Nebraska's Crisis Continuum

988 Planning

NEBRASKA'S REGIONAL PLANNING DISCUSSION SUMMARY

Compiled in July 2021 by the University of Nebraska Public Policy Center in collaboration with the Nebraska Department of Health and Human Services (DHHS), Division of Behavioral Health and Regional Behavioral Health Authorities. Funding for this project is from a grant to DHHS by Vibrant Emotional Health.

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Summary: Regional Behavioral Health Authority 988 Discussions

Vibrant awarded states and territories planning grants in 2021 to plan for the implementation of a new, national, three-digit number (988) for individuals to call when they are experiencing mental health or suicide crises. The vision is for 988 to eventually take the place of the current suicide prevention Lifeline number 1-800-273-TALK (8255). The 988 call center is envisioned as an entry point to Nebraska's continuum of care – connecting callers to local resources and emergency mental health care. Two guided discussions in each Nebraska behavioral health region focused on two areas: 1) Mapping services available and needed in the crisis continuum of care; and 2) Local follow-up to 988 calls.

The University of Nebraska Public Policy Center (Center) is assisting the Nebraska Division of Behavioral Health with the 988 planning grant. The Center worked with each Regional Behavioral Health Authority (Regions) to facilitate two planning sessions and distribute an online survey tool to area stakeholders. Additionally, each Region assembled an overview of their current crisis continuum including a snapshot of the crisis services currently available and accompanying graphic representations of the crisis response service process(s). Regions also completed a self-assessment based on the crisis response standards recommended by the American Association of Suicidology (AAS).[1] These standards represent an "ideal state" with not all services available in all areas of the state. AAS uses this grid to help crisis centers self-evaluate and move toward national accreditation. AAS recognizes that a single organization can rarely provide the comprehensive services necessary to address every crisis, so the crisis service continuum "necessarily requires interorganization coordination and collaboration among groups such as voluntary and governmental mental health agencies, police, emergency medical services, and self-help groups" (page 8). An online survey was distributed by regions to their stakeholders

Information and recommendations garnered from each region's sessions were provided back to Regions for review and editing before being finalized. The state Department of Health and Human Services, Division of Behavioral Health received final copies of each regional document and this summary document with all regional responses aggregated.

[1] American Association of Suicidology. (2012). Organization Accreditation Standards Manual, thirteenth edition, https://suicidology.org/wp-content/uploads/2019/06/13th-EditionFeb-2019-1.pdf

Regional Behavioral Health Crisis System Overview

Regional Behavioral Health Authorities were invited to provide information to the State Department of Health and Human Services at least 30 days prior to their first planning session about the current capacity of the crisis system in their areas. Each Region was first asked about the number and name of crisis response providers in their geographic service area (see Table 1).

Table 1: Crisis Response Providers, by Behavioral Health Region

Region	Crisis Response Service Providers	Eligible Crisis Response Initiator
Region 1	- Box Butte General Hospital (BBGH) -Region 1 Behavioral Health Authority (RBHA) -Western Community Health Resources (WCHR)	-Medical provider -Law enforcement -Family/friend -Mental Health provider -Substance use disorder provider -Children and family services -Probation
Region 2	-Region 2 Crisis Response Triage	-Emergency Support Director -Emergency Support Director Designee -Law enforcement
Region 3	-Region 3 Crisis Response -Co-Responder program in Hall and Buffalo Counties -South Central Behavioral Health Services -CHI Richard Young -Mary Lanning Memorial Hospital -Great Plains Medical Regional Medical Center -Mid-Plains Center for Behavioral Healthcare Services Crisis Treatment	- Anyone
Region 4	-Four regional crisis response teams (Good Life Counseling, Behavioral Health Specialists, and Heartland Counseling Services) -Faith Regional -Richard Young -Great Plains Medical Regional Medical Center	-Self-initiate -Law enforcement -Probation -Medical provider -Family member
Region 5	-Targeted Adult Service Coordination (TASC) -CenterPointe -Mental Health Association (MHA)	-Targeted Adult Service Coordination (TASC) -CenterPointe -Mental Health Association (MHA)
Region 6	-Safe Harbor -Emergency Community Support -Mobile Crisis Response (Crisis Intervention Trained Officers) - Various emergency departments - Lasting Hope Assessment Center - Douglas County Detox - Psychiatric Emergency Service	-Law enforcement -Area shelters, including domestic violence shelter -Boys Town crisis line -Probation -School resource officer -Co-responder with Omaha Police Department

Each Region was asked a variety of supplemental questions regarding the existing crisis system within their region (see Table 2). Law enforcement does not respond to all crisis response requests in most Nebraska Behavioral Health Regions. Counties served by Region 1 Behavioral Health Authority and Western Community Health Resources (in Region 1) are the exception. Variability exists among Nebraska Behavioral Health Regions regarding in-person, telehealth, and telephonic crisis service provision. Each Region has at least some availability of telephonic crisis response services. Follow up contact for crisis response services varies among Nebraska Behavioral Health Regions.

Table 2: Crisis System Overview by Nebraska Regional Behavioral Health Authorities

	Region 1	**Region 2**	**Region 3**	**Region 4**	**Region 5**	**Region 6**
Does Law Enforcement respond to all Crisis Response requests?	Dependent on area	No	No	No	No	No
What validated screening tools are used to make decisions during the crisis encounter?	-Columbia Suicide Severity Rating Scale (CSSRS) -State of NE Centralized Data System (CDS) assessment	-Suicide Risk Assessment -Safety Plan	-SAMHSA SAFE-T Protocol with Columbia-Suicide Severity Rating Scale	-Brief Mental Health Status Exam/Risk Assessment -Suicide Risk Assessment -Crisis Response Safety Agreement	-Suicide Screen (ASQ) -Risk Assessment (CSSR-S) -Safety Plan	None
Are crisis response providers available in all counties to provide *in-person crisis response*?	Yes	No	No	Yes	Yes	Yes
Are crisis response providers available in all counties to provide *tele-health crisis response*?	Mostly Yes	No	Yes	Yes	Yes	Yes
Are crisis response providers available in all counties to provide *telephonic crisis response*?	Sometimes Yes	Yes	Yes	Yes	Yes	Yes, not preferred
What follow-up do the Crisis Response teams do currently?	Varies by county: phone call or service coordinator	Phone call within 24 hours	Phone call within 24 hours	Based on client needs	Face-to-face within 24 hours and phone call at 30 days	Phone call within 24 hours and 30 days

Crisis Continuum Self-Assessment – Region Behavioral Health Authorities

How does your current crisis care continuum compare to the crisis response standards suggested by the American Association of Suicidology (AAS)?

Crisis Receiving/Walk-in Service

Persons in an acute crisis may need immediate personal contact with helpers. The availability of a walk-in crisis service indicates that the program is capable of delivering high quality care. Although it is an optimum situation, it is not mandatory that crisis programs provide walk-in crisis services in the organization's facilities. What is required of the organization to meet minimum standards is that it assures these services are available to provide immediate care to persons in the area served. Such arrangements should be specified by written contract or written operational agreements between the program and agencies such as a mental health center or an emergency department, which has crisis consultation available

Ideal State – Crisis receiving/walk-in service	Available	Partially Available	Not Available
Walk-in service is available to persons through referral that telephone workers can initiate.	2, 3, 6(adult)	1, 4, 5	6 (youth)
The relationship between the crisis program and walk in services is well developed, procedures are in writing and are available 24/7.	3, 6(adult)	1, 2, 4, 5	6 (youth)
The program offers walk-in service or walk-in access during weekday office hours.	2, 3, 6(adult)	1, 4, 5	6 (youth)
The crisis program will handle immediate walk-in service contacts referred either by its own staff or by other gatekeepers.	1, 3, 6(adult)	2, 4, 5	6 (youth)
There is a system that permits monitoring and supervision of the workers.	1, 2, 3, 6(adult)	4	5, 6 (youth)
After hours and weekends an equivalent service is provided by another organization through written agreement. Or, the organization does not operate its own walk-in service but has a seamless referral system and feedback to another service.	3, 6(adult)	4	1, 2, 5, 6 (youth)
Walk-in face to face crisis service is an integral aspect of the service delivery design.	3, 6(adult)	1, 4	5, 6 (youth)
Walk-in service is available during extended hours and weekend times.	2, 3, 6(adult)	1, 4	5, 6 (youth)
There are referrals that can be easily made to 24/7 walk-in services if the program doesn't operate this service 24/7.	3, 6(adult)	2, 4	1, 5, 6 (youth)

Level 1	Level 2	Level 3

Note – Levels refer to the three levels of crisis center accreditation offered by AAS. To achieve accreditation the organization must meet or exceed Level I standards for every component. AAS understands that some organizations do not have the resources to achieve Level II or Level III in all areas. (Page 17).

Outreach Services, (Mobile Crisis Outreach Team)

Some persons in acute crisis or life-threatening situations are unable or unwilling to travel to a face to face meeting. Outreach service may be essential in such cases. As with walk-in service, if an organization cannot provide outreach as part of its own program, it should assure the provision of such service by written contract or written referral protocols. Mobile outreach is a service whereby crisis workers are dispatched to meet with a person in person in order to get a more accurate and complete assessment or intervention than can be obtained by telephone or other methods. This assessment or intervention may be completed in person's home or in a public place (i.e. jail, restaurant, community organization, hospital). Based on the person's history and current need, a plan is developed to assist person in receiving the most appropriate service in the least restrictive environment.

Ideal State – Outreach services (mobile crisis)	Available	Partially Available	Not Available
The crisis center can provide outreach service through a working agreement with another organization and telephone workers or those using texting or crisis chat can initiate this referral.	6 (adult youth)	3, 4, 5	1, 2, 5
The program takes responsibility for calling police or other emergency, mental health or social service organizations.	2, 3, 4, 6 (adult youth)	1	5
Around-the-clock arrangements can be made to transport those in crisis to walk-in services, such as the local mental health center or hospital emergency department.		3, 4, 6 (adult youth)	1, 2, 5
There are written criteria for when crisis workers should employ the crisis outreach service.	3	1, 4, 6 (adult youth)	2, 5
The program takes responsibility for calling police or other emergency, mental health or social service organizations.	2, 3, 4, 6 (adult youth)	1	5
The mobile team meets the person in their residence, the Emergency Room of a local hospital or other community locations.	5	1, 2, 3, 4, 6 (adult youth)	
The mobile team members demonstrate competency in crisis intervention techniques, lethality assessment, problem solving and recognizing indicators of presenting problems. Mobile team members receive personal safety training.	1, 3, 5, 6 (adult youth)	4	2
There is a system that permits monitoring and supervision of mobile crisis team members.	1, 2, 3, 4, 5, 6 (adult youth)		
A safety assessment is performed prior to dispatching the mobile team. This assessment should address whether there are weapons in the home, animals that could pose a threat, other persons in the home and the general safety of the neighborhood. If there are any safety concerns an alternate, safer meeting site may be arranged.	1, 2, 6 (adult youth)	3, 4, 5	

Ideal State – Outreach services (mobile crisis)	Available	Partially Available	Not Available
When meeting a person in their home the team member will not be dispatched to go alone.	1, 2, 3, 6 (adult youth)	4, 5	
Written program policies define collaborative efforts between the mobile crisis team, police, and mental health personnel responsible for implementing involuntary commitment laws.	6 (adult youth)	3, 4, 5	1, 2
The mobile team has a strong working relationship with police, hospital and other emergency service providers.	1, 3, 5, 6 (adult youth)	4	2
Mobile services are available 24/7.	1, 2, 4, 5, 6 (adult youth)	3	
Persons providing mobile services are trained in first aid and CPR.	3, 6 (adult youth)	2, 4	1, 5
There are written emergency procedures that address screening for medical conditions, making referrals to emergency medical services when indicated, identifying personnel trained in emergency procedures, involuntary hospitalization.	3, 6 (adult youth)	1, 4	2, 5
Personnel demonstrate knowledge of the appropriate use of community resources, crisis intervention techniques and procedures for involuntary hospitalization.	1, 2, 3, 4, 6 (adult youth)	5	
Enhanced working relationships with police and other emergency services providers are demonstrated by regular meetings, ride-a-longs, debriefings cross training as examples.	2, 3, 6 (adult youth)	1, 4	5
The crisis assessment leads to an initial crisis intervention plan developed upon contact with each person that includes identified immediate response needs, identified follow-up when referral is made and a statement of crisis resolution.	1, 2, 3, 4, 6 (adult youth)	5	
Mobile team members have access to medical and/or psychiatric consultation 24/7.	2, 6 (adult youth)	3, 4	1, 5

Level 1	Level 2	Level 3

Follow-Up

Crisis intervention follow up services should be an established part of the crisis program. Follow-up includes initiating contact with persons who may have been assessed at risk for suicide and others when appropriate. Follow up may include outreach contacts to the high-risk party of a third party call. This recognizes the reality that when someone calls for a person at risk, the person at risk is likely to be of higher risk for suicide and with more ambivalence about reaching out for help than persons who call the center directly. Crisis centers should have policies and procedures that spell out how third party persons will be handled in situations where the person won't agree to call the person at risk, but will give identifying information. These policies and procedures will document how the organization will reach out and offer appropriate support or intervention with the person at risk. The Follow-up policy should state how often follow-up calls will be attempted and a protocol of how to proceed if the at risk person is unreachable, especially if a follow-up call time was agreed upon. The policies and procedures for follow-up of such persons should be in writing and included in the crisis worker's manual. Follow-up contacts should be included in the person's record.

Ideal State – Follow-up	Available	Partially Available	Not Available
The crisis program makes follow-up calls, specifically in cases involving suicide risk according to a written procedure.	2, 3, 6 (adult and youth)	1, 4	5
Records of follow-up contacts are kept.	1, 2, 3, 6 (adult and youth)	4	5
The program initiates active rescue when appropriate with third party calls.	2, 3, 6 (adult and youth)	4	1, 5
Follow up need, contact information, and outcome is efficiently communicated between crisis workers and other shifts as necessary.	2, 3, 6 (adult and youth)	4	1, 5
The crisis program attempts regular follow-up contacts with persons at risk not only of suicide but of other crisis situations.	2, 3, 6 (adult and youth)	1, 4	5
There is evidence that the crisis center initiates third party contact.	2, 3, 6 (adult and youth)	4	1, 5
There is a staff member dedicated to making sure that follow-up contacts are provided within 24 hours of crisis call for all risk cases.	2, 6 (adult and youth)	3, 4, 5	1

Ideal State – Follow-up	Available	Partially Available	Not Available
The program integrates follow up into all crisis service contacts.	2, 6 (adult and youth)	1, 3, 4, 5	
Supervisors are aware of when follow up is needed and when a follow up contact has been accomplished.	2, 3, 6 (adult and youth)	1, 4, 5	
Follow up contacts to referrals and/or emergency responders is part of the program's protocol.	2, 3, 6 (adult and youth)	1, 4, 5	

Level 1	Level 2	Level 3

Planning Session #1 – Crisis Continuum

What crisis services are a priority for development in your area?

Individuals attending the regional planning sessions and survey respondents were asked which crisis service was a priority for development in their area. Stakeholders in five of the six Nebraska Behavioral Health Regions indicated juvenile crisis facilities were the most important for development. The need for juvenile crisis facilities was also noted as the priority crisis service need by 43.9% (n =58) of survey respondents. Crisis stabilization centers were identified as a priority for development by stakeholders in half of the behavioral health regions and 37.9% (n =50) of survey respondents. Crisis stabilization centers for adults was the priority crisis service selected for development among survey respondents at 22.0% (n =29). Respite centers were identified as a priority for development in four behavioral health regions but only 17.4% (n =23) of survey respondents. See Table 3 for additional information.

Table 3: Crisis Service Development Priority

Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
Aftercare	Staffed acute hospitalization facilities	Bilingual services	Crisis stabilization center	Acute hospitalization bed capacity	Increased service offering and education
Crisis stabilization center	Crisis stabilization center	Detox center (juvenile and adult)	Juvenile crisis facilities	Center with telehealth equipment	Youth-oriented psychiatric emergency services
Detox center	Juvenile crisis facilities	Residential substance use treatment	Juvenile emergency shelter	Integrated crisis response (EMS)	
In-person crisis response	Detox center (medically assisted)	Juvenile crisis facilities	Detox center (medically assisted)	Juvenile crisis facilities	
Juvenile crisis facilities	Respite center	Intensive outpatient programs	Psychiatry urgent care	Respite center (juvenile and adult)	
Respite center			Respite Center (juvenile and adult)		

Legend

Acute hospitalization	Crisis stabilization center	Detox center	Juvenile crisis facilities	Respite center	Other

What resources does your region need to move the crisis continuum from your current state to the ideal state?

A summary of needs identified in the regional planning session to move the crisis continuum from the current state to the ideal state is in Table 4. Commonly identified resources include the following: additional personnel (blue), enhanced collaboration (grey), transportation (yellow), facilities (green), and broadband connectivity (red).

Additional personnel was the most identified need by survey respondents (52.3%, n = 69). Five regions indicated there was a need for adequate staffing at acute hospitalization facilities and/or an increased number of qualified behavioral health providers to meet crisis service needs, including bilingual providers. Commonly identified barriers to adequate personnel included Nebraska's LMHP licensure process and region requirements to work with providers.

Region 5 indicated a need for additional collaboration efforts. Survey respondents echoed this need, as 42.4% (*n* = 56) identified partnerships with existing crisis service agencies as a resource needed to move the crisis continuum from the current state to the ideal state.

Table 4: Resources Needed for Crisis Continuum Development

Region 1	**Region 2**	**Region 3**	**Region 4**	**Region 5**	**Region 6**
Crisis continuum marketing	Financial coverage for crisis services	Statewide crisis service resource guide	Additional vehicles for crisis response	Caller transportation options	Procedures for mobile crisis teams
Trained crisis response person at all healthcare facilities	Adequate staffing for acute hospitalization facilities	Additional, qualified providers to deliver crisis services	Additional licensed mental health therapists	Contracted hospital for acute care beds	Additional, qualified providers to deliver crisis services
Additional, qualified providers to deliver crisis services	Improved broadband connectivity	Improved broadband connectivity	Additional, qualified providers to deliver crisis services	Increased statewide collaboration	Peer support utilization and reimbursement
Improved broadband connectivity	Caller transportation options	Caller transportation options	Increased number of bilingual providers	Increased input from rural region regarding needs	Increased number of crisis facilities and warmlines
Increased number of crisis facilities	Increased number of substance abuse facilities	Increased number of crisis facilities	Caller transportation options		Rapid access for after-hour services

Legend

Additional personnel	Enhanced collaboration	Transportation	Facilities	Broadband connectivity	Other

How should 988 be connected with local providers? 911? Law enforcement?

Survey respondents and regional planning meeting stakeholders explored interconnectivity needs for 988 with 911 and law enforcement. Each Nebraska Behavioral Health Region indicated that 988 and 911 need to be able to immediately transfer data during a life-threatening emergency. Over half of survey respondents (59.1%; n = 78) indicated 911 should be able to transfer callers and data to 988. Stakeholders in every region mentioned some level of shared protocol development between 988 and 911 as a priority. This included 988 collecting the same information required by dispatchers in the event a call is going to need law enforcement response. Most survey respondents indicated that 911 and 988 should have shared protocols (72.0%, n = 95). Region 5 stakeholders suggested a shared system to flag frequent callers for 911 and 988.

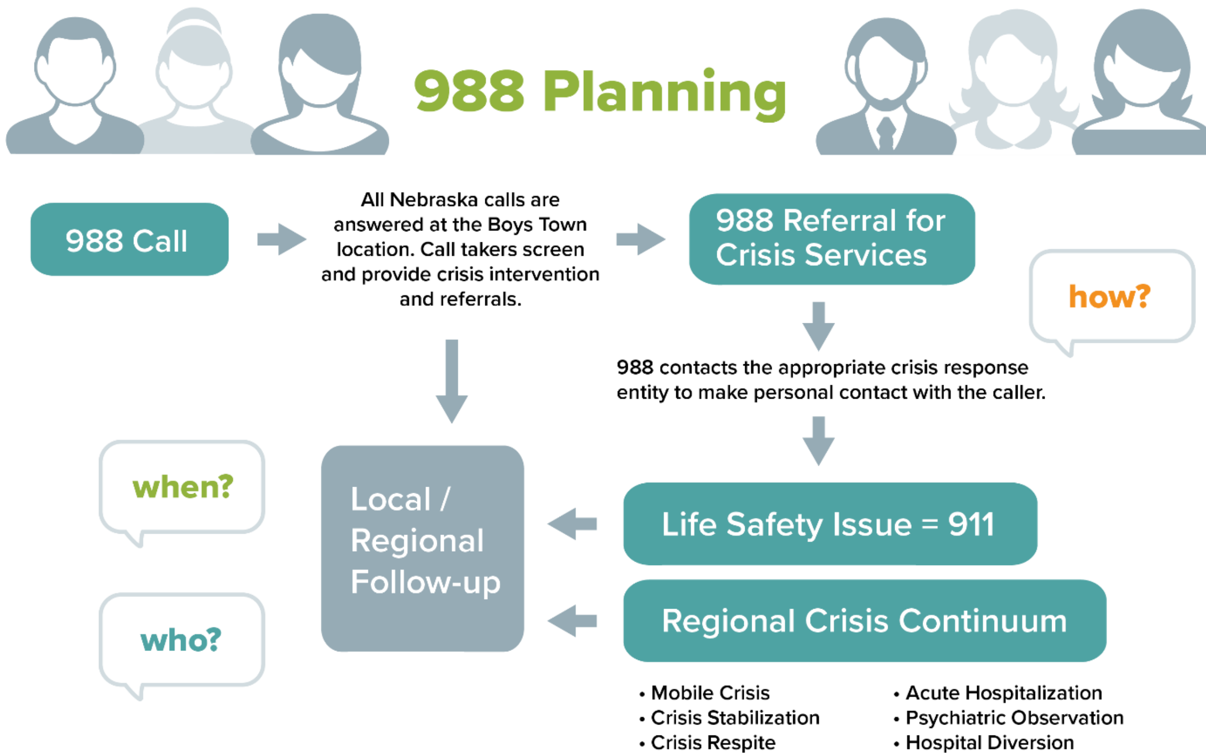
Survey respondents and regional planning meeting stakeholders explored connection between 988 and local service providers. All stakeholders voiced a desire for 988 to be aware of local resources, be able to refer to these services, and to seamlessly engage crisis response services. Region 6 stakeholders indicated that some level of data sharing from 988 to local crisis services would assist in the provision of services. Region 5 stakeholders noted that a projected call volume assessment should be made prior to the implementation of 988 to better asses regional crisis response staffing needs. A frequently updated crisis service resource guide was also a commonly identified need. It was also noted that regional resource guides exist but are not consistently updated nor comprehensive. If a resource guide was to be created, it was determined to be most beneficial if it was widely accessible to all regions.

General questions and comments

Other concerns raised in the regional planning session regarding crisis continuum included the following:

- How can transportation options be increased for callers, especially those using Medicaid and those living in rural areas?
- How will the appropriate level of service be initiated for each region?
- How will marketing regarding 988 be handled?
- How will projections regarding call volume for regional crisis response teams be made?
- How will the school system be factored in? Will they have MOU’s to receive information regarding their students?
- Who would be responsible for payment of services?
- Is there currently a place where juveniles can go outside of the ‘system’ for community-based services?

Planning Session #2 –Regional 988 Follow-Up Contacts Planning



Who should be responsible for follow up contacts for individuals who contact 988 in your area?

Call circumstances may necessitate follow up contacts be made to 988 callers. Regional planning sessions explored which individuals or agencies should be responsible for follow up contact provision. Stakeholders in each of Nebraska's six Behavioral Health Regions indicated that when a caller is referred to providers, services, or crisis response teams in their region, individuals within the region should be responsible for follow up contacts. Region 1 and Region 6 noted that, in the event a particular provider provides services, that provider should be responsible for follow up contact. Region 2, 3, 4, and 5 noted that a centralized follow up contact system should be established in the region. In this system, one or a small number of agencies were responsible for all the follow up contacts. This included the region, service providers or crisis teams.

Some exceptions to the follow up contact provision listed above were voiced for a subset of 988 calls. When a call results in acute hospitalization services, region 4 indicated the hospitals should provide this follow up. Region 2 stakeholders noted that when adult protective services (APS) and child protective services (CPS) hotlines are needed, APS and CPS should handle follow up contact. Region 2, 3, and 4

stakeholders indicated that when 988 does not make a referral to a region the 988 hotline should be responsible for follow up contacts.

A few additional considerations were noted by stakeholders during discussion of follow up contact provision. It was noted that adequate call volume and associated follow up contact provision volume should drive development of staffing resources to meet the demand. This may incorporate needs for additional staffing, incorporation of peer support and expanded emergency support services. Connections between 988 and follow up contact providers need to be established. Special consideration needs to be taken to ensure individuals providing contact services both have adequate crisis information for the caller and follow privacy regulations. A flagging system for frequent 988 callers and protocol to address this situation may need to be developed.

Region 6 stakeholders recommended a dual follow up contact service system. In this system, a caller receives the standard treatment/care follow up contacts discussed above. Additionally, customer centered post service follow up contacts would also be provided for continuous quality improvement.

What resources would be needed for people in your area to provide routine follow-up for 988 callers within 24 hours of each contact?

Commonly identified resources needed to provide follow up contacts are listed in Table 5 and include: additional personnel (blue), enhanced collaboration and information sharing (grey), transportation (yellow), training (green), and broadband connectivity (red).

Additional personnel is the most identified need by survey respondents (69.7%, n = 92). Five regions indicated there was a need for adequate staffing at dispatch facilities and/or an increased number of qualified behavioral health providers to meet crisis service needs, including bilingual providers. Commonly identified barriers to adequate personnel included Nebraska's definition of individuals eligible for crisis service provision.

Four regions indicated a need for increased collaboration efforts. This included the development of protocols regarding the sharing of confidential, crisis-related information about 988 callers to those providing 988 follow up contacts. Three regions also noted the importance of consistent, statewide 988 follow up contact protocol. Survey respondents indicated that revised procedures (31.8%, n = 42) and new partnerships/increased collaboration (40.2%, n = 53) were needs.

Stakeholders in Regions 3 and 4 indicated a need for additional training Survey respondents echoed this need, as 49.2% (n = 65) identified training as an important need regarding follow up contacts. Other identified miscellaneous resource needs were not sorted into categories and are listed as other.

Table 5: Resources Needed for Follow Up Contact Provision

Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
988 call takers need to have mental health knowledge	Call volume projections to estimate follow-up contacts	Consideration for follow-up contact financial compensation	Additional, qualified providers for follow up contact	Increased number of qualified providers to deliver crisis services	Review state definition of those eligible for crisis service provision
Increased dispatch center staffing	Consideration for follow-up contact financial compensation	Additional, qualified providers for follow up contact	Additional licensed mental health therapists	Consistent statewide 988 follow up contact protocol	Consistent statewide 988 follow up contact protocol
Shared protocols for sharing confidential information	Additional, qualified providers for follow up contact	Assessment of peer support capacity to provide follow up contact	Increased number of bilingual providers	Shared protocols for sharing confidential information	
Consistent statewide 988 follow up contact protocol	Additional licensed mental health therapists	Improved broadband connectivity	Improved broadband connectivity	Ability for provider to inform 988 that a caller refused services	
	Improved broadband connectivity	Caller transportation options	Mental health training for law enforcement		
	Caller transportation options	Training resources - CAMS, AMSR, MHFA	Shared protocols for sharing confidential information		

Legend

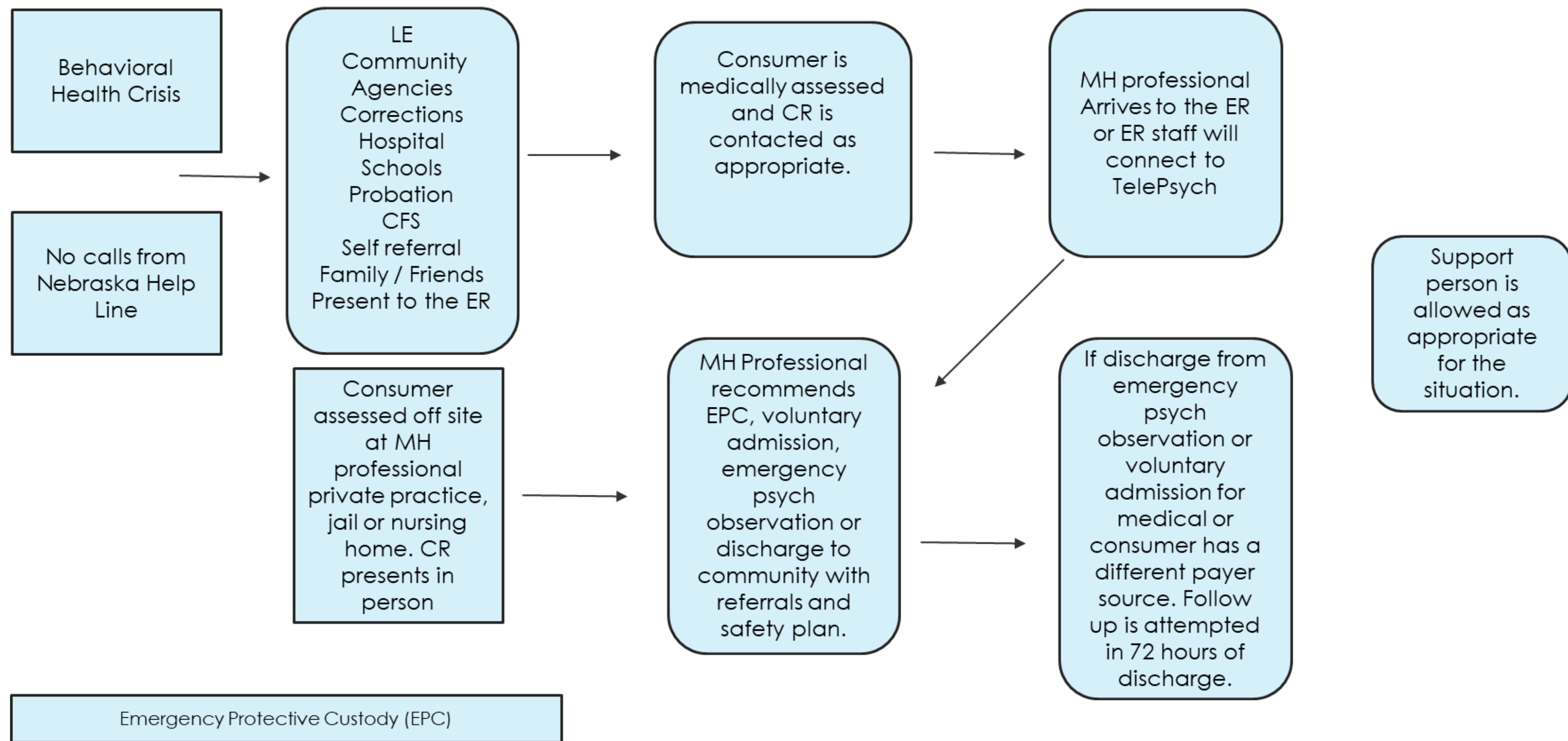
Additional personnel	Enhanced collaboration and information sharing	Transportation	Training	Broadband connectivity	Other

Other questions or comments?

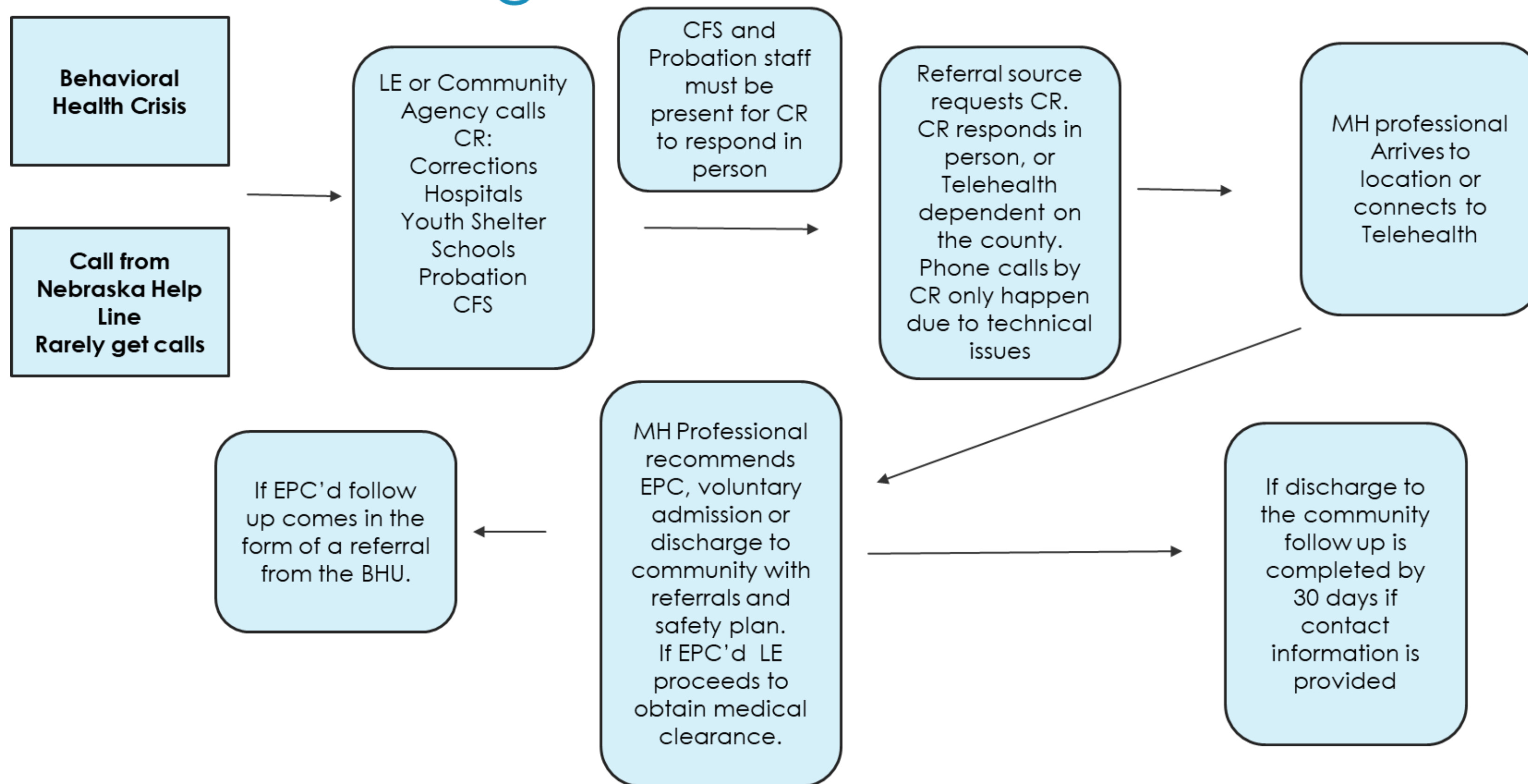
Other concerns raised by the regional planning session stakeholders regarding follow-up contacts included the following:

- Will 988 require new or modified service definitions?
- How can proactive outreach be used to increase awareness of 988?
- Can 988 use the same methodology as the Nebraska Family Helpline for follow-up?
- Could peer-support fill the follow-up contact provision gap?
- How can private therapists be educated to have clients contact 988 instead of 911?
- If telehealth is offered, how can individuals without technology or tech savviness access care?
- How can follow-up be standardized for equitable care?
- What information can be shared with regard to HIPPA?

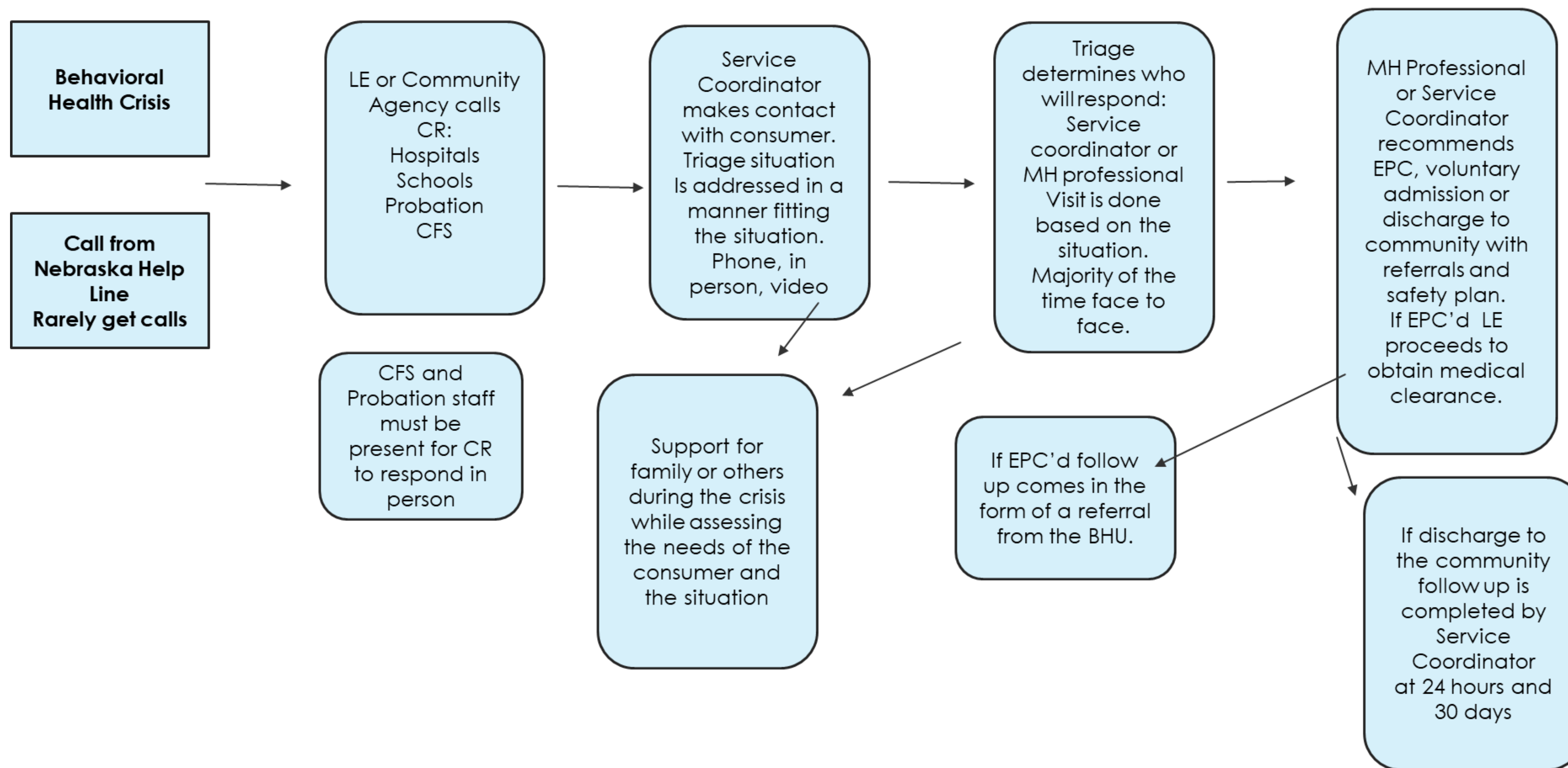
Appendix A: Behavioral Health Region 1



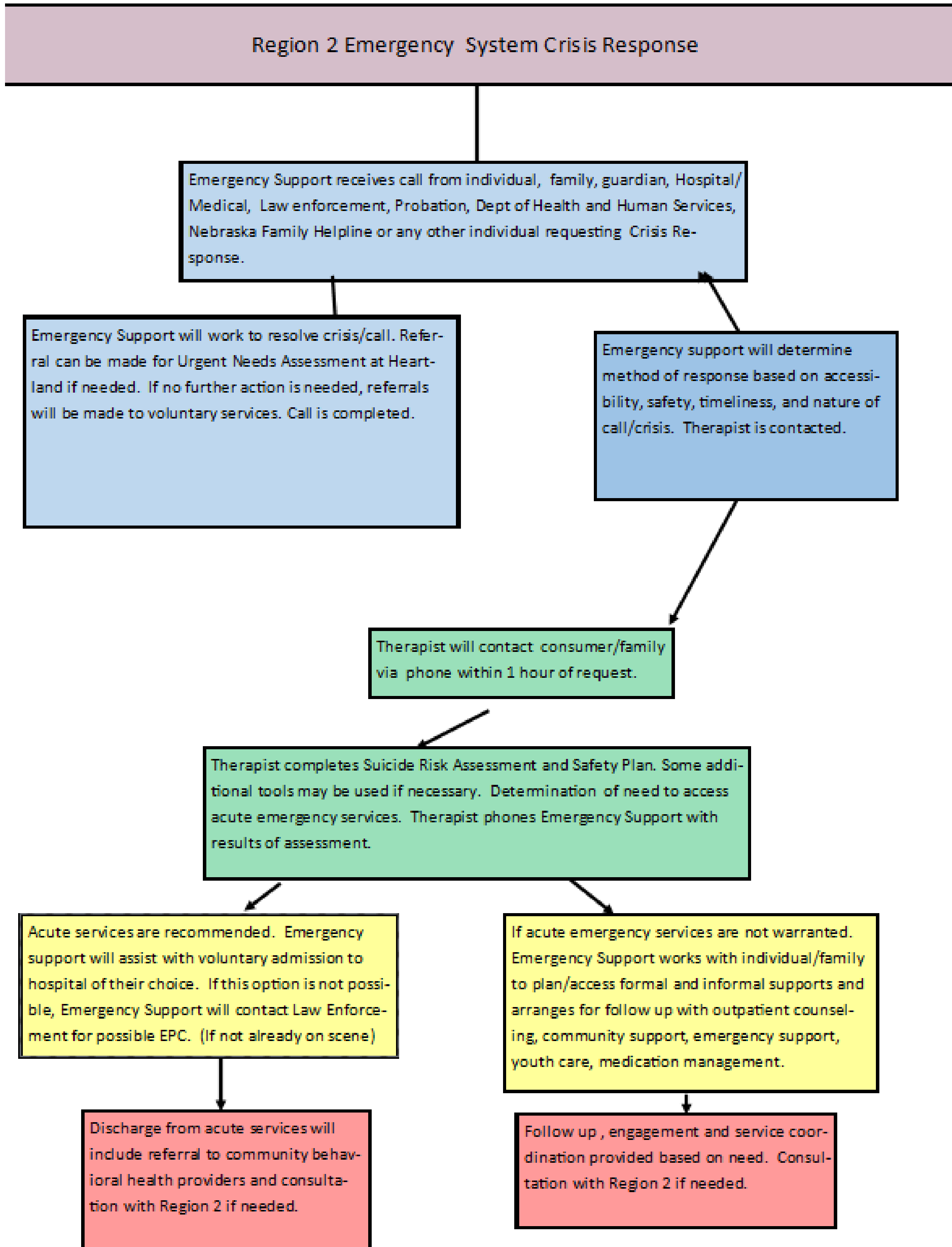
Behavioral Health Region 1 (continued)



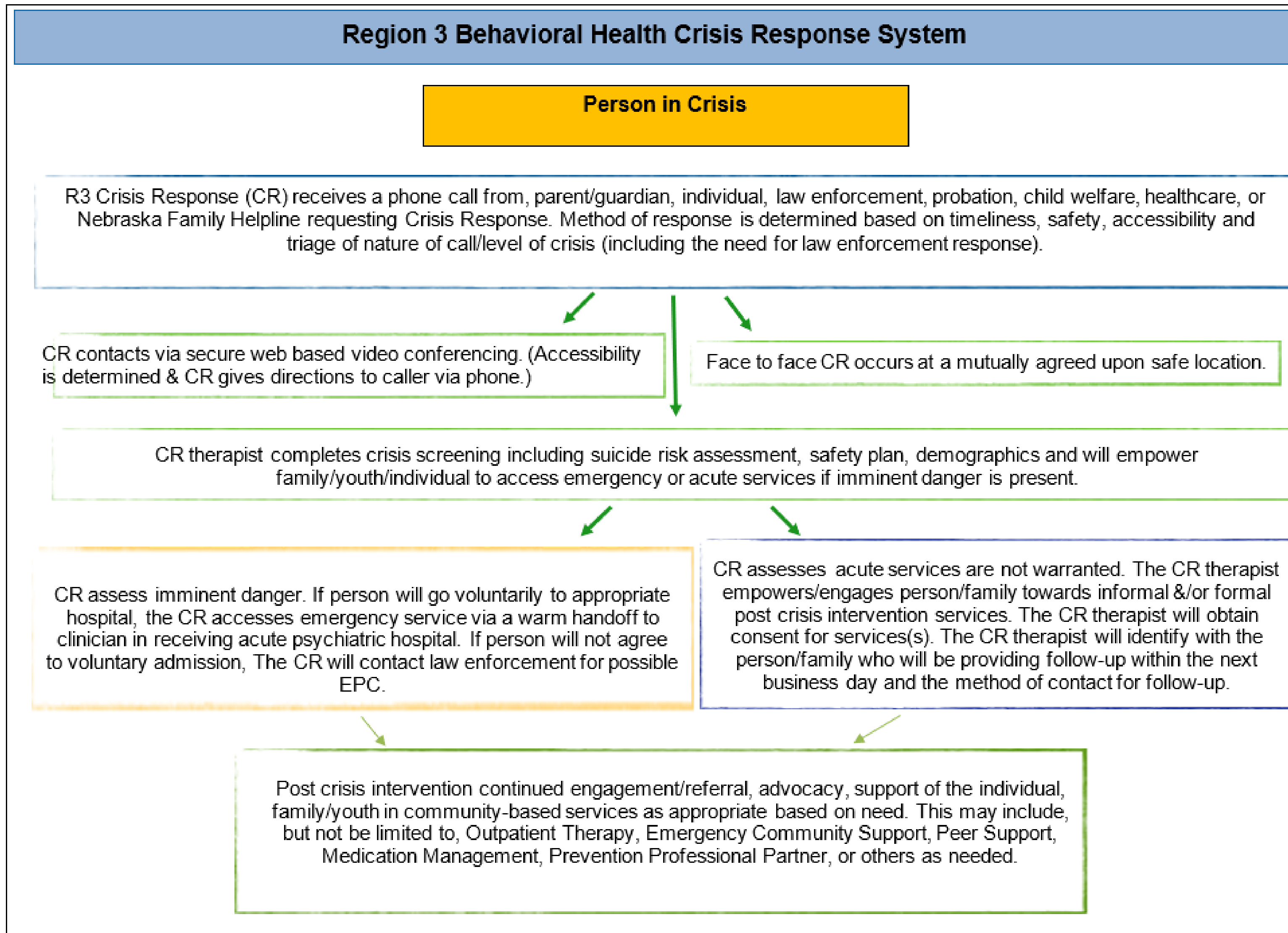
Behavioral Health Region 1 (continued)



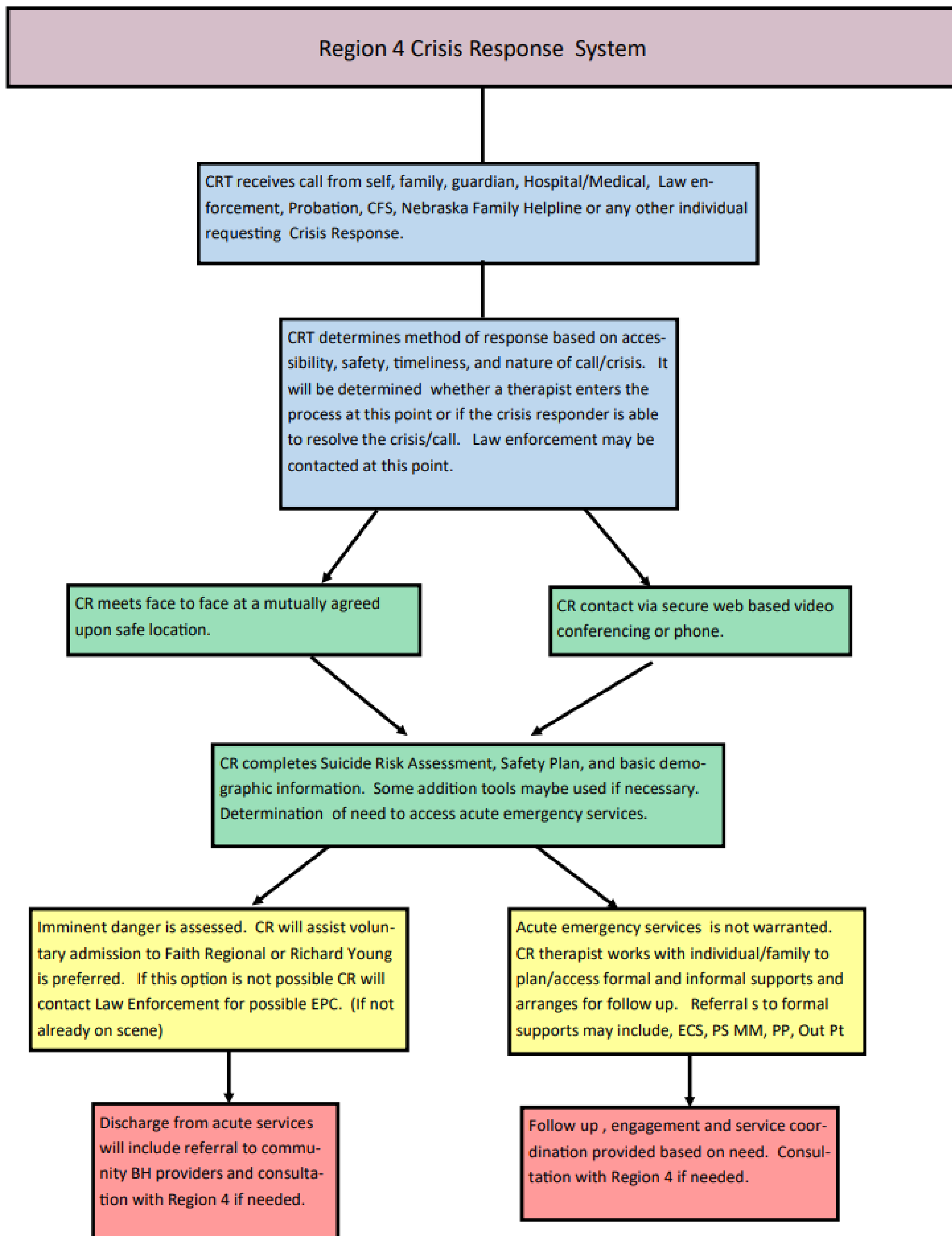
Appendix B: Behavioral Health Region 2



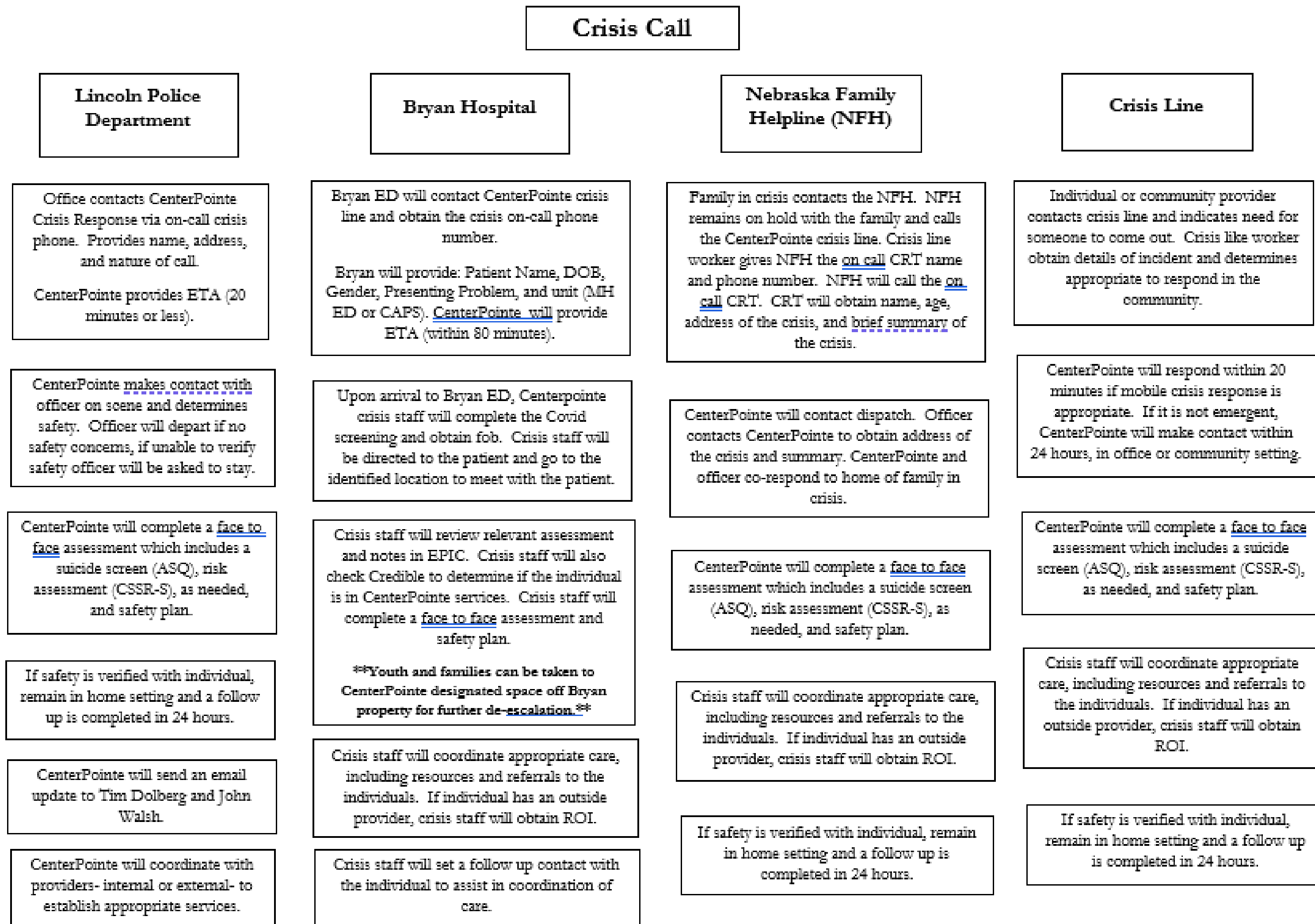
Appendix C: Behavioral Health Region 3



Appendix D: Behavioral Health Region 4



Appendix E: Behavioral Health Region 5



Appendix F: Behavioral Health Region 6

Region 6 Behavioral Healthcare

Emergency System Flowchart - Youth / Family Systems

Youth / Family in Crisis

911 / Law Enforcement

(can request Crisis Intervention Trained officer if available)

Crisis Hotlines

- Nebraska Family Helpline
- Boys Town National Hotline

Emergency Department / Psychiatric Hospital

Mobile Crisis Response

Face to Face or Telehealth Available

(Omaha only - Co-Responder)

Activities

1. Crisis Assessment
2. Consult with Law Enforcement to Determine Plan
3. Referrals and Follow-Up

   24 hour and 30 day follow up contacts

Direct Access to Mobile Crisis Response

- Schools (through School Resource Officers or a pilot project for schools without SRO)
- Probation (families can contact probation officer who accesses crisis response)
- Boys Town Family Helpline

Crisis Resolution

- Home / Home with Community Resources
- Community-Based Treatment

Region 6 Emergency System Flowchart—Youth—revised 6/24/21

Behavioral Health Region 6 (continued)

Region 6 Behavioral Healthcare

Emergency System Flowchart - Adult System

Person in Crisis

911 / Law Enforcement

(can request Crisis Intervention Trained officer if available)

Crisis Diversion

- Safe Harbor (warm line or visit)
- Emergency Community Support

Mobile Crisis Response

Face to Face or Telehealth Available

(Omaha only - Co-Responder)

Activities

1. Crisis Assessment
2. Consult with Law Enforcement to Determine Plan
3. Referrals and Follow-Up

   24 hour and 30 day follow up calls

Mobile Crisis Response can be directly activated by area homeless and domestic violence shelters.

Hospital / Detox

- Emergency Department / Acute Psychiatric Hospital
- Lasting Hope Assessment Center
- Nebraska Medicine Psychiatric Emergency System (up to 24 hours)
- Douglas County (Detox)

Crisis Resolution

- Home / Home with Community Resources
- Community-Based Treatment

Region 6 Emergency System Flowchart—Adult—revised 6/30/21