Law Enforcement & Behavioral Health Landscape in Nebraska

ADDRESSING GAPS & EXPLORING SOLUTIONS

Prepared by the National Criminal Justice Association

WRITTEN BY: Simone Greene & Elisa Nicoletti

October 2025

Table of Contents

Table of Contents continued

Acknowledgements

The National Criminal Justice Association (NCJA) appreciates the strong partnership and continued collaboration with the Nebraska Commission on Law Enforcement and Criminal Justice, commonly referred to as the Nebraska Crime Commission (NCC).

The authors are particularly grateful to NCC Executive Director Bryan Tuma, Director of Federal Grants and Programs Marcella Johnson and Director of Justice Programs Christine Carlile for their invaluable support. Their leadership in arranging and executing the surveys and focus groups that underpin much of this report, as well as their efforts to facilitate access to Nebraska's many criminal justice stakeholders, made it possible to gather the critical, firsthand insights that inform our findings. We also extend sincere thanks to the numerous stakeholders across Nebraska who participated in the NCJA–NCC criminal justice priorities survey and focus groups. This report would not exist without the knowledge, perspectives and observations they so generously shared.

Finally, we are tremendously grateful to those who reviewed and provided valuable advice on this report, including Allison Badger, Bethany Broida and Kellie Rabehnorst, and to Meg Lehman, who expertly designed this report.

The Authors

Simone Greene & Elisa Nicoletti

Executive Summary

This report, developed by the National Criminal Justice Association in partnership with the Nebraska Crime Commission (NCC), presents a comprehensive gap analysis of behavioral health needs in Nebraska, with particular attention to the intersection of behavioral health and the criminal justice system. During NCC's multi-phase strategic planning process to set priorities for Byrne Justice Assistance Grant (Byrne JAG) funding, behavioral health consistently emerged as a pressing concern. Given the overlap between Byrne JAG and Byrne State Crisis Intervention Program (Byrne SCIP) priorities, NCC and NCJA undertook this analysis to better understand statewide behavioral health needs and inform future funding decisions. Drawing on more than 250 survey responses, multiple focus groups, and supplemental data sources, including Sequential Intercept Model workshop reports and public health records, this report identifies critical service gaps and offers recommendations to guide resource allocation.

While this report highlights persistent and emerging challenges, it also recognizes the meaningful progress Nebraska has already made by investing significant resources into behavioral health and criminal justice initiatives. The following findings and recommendations are designed to help sustain that momentum, close critical gaps, and strengthen the state's capacity to respond effectively.

Most Significant Challenges

- Persistently high prevalence of behavioral health needs and workforce shortages, especially in rural areas where some counties struggle with severe prescriber/practitioner shortages.
- Rising suicide rates among adolescents with limited prevention, intervention and local treatment resources.
- Despite an overall decrease in unintentional drug overdose deaths, missed opportunities for intervention still exist.
- A lack of responses to address behavioral health emergencies, including hospital capacity, mobile crisis response team limitations, a lack of crisis stabilization centers, minimal detoxification, residential treatment centers and sober housing.
- There are limited culturally appropriate supports in place to serve growing immigrant populations.
- Transportation is a barrier for many individuals to access services, particularly those in the more rural parts of the state.

Continued on the following page →

Summary of Recommendations

- **Leverage Partnerships:** Build strong collaborations among hospitals, community organizations, schools, law enforcement and behavioral health providers. Share resources, improve referral pathways and coordinate discharge planning.
- **Expand Mobile Crisis Response:** Increase co-response teams, pairing mental health professionals with law enforcement, especially in rural areas. Implement Crisis Intervention Teams (CIT) statewide with specialized training and the involvement of people with lived experience. Use technology and virtual crisis response to address resource limitations in frontier/rural areas.
- **Expand Integration of Behavioral Healthcare into Primary Care:** Embed behavioral health professionals in primary care settings, particularly in rural clinics.
- **Expand Telehealth Access:** Increase telehealth services, especially in rural areas; invest in expanding broadband internet in underserved areas, possibly using models like Minnesota's broadband initiative. Provide telehealth kiosks in community centers, libraries and clinics to improve access.
- **Expand Peer Support Infrastructure:** Embed peer specialists in justice systems, crisis response, reentry programs and mobile crisis teams. Increase training, certification, and specialization tracks for peers. Educate stakeholders on the appropriate roles of peer support. Support peer workforce retention and promote diversity reflecting community demographics.
- **Prioritize Addressing Behavioral Health Workforce Shortages:** Use incentives such as loan forgiveness, bonuses, housing stipends and relocation assistance. Emphasize retention through professional development and supervision. Focus on increasing providers with prescriptive authority.
- **Increase Culturally Responsive Programming:** Build partnerships with trusted community organizations. Hire bilingual and bicultural staff, train providers on cultural responsiveness.
- **Coordinate Resources Across State and Local Agencies:** Regularly assess data to identify gaps and avoid funding duplication; coordinate opioid settlement dollars and other funding sources to maximize impact.
- **Enhance Transportation Services:** Invest in transportation support, especially in rural areas. Leverage existing informal transportation networks, such as faith-based community support.
- **Expand Problem Solving and Diversion Courts:** Implement or expand treatment and specialty courts addressing behavioral health needs. Incorporate peer support components into court programs.
- **Prioritize Youth Mental Health Through Prevention and Early Education:** Integrate evidence-based prevention programs in schools; increase school-based behavioral health staffing (counselors, social workers, psychologists); use screening tools to identify social-emotional needs early.
- **Develop Reentry Support Programs:** Establish structured reentry services for individuals leaving jail or treatment. Partner with probation, health departments and community organizations.
- **Provide Behavioral Health Training for Stakeholders:** Expand behavioral health training by standardizing CIT/CRIT for law enforcement and jail staff while balancing training demands, and by providing training to community members to strengthen local capacity.

Background

About the NCC

The Nebraska Commission on Law Enforcement and Criminal Justice (Nebraska Crime Commission, or NCC), was established to develop comprehensive plans and coordinate activities related to the improvement of criminal justice administration among state and local agencies. The NCC is responsible for the overall improvement of Nebraska's criminal and juvenile justice systems, as well as distributing federal and state grant funds. The NCC is the designated state administering agency (SAA) for the state of Nebraska. SAAs are entities within state and territorial governments responsible for accepting, planning and distributing federal funds. In its role as Nebraska's SAA, NCC is responsible for administering federal funding streams from the U.S. Department of Justice, including the Byrne Justice Assistance Grant (Byrne JAG) program and the Byrne State Crisis Intervention Program (Byrne SCIP). More information about Byrne JAG and Byrne SCIP can be found in **Appendices A and B.** In addition to acting as the SAA for several federal grants, the NCC also houses the Office of Violence Prevention and runs the Nebraska Law Enforcement Training Center.

About the NCJA

The National Criminal Justice Association (NCJA) is a nonprofit membership organization that works with state, local, and tribal governments across the criminal justice community. NCJA seeks to strengthen criminal justice communities and improve lives by empowering stakeholders through training, collaboration and advocacy. NCJA's core membership includes Byrne JAG administrators in addition to local criminal justice coordinating councils, students, universities and other criminal justice practitioners and stakeholders. NCJA also provides training and technical assistance with expertise in strategic planning, public safety best practices and grants administration as well as Byrne JAG, Byrne SCIP and the Victims of Crime Act grant program.

Project Background

As the SAA for Byrne JAG, the NCC is responsible for the creation of a comprehensive strategic plan to determine how best to allocate roughly $1.2 million in annual Byrne JAG funding. As part of its strategic planning process, Nebraska must engage in several strategic planning actions, which include consulting with a diverse set of stakeholders and reviewing relevant data to determine priorities and allocations. In early 2024, NCJA began working with the NCC to assist in its strategic planning process by assessing the state's needs and priorities, as identified by criminal justice stakeholders. Working closely with the NCC, the NCJA developed, administered and analyzed a comprehensive Byrne JAG Justice System Needs Assessment Survey that was disseminated to justice system stakeholders throughout the state from May to September 2024. Over 250 criminal justice stakeholders from 90 Nebraska counties responded to the survey. The survey analysis revealed that the most pressing needs, according to respondents, revolved around the following issues: behavioral health (including mental health), juvenile justice and reentry, technology infrastructure and data sharing, workforce recruitment and retention

and community-based crime prevention. The full survey analysis is available **here,** and an overview of the survey analysis is in **Appendix C.** After reviewing the results and themes of the survey, NCJA conducted a series of focus groups to delve further into the issues identified in the stakeholder survey. In April 2025, NCJA conducted four 90-minute focus groups with a range of stakeholders in both North Platte and in Lincoln. The focus groups were guided by the themes that emerged from the survey analysis, and upon completion, were analyzed for key themes and insights. The full focus group analysis is available **here,** and a brief overview of the focus group analysis is in **Appendix D.** One of the most prominent, recurring themes that arose during each focus group was the need for behavioral health services across the state.

In addition to the creation of a comprehensive strategic plan for Byrne JAG, states must also develop a program plan and engage a Byrne SCIP advisory board for Byrne SCIP funding. While Byrne JAG can fund a variety of program areas (including behavioral health and state crisis intervention programs), Byrne SCIP's focus is a bit more narrow focusing on programs that prevent and address behavioral health crises. Byrne SCIP funding can support specialized court-based programs, referrals to community-based services for people in crisis and law enforcement crisis intervention initiatives, among other things. The Byrne JAG strategic planning process highlighted behavioral health as a key theme, emphasizing the importance of dedicating resources to address this need. With this in mind, NCC and NCJA staff discussed the possibility of conducting a gap analysis to understand both general gaps in the Nebraska behavioral health system and gaps at the intersection of behavioral health and the criminal justice system to better inform other funding streams, including Byrne SCIP.

Goals of and Approach to the Analysis

Utilizing data from a variety of sources, including the qualitative data from the previously mentioned Byrne JAG Justice System Needs Assessment Survey and Stakeholder Focus Groups, and publicly available data, this analysis seeks to reveal both general gaps in the behavioral health system and gaps at the intersection of behavioral health and the criminal justice system. After the gaps are articulated, the analysis includes recommendations about how these gaps might be addressed. To maximize its usefulness, wherever possible, recommendations in the analysis will be made both generally and specifically within a particular geographic area or **Behavioral Health Region.**

NCJA's approach to this analysis was shaped by:

1. the breadth and scope of data available and
2. the agreed-upon goals of the analysis.

Over the past several years, the NCC has championed multiple efforts to develop a better understanding of both the extent of behavioral health issues, including the nexus of behavioral health and the criminal justice system, and to some extent, the availability of resources related to addressing behavioral health issues across the state. To that end, this gap analysis is informed by a wealth of data that has already been collected as a result of these efforts. In addition to the previously mentioned data sources (the Byrne JAG Justice System Needs Assessment Survey and the Stakeholder Focus Groups), this analysis includes a review of numerous Sequential Intercept Model (SIM) Workshop reports, as well as a review of region and public health agency annual reports, media and Law Enforcement Listening Sessions Tour data. Quantitative data sources are utilized throughout the analysis to provide additional clarity and context and are specified throughout.

Nebraska's Landscape:

Demographics, Trends, and Regional Perspectives

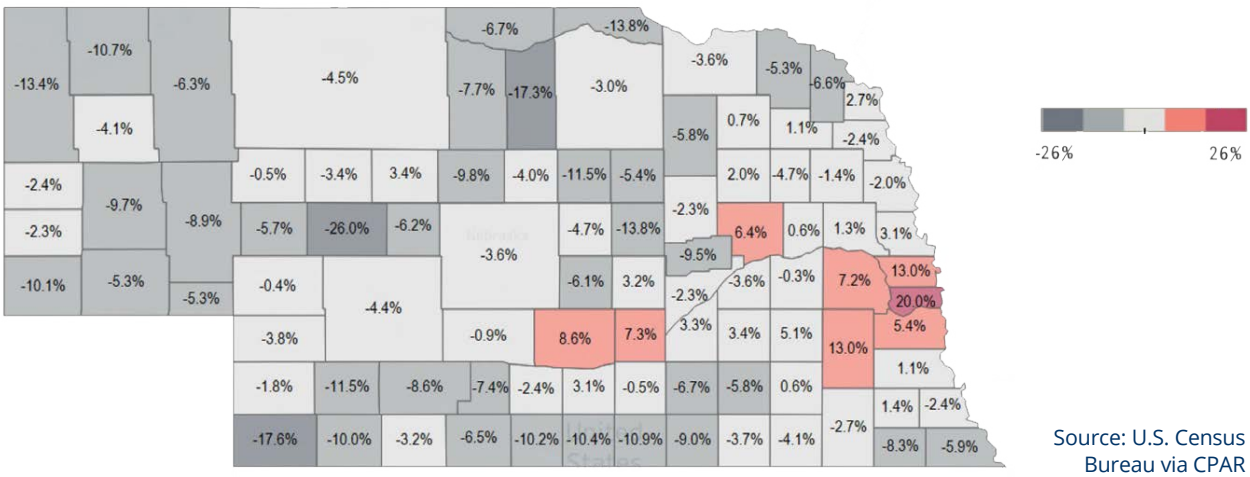
Demographics and Geography

The Nebraska has a population of just over 2 million people who live within 93 counties. Nearly 50 percent of Nebraskans live in Douglas or Lancaster counties, home to Omaha and Lincoln, respectively. While Nebraska is the 38th largest state by population, it is the 15th largest state by land, covering over 77,000 square miles. The state is largely rural, with 69 of Nebraska's 93 counties considered rural according to U.S. Census data. There are 34 counties within the state that are considered frontier. Additionally, Nebraska is neighbored by six states (South Dakota, Iowa, Missouri, Kansas, Colorado and Wyoming), which bring unique challenges and opportunities. According to the Nebraska Commission of Indian Affairs, Nebraska is also home to four federally recognized tribes: Omaha Tribe, Ponca Tribe, Winnebago Tribe, and Santee Sioux Nation[i].

The U.S. population grew by nearly 1.0 percent between 2023 and 2024, according to the Vintage 2024 population estimates released by the U.S. Census Bureau in December 2024. Census data indicates that the Midwest, which includes Nebraska, increased by 3.1 percent[ii] and Nebraska was the second fastest-growing state within the Midwest region[iii].

Nebraska is seeing an increase in its nonwhite population, growing 82 percent from 2010 to 2020 – representing 19.5 percent of the total population. Further, according to the U.S. Census, Nebraska has experienced shifts in its age composition. As of 2020, 15.7 percent of the population was 65 and over, a 17 percent increase from 2010. Looking ahead, the U.S. Census Bureau and the University of Nebraska Omaha Center for Public Affairs Research projects that the 65-and-over population will experience a 29.7 percent increase in population by 2030[iv]. When considering behavioral health, these demographic shifts can have significant implications both on the workforce and for healthcare delivery[v].

PERCENT CHANGE IN POPULATION BY COUNTY (2010–2020)



Source: U.S. Census Bureau via CPAR

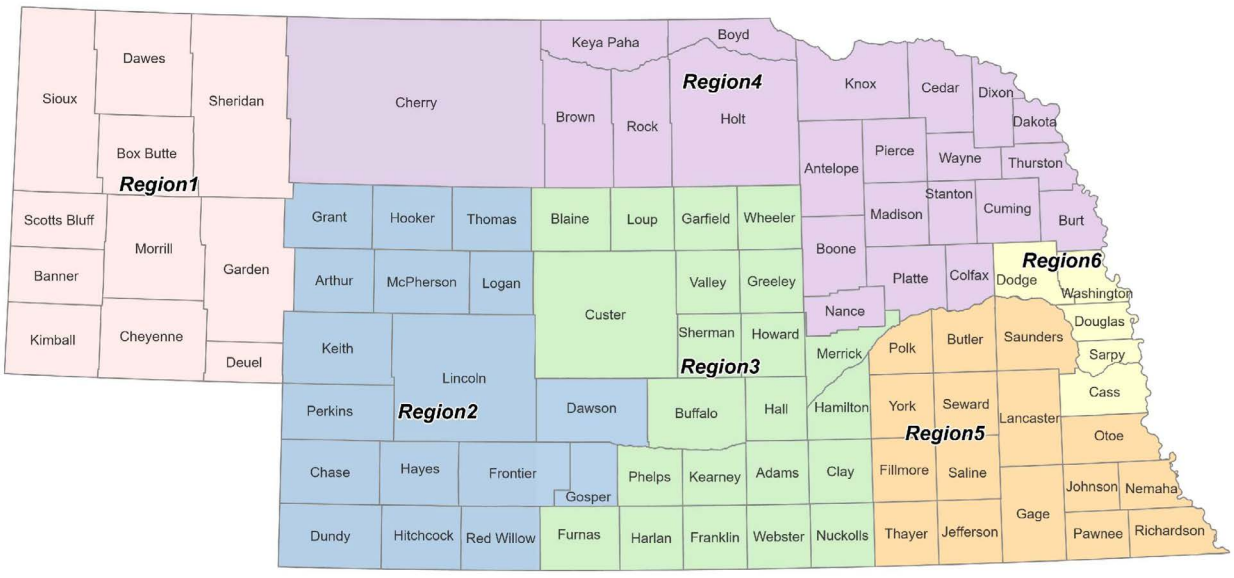
Further, the map on the previous page highlights counties with particularly significant increases in population from 2010 to 2020. From west to east, Buffalo, Hall, Platte, Saunders, Lancaster, Douglas, Sarpy and Cass all had significant growth. Notably, Sarpy County demonstrated a 20 percent increase in population growth over the period[vi]. This population growth has the potential to significantly impact the county's resources, particularly in the areas of housing, transportation, employment, healthcare and other essential services.

Statewide Behavioral Health Overview

Behavioral Health Regions in Nebraska

The Nebraska Division of Behavioral Health is the state's single authority for mental health and substance use disorders. The Division directs the administration and coordination of the public behavioral health systems in providing services to individuals who do not have private insurance and are not eligible for Medicaid. Nebraska is split into six behavioral health "regions," which are local units of government that purchase services from providers in their area[vii]. The regions play a critical role in planning, funding and coordinating a range of behavioral health services, including crisis response, community support, prevention and treatment. They also act as conveners, bringing together local providers, law enforcement, courts and other community partners to identify needs and develop solutions tailored to the unique characteristics of their geographic area. In this way, the regional system provides flexibility to address local challenges while ensuring statewide alignment with the Division's broader behavioral health goals. The map below shows the regions and will be referenced throughout this report. Later in this report, **a dedicated section** highlights the specific strengths, challenges and nuances of each region to provide a more detailed understanding of how behavioral health needs are addressed across Nebraska.

NEBRASKA BEHAVIORAL HEALTH REGIONS



Behavioral Health Snapshot

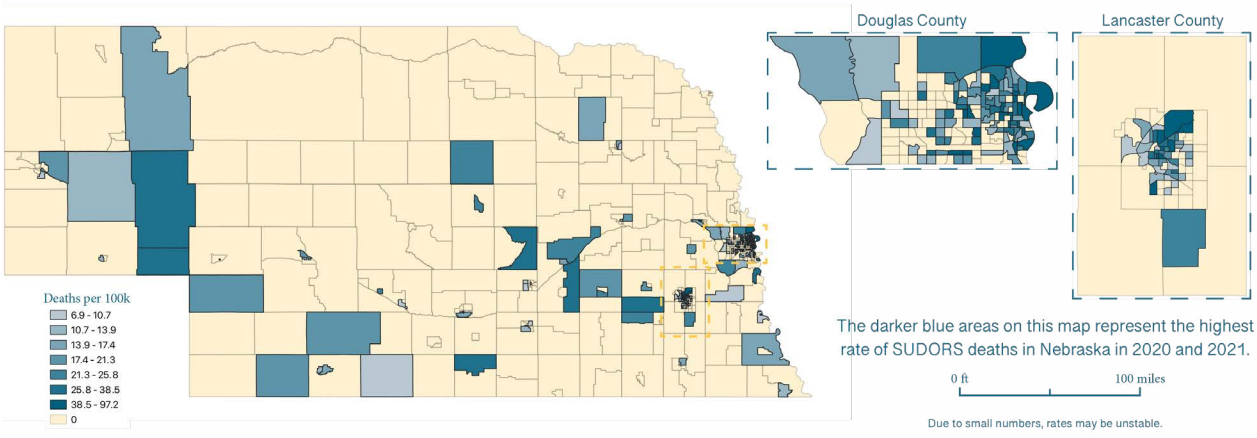
According to the National Alliance on Mental Illness, 1 in 4 people in Nebraska live with a serious mental illness. Suicide deaths in Nebraska increased between 2016 and 2019. After a brief decline in 2020, suicide numbers continued to increase in 2021 and 2022. In Nebraska, suicide is the leading cause of death for individuals ages 10–14 years, the 2nd leading cause of death for individuals age 15–24 years, and the 10th leading cause of death overall in Nebraska.

Nebraska has 10 state prisons and 63 county jails throughout the state. It is estimated that at least 2 in 5 adults in Nebraska's jails or prison have a history of mental illness. Nebraska operates two state-run psychiatric hospitals, referred to as Regional Centers, located in Lincoln and Norfolk. These facilities provide care for individuals under mental health commitments, as well as those determined by the court to have a serious and persistent mental illness (SPMI) and who are not appropriate for placement in a correctional setting. Additionally, Nebraska faces a six-month backlog for mental health competency evaluations.

In 2022, Nebraska recorded 225 drug overdose deaths, a rate of 11 per 100,000. That number decreased to 172 in 2023. While these numbers are well below the national average, and the decrease is encouraging, the numbers still represent preventable deaths. CDC data indicates that there was an opportunity for intervention in just over half of all the Nebraska overdose deaths that occurred in 2023. Specifically, of those who died from an overdose, 5.4 percent were being treated for substance use disorder(s), 26.4 percent had evidence of a mental health diagnosis, 14 percent had a previous nonfatal overdose, and 6.2 percent were recently released from an institutional setting. These missed opportunities are further evidence of gaps in the behavioral health system that the state seeks to address.

The Centers for Disease Control highlights the geographic dispersion of unintentional drug overdoses documented in Nebraska in 2020 and 2021[viii].

SUDORS DEATH RATE BY CENSUS TRACTS



Additionally, data indicate that decedent characteristics across behavioral health regions vary in several important ways. First, those who died from a drug overdose in Region 5 experienced homelessness or housing instability at a higher rate (24 percent) than those in Region 6 (15 percent) or Regions 1–4 (10 percent). Those who died from

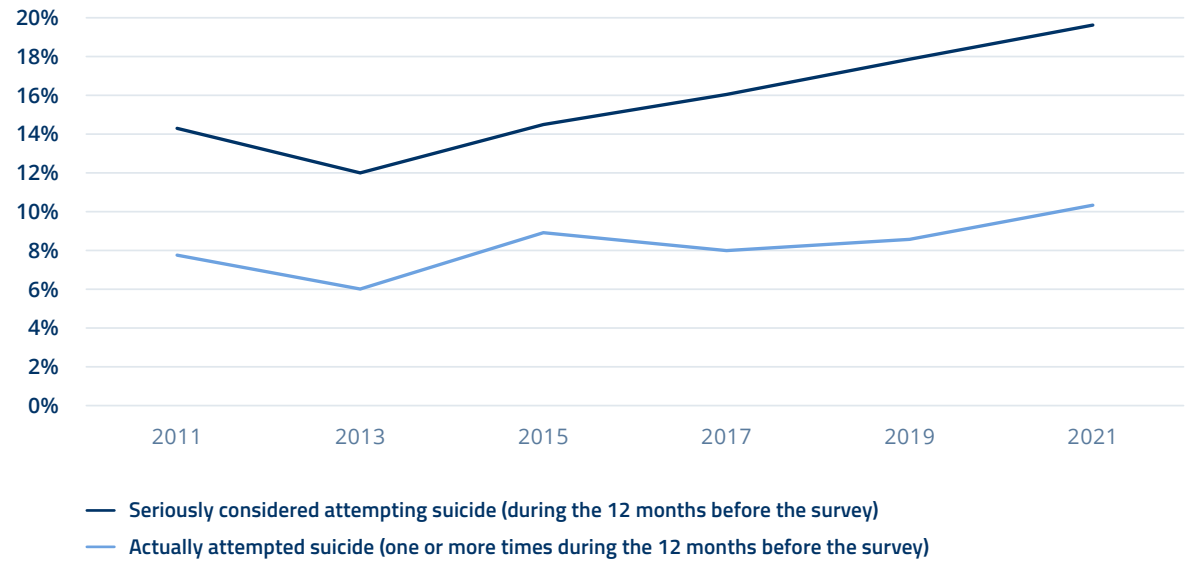
a drug overdose in Region 5 also had a significantly higher rate of historical overdose — 31 percent compared to 9 percent in Region 6 (data was not available for this measure for Regions 1–4). Finally, those who died from drug overdose in Region 5 also had a significantly higher rate of historical suicide attempts than Region 6 (data was not available for this measure in Regions 1–4) — 14 percent compared to 3 percent. These data suggest that Region 5 has higher needs in these key areas compared to the other behavioral health regions[ix x xi]. It is also worth pointing out that the state's primary prison facilities are in Lincoln, and anecdotal evidence suggests that when individuals are released from custody, they often lack the resources to return to the communities they lived in prior to their incarceration. These individuals often end up staying in Lincoln with few supports, both in terms of finances and family/community.

Youth Behavioral Health

In the Justice System Needs Assessment Survey conducted in 2024 as well as the subsequent focus groups, issues related to youth services and resources consistently came up. Specifically, focus group participants noted rising rates of behavioral health issues. According to the Nebraska Department of Health and Human Services (DHHS), the percentage of students reporting persistent feelings of sadness or hopelessness increased from 21 percent in 2011 to 27.2 percent in 2023, underscoring an upward trend in youth behavioral health challenges. Further, data from the Centers for Disease Control (CDC) demonstrate a slight uptick in suicidality among high school-aged adolescents over a ten-year period.

SUICIDALITY AMONG HIGH SCHOOL-AGED YOUTH IN NEBRASKA

Source: CDC YRBS data 2011–2021

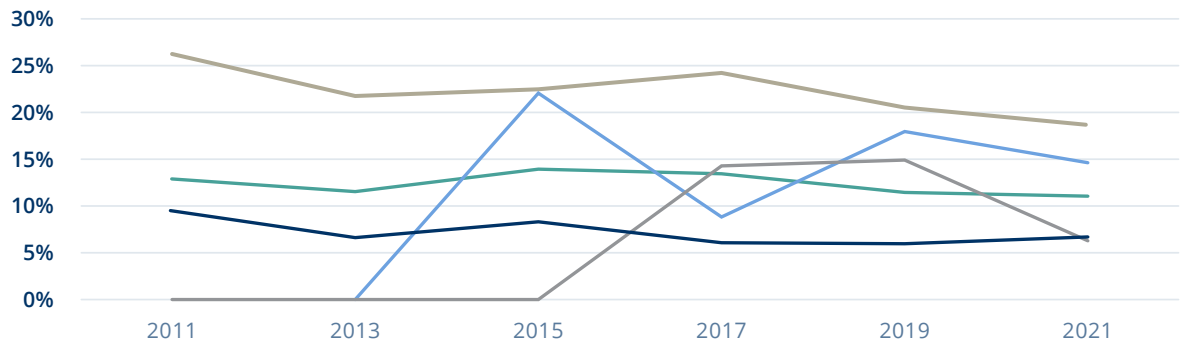


Youth behavioral health services in Nebraska are also limited. The National Survey on Children's Health estimates that less than half (47.6 percent) of youth needing mental health counseling received it in 2022. Additionally, focus group participants noted that there are no inpatient treatment facilities for youth in Western Nebraska, causing youth to be sent to Omaha, Lincoln or out of state for services, where they have few support systems.

Focus group participants also indicated that substance use among youth is a significant problem across the state. Stakeholders indicated that youth as young as middle-school age use vapes, hallucinogens such as psilocybin (often in the form of chocolates), galaxy gas and opiates, which can include fentanyl. The most recent data available from the Center for Disease Control's High School Youth Risk Behavior Survey (YRBS) indicates that overall, substance use has mostly remained steady or saw a slight decrease between 2011 and 2021. The exception to this is that after a considerable jump in the use of vapes between 2017 and 2019, vape use decreased between 2019 and 2021[xii]. More recent data from the fiscal year 2024 Nebraska Department of Health and Human Services Division of Behavioral Health Annual Report highlights that the number of high school students who reported that they were vaping in the past month has decreased from 17 percent in 2023 to 7 percent in 2024, an indication that prevention and intervention programs may be having a positive impact. For instance, one focus group participant shared that youth in one jurisdiction are working with law enforcement on issues related to vaping and have even testified in front of the state legislature in an effort to elevate the issue.

SUBSTANCE USE AMONG HIGH SCHOOL-AGED YOUTH IN NEBRASKA

Source: CDC YRBS data 2011–2021



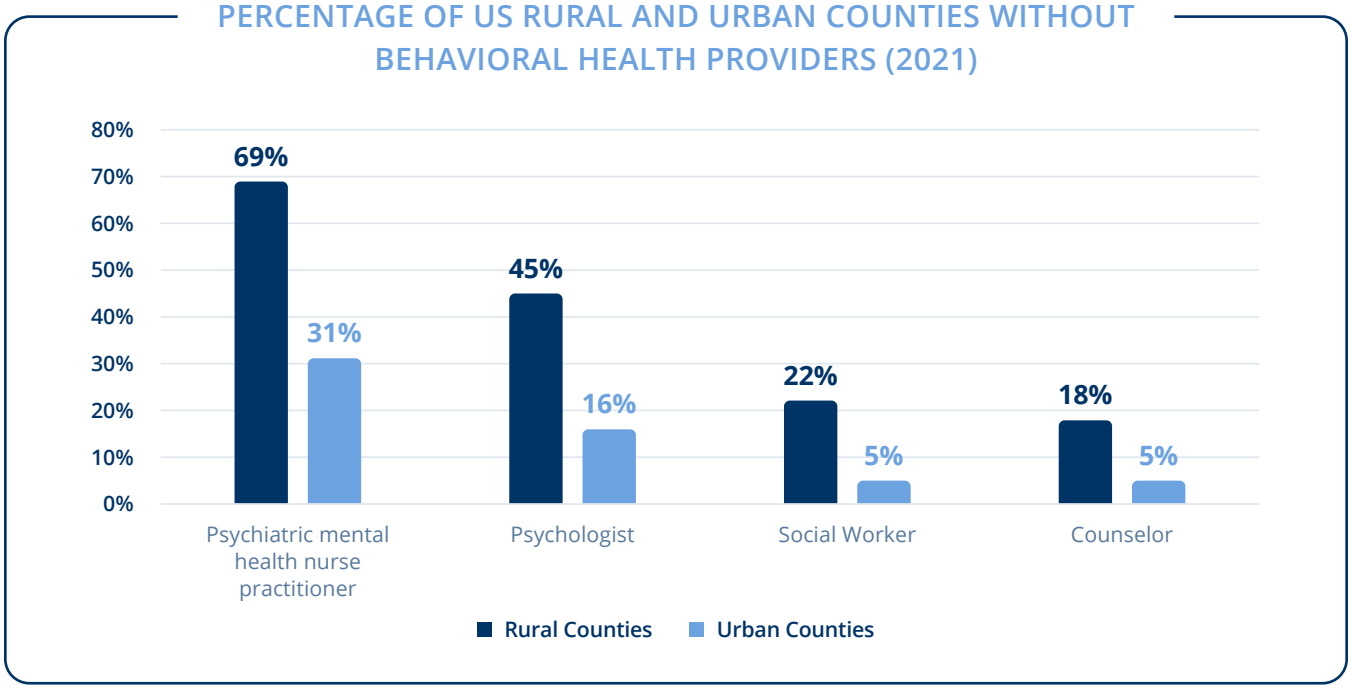
Schools are uniquely well-situated as a place for access to early intervention and/or prevention programming for adolescents, given that they have a captive audience, so to speak. School resource officers, counselors and school social workers often serve in these capacities where possible. Targeting intervention services for schools in areas with higher rates of observed substance use and higher mental health needs would be beneficial.

In focus groups, when participants were asked what they would fund if they could 'wave a magic wand,' many chose prevention and education programs. Further, throughout the focus groups, participants emphasized

the importance of engaging schools as part of the solution and highlighted the potential of School Resource Officers (SROs) to build meaningful relationships with students and serve as valuable resources for teachers and administrators. They offered anecdotal reports of the important impact SROs are having in communities. However, they also noted that in many areas of the state, SROs are either unavailable or stretched across multiple schools, limiting their effectiveness. Without adequate social support staff, SROs are often left to fill counseling roles for which they are not trained. Overall, participants agreed that schools are doing the best they can with limited resources, but additional funding and staffing, particularly for SROs and other support roles, are needed to provide stronger support for students.

Behavioral Health Provider Trends

There is strong evidence that the United States is undergoing a crisis in the availability of behavioral health care for those who need it. According to the National Center for Health Workforce Analysis, the U.S. is experiencing a mental health crisis with increased levels of unmet behavioral health needs among people of all ages. As of August 2024, more than one-third (122 million people) of the U.S. population lives in a mental health professional shortage area[xiii]. Further, rural counties are more likely than urban counties to lack psychiatric mental health nurse practitioners, psychologists, social workers and counselors[xiv xv xvi xvii].



A host of factors affect the ability of the behavioral health workforce to provide quality care. They include, but are not limited to, cost, reimbursement, insurance coverage, burnout and turnover rates within the workforce.

The accessibility of behavioral health services is limited by reimbursement barriers. Low reimbursement rates and administrative barriers have been cited as the main reasons mental health providers choose not to participate in insurance plans[xviii xix xx]. Compared to physical health providers, behavioral health providers are significantly less likely to participate in insurance plans and require payment at the time of service. In many states, primary care

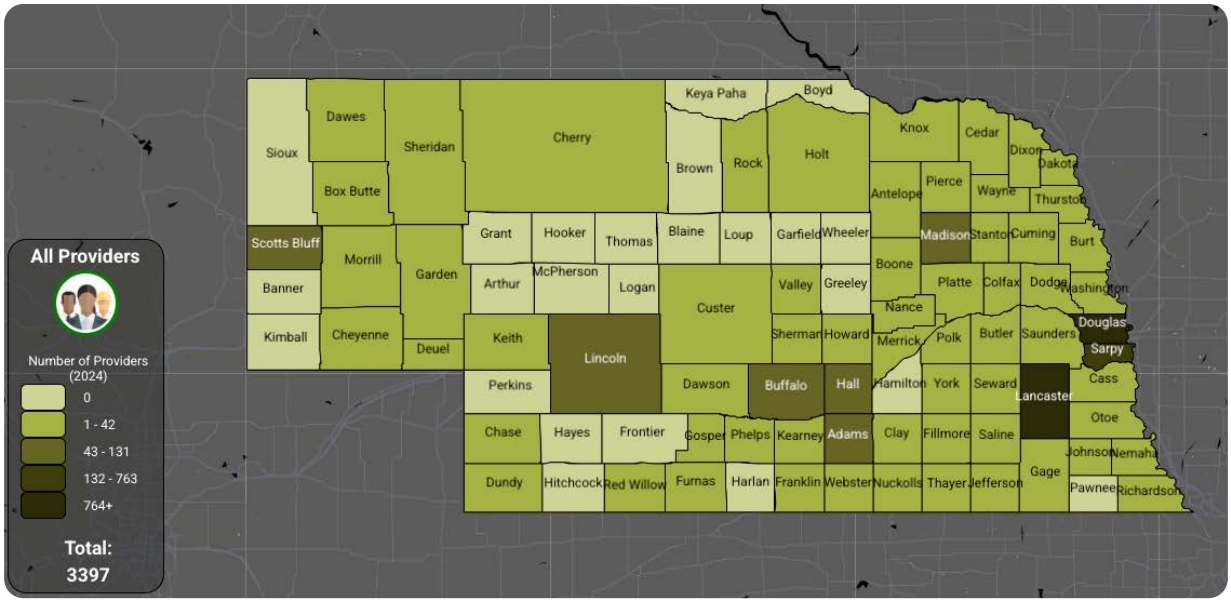
physicians have higher reimbursement rates than psychiatrists for the same behavioral health services[xxi]. On a positive note, 2024 Medicare payment reforms have now increased coverage of services provided by community health workers and peer providers[xxii]. High turnover rates also contribute to the shortage of behavioral health workers, and unfortunately, evidence suggests that the turnover rate is higher in rural areas[xxiii].

The use of telehealth services has no doubt risen and remained strong since the COVID-19 pandemic[xxiv xxv xxvi]. Despite some potential barriers to successful implementation of telehealth services, such as a lack of high-speed internet access, smartphone ownership and low demand for telehealth services in some places, its use can help overcome accessibility barriers to behavioral health services for individuals in underserved and rural areas specifically.

Nebraska is experiencing the same practitioner shortages seen nationwide. Eighty-eight of Nebraska's 93 counties are designated mental health shortage areas by the U.S. Health Resources and Services Administration. Although the state has seen a 44 percent increase in the number of practitioners since 2009, there is still a significant shortage across the state[xxvii]. This was further validated during the Law Enforcement Listening Sessions State Tour that occurred in 2024; 70 percent of counties surveyed indicated that "mental health resources in most areas of the state simply don't exist" (See **Appendix E** for the full Listening Session dataset). Similar sentiments were expressed during the April 2025 stakeholder focus groups.

As indicated in the map below showing the extent of provider coverage in 2024, the highest concentrations of mental health practitioners are present in Douglas and Lancaster counties (where there are over 764 practitioners in each county), and in Sarpy County, where there are between 132 and 763 practitioners. Madison, Hall, Adams, Buffalo, Lincoln and Scotts Bluff follow with between 43 and 131 providers in each county. The counties across the remainder of the state have 42 or fewer providers in each one, including 29 counties with no behavioral health provider of any kind[xxviii].

PROVIDER COVERAGE, 2024



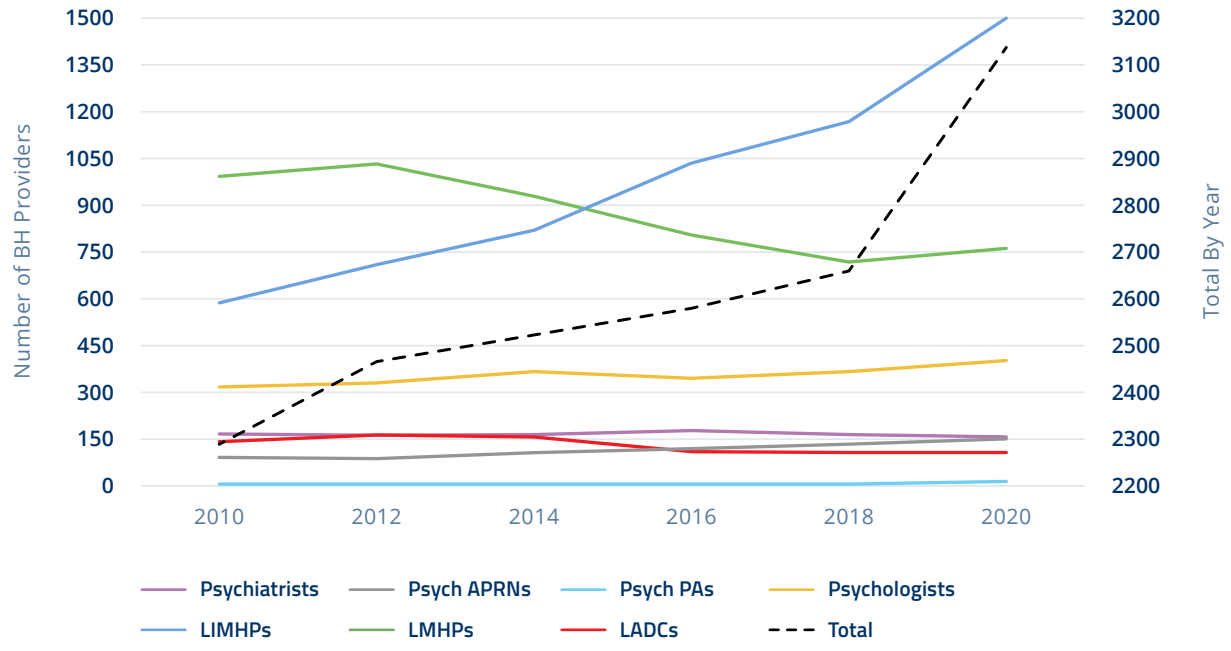
Rural communities are especially hard hit by workforce shortages, particularly prescribers. The table below shows the sharp discrepancy between rural and urban providers[xxix].

NEBRASKA PROVIDER SUPPLY IN 2020 (per 100,000 residents)

PROVIDER TYPE	URBAN NEBRASKA	RURAL NEBRASKA
Psychiatrists	11.8	3
Psychiatric Nurses (APRN)	6.3	8.3
Psychiatric Physician Assitants (PA)	1.5	0.4
Psychologists	27.9	8.7

Despite the disparities in resources between urban and rural areas, overall, the actual number of behavioral health providers has increased over time. The graph below shows the trends in the number of behavioral healthcare providers of all types over time[1]. The total number of providers has increased significantly over the ten-year period, driven primarily by the massive increase in the number of Licensed Independent Mental Health Practitioners (LIMHPs). The number of LIMHPs increased from 600 in 2010 to 3,200 a decade later[xxx].

NEBRASKA BH PROVIDERS TRENDS



[1] The term "behavioral health provider" in this case includes psychiatrists, nurse practitioners, physician assistants, psychologists, licensed independent mental health practitioners, licensed mental health practitioners, and licensed alcohol and drug counselors.

Statewide Investments and Initiatives

While not meant as a comprehensive list of the investments Nebraska has made in addressing behavioral health challenges, the following section provides an overview of noteworthy initiatives.

ADDRESSING THE SHORTAGE OF BEHAVIORAL HEALTH PROVIDERS

In 2009, the Behavioral Health Education Center of Nebraska (BHECN, pronounced "beacon") was established by the Legislature and housed at the University of Nebraska Medical Center. BHECN was charged with leading state behavioral health workforce development efforts, including the recruitment, training and retention of behavioral health workers. BHECN is a tremendous resource for the state and has taken considerable steps to address the workforce shortage. In fact, BHECN is a national leader in behavioral workforce analysis and research because it is one of the few organizations that collects and explores this type of data. The organization focuses on innovative ways to increase the number of behavioral health practitioners and address the state's workforce needs.

Strategies include introducing and connecting young professionals to behavioral health careers while also supporting those already in the field by providing training and other resources. Training opportunities include topics such as recruitment, retention, using data to support the behavioral health workforce, how state policy can support the behavioral health workforce and webinars specific to the unique considerations of rural Nebraska.

Additionally, in 2022, the Nebraska legislature passed LB1014, which allocated American Rescue Plan Act (ARPA) funding to the BHECN, which then allocated funds through a request for proposal process to various entities across Nebraska. **Four specific areas of need were outlined in this legislation:**

1. behavioral health training opportunities,
2. telebehavioral health expansion in rural areas,
3. funding for workforce projects related to the COVID-19 pandemic and
4. funding for the supervision of provisionally licensed providers.

In total, 67 unique organizations (and 105 programs) received funding, and all 93 counties were served by at least one award recipient. The complete list of programs that received funding is available in **Appendix F.** Recipients were selected by July 2023, and the dollars will be dispersed through 2025.

While Nebraska, like other states, still has gaps to fill when it comes to behavioral health workforce shortages, there has been significant progress. BHECN has been a tremendous asset to Nebraska, and it is worth noting that other states that have legislation requiring the exploration of the behavioral health workforce shortage have modeled their work on BHECN. For example, both Nevada and Connecticut have consulted with BHECN as they began discussions around creating behavioral health workforce centers in their states.

INTEGRATED BEHAVIORAL HEALTH PROFESSIONALS

Recently, there has been a growing effort to integrate behavioral health services into primary care settings, and vice versa, and there is a significant body of work indicating the benefits of this integration[xxxi xxxii xxxiii]. In rural areas in particular, this is one of the most meaningful ways to reduce the barriers of access to behavioral healthcare. Establishing on-site or consulting behavioral health professionals in primary care clinics, allowing behavioral health issues to be treated where they often first arise, has changed the access landscape. In Nebraska, as of 2021, 40 integrated behavioral health/primary care centers have been established across the state: 25 serve rural areas and 15 serve urban areas[xxxiv].

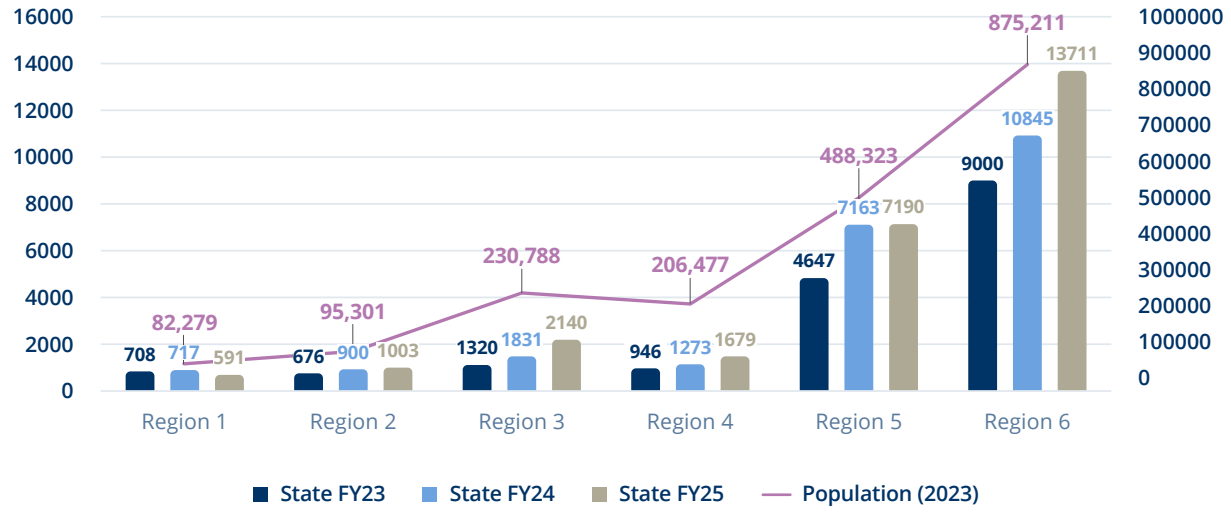
USE OF 988 AND MOBILE CRISIS RESPONSE

In 2020, Congress designated the new 988 dialing code to be operated through the existing National Suicide Prevention Lifeline. According to the Nebraska Department of Health and Human Services, 988 calls are routed through Vibrant Emotional Heath, the administrator of the 988 line, based on the caller's area code. If a call is not answered within a few seconds due to call volume or wait time, it is routed to the National Back-Up Center[xxxv]. If needed, a Mobile Crisis Response (MCR) team can intervene wherever the crisis is occurring, and teams often work closely with the police, crisis hotlines and hospital emergency personnel. Mobile teams may provide pre-screening assessments or act as gatekeepers for inpatient hospitalization and can also connect an individual with community-based programs and other services[xxxvi].

Mobile Crisis Response is only activated when the caller consents to the service; if the caller refuses MCR and the crisis counselor is concerned about the caller's safety, then Emergency Services may be activated instead. According to the FY 2024 Department of Behavioral Health, there were a total of 326 MCR activations within the state during FY 2024[xxxvii]. Additionally, 74 percent of 988 referrals to MCR resulted in the individual remaining in their residence or community, and 57 percent of 988 referrals to MCR reported feeling better at the status check. As seen in the figure below, except for Region 1, across all 6 behavioral health regions, the 988-call volume has generally increased over time.

Further, calls to 988 have generally increased since the fiscal year 2023. The increase in call volume in Regions 5 and 6 is particularly noteworthy — with a 55 percent increase in call volume from FY23 to FY25 in Region 5, and a 52 percent increase over the same period in Region 6. This trend aligns with what is known about the higher rate of historical suicide attempts in Region 5.

NEBRASKA 988 CALL VOLUME ACROSS REGIONS STATE FISCAL YEARS 2023–2025



PROFESSIONAL PARTNER PROGRAM (PPP)

The Professional Partner Program (PPP) is available in regions across the state. The Professional Partner Program utilizes a four-step wraparound approach that brings together a team of supportive individuals to aid each child, youth or young adult in the development and facilitation of a comprehensive service plan. The approach focuses on strengthening community connections and stabilization within the home and is strength-based, team-based, and community-based, providing creative opportunities to meet each youth and family's individualized needs. Throughout the state, program outcomes demonstrate measurable impact: with youth enrolled in PPP showing reductions in indicators of recidivism, underscoring the effectiveness of coordinated, individualized support for children and adolescents with behavioral health challenges.

CIT & CO-RESPONDER MODELS

Crisis Intervention Teams (CIT) and Co-responder Teams, though structured slightly differently, both address the need for appropriate behavioral health supports in scenarios when law enforcement officers respond to a scene where someone is undergoing a behavioral health emergency. CIT and Co-responder Teams have gained increasing popularity with law enforcement departments as behavioral health emergencies have risen over time.

Crisis Intervention Teams are teams of law enforcement officers who have received specialized training on how to identify people with mental health needs and respond to people who are experiencing behavioral health crises. CIT provide a strong foundation for law enforcement's response to individuals experiencing a behavioral health crisis. The CIT training helps officers bridge the gap between their response and behavioral health care. In 2019, the University of Memphis CIT Center reported that there were over 2,700 CIT programs within the U.S.[xxxviii].

Co-responder Teams are teams of police officers paired with mental health staff to respond to individuals who are experiencing behavioral health crises. The exact structure of these teams may vary, including the types of calls they respond to, the types of mental health staff they deploy (e.g., peers, social workers), whether the officer and the clinician respond to scenes together, separately, or the clinician is available virtually and more. While models vary in practice, communities and local leaders can use the model to develop a continuum of crisis care that results in the reduction of harm, arrests and use of jails and emergency departments, and that simultaneously promotes the development of and access to quality mental and substance use disorder treatment and services[xxxix].

Nebraska has already implemented several CIT and Co-responder programs and is a leader in this type of programming. Heartland CIT was formed in 2006 and operates in Region 6. The **REAL program,** which has been in operation since 2011, has been featured by the Substance and Mental Health Services Administration as a model program that uses peer staff to provide free, voluntary, and non-clinical, which has been in operation since 2011, has been featured by SAMHSA as a model program that uses peer staff to provide free, voluntary, and non-clinical support to individuals that have been identified as having a mental health concern[xl]. More recently, in March 2025, the Lincoln PD (LPD) launched a co-responder program in partnership with CenterPointe. As of April there were three co-responder teams. The first three years of the co-responder program are funded by a BJA grant with a match from the city's budgeted general funds[xli].

LAW ENFORCEMENT TRAINING

The Nebraska Law Enforcement Training Center (NLETC), located in Grand Island, serves as the state's central academy for training and certifying law enforcement officers. NLETC is overseen by the Nebraska Crime Commission and plays a critical role in ensuring professional standards are met consistently across Nebraska's law

enforcement agencies, from urban police departments to small rural sheriff's offices. All full-time law enforcement officers in the state are required to complete the academy's basic training program, which includes instruction in criminal law, firearms, defensive tactics, emergency vehicle operations, community policing and other core areas of public safety.

Beyond this foundational training, NLETC also offers a wide range of specialized and advanced courses to support ongoing professional development and public safety needs. These include instruction in areas such as drug enforcement, domestic violence response, leadership development and tactical operations. Importantly, the academy has recognized the growing intersection between law enforcement and behavioral health. To better prepare officers for real-world encounters, NLETC incorporates behavioral health- related curricula into its programming. **These courses, offered under the Human Understanding umbrella, include courses such as:**

1. anti-bias community relations,
2. verbal de-escalation,
3. ethics,
4. mental health issues and
5. juvenile crisis intervention and de-escalation.

In addition to the NLETC, the Lincoln Police Department, Omaha Police Department, and Nebraska State Patrol each operate their own training academies. These academies provide basic law enforcement instruction and may also include specialized training such as crisis response, de-escalation, and mental health awareness.

Strengths, Challenges, and Opportunities Across the State, By Region

Region 1

DEMOGRAPHICS

Region 1 covers 11 counties in the western panhandle of Nebraska (Sheridan, Dawes, Sioux, Box, Butte, Morrill, Scotts Bluff, Banner, Cheyenne, Deuel, Garden and Kimball). The region serves approximately 88,000 people covering 14,000 square miles, and with the exception of Scotts Bluff, is mostly frontier. Despite its geographical size, Region 1 is the smallest region by population. On average, the region has about seven people per square mile, compared to Nebraska's statewide average of 26 per square mile. Some counties (like Sioux and Garden) have fewer than one person per square mile.

BEHAVIORAL HEALTH LANDSCAPE & RESOURCES

A Community Health Survey conducted in 2017 asked respondents to rank their three biggest concerns in the community. Mental health was identified as the biggest concern. Since 2017, mental health challenges in the community have only increased. According to the Panhandle Public Health District (PPHD), the Panhandle area has a higher youth suicide rate than Nebraska as a whole and tends to have a higher per capita suicide rate than surrounding states. Between 2013 and 2025, the suicide death rate was 17.5 per 100,000. Between 2018 and 2022, this number increased to 23.2[xlii]. Further, data from the CDC's State Unintended Drug Overdose Reporting System, discussed on page 9, indicate that several counties within Region 1 have high rates of unintended drug overdoses (Deuel, Garden, Sheridan and Scotts Bluff).

According to data from the Nebraska Behavioral Health Workforce Dashboard referenced above, Region 1 has between 43 and 131 behavioral health practitioners in total. However, most of these practitioners are concentrated in or near Scotts Bluff. Sioux, Banner, and Kimball counties have no behavioral health practitioners, and the other counties within the region have more than 1 but fewer than 43 practitioners in each county.

Despite some challenges, Region 1 continues to expand its reach to support residents in its area. According to the Region's 2024 Annual Report, in FY24, Region 1 contracted with 14 providers, offering 35 services. This is an increase from 11 providers and 33 services in the previous year, reflecting a growing capacity to meet community needs.

Additionally, to guide the use of recently released Opioid Settlement Funds, Region 1 partnered with the PPHD to engage community stakeholders in identifying system needs and gaps in opioid prevention, treatment and harm reduction. This process established four priority areas: Crisis Stabilization, Detox, Restorative Justice and Justice Programs. In 2024, Region 1 began accepting grant applications to address these four areas.

In FY24, Region 1 expanded crisis stabilization services throughout the region, significantly increasing local capacity to address urgent behavioral health needs. Through this, the region was able to provide crisis services to more than 500 individuals through crisis response, a 24-hour crisis line and crisis stabilization. During the fiscal year from July 1, 2023, to June 30, 2024, the crisis response teams in Region 1 were activated to respond to 14, 988 calls. This marks a significant increase from seven calls in the previous fiscal year, reflecting growing community awareness. Additionally, data indicated that 78 percent of law enforcement-involved crisis calls

resulted in avoiding hospitalization, underscoring the importance of providing immediate support and intervention services. Region 1 also operates a 24/7 crisis response team. The Crisis Response Team works in conjunction with local law enforcement to provide the best outcome for persons in a mental health or substance use crisis.

Along with nearly 600 counties across the country, Region 1 is a participant in the **Stepping Up initiative,** which focuses on reducing the number of individuals with mental illness and co-occurring disorders in jail, strengthening connections to treatment, shortening jail stays and lowering recidivism rates. As part of this effort, Region 1 currently operates the Stride Program and the Scotts Bluff County Re-Entry Program. The Stride program supports individuals re-entering the community by helping them navigate the justice and behavioral health systems. Through the Stride program, law enforcement refers individuals charged with low-level offenses to a local service provider, where they are connected with peer support to access resources and schedule appointments. Furthermore, the Scotts Bluff County Re-Entry program supports individuals leaving the Scotts Bluff Detention facility navigate their transition back into the community. Region 1 also employs a Justice Systems Coordinator who supports efforts to strengthen collaboration between behavioral health and the justice system. This coordinator assisted the Scotts Bluff County Jail in implementing its reentry process, provides training to local agencies to foster dialogue around mental health diversion, and coordinates with law enforcement and the Region's Emergency Management team to enhance understanding of the crisis response system at both the state and regional levels.

Additionally, the PPHD has several initiatives to address the behavioral health challenges in the area. In the fall of 2022, PPHD brought training for a program called "The Situation Table" to the Panhandle. The Panhandle Situation Table meets weekly and connects partners across law enforcement, social services and health to provide a "warm handoff" to residents in need. The goal of the Situation Table is to meet acutely elevated-risk individuals and families where they are. In 2024, the Panhandle Situation Table received a NACCHO (National Association of City and County Health Officials) Model Practice Award. This award recognizes local health departments across the country that are implementing programs that demonstrate exemplary and replicable outcomes in response to an identified public health need. Between August 2022 and December 2024, 110 situations were presented to the Table, and 75 individuals were connected to services (75 percent). Another 20 were informed of available services. Seventy-five percent of these individuals were connected to mental health services, with housing, substance use, basic needs and parenting issues also being addressed.

Several police departments in the region also have school resources officers (SROs). As of FY24, the Scotts Bluff police department has two SROs that are supported in part by the Scottsbluff Public School district. A third officer is also available on the campus of the local community college.

CHALLENGES

As referenced above, workforce shortages continue to be one of the most pressing behavioral health challenges in Region 1. Several counties across the region have no practicing behavioral health professionals, leaving entire communities without access to in-person care. Residents in need of support are often left with only two options: use telehealth, which may not be feasible for those without reliable internet or private space, or travel outside their community to the nearest provider. Given the geographic size of Region 1, this can mean driving up to three hours one way. For individuals without access to a vehicle, the lack of public transportation further compounds the difficulty, creating significant barriers to receiving treatment. One major reason cited for the workforce shortage is the lack of affordable housing in the area. Even when providers are willing to relocate, finding a place to live that fits their needs and budget can be difficult, limiting recruitment and retention for behavioral health staff.

Like many rural areas, Region 1's local jail has become a de facto treatment center in the region. At the Scotts Bluff County Detention Center in Gering, it is estimated that nearly half of the inmates live with some form of mental illness. With a capacity of 288 beds, the jail typically operates at 80–90 percent occupancy, underscoring how significant the need is[xliii]. When someone in crisis cannot be admitted to the local hospital psychiatric unit because of capacity, law enforcement officers are forced to transport individuals hundreds of miles away to facilities in Kearney or Lincoln. These transports not only delay treatment for the person in crisis but also remove the officers from their communities for hours at a time, leaving gaps in public safety coverage.

Region 2

DEMOGRAPHICS

Region 2 is a predominantly rural area, encompassing 17 counties (Arthur, Chase, Dawson, Dundy, Frontier, Gosper, Grant, Hayes, Hitchcock, Hooker, Keith, Lincoln, Logan, McPherson, Perkins, Red Willow and Thomas). The region covers approximately 15,000 square miles with a population of just over 102,000 residents. With fewer than seven people per square mile, most of the region is composed of frontier and farming communities. North Platte, the largest city, has fewer than 25,000 residents, underscoring the rural and frontier character of the region.

BEHAVIORAL HEALTH LANDSCAPE & RESOURCES

Data from the CDC's State Unintended Drug Overdose Reporting System, discussed on page 9, indicate that the counties within Region 2 that have the highest rates of unintended drug overdoses are Perkins, Hitchcock and Frontier.

Data from the Nebraska Behavioral Health Workforce Dashboard, referenced above on page 13, indicate that in terms of behavioral health practitioners in Region 2, Lincoln County has the greatest number of behavioral health providers, with between 43 and 131 providers. Keith, Chase, Dundy, Red Willow, Dawson and Gosper counties have more than one, but fewer than 43 practitioners, while the remaining counties (Grant, Hooker, Thomas, Arthur, McPherson, Logan, Perkins, Hayes, Frontier, and Hitchcock) have no behavioral health practitioners.

Although Region 2 faces significant challenges due to its rural nature, Byrne JAG focus group participants consistently commended the region for providing high-quality behavioral health services despite limited resources. Region 2 has built a strong foundation of outpatient behavioral health services, particularly in larger communities such as North Platte, Lexington, Ogallala and McCook. Through Region 2's services, residents can access counseling, therapy, medication management and prevention programming. Region 2 staffs a 24/7 crisis line and manages emergency coordination by working with law enforcement, hospitals and community agencies to facilitate transportation, assess needs and support safe transitions from hospitalization or custody.

Region 2 has also responded to challenges by expanding the use of telehealth, strengthening partnerships with community providers, and investing in mobile and community-based services. These strategies help reduce barriers to care and ensure that individuals and families across the region can access timely behavioral health support. Further, to help mitigate transportation challenges, Region 2 offers transportation support through RYDE Transit. RYDE Transit is a demand-responsive public transportation service. In addition to providing rides to medical appointments, RYDE Transit also offers transportation to shopping areas, senior centers and other key destinations that support daily living and independence. RYDE Transit currently operates in Buffalo, Adams, Dawson, Franklin, Hamilton, Kearney and Gosper counties.

CHALLENGES

A common theme in many regions is workforce shortages and geographic challenges. Many of the smallest and most rural counties in the Panhandle have no practicing behavioral health providers, forcing residents to rely on telehealth or travel long distances for care. The geographic size of the region means that it can take hours to travel within the county, creating challenges for first responders and residents. Moreover, survey data reveal that several counties within the region do not have access to either in-person or telehealth crisis response services. This absence of services creates significant disparities across counties, leaving some residents with limited or delayed access to timely behavioral health interventions and increasing reliance on law enforcement or emergency departments to address behavioral health crises. In addition, the mobile response capabilities within the region are limited; data indicate that existing mobile crisis teams have a limited relationship with police, hospital and other emergency providers, and the team is unable to make around-the-clock arrangements to transport those in crisis to walk-in services such as a mental health center or hospital emergency department[xliv].

Lastly, the region has limited local options for certain services such as detox and inpatient residential treatment. Inpatient psychiatric care is limited, and demand frequently exceeds capacity for adult beds. There are almost no local options for youth requiring psychiatric hospitalization. Families are often left with no choice but to send children far from home to receive care. Residential treatment programs for substance use, along with sober and transitional housing, are limited in the region. The region does not have a dedicated crisis stabilization center and the local psychiatric unit in North Platte is often full, requiring individuals to travel hundreds of miles to another part of the state to receive treatment. Further, services are also concentrated in the North Platte and Lexington areas, leaving gaps in other parts of the region.

Region 3

DEMOGRAPHICS

Region 3 serves 22 counties in Central Nebraska (Blaine, Loup, Garfield, Wheeler, Custer, Valley, Greeley, Sherman, Howard, Merrick, Buffalo, Hall, Hamilton, Phelps, Kearney, Adams, Clay, Furnas, Harlan, Franklin, Webster and Nuckolls). The region covers 15,000 square miles and serves 223,000 people with a mix of rural and urban areas. Hall County (home to Grand Island) and Buffalo County (home to Kearney) are the area's largest population centers. The remainder of the region is considered largely rural.

Region 3 has experienced significant demographic changes over the last 20 years, most notably with the rapid growth of its Hispanic population. According to data from the census, in counties such as Hall, Dawson and Colfax, Hispanic residents make up between 30 and nearly 50 percent of the total population. In Grand Island alone, more than one-third of the population identifies as Hispanic, and nearly 30 percent of residents speak Spanish at home. These numbers are nearly triple the statewide average (12 percent). The area has also seen significant increases in residents from Somalia and Sudan. These demographics present unique opportunities and challenges for Region 3.

BEHAVIORAL HEALTH LANDSCAPE & RESOURCES

Data from the CDC's State Unintended Drug Overdose Reporting System indicate that the counties within Region 3 that have the highest rates of unintended drug overdoses are Franklin, sections of Buffalo, Garfield, central Valley, Howard, Merrick and Hamilton.

Additionally, data from the Nebraska Behavioral Health Workforce Dashboard, referenced previously, indicate that in Region 3, Buffalo, Hall and Adams counties have the greatest number of behavioral health providers, with between 43 and 131 providers in each county. Custer, Valley, Sherman, Howard, Merrick, Phelps, Kearney, Clay, Furnas, Franklin, Webster and Nuckolls counties have more than one, but fewer than 43 practitioners, while the remaining counties (Blaine, Loup, Garfield, Wheeler, Greeley, Hamilton and Harlan) have no behavioral health practitioners.

With a mission to "foster recovery and resiliency for individuals and their families who experience a behavioral health challenge," Region 3 supports 15 community-based agencies and, in 2024, served over 7,500 individuals across the comprehensive mental health and substance use disorder service array and community coalitions.

In recent years, Region 3 has focused on implementing best practices across the crisis care continuum. In 2024, the region expanded its Crisis Stabilization Unit, serving over 1,000 people. According to the region's annual report, this resulted in 99 percent being diverted from Emergency Protective Custody and 87 percent being diverted from a voluntary hospitalization[xlv]. The Emergency Community Support Program (ERCS) is a voluntary case management program for adults and youth who have experienced a behavioral health crisis. This short-term program provides outreach and case management services to individuals and families. The ERCS Coordinator supports the individual in identifying needs, goals and finding the appropriate resources within their community. Additionally, the Region 3 ERCS program supports individuals who experience a behavioral health disorder and are incarcerated at the Buffalo County or Phelps County jail as they transition from incarceration to the community.

Region 3 Behavioral Health Services also operates co-responder programs in Hall and Buffalo counties as part of its crisis response system. These programs pair mental health professionals with law enforcement officers to jointly respond to individuals experiencing a behavioral health crisis. Crisis therapists conduct suicide risk assessments, develop safety plans and connect individuals to appropriate psychiatric care or community-based services. The co-responder program is typically activated when a behavioral health challenge has been identified as a factor on a 911 call. The program typically responds to 12-15 calls per month, and the team is available Monday-Friday between 8:00 am and 5:00 pm. In FY23, nearly 90 percent of individuals served by the co-responder program were diverted from emergency protective custody or jail. Further, 100 percent of individuals reported increases in ability to solve future crises[xlvi].

CHALLENGES

As noted above, Region 3 has seen a significant increase in its Hispanic population over the last several years. While this growth has brought workforce opportunities to the area, it also creates unique behavioral health challenges. This demographic shift necessitates specific resources that the region often lacks. For instance, there are not enough bilingual or bicultural providers to meet demand, and interpreter services are inconsistent across the region. Additionally, outreach materials, intake forms and treatment plans are not always available in Spanish. As a result, many individuals and families struggle to connect with care. This presents an opportunity to offer culturally responsive programming that may include hiring bilingual and bicultural staff, training providers in culturally responsive programming and building partnerships with trusted community organizations.

Region 3 continues to face significant barriers in meeting the behavioral health needs of its residents, despite the presence of Grand Island, Nebraska's third-largest city. Seven counties within the region currently do not have any practicing behavioral health providers, creating large service gaps for rural residents. Even in Grand Island, there is

no dedicated psychiatric care facility, meaning individuals in crisis often must rely on emergency departments or be transported out of the region to access higher levels of care.

Behavioral health services within the justice system remain especially limited. Local jails provide limited treatment options, and there are no formal reentry programs to help individuals transition successfully back into the community. Problem-solving courts, while present, remain restricted in scope. The region does not have a dedicated mental health court, and participation levels in drug courts remain relatively low.

Crisis response services also face challenges. Although the existing co-responder program is a valuable resource, it only operates during standard business hours. This leaves a major gap during evenings and weekends, when behavioral health crises still to occur and law enforcement remains the default responder.

Transportation challenges compound these issues across Region 3. The region spans 22 largely rural counties, and with limited public transportation, many residents struggle to access care. This is particularly burdensome for individuals who must travel long distances to reach providers in other parts of the region or state. Housing instability further complicates recovery. Affordable housing is in short supply, and while shelters exist, community members have raised multiple concerns. At the September 2024 Sequential Intercept Mapping (SIM) workshop held in Hall County, participants highlighted practices such as removing people from shelters if they are actively struggling with substance use disorders, a lack of secure spaces leading to fears of medication theft, and the exclusion of pets and spouses, which discourages some individuals from seeking shelter. Even when housing resources are available, long waitlists and eligibility restrictions, particularly for those with criminal backgrounds, create additional barriers.

Region 4

DEMOGRAPHICS

Region 4 is inclusive of 22 counties in Northern Nebraska (Brown, Rock, Keya Paha, Holt, Boyd, Knox, Pierce, Cedar, Dixon, Dakota, Wayne, Thurston, Burt, Cuming, Colfax, Stanton, Platte, Madison, Nance, Boone and Antelope). The counties serve approximately 200,000 residents. Like much of the state, Region 4 has an expansive geographical footprint and covers over 10,000 square miles. The region has few urban centers, with Madison and Platte counties being the largest.

Region 4 is home to large meatpacking plants, which have drawn significant immigrant and Hispanic populations. In Colfax and Dakota counties, nearly half of the population is Hispanic. Much like in Region 3, the shifting demographics of the region presents unique challenges and opportunities.

BEHAVIORAL HEALTH LANDSCAPE & RESOURCES

Data from the CDC's State Unintended Drug Overdose Reporting System indicate that the counties within Region 4 that have the highest rates of unintended drug overdoses are Pierce and Madison.

Data from the Nebraska Behavioral Health Workforce Dashboard indicate that in terms of behavioral health practitioners in Region 4, Madison County has the greatest number of behavioral health providers, with between 43 and 131 providers in the county. Keya Paha, Boyd and Brown counties have no behavioral health providers, while the remainder of the region has between one and 42 providers in each county.

As of the Sequential Intercept Model (SIM) Workshop held in December 2023, Region 4 was taking steps to strengthen collaboration across the behavioral health and justice systems. Efforts included developing structured opportunities for behavioral health providers, law enforcement, crisis response teams, hospitals and regional staff to meet regularly, review relevant cases and identify system-level solutions. To improve communication and resource mapping, the region also planned to distribute a letter to agencies and organizations requesting updated provider contact information, ensuring a more accurate and accessible regional directory.

Despite persistent challenges tied to its shortage of providers, Region 4 continues to leverage every available resource to support individuals in crisis. The region relies heavily on partnerships with community-based providers, hospitals and state-operated facilities to fill service gaps. For example, the Emergency System Coordination (ESC) team works closely with county attorneys and local mental health boards to address system-level concerns. This includes developing discharge plans for individuals leaving the Lincoln Regional Center and ensuring smooth transitions to community-based or hospital care. ESC also contracts with hospitals within and outside of the region to provide inpatient services.

ESC continuously evaluates emergency services across Region 4, monitoring service demand and waitlists to ensure timely access to treatment. A priority is to coordinate with law enforcement and crisis response teams so that individuals who might otherwise face emergency protective custody or jail can instead be diverted to supportive care. While formal reentry programs within jails remain limited, crisis teams are available to respond to at-risk individuals, and the local public health district provides case management services to help bridge gaps.

Recognizing the importance of cultural and community-based support, Region 4 has incorporated Spanish-speaking peer support specialists into the jail setting to improve accessibility for diverse populations. In addition, the region benefits from a strong presence of faith-based organizations, which provide supplemental resources and services that help stabilize individuals and connect them to community support.

CHALLENGES

Region 4 faces several systemic barriers that limit access to behavioral health care across its largely rural counties. While there are Spanish-speaking peer support specialists available in the local jail, the broader behavioral health workforce lacks sufficient bilingual providers. This creates barriers for Spanish-speaking residents who may struggle to access culturally and linguistically appropriate care outside of the justice system setting.

The Sequential Intercept Mapping (SIM) Workshop hosted by Region 4 in December 2023 further underscored the critical gaps in the region's behavioral health system. Three counties in Region 4 currently have no behavioral health providers, and those that do, have extremely limited resources. The shortage is particularly evident in crisis care. Region 4 does not have a crisis stabilization unit, a Certified Community Behavioral Health Clinic (CCBHC), or a detox facility outside of the jail. Hospital-based emergency departments offer limited psychiatric beds, and participants noted the complete absence of adolescent treatment beds within the region. Only one residential program currently operates in the area, leaving residents with few in-region treatment options.

The crisis response system is also strained by workforce shortages. The provider for the mobile crisis response team is not locally based and may be up to 45 minutes away, delaying timely intervention. Although telehealth has expanded access, there remains a strong community preference for in-person care, particularly during emergencies. Moreover, there are no jail-based medication-assisted treatment (MAT) programs, leaving individuals with opioid or alcohol use disorders without critical supports during incarceration.

Training gaps also present major challenges. The geographic spread of Region 4 makes it difficult to consistently train law enforcement and first responders. Participants in the SIM workshop identified limited access to Crisis Intervention Training (CIT) and the lack of standardized crisis response protocols as key weaknesses.

Like other regions, housing and transportation barriers further complicate recovery. Affordable rental opportunities are scarce in several counties, particularly Columbus and Colfax. SIM workshop participants emphasized that finding rental housing is a persistent challenge, even for individuals with income. Transportation resources are also limited, with Boone, Colfax and Nance counties specifically noted as areas where residents often cannot access services due to a lack of transit options.

Finally, Region 4's justice system resources remain limited. Local jails are not designed to serve individuals in need of treatment, and there is little case management to support individuals released outside of parole. Coordination between agencies is inconsistent, and reentry programs are generally absent. While specialty courts are being explored in some counties, they remain limited across the region, reducing opportunities for diversion and community-based treatment.

Region 5

DEMOGRAPHICS

Region 5 serves 16 counties in Southeast Nebraska (Polk, Butler, Saunders, York, Seward, Lancaster, Otoe, Filmore, Saline, Thayer, Jefferson, Gage, Johnson, Nemaha, Pawnee and Richardson. The area covers over 9,000 square miles and is home to over 482,000 people (nearly 25 percent of the state's population). Lancaster County, home to Lincoln, accounts for 67 percent of the population of the region. While Lancaster County is an urban center, the rest of the region is mostly home to rural communities.

BEHAVIORAL HEALTH LANDSCAPE & RESOURCES

Data from the CDC's State Unintended Drug Overdose Reporting System indicate that the counties within Region 5 that have the highest rates of unintended drug overdoses are York, central Butler, Seward, Saline, Lancaster and Nemaha. As referenced in an earlier section, data indicates that individuals in Region 5 who died of an unintended drug overdose had higher rates of homelessness than the other behavioral health regions and had higher historical rates of both nonfatal overdoses and suicide attempts than other regions for which data were available.

Data from the Nebraska Behavioral Health Workforce Dashboard, referenced earlier in the report, indicate that in terms of behavioral health practitioners in Region 5, Lancaster County has the greatest number of behavioral health providers, with over 764 providers in the county. Pawnee County has no behavioral health providers, while the remainder of the region has between one and 42 providers in each county.

As referenced earlier, suicide is the leading cause of death for youth ages 10–14 and the second leading cause of death for youth ages 15–24 in Nebraska. In Region 5, youth suicide rates have consistently exceeded the state's six-year average, ranging from 9.97 to 20.23 per 100,000 people[xlvii]. By comparison, national suicide rates among youth ages 10–24 increased from 6.8 per 100,000 in 2007 to 11.0 per 100,000 in 2021[xlviii]. Among younger youth ages 10–14 nationwide, the suicide rate rose from 0.9 per 100,000 in 2007 to 2.9 per 100,000 in 2018, before leveling off through 2021.

In FY23-24, Region 5 launched Recovery Wellbeing Support Services through Wellbeing Initiative, Inc. The program began in Lincoln and later expanded to Fairbury, Geneva, Nebraska City and Falls City. Through the program, Wellness & Education Centers (WECs) provide a welcoming, low-barrier, non-clinical space for individuals and families at all stages of recovery. The WECs help people navigate complex care systems, overcome barriers to accessing services, and remain engaged in their recovery journey. Support is available before, during and after formal treatment. Services are also accessible to individuals who may not currently be in treatment but still would like to receive resources and encouragement. Offerings include recovery coaching, peer-led groups, life skills training, wellness classes and one-on-one mentoring.

In recent years, Region 5 has expanded its crisis care services. The High Utilizer Review Team (HURT Team) was created to strengthen communication and coordination among system providers. Meeting weekly for one hour, the team works to identify and support individuals experiencing, or at risk of, a behavioral health crisis. Its primary goal is to respond quickly and help individuals stabilize and return to their pre-crisis level of functioning. Membership includes representatives from law enforcement and behavioral health.

In comparison to other regions of the state, Region 5 has a robust crisis response network. The region's Targeted Adult Service Coordination (TASC) program plays a key role by responding to law enforcement–initiated mobile crisis calls, especially in rural communities. In FY23, TASC served 281 adults and achieved a diversion rate of 94 percent. Similarly, CenterPointe provides crisis response services and reported a 97.5 percent diversion rate, demonstrating the effectiveness of community-based interventions in reducing unnecessary hospitalizations and justice system involvement.

Region 5 offers emergency peer support and a local mental health crisis center to expand the continuum of care. Use of the 988 Suicide and Crisis Lifeline has also grown significantly. Callers to 988 first navigate automated prompts before being connected to a counselor through Vibrant Emotional Health Lifeline technology at accredited Lifeline centers. In FY23–24, the line averaged 61 calls per day, representing a 22 percent increase compared to FY22–23.

In the summer of 2025, a Voluntary Crisis Response Center (VCRC) opened in Lincoln. The VCRC was created to offer crisis care to residents while relieving the pressure placed on law enforcement and health care. In the absence of facilities dedicated to behavioral health crises, individuals in crisis were often transported to hospital emergency departments or jail. The VCRC provides a safe, accessible, and supportive environment designed to promote recovery and well-being for those experiencing a behavioral health crisis. Within the VCRC, the Crisis Stabilization program offers treatment and support throughout the crisis, including assessments, interventions, connections to needed behavioral health services, and assistance with transitioning back to community living.

Several counties in Region 5 participate in the Stepping Up Initiative, a national effort aimed at addressing the intersection of behavioral health and the justice system. As part of this initiative, counties are analyzing local data to develop strategies that reduce the number of people with mental illness entering jail, strengthen connections to treatment, shorten jail stays for individuals with mental health needs, and lower rates of recidivism.

In March 2025, the Lincoln Police Department, in partnership with CenterPointe, launched a Behavioral Health Co-Responder Program. The program deploys two-person teams to respond directly to individuals experiencing a behavioral health crisis. During Lancaster County's Sequential Intercept Model (SIM) Mapping in August 2024, participants highlighted the program as a significant step forward, given the estimated 13,000 mental health-related calls for service the county receives each year. In its first four months, the co-responder teams responded

to 153 calls. Of those, 62 percent were successfully de-escalated on scene without the need for further intervention. Another 24 percent resulted in individuals being transported to a care provider or facility, with 78 percent of those transports occurring voluntarily. Building on early success, the program has since expanded beyond its partnership with the police department to also assist Lincoln Fire and Rescue with its behavioral health-related calls[xlix].

During Lancaster County's 2024 SIM workshops, participants identified staffing shortages within the police department as a major challenge, noting that 45 officer positions were unfilled at the time. By April 2025, however, the Lincoln Police Department had achieved full staffing, a milestone that was highlighted in statewide focus groups as a model for other jurisdictions. This success is largely attributed to significant investments in recruitment and retention, including hiring certified officers from other states, raising pay levels to remain competitive and leveraging social media as a modern recruitment tool.

Further, there are several diversion problem-solving courts in the region. This includes pre-trial diversion programs, intensive supervision, low-risk programs and treatment diversion programs.

CHALLENGES

Region 5 is home to an urban/rural divide. While there is a wealth of resources available in the region, they are concentrated in the Lincoln metro area. As mentioned above, the area also has a high need on key fronts such as homelessness, substance use, and suicidality.

Additionally, Region 5 continues to face significant barriers that limit access to behavioral health care and supports. Rising housing costs and a shortage of affordable rental units make it difficult for many individuals and families to find stable housing. As of 2024, low-barrier shelters were being explored, but there were issues related to funding. A lack of transitional and permanent housing can result in a lack of continuity and can negatively impact the success of behavioral health treatment recovery.

Transportation is another major challenge, particularly in rural areas where public transit is limited. This leaves many unable to reliably reach courts, probation or treatment programs, often resulting in missed appointments and delayed care.

Region 6

DEMOGRAPHICS

Region 6 serves five counties in Eastern Nebraska (Cass, Dodge, Douglas, Sarpy and Washington). Region 6 is the most populous and urban behavioral health region, serving over 850,000 residents across 2,600 square miles. Unlike the other five regions, Region 6 is largely urban or suburban, with more than 90 percent of its residents living in Omaha (Douglas County) or neighboring Sarpy County. In addition, the Omaha metro area spans into Pottawattamie County in Iowa. Due to considerable movement among people between Omaha and Council Bluffs, there are additional resource constraints for both states.

BEHAVIORAL HEALTH LANDSCAPE & RESOURCES

Data from the CDC indicate that the counties within Region 6 that have the highest rates of unintended drug overdoses are Douglas and Washington.

Region 6 is home to the highest concentration of behavioral health service providers in Nebraska, including hospitals, outpatient clinics and community-based organizations. Region 6 faces fewer workforce challenges than some of the more rural areas of the state, and the area is home to a variety of academic training programs that can provide behavioral health practitioners. Data from the Nebraska Behavioral Health Workforce Dashboard reflect this. Douglas County has over 764 providers, and Sarpy has between 132 and 763 providers. The remaining three counties – Dodge, Washington and Cass have between one and 42 providers. Region 6 is the only region in the state that has behavioral health coverage in each county.

Compared with other regions, Region 6 has a greater capacity for behavioral health services, including crisis stabilization units, inpatient beds, outpatient programs and culturally specific services. One indicator of the demand for these services is the steady increase in calls to the 988 Suicide and Crisis Lifeline. Between FY23 and FY24, Region 6 saw a 52 percent rise in 988 call volume, reflecting both growing awareness of the hotline and the increasing need for immediate behavioral health support. Importantly, Region 6 has been able to connect many of these calls to local crisis stabilization resources, law enforcement co-responder teams, and community-based supports, helping to divert individuals from emergency departments and jails.

The region also benefits from the presence of academic medical systems and large hospital systems. Region 6 has integrated behavioral health into primary care in several places across the community. For instance, the Munroe-Meyer Institute (MMI) at the University of Nebraska Medical Center (UNMC) provides behavioral health services directly within primary care settings across the Omaha area, including satellite clinics. These settings have embedded behavioral health professionals who range from graduate trainees to faculty. This collaboration with primary care providers allows for the delivery of more seamless, integrated care. UNMC has also partnered with Heartland Federally Qualified Health Center (FQHC) to launch a Collaborative Care Model at the Durham Internal Medicine Clinic in Omaha and at a rural satellite clinic in Ravenna. Additionally, health systems in Region 6 have embedded behavioral health into several outpatient clinics in communities. The ability for individuals to access both mental health treatment and primary care in the same location can help to address chronic conditions while also reducing avoidable hospitalizations.

The region also has several mobile crisis response teams. For instance, Assessment, Support and Prevention (ASAP) is an on-site Mobile Crisis response program that responds to calls from law enforcement. ASAP practitioners are on call 24/7, 365 days a week. While the goal is to respond within 30 minutes, as reported in a 2022 SIM workshop, the team has a response time of just eight minutes. After assessing the individual in crisis, ASAP practitioners make recommendations to law enforcement for the best course of action to provide safety, support and referral to the individual. ASAP then completes a 24-hour telephone follow-up with the individual to assess needs post-crisis as well. ASAP can also use telehealth services and law enforcement officers are equipped with ASAP tablets to help connect individuals in crisis to ASAP.

The Douglas County Sheriff's office employs an in-house co-responder to immediately serve officers responding to calls involving people experiencing a behavioral health crisis. The Omaha Police Department has co-responders embedded within the department and Lutheran Family Services in Omaha also has a mobile crisis response team that is available 24/7 for adults and youth. Peer support is also used extensively throughout the region and embedded in police departments and jails. This support can help fill the gaps of long wait times and limited providers.

Douglas and Sarpy counties in Region 6 participate in the Stepping Up Initiative, a national effort to reduce the number of people with serious mental illness in jails through data-driven, systems-level change. The initiative

focuses on reducing jail admissions, shortening the length of stay, improving connections to care and lowering recidivism. In FY24, Region 6 advanced these goals by helping Douglas County secure sustainable funding for a full-time Familiar Faces Project case manager, providing educational supervision for students working in reentry and therapy at the Sarpy County Jail, finalizing a Competency Restoration Communication Protocols document and supporting collaboration with both county jails to implement best practices.

Also, as part of the Stepping Up Initiative, Sarpy County, in partnership with Douglas County, Region 6 Behavioral Healthcare and the Omaha Police Department, participates in the Criminal Justice–Mental Health Information Sharing Initiative to build a data-sharing platform that improves outcomes for individuals in crisis and reduces the number of people with mental illness in local jails. Sarpy has been recognized as a Stepping Up Innovator County for its strong use of jail data collection and review through a jail population team. The county also sustains cross-system collaboration through an active Criminal Justice Coordinating Committee.

The region has several problem-solving and diversion court models. This includes Young Adult Courts, Mental Health Diversion, Drug Court, Veterans Court and others. Sarpy County is the first county in the state to launch a dedicated Mental Health Wellness Court. The program is voluntary and is designed for those diagnosed with a serious mental health issue who are charged with a nonviolent felony. To participate, individuals must complete a competency evaluation and enter a guilty plea, following the same process used in other problem-solving courts such as Drug or Veterans Courts. The program provides a comprehensive treatment plan that includes regular meetings with a judge, prosecutor, defense attorney, treatment providers, probation officers and law enforcement. The Mental Health Wellness Court also emphasizes securing stable housing, maintaining sobriety and connecting participants with community-based services and supports to promote long-term recovery after program completion. Recently, JAG funds have been used to support a case worker within the court.

In Douglas County, the Reentry Assistance Program (RAP) supports individuals transitioning from the local jail to the community. RAP works closely with problem-solving courts and connects participants to supervision, employment opportunities, counseling and other community resources aimed at successful reintegration. As of 2022, the program serves 75 individuals with the support of a single case manager who assists with job placement, provider referrals and other service connections. Expanding staffing could strengthen the program's ability to provide timely, comprehensive reentry support and improve long-term outcomes.

CHALLENGES

While Region 6 is the behavioral health hub of the state, it still faces challenges. Despite being the most urban and populous behavioral health region in Nebraska, there are persistent shortages of behavioral health providers. While it may have improved in recent years, participants in a 2022 SIM workshop indicated that while Region 6 does have treatment options available, wait times for treatment can stretch for weeks, especially for residential treatment programs. As of 2022, there were also limited providers of medication assisted treatment in the region, with most of them concentrated in Omaha.

These gaps place added strain on local jails, which have become de facto behavioral health facilities. Individuals with serious mental illness often remain incarcerated far longer than other people, with limited access to meaningful treatment during their stay. In Sarpy County, for example, people with serious mental illness spend an average of 106 days in jail, compared to just 15 days for those without similar conditions[l]. This not only increases costs for counties but also undermines the chances of successful recovery and reintegration.

Access to behavioral health services is also uneven across the region. While Douglas and Sarpy counties benefit from larger provider networks, more rural areas such as Cass, Dodge and Washington counties face behavioral health provider shortages. Residents in these areas often rely on telehealth or must travel long distances for in-person services. Further, while recognizing the value of peer support services, SIM workshop participants emphasized concerns about relying on them as a substitute for formal behavioral health treatment. They noted that peer support can provide encouragement, shared understanding, and a vital sense of connection, but participants stressed that it should complement, and not replace, professional treatment.

Transportation is an issue in this region as well. While Omaha and parts of Sarpy County benefit from some public transit options, residents in Dodge, Cass, Washington and some parts of Sarpy County face limited or no consistent public transportation. This creates challenges for individuals seeking treatment.

Detoxification options outside of jail also remain limited. Douglas County operates a dedicated detox program, but it has very narrow parameters, serving only individuals under the influence of alcohol who are placed in involuntary Civil Protective Custody (CPC). For those using other substances, law enforcement's only alternative is to transport the individual to a hospital emergency department.

Recommendations

The United States is experiencing a behavioral health crisis, and states are working urgently to address the most pressing challenges within their own borders. Like many others, Nebraska has made significant strides, leveraging resources such as the Behavioral Health Education Center of Nebraska (BHECN), implementing evidence-based programming and tracking key data points to monitor progress and identify areas of ongoing need. Recognizing both statewide and regional challenges, continued investment and innovation will be essential to strengthen Nebraska's behavioral health system.

One important resource supporting these efforts is the Byrne State Crisis Intervention Program (Byrne SCIP). While only one of several funding streams available to the state, as its name suggests, Byrne SCIP is designed specifically to support crisis-related programming and provides states flexibility to tailor approaches to their unique circumstances. Since its rollout, the National Criminal Justice Association (NCJA) has tracked how states are using Byrne SCIP funds, both to highlight innovative strategies nationwide and to provide opportunities for states to learn from one another.

Building on the strengths already in place and addressing identified gaps, Nebraska may benefit from considering examples of Byrne SCIP-funded programming from other states, whether by replicating promising models, adapting them to local needs or repurposing elements to align with Nebraska's priorities. This combination of data-driven decision making, cross-state learning and targeted investment can help Nebraska continue to strengthen its behavioral health landscape.

Resource prioritization

Strategically prioritizing the limited available financial resources is critically important for the state of Nebraska. While the state overall could benefit from additional programs and services, the more rural and frontier regions have far less access to resources than more urban areas. The NCC should consider directing resources towards these regions as aggressively as possible. **Approaches that may be most meaningful in these areas include:**

1. Increase the number of behavioral health professionals in the areas where there are currently none.
    a. The BHECN routinely updates its workforce dashboard, and this is an excellent resource for identifying the most pressing geographic locations.
    b. Seek to specifically increase the number of behavioral health practitioners who can prescribe medication.
    c. Invest in programming and/or partnerships that incentivize behavioral health practitioner retention.
2. Prioritize schools as a place where adolescents can access behavioral health supports and where mental health screening can take place.
3. Target telehealth infrastructure investments to rural and frontier areas in order to increase access to behavioral healthcare.
4. Target transportation initiatives or funding transportation services for rural and frontier areas in order to increase access to a variety of services related to behavioral health care as well as including transportation that supports individuals who seek to re-enter their communities post-incarceration.

With this foundation in mind, the following recommendations are offered to guide Nebraska's next steps in improving behavioral health and behavioral health–law enforcement collaboration statewide.

Leverage partnerships

Given the vast geography and sparse provider network within the state, partnerships are key. This can include building strong partnerships between hospitals, community-based organizations, schools, law enforcement and behavioral health providers. Partnerships can maximize limited resources, reduce duplication of services, and improve referral pathways. For example, hospitals could collaborate with community providers to ensure patients discharged from emergency departments are quickly linked to ongoing behavioral health care. Schools could partner with local agencies to provide in-school counseling, early screening, and family supports. Leveraging regional collaborations also allows providers to share specialized staff, such as psychiatric nurse practitioners, across multiple communities. Strengthened partnerships between crisis facilities, hospitals and community providers ensure individuals leaving crisis care are immediately connected to outpatient treatment and case management.

Several states are using Byrne SCIP funding to leverage partnerships. For instance, Delaware has partnered with Boys and Girls Clubs to provide intervention services to middle school students. Montana has implemented programming to train School Resource Officers to better identify and understand youth mental health issues. Georgia has utilized Byrne SCIP funding to implement a school-focused co-responder program to respond to crises that arise among pre-k through12th-grade students and families. Kentucky has used the funding to support nonprofit capacity building to equip agencies to address trauma and resiliency issues within the communities they serve.

Expand mobile crisis response

Many communities throughout the state use a crisis co-response model, where a mental health professional and a law enforcement officer respond together to a crisis and address mental health issues along with any safety concerns. Together, the team has the flexibility to respond to a variety of calls, from outreach to frequent users of services to managing a high-risk situation. The mental health professional provides services including de-escalation, assessment and referral, and sometimes follow-up after a crisis. There are several variations of this model: sometimes the mental health provider is an employee of the law enforcement agency, and in other cases, they work for a provider agency. In some programs, the provider rides in the officer's cruiser, ensuring a simultaneous response; in other programs, the provider travels separately, allowing one provider to serve a larger geographical area. These programs have been shown to reduce unnecessary arrests, decrease use of emergency departments and improve outcomes for individuals in crisis.

Other areas of the state use Crisis Intervention Teams (CIT). When mental health services are not available, the gold standard of response is a Crisis Intervention Team (CIT) officer. CIT programs are led by a cross-systems steering committee of law enforcement, mental health providers and mental health advocates to improve coordination during a crisis and provide specialized training to patrol officers[li]. CIT programs include people with lived experience in mental health conditions to ensure that officers learn to provide a sensitive response.

There are a variety of these programs throughout the state however, most of them are concentrated in the larger cities and counties, thus creating a gap in rural communities. There are several considerations when expanding this type of program into rural communities. When implementing co-response models within a rural environment, the Substance Abuse and Mental Health Services Administration (SAMHSA) recommends leveraging technology; building on established programs instead of developing new interventions and matching resources to the

community's needs. Crisis response teams throughout the state also vary in terms of availability, with some only available during standard business hours, leaving a gap in services on the weekends and at night. See **Appendix G** for additional information regarding best practices related to implementing CIT and Co-responder teams.

Using Byrne SCIP dollars, Colorado is establishing a co-responder mental health crisis intervention program that utilizes a virtual mental health response, available 24hours a day, seven days a week, to address specific challenges faced by frontier law enforcement with limited resources. Wisconsin has engaged in contractual services to provide virtual telemedicine and crisis care services 24 hours a day, seven days per week for people experiencing mental health crises. Kentucky used funds to increase staff capacity to provide crisis intervention services specifically in rural areas. Parts of Texas have created new staff positions so that mental health professionals are embedded in rural law enforcement departments to provide co-response. Kentucky, Alabama and Texas are all utilizing a portion of these funds to increase their capacity for mobile crisis intervention teams; this includes purchasing new patrol vehicles and developing protocols and procedures related to team practices, among other things. On a related note, one of the ways Iowa has used part of the Byrne SCIP funds is to create a Rapid Care Coordination and Treatment (RCCT) team, which will connect people at high risk of initial or ongoing criminal justice system involvement with mental health and/or substance misuse services and mitigate barriers to accessing treatment, such as long wait times.

Expand integration of behavioral healthcare into primary care settings

In rural areas in particular, one of the most meaningful ways to reduce access barriers to behavioral healthcare is through establishing on-site or consulting behavioral health professionals in primary care clinics. This allows behavioral health issues to be treated where they often first arise and has changed the access landscape. There is a significant body of work indicating the benefits of this integration. Nebraska has already successfully started down this road and should continue.

Expand telehealth access

Using telehealth services can help mitigate the impacts of behavioral health provider shortages throughout the state. These services are especially helpful in more rural areas of the state, where it may take up to three hours to reach the nearest provider. Increasing access can include offering telehealth access in traditional and non-traditional locations. For instance, establishing telehealth kiosks in rural libraries, community centers and clinics can ensure equitable access for residents without reliable internet or devices. While there are sometimes preferences for in-person services within some areas of the state, given the geographical sizes of regions, telehealth services remain a critical resource to provide behavioral health services to residents.

Considerations around access to broadband internet are important when expanding telehealth services. In particular, rural areas may struggle with broadband internet connectivity. If necessary, seek out funding to expand broadband internet connectivity. In addition to Byrne SCIP funding, which may qualify for this purpose, historically, there have been federal initiatives (from the U.S. Department of Agriculture, the National Telecommunications and Information Administration and the Federal Communications Commission) that have focused on improving remote learning and accessing telehealth in rural areas. Minnesota, for example, is nationally recognized for its success in increasing broadband access. The approach, discussed **here** and **here,** included clear legislatively established goals, the development of a broadband task force and a broadband mapping initiative. The 'Minnesota Model

for Broadband Access' combines clear statewide speed goals, public investment through the Border-to-Border Broadband Grant Program and cost-sharing with private and local partners to expand service in unserved and underserved areas. As Bernadine Joselyn of the Governor's Broadband Task Force said in 2021, when asked about the success of the Minnesota model, "This work requires partners. Work collaboratively — with internet service providers, other state programs, federal agencies, other agencies in your state, and philanthropic organizations. No one entity has the resources to solve the problem on its own."

Expand peer support infrastructure

Expanding the peer support infrastructure throughout the state can both expand the available behavioral workforce and help to provide more immediate care to those in crisis. This is especially important in areas such as Regions 1, 2, and 4, where treatment providers are limited and geography is vast. **Support can be expanded in many ways:**

- Embed peer support along the justice system: Ensure peer specialists work alongside licensed behavioral health professionals in crisis response, treatment and reentry services. Additionally, expand peer involvement in jail reentry programs, diversion efforts and mobile crisis response teams. Their lived experience can help build trust with individuals and create a stronger continuum of support.
- Expand peer training and certification: Continue building the peer workforce by offering training, certification and supervision opportunities. Specialized tracks, such as peer support for justice-involved individuals, substance use or youth, can help address diverse needs within the state. Historically, the Office of Consumer Affairs (through DHHS) has managed the training and certification of peer support specialists; the exploration of a potential partnership with the Office may be beneficial.
- Clarify the role of peer support: Some stakeholders expressed concerns around overreliance on peer support. Educate providers, law enforcement and community partners on the strengths and limits of peer support. This helps ensure peers are not asked to perform functions outside their scope. Peer support is meant as a complement to clinical support, not a replacement.
- Support peer workforce retention: While peer support can help to address behavioral health shortages throughout the state, it is important not to burn out this group. Supporting wellness and employment opportunities can increase retention.
- Promote diversity within peer network: Recruit peers that mirror the diversity and culture of the communities they serve.

Prioritize addressing the behavioral health workforce shortage

Workforce shortages remain one of the most pressing issues in the state. As noted above, 29 counties within the state have no behavioral health providers, and many other counties have limited resources. Recruitment strategies could include partnerships with community colleges and universities to create a pipeline of behavioral health workers. Loan forgiveness programs, retention bonuses, housing stipends and relocation bonuses can also attract behavioral health professionals to rural areas. Retention efforts should emphasize professional development, clinical supervision support and opportunities for advancement to reduce burnout and turnover.

The BHECN has made impressive efforts to increase the recruitment and retention of behavioral health providers throughout the state. Leverage BHECN to develop a strategy that prioritizes increasing the number of behavioral

health care providers who can prescribe medication, as they are in the shortest supply.

Additionally, Byrne SCIP funding has been used to install behavioral health practitioners in various settings, including across early childhood centers, schools, and throughout the broader community in both Montana and South Carolina.

Increase culturally responsive programming

Many areas of the state, especially Regions 3 and 4, have seen significant increases in their immigrant and non-English speaking populations. This presents a need to offer culturally responsive programming. Without culturally responsive programming, many individuals either forgo care or disengage early from treatment, leading to worsened outcomes and higher costs for emergency or crisis services. For example, Spanish-speaking families may be unable to find providers who can communicate effectively, or immigrant communities may be hesitant to seek help from institutions they do not trust. This can result in untreated behavioral health disorders, which have ripple effects on schools, workplaces and the justice system.

Increasing culturally responsive programming can include the use of translation services. However, these approaches should also go beyond translation services. They can include hiring bilingual and bicultural staff, training providers in culturally responsive programming and building partnerships with trusted community organizations. As the state continues to experience growth in immigrant and non-English speaking populations, culturally responsive services must be prioritized to meet the needs of all communities.

Coordinate resources across state and local agencies

According to the most recent available data, overall, unintentional overdose death rates are decreasing across the state, suggesting that current efforts are achieving some success. Opioid settlement dollars have been dispersed throughout the state to help further support substance use and other behavioral health challenges. Regularly assessing available data and coordinating with state and local agencies across the state to determine what gaps and needs remain in specific locations (for example, Region 5 is an area with higher rates of individuals with a history of overdose compared to other regions for which data is available) could help to avoid duplication of funding and ensure dollars make the greatest impact.

Transportation services

The lack of transportation as a barrier to accessing behavioral health services was one that NCJA staff heard with some frequency during focus group sessions. While telehealth can address this to some degree, there is still a clear need for transportation support within the state, and particularly within the more rural regions. Based on focus group information and other data, transportation needs are currently being addressed at a community level, with churches and individual community members helping people access the services they need. In Ohio, Byrne SCIP funds are being used to provide transportation to and from court through bus tokens. Nebraska may consider directing some funding towards transportation, perhaps leveraging some of the informal transportation infrastructure that's currently exists within the faith-based communities. Additionally, Nebraska could consider funding contracted transportation services to address gaps in access to behavioral health and justice-related care. Leveraging existing transportation companies, including non-emergency medical transport providers, can ensure safe and reliable travel for individuals in need.

Expansion of problem solving and diversion courts

While problem-solving courts or diversion courts were not discussed at length in the survey or focus groups, there is significant evidence of their effectiveness in addressing justice-involved individuals with behavioral health needs. Many states are either implementing or expanding problem-solving courts with Byrne SCIP funding. In Montana, Byrne SCIP funding is supporting the expansion of treatment court programming by providing emergency and/or transitional housing for victims of domestic violence who are entering treatment court. In Georgia, funds are being used to expand treatment resources available for mental health and substance use within a treatment court framework. Georgia is also using funds to add a peer support component to support treatment court participants. South Carolina is utilizing its Byrne SCIP funds to add additional judges and court coordinators to mental health courts. New Hampshire has used funding to establish a statewide treatment court coordinator position, which is responsible for overseeing the planning, implementation and risk analysis for all treatment courts serving individuals with co-occurring mental health and substance use disorders across the state. Iowa is utilizing funding for ongoing training for treatment court staff regarding specialty court best and/or promising practices.

Prioritize youth mental health by expanding prevention and early education programming

In Nebraska, suicide is the number one cause of death for adolescents between 10 and 14 years of age and is the second leading cause of death for 15- to 24-year-olds. Expanding prevention and early intervention is a critical priority for addressing youth suicide. Schools are often the first point of contact for young people experiencing stress, depression or other behavioral health concerns, making them an essential setting for proactive support. By integrating evidence-based prevention programs into the school environment, youth can be equipped with coping strategies, emotional regulation skills and peer support networks that build resilience before crises occur.

In addition to universal prevention, the state could benefit from expanding access to school-based behavioral health providers, including counselors, social workers and school psychologists. Many schools in rural areas face limited staffing and long wait times for youth to see a behavioral health professional, which can delay early identification and treatment. Increasing the presence of trained professionals in schools ensures that students who may be struggling are identified quickly and connected to care. Installing additional licensed clinical social workers in schools in areas with the least access to behavioral health practitioners is one step the state can take to provide a first point of access to young people who may benefit from mental health supports.

Montana has integrated Licensed Clinical Social Workers into its schools and as part of a mobile crisis diversion program. Delaware has implemented a screening tool to identify the social-emotional needs of middle schoolers within a district. In Ohio, a Juvenile Sequential Intercept Model mapping project is being supported with Byrne SCIP funds.

Reentry support

Many areas of the state currently lack formal reentry programs for individuals leaving jail or treatment facilities, creating a significant gap in continuity of care. Establishing structured reentry services is critical. In Missouri and Georgia, Byrne SCIP funding is being used to expand existing jail navigator programs to better support and work with individuals as they prepare for release from jail. In addition, Missouri is also training jail staff in CIT and adding a peer specialist focusing solely on individuals identified as high-risk for violent behavior and behavioral health disorders.

Partnerships with probation, local health departments and community-based organizations could help ensure that individuals receive coordinated support as they transition back into the community.

Behavioral health training for law enforcement and jail staff

While not mental health professionals, law enforcement are often the first (and sometimes only) resource available to respond to a behavioral health crisis. Because of this, training for law enforcement is essential to equip them with the tools needed to address crisis situations.

Crisis Intervention Training (CIT) is one of the most widespread trainings available for law enforcement. The goals of CIT training include reducing stigma, diverting individuals from the criminal system to the mental health system and improving community response systems for mental health emergencies. While several law enforcement agencies throughout the state require CIT training for all of their officers, this requirement is not consistent throughout all communities. Crisis Response Intervention Training (CRIT) is also a helpful tool for law enforcement agencies. CRIT is modeled after CIT but also includes strategies for addressing those with intellectual and developmental disabilities. Byrne SCIP funding is being used to support CIT training programs or refresher training programs in a multitude of states, including Missouri, Iowa, Ohio, Pennsylvania, Colorado, South Carolina, Wisconsin and Texas.

According to the Law Enforcement Listening Sessions State Tour that took place in 2024, 100 percent of counties represented indicated that 32 hours of annual continuing education (of which behavioral health-related topics are included) for all law enforcement officers could benefit from review. This sentiment should be taken into account as any new training requirements or potential adjustments to the curriculum are considered. The perceived excess of training must be carefully balanced against the need for supports that will help law enforcement better address the emerging and increasing needs related to behavioral health. The training objectives and goals for each of these training topics are laid out in **Appendix H** and support officers' ability to appropriately respond to behavioral health crises in one form or another as they go about their work.

In Wisconsin, Byrne SCIP is supporting a program in which jail staff are receiving Crisis Intervention Partners training to guide corrections staff towards the right mindset and communication skills, both verbal and nonverbal, to respond effectively to crises within their jails with empathy.

Behavioral health training for community members

Mental Health Awareness Training (MHAT) prepares individuals and communities to respond appropriately and safely to individuals with mental health challenges. As a result of this training, individuals receive the knowledge, skills, confidence and resources to engage with someone experiencing mental health and/or substance use challenges. Individuals trained might use these skills and resources to help others access needed behavioral health care. MHAT training can be offered to any community that desires it; oftentimes, those who seek training are members of the mental health field, school/higher education field, first responders, human service organizations and others who interface with adolescents or adults who may experience a behavioral health issue.

In Wisconsin, Mental Health First Aid Training (MHFA) is being provided to service providers and farm families to increase awareness of mental health issues and suicide prevention, particularly among farmers. Specifically, the training uses the Applied Suicide Intervention Skills Training (ASIST) curriculum. This may be a particularly valuable tool in Nebraska's areas that have higher rates of suicidality.

Appendix

NCJA Center for Justice Planning

Byrne JAG: Flexible Funding to Prevent Crime, Protect Public Safety and Reduce Recidivism

Overview

The Byrne Justice Assistance Grant (Byrne JAG) program is the nation's cornerstone justice assistance grant program, supporting the federal government's crucial role in improving state and local justice systems. Byrne JAG is flexible, allowing spending across nine broad program areas that enable states, localities and tribal nations to address their most pressing public safety challenges by designing complete programs or filling spending gaps.

Strategic planning technical assistance, offered by NCJA's Center for Justice Planning team, helps states determine priority areas and effective programs and initiatives to address specific needs.

The Nine Byrne JAG Program Areas

Law Enforcement

Law enforcement-led diversion, violent crime reduction, co-responder models, equipment, personnel/operations, training, multijurisdictional task forces.

Prosecution & Courts

Indigent defense, prosecutional initiatives, specialty courts.

Prevention & Education

Crime prevention, domestic violence/sexual assault prevention, at-risk youth prevention.

Corrections, Community Corrections & Reentry

Alternatives to incarceration, probation/parole, reentry and special populations.

Drug Treatment & Enforcement

Housing, community-based treatment, secure facility-based treatment

Planning, Evaluation & Technology Improvement

Improvement of criminal record and forensic science systems, information sharing, outcome and program evaluation, strategic planning.

Crime Victim & Witness

Human trafficking, restorative justice initiatives, victim services for adults and children.

Mental & Behavioral Health

Assessment/evaluation, benefits eligibility/enroillment, crisis intervention team (CIT) training, suicide risk assessments, response and protocols.

State Crisis Intervention Programs

State crisis intervention court proceedings or initiatives including mental health courts, drug courts, veterans courts and Extreme Risk Protection Order (ERPO) programs.

Updated February 2024

Administering the Byrne SCIP Grant Program

Program Overview

In June of 2022, the Bipartisan Safer Communities Act (BCSA) was signed into law, with the goal of reducing firearm-related violence. The Act created the Byrne State Crisis Intervention Program (Byrne SCIP), a five-year funding source to implement extreme risk protection order (ERPO) programs, state crisis intervention court proceedings and related gun violence reduction programs/initiatives. Administered by the Department of Justice, Bureau of Justice Assistance (BJA), funding can be used to implement and support a broad range of activities including, but not limited to:

- **Support** for states implementing ERPO programs; training for those implementing ERPO programs; communication, education and public awareness campaigns/initiatives for existing ERPO laws.
- **Support** for problem solving court programs such as treatment, mental health and veterans treatment courts to expand programming to specifically accept clients with firearm violations.
- **Support** for court-based programs that identify and provide support to people in crisis, including those at risk of harm to themselves or others with a firearm, assessing their circumstances and needs, and connecting them with programs and services that can provide them with needed help and support.
- **Support** for deflection and diversion to behavioral health treatment and support services for those at risk to themselves or others.
- **Funding** for law enforcement agencies on crisis intervention programs or initiatives.

*For additional ideas regarding what Byrne SCIP funds can be used for, refer to **BJA's Byrne SCIP FAQs**.

This document outlines key components of the Byrne SCIP grant administration process, including pass-through requirements, key stakeholders to engage and the training and technical assistance partners attached to this program to help State Administering Agencies (SAAs).

NCJA Center for Justice Planning

Grant Administration Overview

Two foundational resources for State Administering Agencies (SAAs) to consult regarding Byrne SCIP program administration are the Bureau of Justice Assistance's Byrne SCIP **Frequently Asked Questions document** and **fact sheet**. In addition to these resources, the following section of this document outlines some key components of Byrne SCIP grant administration, including the creation of the required crisis intervention advisory board, grant pass-through requirements and three key differences between the administration of the Byrne Justice Assistance Grant (Byrne JAG) and Byrne SCIP programs. For complete information on the Byrne SCIP grant administration process, please refer to the BJA FAQs and past notices of funding opportunities (NOFOs) **on the program overview page**. Any questions regarding administration of Byrne SCIP should be directed to the BJA SCIP program contacts.

SCIP Crisis Intervention Advisory Board

The Byrne SCIP requires Byrne SCIP SAAs to establish a crisis intervention advisory board to provide guidance on gun violence reduction programming and expenditures under this grant. SAAs are permitted to use an existing advisory board or working group, such as the state's Byrne JAG advisory board, for this grant program, provided the existing advisory body contains the required representation. Required representatives include:

- Law enforcement
- Community
- Courts
- Prosecution
- Behavioral health providers
- Victims' services
- Legal counsel

*In determining a community representative for the advisory board, BJA strongly encourages representation from members of the community with lived experience. This could include, but is not limited to a prominent community member, an owner of a local business and/or a community resident. Additionally, BJA urges SAAs to include representation from community-based organizations for behavioral health and victims' services. Keep in mind that advisory boards can have more than one representative per category.

The crisis intervention advisory board must provide input on and approve grant program plans and budgets and will be required to approve any subsequent changes to the state's SCIP project scope or budget.

Before SAAs can draw down SCIP funds, BJA must approve the state's proposed program plan and budget, as developed in conjunction with and approved by the crisis intervention advisory board. Additionally, BJA must approve each subaward before funds are drawn down. However, SAAs may draw down up to $20,000 in advance from their total award for the purposes of developing program and budget plans in conjunction with the crisis intervention advisory board.

NCJA Center for Justice Planning

Grant Pass-through Requirements

The pass-through requirements for this grant program are as follows:

Local Pass-through Requirement

- SAAs are required to award no less than 40 percent of the state's total Byrne SCIP allocation to units of local government. According to BJA and for the purpose of Byrne SCIP, a "unit of local government" is a city, county, township, town, or certain federally recognized American Indian tribes. States have discretion in the process and purpose of the awards, as informed by their crisis intervention advisory body. This pass-through is mandatory and not eligible for a waiver.

Less than $10,000 Pass-through Requirement

- SAAs must pass through the funds that are added to the state's share for the less-than-$10,000 jurisdictions, either to state courts that provide criminal justice and civil proceeding services for the "less-than $10,000 jurisdictions" within the state and/or directly to such jurisdictions. This stipulation mirrors the requirement in Byrne JAG for the less-than-$10,000 jurisdiction funds to be used for state police or for programs that benefit the less-than-$10,000 jurisdictions, but for the Byrne SCIP grant, these funds must go to state courts (or directly to the less-than-$10,000 jurisdictions) as opposed to state police. **View the list here to find a state's allocation.** As informed by the crisis intervention advisory board, states have discretion to utilize the less than $10,000 pass-through funding in several ways:

1. Fund one less-than-$10,000 jurisdiction.
2. Fund multiple less-than-$10,000 jurisdictions.
3. Fund state courts that provide criminal justice and civil justice services to the less-than-$10,000 jurisdictions within the state.
4. Fund a combination less-than-$10,000 jurisdiction(s) and state courts that provide criminal justice and civil justice services to the less-than-$10,000 jurisdictions within the state.
5. Request a waiver to retain some or all of the less-than-$10,000 funds at the state level for a project that would directly benefit less-than-$10,000 jurisdictions.

Program and Budget Plan Guidance

Program and budget plans for Byrne SCIP funds are required to be expressly approved by BJA after receipt of the award through a scope change Grant Award Modification (GAM). The following is a list of components required for both the program and budget plans:

Program Plan Requirements

- Describe overall goals for the use of Byrne SCIP funds.
- Describe the crisis intervention advisory board, its membership and its governance structure.
- Explain the process for awarding subawards.
- Documentation, such as a signed letter, from the crisis intervention advisory board confirming the board coordinated with the SAA to develop the program and budget plans and that the board approves all submitted plans.
- An explanation of how the required 40 percent pass-through requirement and the under $10,000 allocation will be met.

NCJA Center for Justice Planning

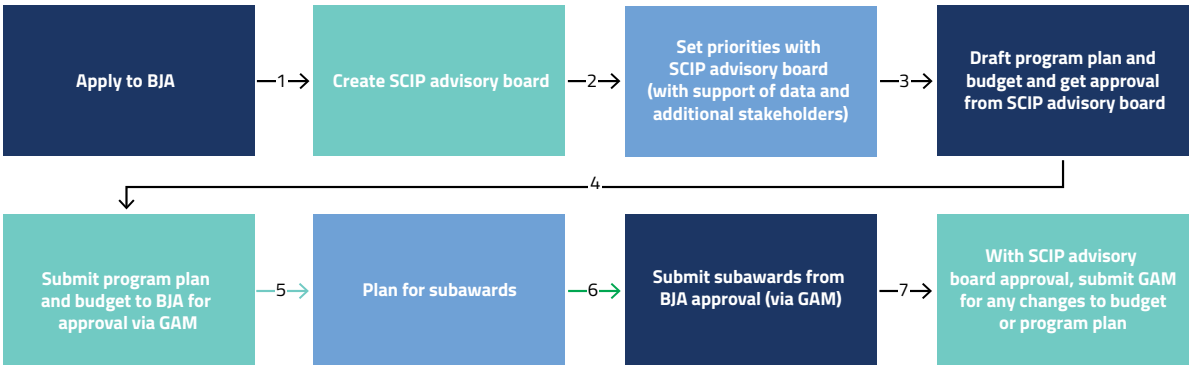
Budget Plan Requirements

- Provide a detailed, itemized budget narrative and breakdown of costs; identify administrative costs and the required pass-through amount by category.
- The budget plan may be integrated into the program plan but must still provide the full itemized breakdown of costs.

When submitting the scope change GAM for program plan and budget approval, make sure to also update the project description for the award; this will populate **the information available to the public about the award**.

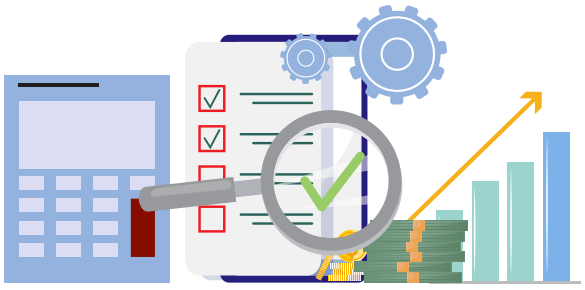
Once the program and budget plans are approved by BJA, SAAs will receive a notification from JustGrants of the GAM approval and BJA will remove the associated withholding condition.

A Graphic Overview of the Byrne SCIP Process



Administrative Costs

SAAs will have access to the full 10 percent of administrative costs once the program plan and budget plan are approved. As a reminder, administrative costs derive from the SAA's entire SCIP award, but will come from the state share of the allocation (the pass-through allocations cannot be reduced). Once the program/budget plan is approved, SAAs will have access to their administrative money as it is spent, not in advance, as Byrne SCIP operates on an immediate disbursement/reimbursement model. Draw downs must be timed to ensure that cash on hand can be disbursed within 10 days.



NCJA Center for Justice Planning

Three Key Differences from Administering Byrne JAG

1. SAAs must utilize the Byrne SCIP grant program as an immediate disbursement/reimbursement model; states will not be allowed to draw down the entirety of the award and place the funds in an interest-bearing account, as many have done with Byrne JAG.

2. Whereas Byrne JAG has a requirement that SAAs must submit a comprehensive statewide strategic plan every five years that details planned resource allocation, use of data and implementation of evidence-informed practices, Byrne SCIP instead requires a BJA-approved program plan and budget plan each award year the SAA seeks to draw down funds.

3. Keep in mind that BJA will need to review and explicitly authorize all subawards under the Byrne SCIP program. Seeking approval of subawards under SCIP includes drafting a scope change Grant Award Modification (GAM) through the JustGrants system and submitting a letter that includes the following: the selection process for the subawards; the entities receiving subawards, along with their grant award amounts and project periods; subaward descriptions; and subaward budgets. Some SAAs may be ready to have their board and BJA approve subawards along with the program plan, whereas other SAAs may need to receive program and budget plan approval first and subaward approval second.

***Keep in mind that the advisory board will need to approve any substantive changes to the SAA's SCIP program plan.**

SCIP Evaluation Component

The Bipartisan Safer Communities Act requires the Department of Justice to evaluate and report to Congress on the effectiveness of the grant funds in reducing gun violence. In addition, BJA is committed to developing a national evaluation of gun violence reduction programming funded by the Byrne SCIP program. The National Criminal Justice Association (NCJA) was selected as the training and technical assistance provider tasked with helping Byrne SCIP recipients collect adequate data for this BJA evaluation. In August 2024 the National Institute of Justice released a **solicitation** on evaluating the Byrne SCIP program. Additional information about the Byrne SCIP evaluation component will be forthcoming. Engaging research partners and/or Statistical Analysis Centers (SACs) is highly encouraged and is an allowable use of Byrne SCIP funds; SAAs are permitted to use funds outside of the amount designated for administrative usage for this purpose.

Extreme Risk Protection Order Programs

For SAAs that intend to allocate some or all of their Byrne SCIP funds to ERPO programs, there are a few specific requirements to be aware of. They are as follows:

- **ERPO Certification:** To ensure all ERPO programs are in compliance with federal minimum requirements, **this signed certification** must be completed annually prior to the use of any funds for ERPO programs. This certification will also be required for the approval of all program and budget plans that include ERPOs.
- **ERPO Requirements:** By statute, ERPO programs are required to meet the following minimum requirements:
  - Pre-deprivation and post-deprivation due process rights that prevent any violation or infringement of the U.S. Constitution.
  - The right to be represented by counsel at no expense to the government.
  - Pre-deprivation and post-deprivation heightened evidentiary standards and proof.
  - Penalties for abuse of the program.

*** Consult the full mandatory requirements for ERPO programs here in the FY 2024 Byrne SCIP state solicitation.**

NCJA Center for Justice Planning

Stakeholder Engagement

Engaging the right stakeholders, including representatives from all affected and relevant parties within and across the criminal justice system, is critical. Stakeholders should be meaningfully involved in the process of determining needs and gaps for this grant program. Involvement and engagement strategies may look different for all active partners, and strategies will need to be reassessed often and deliberately. In addition to ensuring all parties have a seat at the table, it's important to ensure all individuals have an equal voice in this work. Beyond listening to key issues and needs, SAAs should ensure stakeholder perspectives make their way into the program priorities by engaging in frequent follow-up as well as open discussion of how feedback guides program decisions and actions.

Who to Engage

As mentioned, engaging the right stakeholders is critical to ensuring SAAs are aware of all needs, gaps and challenges relating to gun violence and firearm-related suicide in their state. Whether SAAs engage the following non-exhaustive list of stakeholders as part of their crisis intervention advisory board or as part of a separate ongoing stakeholder engagement process, here are some partners to consider in determining how this funding should be allocated:

- State court administrators and judicial officers.
- Statewide treatment court coordinators: these coordinators are responsible for oversight of all treatment courts within the state, which can include drug courts, veterans treatments courts, mental health courts, family courts and juvenile courts.
- 988 partners.
- National Alliance on Mental Health (NAMI): NAMI is a national mental health organization with a mission to provide advocacy, education, support and public awareness so that all individuals and families affected by mental illness can build better lives. NAMI has over 600 local affiliates and 49 state chapters. A local NAMI affiliate search tool is available on NAMI's **website**.
- Court experts familiar with domestic violence protection orders and related charges.
- Community representation: Community representation and engagement should be at the heart of this work. This may mean engaging community-based organizations and nonprofits, but also engaging faith and community leaders, residents and individuals with lived experience.
- State public health and mental health agencies.
- Criminal Justice Coordinating Councils engaged in crisis intervention response initiatives.
- Statistical Analysis Centers and other research partners who can assist in developing a gun violence landscape analysis and program evaluations.
- Partners associated with the **Governor's/Mayor's Challenges to Prevent Suicide Among Service Members, Veterans, and their Families**.
- Victim services representatives, particularly in the domestic violence and gun violence space.

NCJA Center for Justice Planning

Training and Technical Assistance

BJA has ensured that SCIP recipients will receive training and technical assistance (TTA) under this grant program. Three TTA providers have been selected for Byrne SCIP: the National Criminal Justice Association, the Johns Hopkins Center for Gun Violence Solutions and the National Council of Juvenile and Family Court Judges.

Request TTA from any of the three TTA providers **here**:

The **National Criminal Justice Association (NCJA),** through its Center for Justice Planning, is the longstanding TTA provider for the Byrne Justice Assistance Grant (Byrne JAG) program and serves as a TTA provider for Byrne SCIP. NCJA provides guidance, primarily to State Administering Agencies (SAAs) and local Criminal Justice Coordinating Councils (CJCCs), on strategic planning, stakeholder engagement, effective use of data and promising practices, through direct assistance, webinars, workshops, toolkits, resources and other peer-to-peer learning opportunities.

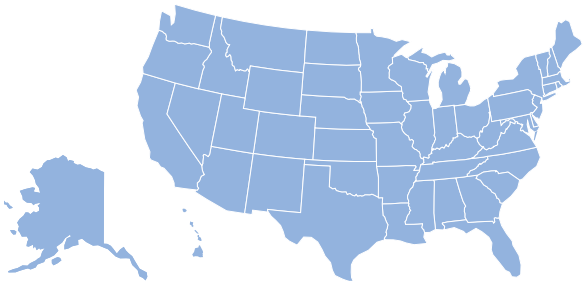
NCJA's Byrne SCIP TTA includes the following:

- Direct assistance in helping Byrne SCIP recipients and subrecipients build capacity to collect and report data as it relates to implementing its BJA-required crisis intervention programming.
- Preparing SAAs receiving Byrne SCIP funds for potential participation in an evaluation on the effectiveness of state crisis intervention programs in preventing gun violence and firearm-related suicide.
- Assisting Byrne SCIP SAAs in the planning and creation of their state Byrne SCIP advisory boards.

Learn more about NCJA's SCIP TTA opportunities **here**. To reach out to NCJA directly, email **ByrneSCIPTTA@ncja.org**.

The **Johns Hopkins Center for Gun Violence Solutions**, in partnership with the U.S. Department of Justice, Bureau of Justice Assistance (BJA), established the **National ERPO Resource Center (ERC)** in 2024. The ERC is a training and technical assistance hub designed to support states and localities in their efforts to establish and implement ERPO programs to fit local needs.

The ERC will also support states so that the ERPO funding received through the Bipartisan Safer Communities Act is effectively utilized and that the law's required constitutional and due process protections are embedded into each relevant state's activities. In collaboration with BJA, the ERC will support ERPO implementers throughout the country, including law enforcement, prosecutors, attorneys, judicial officers, clinicians, educators, veterans' organizations, victim service providers, community organizations, and behavioral health and social service providers.



Johns Hopkins' ERPO Resource Center's TTA includes the following:

- Developing and disseminating stakeholder trainings.
- Providing implementation support.
- Supporting peer-to-peer engagements with model learning sites.
- Performing site assessments.
- Developing presentations and webinars that will advance states and localities' knowledge on key ERPO topics.

To reach out to Johns Hopkins' ERC directly, email **ERPO@jhu.edu**.

NCJA Center for Justice Planning

The **National Council of Juvenile and Family Court Judges (NCJFCJ)** is the nation's oldest judicial membership organization. A trusted source on issues of juvenile justice, family law and domestic violence, the NCJFCJ has a reputation for being at the forefront of systems' change and improvement. NCJFCJ's membership impacts law, policy and practice nationally and in jurisdictions across the country, leading improved systems' response to the issues that affect children, families and victims.

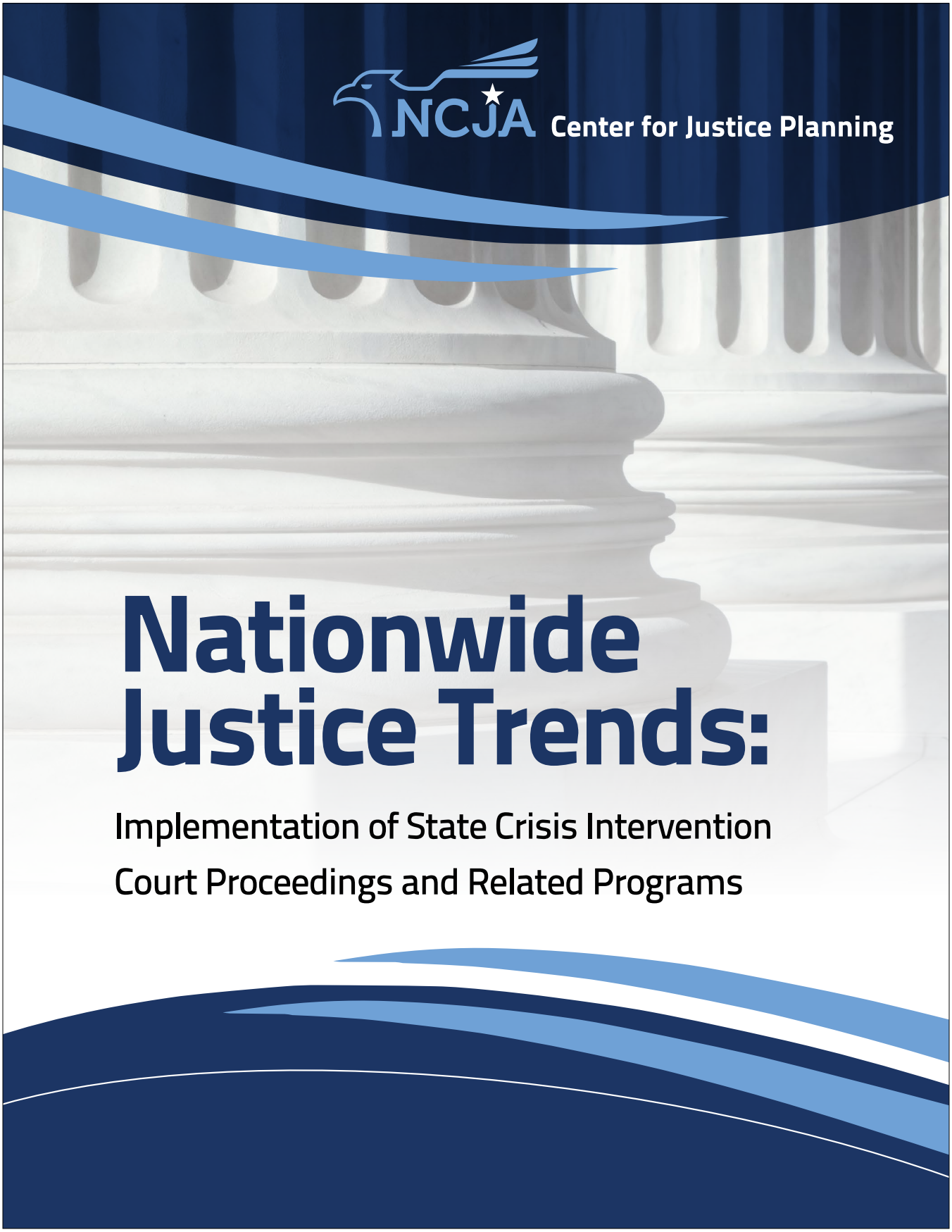
Working in collaboration with BJA and the other TTA providers, NCJFCJ will build and offer support through the Safer Communities Court Resource Center to assist state, local and tribal courts in assessing and responding to court-involved individuals who may pose a risk to themselves or others with a firearm.

The following list represents the TTA offered by NCJFCJ:

- Identifying needs and opportunities to improve court systems' response to people in crisis.
- Developing and providing customized and responsive training and technical assistance for court staff and judicial officers regarding firearms laws and best practice, especially as they apply to court-involved individuals in crisis.
- Providing short on-demand topical court training modules.
- Facilitating peer-to-peer information exchange and interdisciplinary meetings on strategies, overcoming challenges and building relationships with community resources.
- Creating and piloting a court self-assessment protocol to deepen courts' capacities to identify, assess and respond to court-involved individuals in crisis.
- Developing a judicial toolkit on firearms and crisis intervention.

To reach out to NCJFCJ directly, email **SaferCCC@ncjfcj.org**.

This document was created with the support of Grant 15PBJA-22-GK-04999-BSCI awarded by the Bureau of Justice Assistance. The Bureau of Justice Assistance is a program office within the Office of Justice Programs, which also includes the Bureau of Justice Statistics, the National Institute of Justice, the Office of Juvenile Justice and Delinquency Prevention, the Office of Sex Offender Sentencing, Monitoring, Apprehending, Registering, and Tracking, and the Office for Victims of Crime. Points of view or opinions in this document are those of the author and do not necessarily represent the official position or policies of the U.S. Department of Justice.


NCJA
Center for Justice Planning
Nationwide Justice Trends:
Implementation of State Crisis Intervention Court Proceedings and Related Programs

NCJA Center for Justice Planning

CONTENTS

NCJA Center for Justice Planning

Overview

In June of 2022, President Biden signed into law the Bipartisan Safer Communities Act (BCSA), with the goal of reducing firearm-related violence. The Act amended the Byrne Justice Assistance Grant (Byrne JAG) program by adding a new allowable use (a ninth program area) for the implementation of state crisis intervention, certain court and extreme risk protection order programs. Specifically, the new ninth program area authorizes funds to be used for "(i) implementation of state crisis intervention court proceedings and related programs or initiatives, including but not limited to: (i) mental health courts; (ii) drug courts; (iii) veterans courts; and (iv) extreme risk protection order (ERPO) programs." Requirements for ERPOs include the adoption of certain constitutional protections when a court requires the relinquishment of an individual's firearm.

The Act also authorized and appropriated $750 million over five years exclusively for, and limited to, ninth program area activities that advance the gun violence intervention purposes of BSCA. These funds are administered as the Byrne State Crisis Intervention Program (Byrne SCIP) by the Department of Justice, Bureau of Justice Assistance (BJA). State Administering Agencies (SAAs) participating in the Byrne SCIP program must receive approval from BJA for their Byrne SCIP program plan and proposed subawards. If SAAs are administering state crisis intervention programming through the ninth program area of Byrne JAG, these steps are not required. In either case, any funds spent for extreme risk protection order programs would be subject to the protections enumerated in the statute, and all Byrne JAG funds are now authorized to fund civil, as well as criminal, proceedings. Barring a change by a future Congress, the Byrne SCIP funding is separate, and in addition to, funds provided for the Byrne JAG formula program.

While the statutory language is broad, BJA has described an array of possible uses for the Byrne SCIP and the Byrne JAG ninth program area. States and localities may implement and support a broad range of activities including, but not limited to:

- **Support for states implementing ERPO programs; training for those implementing ERPO programs; communication, education and public awareness campaigns/initiatives for existing ERPO laws.**
- **Support for problem solving court programs such as treatment, mental health and veterans treatment courts to expand programming to specifically accept clients with firearm violations.**
- **Support for court-based programs that identify and provide support to people in crisis, including those at risk of harm to themselves or others with a firearm, assessing their circumstances and needs, and connecting them with programs and services that can provide them with needed help and support.**
- **Support for deflection and diversion to behavioral health treatment and support services for those at risk to themselves or others.**
- **Funding for law enforcement on crisis intervention programs or initiatives.**

*For additional ideas regarding what Byrne SCIP funds can be used for, please consult questions 32 and 33 of **BJA's Byrne SCIP FAQ document**.

This brief outlines key trends and programming ideas related to reducing gun violence, improving crisis intervention and preventing firearm-related fatalities. It is intended to be a resource for SAAs as they conduct strategic planning activities and allocate funds whether through Byrne JAG or Byrne SCIP. This document is not an exhaustive list of programing trends. Grantees are encouraged to reach out to BJA directly to ensure planned investments will be allowable as policies can change and are updated frequently.

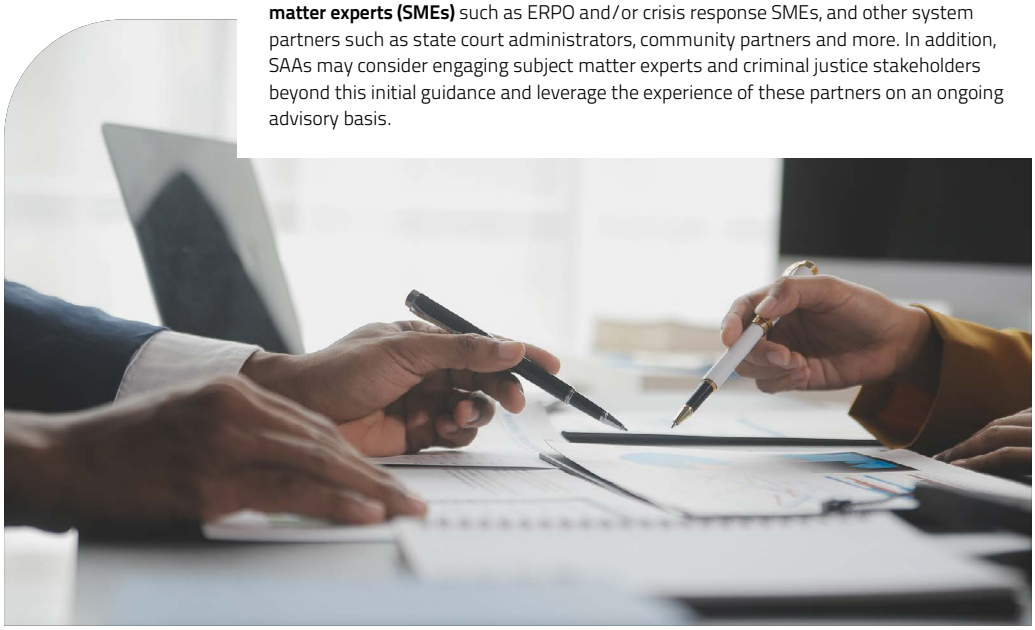
NCJA Center for Justice Planning

Trends & Programming Ideas

I. Research, Planning and Evaluation

Research, planning and evaluation are important components when allocating grant funding and in determining if investments are working as intended. Funding can be allocated towards working with research partners on a variety of projects such as conducting a **firearm violence landscape analysis** to determine trends, needs and baseline data and to assess the type(s) of gun violence to be addressed with these funds, such as domestic violence, suicide, community violence and/or mass shootings.

Research and evaluation partners can help SAAs ascertain the effectiveness of crisis intervention programs and ERPO initiatives in preventing violence and suicide, assess whether ERPOs are issued equitably and ensure measures are taken to safeguard the constitutional rights of individuals subject to these programs and initiatives. Lastly, to determine needs and gaps for a state, it can be useful to **engage and convene subject matter experts (SMEs)** such as ERPO and/or crisis response SMEs, and other system partners such as state court administrators, community partners and more. In addition, SAAs may consider engaging subject matter experts and criminal justice stakeholders beyond this initial guidance and leverage the experience of these partners on an ongoing advisory basis.



TIP: When determining needs and gaps within your state related to addressing gun violence, crisis response and firearm-related suicide, one helpful resource to consult is the **Everytown For Gun Safety Action Fund**, which details news, priorities and gun violence statistics for each of the 50 states.[1]

TIP: Familiarize yourself with the most prominent types of firearm violence in your state and consider how different types of violence may require different solutions and approaches.

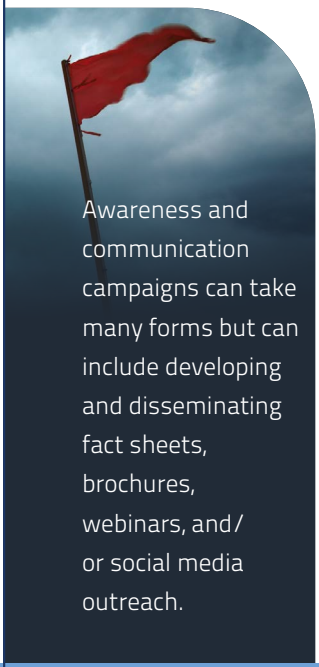
- Suicide by firearm
- Community gun violence
- Youth violence (with a firearm)
- Domestic violence (with a firearm)
- Mass shooting
- School shooting

NCJA Center for Justice Planning

II. Extreme Risk Protection Order Support

Extreme risk protection order (ERPO) laws, often known as red flag laws, allow law enforcement, and, depending on the state, family members, health care providers and school officials to petition a court to temporarily prevent a person from accessing firearms if they are found to be a danger to themselves or others.[2] **Twenty-one states, the District of Columbia and the Virgin Islands** currently have ERPO laws.[3] Funding can be used to expand or support ERPOs in states with existing ERPO laws and to support ERPOs in a variety of ways. Funding cannot be used to "support the enactment, repeal, modification or adoption of any law, regulation or policy at any level of government."[4] SAAs can support **training** for judiciary and court staff, family members and first responders on how to best implement ERPO programs (including support for law enforcement and firearm tracking systems, discussed in more detail below) or to **launch or bolster existing communication, education and public awareness projects in states that have ERPO laws.** Awareness and communication campaigns can take many forms but can include developing and disseminating fact sheets, brochures, webinars, and/or social media outreach. One technique to support ERPOs could be to **discuss the value and public safety benefits of ERPO laws and programs and the importance of effective development and implementation through outreach** to community members, stakeholders, municipal leaders, law enforcement agencies and those engaging with at-risk individuals.

TIP: Specifically, when it comes to outreach to law enforcement agencies on awareness, process and education about ERPOs, it can be useful to enlist a credible messenger, ideally someone with either current or past law enforcement experience.



Awareness and communication campaigns can take many forms but can include developing and disseminating fact sheets, brochures, webinars, and/or social media outreach.

Successful implementation of extreme risk laws requires a robust infrastructure at the state and local levels. These laws create a civil legal remedy that is maximized by coordination among executive leadership, law enforcement agencies, prosecutors and city/county attorneys, judges and court personnel, and social service and mental health care providers (including crisis responders) to ensure that this remedy is widely available and accessible, that it is used in appropriate cases and in an equitable manner, and that the rights of ERPO respondents are protected. A thoughtfully designed ERPO infrastructure will ensure that this coordination is ongoing and that key ERPO partners develop comprehensive processes for each stage of an ERPO case. State and local infrastructure should also include an emphasis on equity from the outset. This includes meaningful collaboration with a variety of representatives from communities disproportionally impacted by gun violence, particularly communities that have historically experienced disinvestment and limited access to gun violence prevention and intervention services. The perspectives of those most impacted by gun violence should be an integral part of the design of ERPO implementation plans. Robust ERPO infrastructure will also enable state and local entities to identify additional resource needs for implementing these laws and to collaborate on shared needs with the state, such as training, public-facing resources and data collection.

Johns Hopkins Center for Gun Violence Solutions, in conjunction with Everytown for Gun Safety, has created a **guide** that presents foundational issues for state and local leaders to consider when developing ERPO infrastructure, with an emphasis on ensuring equitable implementation throughout.[5]

NCJA Center for Justice Planning

Messaging Extreme Risk Protection Orders

In communicating with the general public, conveying what extreme risk protection orders are, and ultimately, what they are not, is just as important as communicating effective implementation. The Ad Council Research Institute and the Joyce Foundation conducted a study in 2023 to understand working knowledge of ERPOs and the best ways of communicating what ERPOs are designed to accomplish. The study included participants from the general public and from law enforcement within the (then) 19 states and the District of Columbia where ERPOS were in place. For analysis purposes, the study collected participant information such as gender, marital status, generation, race, veteran status, political party, knowing someone in crisis, gun ownership and other factors.

Some of the findings include:

- Describing a specific situation such as a planned suicide attempt and explaining the role of an ERPO in prevention resonated with survey respondents.
- Concerns surrounding ERPOs included the temporary nature of the law (some participants wanted it to be permanent, while others did not believe the order would truly be temporary;) unfair application; and Second Amendment violations. ERPO messaging campaigns can be adjusted or adapted in response to these concerns.
- Sixty-six percent of the general public and 79 percent of law enforcement agree that ERPOs can help someone in crisis stay safe, and 48 percent of the public and 59 percent of law enforcement think the law does NOT violate Second Amendment rights.
- Study participants feel they need more information to understand the benefits of ERPOs.
- Language matters when describing what extreme risk protection orders are and how they work; individuals may react differently to the term ERPO or the way the definition is worded.
- The study also indicated some preliminary ideas for how to message ERPOs, although additional information is needed.[6]

III. Behavioral Health Deflection

Deflection, also known as pre-arrest diversion, refers to situations in which law enforcement or other first responders refer individuals in need to community-based services, treatment and support in lieu of traditional interventions such as arrests. This process "deflects" individuals from entering the criminal justice system entirely, and is different from diversion programs, which begin after an arrest has been made.[7] Deflection initiatives and programs include those used in emergency situations, such as mobile crisis units, but also address needs stretching beyond moments of crisis.

A useful level-setting technique for those interested in utilizing funds for deflection programs is to complete an inventory of existing mental health programs in the state/territory prior to determining the primary gaps and needs for behavioral health deflection and crisis intervention. The **NACo Stepping Up Initiative website** has a map that depicts existing mental health programs currently operating in each state.[8] This can help prevent the duplication of existing efforts and also provide resources for programs experiencing successful outcomes.

One important component of behavioral health deflection revolves around supporting individuals who are in immediate crisis. This could include **triage services, telehealth initiatives** and **peer support specialists**. Additionally, **crisis intervention teams** or **mobile crisis units** can be viable solutions to addressing mental health and/or substance use disorders while decreasing or avoiding criminal justice system involvement. Response teams are usually either co-response models, meaning law enforcement arrive simultaneously with trained professionals, or community response-oriented, indicating a non-law enforcement response. For a toolkit about community response programs, **click here**.[9]

NCJA Center for Justice Planning

SPOTLIGHT: One of the longest running mobile crisis units is the community-response program **Crisis Assistance Helping Out On The Streets** (CAHOOTS), based in Oregon.[10] This 24/7 model dispatches response teams comprised of a medical professional and a mental health crisis worker. **Program services** include trauma-informed de-escalation, welfare checks, non-emergency medical aid, suicide prevention and intervention, housing crisis assistance and crisis counseling.[11]

SPOTLIGHT: Telehealth initiatives such as the **CORE Telehealth Program** in Harris County, Texas provide officers with quick access to behavioral health professionals through the use of iPads. The typical time to connect to a behavioral health professional is one minute and the average assessment by the behavioral health professional takes around 20 minutes. Other technology supports include smartphone applications to help families and patients navigate mental health systems and telehealth initiatives.[12] An implementation guide to assist others seeking to start a telehealth program can be viewed **here**.[13]

TIP: The Bureau of Justice Assistance's **Justice and Mental Health Collaboration Program (JMHCP)** supports innovative cross-system collaboration for individuals with mental illness or co-occurring mental health and substance misuse disorders who come into contact with the justice system. BJA funded programs engage in a collaborative project with criminal justice and mental health partners to plan, implement or expand a justice and mental health collaboration program.[14] **View previously funded programs** for ideas on how to structure collaborations between mental health partners and criminal justice stakeholders or to read descriptions of the programs.[15]

Additionally, courts can play an important role in deflecting and diverting individuals in crisis and ensuring the proper services and support are received. Section IV provides additional discussion regarding how courts can identify and assess people in crisis and how courts can take steps to make referrals for individuals in crisis to receive specialized help.

Support for Implementing 988

The **National Suicide Hotline Designation Act of 2020** required the Federal Communications Commission (FCC) to designate 988 as the universal telephone number for the National Suicide Prevention Lifeline. The FCC required telephone providers to make calls to the National Suicide Prevention Lifeline through 988 accessible by July 16, 2022; additionally, states are expected to create an implementation plan for 988.[16]

Given that the **988 dialing code** is in its early days of universal adoption, one potential use of funds for state crisis intervention programming is to **support the implementation of the 988 code**.[17] The creation of the 988 dialing code created standards for crisis call centers and crisis response services including how calls are received and handled, standards for mobile crisis units and expectations for high-quality stabilization programs. Funds can be used to expand current programming to meet needs and fill gaps, evaluate whether programming and services are efficient and meeting national standards, integrate 988 with the 911 system, and provide training on the proper implementation of these standards. View the NCJA fact sheet on 988 **here**.[18]

SPOTLIGHT: In the summer of 2021, Oregon's legislature passed **House Bill 2417**, which set aside general fund dollars to implement 988 call centers, 988 implementation and infrastructure.[19] In addition, this legislation supports the Substance Abuse and Mental Health Services Administration (SAMHSA)'s best practices by including a workgroup to study and evaluate behavioral health supports for 988 including mobile crisis, peer respite and walk-in crisis centers.[20]

NCJA Center for Justice Planning

Suicide Prevention Campaigns

Owning a firearm elevates an individual's risk for death by suicide. A **study by Stanford University** found that men who owned handguns were eight times more likely to commit suicide by firearm in comparison to men who didn't own a handgun and women were 35 times more likely to commit suicide with a firearm in comparison to women who didn't own a handgun.[21] To address this elevated risk, informational campaigns about the prevalence of suicide rates among gun owners, created in conjunction with the community, firearm instructors, gun shop owners and other partners can spread awareness about the role the public can play in preventing firearm suicide.

SPOTLIGHT: In 2009, Means Matter, part of the Harvard T.H. Chan School of Public Health, began working on a **Gun Shop Project** in New Hampshire, focused on reaching out to gun shop owners to let them know the critical role they play in suicide prevention.[22] Guided by the **New Hampshire Firearm Safety Coalition**, this project created materials and resources in conjunction with firearm retailers and range owners with the main intention of sharing guidelines on avoiding selling or renting a firearm to a customer experiencing suicidal ideation and encouraging gun stores and ranges to display and hand out suicide prevention materials specific to their customers.[23] Harvard T.H. Chan School of Public Health also serves as the research partner for this project, which is now nationwide.

TIP: In conjunction with the U.S. Department of Veterans Affairs, SAMHSA created the **Governor's and Mayor's Challenges to Prevent Suicide Among Service Members, Veterans and their Families**. For both challenges, states/territories (Governor's Challenge) and cities/communities (Mayor's Challenge) must convene a wide swath of stakeholders to create an evidence-informed implementation plan to reduce suicide.[24] Ninth program area Byrne JAG funds and/or Byrne SCIP funds could be used to expand a state's/territory's Governor's Challenge work or begin or expand a community's Mayor's Challenge efforts. Additionally, Challenge partners could serve as useful subject matter experts and/or resources for Byrne SCIP advisory boards and other state crisis intervention programming.

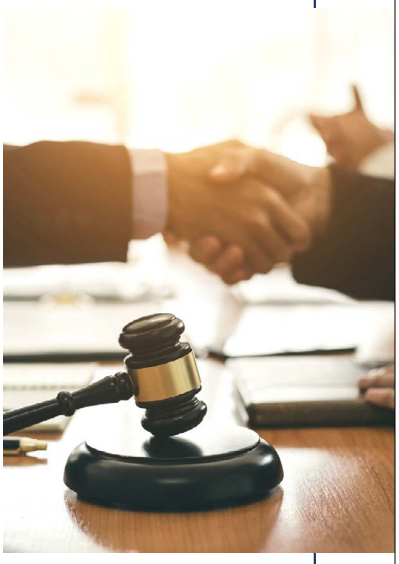
IV. Opportunities for Courts to Assist Individuals in Crisis

Courts can play a vital role in identifying individuals in crisis and making appropriate referrals to services and other court and community-based programs. All court professionals and their colleagues whose work brings them into contact with court-involved individuals on a regular basis can participate in this identification and referral process. This includes judicial officers, court administration and staff, attorneys, advocates and other service providers, and law enforcement. Judicial officers and court managers are well-positioned to take a leadership role in galvanizing support and engagement for community-based behavioral health groups and other important partners to help establish a smooth pathway to services and support for court-involved individuals in crisis.

In the wake of the **report and recommendations** made by the National Judicial Task Force to Examine State Courts' Response to Mental Illness,[25] convened by the Conference of Chief Justices and Conference of State Court Administrators, state offices of court administration across the country have established positions and programs on behavioral health to enhance their courts' response to mental and behavioral health issues among individuals who come into contact with the court system. The work of these professionals has strengthened existing court-based programs and has spurred the development of new and promising approaches within courthouses in diverse parts of the country. SAAs (that are housed in the executive branch) can work with court partners to identify opportunities to fund and support these initiatives, which can include:

- Establishing behavioral health specialists in courts, including in "navigator" positions, to serve as initial referral points for the identification and assessment of individuals in crisis, and to provide "warm" referrals to community-based service providers and programs, as well as to court-based programs where appropriate (e.g., treatment court programs). See the compendium from Policy Research Associates, Inc. for national examples of this approach.[26]
- Placing peer-support specialists in court settings to engage in similar activities and provide additional support to individuals in crisis. For more information, read this brief.[27]
- Training court personnel (clerks, bailiffs, pre-trial supervision, security officers and others) on recognizing and working with people experiencing a behavioral health crisis. For an example of what this could look like, consult the National Center for State Courts (NCSC)'s four-part e-learning series.[28]
- Convening court-led behavioral health summits to engage with a multi-disciplinary group of court staff, behavioral health professionals and community providers. Vermont convened the first judiciary-led mental health summit in September of 2023.[29]
- Cultivating judicial leadership and involvement in resource mapping to identify available services and programs as well as gaps. Consider consulting this toolkit for an example of what this might look like.[30]
- The development of judicial tools, such as bench cards and manuals, regarding the response to behavioral health needs of litigants/defendants. View the Judges and Psychiatrists Leadership Initiative resources[31] for example tools and documents, including this Judges' Guide to Mental Illnesses in the Courtroom.[32] Additionally, the Texas Office of Court Administration created a resource guide to help address the needs of people within the court system with mental illness.[33]
- Training court-based behavioral health navigators, peer-support specialists and related professionals on available support and proper responses when firearms may be an issue for individuals in crisis.
- Court-led implementation of the Sequential Intercept Model (SIM) to identify gaps within criminal justice systems for individuals with behavioral health needs and highlight resources to help bridge those gaps. Developed in the early 2000s, SIM recognizes that individuals with behavioral health problems can be pulled deeper into criminal justice systems, depending on what occurs at each of six touchpoints, or intercepts.[34]
- Preparing for critical incidents, including preparing processes and responses and ensuring staff are debriefed and aware of the proper ways to support individuals in crisis.

Specialty courts, also sometimes referred to as problem-solving courts, focus on one type of criminal offense or person committing the crime. Usually composed of a multidisciplinary team, specialty courts improve case processing and reduce caseloads, and are focused on reducing recidivism through approaches that address underlying issues such as substance misuse and mental illness.[35] Many problem-solving courts promote diversion from further involvement in the criminal justice system. Byrne JAG has been a primary source of funding for drug and other specialty courts for many years and can be a good use of crisis intervention funding in the future. There are many different types of specialty courts, including **drug courts, mental health courts, veterans treatment courts, domestic violence courts and community courts.** Community courts are partnerships between the community and the justice system and are highly localized; these courts do not specialize in a particular type of offense or individual but instead address root causes and needs contributing to instances of crime and social disorganization in target neighborhoods.[36]



SAAs can create a new specialized court based on an established model or **expand the capacity of existing courts to assist clients most likely to commit or become victims of gun crime.** They may also **expand specialty court dockets to include individuals with violent offenses or** individuals with felony offenses, violent or not. Studies of drug court programs show that individuals with felony offenses remain in treatment longer, graduate from drug court programs at higher rates and have lower recidivism while under supervision than individuals with misdemeanor offenses.[37]

NCJA Center for Justice Planning

SPOTLIGHT: Planning for New York's **Brooklyn Mental Health Court** was a year-long planning process that included representatives of several court systems, state agencies, public defender organizations, advocacy groups, individuals with lived experience in the criminal justice system and mental health treatment and service providers. The court is open to individuals with felony offenses, making it one of the first mental health courts to accept felonies. Violent offenses, including felonies, are eligible on a case-by-case basis. In the first 3.5 years of operation, the court had 280 defendants enter the program; of those, 20 percent were charged with misdemeanors, 37 percent with nonviolent felonies and 43 percent with violent felonies.[38] **Compared to a control group**, participants of this court were 46 percent less likely to be rearrested.[39]

SPOTLIGHT: In 2019, Montana's Eighth Judicial District Court received a grant from the **BJA Veterans Treatment Court Program** to create a **Native American Treatment Court Cultural Program**. This program stands in conjunction with the district court's drug court and veterans treatment court. Native American participants receive holistic healing and care that is individualized, trauma-informed and culturally relevant. The grant allowed the court to hire a cultural coordinator and the ability to partner with Indian Family Health Clinic to provide services and cultural opportunities.[40/41] The addition of this program has seen a **64 percent increase** in Native American program enrollees and a nearly 52 percent increase in successful program completion.[42]

Funds can also be used for other court-based programming and technology to support crisis intervention, such as **developing and implementing unbiased case management and navigation programs** to assess the strengths, needs and risks of clients and connecting them to critical services.

V. Domestic Violence Protection Order Support/ Enhancement

When an individual is experiencing domestic violence, they may file a court petition for a protection order to request that the court impose restrictions on the abuser, which can include prohibiting contact with the victim/survivor or others or requiring the abuser to stay away from the victim/survivor's home, workplace or school. Requirements for obtaining an order of protection vary by state. Many states have **firearm surrender programs associated with domestic violence protection orders,** although not all states operate these programs similarly. **Domestic violence protection orders** that require firearm relinquishment reduce intimate partner homicide by 12 percent and reduce firearm-related intimate partner homicide by 16 percent.[43] A best practice is for firearm restrictions to cover temporary domestic violence protective orders.[44] Federal law prohibits current or former spouses and dating partners that have either shared a household or have children with the survivor from accessing firearms. One area for potential expansion, depending on the state, could be closing this "dating partner loophole" and ensuring any dating partner, regardless of whether they share a home or a child with the victim or not, cannot access and possess firearms.[45]

SPOTLIGHT: **AZPOINT** is a free online system that allows individuals in Arizona to complete a petition for a protective order at any time, on any device, from anywhere. The site provides contact information to connect victims to advocates who can assist in the completion of the form.[46] Once a petition is completed, the individual contacts the court via phone or in person to retrieve the petition. The court will then schedule a virtual or in person hearing. According to a 2021 assessment, since AZPOINT's launch in January 2020, 70 percent of orders issued by the court are served within seven days. Previously, with the paper system, it took an average of 23 days from when a judge granted an order of protection until the time it was served. To learn more, read **the NCJA Promising Practice brief**.[47]

SPOTLIGHT: Vermont maintains a list of federally licensed firearms dealers throughout the state that are willing to temporarily store firearms due to protection orders or other reasons. If someone is experiencing domestic violence, a relief-from-abuse order can require the person causing harm to surrender any firearms. If the order is granted, law enforcement serve a copy of the order to the individual and request immediate firearm surrender; once relinquished, law enforcement can store the firearms with one of the participating dealers. Gun owners are also welcome to voluntarily store firearms, for any reason, including someone living within the house experiencing mental health or substance misuse concerns, including being at risk for suicide; travel; or visiting children or grandchildren.[48]

VI. Law Enforcement Programs

Many of the programs and examples listed throughout this brief are the responsibility, or involve the participation, of law enforcement agencies and officers. In addition, police and sheriffs' departments have infrastructure and technology needs for gun violence intervention initiatives that SAAs can support with their crisis intervention funding. These could include **training** for officers on de-escalation, **school safety initiatives, out of the house gun storage programs and gun locks**. More agencies are leveraging virtual reality-based training simulations for law enforcement in recent years, using virtual reality for difficult situations such as intervention techniques for individuals experiencing behavioral health crises and reactions and interventions for other potentially high-risk scenarios. For relinquished firearms, it is important for law enforcement to both safely store those weapons and ultimately, ensure they are returned appropriately in the condition in which the firearm was received. Funds can be utilized to **create or expand programs or software that focus on securing, storing, tracking and returning relinquished guns**.

In recent years, there has been increased attention on ensuring law enforcement officers recognize the signs of an individual in crisis, and importantly, know how to approach a situation where an individual is experiencing a crisis in an appropriate and trauma-informed way. More police departments are integrating behavioral health providers, such as clinical psychologists, into their departments as full-time employees to ensure that when an individual is in crisis, a psychologist can co-respond with a law enforcement officer. The Bureau of Justice Assistance and the Community Oriented Policing Services (COPS) Office are in the process of implementing the Law Enforcement De-Escalation Training Act passed by Congress in December 2022. This new program will establish best practices for de-escalation training, a trainer-the-trainer program and formula grant funding to states and local law enforcement agencies.

SPOTLIGHT: Massachusetts' Cambridge Police Department developed the Family and Social Justice section of the department, which includes the Clinical Support Unit, comprised of a clinical psychologist and two social workers who are embedded in the police department. The goal of the Family and Social Justice section is for non-sworn clinical professionals to partner with police to reduce incarceration of vulnerable populations such as unhoused individuals, juveniles and individuals with mental health and/or substance misuse concerns. One way in which the program achieves this goal is through diversion and by improving access to community-based services.[49]

Sharing information, especially across agencies and segments of the criminal justice system can be difficult. Funds can be used to **improve information sharing systems**, such as those ensuring law enforcement and probation officers, prosecutors and public defenders are informed when a prohibited individual attempts to purchase a firearm.

SPOTLIGHT: The state of California implemented its Armed and Prohibited Persons System[50] in 2006, which monitors several state databases for prohibiting events and compares these events to the list of firearm owners. After determining a firearm has become prohibited, analysts investigate and state agents—usually in conjunction with local law enforcement—request voluntary relinquishment or confiscate the illegal gun(s). Priority is given to individuals under gun violence restraining orders and recent purchasers of ammunition.[51]

NCJA Center for Justice Planning

VII. Community Violence Intervention

Although not specific to Byrne JAG or Byrne SCIP, community violence intervention (CVI) programs can effectively decrease firearm violence. These programs reduce shootings and homicides by establishing relationships with the individuals who are most at risk of engaging in gun violence or being a victim of it. This approach is centered in the community and aims to disrupt the cycle of violence. For an overview of community violence intervention, see the **NCJA fact sheet**.[52] Congress has funded through annual appropriations and the Bipartisan Safer Communities Act a **Community Based Violence Intervention and Prevention Initiative Grant** program.[53] SAAs can use funds to supplement or expand a project under this grant. One potential use for these funds is to **support CVI programs specifically aimed toward connecting youth at risk for gang involvement with community resources, programming and mentoring**.

There are a few key CVI models to consider. Often, community violence intervention programs **employ street outreach workers or violence interrupters** to go into the community and serve as credible messengers. Violence interrupters are usually selected based on their credibility within a community and spend much of their time connecting with high-risk individuals, identifying unresolved conflicts and preventing retaliatory violence. **Crime prevention through environmental design** is based upon studies that have shown that adding greenery, improving lighting, cleaning up trash and providing spaces for community gathering can be effective forms of violence reduction.

SPOTLIGHT: Modeled on Chicago's **Cure Violence** program[54], New York's SNUG Street Outreach Program is an evidence-based gun violence reduction effort established in 2009. SNUG engages individuals at the highest risk of being impacted by gun violence by identifying the source of the violence, interrupting the transmission and offering services and support. Street outreach workers live in the communities in which they serve and have experience themselves with the justice system, which allows them to be seen by the community as credible messengers.[55]

SPOTLIGHT: Seattle, Washington's **Rainier Beach: A Beautiful Safe Place for Youth** is a community-led, data-driven program that uses evidence-informed tailored interventions for high-crime hot spots. With an emphasis on reducing youth crime and victimization, interventions are non-arrest based and include restorative practices, improving the physical environment of the hotspots, engaging local businesses, community healing spaces and more.[56]

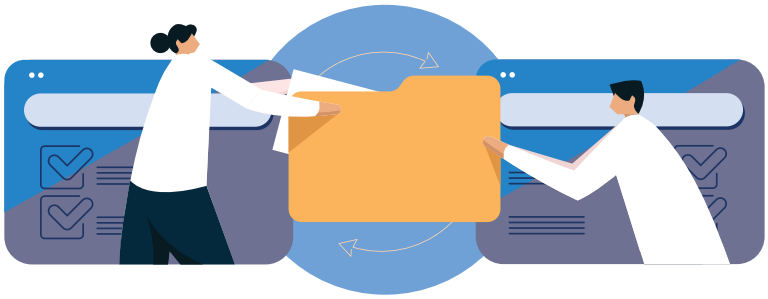
Hospital-based violence interruption programs work to reduce retaliatory violence by intervening when an individual is in the hospital suffering from an intentional gun-inflicted injury. These programs consist of community-based partners and medical staff. Program participants receive mentoring, community-based services, long-term case management and social support. Care and services continue after the individual is discharged from the hospital and reenters the community.[57]

SPOTLIGHT: The **Penn Trauma Violence Recovery Program** (PTCRP) is a hospital-based violence intervention program led by a small staff of employees at Penn Presbyterian Medical Center. The program focuses on survivors of violent injury to address gaps between medical care and ease transitions back to the community by providing individualized support and providing wraparound services, even after discharge. The PTCRP works closely with community partners to link individuals to job training, victims' compensation funds, mental health care and more.[58]

In 2020, gun violence was the leading cause of death for children and teenagers. In comparison to white youth, Black youth are 14 times more likely to die from gun violence and Hispanic youth are three times as likely. These disparities lie in the historic under-investment and disinvestment in communities of color, leaving many with high rates of poverty and lacking vital social services and resources. When thinking about supporting a community violence intervention program, it is important to ensure the program has a comprehensive and holistic approach to gun violence reduction, and that also includes youth. To learn more, **this Center for American Progress article** contains the key elements of youth-focused community violence intervention programs, including two case studies.[59]

SPOTLIGHT: **Operation Peacekeeper** began in 1997 as a law enforcement initiative aimed at combatting gun violence among youth gang members in Stockton, California and has since expanded into a comprehensive violence prevention and intervention program. Operation Peacekeeper uses a problem-oriented "pulling levers" focused deterrence strategy, meaning that the intent is to deter violent behavior by "pulling every lever" possible when an incident of violence occurs. The program's approach includes: a working group of law enforcement professionals; utilizing research to identify key individuals and groups at risk of engaging in violence; providing targeted social services and resources to those who most need them; and repeated engagement with those at highest risk of violence. Outreach workers strive to provide jobs to gang-involved youth and wrapround services for youth and their families. A 2008 evaluation revealed a 42 percent decrease in the number of gun homicides occurring monthly in the city.[60]

NCJA Center for Justice Planning



VIII. Training and Technical Assistance

The **National Criminal Justice Association (NCJA)** is the longstanding federal training and technical assistance (TTA) provider for the Byrne JAG grant and is one of three TTA providers for the Byrne SCIP program. NCJA's Center for Justice Planning team supports Byrne SCIP and Byrne JAG recipients in building their capacity to collect and report data as it relates to implementing crisis intervention programming. The Center for Justice Planning team also prepares SAAs for potential participation in a BJA-led evaluation of the effectiveness of crisis intervention programs in preventing gun violence and firearm-related suicide. NCJA provides guidance on strategic planning, stakeholder engagement, effective use of data and more, through direct assistance, webinars, tools, resources and peer-to-peer learning opportunities. NCJA will continue to provide training and technical assistance opportunities for SAAs, expanded and modified to address crisis intervention-related needs of SAAs and their subgrantees.

To request Byrne JAG TTA from NCJA, please email **strategicplanning@ncja.org.** To request Byrne SCIP TTA from NCJA, the Johns Hopkins Center for Gun Violence Solutions or the National Council of Juvenile and Family Court Judges, complete the **TTA request form**.

IX. Appendix of Trends and Programming Ideas

1. Training for those implementing ERPO programming
2. Communication, education, and public awareness for ERPO programs
3. ERPO programing support, other
4. Assertive community behavioral health treatment
5. Behavioral threat assessment programs and related training
6. Suicide prevention efforts
7. Crisis response programs and/or support for 988 implementation/ coordination with behavioral health agencies
8. Prevention efforts focused on youth
9. Court-based strategies, including threat assessment training for prosecutors, judges, law enforcement and public defenders
10. Expanding capacity of or starting new specialty courts (e.g. drug, mental health, veterans treatment, domestic violence)
11. Technology, analysis, or information-sharing solutions for ensuring law enforcement, probation, prosecutors, the courts, and public defenders are informed when a prohibited person attempts to purchase a firearm
12. Development and implementation of validated gun violence risk assessment tools, service case management, and navigation programs to assess the risks and needs of clients and connect them to critical services to mitigate their risk of gun violence and enhance their access to effective interventions
13. Domestic violence prevention strategies
14. Community-based violence intervention strategies
15. Law enforcement-led intervention strategies
16. Gun safety awareness and training
17. Development and/or delivery of specialized training and overtime for officers to attend training
18. Firearm tracking and relinquishment
19. Other

NCJA Center for Justice Planning

X. Endnotes

1. "States," Everytown for Gun Safety, accessed September 14, 2023, https://www.everytown.org/states/.
2. Executive Office of the President: Office of Management and Budget, Statement of Administration Policy: *H.R.2377—Federal Extreme Risk Protection Order Act of 2022*, June 7, 2022, https://www.whitehouse.gov/wp-content/uploads/2022/06/hr2377-SAP-FINAL.pdf. "
3. "State Laws in Detail," Extreme Risk Protection Order: A Tool to Save Lives, Johns Hopkins Bloomberg School of Public Health, Bloomberg American Health Initiative, August 2023, https://americanhealth.jhu.edu/implementERPO.
4. "Part III Chapter 16: Unallowable Costs," U.S. Department of Justice Office of Justice Programs, accessed November 27, 2024, https://www.ojp.gov/sites/g/files/xyckuh241/files/archives/financial_guides/financialguide09/part3/part3chap16.htm
5. Johns Hopkins Bloomberg School of Public Health: Center for Gun Violence Solutions and Everytown for Gun Safety, *Promising Approaches for Implementing Extreme Risk Laws: A Guide for Practitioners and Policymakers*, May 2023, https://publichealth.jhu.edu/sites/default/files/2023-05/2023-may-cgvs-promising-approaches-for-implementing-extreme-risk-laws.pdf.
6. Ad Council Research Institute and The Joyce Foundation, *ERPOs: Understanding Public Knowledge & Attitudes Toward Extreme Risk Protection Orders*, 2023, https://www.adcouncil.org/learn-with-us/ad-council-research-institute/extreme-risk-protection-orders-erpos-study.
7. "Deflection: A Powerful Crime-Fighting Tool That Improves Community Relations," Jac Charlier, Police Chief Magazine, accessed November 3, 2023, https://www.policechiefmagazine.org/deflection-a-powerful-crime-fighting-tool-that-improves-community-relations/.
8. "The Stepping Up Initiative," National Association of Counties, accessed September 14, 2023, https://www.naco.org/resources/signature-projects/stepping-initiative.
9. "Expanding First Response: A Toolkit for Community Responder Programs," The Council of State Governments Justice Center, accessed September 14, 2023, https://csgjusticecenter.org/publications/expanding-first-response/.
10. "CAHOOTS: Crisis Assistance Helping Out On The Streets," White Bird Clinic, accessed September 14, 2023, https://whitebirdclinic.org/cahoots/.
11. The National Criminal Justice Association, *Promising Practices: The Role of Crisis Intervention Teams and the Success of the CAHOOTS Model*, April 2023, https://www.ncja.org/_files/ugd/cda224_1dbb00722be342c583b7c0841134854d.pdf.
12. "Telehealth Technology in Law Enforcement," Harris County Sheriff's Office, accessed September 14, 2023, http://harriscountycit.org/telehealth-jump-two/#:~:text=Harris%20County's%20CORE%20Telehealth%20Program%20provides%20patrol%20deputies%20and%20officers,mental%20or%20behavioral%20health%20problems.
13. Harris County Sheriff's Office et al., *Telehealth Implementation Guide*, December 2020, https://issuu.com/fwebbhcso/docs/implementation_guide_march_31_2021?fr=sMzk1YTM0MDYyNTQ.
14. "Justice and Mental Health Collaboration Program (JMHCP): Overview," Bureau of Justice Assistance, updated January 2023, https://bja.ojp.gov/program/jmhcp/overview.
15. "Justice and Mental Health Collaboration Program (JMHCP): Funding," Bureau of Justice Assistance, updated May 2023, https://bja.ojp.gov/program/jmhcp/funding#4jj64p.
16. "S.2661—National Suicide Hotline Designation Act of 2020," Congress.gov, accessed September 14, 2023, https://www.congress.gov/bill/116th-congress/senate-bill/2661.
17. "988 Suicide & Crisis Lifeline," Substance Abuse and Mental Health Services Administration, updated April 2023, https://www.samhsa.gov/find-help/988.
18. The National Criminal Justice Association, 988: *A Fact Sheet for State Administering Agencies*, accessed September 15, 2023, https://www.ncja.org/_files/ugd/cda224_9714b107673645f0b25e2bf55e411691.pdf.
19. "2021 Regular Session: HB 2417 Enrolled," Oregon State Legislature: Oregon Legislative Information, accessed September 15, 2023, https://olis.oregonlegislature.gov/liz/2021R1/Measures/Overview/HB2417.
20. Oregon Health Authority, *HB 2417 Report: Statewide Coordinated Crisis Services System*, January 2022, https://www.oregon.gov/oha/ERD/SiteAssets/Pages/Government-Relations/OHA%20HB%202417_Crisis%20System%20Report_1.26.22.pdf.
21. "Handgun Ownership Associated With Much Higher Suicide Risk," Stanford Medicine: News Center, June 2020, https://med.stanford.edu/news/all-news/2020/06/handgun-ownership-associated-with-much-higher-suicide-risk.html.
22. "Means Matter: Gun Shop Project," Harvard T.H. Chan School of Public Health, accessed September 15, 2023, https://www.hsph.harvard.edu/means-matter/gun-shop-project/.
23. "NH Firearm Safety Coalition: Suicide Prevention: A Role for Firearm Dealers and Ranges," Connect: Training Professionals & Communities in Suicide Prevention & Response, accessed September 15, 2023, https://theconnectprogram.org/resources/nh-firearm-safety-coalition/.
24. "Governor's and Mayor's Challenges to Prevent Suicide Among Service Members, Veterans, and their Families," Substance Abuse and Mental Health Services Administration, updated May 2023, https://www.samhsa.gov/smvf-ta-center/mayors-governors-challenges.
25. National Judicial Task Force to Examine State Courts' Response to Mental Illness, State Courts Leading Change: Report and Recommendations, October 2022, revised February 2023, https://www.ncsc.org/__data/assets/pdf_file/0031/84469/MHTF_State_Courts_Leading_Change.pdf.
26. Policy Research Associates, Inc., *A National Compendium of Court Navigation Programs: Providing Support at the Nexus of the Legal and Behavioral Health Systems*, April 2023, https://www.prainc.com/wp-content/uploads/2023/05/CourtNavigatorCompendium-508.pdf.
27. National Judicial Task Force to Examine State Courts' Response to Mental Illness, *Behavioral Health State Court Leadership Brief: Peers in Courts*, July 2022, https://www.ncsc.org/__data/assets/pdf_file/0029/77690/Peers-in-Courts.pdf.
28. "State Court Behavioral Health Series," National Center for State Courts and the National Judicial Task Force to Examine State Courts' Response to Mental Illness, accessed October 6, 2023, https://courses.ncsc.org/course/behavioralhealth?_gl=1*1vt309l*_ga*Mjc5NzE0MDM5LjE2OTY2MTEzOTk.*_ga_HB58441DGF*MTY5NjYxMTM5OC4xLjEuMTY5NjYxMjM4Ni4wLjAuMA.
29. Katharine Huntley, 'Will Better Mental Health Care Help Stop Crime in Vermont?" WCAX3, September 2023, https://www.wcax.com/2023/09/14/will-better-mental-health-care-help-stop-crime-vermont/?utm_campaign=399431_Behavioral%20Health%20Alert%20October%202%202023&utm_medium=email&utm_source=dotdigital&dm_i=7L57,8K7B,4VVXFH,1839M,1.

NCJA Center for Justice Planning

30. National Council of Juvenile and Family Court Judges and State Justice Institute, Targeted Resource Mapping Toolkit: Mapping Resources Along a Continuum of Services to Address Substance Use Disorders, accessed October 6, 2023, https://www.ncjfcj.org/wp-content/uploads/2021/05/NCJFCJ_SJI_Mapping_Toolkit_Final.pdf.
31. "Resources," The Council on State Governments Justice Center, accessed October 6, 2023, https://csgjusticecenter.org/projects/judges-and-psychiatrists-leadership-initiative/resources/.
32. The Council on State Governments Justice Center, Judges' Criminal Justice and Mental Health Leadership Initiative, *Judges' Guide to Mental Illnesses in the Courtroom*, accessed October 6, 2023, https://csgjusticecenter.org/wp-content/uploads/2020/02/judges-guide-to-mental-illnesses-in-the-courtroom.pdf.
33. Texas Office of Court Administration, *Guide for Addressing the Needs of Persons with Mental Illness in the Court System*, accessed October 6, 2023, https://www.txcourts.gov/media/1441120/guide-for-addressing-the-needs-of-persons-with-mental-illness-in-the-court-system.pdf.
34. "The Sequential Intercept Model," Policy Research Associates, accessed October 6, 2023, https://www.prainc.com/sim/.
35. "Problem-Solving Courts," National Institute of Justice, February 2020, https://nij.ojp.gov/topics/articles/problem-solving-courts.
36. "Community Courts Initiative: Overview," Bureau of Justice Assistance, updated April 2023, https://bja.ojp.gov/program/community-courts/overview.
37. *Predictors of Engagement in Court-Mandated Treatment: Findings at the Brooklyn Treatment Court, 1996-2000* quoted in Carol Fisler, "Building Trust and Managing Risk: A Look at a Felony Mental Health Court," Psychology, Public Policy, and Law, 11, 2005, 587-604.
38. Carol Fisler, *Building Trust and Managing Risk: A Look at a Felony Mental Health Court*, 2005 (Psychology, Public Policy, and Law, 11, 587-604, 2005), https://www.innovatingjustice.org/sites/default/files/buildingtrust.pdf.
39. "Brooklyn Mental Health Court," Center for Justice Innovation, accessed September 15, 2023, https://www.innovatingjustice.org/programs/brooklyn-mental-health-court.
40. "Veterans Treatment Court Program: Overview:" Bureau of Justice Assistance, updated March 2023, https://bja.ojp.gov/program/veterans-treatment-court-program/overview.
41. Indian Family Health Clinic and Montana's Eighth Judicial District Drug Treatment Court, *Native American Treatment Court Cultural Program: An Urban Indian Center Transformative Approach, 2019*, http://wellnesscourts.org/files/A%20Native%20American%20Docket%208th%20Judicial%20Distric%20of%20Montana(1).pdf.
42. "Discipline, Not Punishment: Native American Treatment Court Produces First 6 Graduates," Great Falls Tribune, September 18, 2019, https://www.greatfallstribune.com/story/news/2019/09/18/native-american-treatment-court-graduates-six-tuesday/2354295001/.
43. April Zeoli et al., "Analysis of the Strength of Legal Firearms Restrictions for Perpetrators of Domestic Violence and Their Associations With Intimate Partner Homicide," *American Journal of Epidemiology*, 2018, https://pubmed.ncbi.nlm.nih.gov/30383263/.
44. Prosecutors Against Gun Violence & The Consortium For Risk-Based Firearm Policy, "Firearm Removal/Retrieval in Cases of Domestic Violence," February 2016, https://efsgv.org/wp-content/uploads/2016/02/Removal-Report-Updated-2-11-16.pdf
45. Susan Sorenson and Devan Spear, "New data on intimate partner violence and intimate relationships: Implications for gun laws and federal data collection," *Preventive Medicine*, 2018, https://pubmed.ncbi.nlm.nih.gov/29395249/
46. "Welcome to AZPOINT," AZPOINT, accessed September 15, 2023, https://azpoint.azcourts.gov/About.
47. The National Criminal Justice Association, *Promising Practices: Improving the Issuance of Protective orders in Arizona: The Creation of AZPOINT*, March 2023, https://www.ncja.org/_files/ugd/cda224_a565832e5f2141ba8c37c489d668d0a1.pdf.
48. "Firearms Storage Program," Department of Public Safety: Vermont State Police, accessed September 15, 2023, https://vsp.vermont.gov/firearmstorage.
49. "A Promising Model for Integrating Non-sworn Clinical Professionals into Police Departments," James G. Barrett, Police1 by Lexipol, March 28, 2022, https://www.police1.com/mental-health-outreach/articles/a-promising-model-for-integrating-non-sworn-clinical-professionals-into-police-departments-gYWbUZnLAX9x5o3U/.
50. "APPS Database," State of California Department of Justice, Rob Bonta Attorney General, accessed September 15, 2023, https://oag.ca.gov/ogvp/apps-database#:~:text=The%20Armed%20and%20Prohibited%20Persons,its%20kind%20in%20the%20nation.
51. "At the Forefront of Gun Safety: Removing Illegal Guns," Everytown Research & Policy, November 16, 2022, https://everytownresearch.org/report/at-the-forefront-of-gun-safety-removing-illegal-guns/.
52. The National Criminal Justice Association, *An Overview: Community Violence Intervention Strategies*, August 2021, https://www.ncja.org/_files/ugd/cda224_b9dc1a3ecd24467c8efba96ac37a48bd.pdf.
53. "FY2023 Office of Justice Programs Community Based Violence Intervention and Prevention Initiative," Bureau of Justice Assistance, March 2023, https://bja.ojp.gov/funding/opportunities/o-bja-2023-171647.
54. "Cure Violence: About," Cure Violence Global, accessed September 15, 2023, https://cvg.org/about/.
55. The National Criminal Justice Association, *Promising Practices: Community Violence Intervention Programs*, October 2021, https://www.ncja.org/_files/ugd/cda224_790e6680c1da4ff0ae4334517e9279e1.pdf.
56. "Home," Rainier Beach: A Beautiful Safe Place for Youth, accessed September 15, 2023, https://www.rb-safeplaceforyouth.com/.
57. The Health Alliance for Violence Intervention, *What is a Hospital-Based Violence Intervention Program (HVIP)?*, accessed September 15, 2023, https://www.ncdps.gov/documents/files/what-hospital-based-violence-intervention-program/download.
58. "Penn Trauma Violence Recovery Program," Penn Injury Science Center, accessed September 15, 2023, https://www.penninjuryscience.org/outreach/community-violence-intervention-hub/penn-trauma-violence-recovery-program/.
59. "Centering Youth in Community Violence Interventions as Part of a Comprehensive Approach to Countering Gun Violence," Terrell Thomas and Rachael Eisenberg, Center for American Progress, October 11, 2022, https://www.americanprogress.org/article/centering-youth-in-community-violence-interventions-as-part-of-a-comprehensive-approach-to-countering-gun-violence/.
60. "Program Profile: Operation Peacekeeper (Stockton, Calif.), National Institute of Justice: Crime Solutions, June 6, 2011, https://crimesolutions.ojp.gov/ratedprograms/51#pd.

This document was created with the support of Grant No. 15PBJA-22-GK-01566-JAGJ awarded by the Bureau of Justice Assistance. The Bureau of Justice Assistance is a component of the Office of Justice Programs, which also includes the Bureau of Justice Statistics, the National Institute of Justice, the Office of Juvenile Justice and Delinquency Prevention, the Office of Sex Offender Sentencing, Monitoring, Apprehending, Registering, and Tracking, and the Office for Victims of Crime. Points of view or opinions in this document are those of the author and do not necessarily represent the official position or policies of the U.S. Department of Justice.

Nebraska Crime Commission Justice System Needs Assessment

Survey Overview

NCJA | Center for Justice Planning

Scan to explore the full survey analysis.

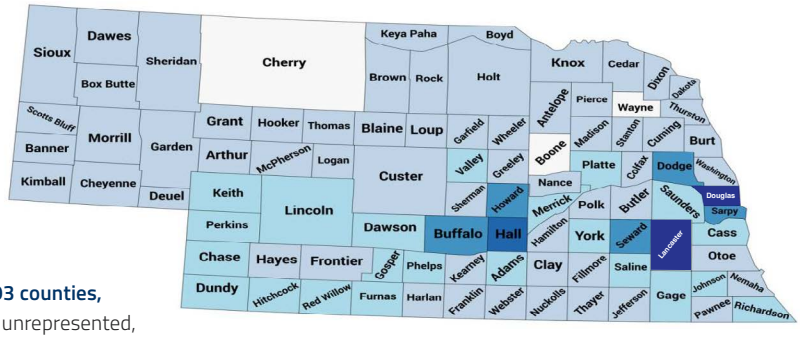
Background

The Nebraska Crime Commission (NCC) conducted a comprehensive Justice System Needs Assessment Survey from May to September 2024 to inform the state's five-year strategy for the Justice Assistance Grant (JAG) and planning for Byrne State Crisis Intervention Program (SCIP) funding. The survey gathered 251 responses from a diverse range of criminal justice professionals, community organizations and justice-impacted individuals. The findings will help guide resource allocation and identify key gaps in Nebraska's criminal justice system, with a focus on technology, mental health, juvenile justice and community-based crime prevention.

Survey Demographics

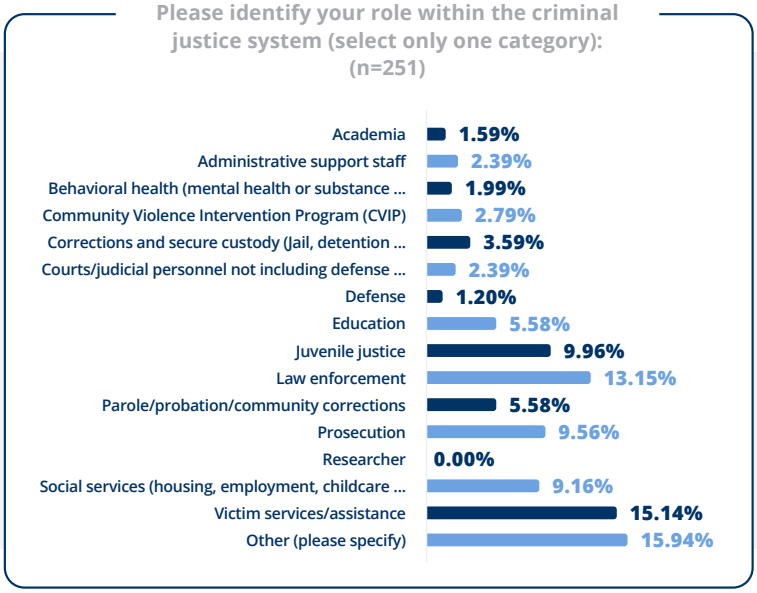
The survey received **251 responses,** with **17% representing agencies serving the entire state**—the largest group. **Lancaster County (15%)** and **Douglas County (12%)** had the highest county-specific responses.

Responses came from **90 of Nebraska's 93 counties,** with **Boone, Cherry, and Wayne Counties** unrepresented, highlighting areas for **targeted outreach.** The map provides geographical context, though it does not reflect statewide service coverage. See the appendix for details.



Survey Respondents Demographics

- The majority of respondents worked in **victim services (13%), law enforcement (15%)** and **juvenile justice (10%),** with **16% identifying as "Other"** (e.g., Child Advocacy Centers, community organizations).
- **Local-level organizations (39%)** made up the largest group, followed by **nonprofit service providers (35%).**
- **Community members represented just over 2%** of respondents, reflecting an opportunity for future outreach.



Survey Respondents Demographics continued

- Roles varied widely, including district court clerks, reentry specialists, legal aid providers, grant administrators and individuals with lived experience.
- Open-ended responses provided valuable insights but some were vague, which may affect targeted engagement.
- Responses also included Nebraska State Probation, tribal agencies and academia, highlighting broad sector representation.

Key Themes & Insights

Technological Infrastructure & Data Sharing

- Many agencies struggle with data access and sharing.
- 45% of respondents have automated data systems, but many report difficulties in utilizing them effectively.
- Modernizing technology is a priority for decision-making and collaboration.

Mental Health & Substance Misuse

- Over 60% of respondents identified mental health services as a critical need.
- Lack of crisis intervention and substance misuse treatment remains a major gap.
- Calls for enhanced behavioral health programming within the justice system.

Juvenile Justice & Reentry Programs

- Strong need for youth-focused interventions, including reentry support and diversion programs.
- Mental health and educational support for justice-involved youth are key concerns.

Workforce Recruitment & Retention

- Hiring and retaining qualified staff is a challenge across law enforcement, probation, and community services.
- Burnout, low wages, and high turnover rates are persistent issues.
- Workforce development programs are needed to improve system resilience.

Community-Based Crime Prevention

- Increased demand for local programs addressing gang violence, intimate partner violence, and bullying.
- Calls for stronger collaboration with schools, faith-based organizations, and community groups.
- Focus on early intervention strategies to prevent crime.

NCJA | Center for Justice Planning

Learn more at **NCJA.org/Strategic-Planning**

This report was created with the support of Grant No. 2019-YA-BX-K002, awarded by the Bureau of Justice Assistance. The Bureau of Justice Assistance is a component of the Office of Justice Programs, which also includes the Bureau of Justice Statistics, the National Institute of Justice, the Office of Juvenile Justice and Delinquency Prevention, the SMART Office and the Office for Victims of Crime. Points of view or opinions are those of the authors.

04/25

NCJA
Center for Justice Planning

Nebraska Crime Commission Byrne Justice Assistance Grant (Byrne JAG) Stakeholder Focus Group Report Overview

Background

To better inform Nebraska's five-year strategy for the Byrne Justice Assistance Grant (Byrne JAG) and Byrne State Crisis Intervention Program (Byrne SCIP) grant programs, the Nebraska Crime Commission (NCC) partnered with the National Criminal Justice Association (NCJA) to conduct four criminal justice stakeholder focus groups throughout the state. These 90-minute focus groups, held on April 9 and 10, 2025, built upon information gathered from a Justice System Needs Assessment Survey that was disseminated to justice system stakeholders throughout the state from May to September 2024. The focus groups were held in Lincoln and North Platte and included 22 stakeholders from across the criminal justice community.

Discussions

The focus groups were designed to obtain insight into key issues affecting the administration of justice in Nebraska, and the themes identified in the survey were used to guide the discussion. Discussions revolved around the following themes identified in the survey, which included mental and behavioral health (including substance misuse); juvenile justice and reentry; technology infrastructure and data sharing; workforce recruitment and retention and community-based crime prevention.

Scan to read the full focus group report.

Key Themes & Insights

BEHAVIORAL HEALTH

- There is a lack of treatment facilities (both inpatient and outpatient) for adults and adolescents, and insufficient detox facilities.
- There is a scarcity of wraparound mental health supports, and a lack of viable transportation options for individuals who need to access the limited treatment options that exist.
- There are significant workforce recruitment and retention challenges in the behavioral health field throughout the state.

continued on next page

Key Themes & Insights continued

GEOGRAPHICAL LIMITATIONS

- The more rural the area, the more limited the treatment options become.
- Workforce challenges are exacerbated in rural communities.
- Nebraska's location along a major highway corridor brings trafficking and enforcement challenges.
- The geographical size of many areas in the state also makes enforcement difficult.

Next Steps & Highlighted Opportunities

Despite the challenges described during the focus groups, the state of Nebraska has proven tremendously resourceful and has been able to chip away at some of its most pressing problems with already available resources. In addition to these resources, other opportunities and solutions exist that may be beneficial to address some of the identified themes. Nebraska may consider the following solutions that were highlighted in the focus groups.

- Increase prevention programming in the community and schools.
- Enhance the state's data sharing infrastructure. Data sharing, specifically as it relates to behavioral health systems, could have a significant and broad, positive impact on service coordination.
- Address workforce shortages by using financial and wellness incentives to attract staff.
- Use the faith-based community and/or volunteer organizations as a way to fill gaps around transportation and support for incarcerated individuals.
- Leverage positive experiences with school resource officers in schools as a tool to not only prevent justice system involvement, but also substance misuse, gang involvement and truancy.
- Explore avenues to address the lack of physical spaces for behavioral health and mental health treatment by partnering with community-based service providers.

Law Enforcement Listening Sessions - State Tour 2024

ISSUE	COMMENTS	SIDNEY	SCOTTSBLUFF	CHADRON	VALENTINE	NEB CITY	ORD	NORTH PLATTE	CLAY CENTER	CENTRAL CITY	MADISON	FREMONT	SCHUYLER	LEXINGTON
Property Tax Lids														
	LB 388 created significant concerns for law enforcement and public safety agencies. Many agencies were not sure how the proposal would impact entities who were experiencing significant growth and how local governmet would be able to address public safety issues.	X	X	X	X	X	X	X	X	X	X	X	X	X
	Property tax reduction measures must consider equipment and operational costs, not just salary and benefits.	X	X										X	
Nebraska Law Enforcement Training Center														
	Class size/enrollment issues	X	X	X	X	X	X	X	X	X	X	X	X	X
	TABE Tests - in some cases there appears to be more difficulty with applicants unable to pass TABE.		X											
	TABE does not appear to have any negative impact on applicants.							X						
	Pre-study or prep exercises seem to help. Invest time and attention with applicants prepping them prior to test administration.		X											
	Test anxiety demonstrated by some applicants, even those with college degrees.													
	Issues with reciprocity certification include: Why are physical standards required for tenured officers? Could administrators determine if an applicant could be exempted?			X										
	Evaluate the utility of the PRET test.			X										
	Why does NLETC not allow students to be able to stay at the facility during weekends? The cost of transportation and overtime is excessive.			X										
	Recorded interviews of students with no consultation with the agency administrator prior to the interview. Please review process.					X								
	Agreement that LE must have a validated test for physical ability. Why is NLETC administering these tests when it is the responsibility of the agency to defend their hiring standards?							X						
	PSAC should consider a requirement that all applicants must complete a polygraph or voice stress analyzer test to confirm application information is valid. If this were mandated would the state pay for these tests?							X						
	The job postings that appear on the NLETC website should be listed by posting date, not placed in alphabetical order.							X		X				

Law Enforcement Listening Sessions - State Tour 2024

ISSUE	COMMENTS	SIDNEY	SCOTTSBLUFF	CHADRON	VALENTINE	NEB CITY	ORD	NORTH PLATTE	CLAY CENTER	CENTRAL CITY	MADISON	FREMONT	SCHUYLER	LEXINGTON
	With the addition of five students to training sessions on a conditional basis could there be consideration for granting those students who separate at the end of five weeks to be granted the conditional officer status until they can return to complete the balance of the basis certification course?											X		
Juvenile Detention/Crisis Intervention Resources														
	Lack of access to detention facility results in excessive time, transportation, overtime costs, loss of officer to address calls for service	X	X	X	X		X	X						
	Intake/placement assessment used by Probation is flawed. Juveniles are often returned to a dysfunctional environment. Only serious crimes against persons likely to result in detention. Several examples of juveniles who have committed violent crime are not confined or adequately supervised.		X				X	X	X					
	Juveniles experiencing mental health or crisis issues have very limited access to services.		X											
	Limited fiscal resources are available to community non-profits who can provide services to juveniles.		X											
	No placement faciities for juvenile females.	X												
	Court-ordered process for juveniles is a lengthy process sometimes taking more than two weeks.													
	DHHS Family Services are not always responsive to law enforcement requests for intervention.						X							
	Parents do not seem to be held accountable for the actions of their children.						X							
	DHHS personnel do not have sufficient training and lack investigative skills to properly address placement and disposition issues for juveniles.						X							
	Probation Administration is not sharing data with law enforcement.							X						
	Probation Administration feels law enforcement is responsible for babysitting juvenile offenders and this creates undue financial strain for agencies to address transportation, overtime, and expenditure of resources.							X		X				
	Lack of service demonstrated by DHHS caseworkers. Difficult to contact and their role with juveniles needs to be changed. The work-from-home model destroyed their effectiveness.								X					

Law Enforcement Listening Sessions - State Tour 2024

ISSUE	COMMENTS	SIDNEY	SCOTTSBLUFF	CHADRON	VALENTINE	NEB CITY	ORD	NORTH PLATTE	CLAY CENTER	CENTRAL CITY	MADISON	FREMONT	SCHUYLER	LEXINGTON
	Probation has become defacto solution for even the most serious juvenile offenders. Unfortunately, some juveniles need to be incarcerated for their protection and the protection of communities.									X				
	Drug courts are a joke.									X				
Mental Health/Emergency Protective Custody Process														
	Intake time for EPC is excessive.	X	X	X	X	X	X	X	X	X	X	X	X	X
	Examine the role of LE vs Medical Practitioners to determine EPC commitment.									X				
	No beds available at hospitals who are supposed to provide services.	X	X							X	X	X		
	Reluctant to accept any patient who exhibits violent behavior which then requires LEO to provide security.	X	X				X				X	X		
	Telehealth concepts are not always effective intervention measures. Online concepts for intervention are not effective.	X		X										
	Mental health resources in most areas of the state simply don't exist.	X		X	X	X	X	X	X	X				X
	Mental health counselors are overwhelmed with patients and case work is backlogged.	X												
	Limited substance abuse treatment programs are available.	X								X				
	Can EPC patients be taken from Nebraska to facilities outside the state? AG review legalities.	X												
	released without follow up care, often begin having issues within a short period of time and law	X	X			X	X			X	X			
	Mental health hearings are a waste of time and an ineffective process.						X				X			
	Need greater clarity on the medical standards to determine need for EPC.			X			X							
	County jails have become the defacto treatment facilities for mental health issues.				X		X		X	X	X			
	EPC commitment results in short-term treatment and then release. This is not effective.					X			X		X			
	Voluntary mental health commitments are not viable in many cases. Once stabilized the person leaves the facility and returns to an inappropriate environment.					X				X	X			
	Currently, an EPC must be medically screened before commitment at the facility. The facility (hospital) then repeats a medical screen resulting in an unneccesary expense of $1600 to the county									X				
	Return to State-run mental health treatment facilities.						X							
Prosecutors														

Law Enforcement Listening Sessions - State Tour 2024

ISSUE	COMMENTS	SIDNEY	SCOTTSBLUFF	CHADRON	VALENTINE	NEB CITY	ORD	NORTH PLATTE	CLAY CENTER	CENTRAL CITY	MADISON	FREMONT	SCHUYLER	LEXINGTON
	Prosecutors are exhausting their resources.		X											
	Pathology services are limited in western Nebraska with coroners using services in Wyoming.	X												
	Examine TASK as a resource for intervention and treatment following release from incarceration.					X								
	Child sexual assault investigations; juveniles are being subjected to depositions by advocacy groups who use a line of questionning intended to demonstrate the victim is in need of advocacy services. There appears to be a profit-driven motive by advocacy groups to demonstrate the victim is in need of their services. Iowa does not use depositions in juvenile sexual assault cases due to harm to the victim. Defense attorneys are subjecting victims to harsh questionning at the expense of juvenile victims.					X								
	Many county attorneys do not fully understand the requirements for victim notification (NEVCAP).					X								
	Some defense attorneys use an intimidation tactic to threaten prosecutors with ethics complaints as a means to leverage plea bargaining deals.					X								
	Review LB 605 which resulted in unfunded mandate on counties. Serious felonies receive county jail time and probation which increases costs locally to house prisoners. The reduction of penalties at the State level shifted this burdon onto the counties. In many cases, probationers must serve 90-day sentences and are not subject to any probation violations until their jail sentence is completed.									X				
	Drug violations are being treated as minimal violations with no serious consequences.									X				
	Drug offenders should be required to identify their suppliers as a condition of probation or allowed to participate in drug courts.									X				
	There is a growing need for prosecutors to have access to technology and forensic services.											X		
Public Defenders														
	Often have limited resources and capacity to address caseload.													
Officer Retention Issues														
	More emphasis should be placed on retirement and pension plans for smaller agencies.	X	X	X	X	X	X	X	X	X	X	X	X	X

Law Enforcement Listening Sessions - State Tour 2024

		SIDNEY	SCOTTSBLUFF	CHADRON	VALENTINE	NEB CITY	ORD	NORTH PLATTE	CLAY CENTER	CENTRAL CITY	MADISON	FREMONT	SCHUYLER	LEXINGTON
	Retention and hiring bonuses are appreciated, but have limited affect on hiring and retention in most cases. The hiring bonus benefit is not viewed in a positive manner by tenured officers.	X	X	X	X	X	X	X	X	X	X	X	X	X
	working for smaller agencies who will work you to death and there is no financial incentive for retirement benefits and working until age 65 or beyond.	X	X	X	X	X	X	X	X	X	X	X	X	X
ISSUE	COMMENTS													
	Nebraska offers excellent quality of life issues for families or individuals who are not interested in living in metro areas. This should be emphasized in recruitment strategies.			X										
	Ord has temporarily disbanded the police department due to the departure of all the officers.						X							
	Are there federal grants that could assist departments with the cost of hiring officers?						X							
	Knowledge of the hiring bonus program was not sufficiently messaged to law enforcement across the state.							X						
	LB 51 has had a negative impact on hiring.							X						
Other Public Safety Concerns														
	Ambulance services are becoming difficult to sustain in rural areas. Private companies struggle to be profitable. Huge cost for local government to sustain.	X												
	Why do emergency responders have to have CDL licenses? Only fire department personnel are exempted.			X										
	There is no statewide radio system repeater in the Atlantic area of northwest Nebraska and this limits the use of the network and is an officer safety issue. The cost to install vehicular repeaters is excessive for small rural agencies in this area. This issue needs to be referred to the OCIO for consideration.			X										
	agencies to comply.					X						X		
	Sheriffs are having to absorb many of the costs for issues being dictated by the State.					X						X		
	Evaluate modifications to the Sex Offender Registry. Major revisions are needed to help Sheriffs maintain the data on offenders who must register with the Sheriff.					X								
	32 hours hours of annual continuing education for all LEO is excessive and needs review.	X	X	X	X	X	X	X	X	X	X	X	X	X
	The reserve officer program was eliminated. Is there any interest in resurrecting this program?						X							

Law Enforcement Listening Sessions - State Tour 2024

ISSUE	COMMENTS	SIDNEY	SCOTTSBLUFF	CHADRON	VALENTINE	NEB CITY	ORD	NORTH PLATTE	CLAY CENTER	CENTRAL CITY	MADISON	FREMONT	SCHUYLER	LEXINGTON
	Small county jails have a difficult time housing high-risk offenders due to staffing and facility limitations.								X					
	behalf of the insurance industry. This form requires considerabel time to complete and detracts from other law enforcemet priorities.										X			
	Courts are often insensitive to the huge demand for resources from law enforcement to support court security and prisoner transport issues.											X		
Department of Corrections														
	Diagnostic and Evaluation Center will not accept transfers unless it is Monday through Friday. Will not accept any transfers after 4:00 PM.								X					
Legislative Issues and Concerns														
	marijuana in this state. Anticipate grow operations to florish in Nebraska due to access to water and lax EPA standards related to pesticide use.								X					
	Evaluate the impact of LB 1241 and LB 51 on law enforcement.								X	X				
	A review of Legislative initiatives introduced by Senator Pansing Brooks created more issues for juvenile offenders than addressing real concerns. Those legislative issues created an environment where juveniles believe they are untouchable.									X				
	YRTC commitments are way down as a result of legislative initiatives.									X				
	Monitor the Legislature's tendency to reduce penalities for criminal convictions. Key block of Senators have been consistently working in concert to reduce penalties.				X									
	LB 876 Newborn Infant; parental surrender of newborn infants to law enforcement, fire, or hospitals. Uncertainty related to how this law impacts law enforcement.	X	X	X	X	X	X	X	X	X	X	X	X	X
	LB 1300 eliminates Chinese manufactured products. This needs further assessment for law enforcement due to the fiscal impact to find reasonably-priced drone and communication equipment.										X			

APPENDIX F- Projects Receiving BHECN-ARPA Funding

In July 2022, the Nebraska Legislature passed a measure allocating American Rescue Plan Act (ARPA) funding to the Behavioral Health Education Center of Nebraska (BHECN) to administer $25.5 million to various organizations across Nebraska to address the shortage of behavioral health providers in the state.

The pandemic caused a dramatic increase in the need for behavioral health services, and with providers already in short supply, many people experienced long wait times or a complete in ability to access behavioral healthcare. This has become a crisis for many areas of the state, particularly in rural and frontier areas.

During a two-phase application cycle, BHECN received 344 applications requesting more than $74 million in funding. After a comprehensive review process, 110 projects were selected to receive funding with 55 of the awards going to urban organizations and 55 to rural organizations. The full list of BHECN-ARPA Awardees is below.

Behavioral Health Training and Education Opportunities

Funding to metropolitan organizations: $5,015,186 or 43%.
Funding to rural organizations: $6,735,151 or 57%.

1. Doane University, Crete, rural, $500,000
2. Lutheran Family Services, Omaha, urban, $500,000
3. UNMC – Integrated care at Kearney, Omaha, urban, $492,191
4. UNMC College of Nursing, Omaha, urban, $499,895
5. Chadron State College, Chadron, rural, $490,500
6. Great Plains Health, North Platte, rural, $33,860
7. Silver Sun Mental Health dba Nebraska Mental Health Centers, Lincoln, urban, $500,000
8. Heartland Family Services, Omaha, urban, $491,680
9. Autism Care for Toddlers Clinics, MMI, Omaha, rural, $416,000
10. Northeast Community College, Norfolk, rural, $343,299.05
11. University of Nebraska at Omaha, Omaha, urban, $500,000
12. University of Nebraska at Omaha, Omaha, urban, $500,000
13. University of Nebraska at Omaha, Omaha, urban, $500,000
14. Restore Rebuild Reconnect Counseling Center, Omaha, urban, $374,934
15. Center for Psychological Services dba Live Well Counseling Center, Kearney, rural, $81,391.92
16. Options in Psychology LLC, Scottsbluff, rural, $398,401
17. Child and Family Therapy Institute of Nebraska LLC, North Platte, rural, $124,088
18. Board of Regents of the University of Nebraska-Lincoln, Lincoln, urban, $500,000
19. Morningstar Counseling and Consultation, Lincoln, urban, $496,681
20. Youth Emergency Services Inc., Omaha, urban, $190,000

21. Western Nebraska Behavioral Health Clinic, Rushville, rural, $438,045
22. Western Nebraska Behavioral Health, Rushville, rural, $81,693
23. CEDARS Youth Services Inc., Lincoln, urban, $254,272
24. HopeSpoke, Lincoln, urban, $499,551
25. Creighton University, Omaha, urban, $499,964
26. Houses of Hope of Nebraska Inc., Lincoln, urban, $45,300
27. Options in Psychology LLC, Scottsbluff, rural, $44,800
28. Options in Psychology, LLC, Scottsbluff, rural, $62,010
29. Heartland Counseling Services Inc., South Sioux City, rural, $496,074.78
30. Northeast Community College, Norfolk, rural, $499,836.40
31. Women's Empowering Life Line, Norfolk, rural, $178,656
32. Women's Empowering Life Line, Norfolk, rural, $317,215
33. Completely Kids, Omaha, urban, $71,000
34. Mary Lanning Healthcare, Hastings, rural, $58,000
35. Mid-Plains Center for Behavioral Healthcare Services, Inc., Grand Island, rural, $55,000
36. CenterPointe, Inc., Lincoln, urban, $72,000
37. AM Counseling and Consulting, Bellevue, urban, $72,000
38. Siena Francis House, Omaha, urban, $72,000

Telebehavioral Health in Rural Areas

Funding to metropolitan organizations: $3,854,310 or 55%.
Funding to rural organizations: $3,120,288 or 45%.
*All projects have rural components.

1. Bryan Telemedicine, Omaha, urban, $1,000,000
2. EVALS BY ECK LLC, Scottsbluff, rural, $59,224.78
3. Heartland Counseling Services Inc., South Sioux City, rural, $731,339
4. Wholeness Healing Center PC, Grand Island, rural, $121,942.61
5. Howard County Medical Center, St. Paul, rural, $200,000
6. Lutheran Family Services of Nebraska Inc., Lincoln, urban, $900,478
7. Midwest Encouragement & Counseling Center LLC, Kearney, rural, $63,100
8. Center for Psychological Services PC dba Live Well Counseling Center, Kearney, rural, $73,773.99
9. Children's Hospital & Medical Center Foundation, Omaha, urban, $500,000
10. Blue Elephant Counseling LLC, Dannebrog, rural, $436,237.03
11. Quality Healthcare Clinic LLC, Sutton, rural, $688,500
12. Silver Sun Mental Health, dba Nebraska Mental Health Centers, Lincoln, urban, $13,911
13. Banisters Leadership Academy, Omaha, urban, $500,000
14. CEDARS Youth Services, Inc., Lincoln, urban, $114,965.12
15. Health Center Association of Nebraska, Omaha, urban, $800,000
16. Boone County Health Center, Albion, rural, $44,199

17. Pender Community Hospital District, Pender, rural, $556,326.91
18. Compass, Kearney, rural, $145,645
19. For All Counseling Services Inc, Omaha, urban, $24,952

Behavioral Health Workforce COVID-19 Projects

Funding to metropolitan organizations: $1,245,974 or 57%.
Funding to rural organizations: $944,661 or 43%.

1. University of Nebraska - Lincoln, Lincoln, urban, $80,000
2. University of Nebraska at Omaha, Omaha, urban, $100,000
3. University of Nebraska at Omaha, Omaha, urban, $50,000
4. University of Nebraska at Kearney, Kearney, rural, $99,999
5. University of Nebraska at Kearney, Kearney, rural, $50,000
6. Lutheran Family Services, Omaha, urban, $100,000
7. Lutheran Family Services, Omaha, urban, $100,000
8. Chadron State College, Chadron, rural, $100,000
9. Cambridge Memorial Hospital Inc. dba Tri Valley Health System, Cambridge, rural, $35,035
10. Restore Rebuild Reconnect Counseling Center, Omaha, urban, $42,788
11. HopeSpoke, Lincoln, urban, $100,000
12. Wholeness Healing Center PC, Grand Island, rural, $96,406
13. Lincoln/Lancaster County Child Advocacy Center, Lincoln, urban, $17,000
14. Miller and Micek Consulting LLC, Wayne, rural, $99,721
15. Scottsbluff Public Schools, Scottsbluff, rural, $100,000
16. Howard County Medical Center, St. Paul, rural, $100,000
17. Wholeness Healing Center PC, Grand Island, rural, $100,000
18. Wholeness Healing Center PC, Grand Island, rural, $73,500
19. UNMC - Wellness Center, Omaha, urban, $100,000
20. UNMC - Wellness Center, Omaha, urban, $50,000
21. The Bridge Behavioral Health, Lincoln, urban, $99,186
22. Board of Trustees of the Nebraska State Colleges, Lincoln, urban, $47,250
23. Completely KIDS, Omaha, urban, $99,750
24. OneWorld Community Health Centers Inc., Omaha, urban, $100,000
25. Silver Sun Mental Health, dba Nebraska Mental Health Centers, Lincoln, urban, $50,000
26. Options in Psychology, LLC, Scottsbluff, rural, $20,000
27. Midtown Health Center, Norfolk, rural, $19,898.95
28. Heartland Counseling Services, Inc., South Sioux City, rural, $50,000
29. Lincoln Medical Education Partnership, Lincoln, urban, $10,000
30. Heartland Family Service, Omaha, urban, $50,000
31. Nebraska Alliance of Child Advocacy Centers, Omaha, urban, $50,000

Funding for Supervision of Provisionally Licensed Providers

Funding to metropolitan organizations: $863,953 or 47%.
Funding to rural organizations: $974,378 or 53%.

1. Heartland Counseling Services Inc., South Sioux City, rural, $25,000
2. Heartland Counseling Services Inc., South Sioux City, rural, $100,000
3. Four Corners Health Department, York, rural, $34,803.53
4. The Bridge Behavioral Health, Lincoln, urban, $100,000
5. Camie L Nitzel, PhD, LP, LLC DBA Kindred Psychology, Lincoln, urban, $99,939
6. Wholeness Healing Center PC, Grand Island, rural, $100,000
7. The Cord: Where Science Meets Connection LLC, Omaha, urban, $100,000
8. AM Counseling and Consulting, Bellevue, urban, $99,354
9. Center for Psychological Services PC dba Live Well Counseling Center, Kearney, rural, $45,000
10. Center for Psychological Services PC dba Live Well Counseling Center, Kearney, rural, $100,000
11. Midwest Encouragement & Counseling Center LLC, Kearney, rural, $31,000
12. Options in Psychology LLC, Scottsbluff, rural, $57,600
13. Restore Rebuild Reconnect Counseling Center, Omaha, urban, $64,660
14. Wholeness Healing Center PC, Grand Island, rural, $99,975
15. Cirrus House Inc., Scottsbluff, rural, $81,000
16. Cirrus House, Inc., Scottsbluff, rural, $100,000
17. Father Flanagan's Boys' Home, Boys Town, urban, $100,000
18. University of Nebraska at Omaha, urban, $100,000
19. Children's Hospital and Medical Center Foundation, Omaha, urban, $100,000
20. Creative Counseling and Studio LLC, Omaha, urban, $100,000
21. Inspirit Counseling, PC, Chadron, rural, $100,000
22. Mid-Plains Center for Behavioral Healthcare Services, Inc., Grand Island, rural, $100,000

How State Administering Agencies Can Support Best Practices in Crisis Response

NCJA Center for Justice Planning

INTRODUCTION

Funds administered through State Administering Agencies (SAAs), such as the Byrne Justice Assistance Grant (Byrne JAG) and the Byrne State Crisis Intervention Program (Byrne SCIP) provide an important opportunity to build a strong crisis response system that relies primarily on the behavioral health system, rather than the criminal justice system. Currently, many states do not have a robust or best-practice crisis response system. It's important that SAAs understand the consensus among behavioral health leaders about the services that should make up an effective crisis response system and where there are gaps in the current systems.

This brief describes the three core services of an effective crisis response system as defined by the federal Substance Abuse and Mental Health Services Administration (SAMHSA). It also describes how these core services intersect with the criminal justice system, and the vital role SAAs can play in supporting the development and expansion of best practice crisis services.

★

KEY DEFINITIONS

As defined by the Bureau of Justice Statistics, **law enforcement** refers to the agencies and employees responsible for enforcing laws, maintaining public order and managing public safety. The primary duties of law enforcement include the investigation, apprehension and detention of individuals suspected of criminal offenses. Some law enforcement agencies, particularly sheriffs' offices, also have a significant role in the detention of individuals convicted of criminal offenses.

A **behavioral health crisis** is any situation where a person's mental health or substance use puts them at risk of hurting themselves or others or interferes with their ability to care for themselves. A crisis is generally defined by the individual experiencing it, and therefore, these individuals need timely and inclusive access to crisis care.

The **crisis response system** consists of an array of mental health services that support an individual in crisis and help move them toward a safe and stable outcome. An ideal crisis response system is easy to access, provides timely responses and is available to all members of the community. An ideal crisis response system is also community-based, meaning the services are provided in the least restrictive setting that can support safety and stability, such as homes, workplaces and other community settings whenever possible.

In the context of the crisis response system, **best practices** are those services defined by SAMHSA that meet the standard of care for people experiencing a behavioral health crisis.

Core Services of the Crisis Response System

Law enforcement agencies and other criminal justice partners have long been the default responders to mental health crises. However, there is a growing recognition that this places an unfair burden on law enforcement and that people in crisis deserve a response from a trained mental health professional.

SAMHSA describes three core services in a best-practice crisis response system. Many communities urgently need to develop these services:

1 **Crisis lines ("Someone to Talk To"),**

2 **Mobile crisis teams ("Someone to Respond"), and**

3 **Crisis receiving and stabilization facilities ("A Place to Go").**

These core services are detailed in SAMHSA's **National Guidelines for Behavioral Health Care.** As communities develop these core crisis response services, the responsibility for responding to a mental health crisis should transition from law enforcement to the mental health system.

Financial support through funding sources such as the Byrne JAG and Byrne SCIP programs administered by SAAs, are vital to supporting these new services. At the same time, collaboration between mental health and criminal justice systems is key to a smooth and safe transition for individuals experiencing crisis. In addition, when criminal justice services are a necessary part of a crisis response, criminal justice partners can design systems that use criminal justice resources strategically.

NOTE: *This brief describes key components of a crisis response system for **adults.** While children and youth require similar services, they are best served by providers specially trained to address their needs and by services tailored to their needs.*

1

"Someone to Talk To"

The first core service in a crisis response system is a crisis line, available 24 hours a day, seven days a week, where a person in crisis can reach a trained counselor to receive support.

BEST PRACTICE:

988 Suicide and Crisis Line

In 2022, the 988 Suicide and Crisis Line was launched as a national number for anyone needing crisis support. Calls to 988 are routed to state or regional crisis lines, where trained counselors provide support for people in mental health and substance use crises.

In most cases, a call to 988 can be resolved through de-escalation or connection to community-based services without the need for an in-person response.

TRANSITIONING TO BEST PRACTICES:

Historically, people have called 911 to report a mental health crisis, often leading to a law enforcement response. Many people still call 911 in these situations, because they are unaware of 988 or because they assume a mental health crisis is a danger to communities. Greater community awareness of 988 is one step to changing this perception and encouraging further use of 988 systems.

There's also an urgent need to promote inter-operability between the 911 and 988 systems, which are typically not designed to work together. To be most effective, 988 crisis lines should be able to triage and transfer a call to 911 if there is a public safety concern. At the same time, 911 centers should be able to transfer calls to a local crisis line in case of a mental health crisis. These connections will ensure that each call receives the safest, most appropriate response.

NOTE: *NCJA created* **this fact sheet** *that provides a concise overview of 988, including its history and opportunities for State Administering Agencies (SAAs) to maximize the benefits of 988.*

2

"Someone to Respond"

Most of the time, a phone conversation can stabilize a mental health crisis. When a phone call is not enough, 988 or 911 will dispatch someone to respond to the person experiencing crisis in the community.

BEST PRACTICE: Mobile Crisis Teams

The best practice for responding to a crisis in the community is a mobile crisis team, which offers a rapid response by specially trained mental health professionals, such as social workers, counselors or peer support providers. These professionals provide an array of services, including de-escalation, triage, assessment and referral to other services if needed. Law enforcement is not typically part of a mobile crisis team, because the presence of officers may not be necessary, and can unintentionally frighten a person in crisis. To learn more about mobile crisis teams, review **this SAMHSA resource.**

TRANSITIONING TO BEST PRACTICES:

In communities with mobile crisis teams, law enforcement agencies can work to ensure that they are dispatched appropriately. In addition to transferring calls to 988, law enforcement agencies can ensure that officers and dispatchers know how to request a mobile crisis team if they identify a mental health crisis. Similarly, the mobile crisis team should be able to request law enforcement backup in case of a safety concern, or assistance needed to transport a person in crisis to a receiving center or emergency room (ER).

ENSURING SAFE AND EFFECTIVE RESPONSES WITHOUT A FULL MOBILE CRISIS TEAM:

When there are no mobile crisis services, it's urgent that all community partners advocate for the expansion of these services. At the same time, law enforcement can partner with mental health providers, mental health advocates and community organizations to ensure that alternative responses are as safe and effective as possible. Continue to the **next page** for examples of programs filling the gap when communities lack best practice mobile crisis services.

2

"Someone to Respond" continued

ENSURING SAFE AND EFFECTIVE RESPONSES WITHOUT A FULL MOBILE CRISIS TEAM:

Here are examples of programs filling the gap when communities lack best practice mobile crisis services:

- **Law Enforcement Only Response: Crisis Intervention Teams:**
  When mental health services are not available, the gold standard of response is a Crisis Intervention Team (CIT) officer. CIT programs are led by a cross-systems steering committee of law enforcement, mental health providers, and mental health advocates to improve coordination during a crisis and provide specialized training to patrol officers. CIT programs include people with lived experience of mental health conditions to ensure that officers learn to provide a sensitive response. To learn more about Crisis Intervention Team Programs, visit **CIT International** or the **National Alliance on Mental Illness.**

- **Law Enforcement/Mental Health Co-Response:**
  Some communities use a co-response model, where a mental health professional and a law enforcement officer respond together to a crisis and address mental health issues along with any safety concerns. Together, the team has the flexibility to respond to a variety of calls, from outreach to frequent users of services to managing a high-risk situation. The mental health professional provides services including de-escalation, assessment and referral, and sometimes follow-up after a crisis. There are several variations of this model: sometimes the mental health provider is employed as an employee of the law enforcement agency, and in other cases, they work for a provider agency. In some programs, the provider rides in the officer's cruiser, ensuring a simultaneous response; in other programs, the provider travels separately, allowing one provider to serve a larger geographical area.

  To learn more about co-response, visit the **International Co-Responder Alliance.**

- **Community Response Teams:**
  Some communities use a community responder model to address crisis in the community and divert low-level, non-violent crisis calls without involving law enforcement. A community response team typically includes two members, such as an emergency medical technician (EMT), a crisis counselor, firefighter and/or peer support specialist. While the scope of these teams varies between communities, they generally respond to an array of community needs including mental health crisis, homelessness and quality of life issues. They may provide de-escalation, first aid, connection to resources, homeless outreach, transportation and other services. They do not respond to high-risk situations.

  To learn more about community response teams, visit the website for **CAHOOTS** and **Denver STAR,** two examples of community response teams.

3

"A Place to Go"

Most mental health crisis situations can be resolved by crisis lines or mobile crisis teams. However, some people may need care in a mental health stabilization facility or inpatient hospital.

BEST PRACTICE:

Crisis Receiving and Stabilization Facilities

The best practice for facility-based care is a crisis receiving and stabilization center. These facilities are open 24 hours a day, seven days a week, all year-round and are staffed by a team of mental health professionals and peer support specialists. While these centers are the least-developed part of the crisis response continuum, they provide vital services to people with a variety of mental health and substance use crises, including connecting people to care that the facility is not equipped to provide (e.g. urgent medical care or detoxification services). Crisis receiving centers should not turn anyone away; they accept walk-ins and referrals, as well as drop-offs by police and other first responders. The **Fusion Model** is one example of a crisis receiving and stabilization service combining a warm and welcoming environment with immediate access to care. To learn more about crisis receiving and stabilization facilities, review **this SAMHSA resource.**

TRANSITIONING TO BEST PRACTICES:

In communities with a crisis receiving center, mobile crisis teams, law enforcement and other responders should transport people in crisis to this service rather than the ER. Law enforcement agencies should also advocate for a dedicated entrance for first responders to facilitate a speedy transfer of custody.

ENSURING SAFE AND EFFECTIVE RESPONSES WITHOUT CRISIS RECEIVING AND STABILIZATION CENTERS:

In the absence of a crisis receiving and stabilization facility, it may be necessary for a person in mental health crisis to go to the ER in certain circumstances, such as a suicidal crisis, overdose or other risk to self or others. Unfortunately, most ERs are not equipped to address mental health crisis. ERs often do not have mental health crisis providers on staff and people in crisis face significant trauma, including the use of restraints and long waits to transfer for inpatient services (a practice called "ER boarding").

In communities without crisis receiving and stabilization facilities, coordination between ERs, mobile crisis teams and law enforcement can save time and improve conditions. Law enforcement agencies should advocate for a speedy, standardized process for transferring custody from law enforcement to the ER. SAAs, along with mental health and law enforcement partners, can also advocate for ERs to offer mental health peer support and develop or use a statewide database to track inpatient psychiatric bed capacity.

To learn more about the challenges ERs face in addressing mental health crisis, visit the **American College of Emergency Physicians** website.

Conclusion

Most states need to expand their crisis response systems. While every state should have a crisis line receiving calls from 988, there are many opportunities to coordinate 988 with 911, and an urgent need for more mobile crisis services and crisis receiving and stabilization facilities.

SAAs can play a key role in supporting and advocating for these services. As new services come online, law enforcement and other first responders should coordinate with the mental health system to ensure the smooth transition of responsibilities. Law enforcement will also need to continue to collaborate with mental health professionals when a mental health crisis involves a safety or criminal concern.

ACKNOWLEDGMENTS

Special thanks to **Laura Usher** for her subject matter expertise and authorship of this document.

This document was created with the support of Grant No. 2019-YA-BX-K002 awarded by the Bureau of Justice Assistance. The Bureau of Justice Assistance is a component of the Office of Justice Programs, which also includes the Bureau of Justice Statistics, the National Institute of Justice, the Office of Juvenile Justice and Delinquency Prevention, the SMART Office, and the Office for Victims of Crime. Points of view or opinions in this document are those of the author and do not necessarily represent the official position or policies of the U.S. Department of Justice.

LESSON PLAN NUMBERING GUIDE

BASIC

001	Student Handbook Quiz

LEGAL PROCEDURES

101	Criminal Justice System
102	Use of Force
103	Constitutional Law
106	Arrest, Search & Seizure
107	Miranda & Confessions
108	Courtroom Performance
109	Criminal Elements
110	Introduction to Juvenile Justice
112	Garrity

PATROL PROCEDURES

201	Radio Communications
202	Report Writing
203	Patrol Procedures
204	Unknown Vehicle Stops
207	Tactical Medicine
209	High Risk Vehicle Stops
212	Hazardous Materials Awareness

OFFICER SURVIVAL

301	Techniques of Arrest
302	Firearms/Patrol Rifle
306	Survival Techniques & Tactics
316	Low Light Tactics
317	Active Shooter
318	Preparation for Survival
319	Stress Management
320	Physical Assessments

Updated September 30, 2025

INVESTIGATION

401	Death and Wound
402	Child Abuse
403	Domestic Violence
404	Elder Abuse
405	Human Trafficking
406	Harassment and Stalking
414	Interview & Interrogation
417	Basic Drugs
420	Investigative Procedures
421	Crimes Against Persons
422	Property Crimes
423	Threat Groups **New 2024

HUMAN UNDERSTANDING

501	Anti-Bias Community Relations
505	Verbal De-escalation
506	Ethics
507	Mental Health Issues
508	Juvenile Crisis Intervention & De-Escalation

TRAFFIC OPERATIONS

601	Accident Investigation
602	NE Motor Vehicle Law
603	S.F.S.T. / P.B.T.
604	D.U.I
605	Defensive Vehicle Operations
606	Emergency Vehicle Operations
607	Radar
608	In-Car-Camera
609	P.B.T.
610	Traffic Incident Management

Within the Umbrella of Human Understanding

1. ANTI-BIAS JOB TASKS

Number	Job Task Description
A-022	Use social media to promote positive information exchanges between law enforcement and the community.
A-075	Talk with people on beat, patrol area, district, etc. to establish positive relations.
A-078	Conduct community relations programs (e.g., safety programs, crime prevention, tours, etc.).
A-079	Distribute printed material for public relations
A-080	Give talks on law enforcement, etc., to community organizations, businesses and/or schools
A-081	Meet with teachers and school officials to discuss methods to provide better security, discus at-risk student, etc.
A-082	Organize neighborhood watch groups and conduct meetings.
H-018	Identify specific religious norms and adjust interactions accordingly
H-020	Provide information to individuals in need of social service referrals.
H-021	Recognize a person's culture and adjust manner of communication accordingly, to ensure understanding.

2. VERBAL DE-ESCALATION JOB TASKS

Number	Job Task Description
A-006	Execute stop of motor vehicle, approach and talk to operator and passengers
A-039	Comfort emotionally upset persons
A-073	Communicate with deaf and/or mute persons
A-075	Talk with people on beat, patrol area, district, etc. to establish positive relationship

A-085	Respond to general information questions from public
A-086	Take control of publicly intoxicated/disruptive person
G-026	Use appropriate verbal commands/communication in use of force situations
H-001	Use verbal de-escalation techniques to communicate with people
H-004	Use voice and words to calm situation, project intention, etc.
H-007	Speak confidently to project control, self-assurance, etc.
H-009	Speak plainly/clearly to encourage understanding
H-011	Use & adjust language appropriate to listeners
H-012	Maintain concentration while many people speak simultaneously
H-015	Use body language to project control & influence.
H-021	Recognize a person's culture and adjust manner of communication accordingly to ensure
H-026	Negotiate/offer alternatives to resolve conflict between disputes (e.g., Landlord/tenant)
N-019	Cope with the emotional and physical impact of being subjected to verbal threats of violence
N-020	Cope with the emotional impact of verbal abuse from persons.

3. ETHICS JOB TASKS

Number	Job Task Description
B-001	Exercise discretion (choice) in selecting appropriate enforcement action
B-002	Apply ethical standards while performing law enforcement duties
B-004	Enforce professional standards among colleagues
B-005	Use proper judgment when confronted with offers of gratuity (i.e., free coffee, meals, services, etc.)

B-006	Recognize and report misconduct of social media
O-020	Read and comprehend Law Enforcement Code of Ethics

4. MENTAL HEALTY ISSUES

Number	Job Task Description
A-039	Comfort an emotionally upset persons.
A-046	File and retrieve documents in records system (e.g., fingerprint cards, reports, etc.)
A-086	Take control of publicly intoxicated/disruptive persons.
A-090	Recognize need for and initiate emergency protective custody detention (EPC).
A-116	Use/monitor social media to identify/anticipate potential public safety problems.
F-035	Recognize signs of suicide risk in inmate/detainee or arrested person.
G-022	Remove weapon from home/residence of suicidal person, scene of domestic violence, etc.
H-001	Use verbal de-escalation techniques to communicate with people.
H-004	Use voice and words to calm situation, project intention, etc.
H-007	Speak confidently to project control, self-assurance, etc.
H-009	Speak plainly/clearly to encourage understanding.
H-011	Use and adjust language appropriate to listeners.
H-015	Use body language to project control and influence situation.
H-021	Recognize a person's culture and adjust manner of communication accordingly to ensure understanding.
H-022	Talk with persons threatening suicide to persuade them not to attempt.
H-024	Contact Mental Health resource (e.g., program, facility, etc.) to obtain assistance for mentally ill or emotionally unstable person.
H-025	Take an apparently mentally ill person into protective custody for an involuntary mental health evaluation.
N-019	Cope with the emotional and physical impact of being subjected to verbal threats of violence.
N-020	Cope with emotional impact of verbal abuse from person

ENDNOTES

[i] Indian Affairs website: https://indianaffairs.state.ne.us/resources/tribes-of-nebraska/

[ii] Historical Population Change Data (1910-2020)

[iii] Migration Drives Highest Population Growth in Decades

[iv] Nebraska State Data Center | Center for Public Affairs Research | University of Nebraska Omaha

[v] US Department of Health and Human Services: Overview of the State - Nebraska 2024; Nebraska - 2024 - III.B. Overview of the State

[vi] Counting Cornhuskers: Population Trends in Nebraska; Legislation Research Office: LRO Snapshot, May 2024

[vii] Nebraska Department of Health and Human Services.

[viii] CDC 2020 and 2021 Nebraska State Unintentional Drug Overdose Reporting System Factsheet

[ix] CDC 2020 and 2021 Nebraska Behavioral Health Region 1 to 4 State Unintentional Drug Overdose Reporting System Factsheet

[x] CDC 2020 and 2021 Nebraska Behavioral Health Region 5 State Unintentional Drug Overdose Reporting System Factsheet

[xi] CDC 2020 and 2021 Nebraska Behavioral Health Region 6 State Unintentional Drug Overdose Reporting System Factsheet

[xii] CDC High School Youth Risk Behavior Survey results, Nebraska 2021

[xiii] Health Resources & Services Administration Health Workforce: State of the Behavioral Health Workforce November 2024

[xiv] Andrilla, C.H.A., Woolcock, S.C., Garberson, L.A., & Patterson, D.G. (2022). Changes in the supply and rural-urban distribution of psychiatric nurse practitioners in the U.S., 2014-2021. WWAMI Rural Health Research Center, University of Washington.

[xv] Andrilla, C.H.A., Woolcock, S.C., Garberson, L.A., & Patterson, D.G. (2022). Changes in the supply and rural-urban distribution of psychologists in the U.S., 2014-2021. WWAMI Rural Health Research Center, University of Washington.

[xvi] Andrilla, C.H.A., Woolcock, S.C., Garberson, L.A., & Patterson, D.G. (2022). Changes in the supply and rural-urban distribution of social workers in the U.S., 2014-2021. WWAMI Rural Health Research Center, University of Washington.

[xvii] Andrilla, C.H.A., Woolcock, S.C., Garberson, L.A., & Patterson, D.G. (2022). Changes in the supply and rural-urban distribution of counselors in the U.S., 2014-2021. WWAMI Rural Health Research Center, University of Washington.

[xviii] Busch, S.H., Ndumele, C., Foster, C., & Kyanko, K.A. (2019). Patient characteristics and treatment patterns among psychiatrists who do not accept private insurance. Psychiatric Services, 70(1), 35-39.

[xix] Saunders H, Guth M. (2023). A look at strategies to address behavioral health workforce shortages: Findings from a survey of state Medicaid programs. Kaiser Family Foundation.

[xx] Zhu, J.M., Renfro, S., Watson, K., Deshmukh, A., & McConnell, K.J. (2023). Medicaid reimbursement for psychiatric services: Comparisons across states and with Medicare. Health Affairs, 42(4), 556-565.

[xxi] Mark, T.L., Olesiuk, W., Ali, M.M., Sherman, L.J., Mutter, R., & Teich, J.L. (2017). Differential reimbursement of psychiatric services by psychiatrists and other medical providers. Psychiatric Services, 69(3), 281-285.

[xxii] Seshamani, M., & Jacobs, D. (2023). Important new changes to improve access to behavioral health in Medicare. Centers for Medicare & Medicaid Services; U.S. Department of Health and Human Services.

[xxiii] Herschell, A.D., Kolko, D.J., Hart, J.A., Brabson, L.A., & Gavin, J.G. (2020). Mixed method study of workforce turnover and evidence-based treatment implementation in community behavioral health care settings. Child Abuse & Neglect, 102, 104449.

[xxiv] Lo, J., Rae, M., Amin, K., Cox, C., Panchal, N., & Miller, B.F. (2022). Telehealth has played an outsized role meeting mental health needs during the COVID-19 pandemic. Kaiser Family Foundation.

[xxv] FAIR Health. (2024). Trends in mental health conditions: An analysis of private healthcare claims.

[xxvi] Cantor, J.H., McBain, R.K., & Ho, P. (2023). Telehealth and in-person mental health service utilization and spending, 2019 to 2022. 2023. JAMA Health Forum, 4(8), e232645.

[xxvii] Behavioral Health Education Center of Nebraska Legislative Report FY 2022 & 2023.

[xxviii] Behavioral Health Education Center of Nebraska. Nebraska Behavioral Health Workforce Dashboard. Accessed on 7/31/2025, 11:27:16 AM.

[xxix] Behavioral Health Education Center of Nebraska Legislative Report FY 2020 & 2021.

[xxx] Behavioral Health Education Center of Nebraska Legislative Report FY 2020 & 2021.

[xxxi] Centers for Medicare & Medicaid Services. (2024). Innovation in behavioral health (IBH) model. U.S. Department of Health and Human Services.

[xxxii] National Council for Mental Wellbeing. (n.d.). Integrated health.

[xxxiii] Agency for Healthcare Research and Quality. (n.d.). The Academy Integrating Behavioral Health & Primary Care.

[xxxiv] Behavioral Health Education Center of Nebraska Legislative Report FY 2020 & 2021.

[xxxv] Nebraska Department of Health and Human Services Public Data Dashboards

[xxxvi] National Alliance on Mental Health Crisis-Service-FS.pdf

[xxxvii] Nebraska Department of Health and Human Services: Division of Behavioral Health Annual Report: State Fiscal Year 2024

[xxxviii] Overview of CIT, The University of Memphis: CIT Center.

[xxxix] Krider, A., Huerter, R., Gaherty, K., & Moore, A. (2020). Responding to individuals in behavioral health crisis via co-responder models. Policy Research, Inc. and National League of Cities.

[xlii] https://pphd.org/Site/Documents/NewsReleases/09%20-%202019%20CHIP%20Annual%20Report.pdf

[xliii] https://www.1011now.com/2025/03/18/amid-mental-health-struggles-rural-nebraska-bill-aims-alleviate-emergency-protective-custody-pains/

[xliv] Nebraska's Crisis Continuum: 988 Planning- Nebraska's Regional Planning Summary

[xlv] https://region3.net/wp-content/uploads/2020/12/FY24-Impact-Report-FINAL.pdf

[xlvi] https://region3.net/wp-content/uploads/2020/12/FY23-R3-Network-QI-Plan-Performance-Measures-1st-Quarter-Results.pdf

[xlvii] Nebraska Youth Suicide Prevention

[xlviii] https://www.cdc.gov/nchs/products/databriefs/db471.htm?utm_source=chatgpt.com

[xlix] https://www.lincoln.ne.gov/News/2025/3/27

[l] https://omahadailyrecord.com/content/mental-health-focus-sarpy-county-law-enforcement?utm_source=chatgpt.com

[li] https://www.nami.org/advocacy/crisis-intervention/crisis-intervention-team-cit-programs/

NCJA.org/Strategic-Planning

LAST UPDATED 10/25