

Continuum of Care, Aftercare and Recovery for Everyone (C-CARE)

Purpose

Lancaster County in partnership with Region V and Nebraska Systems of Care is proposing a collaborative service offering crisis response/de-escalation and short-term care with aftercare support services for youth and their families. All services will be immediate, individualized and tailored to the family. A collaboration between several community partners is necessary to fully accomplish this. Services provided will specifically include, but not limited to:

- Family Supports & Navigation
- Mental Health Screens and Assessments completed within 24 hrs
- Community based referral system
- Follow-up aftercare services
- 24-7 staff trained in de-escalation, therapeutic communication and problem-solving techniques
- Every youth seeking help is provided immediate individualized service

Goal

Youth and their families who need help will have a 24-hour service available to them for immediate research-based supports based on individual youth and family need.

Background

In January 2019, the University of Nebraska Public Policy Center was commissioned to:

1. Review the youth crisis literature for best practices and recommendations;
2. Conduct focus groups to better understand the strengths, gaps, and needs of the youth crisis system in Lancaster County;
3. Identify current services in Lancaster County; and
4. Develop recommendations for youth crisis response practices in Lancaster County.

This report found the following gaps in Youth Crisis Response:

1. Crisis calls often come through law enforcement or public schools.
2. Limited resource availability reduces treatment options.
3. Funding is inconsistent and limited.
4. Short-term care is needed for youth and/or families who do not need hospitalization.
5. Transition care between services is needed to ensure families receive treatment.
6. Transition-aged youth are difficult to navigate through crisis care.
7. A lack of knowledge can lead to escalating crisis.
8. Information sharing could improve services.

Target Population is Youth Ages 11 to 19 who:

- Demonstrate a need for a therapeutic component;
- Are not accepted into shelter due to psychiatric needs and/or aggressive behaviors;
- Do not meet the psychiatric care offered through CAPS; or
- Have a run history or display self or community safety concerns.

Location

The location the collaborative chooses must have at least the following onsite:

- Food service
- Education
- Religion
- Medical Services
- Behavioral Health
- Family Navigators
- Building Maintenance/Cleaning
- Safe Single Rooms
- Transportation

The Youth Services Center is available at no cost and has 30 beds. This space may also be renovated to meet the needs of the collaborative.

Timeline

April 1, 2019	Request for Information released
April 20, 2019	Request for Information due
April 30, 2019	Request for Information reviewed by collaborative
May 15, 2019	Contracted providers chosen, and contracts developed
July 1, 2019	Services provided

Sustainability

- Medicaid and/or insurance reimbursements
- State and local grants
- Reimbursements for care



YOUTH CRISIS RESPONSE REPORT

A review of practices in Lancaster County, NE

January 30, 2019

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EXECUTIVE SUMMARY

Mental health providers, human service organizations, and youth-serving agencies have noted a growing concern about youth who experience a behavioral health crisis. At a national level, the number of youth experiencing a crisis is growing, while resources to serve youth in crisis are decreasing. In the City of Lincoln and Lancaster County, many efforts have focused on addressing this growing need and creating services based on best practices.

To better understand the environment and need, the Youth Crisis Coalition, funded by the Cooper Foundation, commissioned the University of Nebraska Public Policy Center to 1) review the youth crisis literature for best practices and recommendations; 2) conduct focus groups to better understand the strengths, gaps, and needs of the youth crisis system in Lancaster County; 3) identify current services in Lancaster County, and 4) develop recommendations for youth crisis responses practices in Lancaster County.

In sum, this study found that the following practices are key to youth crisis response in previous research literature and previous efforts to study youth crisis care:

1. 24/7 Crisis Hotline
2. Deployable mobile crisis response
3. Crisis residential stabilization facility
4. Short-term stabilization and de-escalation facility
5. Focus care on home-based care, peer counseling, trauma informed care
6. Follow-up post-crisis to ensure families continue treatment

Though SAMHSA does not have a short list of specific evidence-based best practices for youth crisis response, these items are consistent across SAMHSA literature, suicide prevention literature, and previous efforts to study crisis response in Nebraska through programs such as the Systems of Care.

After convening seven (7) focus groups made up of organizations that serve youth in crisis, we identified key strengths, gaps, and recommendations to improve youth crisis response in Lancaster County. Overall, participants noted the continued advancement of youth crisis response care among organizations and partners, such as public schools or law enforcement. At the same time, participants noted gaps that limit access to care.

Based on these results, we propose the following recommendations:

1. Define crisis and crisis response to ensure all partners have a shared understanding.
2. Develop and implement a follow-up procedure for crisis response calls.
3. Utilize an advocacy model to help the youth and family navigate resources and funds, particularly for those families without private insurance.

4. Define the short-term crisis care facility needed in Lancaster County (e.g., 24/7, 23-hour, staffed licensed crisis response personnel, respite, crisis care).
5. Use the aforementioned definition of the needed short-term care facility to identify the cost estimate, resource needs, and sustainability of such a facility and seek out sustainable funding for this short-term care facility.
6. Continue to increase implementation of peer support and peer crisis services.
7. Consider adding information sharing questions in crisis response with families or youth to determine other system involvement and resource use.
8. Pursue efforts to better understand the need for youth crisis response by better tracking data from response, referral, and follow up efforts.

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YOUTH CRISIS RESPONSE PRACTICES REVIEW

According to SAMHSA (2014), Crisis services are “a continuum of services that are provided to individuals experiencing a psychiatric emergency” ... in order to “stabilize and improve the psychological symptoms of distress and engage individuals in the appropriate treatment service.” These services might include short-term residential crisis services, mobile crisis services, 24/7 crisis hotlines, and peer crisis services. In the City of Lincoln and Lancaster County, youth crisis response is needed when a youth or young adult (typically aged 10 – 19 years) needs immediate assistance for a behavioral health need, which may include mental health, substance use, or behavior. Law enforcement is often called to respond and determine next steps following the crisis. Youth may need a behavioral assessment, immediate intervention, immediate stabilization, medical care, referrals to outpatient treatment, or admittance to a residential treatment facility.

Families in crisis often turn to law enforcement and emergency departments for assistance. Nationally, psychiatric beds in hospitals have declined although there is an increasing need for these services for children and teenagers (SAMHSA, 2016). In addition to limited resources, emergency departments don’t often have the needed expertise to treat children experiencing a behavioral health crisis.

Youth experience crisis due to suicidal or homicidal thoughts and behaviors, acute depressive systems, anxiety, traumatic stress reactions, and severe disruptive or oppositional behaviors (Vanderploeg et al, 2016). While many children’s services include a crisis planning service, rapid and mobile response on-site is limited, leading to an over-reliance on hospitals and law enforcement. Youth with mental health needs are more likely to experience both arrest and incarceration.

Previous research indicates that there is a growing need for crisis mental health care, particularly for youth (e.g., National Action Alliance, 2016). SAMHSA suggests that community-based services and home-based services are a better response to youth experiencing a behavioral health crisis than increasing inpatient psychiatric bed space. The National Action Alliance (2016) suggests that crisis services include:

1. Statewide crisis call center;¹
2. Deployable 24/7 mobile crisis response;²
3. Short-term residential crisis stabilization programs; and
4. Essential crisis care practices (including peer counseling, trauma-informed care, and coordination with law enforcement).

Mobile Crisis Response and Stabilization Services (MRSS) are time-limited on demand services and are defined as “mobile, on-site and rapid intervention for youth experiencing a behavioral health crisis,

¹ Nebraska has a the Nebraska Family Helpline:

http://dhhs.ne.gov/behavioral_health/Pages/nebraskafamilyhelpline_about.aspx

² Centerpointe offers a 24/7 mobile crisis response team and walk-in clinic:

<https://www.centerpointe.org/crisistalk/crisistalk.html>

allowing for immediate de-escalation of the situation in the least restrictive setting possible; prevention of the condition from worsening; and the timely stabilization of the crisis” (SAMHSA, 2016, p.2). MRSS can reduce out of home placements and emergency department admissions, thus reducing costs for families. Similarly, the National Action Alliance for Suicide Prevention defines crisis response as providing “...face-to-face professional and peer intervention, deployed in real time to the location of a person in crisis, in order to achieve the needed and best outcomes for that individual” (p. 18). Key elements of such crisis services include 1) meeting the individual where they are geographically, 2) providing resolution/relief quickly, and 3) connecting individuals to the appropriate services thereby avoiding interaction with law enforcement and hospitalization.

Residential Crisis Stabilization (RCS) programs are defined by SAMHSA as “...intensive short term, out of home resources for the child and family, helping to avert the need for psychiatric inpatient treatment. The goal is to address acute mental health needs and coordinate a successful return to the family at the earliest possible time with ongoing services” (SAMHSA, 2016, p.2). RCS includes regular contact between the providers and families to transition youth from in-patient to the home and out-patient treatment. Crisis stabilization can reduce the risk for higher levels of care. RCS may include a respite residential environment.

Likewise, the Nebraska Systems of Care Crisis Continuum emphasizes similar behavioral care crisis services.

1. **23-hour crisis observation or stabilization** provides individuals in severe distress with up to 23 consecutive hours of supervised care to help de-escalate the severity of their crisis and need for urgent care, and to avoid unnecessary hospitalizations.
2. **Short-term, crisis residential stabilization** is designed to prevent or ameliorate a behavioral health crisis and reduce acute symptoms of mental illness by providing continuous 24-hour observation and supervision for individuals who do not require inpatient services.
3. **Mobile crisis teams** provide acute mental health crisis stabilization and psychiatric assessment services to individuals within their own homes and in other sites outside of a traditional clinical setting. Such teams’ main objectives are to provide rapid response, assess the individual, and resolve crisis situations that involve individuals who have a behavioral health disorder.
4. **Crisis hotlines** provide immediate support and facilitated referrals to medical, health care, and community support services, and promote problem-solving and coping skills via telephone (or text or online chat) to individuals who are experiencing distress.
5. **Peer crisis services** are an alternative to a psychiatric emergency department or inpatient hospitalization and are operated by people who have experience living with a mental illness (i.e., peers). Services are intended to last less than 24 hours but may extend up to several days, if needed. Peer crisis services are generally shorter-term than crisis residential services.

Proper referral, access, and follow-up are key to ensuring needs are met and the crisis does not continue. For example, according to SAMHSA’s Kana Enomoto, “Follow-up to releases from the emergency room, jail or prison—times people are at risk and we need to do as much as we can to

ensure no one falls through the cracks. That takes resources, workforce and time” (National Council Magazine, p. 8). Definitions of crisis care are expanding to include crisis prevention, early intervention, crisis response, and postvention.

Barriers to Youth Crisis Response

Funding for behavioral health services is a barrier to service. Utilization of hospital emergency rooms for behavioral healthcare is costly to families and individuals. Funding is needed to sustain multiple appropriate behavioral healthcare options for youth that can be available 24/7 outside of the emergency room.

Transition times can be a barrier for accessing crisis behavioral health care, particularly if referral and admission are not immediate. Transition services from points of care can assist with streamlining services and ensuring individuals receive the needed care in a timely manner. SAMHSA refers to this transition between care as the “chain of care.” This chain of care is particularly vital in ensuring that individuals transition to (and receive) outpatient care, reduce suicide reattempts, and reduce suicide ideation.

Kim and Kim (2017) find that approximately 44% of those who receive a mobile crisis response access community mental health services within 30 days of crisis response. Those individuals who were placed in psychiatric hospitals or residential treatment were more likely to access community mental health services upon discharge than those who were not placed in residential care. Individuals who were referred to and had immediate access to community mental health services were significantly more likely to continue receiving services in the community.

Data streamlining can be difficult, making it challenging to track how individuals access and are referred to services. Significant data manipulations are needed to understand how often individuals interact with the crisis care system and how they are referred between services, particularly after a mobile crisis team intervention (Kim & Kim, 2017).

Inappropriate responses to crises can be a particular challenge. Hospitalization and law enforcement responses are typically the primary options in many communities, but these services may not always be an appropriate response to the crisis. Good coordination and partnership between law enforcement and hospitals can address these concerns. For example, Kisely et al (2010) found that partnerships with law enforcement led to decreased service time, increased outpatient treatment usage, and improved treatment of those individuals with mental illness.

Current Efforts in Lincoln & Lancaster County

In Lincoln, mental health has been identified as a cross-cutting need by the Prosper Lincoln initiative; for example, the Lincoln Vital Signs (2017) report shows the total number of mental health investigations for Lincoln Police Department is increasing, with at least one call per day related to suicide. Further, the arrest rate for juvenile drug violations increased to 55% higher than the national rate. The Nebraska Risk and Protective Factors Student Survey (2016) shows that more than 30% of high school students in Lancaster County report feeling depressed for more than two weeks, and nearly 15% considered

attempting suicide in the last year. Nearly 20% of Lancaster County high school students report that they would not go to anyone if they felt depressed or suicidal.

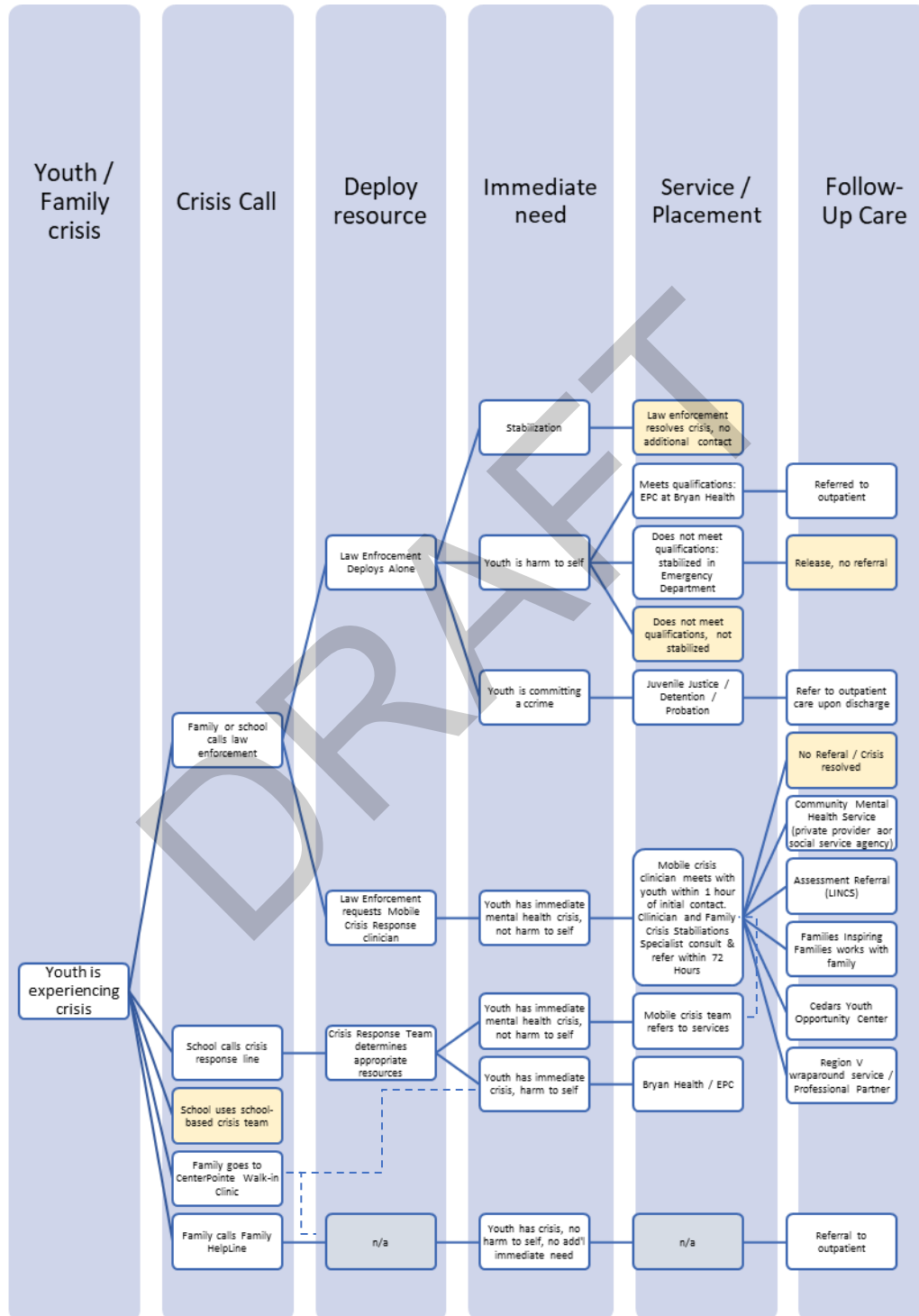
Several initiatives are in place now to address the needs of youth in crisis, either directly or tangentially. These initiatives include:

1. **Behavioral Health Training** for law enforcement (BETA). BEhavioral Threat Assessment (BETA) is a training program that helps law enforcement officers learn ways to handle individuals experiencing mental health crises and resources to assist individuals experiencing a crisis.
2. **Crisis Response Hotline** (Nebraska Family Helpline). The Nebraska Family Helpline provides 24/7 phone response for parents or youth in need of behavioral health assistance.
3. **Systems of Care** Framework: “Nebraska System of Care (NeSOC) creates a comprehensive and sustainable system of care that is youth guided, family-driven, trauma-informed and culturally responsive to improve outcomes for children and youth with serious emotional disturbances and their families. Committed partnerships among public and private agencies, families and youth have emerged under one umbrella called the NeSOC Collaborative to drive the work of the system. Equal partnership, among youth, family and system partners, is the guiding principle of the Collaborative at all levels.” Funding for development of this system in Lancaster County is primarily through Region 5 Services.
4. **Youth Crisis Response Coalition**. The Lincoln/Lancaster County Youth Crisis Response Coalition (YCRC) promotes local interagency collaboration between coalition partners, system of care partners, and interested individuals that can promote the resolution of behavioral/mental health crises that youth and families experience in the Lincoln/Lancaster county area. The YCRC was organized in October 2016 with the support of the Lincoln/Lancaster Human Services.
5. **QPR and SBQ-R in schools**. Teachers and social workers are trained in the Question, Persuade, Refer (QPR) suicide prevention gatekeeper-training framework. Teachers, school counselors, psychologists and nurses are required by state law to complete one hour of suicide prevention training each year. Schools may administer the Suicide Behaviors Questionnaire – Revised (SBQ-R) questionnaire to screen for students at high risk of suicide.
6. **SBQ-R via Professional Partners Program**. Region 5 Services program for serving youth with serious mental health disorders (Professional Partners) screens all youth using the SBQ-R.
7. **Probation Youth Crisis Response**. Probation adopted a manual in 2016 that includes a framework, screening tools, scoring forms and service definition for youth crisis response.

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Current Map of Services in Lancaster County

Below is a map of services as they are understood in Lancaster County. A list of these services with brief descriptions can be found in [Appendix 2](#). Yellow squares indicate where care activation stops.



FOCUS GROUP RESULTS

To better understand youth crisis response practices and gaps, the University of Nebraska Public Policy Center facilitated seven (7) focus groups inclusive of 36 total participants from a variety of fields involved in youth crisis response:

- Healthcare industry and residential treatment (4 participants)
- Human Services administrators and providers (7)
- Law Enforcement response officers (3)
- Mental health providers (8)
- Nonprofit human services agency personnel (5)
- Public School administrators (6)
- State probation (6)

Participants were identified through the Youth Crisis Response Coalition, and the participating organizations selected participants for each focus group. Each focus group lasted approximately 60 minutes and followed a semi-structured focus group process wherein participants were asked to identify 1) what was working well, 2) what gaps existed, and 3) what recommendations they had for youth crisis response in Lancaster County (see [Appendix 1](#) for full protocol).

Each focus group was audio-recorded and transcribed verbatim. Transcripts were reviewed, coded inductively, and then grouped into themes based on patterns that emerged from the data (Corbin & Strauss, 2015). These themes are described below; complete results with exemplary quotes can be found in [Appendix 3](#).

Strengths of Youth Crisis Response

Participants noted many strengths in of youth crisis response in Lancaster County. In particular, they noted many recent changes and improvements between agencies. These strengths include:

1. **Addition of mobile crisis response and Nebraska Family Helpline are valuable resources for families and youth.** As knowledge and use of these resources grows, participants felt that youth and families were receiving better immediate assistance and referrals. They indicated that these provide a valuable resource for families in times of crisis, and the services were helpful to de-escalation and referral.
2. **Growing partnerships are helping to improve care and relationships.** Establishing coalitions like the Youth Crisis Response Coalition and others (e.g., Homeless Coalition) help build relationships between agencies and help with knowledge and resource sharing. These relationships can help connect providers and clients to resources.
3. **Law enforcement integration with crisis response continues to improve.** Law enforcement agencies have professional development opportunities such as BETA training to help improve their knowledge of responding to individuals with mental health needs and their knowledge of available resources. Law enforcement can also activate mobile crisis response if needed in a response situation. The greater awareness among law enforcement who are often a first point

of contact for crisis response is helpful to ensuring that youth and families are connected to the resources needed.

4. **Peer support models improve care and trust among families.** Youth and families experiencing a crisis were often fearful of getting involved in law enforcement or systems of response. Peer support and connection, such as partnership with the Families Inspiring Families, seemed to improve trust as well as the likelihood that the family would seek out additional services.
5. **Public schools are an on-site resource for youth and families.** Often, families and youth have a difficult time accessing care due to time, transportation, or funding limitations. By providing resources where youth already are, more youth are able to receive needed care. Public schools provide multiple resources through partnerships with behavioral health agencies, SBQ-R screening, and their own crisis team. Schools are continuing to education teachers and social workers at schools in QPR and other resources to help students.
6. **The stigma around mental health continues to decrease.** Participants noted the advertisements for the Nebraska Family Helpline and other positive portrayals of mental health services helped to decrease the stigma. Stigma around mental health needs often prevents families from seeking care. However, many participants noted that youth feel less stigma than their parents, which is having a positive impact. This reduction of stigma over time increases the likelihood that families will seek care.

Gaps in Youth Crisis Response

Though participants noted several areas of strengths in youth crisis response, there were several gaps or barriers to youth crisis response as well. In particular, limitations to access services such as availability or funding were primary concerns. These gaps include:

1. **Crisis calls often come through law enforcement or public schools.** While this may be a common way to address crisis, participants noted that use of law enforcement may escalate a situation further or have negative implications for the likelihood to receive or pursue follow-up care. Participants expressed a need to focus more on prevention and treatment prior to a crisis in order to prevent a crisis from occurring at all.
2. **Limited resource availability reduces treatment options. Limited availability reduces care options for youth and families in a variety of ways.** First, youth may be placed in an inappropriate level of care (too high or too low) that may not meet their needs. Second, there may be lengthy wait times which can not only cause the crisis to increase over time, but also reduce the likelihood that the family will pursue services. These limitations are more pronounced for those youth on Medicaid.
3. **Funding is inconsistent and limited. Behavioral health care and crisis care is expensive, and the options to fund it are limited.** Even for those families with private insurance, outpatient treatment and emergency room treatment are expensive enough to deter access. Additional challenges exist for those youth on Medicaid or receiving services through state systems which may have additional requirements for particular treatment services.
4. **Short-term care is needed for youth and/or families who do not need hospitalization.** Many participants indicated that there was a need for a crisis response or de-escalation facility for

families and youth. However, participants did not agree on a definition of this facility such as how it should be staffed, what services it should include, and how often it needed to be available. This short-term care facility was the most pressing need for all participants.

5. **Transition care between services is needed to ensure that families receive the needed treatment.** Often, when youth or families are discharged from a treatment, or when the crisis is over, a referral is made to outpatient treatment. However, wait times, fear, difficulty, and choice may impact the likelihood of attending outpatient treatment. Participants noted that follow-up care beyond the 72 hours following a crisis was needed to help ensure that families both understand the reason for care and understand how to access the care (e.g., funding availability, transportation).
6. **Transition-aged youth are difficult to navigate through crisis care.** The adult age in Nebraska is 19 years old, but for those youth who are 17-19, response must account for a transition from youth services to adult services. Additionally, transition aged youth may have other needs such as shelter, insurance, or social supports that require navigation in addition to treatment services.
7. **A lack of knowledge can lead to escalating crisis.** While stigma and fear may prevent families from reaching out for early care, a lack of knowledge about the available resources may also prevent them accessing care that could be available to them.
8. **Information sharing could improve services but faces limitations.** While many participants wanted more information about youth treatment plans and services, there were also limitations due to both personal privacy and legal regulations that prevented some sharing. Participants noted particular barriers with state agencies and siloed resources between organizations.

Recommendations to address gaps

1. **Defining crisis and crisis response are important to clarifying needs, services, and future efforts.** Participants varied on their definition of crisis and crisis response with some seeing it as an acute need and others seeing it occur on a spectrum. Participants expressed a need to clarify what is meant by crisis and crisis response.
2. **Prevention is key to reducing multiple crisis calls.** Participants wanted to focus on helping youth and families access early care to prevent crisis calls in the first place. Participants felt that when a crisis happened, the situation was escalated more than it needed to be.
3. **Crisis services should focus on a full continuum of care.** Likewise, participants noted that crisis services should be seen as a continuum from prevention and beyond 72 hours of care in order to help prevent additional crises calls in the future.
4. **Follow-up is essential.** Participants noted that follow-up calls and visits were important to ensuring the youth and families received the outpatient treatment or services that were referred to them at the time of crisis.
5. **Formal partnerships can assist in proper care and transition between services.** Participants said that a strength was the coalitions and relationships established. However, formal partnership through memoranda of understanding could improve information sharing between agencies and assist with transitioning youth between treatment services.

6. **Continue to educate organizations and individuals working with youth.** While participants noted continuing knowledge improvements, they noted that parents, educators, law enforcement, and others who regularly work with youth need reminders about the resources available and proper treatment processes. Participants suggested parenting classes to assist parents with youth with mental health needs or who had previously needed crisis services. Participants felt that continued education would also assist in reducing stigma overtime.
7. **Establish a short-term care facility for youth.** As mentioned previously, participants noted the need for a short-term care facility for youth and/or families to help de-escalate and locate services beyond hospitalization, particularly when a crisis is not immediately deescalated.

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CONCLUSION & RECOMMENDATIONS

Overall, respondents were positive about new changes in the youth crisis response system. They saw momentum in reducing the stigma about mental health, sharing knowledge of how to help youth and families in crisis, and a growing number of resources and collaborative efforts to support youth and families in crisis. At the same time, participants noted many barriers to accessing care and preventing crises. Many of these barriers such as funding and availability are noted in the national literature as well. Participants listed key recommendations such as focusing on clarity of shared definitions, supporting prevention efforts, developing follow-up procedures after crises, continuing to educate people on resources and mental health, and establishing a short-term care facility.

Given the focus group findings and the research from the national literature on youth crisis response practices, we make the following recommendations for youth crisis response in Lincoln and Lancaster County:

1. **Define crisis and crisis response** to ensure all partners have a shared understanding.
2. Develop and implement a **follow-up procedure** for crisis response calls.
3. Utilize an **advocacy model** to help the youth and family navigate resources and services, particularly for those families without private insurance.
4. **Define the short-term care service needed** in Lancaster County (e.g., 24/7, 23-hour, staffed licensed crisis response personnel, respite, crisis care).
5. Use the aforementioned definition of the needed short-term care facility to identify the cost estimate, resource needs, and sustainability of such a facility and **seek out sustainable funding for this short-term care service or facility**.
6. Continue to increase implementation of **peer support and peer crisis services**.
7. Consider adding **information sharing questions** in crisis response with families or youth to determine other system involvement and resource use.
8. Pursue efforts to better understand the need for youth crisis response by **better tracking data** from response, referral, and follow up efforts to understand 1) how many youth/families use crisis services and what services they receive as a result; 2) how many youth/families use crisis services but decline other follow-up services (and why); 3) how many youth/families use crisis services but are turned away for follow-up treatment and why; and 4) how many youth/families may need crisis services but are not using them.

Limitations & Future Research

We worked with the Youth Crisis Response Coalition to identify focus group participants. The focus groups results were validated through data triangulation and exemplar data (Suter, 2009). However, this data would be made more robust by obtaining interviews or focus groups with families and youth who have been exposed to the crisis response services to better understand their experiences and needs. Future efforts to understand these needs could supplement the findings by helping prioritize and define specific needs. Partnership with the Nebraska Systems of Care Collaboration could help assess this growing area of need.

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APPENDIX 1. FOCUS GROUP PROCEDURES

Recruitment Script

Dear _____,

The Lincoln-Lancaster County Youth Crisis Coalition is seeking to better understand the resources, data, and process for youth going through crisis response. As an organization involved with or affected by crisis response, we would like your input and expertise to better understand:

1. How crisis response works in Lancaster County;
2. What gaps currently exist in crisis response for youth; and
3. Ways in which such gaps might be filled.

We would like you to join us for a one-hour focus group with others in your field. Focus groups will be held at _____. Please indicate all the times that you are available for a focus group by completing this short poll.

If you have questions about this process, please contact Janell Walther at jwalther2@nebraska.edu or 402-472-2762. If you know others who might be interested or would be relevant to contact, please feel free to share this email or to share their contact information with Janell.

Thank you in advance for your time and expertise!

Janell Walther

Focus Group Protocol

Thank you for joining us today! My name is Janell, and I will facilitate our focus group discussion today. This discussion will last no longer than one hour.

Our focus group discussion should The Lincoln-Lancaster County Youth Crisis Coalition is seeking to better understand the resources, data, and process for youth going through crisis response. As an organization involved with or affected by crisis response, we would like your input and expertise to better understand:

4. How crisis response works in Lancaster County;
5. What gaps currently exist in crisis response for youth; and
6. Ways in which such gaps might be filled.

Your responses to the discussion today will be confidential; I will not report your responses by name or identifying information. Responses will be reported in aggregate. However, I would like to record our discussion to assist with my notetaking, will that be okay?

Do you have any questions before I get started?

1. What is working well with youth crisis response?
 - a. What do you think Lancaster County does especially well?
 - b. What tools and resources work well for youth in crisis?
2. What is not working well in youth crisis response in Lancaster County.
 - a. What gaps exist for youth in crisis?
 - b. What are barriers to filling these gaps?
3. What suggestions do you have for addressing gaps or needs in crisis response?
 - a. Are there existing resources that could be better utilized?
 - b. Are there missing resources that Lancaster County needs?
4. Please describe your experience with youth crisis response in Lancaster County.
 - a. What is your role in crisis response?
 - b. How often do you typically respond to youth crisis response calls?
 - c. Do you have a formal process or protocol that you follow when responding to crisis response calls?
5. Does your organization keep track of any data regarding crisis response? If so, how?
 - a. Do you share that data or information with any other organization?
 - b.
6. Is there anything else I should know about youth crisis response in Lancaster County?

Thank you for your time and expertise today! Our next steps will be to compile all the information into a report to be shared with the Lincoln-Lancaster County Youth Crisis Coalition.

APPENDIX 2: RESOURCE LIST

The following table is a list of commonly referred to organizations in this document. This table should be updated regularly.

Organization Name	Commonly called	Crisis – related service provided
HopeSpoke	Previously Child Guidance Center LINCS	<p>Youth-In-Crisis provides suicide assessments, transitional counseling, and case management to youth being detained at Lancaster County Youth Services Center.</p> <p>Linking Individuals (and families) in Need of Community Support (LINCS) is a prevention program in collaboration with Region V Systems and the Lancaster County Attorney’s Office. This voluntary service provides a strength-based assessment for the youth and family and recommendations for community support.</p> <p>**Sliding fee scale</p>
Bryan Health	CAPS EPC	Inpatient treatment for youth in crisis (at risk of harm to self) / EPC
CenterPointe	TASC, Mobile Crisis Response	<ul style="list-style-type: none"> • 24hr hotline for youth, adults, and families • Free, Walk-in Crisis Counseling • Lincoln Police Department Partnership—providing in-the-field support for youth and families in crisis • Suicide prevention messaging • Recovery Support • Crisistalk.org
Nebraska Family Helpline	The Helpline	<p>The Nebraska Family Helpline at (888) 866-8660 makes it easier for families to obtain assistance by providing a single contact point 24 hours a day, seven days a week. Trained Helpline operators screen calls to assess immediate safety needs. Identify the potential level of a behavioral health crisis, make recommendations or referrals to appropriate resources, and help callers connect to emergency resources or providers. The Helpline is supervised by licensed mental health professionals.</p> <p>Family Helpline operators also can connect eligible families to the Family Navigator Service. This service helps families move through Nebraska's child and family-care system more efficiently to get the assistance they need. Available within 24 - 72 hours after a Helpline referral, Family Navigator helps families identify existing community-based services and provides support from people who have had</p>

Organization Name	Commonly called	Crisis – related service provided
		personal experience in the system.
Blue Valley Behavioral Health	TASC	Outpatient treatment TASC integration (Targeted Adult Services Coordination) Partner with schools
Families Inspiring Families		Mission: Promote a positive future and quality of life for families who have children with emotional, behavioral, and/or mental health issues. Programs: Provide resources for youth, ages 12-18, that have emotional, behavioral, and/or mental health issues, and their families. Family Counseling Family Peer Support
Region V Behavioral Health		Case Management Referral
Lancaster County Youth Services Center	Youth center Youth Shelter	Detention housing for those youth who are placed there by an officer of the court. Day services include meals, schooling, support groups, and activities. Therapy available onsite through partner organizations. Facility may refer services.
Cedars	Reception Center YOC	The CEDARS Youth Opportunity Center is a safe place where runaway, homeless and at-risk youth can drop in for a meal, laundry, hygiene items, emergency shelter access, group programs, others CEDARS used to have a reception center or short respite center, but it does not currently. Cedars has 4 emergency beds.

APPENDIX 3. COMPLETE FOCUS GROUP RESULTS

Strengths of Youth Crisis Response in Lancaster County

Participants suggested that positive changes in adult crisis response have trickled down into positive changes in youth crisis response in Lancaster County. Further, youth crisis response continues to improve in Lancaster County. Participants felt overall that the youth crisis response process is improved by collaboration.

Well, our map of collaboration is really good. I think the flow chart and the design of the process is really good. I think the protocol to always be looking at that process and checking in on that process has been good.

We have a good foundation with community partners. They are willing to come to the table. The crisis coalition came in mid-2016. So in the past 2.5 years, we're really partnering together to work together to help families in crisis. Change doesn't happen fast; this is a 5- to 7-year process to get where we want to go.

The Links program is always responsive, when you say crisis response, that's through the county attorney. Child Guidance [Center / HopeSpoke] does assessment and those seem to be effective. They do those for diversion, too. A mental health evaluation is done and then the family/youth is connected with services.

In addition, some resources seem to be growing. For example, one participant noted that Saint Elizabeth's Hospital now offers screening for intakes and will call crisis response for youth that score high. This engagement with screening and referral helps get families connected to social workers. Participants do see increasing trends to meet the needs of youth in crisis, particularly for those survivors of suicide.

I think with Crisis Response, we've had a lot of youth and families that have friends that have [died by] suicide. People affected by those losses have increased and made youth more at risk.

Participants reported that the behavioral health region was an important resource to youth in crisis outside of law enforcement engagement.

Region 5, they provide community resource without having to be on probation or a state ward. Their community base wrap-around.

Mobile crisis response and helpline provide valuable services

Crisis response services can assist with referrals and determining next steps for youth and families. The newer additions of mobile crisis response and the Nebraska Family Helpline are resources that improve the array and availability of services for youth and families in crisis.

I think one thing, mobile crisis response, through the TASC program, where they actually go out and get called out by law enforcement in Region 5, if there's a crisis, and try to divert or provide services on the spot. I think that's been very, very helpful. I don't know the ratio of adult to youth calls they get, but I know they service both populations.

Their crisis line too is getting utilized more. Mobile response is working well. It was beneficial to expand what CenterPointe was doing for adults to now encompass youth.

The CenterPointe crisis response team provides a useful resource to referrals and de-escalation. Participants noted that while not everyone knows about the service or how to use it, the responses is a helpful resource.

The CenterPointe response is great, they're wanting to deal with behavioral issues. If you're in counseling, they take you to counseling. If they're acting out, take them to Bryan [Health], then to CAPS.³ CAPS will tell you they are not there for behavioral health. They are there for kids that want to harm themselves.

CenterPointe response has been very useful. It may take some time to get it going, but they are typically very quick. They do a good job at calming things down. Everyone is usually in agreement for youth to go back home.

The Helpline is effective not only at providing a resource to call for emergencies, but also as a resource for those helping youth. The presence of a helpline also seems to decrease the stigma of mental health by continuing to share information that crises can happen. Further, this helpline and crisis response put Nebraska ahead of other states' programs for youth crisis response.

Since 2017, we've had a Nebraska Helpline to activate crisis response teams. This isn't even happening in other states, so at least this is available. We've also decreased stigma for mental health services. We continue to bring awareness or train law enforcement, we continue to change stigma and not place it on families. Trying to tell the community that it's okay to ask for help. Those are positive things we've done that we weren't even close to before. It's available, now we just need to fix the tweaks.

As the mobile crisis response team and Nebraska Family Helplines continue to grow, participants anticipate that service calls will get more frequent and more streamlined.

Partnerships improve care and relationships

Partnerships help establish relationships, formal and informal, to improve care and reduce service times. Lancaster County has multiple organizations such as the Homeless Coalition and others to help with information sharing.

³ CAPS, Counseling and Psychiatric Services at Bryan Health. Though no longer called CAPS, this is a recent change and participants often refer to Bryan Psychiatric Health Services as "CAPS" inclusive of residential admission.

...Being able to work with other agencies in town, we all work really well together. The relationships we've created with those agencies, LPS, homeless coalition, etc., are great.

People are responding differently to mental health crisis than they used to. Instead of taking kids to jail, we are taking other directions. We have to be willing to work between organizations. Everybody wants the same thing but have to continue to partner to do some of these things. We are taking baby steps and making progress.

Relationships are helpful to getting youth admitted to care and ensuring that those making the call know whom to call. Often, by participating in coalitions, participants learned of other resources, processes, and points of contact. Some needed resources, like transportation, are provided by some agencies. Knowing how to help families access resources is helpful.

It also depends on their report with MST (multi-systemic therapy) or IFP (intensive family prevention). If I implement that service, usually a family is in crisis 24/7. I make it known that their first call should be that therapist, but it depends on the report.

Law enforcement integration continues to improve

Local law enforcement are recognized for advancing their knowledge of behavioral health needs and resources. For example, multiple participants touted the impact of BETA training as especially helpful to law enforcement knowledge and response.

Some trainings to law enforcement to how to respond to someone having a crisis [improve crisis response]: BETA training and youth BETA training, how to work with behavioral health crisis.

A lot of officers I've worked with, we used to rely on [emergency departments] a lot, but since crisis response has been put into place, we have more options. With crisis response and Families Inspiring Families, we are taking different avenues to get different resources.

As law enforcement knowledge increases, they can assist families in accessing care for youth. Frequent reminders about resources are helpful to ensuring that law enforcement know how to recommend resources.

Most kids are ready to go [seek treatment], but every now and then you get a defiant youth who doesn't want to go. They don't fit any model. They aren't dangerous, but they aren't behaving. The biggest thing in the last few years is having more to use than just [emergency residential psychiatric treatment]. It'd be great to have more follow-up with the families. Sit down with families and make the phone calls with them. It's hard to get providers on the phone.

I think LPD [Lincoln Police Department] does this better than many, but they get called to a crisis and they aren't as proficient in marshalling resources, especially to handle the crisis right in front of them. [The crisis calls are] not frequent for police officers, so that reminder they got 6 months ago at an ...in-service training, they miss that opportunity for those resources that are already in place. LPD is already ahead of others outside of Lincoln, but that problem is very big.

Additionally, participants believe that law enforcement had more buy-in to mental health resources and integration.

We've gotten good buy in from law enforcement. ... Lancaster County Sheriff's office, there's definitely buy in. We've trained the whole department and they regular use us.

We have a number of officers that do buy in to the whole process. There may be more folks that we have yet to reach with that buy in of looking at crisis response mediation step. I have also observed that we have a number of law enforcement that have only used it once. I guess my question is what are those observations, and why haven't they used it again after using it one time.

Participants were better utilizing crisis services and mental health services rather than juvenile justice resources to meet the needs of youth in crisis. Law enforcement knowledge of mental health services and crisis services extends to both the city and county.

LPD isn't calling as often with a kid out of control; they know we can't do much about it. When I was doing intake, I was getting a lot more calls. 15 years ago, I was in a group that was trying to get a crisis response group together.

For crisis response for Blue Valley, we're utilized by Lancaster County Sheriff's Office. It's interesting to hear sheriffs to talk about youth at school, youth at home, how it all works systematically. It's inclusive because they work with the family and the school. It's not that way in the city. LPD works with CenterPointe, schools work with Blue Valley.

Peer support models improve care

For many families, they often feel alone after a crisis is over. Families struggle to navigate complex systems of care. For example, one respondent stated, "Families feel they are left to make all the moves themselves without any help." However, peer support models and family organizations can help families navigate resources and support.

I feel peer support is super great and pivotal in youth especially. We think we know everything as adults, but if they can relate to us more and build rapport, we can avoid crisis before it happens. See eye to eye and know that I've been there and done that.

The REAL program has been useful. We can solve immediate program. Send referral, the MHA sends a therapist or someone to meet with that person. We know they'll make contact within 24 or 48 hours.

Peer support models also help families develop trust in various resources. Participants discussed the use of family organizations and peer organizations to assist with building rapport, sharing knowledge, and answering questions.

There's a lot of families who have the crisis with all these professionals in their life. Law enforcement, therapists, case managers, they don't know who they can open up with. So it's

great to have someone they can trust. If we don't drive home that the goal is support, they are more authentic and share their needs.

Public schools provide an on-site resource for harder to reach youth

Organizations recognized the public-school system was a point of reference for youth and families experiencing a crisis. Lincoln Public Schools (LPS) can offer some on-site resources and referrals.

I think LPS social workers and those folks deserve credit for the work they do. [For] most youth, that's where they interface with the systems in the state. Connecting those youth and families to resources, that makes sense. Developing community-based schools that have an open-door policy, where folks or family members can come in and ask questions to access services. Things they could have now to reduce the need for crisis response, in an acute kind of way.

Schools do things with social workers to help families stabilize. They're swamped already at the school. The school isn't just treating the kid, they are also treating the family. Most cases there are a lot of other things going on.

Lincoln Public School System has a formal partnership with Blue Valley Behavioral Health and HopeSpoke to provide on-site care. In addition, LPS has their own rotating crisis response team inclusive of counselors, social workers, nurses, and psychologists that partner with external resources like Mourning Hope to address student needs. Additionally, professional staff in the school such as masters-level social workers and social workers training in mental health issues are helpful in identifying concerns and working families to seek assistance. At the same time, while schools are doing a lot to meet the needs of students, there is concern about the role of schools in mental health care.

I think it's great that schools have stepped up. I have an issue with using schools too much. There needs to be some privacy, so kids aren't labeled. Many parents don't want schools to know everything about their diagnoses. I'm a little worried. Schools are now doing something about crisis that are now on TV, I worry about the privacy with that. I think we need to be cautious and thoughtful.

In addition, LPS is actively working on suicide prevention by training their staff in suicide prevention and ideation identification. LPS is in the second year of implementing SBQ-R, a short suicide screening tool.

We've also done training for all our counselors in QPR. We have counselors and trainers who are now trained in QPR, so now we can offer that more for our staff and counselors. I think suicide training that's required through the state has helped the staff become more aware of concerns and what to do about those concerns. Our statistic on suicide risk referrals show that 40% of them come from staff. We don't have numbers before the bill was implemented, but it's still great that staff now knows what to do.

Further, schools are continuing to develop safety plans and procedures to assist students with mental health needs. Knowing the needs of individual students helped the school coordinate resources, where

appropriate and necessary. Some participants felt that the addition of school resource officers (SROs) was helpful.

When a student is identified with needs or is transitioning back to school after treatment. That safety plan is put on that student's record and follows them from school to school. It's a consistent way to track a student's mental health needs.

We just got SROs in Middle school. That's a plus.

Having law enforcement in every school can also be a gap. [The school's] first choice is to call the police and have them write a ticket which escalates the problem. Is LPD the crisis response?

Reducing mental health stigma is helping increase families that seek help

While there was concern about stigma prevention people from accessing mental health services, participants also indicated that this stigma continues to diminish over time. Advertisements and sharing of resources has helped to reduce stigma. Participants believe the stigma is reduced for youth even more so than the parents.

The Nebraska Helpline, they have ads that parenting is hard, it doesn't matter where you're at. Using some kind of marketing to get the message out that it is okay to ask for help regardless for where you are and that you [won't] be labeled for the rest of your life if you use these services.

They've done a lot to take away mental health stigma. A lot of kids will tell you that they aren't embarrassed to talk about their problems, especially at the school level.

Continuing efforts to reduce stigma and share information is important to improving care and reducing crises.

Gaps in Youth Crisis Response in Lancaster County

Gaps and challenges in crisis care are due to limited access to services, limited resources, lack of knowledge, and lack of funding. Participants agreed that there was a need to expand crisis services for youth in Lancaster County.

Crisis calls come through law enforcement or public schools

Often, schools or law enforcement are the first contact in the event of a crisis. These calls are often too late for preventive care that may help avoid a crisis.

We are law enforcement driven. ...The youth we are responding too, this isn't the first time there's a crisis, we get called on the escalated situation. It would be great to have a preventative plan in place, so we get it right when the crisis starts.

Further, a law enforcement response to a youth in crisis may escalate the situation further. Some participants believe that having law enforcement respond when a youth is in crisis discourages families from asking for help.

By the time law enforcement is called, parents look at it as they've failed. A lot of people are exhausted by the time law enforcement is called. They'd be good candidates for continued follow up.

Some parents wait to ask for help until a crisis occurs because they are afraid to ask for help. Other families experience barriers because some services are only available Monday through Friday, 9 – 5. This time constraint can be limiting in times of crisis or for parents who are working. When some services are not available, families may call law enforcement or the emergency department. Other times, families will decline services that could prevent a crisis because of the limited hours they are offered.

The problem we see where parents won't take the services, they'll be offered multiple times. Then it gets to that place and we look back that we should have implemented the services early on. We need to soften it somehow so parents can see the benefit of it and the support they will get. A lot of parents have a fear of getting involved in the system.

Additionally, families will only utilize law enforcement and/or juvenile justice resources to get the help they need.

You shouldn't have a kid with a low-level demeanor, piggybacking off that to get out here. Families will ride off that demeanor just to get mental health help, to get services. It's been that way for a while. It was that way with Medicaid.

There is limited resource availability

Limited resources exist for a myriad of services in Lancaster County, similar to trends nationally. Fewer resources for youth needing mental health care, residential or outpatient care is a significant barrier. These limited resources exist throughout the youth crisis-serving system.

There was a point of time when our crisis shelter had a waiting list for youth in crisis. I can't imagine telling my kid in crisis that there's a waiting time for 2 weeks.

Many people have to use their pediatricians or primary care to get medications because of the lack of availability. That's just for medication providers, not for ongoing therapy or anything.

There are not enough child psychiatrists. There're not enough advance practice providers, the mid-levels that specialize in child and adolescent treatment, so that's always an issue.

Having worked as a provider in the community, it used to be easy to get a kid admitted into psychiatric unit, even for a day or two to stabilizing things. Now, it's so rare to get mental health assessment and stabilization before they return to the community.

Further, this barrier is even more pronounced for those youth and families on Medicaid.

A big piece is, if I'm on Medicaid, I have very few options, and the waitlist is very long. Waiting 6 weeks during a crisis is a problem. If I have private insurance, I can go anywhere.

It is especially difficult for Medicaid clients. Not that we can't get appointments with them, the issue that the MCOs [Managed Care Organizations] have specific criteria for access. When you look at, let's just arbitrarily say, "well, there's 10 child psychiatrists in Lancaster county, each one of them let's say we have 10 doctors." The appearance of it is that each one of those doctors are 100% available to each of the plans. So you start to get down to reality. A physician or a provider sees a whole lot of patients on the commercial side, their payer mix is very diverse. But to have them counted as a full FTE for anyone person, it's really kind of smoke and mirrors reporting. Availability of those 10 physicians to Medicaid patients gets down to maybe just one. That's why having a relationship to get kids into appointments is very important. If you just call in, it takes much longer.

This limited resource availability is most noted in wait times to see providers, outpatient service, or obtain more high-level service.

There's probably a shortage of child therapists too. From our standpoint, the therapists we have are very busy. When we refer people out, there's usually a month wait to get someone in to see somebody.

Waiting lists. Availability to get into primary health and behavioral health. The few number that will accept outpatient. I know there is fair amount of work that has been done and is being done, but there's still a pretty big disconnect between being [in residential treatment] and then re-entering into school/home.

A lack of resources reduces the availability of preventative care and/or appropriate care. Often, when families can't get the needed treatment, detention or other services can become a default treatment.

Being able to access preventative care. We don't do a lot of preventative care for mental health. It would be wonderful to do preventative care. Teach coping skills. We have evidence-based practices to help intervene when kids have trauma. It's a real positive, but there's so much more to implement in the schools and communities.

Detention is not a realistic for those kiddos, it's not meeting their needs. It's historically been a default. Our shelters are full. They are experiencing higher needs/mental health kids. They've started crisis stabilization, but that still needs to be ramped up.

We also have a shortage of APRNs, Psychiatrists, specific to adolescents that will partner with us and our kids.

Well, I'm displeased with the system having [detention services] being the housing for crisis kids.

Participants don't believe they know the true extent of the need for youth crisis services in Lancaster County.

Right now, are we able to meet the space, I think Cedars is able to meet current needs of shelters. But, if we actually reach out to who's in need in the community, then we are really in

trouble. There's a lot of families that are rejected at CAPS, so where do they go? When it comes to after care services, when they come into our doors, we offer after care services, but a lot of families choose to not follow up. There's a lot out of there, in-home services, 0-18 years old, but do a lot of families utilize them?

Funding is inconsistent and limited

Funding systems for youth are tied to specific service systems (e.g., Probation, Child Protective Services or Health & Human Services). Some participants said it is unclear when state agency utilization is appropriate. Likewise, it is often difficult to share information with state agencies.

I don't know what the criteria are, but I have no idea what the criteria is, they won't tell you. We can ask if other reports have been made, they won't tell us. We give this information out, and hope that something happens.

Agency representatives discussed the need for more formal intervention before a child is made a ward of the state. These representatives believe that law enforcement response may be required to escalate services. Because service organizations know law enforcement can make a case with state agencies such as CPS, they will partner with law enforcement to make a report.

I think with HHS, it's understanding what the different levels of care are. There are case workers that don't really know what we are here for and expect us to place to the child. They turn over so much, it's like re-educating all over again.

Additionally, multiple organizations expressed concern about barriers and challenges at the state-level that make it difficult to access appropriate crisis care.

I think that the broad experience across a lot of different disciplines, ... is that [state agencies] aren't very responsive to these types of [crisis] issues. They can at times almost get in the way of a response because they have some more controlling role to play and they aren't supporting it. If you think of kids in crisis as not just self-harm or risk towards others, there needs aren't being met, other people are getting really worried in other part of the system.

...The direction that we feel they are going, is not conducive to helping families. The communication and being willing to work with the family is needed. To help them to get where they need to go. The bar seems to be incredibly high to engage with these families. They are the ones that can help the families.

To help kids before things get into such an extreme crisis. It seems like [state agencies] are not willing to engage with other systems like schools. We knock on their door, failing to answer, they close the case. They shut down any effort to help.

Alternative response has a positive impact, but it doesn't get to the more serious cases. [State agencies] aren't flexible and adaptable to these cases.

Insurance often determines the level of care. Even for families on private insurance, experience with an emergency room is costly and may deter families from seeking care.

Health insurance is a pretty big deal, a visit to the emergency room is not what a family wants to do.

A lot of families that we have served, I've heard their fear of the systems, but there's also a financial barrier. They don't have insurance or co-pays and medication is too costly. You're telling me my kid has to go to the emergency room and get evaluated.

We see a lot of families that are either un-insured or under-insured. If they have a choice between therapy vs groceries, they won't go to treatment. ... Medications are expensive too. I had a parent spread out medications across multiple days, so the kid wasn't receiving his medications correctly.

Additionally, funding limits the services that providers can provide. Additional services outside of the regular treatment period are not covered by insurance payments, though therapists often have additional requirements outside of the standard one-hour session. This barrier also means that the most experienced therapists are not seeing youth in crisis.

The MST therapists that are outpatient, I ask too much of them. They're more likely to go to the home or school, they're always there. Yet, they aren't compensated for the extra outside work. Outpatient therapists are not compensated for the extra our kids need.

Our registered service provider process as a system is also a barrier. We ask for additional reporting from providers, which no reimbursement is available for that. Even becoming a registered provider is a pain, there's no benefit to doing it.

Our overall number of therapists have gone down. Also, the ones we get are the ones fresh out of college who have no experience. Yet, we have so many more kids. We've got kids living in hotels right now that are surrounded by crack houses, users, and prostitution. That's hard if you are a green clinician if you've had no exposure right out of college.

Additional therapy services, like interpreter services, represent out-of-pocket costs for providers.

We have a large population that doesn't speak language. Even if we get a situation settled down, and something temporary, follow through services are next to impossible. Sometimes we don't have interpreters that speak that language, or a therapist can't be used because they don't speak or we can't get that interpreter. There's dialectical differences, so interpreters won't get into that due to cultural differences. Providers are required to pay for the interpreter, we don't provide any reimbursement for that. As a system, that's a huge gap, we need to fix processes in terms of interpreters. Spanish is frequently used, but other outlying languages, that's not so much the case.

Short-term care for families in crisis is needed

Multiple organizations mentioned the need for a short-term treatment location for crisis intervention for those youth and families with high needs. The concept for this type of facility differed across participants.

The biggest gap is that there isn't a 24 non-hospital place for these kids to go for Respite or crisis intervention. We've been working on this for a long time. We are in full support for this. It needs to occur.

It's great having warm lines and hot lines and teams that can come out after a period of time, but that's not the same as having a physical structure where someone can go to and see somebody. If our community wants to provide the best array of services, that's the largest level of care that we do not have.

Short-term treatment is especially necessary for youth that are turned away from hospitalization, but still have high needs.

There're cases where there are kids that were sent to the hospital and they weren't admitted or kept because they didn't have medical necessity. They really just needed a place like Respite. So they are two separate populations.

There's not a cooling off spot for kids. It's either hospital or stay home. Cedar will do some but it's very limited. They need an acute care kind of facility that's between the hospital and once or twice a week therapy. Those that aren't accepted in the hospital, but are still in crisis don't have a space to go.

We see kids bouncing off hospitalization because they [don't meet requirements for admission], so then they go to the home where the crisis is created. There's no soft landing anywhere. That's been the case for 30 years. We've heard 40% of youth are admitted. Parents won't take their kids to the [emergency department / EPC] because of the cost.

Participants saw this type of facility as needed for both youth and their families.

Crisis response could use something like that. Sometimes it's a familial issue that can't be resolved in two hours, so a place for them to cool off for a longer period of time and have a family meeting, this would really help out. They're not going to get that in the emergency department either.

A gap: where is there a spot for a kid who needs a break from their parents, etc. Respite care would be a gap that is needed.

Parents also need some respite, just a break for some time to cool down and get a better plan in place. We could prevent some kids from being removed from their homes or prevent the need to go to the hospital.

However, participants struggled on the exact terminology or definition of the needed crisis care facility.

Not respite, but crisis care. It's become more and more difficult to detain someone. Now they need a court order or probation officer has to agree to lodge them. So police get stuck sometimes.

De-escalation and short-term out of home placement is often needed for youth in crisis who do not qualify for hospitalization.

The hardest thing is the outright defiant kid. They aren't breaking the law ... They aren't a danger to themselves, but they'll probably run about and break some laws. We are at a struggle for what to do with them. It's an ongoing problem because we can't grab on to them and treat them. It might be beneficial to take them out of the home to stabilize things. There might need to be out of home placement where they have to do what they're told, it'd have to be secure facility. At Cedars, they'd just walk out the door. Some type of de-escalation period, with counseling or treatment. Parents don't know what to do with their 17-year olds that are defiant.

Transition care between services is needed

Participants noted that youth often have difficulty accessing services after they are discharged from one service. This wait in the transition time can be especially pronounced for foster care youth.

[The foster youth are] in crisis after discharge; they don't know who is going to pick them up. I've seen kids sleep in the office with the case worker. They don't meet criteria [for emergency services], but they don't have a place for them to go. We're talking 8-14 year olds.

Transition planning, support services are integral. There needs to be more resources for that transition.

Further, transitioning and following up with families and youth is essential to ensure they continue to receive services and prevent a crisis in the future.

I think the gaps are system created gaps. For instance, HopeSpoke does family assessment, but those can be 3-4 weeks before families get in. Families cancel. We're involved within 72 hours, with lots of services happening, but there's a huge gap because families just can't do it. Or hospitals say families don't meet medical necessity. Some families just want a babysitter and don't really engage in anything.

When it comes between moving between systems, the wait list and time to get in is the gap. Maybe I'm putting into a higher level of care because there isn't something available for me. We put the kids in places that aren't good for them, spots where they are locked up and learning things they shouldn't be in.

Multiple participants noted a difficulty in finding access to the appropriate level of care for youth and their families. When resources are limited, youth may be pushed into a higher or lower level of care in

order to get them the most immediate help. However, an inappropriate level of care can lead to additional issues.

A gap is the responses after that process is done, having the capacity to the number of youth that need that additional response, whether that's case management or a safe place to afterwards. Do we have the capacity to serve a large number of youth? I can speak to case management and I can tell you we are full, only able to serve 16-18 families at a time. In addition, crisis response, the way I look at it, we do have the ability to respond to the families in need, we've had discussions at every meeting, we have a group who reach a high level of need, but don't meet the high level of medical to be able to be admitted to the hospital, so they are pushed to a low level of care, that doesn't meet their needs. It's good that they have the option to call-in or walk-in, but it's the after care, how do we follow up better?

Adding to challenges in transitioning care, accessing treatment is difficult for youth because it often requires parent or guardian consent. However, in many crisis situations, the parents or guardians can be a significant contributor to the crisis.

Another challenge with youth crisis, we'd like to believe the family is the best place, at times the family is the crisis. For them to access services, they have to have the family sign off it and that's challenging. To be homeless list, the guardian has to sign, but the guardian was the one who kicked them out. We have to have some flexibility when that's the situation.

Transition care from engagement with detention or law enforcement to schools and outpatient care is as important as transitioning from residential to community-based services. On-site services (e.g., at schools), will help youth access services.

The transition from crisis phase to what happens next, even for people not on probation, the mental health field is lacking for the kids. Parents aren't taking kids to therapists. It would be nice to have more therapists go to the homes or schools. That's why it's nice to work with MST or IFP, they go to homes. That's a huge gap to this community.

Transition-aged youth are difficult to navigate through crisis care

Transition-aged youth, and those youth nearing transition age, need special assistance to help them navigate services from youth to adulthood in terms of systems and supports.

...Kids transitioning to adulthood, 17-19 year olds, aging out of juvenile to adult system. There's always room for crisis help with those kids. There's a TAP program through Region 5 that addresses that, but it's voluntary. Getting Medicaid as a kid and as an adult are two different things.

That 17 ½ to 19 years old range. They don't fit into the juvenile or adult system. We serve up to 19. It'd be more consistent if it was 18, but there are states that are 21, so it could be worse.

Further, for transition-aged youth in particular, additional needs such as food and shelter may escalate a crisis.

There's not enough housing for our transition aged youth. If I don't know where I'm sleeping tonight and struggling with behavioral health issues, that's now crisis. For our youth that are in the system and get phased out, where are the services for them? Where can they go? Not all of them need just housing, they need more support. Some don't need support, just an apartment. There needs to be varied housing. When we get to know them, we find out that housing is really the issue and the stress that's affected them for years.

Knowledge gaps can lead to escalating crises

For many, the stigma of mental health for youth and for parents was real and influenced the likelihood of seeking out services. Additionally, many cited an overall lack of knowledge about available services and resources, particularly for those families experiencing a crisis for the first time.

I also think, we talk heavily about young adults in transition, but I also think that assistance in navigating the systems for parents and the supports that are available. We have tried to make strides when it comes to this, but if you don't have some inside awareness of resources, If I am a parent that has never experienced a challenge, I have no idea where to go if my child is in crisis. Or asking for help when my child is in suicidal risk, because is that going to reflect on me as a parent? There needs to be some normalization of what is available. And how to I begin to navigate and advocate for my child. The average parent has no idea what to do or where to begin to find help. If a parent feels alone struggling at home, it's quite insurmountable.

Is our community educated on how to access our services? We have to consider that we have families that will not engage in what is being offered.

Fear of engaging systems can be a barrier to reaching out for services or resources, particularly for youth who have high system involvement.

There's a lot trepidation on those that have experienced any system involvement. Social workers are the enemy. People that are reaching out, they really just want to rip you from your family and move you. They aren't on your side. ... We have a woman who was wraparound, had all the supports, but she wasn't able to have any self-determination in those supports. They told her what she had to do, and if she didn't comply, then her housing was being held over her head. You will lose this if you don't comply and you and your child will be homeless, your child will be taken away from you. All of those things came true, in part of the toxicity of the stress that she was under, because she found it really hard to comply, even with things she was interested in doing. The momentum was not behind her. She didn't even know where to begin.

While law enforcement's response to crisis has improved with more knowledge, it can be a challenge to keep and implement the knowledge.

... It's not uncommon when there's a crisis, law enforcement isn't aware or they forgot about it. They don't know where to start. Once they start the collaboration things work well, but sometimes they don't know where to start and that's a challenge. ...It's such a large department.

Information sharing could improve services, but faces limitations

Data can assist in determinations of treatment and next steps. Participants indicated the usefulness of having more information to best serve the youth; however, they recognized individual concerns about having such documentation and being stigmatized.

It would be nice to have histories of youth, suicidal history, etc. They become adults and we still have no history. Their HIPPA stuff they are worried about, but it's necessary for us to have some information. You don't want to be developing files, but we have to do the searching and create a narrative ourselves. People get nervous about files, but we just want to help them.

I'm not sure I would want all that information. It might overload me. I'd rather a single point of contact like a case worker who has that information. I feel uncomfortable with [our organization] having that data. I think the data should reside in another social service agency.

We just started the Juvenile Detention Alternatives Initiative, we are at the beginning of this. Coming up with a spreadsheet, where everyone puts in their own data, there's a little bit angst among stakeholders in Lancaster. We all want the same outcome....

Data points are often housed by agency. For example, attendees at meetings identified that 611 youth scored significantly high on the SBQ-R in public schools; nearly half of all youth who sought out emergency psychiatric care were turned away from admission (n = ~788).⁴ Multiple organizations noted that there is a lack of known data for youth who are at risk or experiencing crisis but not reaching a service. Further, many organizations are restricted from sharing data, particularly with consent from parents and guardians.

But sometimes parents are hesitant to share information. Parents think it's in the past, they don't want to bring it up. They don't want a pre-determination made on the kid. [The Agency] doesn't think we will use the information. There's privacy issues there too. They think it's not in the youth's best interest to share that info with us.

Participants suggested that coordination between agencies might improve services for youth reentering a school environment from the juvenile justice system or mental health system.

If we don't understand the issue, then we can't put anything in place to keep that youth safe. This lack of sharing, for legal or other reasons. When you see someone who does provide information, things work out much better.

Residential treatment facilities should also share information. When we get a discharge summary that asks for services that we don't have, we've had conversations to tell them we

⁴ As reported at January 2019 Youth Crisis Response Coalition team meeting.

don't have those services, they keep sending the same discharge directions. We have to follow up. The continuity of care, it's really interesting that there's not discharge paperwork to bring to us. Kids ... aren't in a good place when they come to us.

When a kid is removed from placement, our dream it would be nice, when facilities start to talk about discharge, they come up with a plan. Otherwise, the whole process starts over again. We see them come back and we have to do another evaluation. Back to court, more evaluations. Wherever they are coming from, providers already know so much about what's going on. They've been there and we need to hear from those providers.

Though state agencies could be valuable partners, participants believe there are significant limitations to connect between systems. Often, participants only knew if youth were involved in a state system if the youth or family volunteered that information. At the same time, participants recognized that each of these agencies faced limitations and barriers to sharing information.

Another gap, we don't always know immediately other parties involved, HHS, Probation, etc. We have opportunities to partner together to benefit the youth, but we haven't been able to have success in connecting with those systems. It could address the longer term problems if we could work together.

When you try to engage [a department], there becomes a funding question. Are we expecting them to pay for something? They say we have services, but we repeatedly see these kids come back through. If we say we pay for it, at no charge to you, then they say yes go ahead.

Further, participants mentioned that state agencies, such as Probation, often have more interactions with families than other local system partners.

It's not always the youth with the problem, sometimes it's the parents. Probation has more of a leverage with the families. We don't always have that access. Sometimes parents have significant mental health issues or grew up in the system, so they think the system will take care of the issues for them, so I think probation could help with that.

Recommendations to address gaps in Lancaster County

Participants also made recommendations to address the gaps in youth crisis response in Lancaster County. Key to addressing gaps are defining the need across agencies, focusing on prevention and a continuum of care, sharing knowledge and information across agencies, educating others, and establishing a brief or short-term care facility.

Defining crisis and crisis response are important to clarifying needs, services, and future efforts

Various organizations had different definitions of crisis response. Some organizations saw crisis response on a spectrum from prevention to postvention. At the same time, other organizations thought of crisis response as acute intervention at the moment of escalation. Often, this definition depended on the organizational role in crisis response.

The thing I always ask, how are we all defining it and how are we all measuring it? Is it consistent?

How we define things is all very different until we have consistent definition. We are comparing apples and oranges, so nothing good would come out of it.

I think one piece in all of this is the definition of youth crisis. If you're only thinking about it with behavioral health or criminal justice, that's very different than how we define it. We're looking their basic needs and maybe their past and trauma has led them to where they are, they're trying to navigate through all of it. We're looking at a youth in crisis, it's their ability to provide for their basic needs and be self-proficient.

A crisis for youth can be anything they feel is a crisis. One youth just needed a painful tooth removed, we were able to support him get to appointments. That could have turned into a huge crisis if he would have lost his job or unable to pay his bills. It's anything they feel is a crisis, especially without the supports to meet that.

Prevention is key to reducing multiple crisis calls

Participants discussed the need for families to receive early intervention to both prevent crisis and prevent youth from leaving the home. Ideally, families would be connected to services such as outpatient care to prevent a crisis call. This access to services is needed sooner and with reduced wait times.

Potentially have CPS start interventions earlier. Get someone in there and monitor the situation. They've been able to re-staff and get some momentum. To do some positive things now, that'd be cool.

It'd be beneficial for the parents, too. Once they take the kid out of the home, there's a long list for the parents to get the kids back. Family preservation has always been their goal, so doing that differently that would be helpful.

Prevention efforts before a crisis through connected resources can help youth and families. In addition to connecting families to services, they also need to more education and information for parents.

By the time they reach crisis response level, a good chunk of them need that higher level of care, but if we would have just educated them earlier, they wouldn't be there.

Crisis services should focus on a full continuum of care

Organizations considered how the continuum of care can help to prevent crisis. Participants suggested that all organizations understand how and when a youth can be referred can assist in streamlining care for the youth and family.

With the crisis center, it has to be in conjunction with treating the underlying issue. We need the entire continuum of care. ...Let's treat them in outpatient care, and not allow them to get to the higher level of care. [LB] 1083 is 14 years since that was passed, and we aren't doing much

better, we're probably doing worse from regional center treatment to community-based care. ... They are doing a good job, but much more focus on treatment is needed, not just crisis.

Participants noted that it was important to understand all the appropriate service options to assist with referrals and treatment planning.

What happens to the youth that isn't accepted into CAPs? Or they can't pay? Why can't we create options, if it's not your preference to do a face to face with me for an intervention, would you prefer Telehealth? There needs to be options and ask the families what their preferences are. We need to know why they don't engage. Why aren't we thinking as a community how to address those different barriers? Create responses to financial barriers, [for example]. ... Create some "matrix" that helps us understand different directions that families might be sent.

Participants suggested youth being discharged from emergency care need discharge planning and referral, particularly for those youth who are not admitted to residential treatment. Participants all noted that Bryan Health provides a valuable service, and that services should be supported by community resources to streamline follow-up.

At CAPs, there's no recommendations. There's zero discharge planning. We need that liaison. Whose responsibility is that though? Bryan? Community? It needs to be a partnership. We want to help Bryan. We are building to our crisis continuum. Bryan needs to know where to send youth if they don't get in. If a kid does get in, there needs to be a discharge plan.

Further, crisis efforts should focus on families, rather than looking at only the youth.

We cannot look at youth isolated from however that family defines themselves. We've disempowered families in many ways.

Follow-up is essential

Multiple participants indicated there is a strong need for follow-up after a crisis to ensure that families and/or youth are seeking out the next steps in treatment and attending the treatment as recommended.

A lot of families, if you don't nudge them, they let it go until the next melt down. A follow up would just be huge. Someone who encourages them to look for services.

After that initial call, those first 72 hours, connecting that kid or family to the next source of care, that's what's really important, it makes it really successful. A lot of the adult emergency response has really seen that.

After-care is what's missing. We use CenterPointe a lot. We hear kids who slip through the cracks and don't have the after care. They need a safe place, beds, etc. That's a huge gap.

Participants suggested that an advocate at the table could assist with navigating systems, insurance, and recovery.

...There's no insurance advocate for those conversations at the table. If those insurance companies, both private and Medicaid. If those companies reached out to families at crisis, giving out names to free services and how to get things covered, maybe those families would then access something. There needs to be clear education about insurance. ... Bryan Health has to serve so many, there are doing what they can. So there needs to be another place that Bryan Health can refer to. Someone like a case manager can catch them at Bryan when they are not admitted to direct them other services.

Follow-up service for youth could mimic some follow up from the adult crisis services.

On the adult side, when a person goes to a crisis center and they do or don't get in, there's a follow up for mental health. It's a great concept. If you don't get in, you will still get follow up from someone to make a plan or connect with other services. There's someone right there instead of having the families have to search.

Some participants are creating their own follow-up procedures informally. However, participants did note that this informality meant that not everyone was getting the same processes.

One thing that has worked really well for [us] with SOC, it allows us to have 72 hours to stay in contact with the family. What happens when everything de-escalates? I have 72 hours and then 6 hours in that of direct time. Original call is an hour, we have 5 more hours to check in, get connected with services. From there, after those 72 hours, there's a 30 day follow up afterwards. Someone from Blue Valley calls and checks in. I usually provide parents with phone number, after 7 days, I tell them to call me. I've always done that. Not everyone ... gives the phone number out, but some do. I restart the process. Flexibility in the program is important. Flexibility in funding is available in some programs.

Although law enforcement play an integral part in crisis response as they are often the first called, participants suggested that reducing the number of officers on the scene as quickly as possible would assist in de-escalation.

Time is very important to officers and LPD. With youth calls, it's very common you have many officers on the scene, with only one for an adult. So figuring out ways to streamline that process so we are getting as many officers off the scene as quickly as we can.

Formal partnerships can assist in proper care and transition between services.

Participants suggested agency siloes might be broken down by establishing formal partnerships and agreements.

Probation and law enforcement typically have barriers. Law enforcement does not fill probation response. Probation is limited with law and have a huge number of cases. They are typically involved with youth with legal charges, so if we could formally partner during the crisis, we have so much more opportunity to intervene and access to resources. We can provide probation with placement, resources, etc. They have the legal leverage that can open doors, otherwise we don't

have access. We've done that informally, but a formal partnership where they can access us or we can access them would be great.

Partnering with the hospital is a big one. Sometime of formal process for families that are turned away so they aren't just pushed out.

Participants suggested that the formalization of partnerships via MOU could reduce barriers to sharing treatment information.

I don't think a data piece is it. One other thing that states do, there's no silos, no privatization. It would be nice if there was MOUs amongst the people. If Sarah was the shrink at Boystown, she knows a youth that needs higher level treatment, she could work something out with a higher-level entity because she works with them. This continuity of care that could exist between private orgs via MOUs.

I'm a therapist at a group home, I see a youth that needs higher level of care. I'm starting to make recommendations. We have a discharge and a referral ready. It'd be perfect. Have the plan ready before something bad happens. The system is ridiculous. It's about agency needs and not about youth needs. It's about what the agencies want, and not about kids.

Formal partnerships can help with information sharing and a shared treatment approach. Participants mentioned that the Systems of Care approach has helped with this approach, although the impact is somewhat limited.

We're very silo-ed systematically and how we approach crisis response. The county started crisis response 2.5 years ago. Last year, region got systems of care grant, we took a step back and started all over again. It's very silo-ed wherever you go. People want credit.

Participants also suggested better integration with medical care facilities like urgent care to assist in both normalization of mental health issues and reduction of wait times.

Everyone knows where to go when you break a leg, but it hasn't been normalized for mental health. We have this vision that it's all on the same level. ...Have mental health therapist in all urgent cares or shared throughout. Have it available for families. Instead of having to call police, you go to health care. We've had families call and are told they have to wait 3-6 weeks to see somebody. We need somewhere you can walk in and get help, like an urgent care.

Continue to educate organizations and individuals working with youth

Participants noted that it was important for organizations such as schools and law enforcement to be continually aware of the changes in resources, points of contact, and service availability.

I think we also need to educate the schools and educators. They have direct contact with youth and families. Sometimes administrators know of what's in the communities, but teachers need to know where to send families. There's more social workers in the schools, but teachers need to be well-educated on what's available in the community because of how much time they spend with

the youth. They know what the family and youth need more than anyone out there. Sometimes kids that are suspended, they keep the kid in the school because they know there's issues in the family. There is a partnership already, we just need to strengthen it. There needs to be training in those schools.

I talked a sheriff through how to access a bed at Cedars, they had no idea how to do that. There's partnerships, but they don't know about it.

Participants indicated that law enforcement need continued reminders about all services available to families in crisis.

When you have all these agencies, a group will talk about what they have available one month, law enforcement pays attention them. Then the next month it's a different service. There needs to be an understanding how all the services work together. The Region did the BETA training, they asked law enforcement to name 2 services available in the community, and no one knew anything. If they are the first responders, we need to overly educate. They need to "puke" resources out to the family every time they are called.

Parents also need continued information and knowledge to help them develop their parenting skills and access services. Participants indicated that parents were typically receptive to receiving information about resources in the community.

I get phone calls from parents, they're always asking what is available out there because they don't know it's out there. They want to know where to find this information. It's important to get that info out and about.

I've taken brochures over to court when I get a brand new family. I'll explain the program. They're pretty receptive. They always want to call someone, but they don't know who to call. People take information often because they don't know where to get it.

One thing we talked at our last crisis meetings, sometimes youth are in charge of parents. CAPs will admit the youth, but the youth tells the parents that they want go home. So we've thought about using funding for parenting classes to learn skills and strategies to educate parents. We've had kids with suicidal attempts, but then tell the hospital that they are fine, so they don't get admitted. So there's lots of education things like pamphlets, etc. to empower parents to address their youth. If you're going to offer certificate to a parenting class, it needs to be family friendly. If a parent is overwhelmed and busy, another thing on their list or telling a parent they are bad at parenting, they won't go. The messaging would have to be very good. Asking the family what they need is a bigger question. Lack of knowledge from law enforcement and families.

If Nebraska had the ability to order parents to do things, because a lot of them don't. Once a youth is on probation, the requirement is on the youth. Parent education would be nice. If CFS gets involved, parent education is required.

Many participants indicated an interest in integrating care between medical doctors and mental health professions.

I still think there's a bit of stigma with parents with youth that have mental health issues. We see mental health more criminal type a lot more than medical.

I don't know why we don't have any doctors at these meetings. Maybe they don't want to be? That's it, they don't want to be. Some doctors don't want to open that door with mental health. We need to have conversations with medical care if we want to improve the system. LOSS has the medical doctors in the meetings.

Knowledge can also assist with policy-level changes.

... Nebraska has a youth commitment statute. No one knows how to use it. Law enforcement, county attorneys, and others don't know how to access it. It involves the youth being made a temporary state ward and can open many doors for the families, but no one knows how to access it when necessary. It doesn't get used. We're trying all these other things, but maybe we need to do that intervention. We used to do it all the time. It's that state-ward piece that veers people away from it now because the goal is to keep state numbers low and not have them grow. How can that language be relooked at, to say, how can your family enter this with some support and enforcement, without you being on a registry and without being a state ward, it's better for everyone across the board?

Establish a short-term care facility for youth

Youth need a short-term crisis care facility to address immediate needs. A short-term facility requires sustainable funding and policy approval.

We've been trying to get a reception center going at Cedars, but it comes down to funding because we want to staff it 24/7. To do so, is very expensive, we just are trying to put it together. We have living rooms where they can come, but ... Unfortunately, we rely on funding. The funding goes away and the support goes away. We need to find permanent funding otherwise we just go in this circle. At the end of the day, our operation can't be sustained without dollars coming in constantly. Legislative stuff authorizing insurance to pay for this is important. It's exactly what we need. We believe that will mitigate issues. We have plans, we just don't have the funding.

A biggest gap is a "landing pad" for kids coming out of CAPS and then a mental health short term facility. I'm not talking about private, non-profit group running a mental health facility, but trained mental health. We don't have a kid crisis center. We need that, but because of privatization, that worries me. You're talking about information and who is the holder of that information.

While many participants recommended this sort of short-term care facility, the definitions of this facility varied greatly.

A place to get their needs met, we've figured out this braided funding to make it work. Right now, we have to focus on funding, but if we develop a fine streamlined system where they can go into the door and get their needs met. Some other states have it and we are trying to learn how they do so.

Our community needs a medium-level placement. We have respite level for Cedars and beds at Bryan [Health]. What about kids in the middle with issues but don't have the medical necessity? Where your child can come in, we will look at them, community resources will come to them, if the child does need to go to Boystown, they can stay at the location until they go. Let it be a temporary holding.

Respite would be nice, too. Maybe we could help parents take responsibility too, help them coordinate that.

In our dream world, a Honu-type house, a four or five bedroom home where when you experience a mental health crisis, it's supported by peers for adults, but for youth there could be a clinician. It could fill that gap, where young people aren't able to be admitted to Bryan [Health], or stay at home, they have a safe place where they could and find some stabilization.

There should be more safety in the rooms. There's a lack of understanding for what a safe room looks like for suicidal youth. Kids not admitted, shelters full or they don't meet their criteria. If they're under the system, then they come to me. It's clearly a gap, we've talked about it for 30 years.

Be very careful [about facility name], because then you have a silo jump on and create a program. Have a place a kid can spend the night to get stabilized. For old people, it's called "rehab"? Tabitha, Madonna type rehab? ... If we call it shelter, we have certain providers step up. ... Instead of making a program we need, we have a provider try to make something it isn't.

Further, participants were hesitant to define what type of shelter or short-term service this facility would be. Ideally a shelter would be unable to turn youth away. At the same time, such a shelter should not integrate kids with mixed needs.

I want don't want to put a label on what's called. Some place where a youth can be, where there's safety and family connection. Prompt services, allow for kids that are aggressive. No Reject. It doesn't exist unless it's CAPS or here. There's nothing else.

Key to this short-term facility was a safe space for de-escalation. A short-term shelter should not combine youth kids with mixed needs. Some participants stated that private placement often has a "mixed group of youth with needs."

I think with Cedars, we have a place to try. Crisis stabilization, not necessarily crisis response. I'm working on a reception center there, a place where law enforcement can bring a kid, where the kid can hangout while we work out a plan.

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REFERENCES

Corbin, J., & Strauss, A. (2015). *Basics of Qualitative research: Techniques and procedures for developing grounded theory*, 4th Edition. Thousand Oaks, CA: Sage.

Kim, S., & Kim, H. (2017). Determinants of the use of community-based mental health services after mobile crisis team services: An empirical approach using the Cox proportional hazard model. *J Community Psychology*, 45:877–887. <https://doi.org/10.1002/jcop.21899>

Kisely, S., Campbell, L.A., Peddle, S., Hare, S., Pyche, M., Spicer, D., & Moore, B. (2010). A controlled before-and-after evaluation of a mobile crisis partnership between mental health and police services in Nova Scotia. *Can J Psychiatry*, 55(10):662–668.

National Action Alliance for Suicide Prevention: Crisis Services Task Force. (2016). *Crisis now: Transforming services is within our reach*. Washington, DC: Education Development Center, Inc.

National Council Magazine (2016). *Crisis to Recovery*, 2016:1.

Nebraska Risk and Protective Factor Student Survey Results for 2016 (2016). Nebraska Department of Health & Human Services: Division of Behavioral Health and University of Nebraska-Lincoln Bureau of Sociological Research. Retrieved from: <https://bosr.unl.edu/2016StateofNebraska.pdf>.

Shank, N., Hoffman, S., & Smith, T. (2017). *Lincoln vital signs 2017*. University of Nebraska Public Policy Center. Retrieved from: <http://www.lincolnvitalsigns.org/reports.php>.

Substance Abuse and Mental Health Services Administration. Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies. HHS Publication No. (SMA)-14-4848. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

Suter, B. (2009). Validity in qualitative research and personal relationships. *The Kentucky Journal of Communication*, 28 (2), 77 – 96.

Vanderploeg, J.J., Lu, J.J., Marshall, T.M., & Stevens, K. (2016). Mobile crisis services for children and families: Advancing a community-based model in Connecticut. *Children & Services Youth Review*, 71, 103-109.

DRAFT