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UNIVERSITY OF NEBRASKA PUBLIC POLICY CENTER

LINCOLN VITAL SIGNS SUPPLEMENTAL REPORT: BEHAVIORAL HEALTH TRENDS IN LINCOLN

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ABOUT THE CENTER

The University of Nebraska[1] Public Policy Center is a university-wide, multidisciplinary research and outreach policy unit of the University of Nebraska committed to connecting local, state, and federal policymakers to expertise at the University of Nebraska and beyond. Center researchers team with policymakers and other stakeholders to actively inform public policy by bringing expertise in strategic consulting and planning, communication, data collection and analysis, evaluation, events and seminars, facilitation, grant writing, project management, research, and surveys. The Center provides a unique opportunity for decision-makers of all kinds to work together to address the challenges of local, state, and federal policy. Center researchers combine professional expertise with rigorous academic methods and stakeholder involvement.

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EXECUTIVE SUMMARY

Lincoln Vital Signs reports from 2014 and 2015 were created by leaders of Lincoln's largest public and private charitable organizations. Their intention was to create a more comprehensive understanding of Lincoln for themselves, as well as a way to share that information with the larger community. Lincoln Vital Signs identified key trends in seven areas: Community Profile, Economy and Workforce, Basic Needs, Education, Health, Safety, and Community Involvement and Culture. The Lincoln Vital Signs reports have been the basis for the **Prosper Lincoln** movement that is creating a community-wide agenda for making Lincoln an even greater community. As Lincoln's residents are becoming better informed about our community through Lincoln Vital Signs and determining strategies for taking action through Prosper Lincoln, many have expressed a desire to have more complete information about the complexion of Lincoln's behavioral health needs (mental health and/or substance abuse). Data are not available regarding all persons receiving behavioral health services: this report focuses on those receiving Nebraska-funded services, persons identified as homeless, or persons coming in contact with law enforcement. Among those populations:

1. Recent efforts to better identify and coordinate services for persons with behavioral health needs have shown positive results.
2. Persons receiving Nebraska-funded behavioral health services are challenged in employment, housing, completing treatment, and in interactions with police.
3. Parental substance abuse is the second leading reason children are removed from their home.

This report, *Behavioral Health Trends in Lincoln*, presents key data identified and provided by members of the Behavioral Health Advisory Panel. The goal is for these data to help Lincoln understand and take action to create improved systems of care for persons needing behavioral health services.

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INTRODUCTION

Lincoln's major philanthropic organizations, business community, and city and county governments came together to create the Lincoln Vital Signs 2014 report (lincolnvitalsigns.org). Inspired by the community response, an update was written and released as the Lincoln Vital Signs 2015 report. These reports became the basis for community-wide conversations around Community Profile, Economy and Workforce, Basic Needs, Education, Health, Safety, and Community Involvement and Culture. Both reports highlighted three cross-cutting themes:

1. Lincoln does many things exceptionally well and these successes should be nurtured.
2. A growing proportion of Lincoln's population faces real need.
3. Lincoln's children fare poorly on many measures.

Upon the release of the Lincoln Vital Signs 2015 report, a major community initiative, Prosper Lincoln, was started to address these three cross-cutting themes to make Lincoln an even better community. Over 2,100 ideas were collected from persons of all ages and from all areas of the city. A Steering Committee of representatives throughout the community selected three agenda areas and have noted that behavioral health (along with information technology infrastructure) requires special focus.

This report is a supplement to the Lincoln Vital Signs reports, focusing specifically on behavioral health trends. Behavioral health, as used in this report, includes mental health and/or substance abuse.

Special thanks to those individuals who extracted the data upon which this report depends:

| Region V
Behavioral Health Systems | City of Lincoln
Police Department | University of Nebraska-Lincoln
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| --- | --- | --- |
| Erin Rourke
Patrick Kreifels | Jackie Pfeifle | Jeffrey Chambers |

BEHAVIORAL HEALTH ADMINISTRATIVE DATA

There is increasing recognition that solving complex problems requires the participation of community-wide stakeholders.[1] An important step in helping stakeholders work together is to create a common understanding of the community.[2] Many communities have found that tracking and reporting key indicators is a powerful way to understand assets and challenges.[3]

The nation's behavioral health system is fragmented[4] and too often, persons with needs "bounce back and forth between the mental health and substance abuse services systems",[5] access treatment primarily through crisis services,[6] or receive no treatment.[7] This fragmentation means that it is a challenge to identify the true scope of behavioral health needs in communities because each provider or community sector only has one part of the entire picture.

To present behavioral health trends in Lincoln, this report relies on three primary organizations for existing administrative data:

- **Region V Behavioral Health Systems (Region V)** – has a secure data platform that enables Lincoln's behavioral healthcare providers to share a common clinical record for publicly-funded clients.
- **Lincoln Police Department (LPD)** – maintains data on behavioral health-related interactions.
- **University of Nebraska-Lincoln Center on Children, Families, and the Law** – runs the statewide ServicePoint Homeless Management Information System (HMIS) data platform for homeless providers to share service records for homeless and near-homeless individuals.

Administrative data maintained by these three separate organizations provide insights into behavioral health trends in Lincoln. There is little doubt that there are persons who appear in not just one of these data sources, but two or all three. Indeed, national studies indicate persons with behavioral health issues rely more heavily on other public and care systems such as Medicaid/Medicare, housing/homeless shelters, hospital emergency departments, law enforcement and corrections.[8] It is not currently feasible to combine individual-level data from these organizations to provide a single,

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[1] Jolin, Schmitz, & Seldon, 2012.

[2] Kania & Kramer, 2011.

[3] Kania & Kramer, 2011.

[4] Office of the Surgeon General, 1999.

[5] Substance Abuse and Mental Health Services Administration, 2002, p. i.

[6] Coffey et al., August 23, 2010.

[7] Bird et al., 2002; Mojtabai, 2005; Rockett, Putnam, Jia, Chang, & Smith, 2005.

[8] Center for Substance Abuse Treatment, 2006; Chafetz, White, Collins-Bride, & Nickens, 2005; James & Glaze, 2006; Larkin, Claasen, Emond, Pelletier, & Camargo, 2005; Owens, Mutter, & Stocks, 2010; White, Chafetz, Collins-Bride, & Nickens, 2006.

comprehensive ongoing picture of behavioral health services in Lincoln. However, data from each source do provide important overall outlines of behavioral health issues in Lincoln.

This report begins with a review of resident participation in Nebraska-funded behavioral health treatment programs. Next, a profile of persons who are homeless and have behavioral health needs is presented. The report then moves to the use of emergency behavioral health services through the use of emergency and protective custody interventions. The report concludes with police department interventions involving persons with behavioral health needs.

NEBRASKA-FUNDED BEHAVIORAL HEALTH PROGRAMS

The State of Nebraska and local communities are responsible for paying for services for persons with severe and persistent behavioral health needs who are unable to do so. In Lincoln, Nebraska-funded services are paid for by the State of Nebraska, Lancaster County, behavioral health providers' charitable donations or other underwriting, and donors. Persons receiving Nebraska-funded care are only a subset of all individuals receiving behavioral health care services. For example, some persons pay for services through other public programs, such as Medicaid. Others may pay for services through other public or private insurance programs or may self-fund care. In Lincoln, many persons with severe and persistent behavioral health needs cycle between Nebraska-funded and Medicaid-funded care.

This report focuses on the adult behavioral health system, since adults are the largest part of the population in general, as well as the largest part of the population with behavioral health needs. Last year, Region V network providers served 2,372 persons: 225 youth (age 18 and under), 2,115 working age adults (age 19 through 64), and 32 older adults (age 65 or older).

## CO-OCCURRING DISORDER IS THE MOST COMMON TYPE OF DISORDER

When persons enter into any type of service, they are *admitted*. People may be admitted to multiple services simultaneously.[9] Persons admitted to behavioral health services may be diagnosed with a mental health disorder, a substance abuse disorder, or a *co-occurring* disorder. A co-occurring disorder is one that involves both mental health and substance abuse needs.[10] When individuals have a co-occurring disorder, treatments that address both are associated with lower costs and better outcomes. Since 2013, behavioral health treatment providers in Lincoln have participated in activities designed to raise awareness of co-occurring disorders.

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[9] Some admissions are re-admissions of existing clientele into the same services; this is required after a client has received 12 months of continuous services.

[10] In 2012, all Nebraska-funded behavioral health programs in Lincoln underwent an assessment for their capability to serve patients with co-occurring disorders, and they have been implementing improvements identified during their assessment. These improvements are key to serving the substantial proportion of clients with co-occurring disorders.

A **plurality of clients**[11] **are admitted with either a co-occurring disorder** (45% in 2015) **or mental health disorder** (37% in 2015). In Lincoln, there has been a decrease in the number of persons with a substance abuse disorder over the past few years (Figure 1). It is possible that co-occurring disorders are now recognized more often due to recent awareness initiatives, decreasing the number of persons noted as having only a substance abuse disorder.

Figure 1. Type of Disorder at Admission
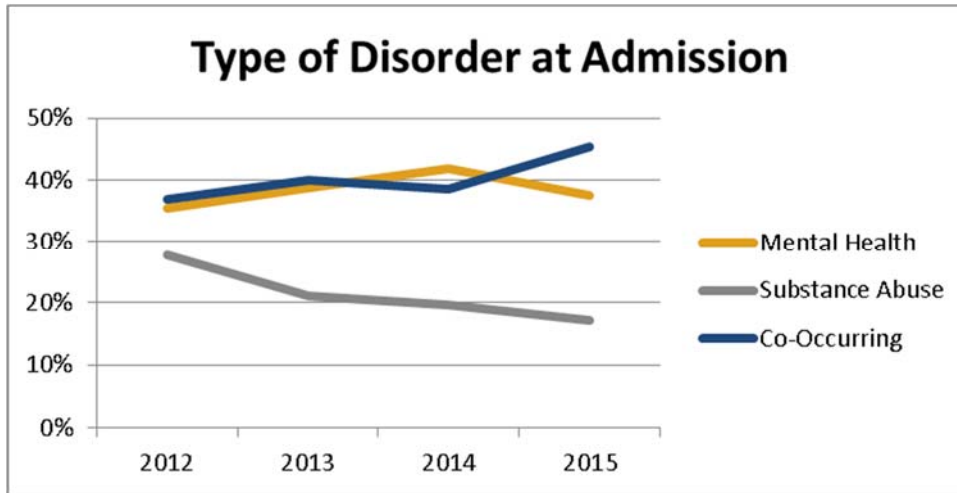
Source: Region V Behavioral Health Systems

A LARGE PROPORTION OF PERSONS DO NOT COMPLETE THEIR PLANNED TREATMENT

When persons end involvement in a service, they are *discharged*. Persons who are discharged may leave services because they have completed the treatment or without having completed the treatment. Completion of treatment is, of course, desirable. However, persons may leave treatment for good reason (transferred to another more appropriate service) or for reasons beyond the service they were receiving (move to another community). Others may just choose to stop receiving treatment. To understand discharge patterns, two categories of discharge were created:

- Treatment complete – client received the entire planned treatment
- Treatment not completed – client did not show up for first treatment appointment, declined additional treatment, voluntarily left treatment against professional advice, was terminated from treatment by a residential facility (for breaking facility rules), was incarcerated, or died by suicide[12]

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[11] Except where noted otherwise, graphs are based on a population of adult Lincoln residents.

[12] The rate of treatment not completed due to suicide is low. For example, there were no discharges due to suicide in 2015.

Figure 2).[13] About one-third of clients (32% in 2015, or 445 out of 1,541 persons discharged) successfully completed treatment. Of those who do not complete a course of treatment for a specific service, 50% either remain enrolled in other services they are receiving or return within a year for additional services. Some behavioral health disorders, such as severe and persistent mental illnesses, are chronic and require repeated episodes of treatment, and different types of treatment at different times.

Figure 2. Discharge Type
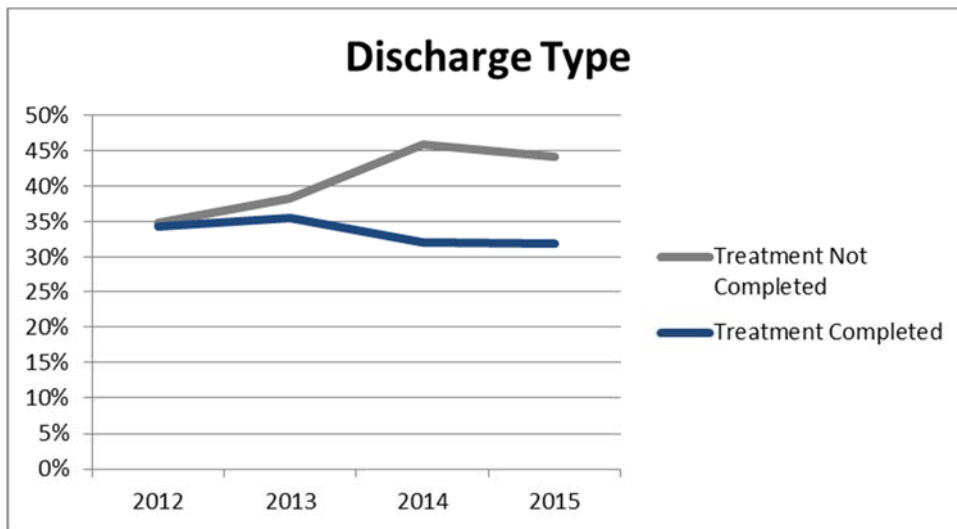
Source: Region V Behavioral Health Systems

Note: The data in this graph does not add to 100% because there are other reasons people may leave treatment, for example: being transferred to another service or program for more appropriate treatment, moving out of the service area, or death (not due to suicide).

EMPLOYMENT AND HOUSING

Housing and employment play an important role in the effectiveness of behavioral health treatment. Region V Services funds evidence-based practices to help clients find housing and employment.[14]

EMPLOYMENT

Across the United States, persons with severe behavioral health needs are more likely to be unemployed. Those who are unemployed are persons who consider themselves active members of the

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[13] The numbers on discharge types presented here differ from data released by Nebraska Department of Health and Human Services, Division of Behavioral Health (DBH) due to data source (DBH data is from the Magellan database, while data used here is from eBHIN), population (DBH data includes all ages, while these data are adults only), and deduplication (DBH data is not unduplicated, while data used here is unduplicated within year).

[14] Center for Substance Abuse Treatment, 2006; Substance Abuse and Mental Health Services Administration. (2010); Substance Abuse and Mental Health Services Administration. (2009).

workforce, but who do not currently have jobs. Persons not in the workforce by choice (e.g., student, homemaker, retired) or due to disability are not included in unemployment rates.

Unemployment is High Among Behavioral Health Clients

In Lincoln in 2015, **55% of persons admitted to Nebraska-funded behavioral health treatment were unemployed**. The unemployment rate varies considerably based on type of disorder: Unemployment among those admitted for **substance abuse, at 66%, was substantially higher than the overall unemployment rate for all behavioral health clients** (Figure 3).

Figure 3. Unemployment at Admission by Disorder
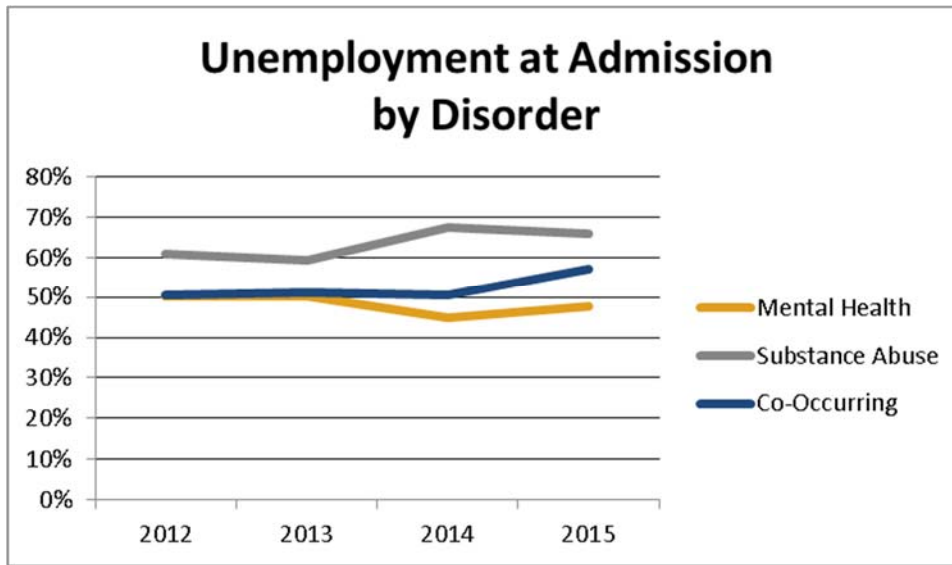
Source: Region V Behavioral Health Systems

Persons with Substance Abuse Disorders are Less Likely to be Eligible for Disability

Persons with mental health and co-occurring disorders, but few persons with substance abuse disorders, qualify for disability programs. Persons with mental health disorders may be eligible to receive support through disability programs and remove themselves from the workforce while those with substance abuse disorders may be unable to receive disability support and therefore stay in the workforce (Figure 4).

Figure 4. Unemployment Status by Disorder (2015)
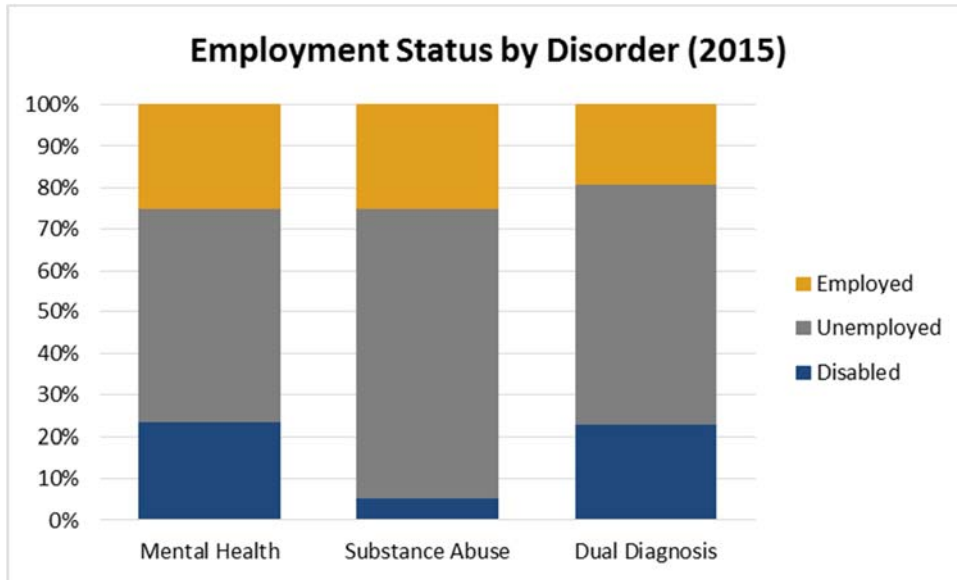
Source: Region V Behavioral Health Systems

Unemployment Corresponds to Lower Treatment Completion Rates

Since 2013, **those who were unemployed at admission were more likely to leave before their treatment was complete** than those who were employed (Figure 5). In 2015, the rate of incomplete treatment was 58% for those unemployed at admission and 47% for those employed at admission.

Figure 5. Treatment Completion by Employment Status
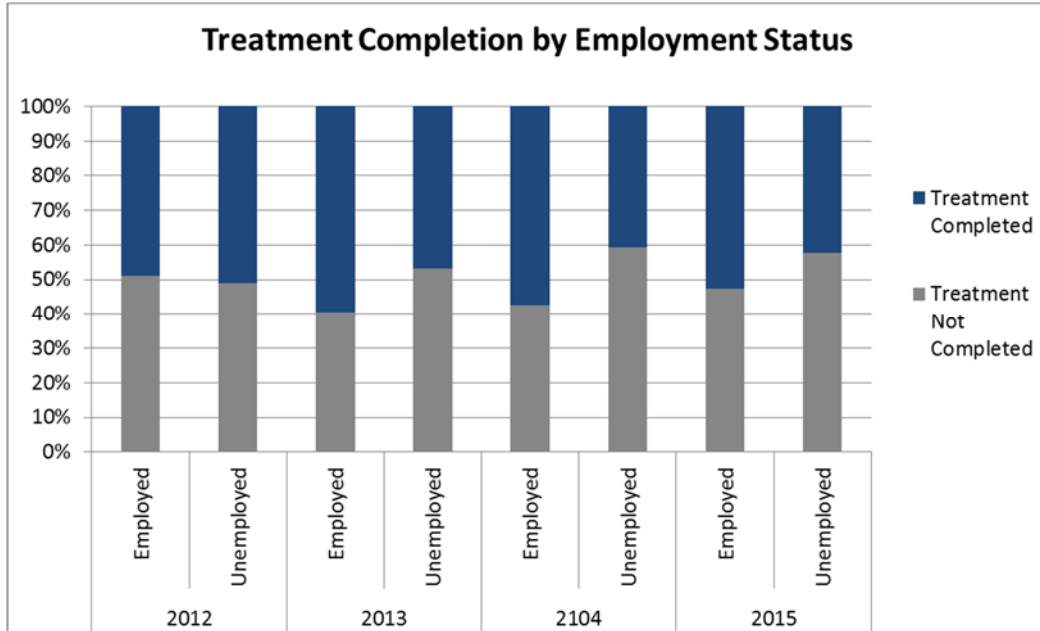
Source: Region V Behavioral Health Systems

Employment Increases While Enrolled in Behavioral Health Services

**A greater number of persons are employed at discharge than at admission**, though the plurality of persons are unemployed at both admission and discharge (Figure 6). For clients who were discharged in 2015, employment increased from 16% at admission to 23% at discharge (representing 107 more people employed at discharge than at admission). This is primarily due to a decrease in unemployment (from 54% to 46% in 2015), not an increase in persons on disability or leaving the labor force for other reasons.

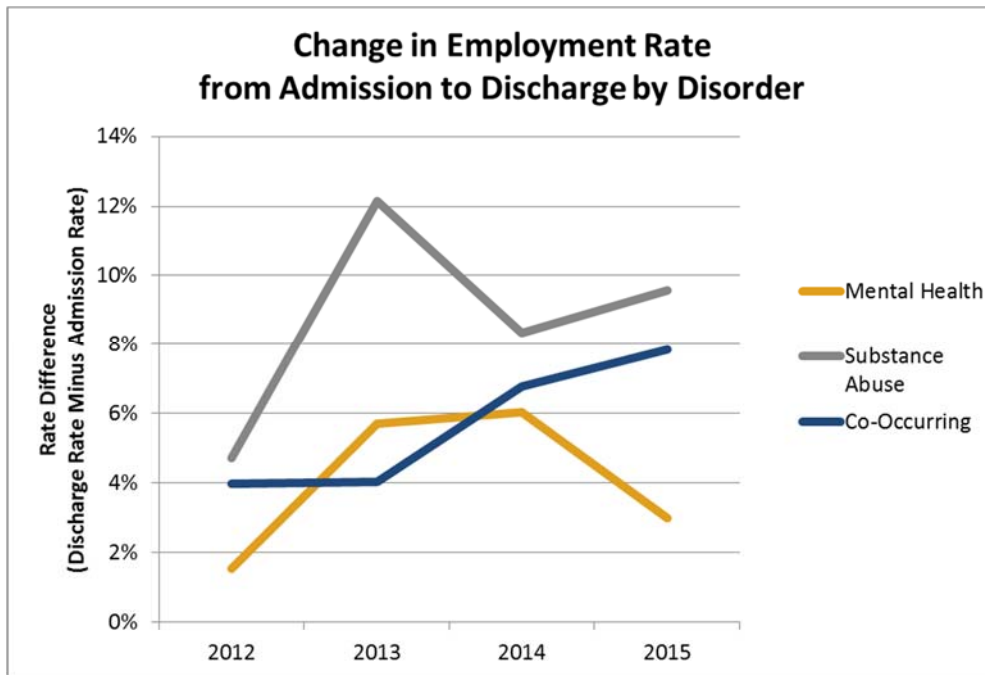Figure 6. Change in Employment Status from Admission to Discharge
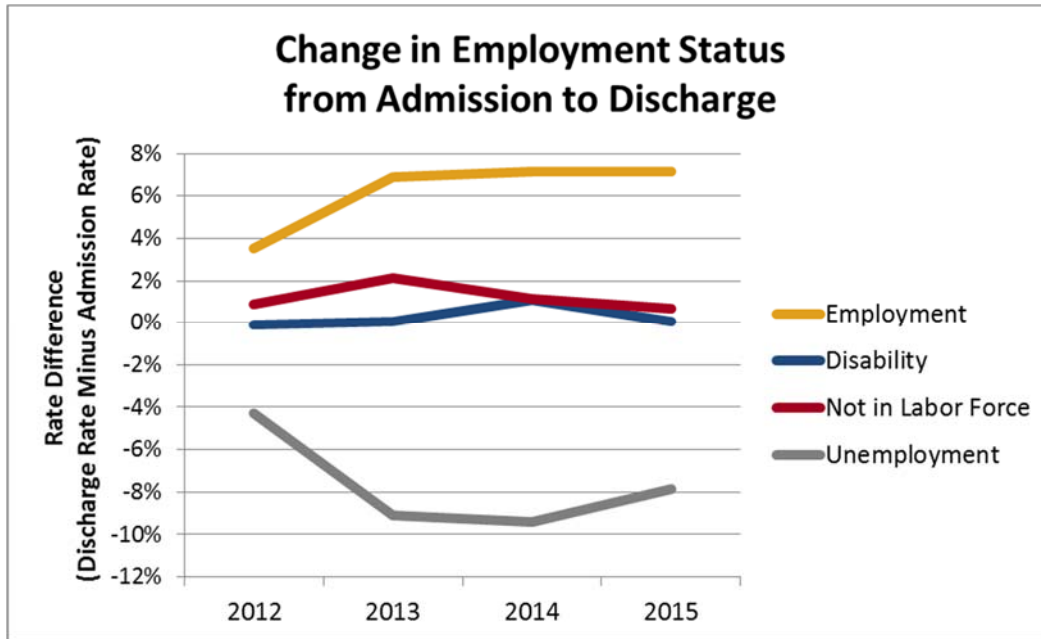
Source: Region V Behavioral Health Systems
Note: Positive percentages indicate an increase in the category (such as employment) and negative percentages indicate a decrease in the category (unemployment).

The pattern of **increased employment at discharge holds for each disorder type** (Figure 7).

Source: Region V Behavioral Health Systems
Note: Positive percentages indicate an increase in the employment rate.

HOUSING

Homelessness is a hardship, particularly among persons with behavioral health disorders. Behavioral health issues may pose economic challenges leaving individuals with low-cost and public housing as viable alternatives. However, public housing presents its own challenges, particularly for persons with substance abuse and co-occurring disorders because law violations related to their substance use could make them ineligible for public housing.

Homelessness is High Among Behavioral Health Clients

In 2015, **22% of patients in Nebraska-funded behavioral health services were homeless at admission**. Homelessness by disorder varies dramatically; persons with mental health disorders have the lowest homeless rate (9%) and those with co-occurring disorders have the highest (33%) (Figure 8).

Figure 8. Homeless Rate at Admission by Disorder
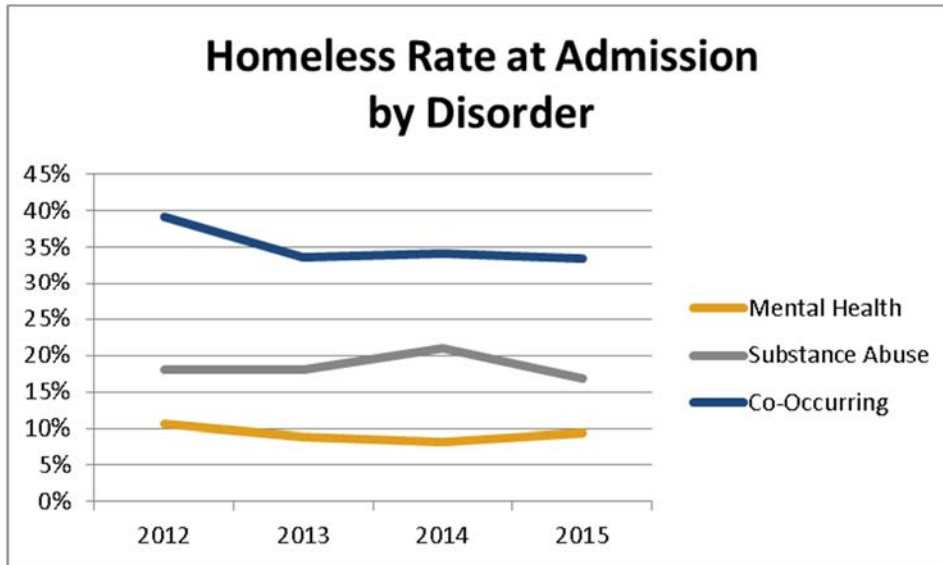
Source: Region V Behavioral Health Systems

Homelessness Corresponds to Lower Treatment Completion Rates

Over the past four years, **clients homeless at admission were more likely to leave before their treatment was complete** than clients with housing (Figure 9). In 2015, the rate of incomplete treatment was 53% for those housed at admission, but 69% for those homeless at admission.

Figure 9. Treatment Completion by Housing Status
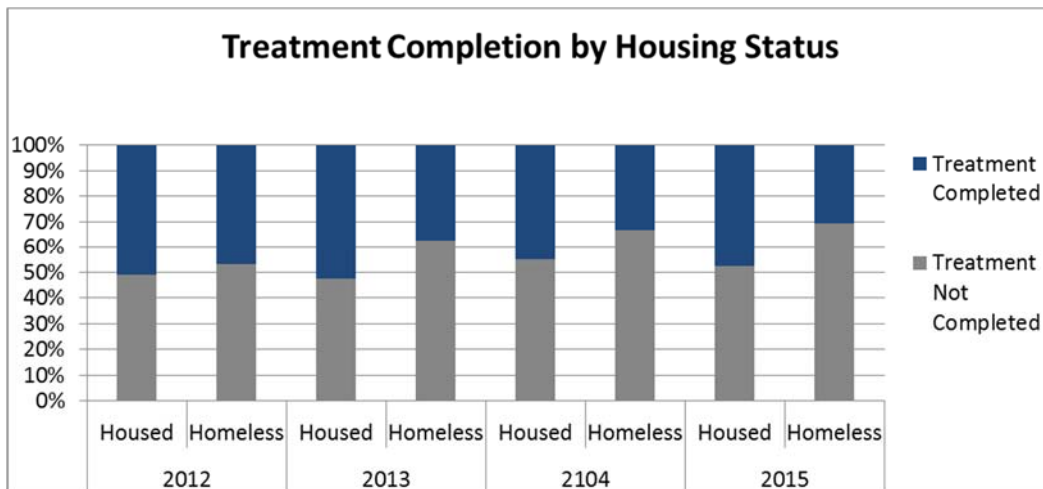
Source: Region V Behavioral Health Systems

Housing Increases While Enrolled in Behavioral Health Services

A greater number of persons are housed at discharge than are housed at admission (Figure 10). For clients who were discharged in 2015, homelessness decreased from 29% at admission to 17% at discharge (representing 182 more people housed at discharge that at admission). Housing status at discharge is based on where people will be living after they are discharged; this may include long-term (more than 30 day) treatment programs.

Figure 10. Change in Housing Status from Admission to Discharge
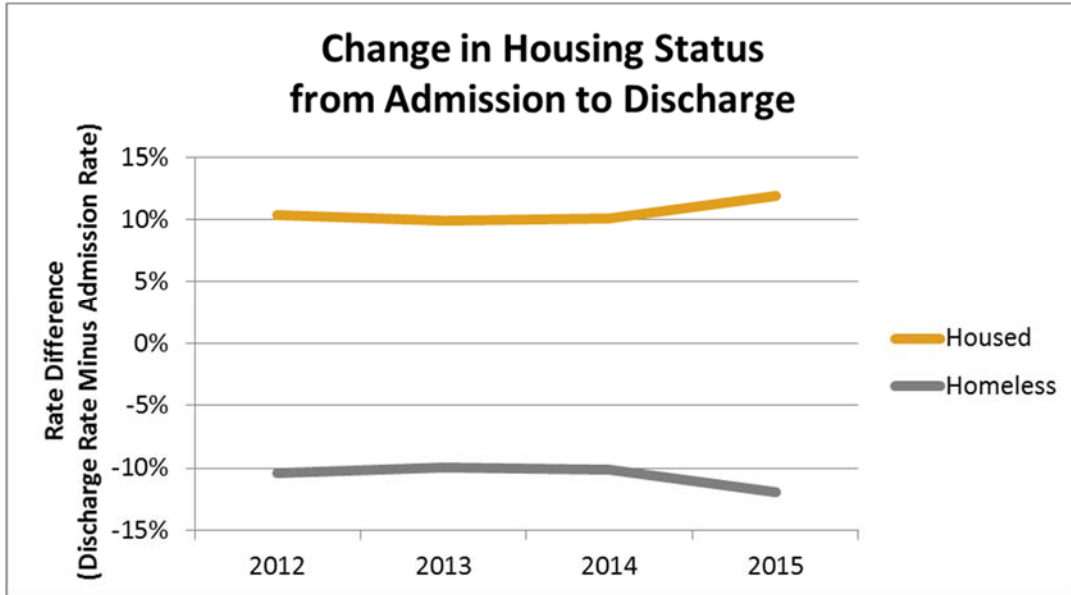
Source: Region V Behavioral Health Systems

Note: Positive percentages indicate an increase in the category (such as housing) and negative percentages indicate a decrease in the category (homelessness).

The pattern of **lower homelessness at discharge holds for each disorder type** (Figure 11). That is, over the past four years, for each disorder type, the change in housing rate has been positive, with more persons housed at discharge than when they were admitted.

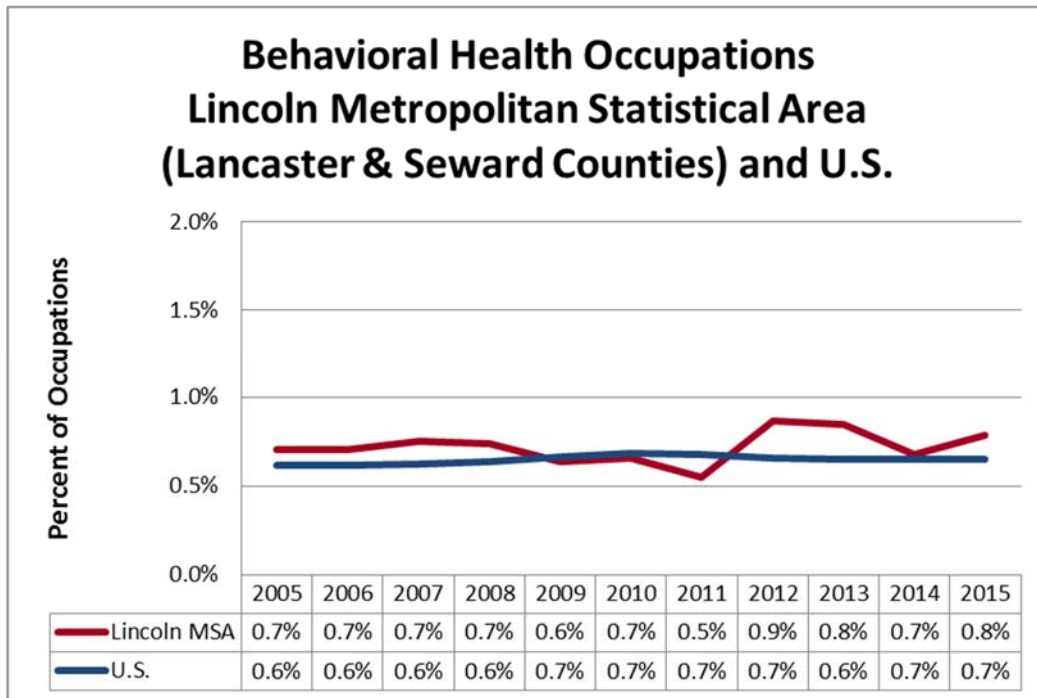**Figure 11. Change in Housing Rate from Admission to Discharge by Disorder**
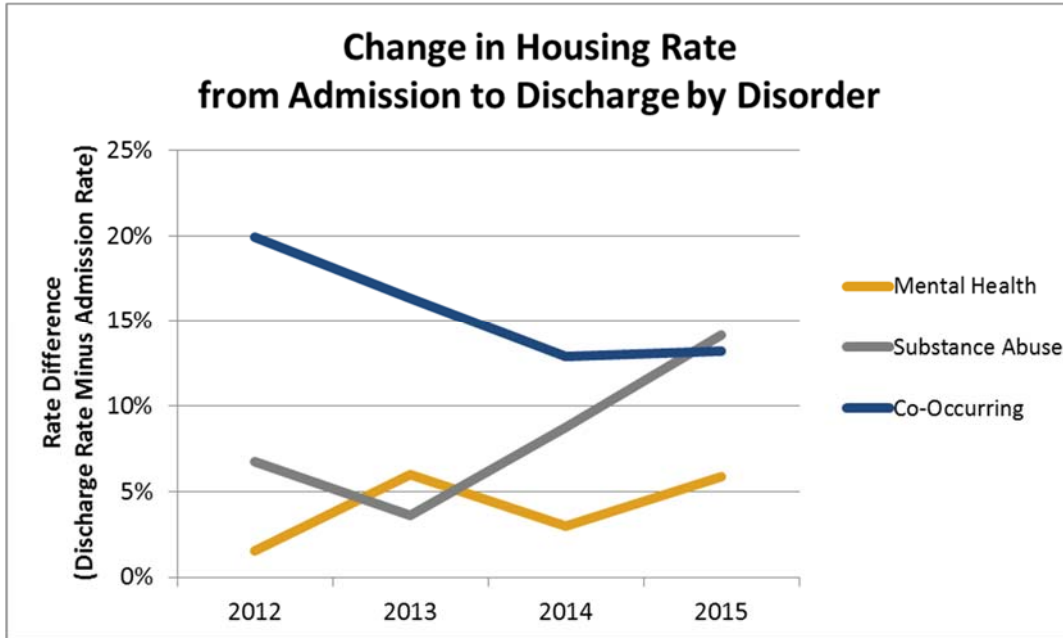
Source: Region V Behavioral Health Systems

Note: Positive percentages indicate an increase in the rate of persons with permanent housing.

LINCOLN'S BEHAVIORAL HEALTH WORKFORCE IS AVERAGE IN SIZE

In the Lincoln Metropolitan Statistical Area (Lancaster and Seward Counties), the number of persons in behavioral health occupations has varied since 2005, hitting a low point of 880 psychologists, counselors, and social workers in 2011.[15] The proportion of behavioral health professionals in Lincoln has hovered around the national average (Figure 12).

Figure 12. Behavioral Health Occupations Lincoln Metropolitan Statistical Area (Lincoln & Seward Counties) and U.S.

Behavioral Health Occupations Lincoln Metropolitan Statistical Area (Lancaster & Seward Counties) and U.S.

	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Lincoln MSA	0.7%	0.7%	0.7%	0.7%	0.6%	0.7%	0.5%	0.9%	0.8%	0.7%	0.8%
U.S.	0.6%	0.6%	0.6%	0.6%	0.7%	0.7%	0.7%	0.7%	0.6%	0.7%	0.7%

Source: Bureau of Labor Statistics – Occupational Employment and Wage Estimates

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[15] Occupations included in the calculation of the behavioral health workforce were selected based on the Bureau of Labor Statistics description of the category, and common industries employing people in these occupations. For example, the category of Psychologists-Other commonly work in Outpatient Care Centers, and Psychiatric and Substance Abuse Hospitals, and so are included in the calculation. Industrial-Organizational Psychologists, who do work related to human resources, management, and marketing, are not included. Occupations included are: Clinical, counseling, and school psychologists; Psychologists-other; Substance abuse and behavioral health disorder counselors; Marriage and family therapists; Mental health counselors; Rehabilitation counselors; Counselors-other; Child, family, and school social workers; and Mental health and substance abuse social workers.

CRISIS-RELATED SERVICES

People with behavioral health issues may have contact with various organizations in the community which coordinate with behavioral health services to ensure people know how to receive these services.

EMERGENCY SERVICES

Emergency services such as Emergency Protective Custody and Civil Protective Custody are typically short term services. **Emergency Protective Custody** (EPC) is authorized by the Nebraska Mental Health Commitment Act.[16] This Act allows law enforcement to take into involuntary custody a person who is mentally ill *and* dangerous to themselves or others, who does not seek voluntary treatment when encouraged to do so by officers. **Civil Protective Custody** (CPC) is used by law enforcement to apprehend a person who appears intoxicated and dangerous to himself, others, or is incapacitated on public property. People are not taken into Civil Protective Custody if they have a friend or family member present who is willing to take responsibility for getting them home. Law enforcement may place the person in custody as necessary to preserve life or prevent injury, and under no circumstances can they be held for more than 24 hours.
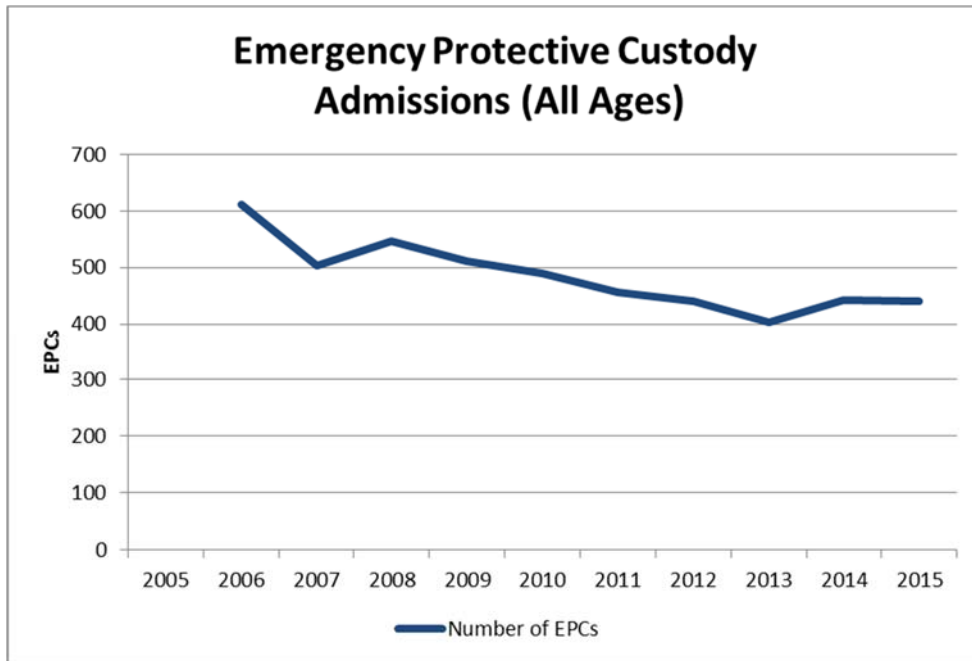
EPCS HAVE DECLINED OVER THE PAST 10 YEARS

The **number of EPCs has declined over the past 10 years**, while the population of Lancaster County has risen by 20% (Figure 13**Error! Reference source not found.**). In 2005, Lincoln Police Department officers underwent awareness training to recognize behavioral health disorders and refer people for treatment. Whereas law enforcement officers used to automatically take people into emergency protective custody, they now offer the opportunity for people to voluntarily commit themselves for treatment. After voluntary admission, people are assessed and offered appropriate services. As a result of this, although the Region V service area contains 25% of Nebraska's population, they have only 10% of the state's population in involuntary commitment.

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[16] Neb. Rev. Stat. § 71-901 – 71-962.

For most people, EPC admission addresses a temporary crisis. Only 10% of EPC admissions are placed in inpatient commitment; alternative appropriate treatment is found for the other 90%. Most people admitted to EPC do not return; **for 87% this is the only time they are place in emergency protective custody**. For those who do have repeated EPC admissions, the majority (86%) return within 13 months of their prior admission. Of those admitted, only 10% are placed in inpatient commitment; alternative appropriate treatment is found for the other 90%.The **great majority of persons (90% on average) admitted for EPC have a mental health disorder**. The percentage of clients with different diagnosis categories does not differ significantly from year to year.

**Figure 13. Emergency Protective Custody Admissions (All Ages)**

Source: Region V Behavioral Health Systems

Note: The population for this graph is Lancaster County residents, rather than Lincoln adult residents.

CPCs Have Declined Over the Past Four Years

In the past four years, the number of adult CPCs per year in Lincoln has decreased somewhat as the population of Lincoln has grown by 2% (Figure 14Figure 14). Given that CPC is designed for intervening with intoxicated persons, it is not surprising that **over 99% of CPC admissions are diagnosed with substance abuse disorders**.

**Figure 14. Civil Protective Custody Admissions**
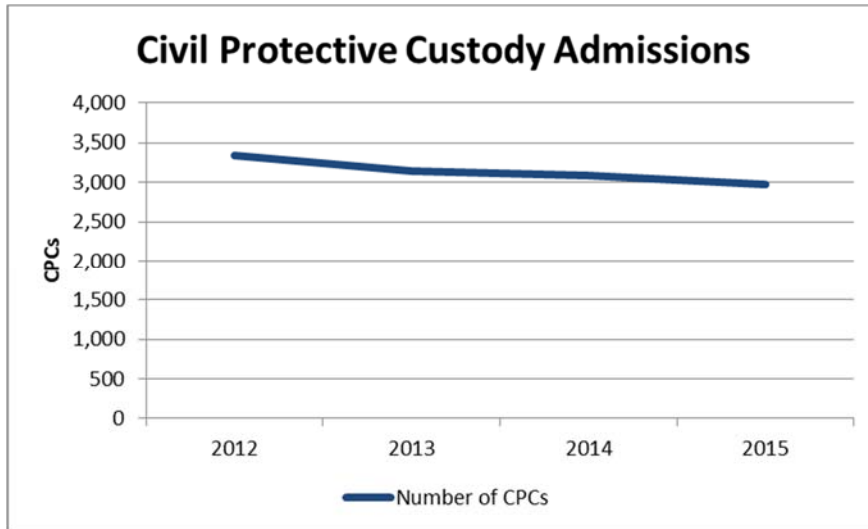
Source: Region V Behavioral Health Systems

SUICIDE

LINCOLN POLICE RECEIVE ONE CALL PER DAY RELATED TO SUICIDE

On average, Lincoln Police Dispatch receives one call per day related to suicide (attempted or completed). Attempted suicides investigated by the police have ranged from about 250 to 380 per year from 2012 through 2015 (Figure 15). There has been a significant increase from 2013 to 2015. **About 18% (62 persons in 2015) of attempted suicide calls result in an EPC (in other cases, people agree to go to treatment voluntarily).** Based on Region V data, 72 persons (3% of total admissions) were admitted to traditional behavioral health services in 2015 with a suicide attempt in the previous 30 days.
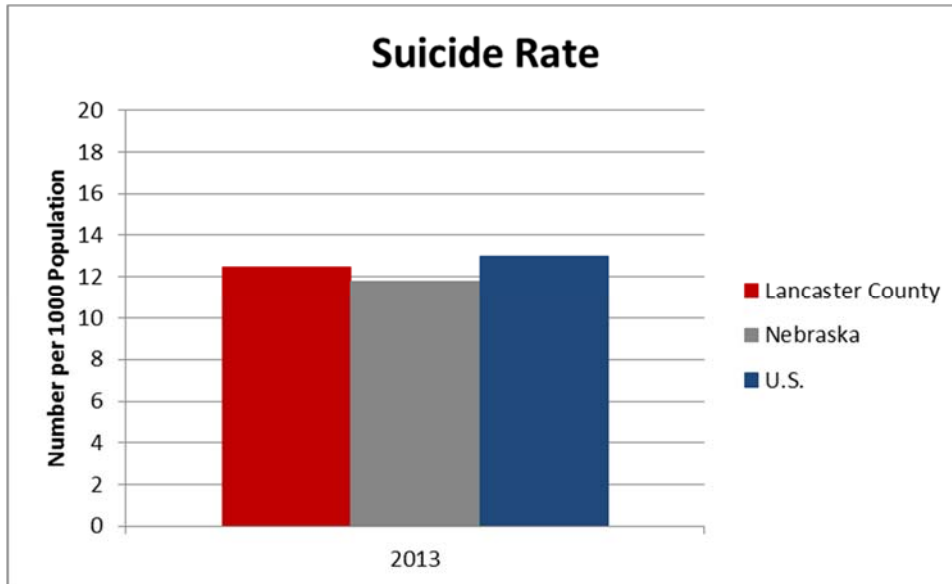
Figure 15. Suicide Attempts
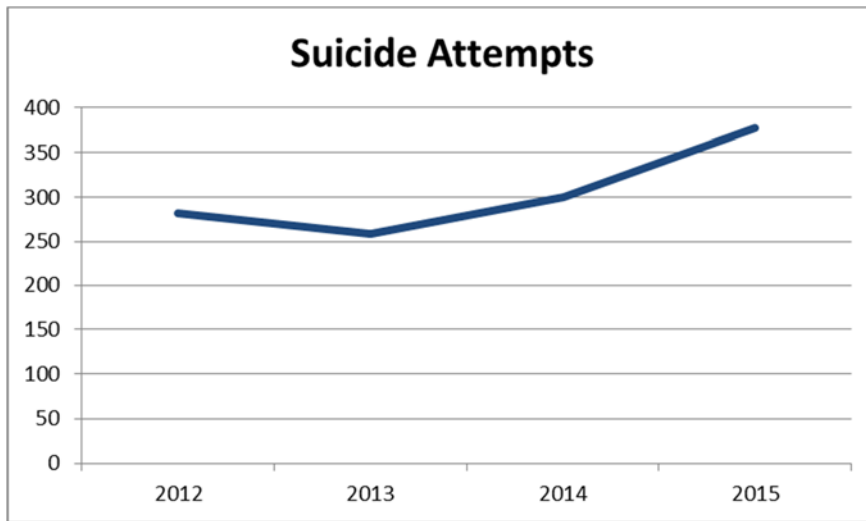
Source: Lincoln Police Department

In Nebraska and nationally, in the past few years **suicide has been the 10th leading cause of death annually**. The rate of suicide in Lancaster County and in Nebraska is about the same as that nationwide (Figure 16).

Figure 16. Suicide Rate

Sources: Nebraska Vital Statistics Reports; National Vital Statistics Reports

Suicides in Lincoln hit a recent high of 44 in 2014 (Figure 17), a significantly higher number than for other recent years, with rates of 32 to 35 suicides per year. **Eighty-five percent of suicides in Lincoln are among working age adults (age 19 to 64), and suicide was the leading cause of death among men 20-44 in Nebraska in 2014. Most people who committed suicide in Lincoln (77%) had no prior law enforcement contact**. Only 7% had a prior suicide attempt on record.

Figure 17. Total Deaths by Suicide
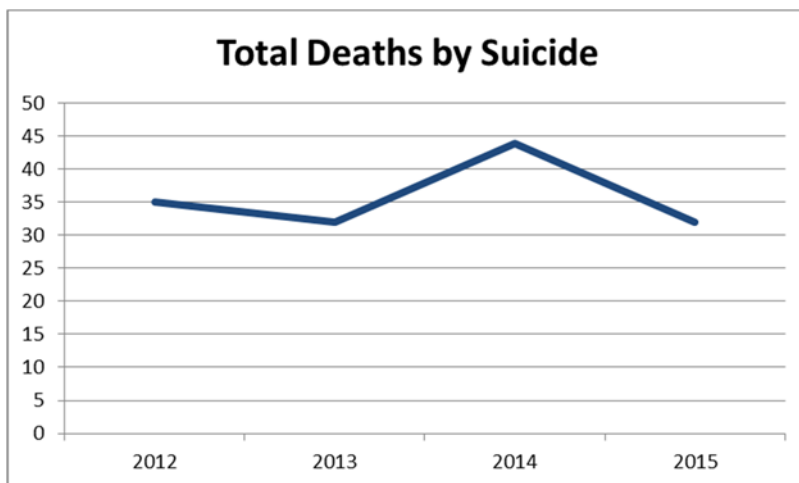
Source: Lincoln Police Department

CHILDREN IN FOSTER CARE: PARENTAL SUBSTANCE ABUSE IS A LARGE CONTRIBUTOR

**Parental drug abuse is consistently the second most common reason children are removed from their parental home and placed in foster care**, accounting for an average of 37% of removals (Figure 18). (Neglect is first, accounting for 61%, and substandard housing is third, accounting for 24%.) Parental methamphetamine use is a growing issue in Nebraska. For the first half of 2015, 61% of parents with a drug issue were identified as using methamphetamine, compared with 57% during the last half of 2014, and 55% during the first half of 2014.[17] **Parental alcohol abuse, parental mental health, and child behavioral and mental health issues are all among the top 10 reasons for child out-of-home placement.**

Figure 18. Reasons for Child Out-of-Home Placement
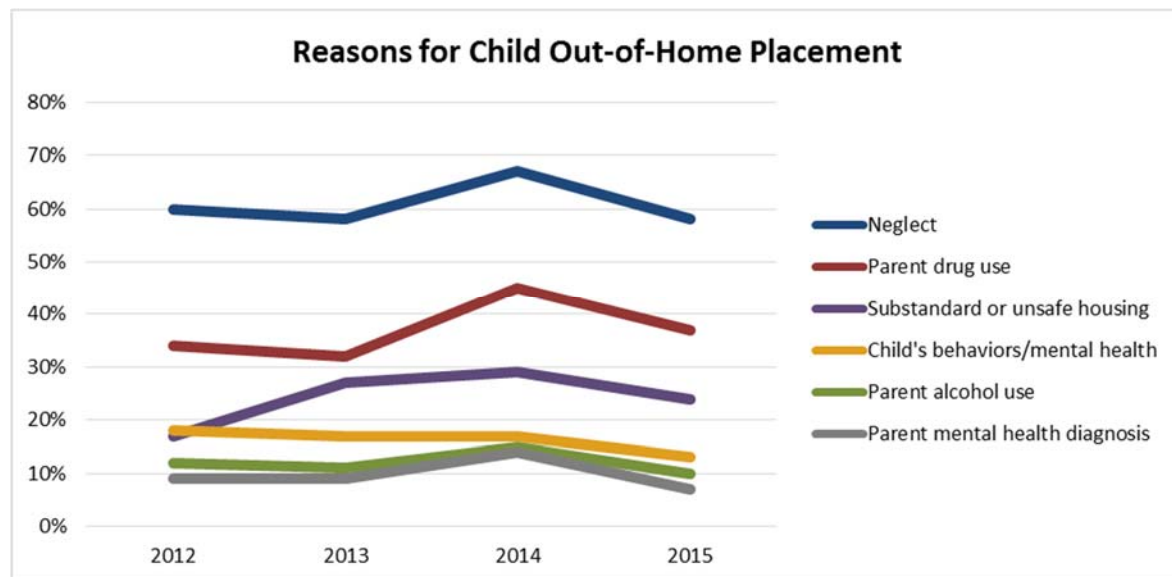
Source: Nebraska Foster Care Review Office Annual Reports

Notes: Percentages may total more than 100% because children may be removed from the parental home for multiple reasons. Not all reasons for removal are displayed in the figure.

HOMELESS PROGRAMS

Among people who are homeless in the United States, rates of behavioral health disorders are substantially higher than the rates for the general population.[18] Persons are homeless for many reasons; behavioral health challenges are just one of these reasons.

Data about persons receiving homeless and related services is available through the ServicePoint Homeless Management Information System. Service providers ask homeless clients about any current or past behavioral health diagnoses or issues. This self-reported data is useful to better understand the challenges facing homeless persons in Lincoln. Data prior to October 2014 are not comparable due to new data protocols implemented at that time.

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[17] Nebraska Foster Care Review Office Annual Report, issued December 1, 2015.

[18] Bassuk, et al., 1998.

MOST HOMELESS ADULTS HAVE BEHAVIORAL HEALTH DISORDERS

In Lincoln, approximately 400 adults enroll in homeless services monthly. **Most of these adults (49% to 69%) entering homeless services have behavioral health disorders** (Figure 19). When agencies identify homeless persons as having behavioral health needs, they are referred to appropriate services.

Figure 19. Homeless Adults with Behavioral Health Needs
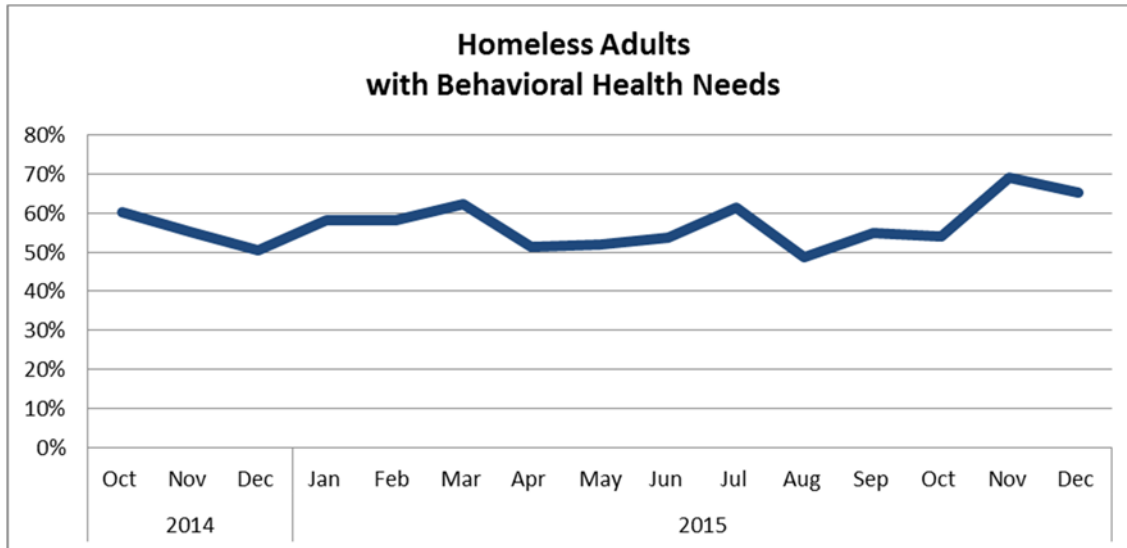
Source: University of Nebraska-Lincoln Center on Children, Families, and the Law

LAW ENFORCEMENT CONTACTS

Persons with behavioral health disorders are more likely than the general population to come into contact with law enforcement,[19] and to be in jails or prisons. Statewide from 2005 through 2009, 48% of those who received publicly-funded community behavioral health services were in jail at some point during the same five years.[20] Data obtained from Lancaster County indicates that in the first half of 2016, **52% of those booked into jail self-reported as having a mental illness**.

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[19] White et al., 2006.

[20] Nebraska Department of Health and Human Services (2011).

LINCOLN POLICE DEPARTMENT HAS OFFICERS TRAINED TO RESPOND TO MENTAL HEALTH CALLS

Approximately 2% of all calls to Lincoln Police Dispatch initiate a mental health investigation (7 out of 330 calls per day, on average). The total number of investigations has been slightly increasing since 2012 (as has Lincoln's population) (Figure 20). Thirteen percent of mental health investigations result in an EPC (i.e., are taken for treatment involuntarily). **Lincoln Police Department has two full-time officers trained to respond to calls involving mental health issues.** When a person is located who may need mental health services, and they are not dangerous, they are provided information on where they can get additional information about available services. Their contact information is also provided to a peer support program, which follows up on all contacts. Thirteen percent of mental health investigations result in an EPC.

Figure 20. Mental Health Investigations
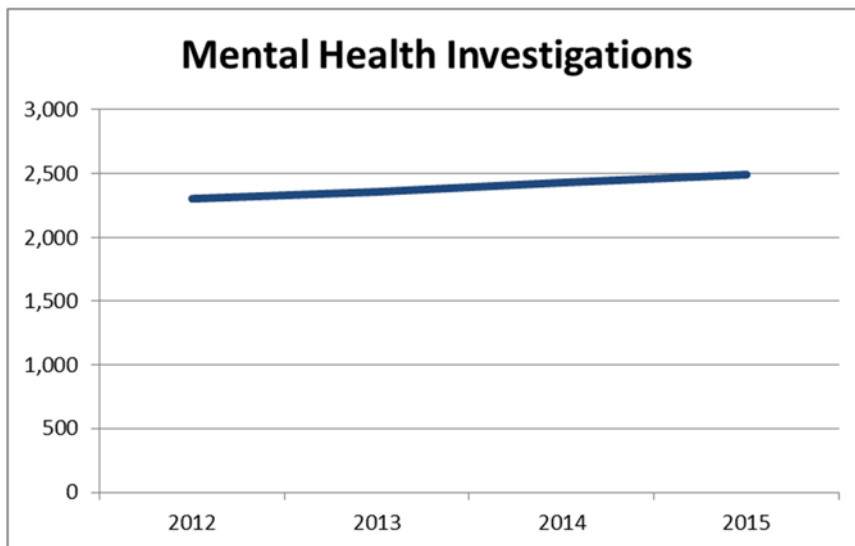
Source: Lincoln Police Department

ONE-FIFTH OF POLICE RESPONSES INVOLVE ALCOHOL AND/OR DRUGS

Eighteen percent of all police responses are for incidents involving alcohol and/or drugs (6,309 calls in 2015). Incidents involving drugs (but not alcohol) have hovered at around 8% over the past four years (Figure 21). The percentage of police incidents involving alcohol alone averages just under 8%. Incidents involving both alcohol and drugs have held steady at about 2% of incidents per year since 2012. This is likely an underestimate of the number of crimes involving alcohol and/or drugs, as it cannot be known for crimes reported for which no one is apprehended. There was a spike in alcohol incidents in September in both 2012 and 2013, but this increase was not seen in 2014 or 2015 (Figure 21).

Figure 21. Incident Reports Involving Alcohol or Drugs
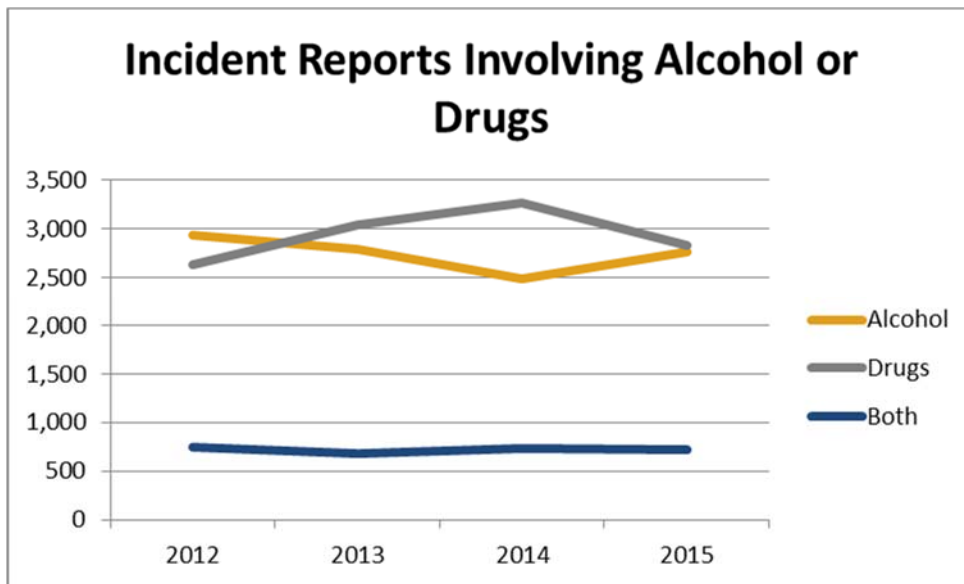
Source: Lincoln Police Department

SUMMARY

Like many communities, Lincoln lacks a complete picture of behavioral health trends. This is due to siloed information resources and the fragmented system of care for persons with behavioral health needs. This report is intended to convey what is known about services to persons with behavioral health needs. It is anticipated that this supplement to Lincoln Vital Signs will, similar to those reports, inform the community and spur action.

There are a number of initiatives in Lincoln working to better identify and serve persons needing behavioral health services. Examples for this are: the Lincoln Police Department dedicating two full-time staff members who respond to mental health-related calls, and connecting people to peer support specialists who follow up on all calls; Lincoln Police offering people who would otherwise be entered into Emergency Protective Custody the opportunity to voluntarily go to treatment; and cooperation between programs for the homeless and behavioral health providers to refer people into appropriate treatment.

These cooperative initiatives could be aided by similar cooperation across data systems maintained by the agencies involved. A core set of integrated measures across data systems could help identify gaps in services, and spark discussion for additional ways for agencies to work together. For example, there is information on how many calls the police department receives for attempted suicide, but no current data system that tracks what happens to those people afterward unless they enter Emergency Protective Custody; i.e., no system tracks what happens to those encountered by the police who voluntarily enter treatment. The behavioral health data system tracks people once they enter treatment, but it is not always known whether these people were referred by Lincoln Police.

Public policy changes to reduce the impact of the stigma of having a behavioral health issue should also be considered. There is no current information specific to Lincoln on how stigma impacts individuals, but national studies indicate it reduces willingness to seek care and impacts other areas of the lives of those with behavioral health issues.[21]

This report is a first step in identifying what information is currently available from various sources about services for individuals with behavioral health issues.

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[21] Byrne, 2000; Corrigan, Druss, & Perlick, 2014; Corrigan & Watson, 2002.

REFERENCES

Bassuk, E. L., Buckner, J. C., Perloff, J. N., Bassuk, S. S. (1998). Prevalence of mental health and substance use disorders among homeless and low-income housed mothers. *American Journal of Psychiatry, 155*(11), 1561-1564.

Bird, C. E., Jinnett, K. J., Burnam, M. A., Koegel, P., Sullivan, G., Wenzel, S. L., . . . Miu, A. (2002). Predictors of contact with public service sectors among homeless adults with and without alcohol and other drug disorders. *Journal of Studies on Alcohol, 63*(6), 716-725.

Burgoyne, A. M. (2010). Dashboards that guide good. *Stanford Social Innovation Review, 8*(2), 23-24.

Byrne, P. (2000). Stigma of mental illness and ways of diminishing it. *Advances in Psychiatric Treatment, 6*, 65-72.

Center for Substance Abuse Treatment. (2006). *Overarching principles to address the needs of persons with co-occurring disorders: Overview paper 3*. DHHS Publication No. SMA-06-4165). Rockville, MD.

Chafetz, L., White, M. C., Collins-Bride, G., & Nickens, J. (2005). The poor general health of the severely mentally ill: Impact of schizophrenic diagnosis. *Community Mental Health Journal, 41*(2), 169-184. doi: 10.1007/s10597-005-2651-z

Coffey, R. M., Houchens, R., Chu, B. C., Barrett, M., Owens, P., Stocks, C., . . . Buck, J. A. (August 23, 2010). Emergency department use for mental and substance use disorders *Healthcare Cost and Utilization Project*. Washington, DC: U.S. Agency for Healthcare Research and Quality (AHRQ).

Corrigan, P.W., Druss, B. G., & Perlick, D. A. (2014). The impact of mental illness stigma on seeking and participating in mental health care. *Psychological Science in the Public Interest, 15*(2), 37-70.

Corrigan, P. W., & Watson, A. C. (2002). Understanding the impact of stigma on people with mental illness. *World Psychiatry, 1*(1), 16-20.

James, D. J., & Glaze, L. E. (2006). Mental health problems of prison and jail inmates *Bureau of Justice Statistics Special Report*. Washington, DC: U.S. Department of Justice.

Jolin, M., Schmitz, P., & Seldon, W. (2012). Needle-moving community collaboratives: A promising approach to addressing America's biggest challenges: The Bridgespan Group.

Kania, J., & Kramer, M. (2011). Collective impact. *Stanford Social Innovation Review, 9*(1), 36-41.

Larkin, G. L., Claasen, C. A., Emond, J. A., Pelletier, A. J., & Camargo, C. A. (2005). Trends in U.S. emergency department visits for mental health conditions, 1992-2001. *Psychiatric Services, 56*(6), 671-677.

Mojtabai, R. (2005). Trends in contacts with mental health professionals and cost barriers to mental health care among adults with significant psychological distress in the United States: 1997-2002. *American Journal of Public Health, 95*(11), 2009-2014.

Nebraska Department of Health and Human Services. (April 2011). *Nebraska behavioral health & criminal justice joint statistics brief.* Lincoln, NE: Author.

Office of the Surgeon General. (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services.

Owens, P. L., Mutter, R., & Stocks, C. (2010). Mental health and substance abuse-related emergency department visits among adults, 2007. Rockville, MD.

Rockett, I. R. H., Putnam, S. L., Jia, H., Chang, C. F., & Smith, G. S. (2005). Unmet substance buse treatment need, health services utilization, and cost: A population-based emergency department study. *Annals of Emergency Medicine, 45*(2), 118-127. doi: 10.1016/j.annemergmed.2004.08.003

Substance Abuse and Mental Health Services Administration. (2010). *Permanent Supportive Housing: The Evidence. (*HHS Pub. No. SMA-10-4509). Rockville, MD: Center or Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

Substance Abuse and Mental Health Services Administration. (2009). *Supported Employment: The Evidence. (*HHS Pub. No. SMA-08-4364). Rockville, MD: Center or Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

Substance Abuse and Mental Health Services Administration. (2002). Report to Congress on the prevention and treatment of co-occurring substance abuse disorders and mental disorders Rockville, MD: U.S. Department of Health and Human Services.

White, M. C., Chafetz, L., Collins-Bride, G., & Nickens, J. (2006). History of arrest, incarceration and victimization in community-based severely mentally ill. *Journal of Community Health, 31*(2), 123-135.

LINCOLN VITAL SIGNS SUPPLEMENTAL REPORT: BEHAVIORAL HEALTH TRENDS IN LINCOLN

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