
<td>5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Community</th>
<th>Phone</th>
<th>Telehealth</th>
<th>Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
Vision of Somewhere to Go/Community Supports

• Continue to develop Crisis Receiving and Stabilization Services across the state
• Bed Registry/Availability for Referrals
• Same day or next day assessment, outpatient, medication management
• Mental Health and Substance Use crisis respite for youth and adults
• Peer Run Hospital Diversion/Peer Run Crisis Respite
Visit our DHHS 988 Webpage located at: https://dhhs.ne.gov/Pages/988.aspx where you will locate a Marketing Toolkit containing numerous marketing materials for you to print and share!

Items in the Toolkit include:

- PSAs in English and Spanish
- 988 FAQ Sheet in English and Spanish
- Message for Messengers slide deck
- Flyers
- Posters
Questions?

Sheri Dawson
Sheri.Dawson@nebraska.gov

Michelle Nunemaker
Michelle.Nunemaker@nebraska.gov
Thank you!

July 16, 2022

Learn more about Nebraska’s 988 efforts here:
https://dhhs.ne.gov/Pages/988.aspx
Division of Behavioral Health:

Mini Application
Financial Projections
FY2022 - FY2023
<table>
<thead>
<tr>
<th>FY23 Planned Expenditures</th>
<th>A. Substance Abuse Block Grant</th>
<th>B. Mental Health Block Grant</th>
<th>D. Other Federal Funds</th>
<th>E. State Funds</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Substance Abuse Prevention and Treatment</strong></td>
<td>$519,408</td>
<td></td>
<td>$277,886</td>
<td></td>
</tr>
<tr>
<td>a. Pregnant Women and Women with Dependent Children</td>
<td>$4,667,748</td>
<td></td>
<td>$4,071,265</td>
<td>$31,045,186</td>
</tr>
<tr>
<td>b. All Other</td>
<td>$2,225,097</td>
<td>$1,632,916</td>
<td>$179,936</td>
<td></td>
</tr>
<tr>
<td>a. Substance Abuse Primary Prevention (20%)</td>
<td></td>
<td>$383,335</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10%)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24-Hour Care (non-State Hospital)</td>
<td>$40,000</td>
<td>$9,525,970</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulatory/Community Non-24 Hour Care</td>
<td>$3,026,676</td>
<td>$288,000</td>
<td>$50,004,989</td>
<td></td>
</tr>
<tr>
<td>Administration (excluding program/provider level)</td>
<td>$390,119</td>
<td>$191,667</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crisis Services (5%)</td>
<td>$191,667</td>
<td>$583,855</td>
<td>$17,594,683</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$7,802,372</td>
<td>$3,833,345</td>
<td>$6,576,036</td>
<td>$108,628,651</td>
</tr>
</tbody>
</table>
# Mental Health Block Grant

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>MHBG Award</td>
<td>3,833,345.00</td>
</tr>
<tr>
<td>5% admin (max)</td>
<td>191,667.25</td>
</tr>
<tr>
<td>20% Prevention (minimum)</td>
<td></td>
</tr>
<tr>
<td>10% FEP (minimum)</td>
<td>383,334.50</td>
</tr>
<tr>
<td>5% crisis (minimum)</td>
<td>191,667.25</td>
</tr>
<tr>
<td>MH Services Youth &amp; Adult</td>
<td>3,066,676.00</td>
</tr>
</tbody>
</table>

**Budget Period:** October 1, 2022 – September 30, 2024

- Children with SED and their families
- Adults with SMI
- Older Adults with SMI
- Individuals with SMI or SED in the rural and homeless populations
- Individuals who have an Early Serious Mental Illness (ESMI)
## Substance Abuse Block Grant

<table>
<thead>
<tr>
<th>SAPTBG Award</th>
<th>7,802,372.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>5% admin (max)</td>
<td>390,118.60</td>
</tr>
<tr>
<td>20% Prevention (minimum)</td>
<td>1,560,474.40</td>
</tr>
<tr>
<td>Treatment &amp; Non-Primary Prevention</td>
<td>5,851,779.00</td>
</tr>
</tbody>
</table>

**Budget Period:** October 1, 2022 – September 30, 2024

- Primary Substance Use Disorder Prevention, Treatment and Recovery Services for Individuals, Families and Communities
- Primary Prevention
- Pregnant Women and Women with Dependent Children
- Persons Who Inject Drugs
- Tuberculosis Services
- Group Homes for Persons in Recovery from Substance Use Disorders
- Referrals to Treatment
- Professional Development.
Karen Harker
Deputy Director of Division Finance

Karen.harker@nebraska.gov
402-471-7708
Division of Behavioral Health:

Mini Application and Priority Area Review
FY2022 - FY2023

August 18, 2022
Purpose of Block Grant

The Substance Abuse and Mental Health Services Administration (SAMHSA) is a branch of the U.S. Department of Health and Human Services.

It is charged with improving the quality and availability of treatment and rehabilitative services in order to reduce illness, death, disability, and the cost to society resulting from substance abuse and mental illnesses.

- **Fund** priority treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time.

- **Fund** those priority treatment and support services not covered by Medicaid, Medicare or private insurance for low income individuals and that demonstrate success in improving outcomes and/or supporting recovery.

- **Fund** primary prevention-universal, selective and indicated prevention activities and services for persons not identified as needing treatment.

- **Collect** performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment and recovery support services and plan implementation of new services on a nationwide basis.
DBH Needs Assessment and Future Planning

Where are we thus far?
What can go wrong?
Knowing that, what needs to be done now?
Current Block Grant Priority Areas FY22/23

1. Prevention of binge drinking among youth and young adults
2. Increase the use of Evidence-Based Strategies employed by prevention coalitions to reduce alcohol and substance use
3. Increase support for consumers to secure and maintain permanent housing (Stable Living Arrangement – residential services)
4. Increase support for consumers to sustain and acquire employment (across all services)
5. Increased access to community-based services for priority populations
6. Increase utilization of treatment program for first-episode psychosis
7. Referral to services for persons with tuberculosis
Community Based Services

25,261

(FY21 = 29,523)

*20,585 = Mental Health (MH)
(FY21 = 24,049)

*6,301 = Substance Use Disorder (SUD)
(FY21 = 8,279)

Data Source: DBH Annual Report; CDS – as of 10/1/2021; 8/1/2022;
These statistics differ from official block grant totals because they are for Community Based Services only and do not include individuals served at the Regional Centers.

* Some individuals engage in both MH and SUD services. As per federal reporting, consumers who receive dual services are counted in both mental health and substance use disorder services, therefore, the sums of consumers across the service types are greater than the total served.
Priority #1: Alcohol use among youth & young adults

Priority #1: Alcohol use among youth and young adults

Indicator #1: Prevalence of binge drinking reported by youth and young adults, ages 18-24

Data Source: Behavioral Risk Factor Surveillance Survey (BRFSS)

Baseline 31.5% BRFSS 2020 30.4%

| Year 1 target | 31.5% |
| Year 2 target | 30.0% |

Note: Goal is to maintain the baseline and this target was met with a positive change of 1.1%

The National Survey of Drug Use and Health (NSDUH) indicates youth alcohol use rates, and binge drinking in particular, are persistently higher in Nebraska compared to national rates.

Prevalence of Binge Drinking 2020

<table>
<thead>
<tr>
<th>Ages</th>
<th>NE</th>
<th>US</th>
<th>NE Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>12+</td>
<td>27.8%</td>
<td>23.1%</td>
<td>49th</td>
</tr>
<tr>
<td>12-17</td>
<td>5.8%</td>
<td>4.5%</td>
<td>46th</td>
</tr>
<tr>
<td>18-25</td>
<td>40.6%</td>
<td>32.8%</td>
<td>42nd</td>
</tr>
<tr>
<td>26+</td>
<td>28.5%</td>
<td>23.7%</td>
<td>49th</td>
</tr>
</tbody>
</table>

Percent of Young Adults (18-24) Reporting Binge Drinking, NE Compared to US 2011-2020

Note: values indicate percent of young adults reporting consuming at least 5 drinks for males or 4 drinks for females in one occasion during the preceding 30 days. Source: Behavioral Risk Factor Surveillance Survey (BRFSS)
**Trends in Substances Reported: Alcohol and Opioids**

**FY 2021: Top Substances Reported**
- Alcohol = 52% of the primary substances identified at admission
- Other Opiates or Synthetics: 3%
- Methamphetamine / Speed: 22%
- Marijuana / Hashish: 17%
- Cocaine / Crack: 2%
- Amphetamine: 1%
- Other Drugs: 2%
- Alcohol ONLY: 27%
- Alcohol WITH a Secondary Drug: 25%

**FY 2022: Top Substances Reported**
- Alcohol = 51% of the primary substances identified at admission
- Other Opiates or Synthetics: 3%
- Methamphetamine / Speed: 23%
- Marijuana / Hashish: 18%
- Cocaine / Crack: 2%
- Amphetamine: 2%
- Other Drugs: 2%
- Alcohol ONLY: 27%
- Alcohol With secondary drug: 24%

**35% of all admissions reported one or more substances used**

**40% of all admissions reported one or more substances used**

Data Source: CDS – as of 10/1/2021; 8/1/2022
Percentage of Nebraska YOUNG ADULTS reporting past year alcohol impaired driving

<table>
<thead>
<tr>
<th>Year</th>
<th>Nebraska</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>24.1%</td>
<td>22.1%</td>
<td>26.0%</td>
</tr>
<tr>
<td>2014</td>
<td>21.9%</td>
<td>20.0%</td>
<td>23.7%</td>
</tr>
<tr>
<td>2016</td>
<td>17.2%</td>
<td>15.1%</td>
<td>19.1%</td>
</tr>
<tr>
<td>2018</td>
<td>19.8%</td>
<td>19.9%</td>
<td>19.8%</td>
</tr>
<tr>
<td>2020</td>
<td>12.4%</td>
<td>9.7%</td>
<td>15.0%</td>
</tr>
</tbody>
</table>

Nebraska Young Adult Alcohol Opinion Survey (NYAAOS)

2020 Drink and Drive:

12.4% of young adults in Nebraska reported driving under the influence of alcohol in the past year.

18.2% reported having ridden in a vehicle driven by someone who was under the influence of alcohol in the past year.
Considering Recent Relevant Developments

Nebraska Young Adult Alcohol Opinion Survey (NYAAOS)

**Young Adults and Alcohol To-Go**

**Policy:**
- In response to the Covid-19 pandemic issues, Executive Order 20-09 was implemented in March 2020 allowing the sale of alcohol on a “to-go” basis.
- In May 2021, this policy was made permanent through the legislative process.

**Action:**
- ✓ A follow-up wave of the NYAAOS was conducted between December 2020 and March 2021 that focused on pandemic related factors.
- ✓ As part of this effort, respondents were also asked about “to-go” alcohol.

24.0% of NYAAOS respondents reported purchasing an alcoholic beverage “to-go”

Of the respondents who reported purchasing an alcoholic beverage “to-go”

- 24.0% reported consuming “to-go” alcohol while driving a motor vehicle
- 26.1% reported consuming “to-go” alcohol as a passenger while in a motor vehicle

Priority #2: Increase Use of Evidence-Based Strategies

Priority #2: Increase Use of Evidence-Based Strategies

Indicator #1: PP, Other (Adolescents w/SA and/or MH, Students in College, Rural, Children/Youth at Risk for BH Disorder, Underserved Racial and Ethnic Minorities

Data Source: NPIRS

<table>
<thead>
<tr>
<th>Baseline</th>
<th>33.6%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1 target</td>
<td>36.1%</td>
</tr>
<tr>
<td>Year 2 target</td>
<td>38.6%</td>
</tr>
</tbody>
</table>

*Universal

Prevention strategies address an entire population with programs, policies and practices aimed at preventing or delaying the misuse of alcohol, tobacco and other drugs. This FY22 data represent a subset of the EBPs (i.e. only universal indirect strategies)

Data Source: NPIRS; Evidence-Based Report

Funding Source: SAPT Block Grant & SAPT Mini-grant

Date Range: 07/01/2021 TO 06/30/2022
Priority #3: Consumers in Stable Living Arrangements

Indicator #1: Percentage of consumers in stable living arrangements at discharge from residential services

Data Source: CDS

<table>
<thead>
<tr>
<th>Baseline</th>
<th>60%</th>
<th>Year 1 target</th>
<th>65%</th>
<th>Year 2 target</th>
<th>65%</th>
</tr>
</thead>
</table>

Statewide quarterly percent of behavioral health consumers who were in stable living arrangements at the time of discharge from any residential service

Data Source: DBH Centralized Data System (CDS); Encounters Current/Funding Region/Living Arrangements/Discharge/Residential Service
Numbers in Parentheses represent statewide counts (not including persons whose housing status was "not available")
Data current as of 7/21/2022
Last Known Living Arrangement Reported by MH & SUD

<table>
<thead>
<tr>
<th>Living Arrangements</th>
<th>MH</th>
<th>SUD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment Facility</td>
<td>3.2%</td>
<td>3.3%</td>
</tr>
<tr>
<td>Unknown</td>
<td>16.6%</td>
<td>5.9%</td>
</tr>
<tr>
<td>Private Residence</td>
<td>53.3%</td>
<td>63.6%</td>
</tr>
<tr>
<td>Correctional Facility or Other Intsitutional Setting</td>
<td>2.6%</td>
<td>8.3%</td>
</tr>
<tr>
<td>Child w/Parents/Relative; Foster Home; Youth Living Independently</td>
<td>11.3%</td>
<td>2.1%</td>
</tr>
<tr>
<td>Homeless or Shelter</td>
<td>8.7%</td>
<td>11.4%</td>
</tr>
<tr>
<td>Other</td>
<td>4.5%</td>
<td>5.4%</td>
</tr>
</tbody>
</table>

Data as of 8.1.2022 FY22 Data Source: Centralized Data System (CDS) DBH – Preliminary Anchor Dataset
Priority #4: Employment Trends

**Priority #4:** Consumers Employment

**Indicator #1:** Percentage of consumers in the labor market who are employed at discharge from any DBH funded service

**Data Source:** CDS

| Baseline | 55% |
| Year 1 target | 55% |
| Year 2 target | 58% |

---

**Statewide quarterly percent of behavioral health consumers who were in the labor market and employed at the time of discharge from any MH or SUD service**

<table>
<thead>
<tr>
<th>Quarter</th>
<th>FY21</th>
<th>FY22</th>
<th>FY23</th>
<th>FY24</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>59%</td>
<td>59%</td>
<td>61%</td>
<td>62%</td>
</tr>
<tr>
<td>(N=2,176)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q2</td>
<td></td>
<td></td>
<td>63%</td>
<td></td>
</tr>
<tr>
<td>(N=1,786)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q3</td>
<td></td>
<td></td>
<td></td>
<td>70%</td>
</tr>
<tr>
<td>(N=1,675)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(N=1,375)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(N=1,313)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(N=1,064)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Data Source: DBH Centralized Data System (CDS); Encounters Current/Funding Region/Employment Status/Discharge/Any MH or SUD Service (except Emergency/Crisis, Hospitalization, and Assessment Services)

Numbers in Parentheses represent statewide counts of persons discharged to the labor market

Data current as of 7/21/2022

“EMPLOYED” = sum of employed & armed forces full time AND employed & armed forces part time

“LABOR MARKET” = Employed AND Unemployed but Looking

Priority #5: Access for Priority Populations to SUD Services

**Priority #5**: Priority Populations

**Indicator #1**: Percentage of persons reported as injecting drugs who are admitted to Short Term Residential services within 14 days of seeking treatment

**Data Source**: CDS

<table>
<thead>
<tr>
<th>Baseline</th>
<th>Year 1 target</th>
<th>Year 2 target</th>
</tr>
</thead>
<tbody>
<tr>
<td>80%</td>
<td>85%</td>
<td>85%</td>
</tr>
</tbody>
</table>

**P1.** Pregnant and current intravenous drug using women;

**P2.** Pregnant substance abusing women;

**P3.** Current intravenous drug users;

**P4.** Women with dependent children, including those attempting to regain custody of their children

---

### Priority SUD Group

<table>
<thead>
<tr>
<th>Service/Description</th>
<th>2022 (DAO-8.1.2022)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IV Drug User</strong></td>
<td></td>
</tr>
<tr>
<td># of STR encounters</td>
<td>109</td>
</tr>
<tr>
<td>Average wait time</td>
<td>7 days</td>
</tr>
<tr>
<td>Admitted within 14 days</td>
<td>88%</td>
</tr>
<tr>
<td>Admitted within 30 days</td>
<td>94%</td>
</tr>
<tr>
<td>Priority sub population of all encounters waitlisted for STR and served for Substance Use</td>
<td>25.8%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NEBRASKA DHHS-DBH TOTAL</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td># of STR encounters</td>
<td>423</td>
</tr>
<tr>
<td>total # unduplicated STR consumers</td>
<td>409</td>
</tr>
<tr>
<td>Average wait time</td>
<td>6 days</td>
</tr>
<tr>
<td>Admitted within 14 days</td>
<td>89%</td>
</tr>
<tr>
<td>Admitted within 30 days</td>
<td>96%</td>
</tr>
<tr>
<td>total # unduplicated consumers</td>
<td>25,657</td>
</tr>
</tbody>
</table>

*Waitlisted in FY22 computations include all encounters for which a value was entered (including zero) for waitlist in CDS*
Recognizing challenges and addressing issues in the system: Nebraska First Episode Psychosis program

- Designated service in the CDS, *Coordinated Specialty Care*, rolled out in Fall of 2021 to improve data collection
- Changed model from *OnTrack New York* to *Raise NAVIGATE*
- Omaha team now under one agency – Community Alliance
- Training occurred for all team members in January and subsequent consultation ongoing
- Goal are to
  - strengthen treatment skills
  - increase participants
  - promote fidelity to the evidence-based practice

**Priority #6: First Episode Psychosis (FEP)**

**Priority #6:** First Episode Psychosis  
**Indicator #1:** Number of statewide admissions into FEP programs  
**Data Source:** FEP Programs funded by DBH

<table>
<thead>
<tr>
<th>Baseline</th>
<th>16</th>
<th>FY2022</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1 target</td>
<td>18</td>
<td>30</td>
</tr>
<tr>
<td>Year 2 target</td>
<td>20</td>
<td></td>
</tr>
</tbody>
</table>
Priority #7: Tuberculosis

Priority #7: Tuberculosis (TB)

Indicator #1: Maintain the contract requirement with the Regional Behavioral Health Authorities (RBHA) for Tuberculosis screening provided to all persons entering a substance abuse treatment service

Data Source: DBH contracts with the RBHAs

Signed contracts between the Nebraska Department of Health and Human Services (DHHS)- Division of Behavioral Health (DBH) and the six Regional Behavioral Health Authorities (RBHA) include requirements regarding screening for Tuberculosis.

Additional services and/or referrals for services are made available to those individuals whose screening indicates “high risk” for TB.
Critical Areas for Treatment and Recovery Success

• Stable Housing
• Employment
• Treated as worthy human being
  • Trauma informed care
  • Respect & dignity
  • Cultural sensitivity & equity
• Access to treatment and support systems in one’s community
  • At the level of care needed; timely
  • Minimal interaction with law enforcement
Consumer Survey: Percent of respondents with positive indications for ...

“I am better able to handle things when they go wrong.”

2019-2021

2019 2020 2021

72.1% 75.3% 74.5%

“I am an active member of my community.”

2019-2021

2019 2020 2021

43.3% 47.2% 43.7%

“Staff were sensitive to my cultural background (race, religion, language, etc.).”

2019-2021

2019 2020 2021

86.9% 87.7% 87.3%
Thank you!

Photo credit: https://images.app.goo.gl/643Ba5Q1T4AeeMKd8
HOUSING AND BEHAVIORAL HEALTH

FRAMEWORK


https://www.google.com/books/edition/Pandemic/33d6CwAAQBAJ?hl=en&gbpv=1&printsec=frontcover
FOUNDATIONAL DATA & STATISTICS

FOUNDATIONAL DATA: PREVALENCE

Non-institutionalized, male or female, all ages, all races, regardless of ethnicity, with all education levels in Nebraska who reported a disability in 2019


www.disabilitystatistics.org
PREVALENCE IN NEBRASKA

**PERCENTAGE**

- Disability: 11.9%
- Cognitive Disability: 4.4%
- Independent Living Disability: 4.7%

**NUMBER**

- Disability: 228,310
- Cognitive Disability: 79,000
- Independent Living Disability: 70,900

---

PREVALENCE IN NEBRASKA COUNTIES

- The county with the greatest number of people with disabilities: Douglas (58,463 people).
- The county with the least number of people with disabilities: McPherson (46 people).
- The county with the highest percentage of people with disabilities: Hooker (20.8%).
- The county with the lowest percentage of people with disabilities: Sarpy and Sioux (9.5%).

- Douglas County prevalence:
  - 58,463 people
  - 10.6%

- Lancaster County prevalence:
  - 32,808 people
  - 10.6%


https://disabilitycompendium.org/
FOUNDATIONAL DATA: POVERTY

Non-institutionalized persons aged 21 to 64 years with a disability in Nebraska living below the poverty line in 2019.

23,000 people (± 4,690)
22.2% (± 4.01%)

OVERLAP

“Point-in-time counts ... suggest that nearly one quarter of individuals experiencing homelessness have a disability, including physical, intellectual, and developmental disabilities, as well as mental health and/or substance abuse disorders.”

“When denied access to shelters, nearly 7 in 10 people with disabilities who experience homelessness stay in dangerous locations (e.g., on sidewalks or under bridges), directly affecting their health outcomes.”


VINCENT LITWINOWICZ


SUPPORTIVE HOUSING
SYMBIOSIS

From Bazelon Center for Mental Health Law Supportive Housing Fact Sheet:

• A growing body of evidence confirms that supportive housing works for people with mental disabilities, including those with the most severe impairments.
  • Indeed, these individuals may benefit the most from supportive housing.
• Research confirms that people with disabilities vastly prefer living in their own apartment or home
• Housing is a key aspect of well-being and recovery.
  • People with mental disabilities cannot be expected to succeed without a safe, secure home, particularly if they are struggling to recover from a mental illness.
• Stable housing can act as a motivator for people to seek services and supports and to engage in and sustain treatment.
• Supportive housing is built around individuals’ preferences and strengths.
  • Client-driven planning provides an opportunity for individuals to gain control over their lives and determine their own path of recovery.
  • Greater choice of residence not only correlates positively with consumer satisfaction but also is a significant predictor of housing stability.


CONNECTIONS AND COMMENT

• Making connections between housing professionals, behavioral health professionals, AND individuals with lived experience is critical
• Most effective tool to increase awareness and highlight unseen linkages and “feedback loops”
  • “Ignorance” may not be intentional– everyone has their “knowledge niche”
  • Establishing common definitions, language, and concepts
• Making comments (at every turn)
  • Comment, Comment, Comment! You have information developers and planners NEED!
  • State Plans on Housing/homelessness, state advisory committees, etc
  • Community / City plans on housing/homelessness
  • Funders and Developers
EXAMPLES

- Omaha Housing Plan (I believe they are accepting comments on revisions): https://rdgusa.mysocialpinpoint.com/omaha-affordable-housing-action-plan
  - Why is your input important? See Comments next slide
- Nebraska Dept of Econ Development: Housing Initiatives: https://opportunity.nebraska.gov/programs/housing/
  - Commission Member: John Turner with Neb Investment Finance Authority
  - Nebraska Commission on Housing and Homelessness (NCHH): https://opportunity.nebraska.gov/nchh/ (they have monthly meetings!)
  - The Education and Awareness Committee provides education and awareness to the general public in the State of Nebraska in relation to housing and homelessness issues. This includes collaboration with housing providers, housing developers and local continuums of care for the purpose of dissemination of information via social media outlets, public service announcements, news and radio media, etc.

https://opportunity.nebraska.gov/programs/housing/
https://opportunity.nebraska.gov/nchh/

COMMENTS FROM “DISABLED POPULATIONS” (OMAHA PLAN)

- Very few accessible units apart from age restricted options
- If it’s affordable, it’s not safe; if it’s safe, it’s not affordable
- Challenges that work against persons with disabilities—distance from transit and amenities, poor credit, past evictions, tendency to live in poverty
- Units marketed as accessible are not truly accessible; an entrance ramp to the front door does not make a unit accessible; also includes transit options, online applications, notices in print, etc.
- City should require Universal Design on all housing that receives public assistance or incentives
- Accessible housing should not be segregated; should be integrated across city, all developments, etc.
- Making units accessible should not be thought of as special, rather as universally needed (parents with strollers, aging adults, etc.)
- Impossible to purchase a home that is fully accessible and affordable; difficult to find a builder for this
- Need more persons with disabilities engaged in planning processes
EXAMPLES

The Legislature is another outlet for advocacy: Funding for housing developments, trust funds, etc.; funding for and direction for HHS and departments

- LR 387: Review of Homestead Exemptions
- I can help! brad@drne.org

brad@drne.org

CONCLUSION (FROM BAZELON)

Public officials and stakeholders should push for supportive housing and turn into reality the desire of people with mental disabilities to live in the community like everyone else.
PERMANENT SUPPORTIVE HOUSING:
The Most Effective and Integrated Housing for
People with Mental Disabilities

Introduction

People with mental disabilities can successfully live in the community like everyone else, as envisioned by the Americans with Disabilities Act. Supportive housing makes this possible. Permanent supportive housing gives them their own apartment or home while making available a wide variety of services to support recovery, engagement in community life and successful tenancy.

A growing body of evidence confirms that supportive housing works for people with mental disabilities, including those with the most severe impairments. Indeed, these individuals may benefit the most from supportive housing. Permanent supportive housing gets much higher marks than less integrated alternatives; research confirms that people with disabilities vastly prefer living in their own apartment or home instead of in group homes or buildings housing primarily people with disabilities. Moreover, permanent supportive housing is less costly than other forms of government-financed housing for people with disabilities. Studies have shown that it leads to more housing stability, improvement in mental health symptoms, reduced hospitalization and increased satisfaction with quality of life, including for participants with significant impairments, when compared to other types of housing for people with mental disabilities. Supportive housing has been endorsed by the federal government, including the U.S. Department of Housing and Urban Development, the Surgeon General, the U.S. Department of Health and Human Services and the National Council on Disability.

The Basic Principles of Permanent Supportive Housing

Three basic principles guide permanent supportive housing. First, supportive housing gives participants immediate, permanent housing in their own apartments or homes. Unlike most other housing for people with disabilities, there is no limit on how long the person can stay in the residence, and temporary absences do not lead to disenrollment. Treatment compliance or sobriety is not a requirement for receiving or remaining in housing. Supportive housing
participants have the same rights and responsibilities as any other tenant. They may lose their unit, for example, for disruptive behavior or drug use. Supportive housing staff, however, try to avoid this situation by providing supports and the accommodations necessary to help ensure successful tenancy.

Permanent supportive housing provides housing first, allowing participants the opportunity to focus on recovery next. Adequate, stable housing is a prerequisite for improved functioning for people with mental disabilities and a powerful motivator for people to seek and sustain treatment. Studies find that providing immediate, permanent housing leads to more long-term housing stability when compared to housing conditioned on treatment.

Second, individuals in supportive housing have access to a comprehensive array of services and supports, from crisis mental health services to cooking tutors. Services are provided as needed to ensure successful tenancy and to support the person’s recovery and engagement in community life. Services and supports are provided in the home and other natural settings, allowing individuals to learn and practice skills in the actual environment where they will be using them. Services are available whenever people need them, including after working hours and on weekends when necessary. Service providers are highly flexible and supports are highly individualized. A creative “whatever it takes” approach is pursued. No “program” attendance is required and services are increased, tapered or discontinued as decided by the individual in consultation with the provider. As a result, individuals “buy in” to the treatment plan—the most important predictor of plan success.

Available services and supports include mental health and substance abuse treatment and independent living services, including help in learning how to maintain a home and manage money as well as training in the social skills necessary to get along with others in the community. Medication management, crisis intervention and case management are also available. Peer-support services are especially effective in securing good results. For individuals who are unable to do certain tasks, such as cooking and cleaning on their own, personal care and/or home-care services are provided until no longer needed.

Assertive Community Treatment (ACT) teams serve the clients with the greatest challenges, including individuals with serious mental illnesses who have co-existing problems such as homelessness, substance abuse or involvement with the judicial system. ACT teams are interdisciplinary and mobile, typically including a social worker, psychiatrist, substance abuse counselor, nurse, vocational counselor and housing specialist. They develop individualized treatment plans with their clients and provide services around-the-clock in consumers’ homes and in the community. Among the services ACT teams may provide are: case management, initial and ongoing assessment, psychiatric services, rehabilitation services, employment and housing assistance, family support and education, substance abuse services, and other supports critical to
an individual's ability to live successfully in the community. ACT teams have been widely recognized as one of the most effective ways to provide services to individuals with mental illnesses. They can be covered by Medicaid.  

Third, permanent supportive housing facilitates full integration into the community. Individuals are encouraged to integrate into the community through employment, volunteer work and social activities. People are encouraged to participate in neighborhood activities or become members of community organizations of their choosing. Vocational training, training in managing symptoms in the workplace and conflict-management skills are available to those ready to seek employment. Research has shown that employment can be critical to recovery; it helps individuals with mental disabilities live autonomously, build meaningful personal relationships, become integrated into society, improve self-esteem and learn to control symptoms. Moreover, unlike the case with traditional disability housing, supportive housing participants do not live and interact only with other mental health clients; nor are they in an identifiable mental health program.

Permanent Supportive Housing Works

Permanent supportive housing is effective for various reasons. First, housing is a key aspect of well-being and recovery. People with mental disabilities cannot be expected to succeed without a safe, secure home, particularly if they are struggling to recover from a mental illness. Moreover, stable housing can act as a motivator for people to seek services and supports and to engage in and sustain treatment.

Second, supportive housing is built around individuals' preferences and strengths. Client-driven planning provides an opportunity for individuals to gain control over their lives and determine their own path of recovery. Supportive housing participants are involved in the process of choosing their housing unit, rather than unilaterally being placed in a residence. The services offered are highly flexible and individualized to meet the participant’s needs and preferences, rather than defined by a “program.” Research shows that greater choice of residence not only correlates positively with consumer satisfaction but also is a significant predictor of housing stability. It also establishes that consumer choice and buy-in to service plans is a great predictor of success. A “good” plan that is not accepted by a consumer is not likely to work.

Supportive housing takes advantage of the clear preferences of people with mental disabilities about how they want to live. Studies show that consumers prefer living in their own homes, either alone or with one or two roommates, rather than in congregate settings with many other people with mental disabilities, particularly when they receive supports to help them engage socially in their own communities. “They want to be able to choose, among other things, the type of housing in which they live, the neighborhood, with whom they live (if
they choose not to live alone), what and when to eat, whether or not to participate in mental health services (and, if they want services, to choose the ones they want) and how to schedule their days.”

Hence, it is no surprise that study after study has found that supportive housing programs work for people with mental disabilities, even those who are hardest to house, such as chronically homeless individuals with mental illnesses. Research has shown that providing immediate, permanent housing leads to more long-term housing stability when compared to traditional housing programs. Other positive outcomes for supportive housing participants include reduced hospitalization, decreased involvement with the criminal justice system, participants’ greater satisfaction with their quality of life and improvement in mental health symptoms.

**Permanent Supportive Housing Reduces Costs**

Permanent supportive housing is less costly than other forms of government-financed housing for people with disabilities. Even for clients with the greatest challenges, quality supportive housing, including necessary community treatment and support services, compares favorably with the cost of traditional mental health housing and services. Supportive housing also costs far less than other places where people with mental disabilities end up: The cost of serving a person in supportive housing is half the cost of a shelter, a quarter the cost of being in prison and a tenth the cost of a state psychiatric hospital bed. Moreover, most of the cost of supportive housing can be funded through existing programs, including Medicaid and federal housing and rental assistance programs.

Supportive housing reduces costs in several ways. It saves money by utilizing apartments or houses available for rent on the market. Unlike other housing for people with disabilities, such as group homes or buildings designated exclusively for people with disabilities, supportive housing does not require investment for new construction or purchase and rehabilitation. Moreover, supportive housing’s use of scattered-site rental units avoids the delay and expense of fighting neighborhood opposition to the siting of permanent housing for people with disabilities, as often occurs. In addition, supportive housing saves money by reducing participants’ use of expensive resources, such as day programs, shelters, inpatient psychiatric hospitals, public hospitals, and prisons and jails, which can cost tens of thousands of dollars per person in a year.

**Implications**

Permanent supportive housing should be the primary housing option available though mental disability service systems. In most communities, this will require a substantial shift, including replacing existing congregate settings with scattered-site supportive housing. Public officials and stakeholders should work to ensure that housing, when provided as a service, has the following characteristics:
Housing units are scattered-site or limited to relatively few units in a building.

A wide array of flexible, individualized services and supports is available to ensure successful tenancy and support participants’ recovery and engagement in community life.

Services are delinked from housing. Participants are not required to use services or supports to receive or keep their housing.

Participants have a say in choosing their housing unit, any roommates (if they choose not to live alone) and which services and supports (if any) they want to use.

Participants have the same rights and responsibilities as all other tenants. They should be given any accommodations necessary to help ensure successful tenancy.

To achieve this end, mental health systems must play an active role, both by contracting with supportive housing providers and helping them secure rental subsidies, and by declining to finance or support the expansion of congregate housing, including through building purchases.

Conclusion

Permanent supportive housing is what people with disabilities want. It is the most integrated type of housing and helps people with mental disabilities be a successful part of the community—an opportunity to which they are entitled under the Americans with Disabilities Act. Supportive housing programs are the most clinically and cost-effective and offer the most integrated housing available for people with mental disabilities. Public officials and stakeholders should push for permanent supportive housing and turn into reality the desire of people with mental disabilities to live in the community like everyone else.

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1 This paper was developed by the Bazelon Center for Mental Health Law under a grant to the University of Pennsylvania from the Department of Education, NIDRR grant number H133B080029 (Salzer, PI). However, the contents do not necessarily represent the policy of the Department of Education, and you should not assume endorsement by the Federal Government.


7 Some people use the term “supported” housing. Fidelity to the basic principles set out in this paper – not the terminology – is what is important. In many communities, much of the housing that is called “supportive” or “supported” does not follow these basic principles.

8 The strict admission criteria and program rules of traditional mental health housing often deny housing to those most in need. Pathways to Housing, Inc. “Providing Housing First and Recovery Services for Homeless Adults with Severe Mental Illness.” *Psychiatric Services*, 56.10 (2005): 1303.


11 In some communities, existing “supportive” or “supported” housing is of uneven quality because the full array of necessary services and supports is not available.

12 Tsemberis. supra note 10, at 488.


14 Surgeon General, supra note 4.

15 Some supportive housing providers have their own dedicated ACT teams, while other individuals in supportive housing receive ACT services through the mental health system.


18 National Council on Disability, supra note 6, at 23.

19 Id.

20 Id.

21 Tsemberis, supra note 9, at 655.

22 The federal government has recognized the importance of consumer choice in housing and the role of housing in promoting recovery. U.S. Substance Abuse and Mental Health Services Administration. *Blueprint for Change: Ending Chronic Homelessness for Persons with Serious Mental Illnesses and Co-Occurring*

24 Tsemberis. supra note 9, at 651. Nelson, supra note 13, at 160.


26 National Council on Disability, supra note 6, at 22-23. This paper is not intended to imply that all people with mental disabilities prefer supportive housing. Some do not. Individuals with disabilities should have choices, like everyone else, about their living options.

27 Id. at 654-55. U.S Dept. of Housing and Urban Dev., supra note 3, at 80-104.

28 Tsemberis. supra note 9, at 654-55.


30 Based on a survey of costs in several states.


32 These include the Section 8, Section 811, Home, Shelter Plus Care, and Hope VI programs. See [www.nationalhomeless.org/publications/facts/Federal.pdf](http://www.nationalhomeless.org/publications/facts/Federal.pdf)


34 See Culhane, supra note, at 135-41.
May 20, 2022

Disability Rights Nebraska is the designated Protection and Advocacy organization for people with disabilities in Nebraska. We are pleased to take this opportunity to comment on the 2022 Annual Action Plan for addressing homelessness in Nebraska. We are particularly interested in this topic as housing is a significant and pressing policy issue for the disability community.

We are pleased to see the recognition that successful housing is multifaceted and requires collaboration among a variety of networks and agencies that are not housing authorities. This is especially important in the disability context as persons with disabilities often interact with multiple systems, depending on their own individual health and social needs.

Demographics

Approximately 11.5% of our state’s population identify as a person with a disability—in other words, 218,800 individuals of all ages in Nebraska reported one or more disabilities in 2018— and there are Nebraskans with disabilities in every county.

Using data from the 2018 Disability Status Report, the living experiences of people with disabilities and those without disabilities are sharply contrasted:

- The poverty rate of working-age people with disabilities in Nebraska was 27.8%. The poverty rate of working-age people without disabilities in Nebraska was 8.6%.
- The median income of households that include any working-age people with disabilities in Nebraska was $50,700. Median income of households that do not include any working-age people with disabilities in Nebraska was $70,900.
- The percentage of working-age people with disabilities working full-time/full-year in Nebraska was 30.2%. The percentage of working-age people without disabilities working full-time/full-year in Nebraska was 67.9%.
- The employment rate of working-age people with disabilities in Nebraska was 49.5%. The employment rate of working-age people without disabilities in Nebraska was 85.9%. The gap: 36.4 percentage points.

Living with a disability is expensive. Stabile and Allen (2012) estimate the additional annual cost per family with children with disabilities: $10,830 (including direct and indirect costs). Indirect and direct

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costs associated with disability “have a deleterious long-term impact on family finances, including later life asset accumulation and financial security”\(^5\). People with disabilities are more likely to experience being in poverty over 1 year\(^6\).

Poverty limits housing options and disability limits those options even further. For some, their disability requires housing to be physically accessible, yet accessible housing is scarce. Forced into unfavorable neighborhoods, people with disabilities are more likely to be victims than perpetrators of crime. Poverty compromises the ability to make rental deposits or other ancillary housing expenses. For many Nebraskans with disabilities, their future consists of long waiting lists and decreased availability of affordable, safe, decent housing\(^7\).

Consequently, the overlap between disability and homelessness is significant. The National Association of County and City Health Officials (NACCHO) reports that people with disabilities are disproportionately likely to experience homelessness: “Point-in-time counts ... suggest that nearly one quarter of individuals experiencing homelessness have a disability, including physical, intellectual, and developmental disabilities, as well as mental health and/or substance abuse disorders.” (emphasis added)\(^8\).

Noting the significant interrelated nature of homelessness and disability and the specific portions of the action plan mentioning “special needs” housing, we are curious why there does not appear to be outreach and input from the disability community in the plan. People with lived experience of having a disability should be front and center in the discussion of not only “special needs” housing in this plan but also in the affordable housing discussion overall. People with disabilities should be involved at every level of planning and implementation of state or local housing policy. Without such direct input and lived experience expertise, effective outcomes of the plan for this particular community seem suspect. Disability Rights Nebraska would be happy to collaborate as we can regarding communications to and from the disability community.

We are dismayed that the goal for the federal funding of 7 different programs/projects in this plan results in only 15 “Special needs” households supported; while households in other communities receiving supports are exponentially larger (see page 90).

Affordability is meaningless if a person cannot physically access the home. Accessibility must be accounted for in any affordable housing plan or actions. These concepts are not mutually exclusive. “Universal Design” is a concept where buildings and dwellings can be designed to be accessible to all persons, those with disabilities and those without. If we build universally accessible housing initially, modification costs can be avoided and more people can be served.

Shelters are not always accessible. Staff may not be adequately trained to work with people with disabilities. Shelters may not have the appropriate technology, equipment, or protocols to address the needs of people with various types of disabilities. Thus, relying on shelters is an insufficient answer to the


issue of homelessness and people with disabilities. This is a critical assumption to dispel for NACCHO reports, “When denied access to shelters, nearly 7 in 10 people with disabilities who experience homelessness stay in dangerous locations (e.g., on sidewalks or under bridges), directly affecting their health outcomes.”9 Vincent Litwinowicz’s story on KETV presents a stark picture of this reality10.

Recommendations and Suggestions

1. A significant increase in the inclusion of people with disabilities in all phases of planning and implementation. The lived experience of people with disabilities will be a key component to make attempts to reduce homeless; disability provides unique circumstances that will likely not be adequately addressed or accounted for without the inclusion of persons who have lived experience.
   a. There are many opportunities to connect with the disability community—come to meetings, present to groups, participate in conferences, etc. Disability Rights Nebraska would be happy to help be a conduit here.

2. An increase in “Special needs” supports from the current goal of 15.

3. Employment
   a. Support for Employment First policies or legislation
      i. See Nebraska’s chapter of the Association of People Supporting Employment
   b. End paying some people with disabilities a sub-minimum wage
   c. Increase collaboration with benefits planners who know what work incentive programs are available to persons with disabilities. We suggest reaching out to Easterseals benefits planners.
   d. Increase awareness of the Medicaid Insurance for Workers with Disabilities program, which makes it easier for people with disabilities who utilize Medicaid to go back to work.

If there is further question or to discuss possible areas where our organization can be of assistance, please do not hesitate to contact me.

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9 Ibid.