988
Nebraska
Manual

Division of Behavioral Health
Nebraska Department of Health and Human Services

Effective June 01, 2024

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988 Nebraska

Overview: In 2020, Congress designated 988 as the universal number for a national suicide prevention and mental health crisis hotline to replace the National Suicide and Prevention Lifeline.[1] On July 16, 2020, the Federal Communications Commission issued the final order designating 988 as the new crisis hotline and Veterans Crisis Line number, requiring all U.S. telecommunication providers to activate 988 for all subscribers by July 16, 2022. The new 988 phone number provides a 24/7 connection to trained, compassionate crisis counselors for anyone experiencing thoughts of suicide or experiencing a behavioral health crisis in Nebraska. Trained crisis counselors listen and work to understand how a caller's crisis is affecting their life, provide support, and connect them to resources to include activation of mobile crisis response services.

The purpose of 988 Nebraska is to:

- Connect a person experiencing suicidal thoughts, mental health or substance use crises to a trained crisis counselor who can address immediate needs and connect to community-based resources.
- Reduce use of law enforcement and emergency rooms as first point of contact for a behavioral health crisis.
- Utilize community-based resources to maintain individuals in their homes and communities.
- Help end stigma towards seeking or accessing behavioral health care.

The implementation of 988 Nebraska would not have been possible without the support of various stakeholders across the state to include, but not limited to regional behavioral health authority partners, law enforcement, behavioral health service providers, the University of Nebraska - Public Policy Unit, persons and parents with lived experience, the Administrative Office of the Courts and Probation, Boys Town, the Nebraska chapter of the National Alliance for Mental Illness, the Kim Foundation, Local Outreach to Suicide Survivors program, local Native American tribes, and schools.

[1] *See* the National Suicide Hotline Designation Act of 2020, Pub. L. No. 116-172, 134 Stat. 832 (2020).

This manual will serve as a guide to the 988 Nebraska processes, guidelines, and expectations.

988 Nebraska is based upon three core premises:

1. Someone to Call
2. Someone to Respond
3. Somewhere to Go

I. Someone To Call

It is important to note that when a caller dials 988, they are not directly connected to their local call center. Callers will be connected first with Vibrant Behavioral Health's automated system.[2] Callers will be offered the option to reach specialty subnetworks (i.e., Veterans, Spanish, Deaf, LGBTQA) or to remain on the line to be connected to their local call center. This recording is approximately 70-90 seconds long. Calls are routed to a local call center based upon the area code of the phone number the caller is calling from. Should the caller be calling from an area that is different than the area code, the area code associated call center will still serve the caller and connect them to their local call center when appropriate.

A. 988 Nebraska Call Center

Nebraska has one call center located at Father Flanagan's Boys' Home (also known as Boys Town) in Omaha, Nebraska. Boys Town has been the provider for the Suicide and Prevention Lifeline since 2005 and it was natural to maintain this partnership for 988 Nebraska.

When a call is received by 988 Nebraska, a trained crisis counselor will attempt to de-escalate the individual, assess for safety, safety plan with the caller, or activate a mobile crisis response when appropriate. The crisis counselor will attempt the least restrictive options first. This may include a referral to services or access to a same or next day appointment. Boys Town has over 1,600 referral sources in their database that may be offered to callers.

If the caller disconnects or becomes disconnected, the crisis counselor will immediately call back unless it is unsafe to do so (e.g., in domestic violence situations). The 988-call center will track frequent callers so outreach may be done to engage the individual in community-based services.

In the event Emergency Medical Services (EMS) or law enforcement is needed, the crisis counselor will remain on the phone with the individual

[2] Vibrant Behavioral Health is a federally contracted partner.

and contact 911. Events that warrant contacting 911 on the caller’s behalf include when the caller has already made an attempt to end their life, has ended someone else’s life, is actively suicidal or homicidal and is refusing mobile crisis response or to engage in safety planning, and/or is deemed to be at risk based upon the Lethality Risk Assessment utilized by Boys Town.

The determination to activate mobile crisis response is made by the crisis counselor and the caller. Mobile crisis response is a voluntary service and must be agreed to by the caller. Mobile crisis teams will be activated by 988 Nebraska through an established process with each of the six regional behavioral health authorities. In situations where the person calling is a third-party, mobile crisis response will be activated, but services may be denied upon arrival by the individual in crisis.

988 Nebraska will conduct follow-up contact within 24 to 72 hours when the caller consents to follow-up and had suicidal thoughts/ideations or when the caller consents to follow-up and was referred to a same or next day appointment. Follow-up is not required when the caller was seeking information only, was a third-party caller, an anonymous call, or the caller does not consent to follow-up contact.

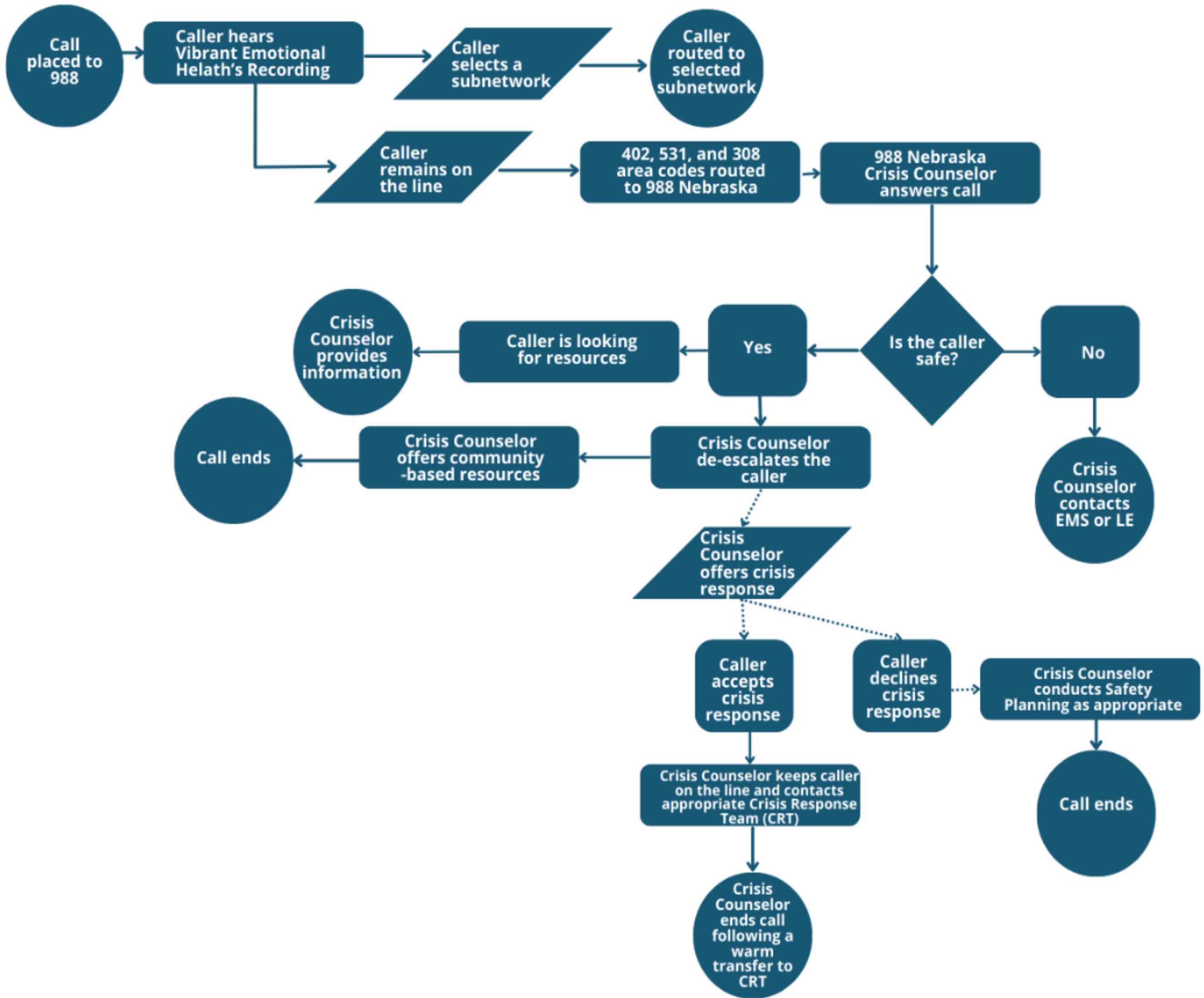
Follow-up will include asking:

1) Since the last call, does the caller feel worse, better, or the same,

2) If a referral was offered, was the caller able to access the service and if not, they will problem solve with the individual, and

3) Has the caller utilized crisis services since the last call and if yes, which kind?

The figure below is a visual representation of the initial 988 Nebraska call flow:



B. 988 Nebraska Caller Data Collection

Nebraska caller data provides insight into who is utilizing 988 Nebraska--the person in crisis or someone else on their behalf—and that insight can be used to respond appropriately to the needs of the individual in crisis. Data collected about youth system involvement informs the appropriate system to shape the types of supports needed for youth in crisis. Data

collected by crisis counselors about health insurance is used to guide referrals for services.

Data Elements:

Who is calling?

- Self
  - Adult
  - Youth
    - Any system involvement?
      - Child and Family Services
      - Developmental Disabilities
      - Probation/Diversion

Third-Party

What type of insurance does the individual in crisis have?

- Private
- Medicaid
- Medicare
- No Insurance

C. 988 Nebraska Call Center Performance Metrics

The 988 Nebraska Call Center is expected to meet certain performance metrics. These metrics were developed by a team of stakeholders as identified by best practice guidelines and federal requirements. 988 Nebraska is expected to have an answer rate at 90% or above for calls and an answer rate of 80% or above for digital contacts (chat and text).

Metrics

Call volume

- Number of calls offered to 988 Nebraska.
- Number of calls answered by 988 Nebraska.
- Number of calls that were abandoned. Abandoned is defined as a call that disconnects in less than 10 seconds of being offered to 988 Nebraska.

Answer Rate

- Average speed of answer.
- Average length of a call.
- Average talk time.
- Number of calls not answered by 988 Nebraska that rolled over to a national back-up center.

II. Someone to Respond

Community-based mobile crisis services use face-to-face professional and peer intervention, deployed in real time to the location of the person in crisis to achieve the needed and best outcomes for that individual. Per the National guidelines for Behavioral Health Crisis Care: Best Practice Toolkit, mobile crisis team services should:

- Include a licensed and/or credentialed clinician capable to assess the needs of the individual.
- Respond where the person is (e.g., at home, work, the park, etc.) and not restrict services to select locations within the region or particular days/times.
- Connect individuals to facility-based care as needed through warm hand-offs and coordinating transportation when and only if situations warrant transition to other locations.

A. Nebraska Mobile Crisis Response

Mobile Crisis Teams (MCR) is a community-based intervention to individuals in need wherever they are—at home, work, or anywhere in the community where the person is experiencing a crisis. MCR services are contracted through each of the six Nebraska Regional Behavioral Health Authorities. In rural parts of Nebraska, an in-person response may not be possible. In those instances, MCR will engage the caller either by phone or telehealth.

When the 988-crisis counselor is unable to safety plan with the individual, MCR will be activated upon the consent of the caller. MCR is available in-person, by phone, or via telehealth. Callers are offered these three choices unless the caller is located in a rural area where the services may be limited to phone or telehealth.

Protocols have been established with each of the MCR providers. The 988-crisis counselor will conduct a warm hand-off with the appropriate MCR provider. The crisis counselor will provide the following information to the appropriate MCR team by phone and will send an email with this same information:

- Synopsis of the crisis and attempts made to safety plan with the caller
- Demographic information of the caller
- Assessment of safety risk and risk of dangerousness to others
- Presence of the following symptoms: auditory command hallucinations, grandiosity, excitement or agitation, mood lability (e.g., mood swings), persecutory delusions, paranoia, or hostility

- History of autism, intellectual disability, or other significant mental health issue
- Whether the caller is under the influence of alcohol or drugs
- Any known history of assault or violence
- If the crisis involves violence or threat of violence

B. Mobile Crisis Team Standards

The standards followed by mobile crisis response (MCR) teams were developed by a statewide stakeholders workgroup and are based upon best practice, MCR historical functioning prior to 988 Nebraska, and the inclusion of the crisis response service definition from the Continuum of Care Manual. Best practice indicates MCR teams should respond without law enforcement accompaniment unless special circumstances warrant inclusion to support true justice system diversion. Inclusion of law enforcement is at the discretion of each mobile crisis response team, but the preference is that law enforcement is excluded.

MCR Team Standards are as follows:

1) MCR will have a face-to-face meeting with individual in crisis within one (1) hour of initial contact.
2) An in-person response by two (2) team members is preferred. The in-person MCR response members should include:
    - At least one Behavioral Health Professional (trained, non-licensed MCT member) who can complete screening tools, follow-up support and safety planning.
    - A Certified Peer Support Specialist who can complete screening tools, follow-up support and safety planning.
    - A clinician **available** to conduct assessments as needed, complete screening tools, triage, follow-up support, safety planning and clinical assessments. The clinician will respond within 30 minutes of contact by the team member(s). Response may indicate a need for the clinician to arrive in-person.
3) To ensure youth and adults are assessed for suicidality, homicidality, substance use, and current symptoms; the MCR team will conduct various assessments including a brief mental health status exam (i.e., exam of the appearance, activity level, behavior, speech, and attitude) and utilize at least one of the following assessments/screening tools:
    - CAGE-AID to assess for substance use
    - Suicide Behaviors Questionnaire-Revised (SBQR)
    - Ask Suicide-Screening Questions (ASQ)
    - Columbia Suicide Severity Rating Scale (C-SSRS)

The MCR team will also gather and assess information related to the individual's crisis and current situation. This information may include but is not limited to:

- Level of consciousness, thought content, affect and mood, cognition, and reality contact.
- Situational factors impacting behavior and safety.
- Strengths and resources of the person experiencing the crisis, as well as those of family members and other natural supports.
- Recent inpatient hospitalizations and/or any current relationship with a BH provider.
- Medications and compliance with medication regimen.
- Medical history as it relates to the crisis.
- Consumer data (e.g., contact information, referral source, demographics, etc.)

C. De-escalation and Resolution

Community-based mobile crisis teams engage individuals in de-escalation techniques throughout the encounter and intervene to de-escalate the crisis. The goal is not just to determine a needed level of care to which the individual should be referred, but to resolve the situation so a higher level of care is not necessary.

Mobile Crisis Response (MCR) teams assess and ensure the environment is appropriate to facilitate de-escalation and stabilization. MCR teams will work with the individual to move them to a more suitable location for de-escalation when appropriate.

Additional required activities conducted by MCR teams include:

- Engaging the individual in collaborative crisis planning when appropriate and utilizing the Brown-Stanley Safety Planning Template to develop a safety plan.
- Mobilizing support as needed to ensure safety and crisis resolution.
- Engaging Peer Support as needed and available.
- Making referrals as appropriate to resolve the crisis and/or stabilize the individual or situation such as same day or next day assessment, outpatient, and medication management.
- Contacting the 988 Crisis Counselor following the event and advising the counselor of the outcome.
- Connecting individuals to facility-based care, as needed, through warm hand-offs and coordinating transportation when situations warrant transition to other locations.

D. Follow Up Requirements

Each mobile crisis response (MCR) encounter is not a “one and done” encounter.

Reporting expectations include the following:

- Creating an encounter, in the CDS, shortly after the crisis event. Data should be entered, preferably upon completion of service being delivered but, minimally by the end of the month.
- Updating the CDS encounter after each follow up attempt and/or follow up completion.
- Discharging the encounter within 72 hours.
  - After 3 days, if the CDS is not updated and the encounter is not discharged, a system generated alert will be sent from the CDS (do not ignore).

Note: information is time stamped in the CDS. (Below are two examples of untimely data entry).

Service to be Provided Crisis Response - MH
Admission Date 11/22/2023 10:15 AM

Update History

Update Date	State	Event	Updated By
11/27/2023 10:09 AM	Admitted	Consumer Admitted	BF200LNK\e
11/27/2023 10:09 AM	New	Encounter Edited	BF200LNK\e

Service to be Provided Crisis Response - SUD
Admission Date 4/12/2023 8:05 AM
Discharge Date 4/12/2023 8:20 AM

Update History

Update Date	State	Event	Updated B
5/2/2023 4:00 PM	Discharged	Discharged	bf200lnk\st
5/2/2023 4:00 PM	Admitted	Consumer Admitted	bf200lnk\st
5/2/2023 3:59 PM	New	Encounter Edited	bf200lnk\st

MCR teams will offer follow-up to all individuals to check to see how they are doing and assist with any service connections as needed. Follow-up

can be conducted by a Certified Peer Support Person. At least three attempts will be made to contact the individual for follow-up care.

The first contact for follow-up will take place within 24 hours of the crisis event. If contact is not made, two additional attempts will be made within 72 hours unless the individual is placed in emergency protective custody (EPC), inpatient psychiatric hospitalization, or are sent to jail/detention. Each follow-up call will consist of:

1. Asking if the individual feeling worse, better, or the same?
2. If a referral was offered, asking if the individual was able to access the service?
3. If not, asking what the barrier(s) to accessing services? The MCR team is expected to problem solve with the individual to overcome the barrier(s).
4. Review the safety plan that was created and/or create a new safety plan with the individual.

E. Training standards for Mobile Crisis Response Teams

The following training standards were identified by a group of stakeholders from across the state including multiple providers of mobile crisis response (MCR) services. Training was placed into four categories:

1. Core Training for ALL team members
    - CPR and First Aid
    - Suicide prevention/response training such as:
        - Question Persuade Refer (QPR)
        - Assessing and Managing Suicide Risk (AMSR)
        - Collaborative Assessment and Management of Suicidality (CAMS)
    - Diversity training and accessing interpretation services
    - Opioid overdose safety
    - Trauma informed services
    - Mental Health First Aid for team members who are not clinicians
    - Adolescent development
    - Working with system involved individuals
    - EPC alternatives for youth under the age of 18

2. Assessments
    - Suicide Behaviors Questionnaire-Revised (SBQR)
    - Ask Suicide-Screening Questions (ASQ)
    - Columbia Suicide Severity Rating Scale (C-SSRS)

3. Crisis Planning and Follow Up, and
    - Use of the Brown-Stanley Safety Plan
    - Counseling Access to Lethal Means (CALM)

4. Optional Training Topics (may include but are not limited to):
    - Basic Behavioral Health Threat Assessments for clinicians
    - Cross training with local law enforcement
    - Crisis specialty training for Certified Peer Support Specialists

Nebraska was awarded a Transformation Transfer Initiative grant through the National Association of State Mental Health Program Directors in January 2023. These grant funds are being utilized to develop a comprehensive training curriculum for all persons providing mobile crisis response services in Nebraska.

F. Mobile Crisis Response Data Collection

Data for mobile crisis response will be housed in Nebraska's Centralized Data System (CDS). The data is utilized to fulfill federal requirements for reimbursement of services rendered, identify trends, and track consumer outcomes to inform how 988 Nebraska is functioning to meet the crisis needs of Nebraskans. Data should be entered, preferably by completion of service being delivered but, minimally by the end of the month. The following data points are required:

- Demographics
- Type of Contact – Community (in person), Phone, Telehealth
- Date of Event
- Crisis Location
- Call Out Reason
- Referral Source
- Crisis Disposition
- Start Time, Stop Time, Face to Face Time, Travel Time
- Trauma History
- Crisis Dangerousness
- Crisis Response Diversion
- Law Enforcement requesting resources only
- Outcome if Crisis Response was delivered in a jail or correction facility:
- If the individual was referred to community-based services and identify which services specifically
- Follow-Up information

If a person is experiencing psychosis or is inebriated and is unable to provide the required information at the initial contact, the person conducting follow-up should try to obtain that information when the individual is more stable.

G. Mobile Crisis Response Key Performance Indicators

The following performance metrics are collected for mobile crisis response:

- Percentage of individuals with crisis resolved and were able to remain in their home.
- Percentage of individuals referred to community-based resources and able to stay in their community.
- Percentage of individuals placed in emergency protective custody (EPC).

- Percentage of individuals arrested.
- Percentage of individuals transported to a hospital/emergency room.
- Percentage of individuals who do not have a repeat mobile crisis event within 120 days of initial MCT contact.
- Percentage of MCR calls where law enforcement is requesting resources for the individual.
- Percentage for each type of Crisis Disposition at discharge.
- Timeliness of services – expectation is for contact to be made within 1 hour of the MCR team being activated.
- Safety – number. and types of reasons that MCT is activated.
- Quality – customer satisfaction and crisis resolution.

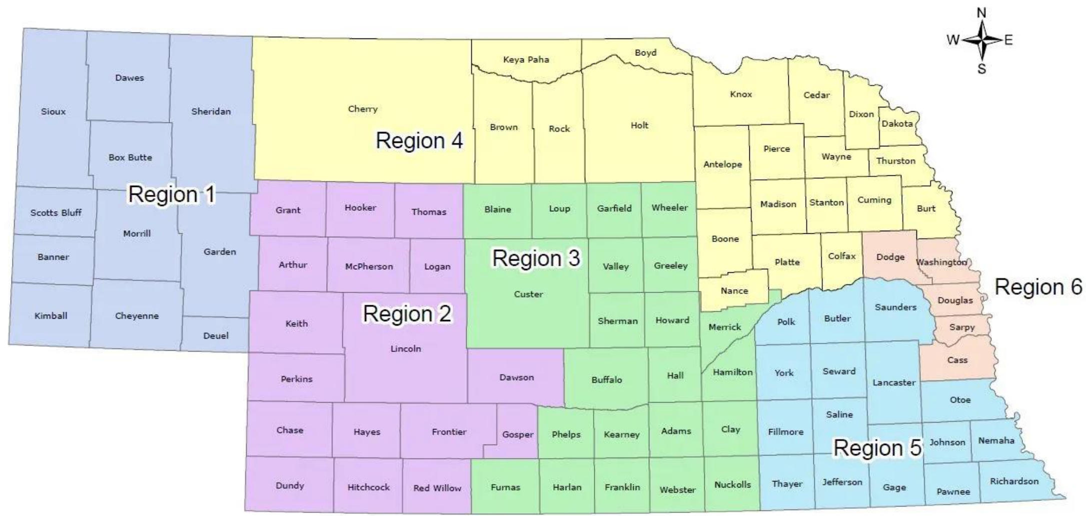
A data dashboard is available on the Nebraska Department of Health and Human Services, Division of Behavioral Health's web page. This dashboard is updated monthly. Outcome data is also included the Division of Behavioral Health's Strategic Plan. It is common to receive requests for data from various federal partners to include SAMHSA, NASMHPD, etc.

III. <u>Somewhere To Go</u>

Regarding 988 Nebraska, "Somewhere to Go" refers to a location that a person experiencing a crisis can go to or can be taken to if needed. These services will take time to develop as they are true brick-and-mortar locations. The Nebraska Department of Health and Human Services – Division of Behavioral Health contracts with each of the six Behavioral Health Regions in Nebraska.[3] Below is a map of the Behavioral Health Regions.

[3] Nebraska's Behavioral Health Regions are set forth in statute at Neb. Rev. Stat. § 71-807.

Behavioral Health Regions



Planning took place with the Behavioral Health Regions and various stakeholders to identify needs and gaps related to the community-based crisis continuum of services. Discussion resulted in identifying the following community-based crisis services that are required to be developed (if they are not already in existence).

- Crisis Stabilization Facilities (at least one in each geographic region)
- Intensive community-based services
- Co-occurring Intensive Outpatient Services
- Substance Use Disorder (SUD) Crisis Residential Services
- Peer-run Respite/Peer-run Hospital Diversion

A. Crisis Stabilization Facilities:

Crisis receiving and stabilization services offer the community a no-wrong-door access to mental health and substance use care. They operate much like a hospital emergency department that accepts all walk-ins and ambulance, fire, and police drop-offs. There are two crisis receiving and stabilization facilities in Nebraska. They are located in Grand Island (Region 3) and Lincoln (Region V). As of November 2023, service development and/or contracting are in progress in the other Behavioral Health Regions.

B. Intensive Community-Based Services

Services such as Assertive Community Treatment (ACT), Wraparound/Professional Partner Program (PPP), Multi-systemic Therapy

(MST), and Functional Family Therapy (FFT) are examples of intensive and lengthier community-based services in Nebraska.

C. Co-Occurring Intensive Outpatient (IOP) Services

Co-occurring enhanced IOP programs offer access to psychiatric services and specific programming to address co-occurring mental health issues with substance use issues. IOP is a service comprised of therapy (both group and individual) two to three hours a day, three to five days a week.

D. **Outpatient services**

Outpatient services are available in all 6 Behavioral Health Regions. Some regions can offer same-day or next-day services for persons experiencing a crisis.

E. Short-term Residential Services

Short-term residential facilities can be seen as a step-down option after a crisis episode. These facilities deliver a safe and stable intensive treatment to treat complex biopsychosocial issues, facilitate the recovery process and development of a supportive recovery network, promote successful involvement in regular productive activity, and prevent the use of substances.

F. Peer-Run Respite/Peer-Run Hospital Diversion

Another model of short-term facility-based care is a peer-operated respite program. These programs do not typically incorporate licensed staff members on-site although some may be involved to support assessments. They provide peer-staffed, restful, voluntary sanctuary for people in crisis. The Behavioral Health Regions are working on growing peer-run respite and/or hospital diversion programs. Peer-run services are currently available in Lincoln and Omaha.

IV. Marketing and Communication for 988 Nebraska

The Substance Abuse and Mental Health Services Administration (SAMHSA) has created and continues to add to the 988 Partner Toolkit. Marketing materials for post, print, and/or purchase are available at this site. 988 Nebraska has created a marketing toolkit with Nebraska specific marketing information as well as a link to request 988 Nebraska Wallet Cards in English and Spanish. Nebraska continues to work toward implementing a comprehensive communication plan to increase 988 system awareness.