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Lindsey Wylie
University of Nebraska at Omaha, slwylie@unomaha.edu

Anne M. Hobbs
University of Nebraska at Omaha, ahobbs@unomaha.edu

Juvenile Justice Institute, University of Nebraska at Omaha

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EVIDENCE-BASED NEBRASKA

CRISIS RESPONSE PROGRAMS

FY 2015 - 2020

Lindsey Wylie, J.D., Ph.D.
Anne Hobbs, J.D., Ph.D.

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Lindsey Wylie, J.D., Ph.D.

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Layout by Marcus Woodman

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EXECUTIVE SUMMARY

There are a significant proportion of youth with mental and behavioral health issues, often undiagnosed or untreated, that may contribute to problems at school, home, and within the community. Families and others may not know how to best handle the crisis and often turn to law enforcement or emergency departments to assist; however, this can lead to unintended negative outcomes for youth.

To best address crises, the Substance Abuse and Mental Health Services Administration (SAMHSA) states that communities should have a well-developed continuum of crisis services. Crisis services are "no-wrong-door" safety net services that are available for "anyone, anywhere and anytime" (SAMSHA, 2020, p. 8). If interested in learning more about best practices in a crisis continuum of care, we suggest the reader obtain The National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit (SAMSHA, 2020), which provides guidelines for implementation and evaluation of crisis services.

Crisis response programs are one cog in a continuum of crisis services. In Nebraska, most crisis response services are currently provided by Nebraska Systems of Care through the Regions (with the exception of Region 6). Some services, however, are supported with funds from the Nebraska Community-based Juvenile Services Aid program (CBA). While the focus of the current report are CBA-funded programs in counties that are located in Region 6, we also describe evidence-based models utilized nationally (i.e., Crisis Intervention Teams; Mobile Crisis Services). Currently, only two crisis response programs are funded by CBA; however, this may increase if the Systems of Care SAMSHA grant awarded to the state is not renewed.

Overall, the crisis response programs that are the subject of this report are effectively working with law enforcement, keeping youth in crisis in the community and not detention/hospitals, and establishing crisis plans with youth to reduce the risk of crisis in the future.

NEBRASKA'S COMMUNITY-BASED JUVENILE SERVICES AID PROGRAM

Recognizing that unnecessary formal involvement in the juvenile justice system may be contrary to the best interests and well-being of juveniles, the state of Nebraska established a fund entitled the Nebraska Community-based Juvenile Services Aid Program (CBA) Fund to support local programs and services for juveniles (Neb. Rev. Stat. § 43-2404.02). The purpose of the Community-based Aid Fund is to assist counties with developing intervention activities "designed to serve juveniles and deter involvement in the formal juvenile justice system" (Neb. Rev. Stat. § 43-2404.02(b)). This fund encourages the provision of appropriate intervention and/or diversionary alternatives for juveniles, as well as better coordination of the juvenile services system. Specifically, lawmakers intended the CBA funding to be utilized for:

"programs for local planning and service coordination; screening, assessment, and evaluation; diversion; alternatives to detention; family support services; treatment services; truancy prevention and intervention programs; pilot projects approved by the commission; payment of transportation costs to and from placements, evaluations, or services; personnel when the personnel are aligned with evidence-based treatment principles, programs, or practices; contracting with other state agencies or private organizations that provide evidence based treatment or programs' preexisting programs that are aligned with evidence-based practices or best practices; and other services that will positively impact juveniles and families in the juvenile justice system." (Neb. Rev. Stat. § 43-2404.02(b)).

Programs funded through CBA, including crisis response programs, are statutorily required to report data to the Nebraska Commission on Law Enforcement and Criminal Justice (Nebraska Crime Commission) (Neb. Rev. Stat. § 43-2404.02(4a)). This requirement is fulfilled when programs enter youth information into the Juvenile Case Management System (JCMS). The JCMS is a secure, web-based tool that allows programs to meet their reporting requirements while measuring whether the program is meeting the goals they set out to achieve.

More importantly, as a statewide system, programs are held to a uniform standard of reporting by utilizing common definitions. An overarching aim of the JCMS is for programs to utilize consistent definitions for key data elements.

YOUTH CRISIS SERVICES

Data indicates that justice-involved youth have higher rates of mental health issues than youth generally, and that fewer than 20% of juveniles with mental illness receive any form of treatment. Although, research demonstrates mental health issues alone do not predict system involvement, mental health symptoms can contribute to initial system involvement or moving deeper into the system. Caregivers and families may feel they have limited options when their child experiences a behavioral health crisis, and frequently turn to law enforcement, hospital emergency departments, and inpatient treatment to assist, when a community-based intervention may be more appropriate (Shannahan & Fields, 2016).

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), crisis services are "a continuum of services that are provided to individuals experiencing a psychiatric emergency" to "stabilize and improve the psychological symptoms of distress and engage individuals in the appropriate treatment service" (SAMHSA, 2014). To have an effective continuum of services, SAMHSA's essential elements of a "no-wrong-door" integrated crisis system must include:

1. Regional or statewide crisis call centers coordinating in real-time;

2. Mobile crisis response and stabilization teams available to reach any person at any community location in a timely manner; and

3. Crisis receiving and stabilization facilities for short-term observation and crisis stabilization services.

This report focuses on the second element, mobile crisis response/intervention teams, which provide acute crisis care in community settings (home, school, the community), with the longer-term goal of linking youth to any needed services (SAMHSA, 2020).

MOBILE CRISIS RESPONSE/INTERVENTION TEAMS

Mobile Crisis Response services include individuals trained to intervene when a youth has a behavioral health crisis. In some of these models, referrals come exclusively from law enforcement (i.e., Crisis Intervention Teams), while other models primarily receive referrals from emergency rooms or hotlines (Mobile Crisis Services, Mobile Crisis Response, and Stabilization Teams).

CRISIS INTERVENTION TEAMS

Crisis Intervention teams are police-based teams intended to improve the interactions between law enforcement and individuals with behavioral health needs to divert them to appropriate services, rather than the criminal justice system (see Markey et al., 2011). Although crisis intervention teams (CITs) were originally established to address adult needs, nationwide, communities have expanded the program to address the specific needs of youth with programs called Juvenile-CIT (J-CITs).

J-CITs aim to prevent the criminalization of youth with behavioral health needs by utilizing law enforcement contact as an opportunity to intervene and connect youth/families to services, instead of moving deeper into the juvenile justice system. CITs follow the Memphis Police Department model, developed in 1988, and rely on three components: (1) community collaboration, (2) a 40-hour training program for law enforcement on therapeutic skills, and (3) consumer and family involvement in the program's development and improvement. J-CIT officers are dispatched to juvenile crisis situations and work to de-escalate the crisis based on specialized training instead of a traditional law enforcement mindset. Officers do not provide mental health services themselves, but instead connect youth to appropriate community resources (Doulas & Lurigio, 2014).

To date, there has been limited research on J-CITs. However, research on the Memphis CIT model found CITs were effective at increasing the number of police referrals to mental health centers, reduced jail time for people with mental health problems, and reduced the rate of officer injury and use of force calls for service (Strauss et al., 2005; Borum et al., 2000).

MOBILE CRISIS SERVICES

Mobile crisis services (also known as Mobile Crisis Response and Stabilization Services, or MRSS) offer community-based interventions to individuals wherever they are—home, school, or anywhere in the community. The short-term objectives of mobile crisis teams are to provide a rapid response, assess the individual, resolve the crisis situation, and link people to needed services; the longer-term objectives are to reduce psychiatric hospitalizations. In 2020, SAMHSA released the National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit and outlined the minimum expectations and best practices to operate a mobile crisis team (p.18).

Mobile crisis teams must:

1. Include a licensed and/or credentialed clinician capable of assessing individual needs
2. Respond at the location of the person (home, school, park) and not restrict services by location and time of day

Essential functions of mobile crisis services include:

- **Triage/screening, including explicit screening for suicidality;**
- **Assessment;**
- **De-escalation/resolution;**
- **Peer support;**
- **Coordination with medical and behavioral health services; and**
- **Crisis planning and follow-up.**

3. Connect individuals to facility-based care through "warm hand-offs" and coordinating transportation, and only if situations warrant transition to another location.

According to SAMHSA (2020), mobile crisis services are thought to serve a broad range of individuals in less acute crisis situations. A survey of higher-performing mobile crisis teams demonstrated that approximately 70% of calls resulted in community stabilization. The remaining 30% would then be connected to facility-based care aligned with assessed needs (i.e., crisis receiving and stabilization facilities, respite or residential treatment programs).

Furthermore, quasi-experimental studies indicate that when crisis interventions occurred in the community, as opposed to a hospital-based emergency service, service-users were less likely to be admitted into a psychiatric hospital at the time of crisis (Hugo et al., 2002) and within 30 days (Guo et al., 2001). As such, Crisis Response programs appear to be effective in connecting people to services in the least restrictive environment.

NEBRASKA'S SYSTEMS OF CARE CRISIS CONTINUUM

As a means of comparison, we looked at other current programs in Nebraska. Currently, Crisis Response is offered by the Department of Health and Human Services (DHHS) Systems of Care through the Nebraska Regions but may only have federal grant funding through FY 20/21.

Systems of Care (SOC) is a framework for designing mental health services and supports by coordinating the work of committed partnerships under one umbrella. SOC draws on the expertise of partner agencies (i.e., government, behavioral health providers, families, and advocates) to assist youth and families in functioning better at home, school, and the community (DHHS, 2016). An essential component of any SOC is crisis services.

In the past, behavioral services in Nebraska were fragmented and there were high rates of out-of-home/community placements. In 2016, Nebraska received a $12-million, four-year SAMHSA grant to provide crisis services statewide (Gage, 2017). Data for the first three years of the grant were provided to the Juvenile Justice Institute (JJI) by the Nebraska System of Care (NeSOC) Administrator (see Table 1).

During the second and third year of the NeSOC grant, an average of 600 youth were served in Regions 1 to 5.[1] Similar to data reported by SAMHSA (2020) above, approximately 75% of youth remained in the community, and approximately 25% were referred to a hospital following mobile crisis response services.

Table 1. Nebraska System of Care Youth Mobile Crisis Response for Nebraska Regions 1 to 5				
Crisis Outcome	**FY 16/17*** $n = 46$	**FY 17/18** $n = 578$	**FY 18/19** $n = 625$	**Total** $n = 1578$
Remained at Home	84.8%	73.2%	72.8%	72.7%
Informally Placed with Relative/Friend	6.5%	1.0%	1.3%	1.2%
Placed with CFS/AOP	0.0%	2.6%	2.1%	2.0%
Referred to Hospital	6.5%	21.8%	22.9%	21.9%
Unknown	2.2%	1.4%	1.0%	1.0%

Note. *Program implemented 5/1/17

COMMUNITY-BASED AID FUNDED CRISIS RESPONSE PROGRAMS

Within Nebraska, there have been eight Crisis Response programs funded under CBA since 2015; however, only two are currently funded during FY 19/20 (see Table 2). Most of these programs receive referrals from law enforcement (except for Douglas County programs that received referrals from the Juvenile Assessment Center following a suicide screening).

Table 2. Continuity of CBA Funding for Crisis Response Programs						
Program Name	**County**	**FY 15/16**	**FY 16/17**	**FY 17/18**	**FY 18/19**	**FY 19/20**
Heartland Family Service	Cass	X	X	X	X	X
KVC Nebraska	Douglas	P	X	X	X	
Capstone Behavioral Health	Douglas	P	X	X	X	
Safe Harbor	Lincoln		X			
Heartland Family Service	Otoe		P	X		
Crisis Response	Red Willow	X	X			
Heartland Family Service	Sarpy	X	X	X	X	X
Crisis Response Team	Saunders	P	X			

Note. X = funded the entire fiscal year; P = funded part of the fiscal year

Once law enforcement calls the Crisis Response program, a licensed mental health practitioner is dispatched to the location of the incident to de-escalate the crisis. While on scene, the practitioner may create a safety plan with the youth and family and then refer youth/families to community-based services. While the ultimate goal is to keep youth at home with their families, while avoiding detention and juvenile system involvement for crisis situations, there may be occasions that also require out-of-home placement, hospitalization, or detention. Typically, law enforcement remains on-scene until the therapist leaves, but law enforcement may move to a less invasive location (e.g., another room, their cruiser) to allow privacy when it is safe.

Telehealth services have also been utilized in some of the programs, and Cass County's program administered by Heartland Family Services began solely using telehealth services (11/12/2019) to decrease response times to more rural areas. The telehealth services utilized by the crisis response program include a face-to-face interaction with the licensed mental health professional via an online HIPPA compliant application.

Most of the programs indicate that they do follow-ups between the therapist and youth/family; however, youth/families may opt-out of the follow-up. The currently funded programs administered by Heartland Family Services (Cass, Sarpy, and previously funded Otoe) have a 24 hour and 30-day follow-up. Another previously funded program in Saunders County indicated a 72-hour and 30-day follow-up.

CRISIS RESPONSE CASES ENTERED INTO JCMS

YOUTH DEMOGRAPHICS

Youth information is presented in Table 3 for each previously and currently funded program, except for the program in Red Willow that did not enter any cases during the two fiscal years it was funded. Most of the programs are serving approximately the same number of males and females, with a mean age of 14 or 15 (and some programs serving youth as young as 5 or 6).

Table 3. Demographic by Crisis Response Program

Program Name	County	Number of Youth	Percent of Youth	Female (%)	Age (*M*)	Age (range)
Heartland Family Service	Cass	67	10.7	50.7	14.2	6 to 18
KVC Nebraska	Douglas	17	2.7	29.4	16.3	16 to 17
Capstone Behavioral Health	Douglas	30	4.8	43.3	15.1	11 to 18
Safe Harbor	Lincoln	1	-	-	-	-
Heartland Family Service	Otoe	8	1.3	50.0	13.9	10 to 17
Heartland Family Service	Sarpy	479	76.6	53.0	14.1	5 to 18
Crisis Response Team	Saunders	22	3.5	72.2	15.4	11 to 18
Total		625	100	52.2	14.4	5 to 18

Note. KVC Omaha indicated after analysis that they only served 2 youth for Crisis Response; the 15 other youth were incorrectly entered as crisis response but were served by the Intensive Family Preservation (IFP) program. Because most of the data were missing for the remaining variables in this report, the 15 youth served by IFP were not included in the remainder of the analysis.

Table 4 displays the race/ethnic composition of the youth served across all programs. For comparison, we included the racial/ethnic 2019 population estimates from the United States Census (census.gov/quickfacts) for three of the counties with the most cases and the statewide. Compared to county and statewide estimates, there is over-representation of Black youth, and an under-representation of Hispanic and White youth served by CBA Crisis Response programs. Detailed race/ethnicity by program is available upon request but is not reported here due to some cells having smaller values (less than 5).

Table 4. Race/Ethnicity of Youth Served Across All Crisis Response Programs					
	JCMS	2019 U.S. Census Population Estimates			
		Cass County	Douglas County	Sarpy County	Nebraska
White	74.7	96.5	80.3	88.9	88.3
Black	11.7	0.7	11.4	4.3	5.1
Multiple Races	5.3	1.7	2.8	3.3	2.3
Hispanic	2.1	3.4	12.8	9.8	11.2
Other Race	0.9	-	-	-	-
American Indian, Alaska Native	0.6	0.6	1.2	0.7	1.5
Asian	0.6	0.5	4.2	2.6	2.7
Native Hawaiian, Other Pacific Islander	0.5	0.1	0.1	0.1	0.1
Missing/Unspecified	3.5	-	-	-	-
Total	100	100	100	100	100

LOCATION OF CRISIS AND PRESENTING SITUATION

One of the essential elements of a Crisis Response service according to SAMHSA is that the program meets the youth at the location of the crisis, as opposed to a facility (i.e., emergency room, other inpatient facility). As Table 5 displays, most calls were dispatched to the residence of youth across all crisis response programs. The next most common locations were schools, then community locations or other locations (i.e., family/friend residence, probation office).

Table 5. Location of the Call and Delivery of Crisis Response Services						
Program and County	Number of Cases[1]	Residence (%)	Community (%)	School (%)	JJC/JDC (%)	Other (%)
Heartland - Cass	67	71.6	11.9	13.4	0.0	3.0
KVC Nebraska - Douglas	2	0.0	0.0	50.0	0.0	50.0
Capstone - Douglas	2	50.0	0.0	0.0	0.0	50.0
Safe Harbor - Lincoln	0	-	-	-	-	-
Heartland - Otoe	8	37.5	25.0	0.0	0.0	37.5
Heartland - Sarpy	474	75.7	2.5	19.4	0.4	1.9
Crisis Response - Saunders	6	66.7	0.0	16.7	0.0	16.7
Total	415	74.2	3.9	18.4	0.4	3.0

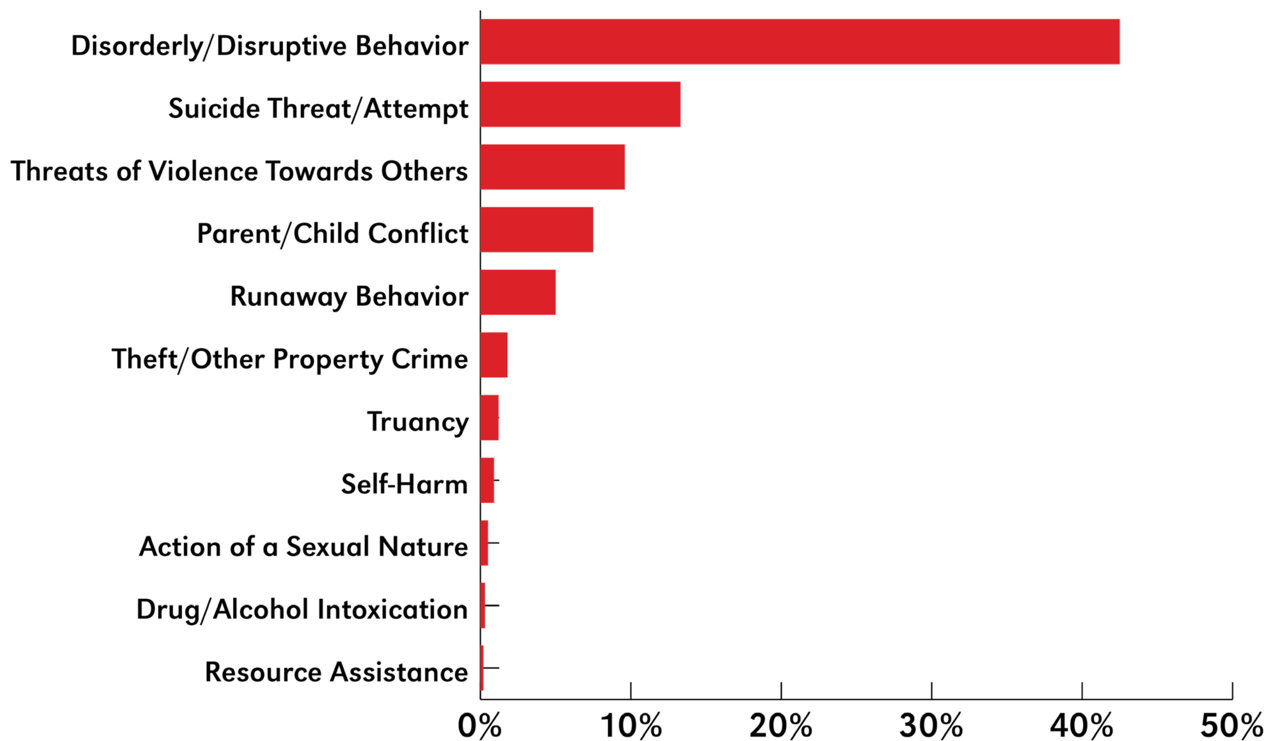
Note. [1] Location was not included for 66 (10.6%) of cases

Figure 1 displays the presenting situation as noted by the Crisis Response program staff (not as indicated to law enforcement during the initial call). While some of these presenting situations do not necessarily appear to be a "crisis" per se (e.g., resource assistance, truancy, action of a sexual nature, runaway), overall, it appears that the Crisis Response programs are being dispatched for crisis situations best handled by a mental health professional (e.g., disorderly/disruptive behavior, suicide threat/attempt, threats of violence to others). Moreover, some cases may appear to be less of a crisis as identified, because the crisis is "defined by the caller" and not law enforcement or clinicians. In other words, youth/families/school officials who called for assistance could very well feel in crisis, even if the presenting situation does not appear to be one on its face.
In addition, we also examined other characteristics of the presenting situation because research demonstrates

that youth are more likely to have justice involvement following a crisis situation when specific circumstances are present, including whether there were injuries, a weapon present, and what family members were involved (Wylie & Armstrong, 2018).

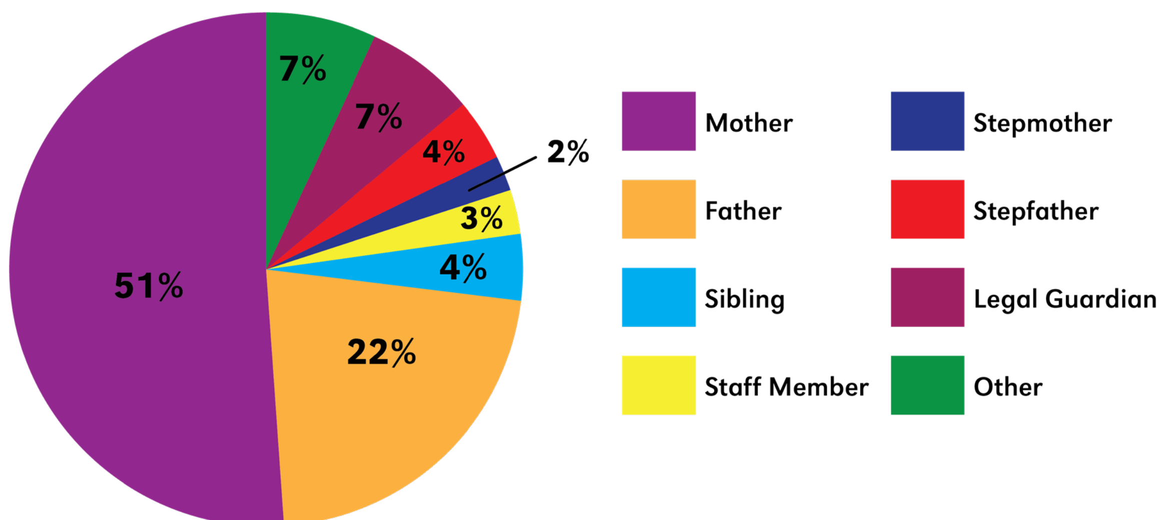
Data in JCMS for these variables were missing for earlier cases (prior to the design of the JCMS for this program type) but for the cases with data, most crisis situations did not result in an injury (90.1%; $n = 290$). Of those situations with an injury, it was most common for the youth to be injured (4.7%; $n = 15$), followed by the parent (1.9%; $n = 6$), both the youth and parent (1.9%; $n = 6$), or other (1.6%; $n = 5$). Furthermore, in 96.3% ($n = 311$) of situations there was no weapon present, but in 12 cases (3.7%) there was a weapon present.

FIGURE 1. PRESENTING SITUATION (%) AS DESCRIBED BY CRISIS RESPONSE PROGRAM



The most common person to be involved with the crisis situation was a mother (51%; $n = 214$), followed by father (22%; $n = 95$). Although less common, some situations also included siblings, stepparents, staff members, legal guardians, and others (see Figure 2).

FIGURE 2. WHO WAS INVOLVED IN THE PRESENTING SITUATION?



LAW ENFORCEMENT PARTICIPATION

One of the over-arching goals of crisis response programs is for law enforcement to utilize the services. Table 6 displays the law enforcement agencies within each jurisdiction that utilized any CBA-funded crisis response service. It also indicates the number of calls that originated from a helpline (Boystown and Nebraska's). In general, there appears to be consistent utilization across agencies – especially in Sarpy County—of both local and state law enforcement. If a law enforcement agency is not listed below but serves the county, the Crisis Response programs should work to strengthen relationships and training with those agencies to ensure service utilization.

Table 6. Law Enforcement Agencies Utilizing CBA-Funded Crisis Response

	County	Number of Youth	Percent of Youth
Cass County Sheriff	Cass	56	9.0
Juvenile Probation	Cass	2	0.3
Plattsmouth Police	Cass	14	2.2
Boys Town Family Hotline*	Douglas	2	0.3
Omaha Police Department	Douglas	1	0.2
Bellevue PD	Sarpy	125	20.0
Juvenile Justice Center	Sarpy	7	1.1
La Vista Police	Sarpy	52	8.3
Nebraska Family Help Line*	Sarpy	2	0.3
Nebraska State Patrol	Sarpy	1	0.2
Papillion PD	Sarpy	60	10.1
Sarpy Co Sheriff Dept.	Sarpy	220	35.2
Nebraska City PD	Otoe	8	1.3
Otoe Co Sheriff's Dept.	Otoe	1	0.2
Ashland PD	Saunders	3	0.5
Cedar Bluffs PD	Saunders	2	0.3
Saunders County Sheriff	Saunders	4	0.6
Wahoo PD	Saunders	4	0.6
Missing		58	9.3
Total		625	100

Note. * indicates non-law enforcement referrals from the Boys Town Family Hotline and the Nebraska Family Helpline

It is not clear from this data what is practiced in Douglas County, but crisis response services do not appear to be stemming from law enforcement contacts as is the case with the other programs. While we know that Region 6 (Cass, Dodge, Douglas, Sarpy, and Washington counties) did not receive grant funds from SAMHSA through NeSOC, only Cass and Sarpy counties are meaningfully utilizing CBA funds for crisis response, and Douglas County (and Dodge and Washington) are not.

It is unclear from the information how crisis services operate in Douglas, Dodge, and Washington counties, but perhaps these counties are served by agencies not funded by CBA or NeSOC. Although specific recommendations for Douglas County are beyond the scope of this report, in discussions with various stakeholders in Douglas County, it appears there is room for improvement on the referral and utilization of crisis response services.

LAW ENFORCEMENT AND CRISIS RESPONSE PROGRAM RESPONSE TIME

Another goal of crisis response is to reduce the time law enforcement is working with youth and families, and instead have youth and families working with a mental health professional. To examine law enforcement time on the scene, JJI contacted law enforcement agencies in Cass and Sarpy counties (i.e., for the programs that are currently funded) to request data. Although these fields are available for data entry in JCMS, JJI was told that these values are difficult to obtain from law enforcement by programs. We were able to gather law enforcement times for 343 of 479 (72%) cases in Sarpy County and 60 of the 67 (90%) cases in Cass County.

Table 7. Law Enforcement and Crisis Response Program Response Times

Program and County	Number of Cases	LE Time on Scene	CR Time to Scene	CR Time on Scene
Heartland - Cass*	67	2:20:14	0:31:44	1:10:00
KVC Nebraska - Douglas	2	-	-	3:30:00
Capstone - Douglas	4	-	0:22:30	1:07:30
Safe Harbor - Lincoln	0	-	-	-
Heartland - Otoe	8	-	0:14:52	0:57:22
Heartland - Sarpy	474	1:56:41	0:23:27	1:06:55
Crisis Response - Saunders	3	-	-	1:58:40
Total	558	2:00:12	0:24:32	1:07:57

Note. * Cass County began solely delivering telehealth services on (11/12/2019) to decrease response times but these data do not include cases prior to 9/29/19.

The crisis response programs also report the time they spend with clients and the time spent in collaboration with others on the scene. On average, the mental health professional spends approximately 45 minutes with youth and 25 minutes in collaboration with others (e.g., family members, law enforcement, others at the scene).

CRISIS SITUATION OUTCOMES

Once the crisis has been de-escalated, the mental health professional works with youth and families to develop a plan for crisis risk reduction. Data for whether a plan was made was missing for 10% ($n = 62$) of the cases. In approximately 99.8% of the cases with data, a plan was put into place on the scene ($n = 562$) and a plan was not put into place for 1 case.[2]

On average...

45 minutes were spent working with helping the youth on the scene.

In addition...

25 minutes were spent making a plan with family, law enforcement, and others on-site.

In most of the cases (92.9%; $n = 523$), a parent was involved in the plan, and the parent was not involved in 7.1% ($n = 40$). The data does not indicate any systematic reasons for lack of parent participation (e.g., location of the call) but because parent participation is so important, programs should examine ways to improve parent participation.

Next, we examined the final outcome for each case to see if programs are effectively keeping youth in the community. In most circumstances, the youth remained in the community or remained in the community with an intervention, such as an alternative to detention (EM, Tracker, etc.).

In this sample, only eight youth (1.4%) were placed out of home. Of those, two were placed out of the home as a detention alternative (i.e., group home or respite), five were brought to detention, and one was hospitalized under emergency protective custody (EPC).

Table 8. Crisis Situation Youth Outcomes

Program and County		Remained in Community	Remained in Community with Intervention	Out of Home Placement
Heartland - Cass	67	96%	0%	5%
KVC Nebraska - Douglas	8	88%	13%	0%
Capstone - Douglas	4	50%	50%	0%
Heartland - Otoe	8	100%	0%	0%
Heartland - Sarpy	479	99%	0%	1%
Crisis Response - Saunders	6	83%	0%	17%
Total	572	560	4	8

CONNECTION TO SERVICES AND FOLLOW-UP

After the crisis is de-escalated, a secondary goal of crisis response programs is to connect youth and families to appropriate services. The JCMS has fields for programs to enter referral information, including the type, agency, and whether the youth/family attended the referred service. Data was only available for 72 cases (76 referrals); therefore, we did not conduct additional analysis. We recommend that programs enter this data completely and identify whether youth/families are attending the services referred to better understand any barrier to referrals or connection to services.

Another recommendation is that programs conduct a follow-up to ensure youth/families are no longer in acute crisis and are taking steps to reduce the risk of future crises (see Table 9).

Program staff entered data for approximately 400 cases, but this data is missing for all programs with the exception of Heartland Family Services in Sarpy county. Of the data that was available for follow-up, there was little data on outcomes (i.e., whether youth/families contacted the referred service). In the future, programs should enter this data to get an accurate picture of service utilization.

Table 9. Follow-up after Crisis Situation

Program and County	Number of Youth	Percent of Youth
Heartland - Cass	49	12%
Capstone - Douglas	2	1%
Heartland - Otoe	8	2%
Heartland - Sarpy	338	84%
Crisis Response - Saunders	7	2%
	404	404

CONCLUSIONS & FUTURE DIRECTIONS

Overall, crisis response programs are effectively working with law enforcement, keeping youth in crisis in the community, and establishing crisis plans with youth. Although anecdotally we know that crisis response programs are making referrals to services, the data on this is not yet informative. The rate at which youth in this sample are being placed out of home is lower than what national research and NeSOC data indicate. A potential explanation for this is that youth referred to the CBA-funded crisis response programs are a different population than youth utilizing NeSOC crisis response services. It may be that our sample of youth were not experiencing mental health problems to the extent that youth utilizing the NeSOC services were, as evidenced by most NeSOC out-of-home placements were hospitalizations (see Table 1).

In addition to the data that is collected through JCMS, there are additional performance measures published by NAMI (Markey et al., 2011) to measure the effectiveness of crisis response services. In addition, SAMSA (2020) published a Crisis Service Best Practice Review Toolkit that provides crisis continuum performance measures to evaluate the community and system level factors that will assist any communities wanting to evaluate their current crisis continuum practices for improvement.

- **Are fewer youth getting discipline referrals in school?**
- **Are there fewer arrests and fewer youth entering the juvenile justice system to access services and supports?**
- **Are more youth getting referred to community mental health services and supports?**
- **Are crisis situations involving youth being resolved more safely and effectively?**
- **Do youth who encounter CIT for Youth officers ultimately experience improved behavioral and academic performance in school?**
- **Are law enforcement officers learning how to safely de-escalate a crisis and refer youth to services and supports? Do officers feel more prepared to effectively address mental health crises?**
- **Are schools seeing a reduction in discipline referrals and disruptions in the hallways and classrooms? Are they seeing an overall improvement in school climate?**
- **Are more youth with mental health needs being connected to and using mental services and supports?**

FOOTNOTES

[1] **While Region 6 (Cass, Dodge, Douglas, Sarpy, and Washington counties) does have crisis services (https://www.regionsix.com/services/crisis-services/), cases in Region 6 are not included because SAMHSA grant funds did not pay for mobile crisis response in Region 6.**

[2] **The presenting situation, in this case, was theft/other property crime and perhaps not a crisis situation that required a safety plan.**

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Juvenile Justice Institute
University of Nebraska Omaha
Phone: 402.476.0113
Email: unojji@unomaha.edu
juvenilejustice.unomaha.edu
jjinebraska.org