OFFICE OF
INSPECTOR GENERAL OF NEBRASKA CHILD WELFARE

Report of Investigation

Subject: Death by Suicide – 3 Case Review
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Trigger Warning

The following report discusses suicide. If this topic will be difficult or triggering for you, please do not continue reading. If you feel you need help, do not continue reading this report and reach out for help. Options include:

- Call or text **988** to access a trained crisis counselor at the National Suicide Prevention Lifeline;
- **Call 911**, and ask someone such as a friend or family member to stay with you until emergency medical personnel arrive to help you.

Helpful information on suicide awareness and prevention has been provided for this report by The Kim Foundation, and can be found in Appendix A, on page 38 of this report.

The Kim Foundation's mission is to serve as a supportive resource and compassionate voice for lives touched by mental illness and suicide throughout Nebraska. Please keep in mind that the information in no way substitutes for seeking professional help or advice from your doctor.

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EXECUTIVE SUMMARY

Between December 2018 and December 2022, the Department of Health and Human Services notified the Office of Inspector General of Nebraska Child Welfare of three system involved youth who had died by suicide. The youth ranged in age from eleven to sixteen years, they were from different areas of the state, their family dynamics were diverse, and their families were involved with the Division of Children & Family Services at three different points of the system. What they had in common was a suicidal crisis resulting in their deaths.

While adolescents in general are at an increased risk of death by suicide, youth involved with the child welfare system are impacted at an even higher level than when compared to their peers. Youth involved in the child welfare system report higher rates of suicidal ideation and self-harm behaviors. Youth who have been made wards of the state and placed in foster care face unique challenges given their adverse life experiences, transient home placements, and disruptions in social support networks, making them three times more likely to attempt suicide than those youth involved with the child welfare system, but not in state care. It is important to note that this increased risk and impact does not necessarily mean that all adolescents involved in the child welfare system will experience suicidal thoughts or behaviors. However, the impact of the increased risk does highlight the need for awareness and an equally impactful response.

It is generally understood that suicide can be deterred through awareness, prevention practices, and targeted training and policy efforts. This report presents the findings of an OIG review conducted to assess suicide prevention practices within the Nebraska Department of Health and Human Services Division of Children and Family Services. The investigation aimed to understand the existing policies, procedures, and training related to suicide prevention within the Division of Children & Family Services, with a specific focus on case management, foster care support, and foster parents. Nothing in this report should be interpreted to mean that the agencies, or people working with the Stern, Johnston and Hensley families contributed or were responsible for the deaths of the three youth.

While the review identified that the Department of Health and Human Services, along with various partners within the state, is committed to reducing instances of suicide in Nebraska, inconsistencies

were found in the implementation of suicide prevention practices within the Division of Children & Family Services.

As a result of the investigation, the OIG found that within the Department of Health and Human Services Division of Children & Family Services there is a distinct lack of policy and procedure articulating suicide prevention protocol, or a cohesive suicide prevention plan. Additionally, the OIG found that within the division there are training gaps related to suicide prevention.

As a result of these findings the OIG made the following recommendations to DHHS:

1. Develop a comprehensive suicide prevention plan.

2. Develop dedicated suicide prevention policy and procedure.

3. Mandate gatekeeper training for all staff members.

4. Standardize training requirements for Child Placing Agencies.

5. Provide suicide prevention content including required gatekeeper training to foster care providers.

6. Actively participate in the State Suicide Prevention Coalition.

In conclusion, the OIG indicated that it is crucial for the Department of Health and Human Services Division of Children & Family Services to establish a comprehensive and standardized approach to suicide prevention, integrating training requirements, clear policy and procedure guidance, and a cohesive plan that ensures consistent and effective prevention efforts across the Division as a means of better protecting the well-being of vulnerable youth and families.

Note that the names and other identifying information related to the youth and their family members mentioned in this report have been changed to protect their identity. The names used in this report are fictitious.

JURISDICTION

The Office of the Inspector General of Nebraska Child Welfare (OIG) provides oversight and accountability for Nebraska's child welfare and juvenile justice systems through independent investigations, system monitoring and review, and recommendations for improvement.

The Office of Inspector General of Nebraska Child Welfare Act mandates that the OIG investigate any death of a child occurring while the child's family is receiving services from or involved in an investigation with the Department of Health and Human Services Division of Children and Family Services (CFS), and when the office determines the death did not occur by chance.[1]

In December 2018, the OIG received notice from CFS indicating a fourteen-year-old state ward, Bryan Stern, had died by suicide while he was a ward of the state.

In May 2021, the OIG received notice from CFS reporting that sixteen-year-old Oliver Johnston had died by suicide while his family was involved in a CFS case that had transferred to a voluntary ongoing case the same day as his death

In December 2022, the OIG was notified by CFS that eleven-year-old Luis Hensley had died by suicide. Luis and his two siblings were part of an Alternative Response CFS case.

[1] Neb. Rev. Stat. §43-4318 (1) (b).

SCOPE OF THE OIG INVESTIGATION

The following report is the result of the OIG's investigation into three incidents where juveniles, while involved with CFS, died by suicide. Readers should be advised that some of the report's content could be upsetting or disturbing.

The scope of this report includes suicide awareness, prevention, and training as it is currently implemented by CFS through policy, procedure. The intent of this report is to offer recommendations to the division for improvements that can be made in responding to the heightened levels of risk for death by suicide when youth are system involved. Nothing in this report should be interpreted to mean that the agencies, or people working with the Stern, Johnston and Hensley families contributed or were responsible for the deaths of the three youth.

During the course of its investigation the OIG gathered information from the following sources:

- CFS records;
- Center for Children, Families and the Law (CCFL);
- Child Placing Agencies (CPA) currently contracted with DHHS;
- DHHS employees;
- Suicide Prevention experts familiar with prevention efforts in Nebraska;
- CFS policy and procedure documents;
- Nebraska state statutes; and,
- A literature review of over 50 relevant scholarly research and literature documents.

CASE SUMMARIES

Case # 1- Bryan Stern

Age at time of death: 14 yrs.

Point in System: Current State Ward

Timeframe from being made a ward of the state to death: 1 year

Summary

The Stern family had most recently become involved with CFS in July 2017, due to an incident of domestic violence between Tim and Helen Stern (bio-father and step-mother to Bryan). During the incident Helen's oldest son, Clark, tried to stop Tim from disabling the family's car and in the process was bitten by Tim on his outer thigh. Tim was admitted to a local mental health ward; he was arrested upon his release. Law enforcement notified the Hotline of the event, and the call was accepted for Initial Assessment.

Even though Tim and Helen agreed to a voluntary case with CFS, the county attorney filed a petition in juvenile court alleging the Stern children lacked proper parental care. The petition did not request that the children be made wards of the state. Bryan, along with his siblings (Clark, Wyatt, Tess & Jimmy) were made wards of the state five months later when Tim and Helen Stern requested it and the judge ordered it at a December 2017 disposition hearing. All of the children were placed in the family home with both parents, and they remained in the home for the duration of the CFS case.

A court ordered trauma assessment specifically recommended that Bryan participate in family therapy, which was never initiated. He did attend individual therapy, which was noted within documentation to be occurring weekly. The trauma assessment for Bryan's sibling, Clark, highlighted that he was experiencing high levels of depression and anger which resulted in a concern for an increased risk of death by suicide.

For the life of the case, the Family Strengths and Needs Assessment (FSNA) consistently identified a single area of need–Family Relationships/DV. As a result, the case plan consisted of one goal for the parents – that they would provide a safe, clean and stable home free from domestic violence. Goals for the children were not included as the FSNA did not identify any areas of need for the children, thus case

plans did not include goals specific to the children.[2] Intensive Family Preservation (IFP) was put in the home in August 2017 for a period of six weeks. Based on a review of the service referral, the focus of the IFP was on Helen's mental health and co-parenting skills between Tim and Helen.

Between the July 2017 intake and the December 2018 critical incident there were over 50 documented contacts with the family. Required contact narratives indicated that contact with Bryan most often centered on being asked questions about his father and step-mother's relationship/fighting, and occasionally about school or his current employment status.

A year after being made a ward of the state, in December 2018, Bryan had an argument with his father and step-mother, later that evening it was discovered that Bryan had died by suicide.

[2] The FSNA is used to identify safety related needs and strengths of the family so that a case plan can be developed. Using information gathered for the FSNA, case plan goals, strategies and services are established.

Case # 2 – Oliver Johnston

Age at time of death: 16 yrs.

Point in System: Ongoing Services

Timeframe from CFS Initial Assessment contact to death: 3 weeks

Summary

The Gilbert-Johnston family first became involved with CFS in February 2021 when Oliver disclosed that as a child he was sexually abused by his half-brother, Martin Watkins. Martin and Oliver shared a biological mother, Corina Gilbert. He reported to a forensic interviewer that he had recently told his mother about the abuse, but she did not believe him, and after he told his mother about his abuse, she called Martin and told him about the disclosure. The completed Safety Assessment deemed Oliver safe because there was no contact between Martin and Oliver, as Oliver was living with his father. The CFS case was closed without further action.

Two months later a second intake for the home of Ms. Gilbert was accepted by the Hotline. The intake alleged that Martin Watkins was being allowed into the family home of Corina Gilbert while Oliver was living there. The reporter stated that the contact with Martin was causing Oliver stress. The intake also noted that Oliver was suffering depression and anxiety, due in part, to the death by suicide of his sister 5 years ago.[3]

Oliver reported to the assigned case worker that he had been living with his father until early March, and then it became too much for him because his father's depression was impacting his own. Oliver reported that during a recent period of suicidal crisis he cut a hole through his bedroom wall into his mother's bedroom to gain access to her guns. On top of a gun safe was an unsecured firearm that Oliver mistakenly loaded with the incorrect ammunition during a suicide attempt. After this event, Oliver was admitted to the hospital, and Ms. Gilbert tried to get Oliver into a residential treatment program. It was

[3] Oliver would have been 12 yrs. old at the time of his sister's death by suicide, and the 5 year anniversary of her death was within 2 days of the report to the Hotline.

reported to the case worker that Oliver had been skipping his therapy sessions and not taking his medications.

The Safety Assessment identified an active safety threat: Child behaviors—imminent threat of serious harm, in spite of appropriate response by caregiver(s), and found Oliver to be Conditionally Safe with a Safety Plan. The associated safety plan stated that the family would participate in intensive in-home services, and the CFS case worker would be in weekly contact with safety plan participants until the in-home services were in place. Risk Assessment narratives documented that Oliver felt his mother both verbally and emotionally abused him and was not emotionally available to him.

The CFS case worker initiated a service referral for in-home services, but before a meeting between the provider and Oliver could occur, Oliver Johnston died by suicide.

Case # 3 – Luis Hensley

Age at time of death: 11 yrs.

Point in System: Open Alternative Response Case

Timeframe from accepted Alternative Response intake to death: 24 days

Summary

Luis Hensley's parents were deported in 2018. Because Luis and his older siblings, Maya and Philip, had all been born in the United States they were allowed to remain in the state. Eventually a guardianship was established with the children's older sister, Vanna (age 25). Luis had not had face-to-face contact with his parents since their deportation, but he did have virtual contact. A visit with his parents had been planned for the summer of 2022, but an issue with obtaining passports delayed the visit.

During November 2022, Vanna had requested law enforcement assistance twice; first because Luis was self-harming and the second time because Maya was refusing to come out of a locked bathroom after an argument with Vanna. As a result, law enforcement made a report to the Hotline. In addition to concerns for the children, the reporter indicated that an officer had made a referral for Luis to a mental health provider as part of an available community outreach program. The report to the Hotline was accepted based on the allegations of the emotional abuse of Philip, Maya, and Luis by their sister Vanna. The intake was assigned to Alternative Response.

A Safety Assessment completed in December documented that Luis described the situation at home as increasingly difficult because Vanna had recently miscarried and was having a "hard time dealing with it." When asked how safe he felt on a scale from one to ten, Luis indicated he assessed his safety as a five and a half. Noting to the case worker that he would be safer if he felt more included in the family and loved. When the case worker met with Vanna, the sister reported that Luis was picked on by his older siblings so she was moving his bedroom closer to her bedroom and further away from his siblings. Vanna also told the case worker that she had a history of suicide attempts and that since the loss of her unborn child she had been dealing with depression. During the course of contact with Vanna, the case worker provided her with a community resource packet and information about the national 988 suicide number. The assessment concluded that the Hensley children were safe in the care of their sister. The Prevention Assessment indicated that the family's risk scored high and that they would benefit from

continued services. However, according to documentation, Vanna felt that mental health referrals were sufficient and she declined further services.

Five days later Luis Hensley died by suicide. Based on a review of law enforcement reports, Vanna Hensley provided a version of events indicating that she and her brother had argued. Following the argument she checked on Luis, finding him standing on a chair in his closet. However, at the time, Vanna did not believe her brother's actions to be suspicious or dangerous; 30 minutes later Luis was found dead by suicide.

SUICIDE DEFINED [4]

Suicide is death caused by injuring oneself with the intent to die.[5] The emotional state of people considering suicide is described as suffering a sense of unbearable psychological pain, a sense of isolation from others, and a feeling of being trapped and hopeless or like they are a burden to others. Often there is a perception that death is the only solution when an individual is temporarily overwhelmed and not able to think clearly—in this moment—suicide becomes an acceptable option. Despite their desire for the pain to stop, many suicidal people are conflicted about ending their own lives. They want an alternative to suicide, but they just cannot see one.[6]

Self-harm, also known as non-suicidal self-injury, is the intentional infliction of harm to oneself without the intent to die. Examples of self-harm include cutting, burning, and scratching. While self-harm is not necessarily a suicide attempt, it may be a coping mechanism for dealing with emotional pain and a warning sign of suicidal ideation.

Suicidal ideation refers to thoughts or ideas about taking one's own life. These thoughts may range from fleeting, passing thoughts to persistent and obsessive thoughts about suicide, and can be a serious warning sign that a person may be at risk of attempting suicide.

Suicide attempts, on the other hand, involve intentionally taking actions to end one's life. Suicide attempts can range in severity from non-fatal attempts to life threatening injury.

Acute crisis encompasses a profound intent to act on suicidal thoughts. Warning signs become a clear set of indicators of imminent danger allowing for an intervention period of hours to days.[7]

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[4] National Institute of Mental Health. (n.d.) Retrieved from https://www.nimh.nih.gov/health/statistics/suicide.
[5] Crosby A, Ortega L, Melanson C. Self-directed violence surveillance: Uniform definitions and recommended data elements, version 1.0 [PDF – 1 MB]. (2011) Atlanta, GA: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control.
[6] Beyond Blue. (n.d.). Retrieved from https://www.beyondblue.org.au/the-facts/suicide-prevention/understanding-suicide-and-grief/understanding-suicide.
[7] Tim, Sean & Bryant, Heather. (2007). Evidence-Based Suicide Prevention Screening in Schools. Children & schools. 29. 219-227. 10.1093/cs/29.4.219.

Suicide – A Continuum of Behaviors

Suicide is best understood as a continuum of behaviors and thoughts.[8] This continuum includes several phases, each of which can be characterized by differing levels of risk and severity. At the lowest end of the continuum are passive suicidal thoughts, which involve fleeting or occasional thoughts of death or self-harm. These thoughts may be distressing, but the person does not have a concrete plan to harm themselves. Moving up the continuum, someone may begin to experience active suicidal thoughts, which involve a more persistent desire to die or self-harm. During this phase, the person may start to make plans or take steps towards harming themselves. Suicidal ideation involves a strong desire to end one's life, along with specific plans and intent to carry out the act. At this phase, the person is at high risk for attempting suicide. This phase represents a clear indication of a person's intention to end their life. These suicidal attempts occur within an acute suicidal crisis phase. Psychologist Edwin Shneidman, considered to be one of the most significant pioneers in suicidology, describes the acute suicidal crisis as "a period of high and dangerous lethality; an interval of relatively short duration – to be counted, typically, in hours or days, not usually in months or years. An individual is at a peak of self-destructiveness for a brief time and is either helped, cools off, or is dead."[9]

It is important to note that not everyone who experiences thoughts or behaviors related to suicide will progress through all of these stages, or enter a suicidal crisis period, and that this continuum of behavior is not always linear.

> Suicide occurs in response to multiple biological, psychological, interpersonal, environmental, and societal influences that interact with one another, often over time.[10]

[8] Gvion Y, Levi-Belz Y, Hadlaczky G, Apter A. On the role of impulsivity and decision-making in suicidal behavior. World J Psychiatry. 2015 Sep 22;5(3):255-9. doi: 10.5498/wjp.v5.i3.255. PMID: 26425440; PMCID: PMC4582302.
[9] Shneidman, E. S. (1997). The Suicidal Mind. Oxford University Press.
[10] CDC. (2022). Suicide Prevention Resource for Action: A Compilation of the Best Available Evidence. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

THE SUICIDE CRISIS

Suicide is a worldwide public health crisis. According to the World Health Organization (WHO) more than 700,000 people around the world die as a result of suicide, making it one of the leading causes of death for people between the ages of 15 and 29.[11] Consistent with global data, the Center for Disease Control and Prevention (CDC) has identified suicide as a leading cause of death in the United States.[12] According to the CDC, in the last twenty-one years (2000-2021), suicide rates increased an alarming 36%. In 2021, suicide was among the top 9 leading causes of death for people ages 10-64, and the second leading cause of death for people ages 10-24.[13]

According to the *Health of Women and Children Report*, released by the United Health Foundation in 2022, adolescent suicides in the United States has increased 29% among adolescents ages 15 to 19 over the last decade (2012-2020).[14] Also related to the rate of suicide among adolescents, during the COVID-19 Pandemic there were higher than expected suicide deaths among preteens and young adults, with suicide deaths involving firearms also higher than expected within the group.[15]

While the total number of deaths by suicide is alarming, there are many more people who attempt suicide each year; the American Association of Suicidology estimates that there are 25 suicide attempts for every one reported death by suicide in the United States alone.[16]

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[11] World Health Organization Suicide Key Facts (2021, June 17). Retrieved from https://www.who.int/news-room/fact-sheets/detail/suicide.
[12] Crosby AE, Ortega L, Melanson C. Self-directed Violence Surveillance: Uniform Definitions and Recommended Data Elements, Version 1.0. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2011.
[13] Centers for Disease Control and Prevention, National Center for Health Statistics. Disparities in Suicide. Retrieved from https://www.cdc.gov/suicide/facts/disparities-in-suicide.html.
[14] America's Health Rankings-United Health Foundations. (2022). Health of Women and Children Report retrieved from https://www.americashealthrankings.org/learn/reports/2022-health-of-women-and-children-report.
[15] Bridge, J. A., Ruch, D. A., Sheftall, A. H., Hahm, H. C., O'Keefe, V. M., Fontanella, C. A., Brock, G., Campo, J. V., & Horowitz, L. M. (2023). Youth Suicide During the First Year of the COVID-19 Pandemic. Pediatrics, 151(3).
[16] American Association of Suicidology (2023, March 15). Why Suicide Prevention is Everyone's Job and How You Can Help. Retrieved from https://suicidology.org/2023/03/15/why-suicide-prevention-is-everyones-job-and-how-you-can-help/.

The Suicide Crisis in Nebraska

As a state, Nebraska has not been immune to the suicide crisis. Nebraska first saw suicide ranked in the state's top ten overall causes of death in 2016.[17] However, the CDC has been consistently ranking suicide within the top three causes of death for Nebraska youth ages 10-18 years since 2006. [18] In the not too distant past (2014-2016) suicide was identified in Nebraska as the number one leading cause of death for youth ages 10-14 years old.[19]

According to this most recent Nebraska Statewide Suicide Prevention Plan, Nebraska's suicide rate was slightly higher than the national average in 2020, with the state ranked 28th in the nation for suicide deaths. Similar to the national trend, the report also highlighted that suicide among Nebraska's youth is a continuing concern, as death by suicide has consistently been either the first or second leading cause of death for youth ages 10-24 years-of age for the past 20 years.

The Nebraska Youth Risk Behavior Survey

The Nebraska Youth Risk Behavior Survey (YRBS)[20] provides additional insights into teen suicide within the state.[21] In 2021, 22% of Nebraska high school students reported seriously considering attempting suicide in the past 12 months, 18% of high school students, during that same period, made a suicide plan, and 10% of surveyed students reported attempting suicide at least once in the 12 month period.[22]

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[17] National Center for Health Statistics -Stats of the State of Nebraska. (2017, March 31). Retrieved from https://www.cdc.gov/nchs/pressroom/states/nebraska/nebraska.htm

[18] McIntosh, J. L. (for the American Association of Suicidology). (2010). U.S.A. suicide 2007-2016: Official final data. Washington, DC: American Association of Suicidology, dated May 23, 2010-December 24, 2017, downloaded from http://www.suicidology.org.

[19] 10 Leading Causes of Death, Nebraska 2012-2020, All Races, Both Sexes. (n.d.). Retrieved from https://webappa.cdc.gov/cgi-bin/broker.exe

[20] Nebraska began conducting the YRBS in 1991 as a monitoring system that targets youth enrolled in public high schools in Nebraska. The system utilizes a survey conducted in partnership between the Nebraska Department of Education, and the Nebraska Department of Health and Human Services, with the Bureau of Sociological Research at the University of Nebraska-Lincoln administering the survey since the fall of 2010. They YRBS is the only survey in Nebraska that provides state level estimates of high school students across a variety of important health areas. The data is used to monitor and evaluate priority health-risk behaviors and prevention efforts among high school students in Nebraska.

[21] Information retrieved from the University of Nebraska-Lincoln Bureau of Sociological Research at https://bosr.unl.edu/youth-risk-behavior-survey-yrbs.

[22] 2021 Youth Risk Behavior Survey Results: Nebraska High School Survey 10-year Trend Analysis Report. Nebraska Department of Education. Retrieved from https://www.education.ne.gov/csss/school-health-education-and-services/2018-19-ne-yrbs-results/.

The YRBS indicated that suicide ideation and action was higher among Nebraska high school students who reported having one or more Adverse Childhood Experiences (ACEs). For the purpose of administering the YRBS survey, ACEs were defined as the following situations:

- Lived with someone who was depressed, mentally ill, or suicidal
- Lived with someone who has/had a problem with alcohol or drug use
- Been separated from a parent/guardian because they went to prison, jail, or a detention center
- Usually did not sleep in their parent's/guardian's home
- A parent or other adult in their home frequently swore at them, insulted them, or put them down
- A parent or other adult in their home frequently hit, beat, kicked or physically hurt them in any way
- Their parents or other adults in the home frequently slapped, hit, kicked, punched, or beat each other up

According to the 2021 YRBS data, of Nebraska high school students reporting one or more of the above ACEs – 28% seriously considered suicide, 22% made a plan of how they would attempt suicide, and 16% attempted suicide in the 12 month survey period. To be clear, Nebraska high school students who reported experiencing one or more ACE were 60% more likely to report having attempted suicide at least once in the 12 month time period, than their Nebraska high school peers who did not report experiencing an ACE.

Suicide Risk–Youth, Young Adults and Child Welfare Involvement

While suicide can affect people of all ages from all walks of life all with varied life experiences, some groups experience more negative conditions or factors related to suicide. These characteristics can make it more likely that a person will think about suicide or engage in suicidal behaviors (risk). Factors linked to a higher risk for suicidal behavior within the general population are listed below in Figure 1.[23]

Youth & Young Adults

As noted earlier in the report, the CDC reports that in 2021 youth and young people ages 10–24 years accounted for 15% of all suicides. Suicide is the second leading cause of death for this age group, with the rate of death increasing 52% over the last 20 years. While a teen's risk for suicide shifts with age, gender, and cultural and social influences, there are common threads of risk associated with the age group.[24]

Figure 1. Suicidal Risk Factors – Youth & Young Adults

- One or more mental or substance abuse problems;
- Impulsive behaviors;
- Undesirable life events such as being bullied or recent losses, such as the death of a parent;
- Family history of mental or substance abuse problems;
- Family history of suicide;
- Family violence, including physical, sexual, or verbal or emotional abuse;
- Involvement with the juvenile justice and child welfare systems;
- Past suicide attempt;
- Gun in the home;
- Imprisonment or detention; and,
- Exposure to the suicidal behavior of others, such as from family or peers, in the news, or in fiction stories.

[23] Office of the Surgeon General (US); National Action Alliance for Suicide Prevention (US). Washington (DC): US Department of Health & Human Services (US); 2012 Sep.
[24] Stanford University-Stanford Medicine, Children's Health. Teen Suicide. Retrieved fromhttps://www.stanfordchildrens.org/en/topic/default?id=teen-suicide-90-P02584.

Child Welfare Involvement

While adolescents in general are at an increased risk of death by suicide, youth involved with the child welfare system are impacted at an even higher level when compared to their peers. Contributing to the increased level of risk, youth involved in the child welfare system have been found to engage in substance and alcohol misuse, unsafe sexual behaviors, delinquency, and truancy at a younger age and at a much higher frequency and intensity than their peers.[25] In addition, the very factors that bring these youth into the child welfare system – abuse and neglect – compounds their vulnerability to suicidal thoughts and behaviors; this elevated vulnerability is not limited to youth in the care of the state, but applies to youth who remain in the home after alleged or substantiated maltreatment.[26] Youth involved in the child welfare system report higher rates of suicidal ideation[27] and self-harm behaviors.[28] They have potentially experienced significant trauma and abuse, which can increase their risk for suicidal behavior, as reporting six or more ACEs has been shown to have a 24% increased likelihood of attempting suicide.[29] Research tells us that 27% of youth involved in the child welfare system are at *imminent risk* for suicide– having current suicidal thoughts, planned suicide preparations, and means.[30] Youth who have been made wards of the state and placed in foster care face unique challenges given their adverse life experiences, transient home placements, and disruptions in social support networks, making them three times more likely to attempt suicide than those youth involved with the child welfare system, but not in state care.[31] It is important to note that this increased risk and impact does not necessarily mean that all adolescents involved in the child welfare system will

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[25] Leslie, L.K., James, S., Monn, A., Kauten, M.C., Zhang, J., & Aarons, G. (2010). Health-risk behaviors in young adolescents in the child welfare system. Journal of Adolescent Health, 47 (1), 26-34.
[26] Palmer, L., Prindle, J., Putnam-Hornstein, E. (2021). A population-based examination of suicide and child protection system involvement. Journal of Adolescent Health 69(3), 465-469.
[27] He, A.S., Fulginiti, A., & Finno-Velasquez, M. (2015). Connectedness and suicidal ideation among adolescents involved with child welfare: A national survey. Child Abuse and Neglect, 42, 54-62.
[28] Gabrielli, J., Hambrick, E.P., Tunno, A.M., Jackson, Y., Spangler, A., & Kanine, R.M. (2015). Longitudinal Assessment of Self-Harm Statements of Youth in Foster Care: Rates, Reporters, and Related Factors. Child Psychiatry and Human Development, 46(6), 893-902.
[29] Merrick, M.T., Ports, K.A., Ford, D.C., Afifi, T.O., Gershoff, E.T., & Grogan-Kaylor, A. (2017). Unpacking the impact of adverse childhood experiences on adult mental health. Child Abuse and Neglect, 69, 10-19.
[30] He, A.S., Fulginiti, A., & Finno-Velasquez, M. (2015). Connectedness and suicidal ideation among adolescents involved with child welfare: A national survey. Child Abuse & Neglect, 42, 54-62.
[31] Evans, R., White, J., Turley, R., Slater, T., Morgan, H., Strange, H., Scourfield, J. (2017). Comparison of Suicidal Ideation, Suicide Attempt and Suicide in Children and Young People in Care and Non-Care Populations: Systemic Review and Meta-analysis of Prevalence. Children and Youth Services Review, 82(2017) 122-129.

experience suicidal thoughts or behaviors. However, the impact of the increased risk does highlight the need for awareness and an equally impactful response.

SUICIDE PREVENTION

Suicides are preventable. The WHO notes there are measures that can be taken at all levels to prevent suicide, including limiting access to the means of suicide and promoting early identification, assessment, management and follow up for anyone who is affected by suicidal behaviors.[32] WHO's global suicide prevention plan, entitled *Live Life,* notes that suicide prevention efforts require coordination and collaboration among multiple sectors of society, and must be comprehensive and integrated as no single approach alone can make an impact on an issue as complex as suicide.

Historically suicide was considered a mental health issue[33], meaning that if a person was displaying suicidal behaviors or making suicide attempts it was because they were suffering from a mental health condition, thus the focus was on addressing mental health interventions and services. A report from the Action Alliance report, noted earlier, said that it is imperative that suicide prevention efforts not be limited to only the mental health profession, but instead address the myriad of high risk circumstances surrounding suicide, and be inclusive of all related systems in addressing the problem.

In the 2012 Action Alliance report, the Alliance directed that prevention efforts should expand beyond the silo of mental health.

> Because suicide is closely linked with mental illness, in the past, suicide prevention was often viewed as an issue that mental health agencies and systems should address. However, the vast majority of persons who many have a mental disorder do not engage in suicidal behaviors. Moreover, mental health is only one of many factors that can influence suicide risk. In addition to mental health conditions, prior suicide attempts, other contributing circumstances such as social and economic problems, access to lethal means (e.g., substances,

[32] World Health Organization. (2021). Live Life: an implementation guide for suicide prevention in countries. World Health Organization. https://apps.who.int/iris/handle/10665/341726.

[33] In the United States, the American Association of Suicidology was founded in 1968. It was during this period of time that researchers began to study the underlying causes of suicide, leading to the development of evidence-based prevention strategies. In the 1960s and 70s, pioneering researchers like Edwin Shneidman and Aaron Beck helped to establish the field of suicidology, which seeks to understand and prevent suicidal behavior. As a result of this earliest understanding of suicide, prevention efforts were initially directed at mental health professionals. Today, suicide prevention efforts continue to evolve and expand, with a growing focus on addressing the factors that contribute to suicide risk in addition to mental health issues.

firearms) among persons at risk, and poor coping and problem-solving skills also factor into suicide.

Suicide prevention efforts focus on reducing the incidence of death by suicide by identifying and addressing risk factors, providing resources for those who are struggling, and intervening when someone is either at risk or in immediate crisis. Prevention efforts can be implemented at the individual, community, organizational, and societal levels.

Prevention Strategies

Suicide prevention can be an umbrella term used to refer to strategies which are elements of a larger suicide prevention plan. Similarly, the term suicide awareness is often used interchangeably with the term suicide prevention. Suicide prevention strategies are typically categorized as either case finding or risk factor reduction.[34]

Case finding strategies include those strategies focused on increasing awareness, education, and direct screening. Examples of case findings strategies are public education programs, gatekeeper training, school based and primary care provider screening.

Risk reduction strategies include individual treatments such as psychotherapy and pharmacotherapy, means restriction, and media handling of deaths by suicide.[35]

Suicide Prevention Plans

Suicide prevention plans involve a combination of strategies, utilized for the purpose of reducing the occurrence of death by suicide. Examples of prevalent strategies include:

- Promoting suicide awareness and education about suicide risk factors, warning signs, and how to get help;
- Providing intervention methods such as crisis hotlines that can provide immediate support to individuals who are in crisis;

[34] Gould, M. & Kramer, R. (2001). Youth suicide prevention. Suicide and Life-threatening Behavior, 31 (supplement) Spring, 6-31.
[35] Mann, J., Apter, A., Bertolote, B., Beaurtais, A., Currier, D., Haas, A. et al. (2005). Suicide prevention strategies: A systemic review. JAMA, 294(16), 2064-2074.

- Ensuring people have access to affordable and quality mental health services;
- Utilizing suicide screening to identify those who are at risk of suicide for the purpose of offering intervention and support;
- Training (at both the community and professional level) individuals to assess and respond to suicide risks and warnings;
- Reducing access to lethal means of suicide, such as firearms or certain medications;
- Developing postvention responses – the act of providing support and care for individuals and communities affected by suicide; and,
- Collaboration and coordination between organizations, agencies, and stakeholders to develop and implement effective suicide prevention strategies.

The following section provides a brief overview of selected individual prevention strategies which are usually part of a larger prevention plan. These strategies are highlighted because they are considered some of the most effective prevention strategies, and applicable to the child welfare system (specifically child protective services). For a more in depth review of suicide prevention strategies the report *Suicide Prevention Resource for Action: A Compilation of the Best Available Evidence*, a 2022 publication by the Division of Injury Prevention, National Center for Injury Prevention and Control & Center for Disease Control and Prevention can be found on the CDC website. [36]

Suicide Awareness

Suicide awareness is meant to bring attention to the issue, reduce stigma around suicide and encourage individuals to seek help if they or someone they know is struggling with suicidal thoughts or behaviors. The strategy is intended to increase the knowledge and understanding of suicide as a public health issue. It covers topics such as suicide statistics, risk factors, warning signs and how to respond to them, and the impact of suicide on individuals, families, and communities in a broad manner.

Gatekeeper Training

Gatekeeper training is one of the most commonly used suicide prevention strategies. The idea behind gatekeeper training is transitioning from having knowledge about suicide to taking action. It is focused on equipping "Gatekeepers" (individuals both professional and non-professionals who are likely to come

[36] CDC. (2022). Suicide Prevention Resource for Action: A Compilation of the Best Available Evidence. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. Retrieved from https://www.cdc.gov/suicide/resources/prevention.html.

into contact with at-risk individuals) with the skills and knowledge necessary to intervene.[37] The goal of gatekeeper training is to help individuals feel confident in speaking with at risk individuals and competent in responding to a suicide crisis.[38] It is an essential part of suicide prevention, as it helps to identify individuals who may not otherwise seek help or disclose their suicidal thoughts or behaviors.[39]

Gatekeeping can be done by people who are not mental health professionals, provided they have received appropriate training and have the necessary knowledge and skills to conduct the screening effectively. This could include teachers, school counselors, healthcare providers, crisis hotline staff, religious leaders, and others who have regular contact with individuals who may be struggling with suicidal thoughts or behaviors. It's important to note that training as a gatekeeper is not intended to be a substitute for a comprehensive mental health assessment.

Generally speaking, the training should support the following skills:

- Increased awareness of risk factors;
- Early identification of warning signs;
- Enhanced communication skills such as active listening, empathic responding, and providing support in a non-judgmental and compassionate manner; and,
- Efficiency at connecting people with appropriate mental health services and other resources that can support their well-being. This can include crisis hotlines, counseling services, and peer support groups.

While there are multiple quality, research-based, gatekeeper programs available, such as Question, Persuade, and Refer (QPR) and Applied Skills in Suicide Training (ASIST), research indicates that there are three factors related to an increased effectiveness of such training:

[37] Isaac M, Elias B, Katz LY, et al. (2009). Gatekeeper training as a preventative intervention for suicide: a systematic review. Canadian Journal of Psychiatry, 54, 260–268.
[38] Lamis, D.A., Underwood, M., & D'Amore, N. (2017). Outcomes of a suicide prevention gatekeeper training program among school personnel. Crisis, 38, 89-99.
[39] Condron, D.S., Garraza, L.G., Walrath, C.M., McKeon, R., Goldstone, D.B., & Heilbron, N.S. (2014). Identifying and referring youth at risk for suicide following participation in school-based gatekeeper training. Suicide and Life Threatening Behavior, 45, 461-476.

- The length of the training;
- The incorporation of simulation based training; and,
- The inclusion of booster, or follow up sessions.

The optimal length of time for gatekeeper training programs can vary depending on the specific program, the audience, and the training goals. However, gatekeeper training programs should be of sufficient length to ensure that participants develop a solid understanding of the warning signs of suicide and the skills necessary to intervene effectively. A review of suicide prevention training programs found that lengthier programs were generally more effective than shorter programs. Of the available evidence-based gatekeeper trainings currently available, they vary in length from 90 minutes to two full training days. However, a four-hour training program has been identified as optimally increasing participant confidence, willingness to discuss suicide, and knowledge of suicide.[40]

The inclusion of reinforcing activities has also been noted to increase positive training outcomes as they effectively change the attitude and skill level of participants. Suicide prevention training should include interactive components, such as role-playing and group discussion, to help participants apply what they have learned to real-life situations.[41]

Finally, programs that include ongoing support and follow-up training are more effective than one-time training sessions. Gatekeeper training programs that included booster sessions produced participants with higher levels of knowledge and confidence in their ability to intervene effectively in comparison to participants in a program that did not include booster sessions.[42]

[40] Bailey, E., Spittal, M.J., Pirkis, J., Gould, M., & Robinson, J. (2017) Universal suicide prevention in young people: An evaluation of the safeTALK program in Australian high schools. Crisis, 38(5), 300-308.
[41] Richard, O., Jollant, F., Billon, G., Attoe, C., Vodovar, D., & Piot, M.A. (2023). Simulation training is suicide risk assessment and intervention: A systemic review and meta-analysis. Medical Education Online 28(1).
[42] Keller, D.P., Puddy, R.W., Stephens, R.L., Schut, L.J., Williams, L., McKeon, R. (2009). Tennessee lives count: Statewide gatekeeper training for youth suicide prevention. Professional Psychology: Research & Practice, 40(2) 126-133.

Even when factoring out the length of training, the use of simulation, and booster training, completing gatekeeper training results in less anxiety and reluctance to engage with individuals at risk for suicide and increased self-efficacy.[43]

Restricting Access to Lethal Means

These previous interventions have all been considered case finding strategies, meaning they are intended to help identify people at risk, while this final intervention is considered a risk factor reduction strategy. Restricting access to lethal means is important because it reduces the availability of methods that people use to harm themselves, such as prescription drugs, and most commonly firearms. In 2021, 54% of all gun-related deaths in the U.S. were death by suicide; also in 2021, more than half of all suicides (55%) involved a gun, the highest percentage since 2001.[44] The odds of death when the attempt includes a firearm are three times greater than with suffocation, the second most lethal method.[45]

The CDC's 2022 Suicide Prevention Resource for Action, reported firearms being stored unloaded, separate from ammunition, and in a locked place helped protect against suicide attempts among adolescents.[46] Counseling on Access to Lethal Means (CALM) is a suicide prevention program designed to reduce access to lethal means noted in the CDC's report. While CALM was developed for use by mental health professionals it has been expanded to other types of professionals. A 2019 study found that providing CALM training to case managers employed by the Area Agency on Aging resulted in the case managers having a positive effect on their attitudes, beliefs and behavior when counseling others on the subject of access to lethal means.[47]

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[43] Jacobson, J. M., Osteen, P. J., Sharpe, T., Pastoor, J. (2012b). Randomized trial of suicide gatekeeper training for social work students. Research on Social Work Practice, 22, 270-281.
[44] Pew Research Center (2023, April 26). What the Data Says about Gun Deaths in the U.S. Retrieved from https://www.pewresearch.org/short-reads/2023/04/26/what-the-data-says-about-gun-deaths-in-the-u-s/.
[45] Shenassa, E.D., Catlin, S.N., Buka, S.L. (2003). Lethality of firearms relative to other suicide methods: A population based study. Journal of Epidemiol Community Health, 57(2) 120-124.
[46] CDC. (2022). Suicide Prevention Resource for Action: A National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.
[47] Slovak, K., Pope, N., Giger, J., & Kheibari, A. (2019). An Evaluation of the Counseling on Access to Lethal Means (CALM) Training with an Area Agency on Aging. Journal of Gerontological Social Work, 62(1), 48–66.

With regard to juveniles, caregivers play a critical role in restricting access to lethal means like guns and prescriptions drugs. Caregivers or other individuals close to them have the ability to ensure their safety by securing firearms during a period of crisis and locking up prescription drugs.

Nebraska Prevention Efforts

Suicide prevention efforts in Nebraska involve a combination of state and community-based initiatives. Prevention efforts include a state suicide prevention coalition, a state prevention plan, a project focused specifically on youth suicide prevention, active state chapters of national suicide prevention organizations, local outreach and education entities, the implementation of a suicide crisis hotline, and legislative action.[48]

The Nebraska State Suicide Prevention Coalition was established in 2001 to provide leadership and direction for suicide prevention efforts in the state. The coalition is made up of a diverse group of stakeholders, including mental health professionals, educators, law enforcement officials, and representatives from various community organizations. The coalition has developed a comprehensive suicide prevention plan that includes strategies for increasing public awareness of suicide and its risk factors, improving access to mental health services, and reducing the stigma surrounding suicide and mental illness. Their purpose is to develop local expertise in preventing suicide throughout the state, focusing on the following three goals:

1. Increase awareness and knowledge among the target audiences of warning signs, risk factors and interventions to prevent suicide;
2. Reduce stigma; both surrounding suicide and associated with survivors seeking help for the loss of a loved one by suicide; and,
3. Positively influence the suicide rate for Nebraska. [49]

Nebraska also offers a suicide crisis line that provides free and confidential crisis counseling and referrals to local resources. The Nebraska Department of Health and Human Services Division of Behavioral

[48] Legislative Bill 923, passed in 2014, requires at least one hour of suicide awareness and prevention each year for Nebraska school personnel.
[49] NSSPC: Home. (n.d.). Retrieved from http://www.suicideprevention.nebraska.edu/

Health (DBH) in partnership with community organizations and mental health providers provides programming targeted at reducing the state's suicide rate. The two most common trainings offered are Question, Persuade, and Refer (QPR) and Mental Health First Aid. The training is made available to a wide range of individuals, including healthcare providers, educators, law enforcement officials, and community members.

Several community-based organizations in Nebraska also offer suicide prevention services, such as counseling, support groups, and educational programs. One example is the Kim Foundation, a nonprofit organization that provides resources and support for individuals and families affected by mental illness and suicide.

The Nebraska Youth Suicide Prevention Project is a partnership between DHHS-DBH, Nebraska's Behavioral Health Regions, the University of Nebraska Public Policy Center and the Nebraska State Suicide Prevention Coalition to carry out activities for this grant funded project. The purpose of the project is to prevent suicides and reduce the number of suicide attempts for youth ages 10-24.[50] They serve youth across the entire state, with attention to:

1. Preventing youth suicide in Nebraska;
2. Pursuing standardized screening protocols for youth at risk for suicide in child serving systems; and,
3. Implementing culturally appropriate suicide prevention strategies in Nebraska communities

In addition to the efforts mentioned, Nebraska has implemented the Zero Suicide Initiative, which is a national program that provides a framework for health and behavioral health care systems to improve care and outcomes for individuals at risk of suicide. This initiative focuses on enhancing care quality, improving safety, and providing a systematic approach to suicide prevention.

Nebraska's suicide prevention efforts involve a multifaceted approach that addresses various aspects of suicide, including education, early intervention, crisis management, and support for at-risk populations. It is evident that as a state, Nebraska has made a concerted effort to address the issue of suicide

[50] Who We Are. (n.d.). Retrieved from http://youthsuicideprevention.nebraska.edu/

prevention through collaboration between state and community-based organizations and the implementation of comprehensive prevention strategies.

Child Welfare & Prevention

Youth involved in the child welfare system are vulnerable to high rates of suicide. The development of suicide prevention capacity within systems that serve vulnerable youth is a national priority. One critical and foundational prevention strategy is gatekeeper training to equip the people who by virtue of their interactions with and roles in the lives of the youth are in the best position to be trained to recognize and respond to at risk youth.[51] This is an essential and commonly utilized approach to youth suicide prevention that has been implemented with staff in schools, health care settings, juvenile justice facilities and faith communities.[52]

Child welfare staff and providers serve as an optimal point of intervention as gatekeepers due to their proximity and engagement to a population of youth identified at an increased level of risk for suicide.[53] In response to this optimal point of intervention, the Youth Depression and Suicide: Let's Talk (YDS) gatekeeper training was developed specifically for use with staff within the child welfare system.[54] The core curriculum of the YDS training focuses on: addressing myths, risk factors, protective factors, and warning signs associated with suicide; developing active listening skills, assessing degree of risk, and skill practice using scenarios and role plays; and improving communication skills when working with other professionals for the purpose of crisis management.[55]

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[51] U.S. Department of Health and Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention. (2012). National Strategy for Suicide Prevention: Goals and Objectives for Actions. Washington D.C.: HHS September 2012.

[52] Condron et al., 2015.

[53] Kahsay, E., Magness, C., Persky, S., Smith, P.K., Ewell Foster, C. (2020) Suicide Prevention Training in the Child Welfare Workforce: Knowledge, Attitudes, and Practice Patterns Prior to and Following safe TALK Training Child Welfare, Vol. 98, No. 1 (2020), pp. 95-114

[54] The YDS training was developed by the Massachusetts Society for the Prevention of Cruelty to Children in collaboration with the Massachusetts Department of Children and Families. The training was created using a federal grant from the Garret Lee Smith Foundation and is listed on the Suicide Prevention Resource Center (SPRC) Best Practices Registry (BPR) as adhering to BPR standards.

[55] Osteen, P.J., Lacasse, J.R., Woods, M.N., Greene, R.M., Frey, J., & Forsman, R.L. (2018).Training youth services staff to identify, assess, and intervene when working with youth at high risk for suicide. Children and Youth Services Review, 86, 308-315.

It has also been recommended that the definition of providers and requirements for suicide prevention training be expanded to include out-of-home care givers such as foster parents and kinship caregivers.[56] These caregivers make the best gatekeepers because of their relationship to the youth and daily contact with them.[57] A 2014 large scale study of suicidal ideation, plans, and attempts among youth in foster care found that two thirds of caregivers were not aware of the child's imminent suicide risk.[58] Foster parents play a critical role in the lives of youth in the child welfare system, they are often the first point of contact for young people who may be struggling with suicide.

[56] Evans, R., White, J., Turley, R., Slater, T., Morgan, H., Strange, H., & Scourfield, J., (2017). Comparisons of suicide ideation, suicide attempt, and suicide in children and young people in care and non-care populations: Systematic review and meta-analysis of prevalence. Children and Youth Services Review, 82, 122-129.
[57] Moskos, M., Olson, L., Iiaber, S., Keller, T., & Gray, D. (2005). Utah youth suicide study: Psychological autopsy. Suicide and Life-threatening Behavior, 35(5), 536-546.
[58] Taussig, H.N., Harpin, S.B., & Maguire, S.A. (2014) Suicidality among preadolescent maltreated children in foster care. Child Maltreatment, 19,17-26.

OIG REVIEW

Bryan Stern, Oliver Johnston, and Luis Hensley ranged in age from eleven to sixteen years, they were from different areas of the state, their family dynamics were diverse, and their families were involved with CFS at three different points of the system. What they had in common was a suicidal crisis resulting in their deaths.

It is generally understood that suicide can be deterred through awareness, prevention practices, and targeted training and policy efforts. The goal of this investigation was to understand the content and structure of suicide prevention within DHHS's division of CFS through interviews and review of relevant policy, procedure, and practice as applied to case management, foster care support, and foster parents. The OIG conducted a high level survey of CFS policy and procedure documents related to suicide prevention, and analyzed whether CFS as a division of DHHS had a comprehensive suicide prevention plan. Through the course of its investigation the OIG was able to clearly identify that DHHS, along with many partners within the state, are committed to the goal of reducing incidences of suicide in Nebraska.

Prevention & Training in the CFS System

Case Managers

Case managers interact with youth and families who are system involved numerous times during the course of an IA and during ongoing case management, such as when conducting assessments, making required monthly contacts, or holding family team meetings. What follows is a summary of the training and resources provided to case managers regarding suicide and suicide prevention.

New Worker Training

Newly hired CFS Specialists (case managers) are provided training through a contract with the University of Nebraska's Center for Children, Families, and the Law (CCFL) and within their local CFS office under the supervision of CCFL trainers and CFS supervisors. The training is guided by a structured training plan. During new worker training trainees are given a basic level of suicide awareness and prevention exposure through CCFL (See Appendix B). Trainees are then expected to complete gatekeeper training, often QPR, as initiated by their home office. It was reported to the OIG that new workers most often attend gatekeeper training offered through a local Regional Behavioral Health Office which is administered by DHHS-DBH. Administrators reported that new workers are generally expected to

complete the gatekeeper training within their first year of service. Based on the OIG interviews, conformity with this practice is inconsistent across the CFS Division.

Booster Training

The OIG was told that ongoing or "booster" suicide awareness and prevention education can be made available to CFS employees through multiple channels, including:

- DHHS Noontime Knowledge program which offers one-hour webinars that are recorded and available to workers to access at their own discretion;
- The Bridge to Independence program (B2I), a program providing services to youth who are aging out of the child welfare system. It was reported that the B2I training is made available to all CFS case managers about every two years, but attendance is not mandatory; and,
- Mandatory staff meetings held at the service area level.

It was noted by the OIG that while there is the opportunity to provide mandatory booster training, there is no set training schedule to assure booster training is consistently covered or attended.

Procedures

The OIG asked about how case managers and supervisors address situations related to suicide. The OIG was told that, in cases of a self-harming youth and suicidal crisis including suicide attempt when there is not a therapist familiar to the youth available, the case managers can access medical and mental health providers for a consult via Central Office. This method of response indicates that case managers have some resources available to them to react to a situation, but overall lack proactive options.

While some of the service areas have not had an incident of death by suicide in the recent past, of those with recent incidents, it was reported to the OIG that there had been no change in prevention practices within the local service area as a result of the death. However, the cases were used as examples to examine current practices and to assess for areas where the worker, supervisor, or administrator could have done something differently.

Postvention

Postvention refers to interventions for bereaved survivors, community members, caregivers, and health care providers to destigmatize suicide, assist with the recovery process, and serve as a secondary

prevention effort to minimize the risk of future suicides due to complicated grief, contagion, or unresolved trauma. The goals of postvention are to:

- Support those impacted by the suicide
- Identify those at risk for suicide and refer them to care
- Reduce situations where people identify with suicide victims and model behavior
- Provide appropriate and accurate information about the suicide

It was explained to the OIG that death by suicide has impacted workers not just on a case level, but on a personal level (family or loved one), or when parents and youth known to employees but no longer involved with CFS die by suicide. DHHS administration indicated responses to serious self-harming or death by suicide are provided through an internal resiliency program recently implemented by the department. Additionally, all case workers have access to the Employee Assistance Program (EAP). EAP is offered to all employees of the state as part of their benefits package. The EAP program allows employees to access short-term mental health services and other programing at no cost to the employee. All of the administrators also spoke about the genuine level of caring and inter-office support systems that exist amongst the workers within each individual office. These types of responses to death by suicide are referred to as postventions within the context of global suicide prevention plans.

Similar to prevention interventions, postvention plans should be in place prior to a suicide. Then, in the event of a suicide, key stakeholders can be involved in the response, support can be evenly distributed, and efforts are concerted rather than driven by emotions.[59]

Child Placing Agencies

DHHS contracts with private entities called child placing agencies (CPA) to assist the Department in its mission to recruit, license, and support foster homes. CPA's additionally provide trainings for foster parents, direct in-home support services, and can be contracted to provide family support services.

[59] Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services. Retrieved from https://www.ruralhealthinfo.org/toolkits/suicide/2/postvention.

The OIG sent out a series of questions related to suicide awareness and prevention to the 22 CPAs identified by DHHS as currently under contract with the state to provide support services. Of the 22 agencies contacted, 14 provided responses in varying detail.

In general, the answers indicated that suicide awareness and prevention training, and specifically gatekeeper training, requirements vary widely from agency to agency. Some agencies have incorporated mandatory training for employees but not foster parents; others have it available to both employees and foster parents but do not make it mandatory; and some have made it mandatory for both employees and foster parents. Still others indicated they do not utilize it all.

DHHS does not currently incorporate requirements for suicide awareness or gatekeeper training into CPA contracts, meaning that while some CPAs may utilize suicide awareness and/or gatekeeper training with either employees or foster care providers, they are not required to do so. It is at the discretion of each individual agency.

The OIG also learned from agency responses that some agencies used training developed in-house while others used commercially available standardized training. Of the responding agencies, more used training material developed in-house than used standardized training material.

Foster Care Licensing

It was reported to the OIG that currently foster parents are not required to receive suicide awareness programming or complete gatekeeper training as part of the foster care licensing process. Nebraska Administrative Code requires a foster care provider to complete pre-service training, which DHHS facilitates through the use of a training program called TIPS-MAPP (Trauma Informed Partnering for Safety-Model Approach to Partnerships in Parenting). This pre-service training was developed through the Children's Alliance in Kansas. Based on a review of the TIPS-MAPP curriculum by DHHS administration, it was reported to the OIG that information about suicide prevention within the training is limited.

Existing Policy, Procedure & Practice Guidance

During the review of CFS policy and procedure, no specific documents related to suicide awareness and prevention were found. However, elements of suicide awareness and gatekeeper training were revealed to be dispersed within policy and procedure created for other purposes. This aligned with the fact that all personnel interviewed by the OIG indicated they were unaware of any policy or procedure associated with suicide prevention. They further noted that it was typically left to individualized implementation at the local office level.

Furthermore, the review revealed that CFS lacks an overarching suicide prevention plan that integrates these fragmented elements into a well-articulated and cohesive framework. The OIG identified multiple examples of policy and procedure that could easily contribute to a broader suicide prevention plan. For instance, the introductory gatekeeper training conducted by CCFL, the Standard Work Instructions pertaining to transportation during Emergency Protective Custody or a behavioral/mental health crisis, the utilization of trauma-informed communication, and the incorporation of the Nebraska Administrative Code, which requires foster parents to ensure that all weapons and firearms are inaccessible to children. The code also stipulates that these items should be unloaded, locked by a child-proof safety lock or stored in a locked cabinet or area. Additionally, the code specifies that all ammunition should be stored separately from the firearms and be inaccessible to children, kept in a locked cabinet or area.

FINDINGS

I. Within the Department of Health and Human Services Division of Children & Family Services there is a distinct lack of policy and procedure articulating suicide prevention protocol, or cohesive suicide prevention plan.

The OIG found the CFS does not have a comprehensive and standardized approach to suicide prevention and lacks policy and procedure specifically addressing suicide prevention. While the Division of Behavioral Health (DBH) has been active in the state's suicide prevention efforts, DBH's knowledge and expertise has been underutilized within the Division of CFS. Elements of suicide awareness and gatekeeper training exist within CFS, but suicide prevention as a whole is not well-integrated into CFS policy and procedure. As noted, prevention efforts are not consistent across service areas and are often handled on a case-by-case basis. There is a lack of policy and procedure providing each service area with a baseline of best practices such as consistent gatekeeper training for all staff members, regular booster trainings, the inclusion of suicide awareness and prevention training requirements in contracts with third party providers, or required suicide prevention content for foster care licensing.

The implications of these findings are particularly concerning considering that children involved in the child welfare system, especially those in out-of-home care, are at a heightened risk of suicide. It is crucial to recognize the urgency and significance of implementing deliberate and intentional suicide prevention efforts for this vulnerable population.

II. Within the Division of Children and Family Services there are Training Gaps Related to Suicide Prevention.

Gatekeeper training plays a central role in suicide prevention efforts and is considered a foundational strategy.

Currently, CFS case managers receive a partial introduction to gatekeeper training during their new worker training, with the expectation that the full training will be completed within the first year. However, this completion occurs on an inconsistent basis. Booster training, which reinforces and

updates the knowledge and skills acquired during initial training, is not consistently delivered and is often left to the discretion of the employee.

Furthermore, gatekeeper training requirements for employees of child placing agencies (CPAs) vary widely, and there is a greater reliance on in-house training materials rather than standardized training. DHHS administration indicated that it is highly unusual for contract language with providers, such as CPA or family support agencies, to require their employees to have gatekeeper training. This is not to say that contracted employees do not receive gatekeeper training, but instead that it is not a requirement of the contract thus left to the discretion of the contracted agency as to if or when to provide the training, and what content to utilize should it be provided.

Foster parents are often in the closest contact with the youth. However, foster parents are not required to receive suicide awareness programming or complete gatekeeper training as part of the licensing process. DHHS administration confirmed that mandatory gatekeeper training is not required as part of the licensing process for individuals seeking to become traditional foster care providers. This gap in training widens when considering unlicensed foster care providers are under no obligation to take any training, including suicide awareness and gatekeeper training.

Ensuring consistent and comprehensive suicide awareness and gatekeeper training across these groups is essential for effective suicide prevention within CFS.

RECOMMENDATIONS

Suicide is a leading cause of death for youth, and youth involved in the child welfare system are at an even higher level of risk for suicide, making child welfare staff an optimal audience for suicide prevention training. The National Strategy for Suicide Prevention advocates for an approach to suicide prevention that includes identifying vulnerable populations and building capacity within the systems that serve them. Child welfare staff are in an especially unique position to prevent suicide considering their engagement with and proximity to youth who are vulnerable. Child welfare professionals and foster care providers also serve as an optimal point of intervention in identifying youth at risk of suicide and connecting them to life-affirming resources and effective treatment services. Gatekeeper training has been implemented for youth and professional staff in schools, health care settings, juvenile justice, law enforcement, and faith communities. Multiple studies have demonstrated increases in knowledge, positive attitudes toward suicide prevention, and confidence in the ability to intervene with an individual at risk following participation in gatekeeper trainings.

Based on these findings, the OIG makes the following recommendations to improve the suicide prevention efforts within the Department of Health and Human Services Division of Children & Family Services:

1. The Department of Health and Human Services Division of Children & Family Services should develop a comprehensive suicide prevention plan.

CFS should create a comprehensive suicide prevention plan that integrates training, policy, and procedure within the DHHS-CFS division. This plan should outline clear objectives, strategies, and responsibilities for implementing effective suicide prevention efforts for all youth involved with CFS. It should also address system-wide training gaps and inconsistencies. It is recommended that the plan be developed with input from the Nebraska State Suicide Prevention Coalition.

2. The Department of Health and Human Services Division of Children & Family Services should develop dedicated suicide prevention policy and procedure.

CFS should create specific policy and procedure documents that address suicide prevention within CFS. These documents should provide clear guidance on suicide awareness and prevention, ensure consistent efforts across different service areas, and mandate training requirements, as well as provide case managers direction on how to handle instances of self-harming and suicide crisis including suicide attempts.

3. The Department of Health and Human Services Division of Children & Family Services should mandate gatekeeper training for all staff.

CFS should mandate the completion of gatekeeper training for all case managers prior to their independent contact with youth and families. Yearly booster training for all case managers should also be required. In addition, CFS should not limit mandatory gatekeeper training to only case managers, but instead mandate the completion of gatekeeper training for any newly hired division staff within the first year of employment. As noted, CFS staff are affected by suicide both in their work and in their personal lives. Providing all staff with a base of knowledge on suicide – related to both prevention and postvention – allows the entire staff to support case managers in their efforts to support families and also provides helpful information and support to CFS staff generally, in their professional and personal lives. The gatekeeper training should be standardized and incorporate evidence-based practices.

4. The Department of Health and Human Services Division of Children & Family Services should standardize training requirements for Child Placing Agencies.

CFS should establish consistent suicide awareness and gatekeeper training requirements for all CPAs. This requirement ensures that all CPA employees receive proper training to enhance suicide prevention efforts within the foster care system. The training should incorporate a baseline standardized curriculum, while also allowing CPAs to incorporate elements of in-house training that meet the specific needs of individual agencies.

5. The Department of Health and Human Services Division of Children & Family Services should provide suicide prevention content and required gatekeeper training to foster care providers.

CFS should implement mandatory suicide awareness programming and gatekeeper training for all foster care providers, including both licensed and unlicensed caregivers. This training should be integrated into the preservice licensure training for licensed foster parents. Additionally, the department should devise a method to offer no-cost access to non-licensed foster care providers when they are caring for children aged ten years or older. Since foster care providers, licensed and unlicensed alike, serve as the primary contacts for at-risk youth, this initiative will ensure that all foster parents possess the necessary knowledge and skills to effectively support suicide prevention efforts in collaboration with CFS.

6. The Department of Health and Human Services Division of Children & Family Services should actively participate in the State Suicide Prevention Coalition.

The Division of Children and Family Services should actively participate in the Nebraska State Suicide Prevention Coalition. Participation would allow the division to stay updated on best practices, coordinate training initiatives, and leverage resources available through the coalition to enhance CFS's suicide prevention efforts. This collaboration will provide valuable networking opportunities and access to expertise in the field, further strengthening the division's ability to prevent suicide among youth in their care. DHHS should consider the designation of a suicide prevention coordinator serving as a liaison between CFS and the coalition as a means of fostering consistent collaboration and information sharing with the coalition while also ensuring the dissemination of information throughout CFS.

By implementing these recommendations, CFS can improve its suicide prevention efforts and better protect the well-being of vulnerable youth and families. It is crucial to establish a comprehensive and standardized approach to suicide prevention, integrating training requirements, clear policy and procedure guidance, and a cohesive plan that ensures consistent and effective prevention efforts across the division.

APPENDIX

Appendix A: Suicide Prevention Information provided by The Kim Foundation[60]

Suicide Warning Signs

Learning the warning signs of suicide could save someone's life. While an individual may not be experiencing all of these warning signs, most will experience more than one and for an extended period of time. Some are obvious while some are more subtle, so it's important to know what to look for and what to do next if you do notice these behaviors in someone you care about. With each of these warning signs, watch for a change from the individual's typical behavior.

- Withdrawal
- Saying Goodbye
- Displaying Extreme Mood Swings
- Changes in Sleep
- Giving Away Possessions
- Looking for a Way to Kill Themselves
- Risky, Reckless Behavior
- Talking or Writing About Wanting to Die
- Talking About Being a Burden
- Excessive Drinking or Substance Use
- Feeling Hopeless
- Acting Anxious or Agitated
- Unexplainable Physical Pain
- Feeling Trapped or in Unbearable Pain
- Increase in Anger or Rage

[60] Sources as cited by The Kim Foundation: 13Minutes.org, Nebraska State Suicide Prevention Coalition, National Suicide Prevention Lifeline, Mayo Clinic

Suicide Related Risk Factors

Some factors do exist that may put people at a higher risk for suicide. The presence of a single risk factor doesn't necessarily mean that a person is at high risk of suicide, but a number of risk factors together should signal concern.

In addition, the presence of depression or bipolar disorder, hopelessness, and/or substance abuse, in combination with other risk factors, increases an individual's risk of suicide significantly.

- Previous suicide attempt(s)
- Mental disorders- particularly mood disorders, schizophrenia, anxiety disorders, and certain personality disorders
- Co-occurring mental and alcohol and substance abuse disorders
- Family history of suicide
- Hopelessness, thoughts and feelings of being a burden to others
- Impulsive and/or aggressive tendencies
- Barriers to accessing mental health treatment when it is needed
- Relational, social, work, or financial loss
- Major physical illness
- Easy access to lethal methods, especially guns
- Lack of connectedness, social support, or a sense of isolation
- Substance abuse
- History of trauma or abuse, particularly sexual abuse
- Cultural and religious beliefs, such as the belief that suicide is a noble resolution of a personal dilemma
- Losing a loved one to suicide
- Bullying, harassment, or victimization by peers
- Persistent serious family conflict

Protective Factors

While the presence of multiple risk factors can put someone at a higher risk for suicide, the presence of multiple protective factors can help reduce risk of suicidal behavior. The more protective qualities a person has, the lower their risk for suicide.

- Strong problem solving skills
- Close family relationships
- Community connectedness
- Positive self-image
- Strong peer support systems
- Access to treatment
- Spiritual life/faith
- Involvement in hobbies or activities
- Restricted access to means

Safeguarding Your Home

A survey of people who had seriously considered suicide in the past year found that for about 30%, the suicidal period lasted under an hour. It also found that the interval between deciding on suicide and attempting was 10 minutes or less for 24%–74% of attempters. The choice of suicide method generally depends on one simple factor: availability. If a loved one is having thoughts of suicide, it is important to safeguard your home. Below are some ways you can reduce a possible suicide attempt.

- Keep all guns locked up and hidden or temporarily remove them from the home
- Store guns away from ammunition
- Lock up large quantities of prescription and over the counter drugs
- Request smaller prescription refill quantities (e.g., weekly rather than monthly refills)
- Dispose of all old and unused prescription drugs
- Keep knives and sharp objects hidden or out of reach

Ask the Question –

Starting the Conversation

The first step is to find out whether the person is in danger of acting on suicidal thoughts. Be sensitive, but ask direct questions. Asking about suicidal thoughts or feelings won't push someone into doing something self-destructive. In fact, offering an opportunity to talk about feelings may reduce the risk of acting on suicidal thoughts.

1.) Before starting a conversation with someone you are concerned about, be sure to have suicide crisis resources on hand.

2.) Find a private place to talk where there won't be any distractions and set aside plenty of time to have a conversation. If possible, try to find a comfortable place where you both can sit.

3.) Let the person know why you asked to speak with them. For example, *"I've noticed that you quit the baseball team and have no interest in participating in the things you once enjoyed. I'm concerned about you, what's going on?"*

Listen – Express Concern – Reassure

1.) Try to get as much information about the individual's circumstances as possible by asking open ended questions, such as: *"You seem down lately, how have things been going at_____?" "Tell me more about how you are feeling."*

2.) Listen to what they have to say and reassure them that you are listening by summarizing their response. *"So it sounds like things at home have been really stressful and you are worried about your slipping grades."*

3.) Validate their feelings, and provide them with support. *"It sounds like things have been really tough for you lately, no wonder you have felt so stressed. Please know that I'm concerned for you and that there's help to get you through this." "Thank you so much for sharing with me. I can't imagine how difficult_____ has been. What can I do to help?"*

4.) Follow your gut. If you feel like they may be having thoughts of suicide, be direct and ask the question, *"Have you ever felt so badly that you think about suicide?" or "Are you thinking about killing yourself?"* Asking these questions will not put the idea in their head or make it more likely that they will attempt.

5.) If they say yes, stay with the person. Connect them either to an adult, a mental health professional, or if they are in immediate danger to themselves or others, call **911**. If you are unsure how to locate a mental health professional, contact the Lifeline at **988**.

Create a Safety Plan

1.) If they have not made a plan or thought about method, help them locate a mental health professional, and call to make an appointment as soon as possible. Consider offering to take them to their initial appointment. Follow up with them regularly and stay involved in their recovery process. Continue to be supportive, compassionate, and encouraging.

2.) If they have made a plan and have access to means, help remove the means from the vicinity (means are any objects that could be used in a suicide attempt, such as pills or a hand gun). You may need help with this from family or law enforcement. Never put yourself in danger. If you are concerned about your own safety, or the individuals, call **911** immediately.

3.) Create a plan to keep them safe until they are able to meet with a mental health professional. This may include means removal, abstaining from alcohol or drugs, creating a list of people they can call if they are having suicidal thoughts, connecting them with the **988 Suicide & Crisis Lifeline**, and getting a verbal commitment that they will not act on their suicidal feelings.

Get Help

1.) Provide them with the resources you have prepared including the **988 Suicide & Crisis Lifeline** or see other available resources on our **Emergency Response** page.

2.) If you feel that they are in immediate risk, call **911** or take them to the Emergency Room. Don't leave them alone.

What Not to Say

1.) *"You aren't thinking of killing yourself are you?"* When you word the question in such a way, it sets them up to say no, even if they are having suicidal thoughts.

2.) *"How could you be so selfish?! Don't you know how hurt your family would be if you killed yourself?"* Making someone feel guilty will only add to their pain. Instead, instill hope and focus on assisting they find help.

3.) Never promise to keep a suicide plan a secret. You may be concerned that they will be upset with you, but when someone's life is at risk, it is more important to ensure their safety.

Appendix B: CCFL New Worker Training – Suicide Prevention Job Aid

Self-Harming Concerns

Self-harm refers to a person's harming of their own body on purpose. A person who self-harms usually is not suicidal, but they are at higher risk of attempting suicide if they do not get help.

Many people cut themselves because it gives them a sense of relief. Some people use cutting as a means to cope with a problem. Some teens say that when they hurt themselves, they are trying to stop feeling lonely, angry, or hopeless.

What to look for:

- Cutting on themselves (such as using a razor blade, knife, or other sharp object to cut the skin)
- Punching self or punching things (like a wall)
- Burning self with cigarettes, matches, or candles
- Pulling out own hair
- Poking objects through body openings
- Breaking bones or bruising self

Self-harm tends to begin in teen or early adult years. Some people may engage in self-harm a few times and then stop. Others engage in it more often and have trouble stopping.[16]

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http://www.suicidepreventionlifeline.org/

Suicidal Concerns

People who complete suicide exhibit one or more warning signs, either through what they say or what they do. The more warning signs, the greater the risk.

What to look for:

Talking: **If a person talks about**

- Killing themselves
- Having no reason to live
- Being a burden to others
- Feeling trapped
- Unbearable pain

Behavior: **A person's suicide risk is greater if a behavior is new or has increased, especially if it's related to a painful event, loss, or change.**

- Increased use of alcohol or drugs
- Looking for a way to kill themselves, such as searching online for materials or means
- Acting recklessly
- Withdrawing from activities
- Isolating from family and friends
- Sleeping too much or too little
- Visiting or calling people to say goodbye
- Giving away prized possessions
- Aggression

Mood: **People who are considering suicide often display one or more of the following moods:**

- Depression
- Loss of interest
- Rage
- Irritability
- Humiliation
- Anxiety[18]

You must gather the F.A.C.T.S. to move through the G.A.T.E.

Feelings	**G**ather Information (FACTS)
Actions	**A**ccess Supervision
Changes	**T**ake Responsible Action
Threats	**E**xtend the Action
Situations	

Suicidal Concerns (cont.)

Information accessed April 10, 2019: http://suicideprevention.nebraska.edu/whensomeoneissuicidal.htm

NEBRASKA STATE SUICIDE PREVENTION COALITION

- Main Page
- About the Coalition
- When Someone Is Suicidal
- Nebraska State Suicide Prevention Plan
- Resources and Links
- Suicide Attempt Survivors
- NE Youth Suicide Prevention
- School Safety and Suicide Prevention
- Post Secondary
- Nebraska LOSS Team

NATIONAL SUICIDE PREVENTION LIFELINE
1-800-273-TALK (8255)
suicidepreventionlifeline.org

para la

When Someone is Suicidal

What To Do When Someone Is Suicidal

There are actions you can take to help someone when warning signs of suicide are detected. Introducing the topic of suicide will not put the idea into their head, instead, the person will probably feel relief that they can finally share and talk about it. Saying things out loud may help the person actually hear it for the first time and bring a new perspective to the situation.

- **ASK THE QUESTION**
  - "I have the feeling you are thinking about suicide but are having trouble bringing it up."
  - "Are you thinking about suicide?"
  - "Sometimes people in certain situations feel suicidal. Have you been thinking about killing yourself?"
- **LISTEN**
  - LISTEN AND LOOK FOR WARNING SIGNS / RISK FACTORS
  - Ask what is causing the distress
- **ASK ABOUT REASONS FOR LIVING AND PLANS FOR SUICIDE**
  - Find out what is important to the person and why they may chocse to live
  - "Do you have a plan to kill yourself?"
    - Ask How, Where, When, and if they have the means in p ace (Do they have a gun/ pills/ rope or whatever they plan to use?)
- **TAKE ACTION**
  - Remove means like guns & pills
  - Offer your support in obtaining help from a professional
  - Don't leave the person alone once you have determined he or she is at risk
  - Remind the person that seeking help for depression isn't a sign of weakness and that chances for recovery are excellent

Suicide Prevention for Youth, Schools, and Families: What You Need to Know
Suicide Prevention for Military Members and Families: What You Need to Know
Restricting Lethal Means of Suicide: What You Can Do to Make Your Home Sa'er

In an Emergency, Contact:[21]

⇒ **Suicide Prevention Hotline: 1-800-273-TALK (8255)**
⇒ **Psychiatric hospital walk-in clinic**
⇒ **Hospital emergency room**
⇒ **Urgent care center/clinic**
⇒ **Call 911**

Suicidal Concerns (cont.)

SUICIDE PREVENTION RESOURCES

General Resources	
National Suicide Prevention Lifeline	Phone: 988 as of July 16, 2022 1-800-273-8255 will expire July 2023 https://suicidepreventionlifeline.org/ NATIONAL SUICIDE PREVENTION LIFELINE 1-800-273-TALK (8255) suicidepreventionlifeline.org
The National Hopeline Network	1-800-SUICIDE (1-800-784-2433) https://www.crisistextline.org/ Text HOME to 741741 in US 
HOME B.A.S.E. Warmline	Warmline (24/7): (402) 975-2032 https://mha-ne.org/programs-services/home-base.html MHA NEBRASKA

Parent Resources	
Nebraska State Suicide Prevention Coalition	http://suicideprevention.nebraska.edu/ NEBRASKA STATE SUICIDE PREVENTION COALITION
Nebraska Family Helpline	(888) 866-8660 http://dhhs.ne.gov/Pages/Nebraska-Family-Helpline.aspx/
Youth Resources	
Your Life Your Voice	www.yourlifeyourvoice.org/Pages/home.aspx
LGBTQ Youth	(866) 488-7386 https://www.thetrevorproject.org/get-help-now/
Transgender Hotline	(877) 565-8860 https://www.translifeline.org/hotline Our Hotline: 877-565-8860
Nebraska Youth Suicide Prevention	http://youthsuicideprevention.nebraska.edu/ Nebraska Youth Suicide Prevention
Crisis Lines by Region	
Region 1	(877) 492-7001 – 24/7 Mental Health Crisis Line for Western Nebraska (308) 762-7177 – 24/7 Substance Abuse Crisis Line for Western Nebraska
Region 2	(877) 269-2079 Region II Behavioral Health Emergency Support Line
Region 3	(800) 464-0258 Nebraska Rural Response Hotline
Region 4	(888) 370-7003 Madison, Stanton, Pierce, Antelope, Cuming, Cedar, Knox (866) 758-4749 Platte, Boone, Nance, Colfax (877) 488-9928 Boyd, Brown, Cherry, Holt, Keya Paha, Rock (877) 958-7776 Dakota, Dixon, Thurston, Burt, Wayne (800) 515-3326 Crisis Stabilization – Mid Plains
Region 5	(402) 475-6695 Centerpointe Helpline
Region 6	(888) 866-8660 Nebraska Family Helpline

Appendix C: DHHS Contracted Child Placing Agencies[61]

Agency	Service Area Served	Provided Requested Information to the OIG
Apex Foster Care, Inc.	Eastern	**YES**
Behavioral Health Specialists	Northern	No
Better Living Counseling Services Inc.	Eastern	**YES**
Building Blocks	Central	**YES**
Cedars Youth Services	Southeast	No
Child Saving Institute	Eastern	**YES**
Compass	Central	**YES**
Epworth Village	Northern	**YES**
Father Flanagan's Boys Home	Eastern	**YES**
Guardian Light Family Services	Western	**YES**
Jenda Family Services	Southeast	No
KVC Behavioral Healthcare Nebraska, Inc.	Eastern	**YES**

[61] The list of contracted Child Placing Agencies was provided to the OIG by DHHS on April 5, 2023. An email requesting information was sent to all listed agencies on April 11, 2023 with responses to five questions due by April 18, 2023.

DHHS Contracted Child Placing Agencies continued

Agency	Service Area	Provided Suicide Training Information to the OIG
Nebraska Children's Home Society	Eastern	**YES**
Nova Treatment Community, Inc.	Eastern	No
Omni Inventive Care	Eastern	**YES**
Priority Foster Care	Southeast, Northern, Central	No
Renewed Horizon	Southeast, Northern, Central	**YES**
South Central Behavioral Services	Central	**YES**
Saint Francis	Central	No
TFI Family Services, Inc.	Central	**YES**