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Mental Health Provider Perceptions on the Implementation of Behavioral Health Interventions to Increase Access to Mental Health Care Services in Rural Nebraska

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Community Oriented Primary Care

Service Learning/Capstone Experience

University of Nebraska Medical Center, College of Public Health

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Table of Contents

Table of Contents

Abstract

Rural Nebraska communities are influenced by socioeconomic conditions and lack health care resources which contributes to the prevalence of mental health. As such, there is a need to implement effective intervention programs and evaluate current programs to reduce morbidity and mortality associated with mental health.

Goals: To assess the perceptions of mental health practitioners regarding public health programs and support services. This project also intends to gauge the effectiveness and viability of specific programs as potential solutions for increasing access and use of rural mental health care services. Furthermore, this project aims to inquire perceptions about the role of public health and primary care in the context of behavioral health.

Methods: Specific program types were identified from the results collected by Johansson et al. (2017). Practitioner perceptions regarding these specific behavioral services and support programs were assessed utilizing a survey instrument that collected both quantitative and qualitative data.

Impact: This Service Learning and Capstone Experience project will contribute to the current data regarding the present state of mental health care in rural Nebraska. This project examines the feasibility of public health programs – community and school-based programs – and public education regarding mental health awareness and access to services to help inform community programming decisions and policy recommendations. Also, this project further explores integrating public health, primary care, and behavioral health to meet the objective of the 2017-2021 Nebraska State Health Improvement Plan.

Introduction

Agency Background

The Rural Health Education Network (RHEN) resides within the College of Public Health at the University of Nebraska Medical Center (UNMC), located on 519 S 40th Plaza in Omaha, Nebraska (UNMC, 2017a). RHEN was established in 1991 following the passage of LB 625e by the Nebraska State Legislature, which served to promote the rural practice of health care professionals (UNMC, 2017b). RHEN is "committed to building strong partnerships at local, state, and national levels to develop a workforce of professionals to meet the health care needs of people living in rural and underserved communities in Nebraska" with the vision of being "recognized as a national and international leader in workforce development with regards to addressing health care workforce shortages in rural communities" (UNMC, 2017c). To accomplish its mission and goals, RHEN participates in student outreach and recruitment events to encourage future matriculation at the UNMC College of Public Health. Similarly, RHEN staff are active partners in the UNMC Public Health Early Admissions Student Track, a program designed to provide financial incentives and guaranteed admission into the College of Public Health for junior and senior undergraduate students attending the University of Nebraska at Kearney or one of the Nebraska state colleges (UNMC, 2017d). Lastly, RHEN conducts and participates in various research activities that aim to further improve the health of rural Nebraska communities.

Background Information and Literature Review

Roughly twenty percent of Nebraska residents have experienced mental illness (UNMC, 2016). Rural Nebraska communities are at a disadvantage due to many socio-economic, cultural,

and infrastructure shortfalls. Rural residents tend to have lower incomes, higher rates of unemployment, are more likely to be uninsured, and experience greater challenges in accessing transportation compared to their urban counterparts (National Rural Health Association, 2017). Also, a negative stigma exists concerning mental illness in rural communities. Rural residents are more apt to perceive mental illness as an unfavorable attribute thus limiting a person's desire to seek treatment to avoid being stigmatized (Stark, Riordan, & O'Connor, 2011). Furthermore, a cultural attitude of self-reliance and independence further inhibits the desire to seek help (Gessert, Siahpush, & Singh, 2003).

The lack of mental health practitioners in rural Nebraska further compounds the prevalence of mental health illness. In 2017, ninety of the ninety-three Nebraska counties were state-designated shortage areas for mental health, including those counties that are considered partial shortage areas (Nebraska Department of Health and Human Services [NDHHS], 2017a). As of January 2017, twenty-two physicians, thirty-three nurse practitioners, and three physician assistants with mental health specialties were actively practicing in rural Nebraska (Health Professions Tracking Service, 2017). Furthermore, the provider-to-patient ratio for all behavioral health professionals is disproportionately lower in rural and frontier counties as only 27.3% and 1.5% of all providers practice in these county types, respectively (Nguyen et al., 2016).

Various interventions and programs have shown success in reducing the prevalence of mental illnesses in different settings. School-based programs have demonstrated effectiveness in promoting adolescent ability to learn and employ coping strategies, reducing depressive symptoms and anxiety (Hoying, Melnyk, & Arcoleo, 2016; Puskar, Sereika, & Tusaie-Mumford, 2003). Additionally, school-based health centers show promise in reducing mental health care

costs while increasing utilization of services, particularly for those insured through Medicaid (Guo, Wade, & Keller, 2008).

Community-based educational programs and interventions have also been effective in reducing mental health morbidity. For example, graduates of Mental Health First Aid (MHFA) training have documented their perceived ability to provide support to peers with behavioral needs, establish community networks that foster peer intervention, reduce behavioral health stigma, and encourage the expansion of behavioral health services in rural communities while increasing their mental health literacy and empathy (Talbot, Ziller, & Szlosek, 2017; Crisanti, Luo, McFaul, Silverblatt, & Pyeatt, 2016; Lucksted, Mendenhall, Frauenholtz, & Aakre, 2015). Similar results have been collected from Nebraska MHFA graduates and the training itself has received support from the Nebraska Legislature through the passing of LB 931 (Nebraska Legislature, 2014; UNMC, 2016). Unique to agricultural communities, the former Sowing the Seeds of Hope program provided a means to reduce the barriers associated with lack of mental health care infrastructure by providing 24-hour accessibility via telephone helplines and websites, behavioral health counseling, and referrals (Rosmann 2005). Lastly, the U.S. Department of Health and Human Services (USDHHS) has collected an extensive list of evidence and community-based mental health programs, tailored for rural communities (USDHHS, 2011a).

Nebraska policy initiatives have primarily focused on provider recruitment and retention as a means of alleviating mental health morbidity in rural Nebraska (Watanabe-Galloway, Madison, Watkins, Nguyen, & Chen, 2015). However, the lack of providers in rural communities is only one facet of a much larger problem and input from existing providers needs to be collected to understand the full scope of the issue. The 2017-2021 Nebraska State Health

Improvement Plan (SHIP) currently aims to address shortfalls in the state's health care system by focusing on and promoting the integration and collaboration between public health, primary care, and behavioral health, thus bridging the gap between these health care disciplines (NDHHS, 2017b).

Johansson et al. (2017) conducted a study to document the perceptions of non-prescribing mental health care professionals (i.e. licensed independent mental health practitioners, licensed mental health practitioner, and licensed alcohol/drug counselors) to inquire information on patient barriers to receiving mental health services, solutions for providing access to rural mental health services, and challenges and solutions to providing mental health services. Results from this study suggest that public health should be at the forefront of addressing the mental health crisis in rural Nebraska. School and community-based programs, and public education campaigns concerning mental health awareness and accessing mental health care services were regarded as beneficial public health programs that should be implemented. These findings, coupled with the shortfall of historical policy initiatives and the future direction outlined in the 2017- 2021 Nebraska SHIP, indicate the necessity for continued research on the effectiveness of various public health-based programs and the integration of public health, primary care, and behavioral health care services.

Project Significance

This Service Learning/Capstone Experience project acts as a continuation of the study conducted by Johansson et al. (2017). This project examines the effectiveness of public health programs, specifically community and school-based programs, and public education on mental health awareness and access to services to help inform community programming decisions and

policy recommendations. Also, this project further explores integrating public health, primary care, and behavioral health to meet the objective of the 2017-2021 Nebraska SHIP.

Objectives

The goal of this Service Learning/Capstone Experience project was to assess the perceptions of mental health practitioners regarding public health programs and support services. Also, this project intends to gauge the effectiveness and viability of these programs as potential solutions to increasing access and use of rural mental health care services.

Objective #1: Assess practitioner awareness and perceptions of the effectiveness of MHFA training.

Objective #2: Assess practitioner awareness, familiarity, and perceptions of the effectiveness of school-based behavioral health services and support programs.

Objective #3: Assess practitioner understanding and perceptions of the integration of primary care, public health, and behavioral health.

Objective #4: Assess practitioner awareness of current and former behavioral health services and support programs.

Methods

Research Aim

This project aimed to evaluate current and past behavioral health services and support programs by assessing practitioner perceptions of community and school-based programs. In addition, this project collected feedback on practitioner perceptions on the integration of primary

care, public health, and behavioral health; and inquired on current and former behavioral health services, and support programs that benefit rural Nebraska communities.

Application of Theoretical Models

Community Oriented Primary Care (COPC) framework was the primary theoretical model used. The COPC framework is guided by five principles: (1) Responsibility for the health of a defined population, (2) Care is based on the identified health needs at a population level, (3) Prioritization, (4) Program of intervention covering all the stages of the health-illness continuum of the selected condition, and (5) Community involvement (Gofin & Gofin, 2011). As a part of the framework, a program planning cycle (Figure 1) is incorporated and focuses on six key elements that identify and address specific health needs of a community. These elements include: (1) Community definition and characterization, (2) Prioritization of health needs, (3) Detailed problem assessment, (4) Intervention planning and implementation, (5) Evaluation, and (6) Reassessment (Gofin & Gofin, 2011). Lastly, one of the core elements of COPC framework focuses on the integration of public health and primary care.

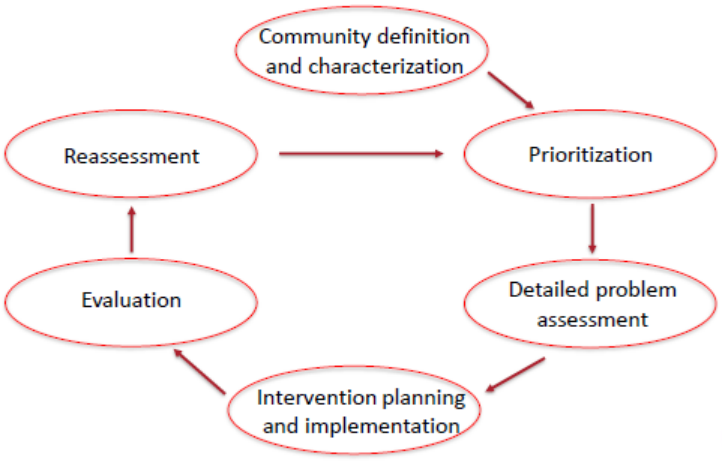

Figure 1. COPC cycle diagram

It is not the intent of this project to complete the entire COPC cycle or address every core principle. Instead, this project intends to address aspects of the framework to provide preliminary data to be used for future studies conducted by RHEN. This project specifically focuses on the continuation of the detailed problem assessment and initial intervention planning segments of the COPC cycle. Moreover, this project addresses the integration of public health and primary care by inquiring on perceptions of the integration of these two health care disciplines.

Other frameworks utilized in this project include the social-ecological model of health by specifically examining the context of behavioral health at the community and public policy levels. Lastly, this project incorporates social determinants of health, specifically by considering the social and community context; and health and health care context.

Study Design

This project employed a cross-sectional design and collected both quantitative and qualitative data through survey administration.

Survey instrument. A survey instrument was designed to assess practitioner perceptions of various behavioral health services and support programs as a continuation of the study conducted by Johansson et al. (2017). The survey (Appendix A) consisted of four main parts, containing both closed-ended and open-ended responses, that assessed and measured practitioner perceptions of identified programs. Five-point Likert response sets were used to gauge practitioner awareness and familiarity of identified programs; practitioner perception of the effectiveness and potential helpfulness of these programs. Responses were worded using following response order: Not at all, Slightly, Somewhat, Fairly and Very.

Part 1 – ***Mental Health First Aid.*** This section assessed practitioner awareness and perception of the effectiveness of MHFA training and consisted entirely of closed-ended response options. First, participants were first asked to rate their awareness of MHFA. After reading a short description of MHFA training, participants were asked to rate how helpful MHFA training is or would be in improving behavioral health outcomes. Next, participants were asked how helpful MHFA training is or would be in reducing stigma regarding seeking behavioral health services. Lastly, participants were asked if they were aware of MHFA being offered in the community they serve using a yes/no/not sure response option.

Part 2 – Behavioral health services and support programs offered in schools. This section assessed practitioner familiarity and perceptions of the effectiveness of school-based behavioral health services and support programs, and consisted of both closed-ended and open-ended questions. First, participants were asked if they were aware of any school-based behavioral health services or programs offered in their communities using a yes/no response options. If the participant indicated yes, they were then asked to list up to three of the programs or service. Next, participants were asked to rate their familiarity with the listed programs and to rate their perception of the overall effectiveness of the programs or support services. Participants were then asked to list up to three services or support programs that they would like to see offered that are not currently available. If the participant indicated no to the first question, they were then asked to rate how helpful school-based services or support programs would be in improving the behavioral health of school children and adolescents.

Part 3 – Integration of primary Care, public health, and behavioral health. This section assessed practitioner understanding and perception of the integration of primary care, public health, and behavioral health using two open-ended questions. First, participants were

asked to document their understanding of the integration of primary care and behavior health. Participants were then asked to document their understanding of the integration of primary care and public health in the context of behavioral health care.

Part 4 – Past and current programs that benefit your community's behavioral health and well-being. This section assessed practitioner awareness of current and former behavioral health services and support programs using a combination of both closed-ended and open-ended questions. First, participants were asked if they were aware of any current programs that are beneficial to their community's behavioral health and well-being using a yes/no response option. If the participant indicated yes, they were then asked to list up to three programs currently offered within their community. Participants were then asked if they were aware of any programs previously offered that benefited their community's behavioral health and well-being using a yes/no response option. If the participant indicated yes, they were then asked to list up to three former programs offered in their community.

Part 5 – Demographics. This section collected demographic data including gender, age range, race and ethnicity, practitioner license type, how long the provider has been practicing, and the provider's focus area.

Study sample. The sample was defined as non-prescribing licensed mental health providers who practice in rural communities. Specifically, non-prescribing providers included psychologists or those with at least one of the following licenses: Licensed Independent Mental Health Practitioner (LIMHP), Licensed Mental Health Practitioner (LMHP), and Licensed Alcohol/Drug Counselor (LADC) (Johansson et al., 2017). Rurality was defined using the UNMC's Rural Health Opportunities Program (RHOP) definition. Utilizing the RHOP definition, providers practicing in the following communities or locations were excluded from

the sample: Omaha, Ralston, Boys Town, Elkhorn, Lincoln, Bellevue, Papillion, LaVista, Chalco, and Offutt Airforce Base. UNMC's Health Professions Tracking Services (HPTS), who maintains a database of all health care professionals practicing in Nebraska, identified mental health providers who met the inclusion criteria and mailed surveys to the included providers. To maintain the confidentiality and anonymity, each provider was assigned a random identifier that was linked to their respective identifier in the UNMC HPTS database, which can only be accessed by UNMC HPTS staff

Sample size and power. A total of 689 non-prescribing licensed mental health providers met the inclusion criteria. This Capstone project acted as the preliminary data collection portion of a larger project, to be continued further by RHEN later. Therefore, surveys were only collected up until March 26, 2018. As such, there was no needed justification for statistical power due to the project's preliminary data collection emphasis.

Data sources and data collection. Primary data was collected through survey administration. A time frame of two weeks was defined as the data collection period, with the first round of surveys mailed on March 8, 2018, and the final collection date was set at March 26, 2018. Secondary data sources included UNMC Health Professions Tracking Service's records of non-prescribing mental health professionals.

Statistical methods. Percentages were used to summarize participant's responses. Reported percentages were based on the summation of participants who check "Fairly" and "Very" response options. Quantitative data was analyzed using IBM SPSS Statistics for Windows, version 23 (IBM Corp., Armonk, N.Y., USA). Reoccurring themes and behavioral health programs were documented and reported for qualitative data collected from open-ended questions.

Expected policy analysis, interventions, and program development recommendations. This Capstone project's preliminary data collection emphasis limits the ability to accurately inform policy and program development recommendations. Such recommendations should be examined and informed when all data is collected and analyzed. However, obtained preliminary data, detailed below, provides insight on the potential feasibility and effectiveness of public health programs examined in this project.

Results

Demographics

Appendix B provides a summary of the demographic information of the participants. A total 103 participants completed the survey, yielding a response rate of 14.9%. A majority of the participants were female (78%), white (98%), and between the ages of 56 and 65 years (33%). The three most common license types represented in the sample were LIMHP (57%), LMHP (38%), and LADC (26%). Lastly, the three most common behavioral health focus areas practiced were adults (78%), adolescents (63%), and children (43%).

Mental Health First Aid

Appendix C provides a summary of results regarding participant awareness and perceptions of helpfulness of MHFA training; and whether they were aware of MHFA offered in their communities. Over half (51.4%) of the participants were aware of MHFA training and 76.7% of participants believed that MHFA training is or would be helpful in improving behavioral health outcomes in their communities. Moreover, 76.7% of participants believed that MHFA training is or would be helpful in reducing stigma regarding seeking behavioral health

services. Lastly, only 34% of participants indicated that they were aware of MHFA training offered in the community they serve.

School-Based Services and Programs

Appendix D provides a summary of results regarding participant awareness and familiarity, and their perceptions on effectiveness and helpfulness of school-based behavioral health services or programs. Of respondents, 44.1% were aware of behavioral health services or support programs offered in schools in their communities. Of those who indicated they were aware of services or programs, 68.8% indicated they were familiar with the programs and 65.9% perceived that these services or programs were effective. For those who indicated that they were not aware of school-based behavioral health services or programs, 81.7% perceived that offering school-based services or programs would be helpful in improving the behavioral health of students.

Common themes were identified when assessing current school-based behavioral health services or support programs. In general, participants indicated that schools had access to several sources for counseling resources, utilized services and support from state behavioral health regions (i.e., Region III Behavioral Health Services) and local Educational Support Units (ESU), and incorporated specific youth programs in their communities including Youth Advocate Programs (YAP) Inc.

Lastly, common themes were identified when participants were asked to list school-based behavioral health services or support programs that they would like to see offered. Respondents indicated that they would like to see an increase in behavioral health staff availability; educational events offered for staff, students, and general community members to include anti-

bullying, suicide prevention, and substance abuse education/programming; parent involvement with student behavioral health needs; and MHFA training for staff, students, and community members.

Integration of Primary Care and Behavioral Health Services

Participant perceptions collected from open-ended questions, regarding the integration of primary care and behavioral health services, included themes that focused on the following elements: open communication and information sharing amongst providers, improved coordination and collaboration, treatment of the patient as a whole regarding physical and mental health, and embedding mental health services within the primary care setting.

Maintaining open communication and information sharing between provider types was a major theme expressed by participants. Participants highlighted the former and its importance in sustaining continuity of care. "*It means maintaining open communication and between PCP and other professional services to provide continuity of care and consistency across informal and formal support"* (Participant 1789). Others inferred that promoting open lines of communication will reduce seclusion among practice locations. "*Ease of communication and referral. I can't collaborate if I am not aware of whom to contact. Get out of the silo. Be willing to use multi-disciplinary tools available"* (Participant 2650). Regarding information sharing, one participant suggested that providers should be able to provide information on available resources. "*Screening for mental illness at the doctor's offices and clinics, having information/resources readily available at these clinics"* (Participant 3466).

Regarding coordination and collaboration, participants highlighted the need for an interdisciplinary team approach. "*Medical and behavioral health providers collaboratively*

caring for the whole patient to improve public health outcomes for the community" (Participant 1184). Specific to coordination, one participant spoke to its importance in providing care. "*Coordination with physicians and therapists to provide the best overall care for the client"* (Participant 3117).

Several responses suggested that the integration of these services would incorporate treatment of the whole or person, both physically and mentally. "*A more comprehensive treatment to meet individuals' physical and mental health needs"* (Participant 4232). Likewise, the importance of these two services meshed together was expressed as it relates to a patient's overall health and placing equal importance on a person's mental health. "*It means accepting mental health as being as important as medical health. Mental health should not be thought of as distinct from physical health. Mental problems are brain problems, therefore, are medical problems"* (Participant 1741).

Participants suggested that behavioral health should be an integral part of the primary care clinic and should be embedded within the clinic or practice. "*Involving behavioral health services as part of the health care team, including providing services at the same location and increased communication between providers"* (Participant 5969). Additionally, participants indicated locating these service within the same location will increase efficiency. "*One stop shop with opportunity for providers to streamline services"* (Participant 2050).

Integration of Primary Care and Public Health, in the Context of Behavioral Health Care.

Like the previous section, participant perceptions on the integration of primary care and public health, in the context of behavioral health care, included themes that centered on communication and information sharing, and on improved coordination and collaboration.

Unique to the integration of these services, the following additional themes were observed: increasing access to services, referral to services or programs, community awareness. and stigma reduction.

Increasing access to services was highlighted throughout the responses and included various facets. *"That in rural areas there will be more access to behavioral health services"* (Participant 3095). One participant highlighted increasing access in the physical sense. "*Making behavioral health care more accessible: that means providing transportation or better technology for telehealth. In my opinion, telehealth cannot be the sole method of delivery – you miss too much"* (Participant 2292). Another participant underscored the importance of this integration from a financial point of view. *"Working towards meeting the behavioral health, physical health needs of uninsured, underinsured, low-income community members"* (Participant 5151). Participant perceptions also tied this integration to promoting referrals, between primary care and public health, to available resources. *"Integration of primary care and public health in the context of behavioral health care means providing referrals to each of these areas – talking to clients about resources available – helping them access the resources"* (Participant 3745). Moreover, participants highlighted the importance of sharing information on available programs. *"Getting the word out about available programs and resources. Mobile units to come to rural areas, provide a way of care at a lower cost, offering free screenings for cancer, etc."* (Participant 3466).

Regarding community awareness, participants signified the importance of this integration on its effect on the community. *"Collaboration of providers across all health divisions and awareness in the community of the impacts of physical health on mental health and vice versa"* (Participant 1793). Lastly, a majority of the awareness talking points centered on reducing

stigma as a part of increasing awareness. "*Access to mental health service and education/support to lessen and remove any attached stigmas"* (Participant 1166).

Current Behavioral Health Programs

When asked to list examples of current programs that benefit their community's behavioral health and well-being, participants listed specific organizations and advocacy groups, and included programs at the local, state, and national levels. Appendix E outlines noteworthy organizations and programs identified by the participants. Lastly, participants listed local community groups (non-specific) and health care facilities (i.e., community hospitals, local public health departments, and federally qualified health centers) as valuable services that serve to address their community's behavioral health needs.

Former and Other Behavioral Health Programs

When asked to list past and other programs that benefited their community's behavioral health and well-being, participants detailed specific organizations and programs at the local, state, and national levels. and general community programs and trainings. Appendix F outlines specific local, state, and national organizations and programs listed by respondents. Community programs and training included individual and group counseling or support groups, and community MHFA training.

Discussion

This project examined mental health provider perceptions on the feasibility and effectiveness of selected behavioral health services and support programs. Quantitative and qualitative data were collected that provided additional insight into the detailed problem assessment of the COPC cycle as it relates to the behavioral health of rural Nebraska

communities. Additionally, identified programs presented by participants help preliminary inform future intervention planning and implementation stages of the COPC cycle.

Survey results suggest that MHFA training continues to be a valuable community-based program in improving behavioral health outcomes and reducing the inherent stigma associated with seeking behavioral health services. While participants were not asked whether they had received the MHFA training, their perceptions align with results collected from previous studies that assessed MHFA training recipient perceptions in improving behavioral health outcomes and reducing stigma (Talbot et al., 2017; Crisanti et al., 2016; Lucksted, et al., 2015). Surprisingly, a high percentage (76.7%) of participants indicated that MHFA training is or would be helpful in improving behavioral health while only one-third were aware of the training being offered in their community. This may suggest that training is still in its infancy regarding the state-wide implementation or that the respondents have not actively been involved in training events offered in their communities.

Participants indicated that school-based programs and services are valuable in addressing the behavioral health needs of school-age children and adolescents. Unsurprisingly, participants suggested that additional behavioral health staff would be beneficial in addressing these needs. Financial limitations may limit these opportunities thus requiring alternative funding modalities to support increasing staff numbers. Fortunately, the Affordable Care Act of 2010 provides a funding mechanism for school-based health centers, thus alleviating potential financial burdens (USDHHS, 2011b). The success of school-based programs in addressing behavioral health and its benefits regarding increasing access and utilization of services, including in rural communities, has been documented in previous studies (Keeton, Soleimanpour, & Brindis, 2012; Gao et al., 2008). Further, school-based health centers can be operated by outside entities,

including community health centers, hospitals, and local public health departments, thus reducing barriers for school districts that lack the physical capacity to build and maintain these centers (Keeton et al., 2012).

Perceptions on the integration of primary care, behavioral health, and public health were collected to better understand necessary elements in establishing this interdisciplinary approach. This project is unique as it openly asked participants to document what they feel this integration should look like and recorded the common elements. While no similar study was found, previous work had shown positive provider and patient perceptions on the integration of these services, especially when behavioral health services were collocated within the primary care setting (Ede et al., 2015). Findings suggest that non-prescribing providers see a benefit in the integration of these services especially considering improving access to and utilization of care. Understanding the elements identified in this project will help better understand the challenges and barriers that impede its establishment. Further, the current and future assessments of the integration of primary care, behavioral health, and public health will help inform Nebraska SHIP objectives in deciding what strategic activities need to be implemented to accomplish the objectives.

A preliminary list of school-based and community-based services and programs was created to document programs that benefit rural Nebraska behavioral health needs. Moreover, an additional list of current and past behavioral health programs was documented to provide insight on available resources offered in rural committees. It was not the intent to examine these programs as this was outside the scope of this project. An examination of such programs would require a significant time commitment and an assessment of outcome measures to determine their efficacy and sustainability.

Limitations

This project has several limitations. First, low response rates due to this project's timeline and preliminary emphasis limit generalizability. This limitation will be strengthened as more surveys are collected, and the additional data is analyzed. Further, this project only examines the perceptions of non-prescribing providers, thus limiting generalizability of all Nebraska's rural behavioral health workforce. Lastly, the design of survey included multiple open-ended response questions, introducing nonresponse bias to portions of the survey.

Recommendations

First, data collection should continue past this project to further strengthen the results presented in this paper. Future research should focus on the specific programs identified in this project and solicit feedback from providers on the effectiveness of these programs, regarding their implementation and sustainability, while also assessing challenges and barriers. Also, future results should be published, and identified evidence-based programs and services should be disseminated to applicable stakeholders. Finally, other provider types (i.e., physician, physician assistants, and nurse practitioners) should be included in future research to obtain their feedback on improving rural behavioral health.

Ethical Considerations

This project was reviewed by UNMC Institutional Review Board (IRB) and classified as a program evaluation project. As such, the UNMC IRB determined that this project did not constitute human subjects research as defined by 45CFR46.102 and was not subject to federal regulations.

Conclusions

Rural Nebraska communities face sizable challenges regarding access and utilization of behavioral health care services thus the need for other avenues to reduce morbidity and mortality associated with behavioral health issues. Public health can serve as such an avenue by implementing evidence-based programs to address community behavioral health concerns and bridge the gaps between behavioral health and primary care. Programs identified in this project should be examined further to determine their feasibility and effectiveness to ensure high sustainability and efficacy for the communities they serve.

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Service Learning/Capstone Experience Reflection

See above in the Agency Background section for a description of RHEN. I first learned about RHEN while enrolled in CPH 504 Epidemiology in Public Health. While visiting with the instructor and discussing various on-campus organizations where I could engage; she suggested I contact RHEN and facilitated the initial contact with the director.

Service Learning activities took place during August through December, for a total of approximately 150 hours. Activities performed during the Service Learning portion of this project included: conducting literature reviews on health care professions and public health pipeline programs for undergraduate and graduate students; participated in undergraduate recruitment events for students enrolled in the state college system and the University of Nebraska at Kearny; and creating recruitment videos for the Master of Public Health (MPH) and Doctor of Medicine (MD)/Master of Public Health dual degree programs.

A few products were developed during the Service Learning portion of this project. First, three UNMC recruitment videos were created targeting different audiences and relating to different UNMC programs. The first recruitment video created targeted students enrolled in the College of Medicine who have an interest in community medicine and aimed to increased enrollment into the MD/MPH dual degree program. The last two recruitment videos targeted students interested in applying to UNMC College of Public Health and described the purpose and definition of public health, and provided information as to why a student should attend UNMC to obtain an MPH degree.

Aside from the recruitment videos, other products created included various literature reviews that outlined successful health care professions and public health pipeline programs for undergraduate and graduate students, and successful strategies for recruitment and retention of

students interested in practicing in rural environments. Lastly, a PowerPoint presentation was created to provide an overview of COPC that was incorporated into the lesson material for an interprofessional rotation that took place at East Central District Health Department and included students from the College of Nursing, College of Allied Health, and College of Public Health.

Regarding Service Learning activities, I believe that my greatest contributions and accomplishments took place during the undergraduate student recruitment events held at the University of Nebraska Kearney and Peru State College. During these events, I was afforded the opportunity to meet with students who were interested in pursuing a MPH degree at UNMC and shared information about the program, future career opportunities in public health, and personal experiences while enrolled in the program. Because of these events, I had the opportunity to speak with a couple of students afterwards, continuing our conversation further; diving deeper into the details of the program. Also, I was able to assist one of these students with a shadowing opportunity with the Centers of Preparedness Education within UNMC College of Public Health.

The greatest challenge I faced during the Service Learning/Capstone Experience was the creation of the survey tool used for data collection. I did not anticipate or fully respect the amount of work that had to be put forth while creating the survey tool. Countless hours were dedicated solely to creating and revising the survey, incorporating feedback from my committee members and various UNMC College of Public Health faculty. The feedback and encouragement provided by all that assisted in developing the survey helped make this daunting task into a manageable and well-developed survey.

As someone who is currently employed in the public health field, this Service Learning/Capstone Experience project has provided an opportunity that I have not been able to experience through my current employment. Most of my day-to-day work activities focus on

grant deliverables required by NDHHS, limiting my ability to pursue work-related research and program improvement activities. Completing this project has afforded me a valuable experience regarding the research aspect of public health and has the potential to influence policy decision regarding Nebraska's behavioral health care system.

My public health education and coursework in COPC prepared me to confront the issues I encountered during my Service Learning/Capstone project. Specifically, CPH 551 Community Oriented Primary Care Principles and Practice was relevant as it provided me with the essential knowledge of the COPC framework and guiding principles. Additionally, this course also helped frame one of the sections of the survey tool that focused on participant perceptions on the integration of public health, primary care, and behavioral health. Lastly, the course CPH 626 Health Information and Surveillance was crucial as it provided the foundation for developing the measures that were the focal point of this project.

Application of Public Health Competencies

Form I to be submitted as a separate document after completion by Committee Chair

Acknowledgments

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Appendix A

Survey Tool

UNIVERSITY OF NEBRASKA MEDICAL CENTER
COLLEGE OF PUBLIC HEALTH

Instructions
- Complete this form using a pen or pencil (not felt-tip marker).
- Check entire box; print above lines.

Correct Marking	Incorrect Marking
☒ AB	☑ ~~AB~~

This survey consists of five parts. In part 1, we are examining your level of knowledge and awareness of Mental Health First Aid, a program endorsed by the Nebraska Legislature. In part 2, we examine your level of knowledge and need for school-based programs. In part 3, we inquire about your understanding of the integration of primary care, public health, and behavioral health. In part 4, we inquire about your knowledge and need for current and past programs that would benefit members of your rural community. Finally, in part 5 we simply collect some demographic data to help us better describe our study sample.

For consistency purposes, behavioral health is defined to include both mental disorders and substance use disorders

Part 1. Mental Health First Aid

1. Using the response options below, please indicate your level of awareness of Mental Health First Aid Training.

☐ Not at all aware ☐ Slightly aware ☐ Somewhat aware ☐ Fairly aware ☐ Very aware

PLEASE READ BEFORE ANSWERING QUESTIONS 2-4

Mental Health First Aid training is an educational program for youth and adult community members that promotes early detection and intervention of behavioral health problems by training community members to identify and respond to signs of mental illness and substance use disorders. The program also provides trained individuals with knowledge of resources available to treat mental illness within their community.

2. When thinking about members of the rural community you serve, how helpful is/would Mental Health First Aid training (be) for improving behavioral health outcomes?

☐ Not at all helpful ☐ Slightly helpful ☐ Somewhat helpful ☐ Fairly helpful ☐ Very helpful

3. When thinking about the rural community you serve, how helpful is/would Mental Health First Aid training (be) in reducing stigma regarding seeking behavioral health services?

☐ Not at all helpful ☐ Slightly helpful ☐ Somewhat helpful ☐ Fairly helpful ☐ Very helpful

4. Are you aware of Mental Health First Aid training being offered in the rural community you serve?

☐ Yes ☐ No ☐ Not Sure

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Part 2: Behavioral health services and support programs offered in schools

5. In the rural community you serve, are you aware of any behavioral health services or support programs offered in schools?

☐ Yes ☐ No **(If no skip to Question 10)**

6. If you said yes to questions 5, what are examples of behavioral services or support programs offered in schools in your rural community?

1. _____
2. _____
3. _____

7. If you said yes to Question 5, how familiar are you with these services or support programs?

☐ Not at all familiar ☐ Slightly familiar ☐ Somewhat familiar ☐ Fairly familiar ☐ Very familiar

8. If you said yes to Question 5, how effective are these services or support programs?

☐ Not at all effective ☐ Slightly effective ☐ Somewhat effective ☐ Fairly effective ☐ Very effective

9. What are examples of behavioral services or support programs you would like to see offered in schools in your rural community, that aren't already offered?

1. _____
2. _____
3. _____

(Skip to Question 11)

10. If you said no to Question 5, how helpful would school-based behavioral health services or support programs be in improving the behavioral health of school children?

☐ Not at all helpful ☐ Slightly helpful ☐ Somewhat helpful ☐ Fairly helpful ☐ Very helpful

Part 3: Integration of primary care, public health, and behavioral health

11. What does the integration of primary care and behavioral health services mean to you?

_____

_____

_____

_____

_____

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12. Thinking specifically within the context of behavioral healthcare, what does the integration of primary care and public health mean to you?

_____

_____

_____

_____

Part 4: Past and current programs that benefit your community's behavioral health and well-being

13. Are you aware of any current programs that benefit your community's behavioral health and well-being?

☐ Yes ☐ No **(If no skip to Question 14)**

If yes, please list:

1. _____
2. _____
3. _____

14. Are you aware of any programs that were offered in the past and are no longer offered, or other programs that would benefit your community's behavioral health and well-being?

☐ Yes ☐ No **(If no skip to Question 15)**

If yes, please list:

1. _____
2. _____
3. _____

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Part 5: Demographics

15. What is your gender? *(Please check one)*

☐ Male ☐ Female ☐ I prefer not to answer

16. What is your age? *(Please check one)*

☐ 19-25 ☐ 26-35 ☐ 36-45 ☐ 46-55 ☐ 56-65 ☐ 66+ ☐ I prefer not to answer

17. Which one of the following would you say BEST represents your race/ethnicity? *(Please check one)*

☐ Non-Hispanic White ☐ Hispanic/Latino ☐ Don't Know/Not Sure
☐ Black or African American ☐ Asian ☐ I prefer not to answer
☐ Native Hawaiian or Other Pacific Islander ☐ American Indian or Alaska Native ☐ Other (specify:)

18. Which license do you practice under? *(Please check all that apply)*

☐ Psychologist (PhD or PsyD) ☐ LIMHP
☐ LMHP ☐ LADC
☐ Other (specify) ☐ I prefer not to answer

19. How long have you provided mental health services? *(Please check one)*

☐ Less than 1 year ☐ 11-15 years
☐ 1-5 years ☐ More than 15 years
☐ 6-10 years ☐ I prefer not to answer

20. What is your area of focus? *(Please check all that apply)*

☐ Children ☐ Adults
☐ Marriage and Family ☐ I prefer not to answer
☐ Adolescents ☐ Other (specify:_____)
☐ Substance Abuse

Thank you for your assistance in helping us identify relevant recommendations aimed at improving population health outcomes in rural Nebraska communities.

Appendix B

Demographics and Characteristics of Participants.

Demographics

Characteristics		N	%
Sex	Male	22	22.0
	Female	78	78.0
Race	Non-Hispanic White	98	98.0
	Hispanic or Latino	1	1.0
	Other	1	1.0
Age	26-35	14	14.0
	36-45	24	24.0
	46-55	17	17.0
	56-65	33	33.0
	66+	12	12.0
Length of service: How longs have you provided mental health services		N	%
	1-5 years	8	8.0
	6-10 years	21	21.0
	11-15 years	20	20.0
	More than 15 years	50	50.0
	I prefer not to answer	1	1.0
Licensure Type: What license(s) do you practice under		N	%
	Psychologist (PhD or PsyD)	10	10.0%
	LMHP	38	38.0%
	LIMHP	57	57.0%
	LADC	26	26.0%
	Other	21	21.0%
Focus Area: What is (are) your area(s) of focus		N	%
	Children	43	43.0%
	Marriage and family	35	35.0%
	Adolescents	63	63.0%
	Substance abuse	36	36.0%
	Adults	78	78.0%
	Other	22	22.0%

Appendix C

Awareness and Perceptions on Helpfulness of MFHA Training

Mental Health First Aid Training

Awareness of MHFA training	N	%
Not at all aware	18	17.5
Slightly aware	18	17.5
Somewhat aware	14	13.6
Fairly aware	19	18.4
Very aware	34	33.0
Perceived helpfulness of MHFA training in improving behavioral health	**N**	**%**
Not at all helpful	0	0
Slightly helpful	4	3.9
Somewhat helpful	20	19.4
Fairly helpful	40	38.8
Very helpful	39	37.9
Perceived helpfulness of MHFA training in reducing stigma	**N**	**%**
Not at all helpful	1	1.0
Slightly helpful	5	4.9
Somewhat helpful	18	17.5
Fairly helpful	36	35.0
Very helpful	43	41.7
Aware of MHFA be offered in community	**N**	**%**
Yes	35	34.0
No	51	49.5
Not Sure	17	16.5

Appendix D

Awareness and Perceived Familiarity, Effectiveness, and Helpfulness of School-Based Behavioral Health Services and Support Programs

School Behavioral Health Services and Support Programs

Awareness of school behavioral health services or programs	N	%
No	57	55.9
Yes	45	44.1
Familiarity of school behavioral health services or programs	**N**	**%**
Not at all familiar	2	4.4
Slightly familiar	2	4.4
Somewhat familiar	10	22.2
Fairly familiar	20	44.4
Very familiar	11	24.4
Effectiveness of school behavioral health services or programs	**N**	**%**
Not at all effective	0	0
Slightly effective	3	6.8
Somewhat effective	12	27.3
Fairly effective	21	47.7
Very effective	8	18.2
How helpful would school behavioral health services or programs be, if offered	**N**	**%**
Not at all helpful	1	1.7
Slightly helpful	2	3.3
Somewhat helpful	8	13.3
Fairly helpful	13	21.7
Very helpful	36	60.0

Appendix E

Current Programs That Benefit Community's Behavioral Health and Well-Being

Organization/Program	Focus area
Addiction Counseling Consultation Services (2018)	Youth and adult substance abuse
Al-Anon Family Groups (n.d.)	Family support groups for alcohol dependency
Big Brothers and Big Sisters of America (2018)	Youth mentoring
Cirrus House (n.d.)	Housing, employment, and education for those with mental health
Multisystemic Therapy (n.d.)	Family-focused and community-based treatment for troubled youth
National Alliance on Mental Health (2018)	Mental health education and advocacy
Nebraska Counseling, Outreach, and Mental Health Therapy Project (n.d.)	Crisis counseling for farm and rural families
Nebraska Early Childhood Interagency Coordinating Council (n.d.)	Early childhood care and education
Nebraska Behavioral Health Regions (2018)	Various behavioral health emphases.
Nebraska Family Helpline (2017c)	Family mental health
Nebraska Local Outreach to Suicide Survivors Team (n.d.)	Suicide prevention
Nebraska State Suicide Prevention Coalition (n.d.)	Suicide prevention
Panhandle Health Group (n.d.)	Family and individual mental health, substance abuse, gambling, and medication management

Pyramid Model (2016)	Infant and child social skills and emotional competence
Project SKIP (2018)	Child mental health assessment tool
Question Persuade Refer (n.d.)	Suicide prevention
Residential Drug Abuse Program (n.d.)	Substance abuse for federal prisoners
SOZO Family Services (n.d.)	Mental health counseling, mental health assessments, substance abuse, support groups, and trauma
TeamMates Mentoring Program (2018)	Youth mentoring
Through the Eyes of the Child Initiative (2018)	Child welfare
Wellness Recovery Action Plan (2016)	Mental health wellness, depression, trauma

Appendix F

Past and Other Programs That Benefit Community's Behavioral Health and Well-Being

Organization/Program	Focus area
Al-Anon Family Groups (n.d.)	Family support groups for alcohol dependency
Big Brothers and Big Sisters of America (2018)	Youth mentoring
Celebrate Recovery (2018)	Substance abuse recovery
Community Alliance (2017)	Mental health and substance abuse
Community Treatment Aide (2010)	Youth mental health and substance abuse management
Healthy Start (2018)	Maternal and child health
National Alliance on Mental Health (2018)	Mental health education and advocacy
Nebraska Behavioral Health Regions (2018)	Various behavioral health emphases.
TeamMates Mentoring Program (2018)	Youth mentoring