

Children's Behavioral Health Oversight Committee

(LB 603 - 2009)

Report to the Governor and Legislature

December 1, 2011

Committee Members

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Committee Staff

Claudia Lindley, Legislative Aide to Senator Kathy Campbell

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INTRODUCTION

This is the third report required of the Children’s Behavioral Health Oversight Committee. The committee was created by LB 603, passed by the Nebraska Legislature in 2009. LB 603 included the Children and Family Behavioral Health Support Act. The act authorized the Executive Board of the Legislative Council to appoint members of the Legislature to serve on the committee as follows: (a) Two members of the Appropriations Committee, (b) two members of the Health and Human Services Committee, (c) two members of the Judiciary Committee, and (d) three members of the Legislature who are not members of such committees (at-large). The committee terminates on December 31, 2012. *LB 603, Sec. 11 (1)*

COMMITTEE RESPONSIBILITIES

The committee is to monitor the effect of implementation of the Children and Family Behavioral Health Support Act and other child welfare and juvenile justice initiatives by the Department of Health and Human Services related to the provision of behavioral health services to children and their families. *LB 603, Sec. 11 (2)*

New Children and Family Support Helpline *LB 603, Sec. 6*
Programs: Family Navigator Program *LB 603, Sec. 7*
Post-adoption and post-guardianship services *LB 603, Sec. 8*
The Behavioral Health Education Center *LB 603, Sec. 13, 14*

Expanded Professional Partner Program *LB 603, Sec. 10*
Programs: Medical assistance (Medicaid) – the bill directs the Department of Health and Human Services to submit a state plan waiver to the federal Centers for Medicare and Medicaid Services to provide coverage for community-based secure residential and subacute behavioral health services. *LB 603, Sec. 1*

Medical assistance (Medicaid) – for access to the State Children’s Health Insurance Program (SCHIP), the bill changed eligibility for children under 19 from 185% to 200% of the office of Management and Budget income poverty guideline. *LB 603, Sec. 2*

Program LB 603 requires the Department of Health and Human Services to evaluate the
Evaluation: Children and Family Support Helpline program, the Family Navigator Program, and post-adoption and post-guardianship services.

The committee is required to provide a report to the Governor and the Legislature no later than December 1 of 2009, 2010, 2011, and 2012. The report shall include, but not be limited to, findings and recommendations relating to the provision of behavioral health services to children and their families. *LB 603, Sec. 11 (5)*

COMMITTEE MEETINGS

August 26, 2011

The committee held a joint public hearing with the Health and Human Services Committee in Room 1510 of the Capitol at 9:00 a.m. The purpose was to hear status reports on programs and to be briefed on state Medicaid changes that affect children's access to residential treatment.

Program updates for Right Turn, Family Navigator, the Children and Family Helpline, and the Behavioral Health Education Center of Nebraska were presented. The committee received a fiscal status report. Scot Adams, Director of the Division of Behavioral Health of the Department of Health and Human Services, distributed the *Fourth Quarterly Evaluation Report (FY 2010-2011) April 1, 2011 – June 30, 2011*, by Hornby Zeller Associates, Inc.

The committees were briefed on changes in Medicaid which affect access to residential treatment facilities, and Magellan's role as program administrator. According to Vivianne Chaumont, Director, Division of Medicaid and Long-Term Care, changes regarding residential treatment are required by directives from the federal Centers for Medicaid and Medicare Services (CMS). The committees heard from Ms. Chaumont as well as Sue Mimick, General Manager, Nebraska Magellan Health Services, and Todd Reckling, Director, Division of Children and Family Services.

December 5, 2011

The committees held a second joint public hearing on state Medicaid changes that affect children's access to residential treatment with the Health and Human Services Committee in Room 1510 of the Capitol at 1:30 p.m. Vivianne Chaumont and Sue Mimick provided a review of the issue and then the committees heard from behavioral healthcare providers.

COMMITTEE OBSERVATIONS

Nebraska should review proposed Medicaid changes for residential treatment and the definition of "medical necessity." The critical issue for children's behavioral health in 2011 is reduced access to residential treatment. Numerous Nebraska organizations that serve children, youth, and families indicate the state has taken a highly restrictive view of CMS directives. The committee understands that the state must adopt a corrective action plan. However, the committee believes that Nebraska should delay implementing proposed Medicaid changes for residential treatment so that the Legislature may review Nebraska's interpretation and application of those directives.

Nebraska needs more mental and behavioral health services for children. Resources used in this report cite LB 603 program results which attest to this. In Family Navigator, 84% of families were seeking help with a child's mental or behavioral health April – June 2011. In the Helpline program, mental health was – as in previous reporting periods – a significant factor

among families seeking Helpline assistance. 29% of identified children had undergone at least one mental health treatment prior to the Helpline call.

Funding for LB 603 programs generally: The committee believes that initial funding for all programs was set in light of the fact that these were pilot programs. As the programs proceed in the future, continued funding will be necessary.

**PROGRAMS CREATED BY LB 603:
BACKGROUND, PURPOSE, FUNDING, ACTIVITIES, AND
EVALUATION**

Children and Family Helpline

Background of the Helpline

The Nebraska Family Helpline (1-888-866-8660) is operated by Boys Town under contract with the State of Nebraska. Boys Town's contract with the state requires specific Helpline standards. For example, calls are to be answered by a counselor at least 95 percent of the time, and the waiting time for a call on hold or in the call queue should be no more than an average of 100 seconds. Staff receive ongoing clinical supervision and training by licensed mental health professionals.

Purposes of the Helpline

The Helpline is intended to be a single point of access to children's behavioral health resources through a 24-hour, year-round telephone service. The Helpline is intended to (1) refer children and families to Family Navigators and Right Turn and (2) help children and families through crisis intervention and support, screening for immediate safety needs, connecting with emergency responders, referral to community resources, and assistance in using the behavioral health services system.

Funding:

FY09-10:	\$1,015,000
FY10-11:	\$1,700,000
FY11-12:	\$1,390,000
FY12-13:	\$1,390,000

Due to lower than anticipated use, the contract for the Helpline was reduced by \$500,000 in FY11 from \$1.7 million to \$1.2 million. In FY12 and FY13 there is an increase for the helpline of \$190,000, bringing the appropriation to \$1,390,000 in FY12 and FY13.

Summary of 2011 Helpline Activities:

The following are for fiscal year 2011 unless otherwise noted.

Program Marketing

Boys Town advertised the the Children and Family Helpline

- in newspapers, on radio, cable TV, and network TV
- in *Omaha Family* and *Family Spectrum* magazines, the Lincoln Public Schools newsletter, and in programs of the statewide Nebraska School Activities Association.
- On its website, which the provider monitors for numbers of visitors, unique visitors, total page views, how traffic arrived at the site (which keywords were searched, which sites referred traffic), and other data.

Call Volume, Answer Rate and Average Wait Time

- The Helpline received 3,861 calls where information was collected from callers.
- A total of 2,717 unique families called the Helpline.
- Helpline counselors made 2,303 outbound follow-up calls to assess whether additional help was needed.
- The Helpline met contract requirements with a call answer rate of 98% and an average call wait time of 13 seconds.

Most Frequent Reasons for Calls

- children not following family rules
- children being aggressive in the home
- children arguing with parents, guardians and other authority figures.
 - These “top three” reasons reflect previous quarters' results.
- Other reasons for calling (in order of most to least frequent) included problems with school authority, grades, sibling relationships, aggression at school, running away, depression, and substance abuse.

As in previous reporting periods, mental health was a significant factor among families seeking Helpline assistance.

- 14% of identified children had a previous mental health evaluation.
- 19% had a previous mental health diagnosis
 - The most reported diagnosis was ADHD / ADD.
- **24% of families had a child and/or parent with a mental health diagnosis prior to calling the Helpline.**
- **29% of identified children underwent at least one mental health treatment prior to the Helpline call.**
 - A form of outpatient treatment was reported 52% of the time.
 - Medication was reported in use 23% of the time.
- **Most barriers to success which families identified had to do with getting mental health services.** The most common were
 - counseling or medication ineffective

- child wouldn't attend or did not find it helpful or stopped taking medications or participating in sessions
- family didn't follow through because of scheduling, costs, or other factors.
- A significant “stressor” reported to counselors **continued to be inability to get the services parents wanted for their child.**
 - This stressor occurs often when a child's behavior **does not warrant hospitalization, but does pose safety risks to the child and/or family.**

Callers' Insurance Status (of those who reported their status)

- Medicaid/Kids Connection – 46%
- private insurance – 44%

Calls by Behavioral Health Region

- Region 6 (Dodge, Washington, Douglas, Sarpy, and Cass counties) – 2,116 (58%)
- Region 5 (southeastern Nebraska) – 744 (20%)
- Region 3 (central Nebraska) – 82 (12%)
- Region 4 (north central and northeastern Nebraska) – 229 (6%)
- Region 2 (west central and southwestern Nebraska) – 69 (2%)
- Region 1 (Panhandle) – 56 (2%)

The Helpline received calls originating from 79 (85%) of Nebraska's 93 counties.

Rate of Calls by Region

- Region 6 – 10.7 calls per 1,000 residents under 18
- Region 3 – 8.5 calls per 1,000 residents under 18
- Region 5 – 7.3 calls per 1,000 residents under 18
- Region 4 – 4.5 calls per 1,000 residents under 18
- Region 2 – 2.9 calls per 1,000 residents under 18
- Region 1 – 2.8 calls per 1,000 residents under 18

Caller and Child Demographics

- 81% of callers were female.
- Median age of callers was 40.
- In the sixth quarter, 80% of callers identified themselves as parents.
- In the sixth quarter, 55% of the children involved in the situations that prompted calls were male.
- Parents most often called about children age 13 to 16.
 - 3% of children were 4 and younger.
 - 8% were age 5 to 8
 - 20% were age 9 to 12
 - 52% were age 13 to 16
 - 16% were age 17 to 19

Referrals (sixth quarter)

- 38% of families requested specific referral types.
- Most requested was community-based outpatient services, followed by residential treatment.
 - Residential treatment was requested by callers twice as often as it was suggested by counselors.
 - Counselors told callers about the continuum of services and most often suggested outpatient services, followed by mental health evaluations.

Client Satisfaction (sixth quarter)

- As gauged by the Helpline through voluntary phone survey
 - Of the 28 people surveyed, the average ratings on a scale of 1 (poor) to 5 (excellent) were
 - Operator's ability to listen and understand: 4.9
 - Staff person's suggested options for you to try: 4.6
 - Overall effectiveness of Helpline's service: 4.7
 - If you got a follow-up phone call, how would you rate the helpfulness of the follow-up call? 4.6
- As gauged by the Helpline through follow-up calls
 - 51% said their situation was the same as it was before the call.
 - 37% said their situation was better.
 - 13% said their situation was worse.

Evaluation of Helpline:

LB 603 requires the Family Helpline to be evaluated. Section 6 of the legislation states that the evaluation “shall include, but not be limited to, the county of the caller, the reliability and consistency of the information given, an analysis of services needed or requested, and the degree to which the caller reports satisfaction with the referral service.”

The Legislature has appropriated a total of \$450,000 in General Funds over FY10, FY11, and FY12 for evaluation of the Helpline, Family Navigator, and Right Turn programs. Funding for evaluation is discontinued in FY13. Hornby Zeller Associates, Inc. (“HZA”) received the contract for evaluation of the Helpline and reported its findings in its *Fourth Quarterly Evaluation Report (FY2010-2011) April 1, 2011 – June 30, 2011*. The report evaluated three areas of performance.

First area of program evaluation: Fidelity: Compliance with Program Requirements.

HZA looked at whether Helpline counselors are (1) identifying immediate safety concerns and other high priority situations; (2) appropriately identifying eligible callers for referral to either the Family Navigator or the Right Turn program; and (3) identifying the need for and referring to other appropriate services.

Reviewing six quarters of data, HZA found that counselors are identifying non-priority and priority calls. In the sixth quarter, counselors designated 45% of standard inbound calls as high priority – meaning a counselor perceived a safety, risk, or crisis situation. This was a slight increase – from 41% – in the fifth quarter. Overall, the proportion of high priority calls is between 40% and 50% of all standard inbound calls.

HZA found that counselors are making referrals to Family Navigators, but that the rate of referral in the sixth quarter – 69 of 349 standard inbound calls – was the lowest rate since the program began. HZA believes that the decrease is explained by the change in providers. (In early June, the transition plan between the Helpline and the new provider had not been finalized. Boys Town decided that the best course of action was to stop making referrals to Family Navigators so that open cases could be served and closed. This also avoided having to move recently-opened cases to a new provider.)

Counselors are referring callers to Right Turn for post-adoption and post-guardianship services. HZA found that eleven families were referred to Right Turn in the sixth quarter. Note: Boys Town's FY2011 Family Navigator summary shows that Family Navigator service was offered to 25% of families (636) in FY2011. Of those families, 17% (460) accepted the service, for a 67% acceptance rate.

HZA found that counselors are also identifying the need for services besides Right Turn and Family Navigators, and making referrals to those services. In the sixth quarter, counselors made 1,703 service recommendations to 440 families for services other than Family Navigators and Right Turn. In most cases, counselors offer a range of options for referral and on average, offered between four and five options per family; the actual number per family ranged from one to 28.

Second area of program evaluation: Effectiveness: Service Referral and Provision. HZA looked at whether counselors are helping callers defuse the problem situations which prompt calls. HZA found that counselors are doing this. Based on sixth quarter evidence, 79% of callers felt confused at the beginning of the call; 8% still felt confused at the end. Further evidence of effectiveness, according to HZA, is that 92% of callers “appeared to accept the service recommendations made by counselors.”

HZA also analyzed repeat calls as an indication of effectiveness. Because the rate of repeat calls is “generally” very low, it appears counselors are handling problems with a family's first call. HZA also looked at how counselors get information on callers' strengths and stressors. These include, for instance, past difficulties getting services (a stressor) or past success in getting at least some services (a strength). HZA notes that the sixth quarter call review “continues to suggest that counselors record their impressions about the strength and stressors that callers choose to disclose, as opposed to screening callers for all potential strengths and stressors.” HZA did not review all calls for its evaluation but found that only 14% of those it reviewed showed counselors were “directly” collecting this information. HZA believes this is important because more direct screening helps counselors get a better understanding of the situation. Also,

if a caller is referred to Family Navigators, that program needs as much information as possible to prepare to meet with a family for the first time. Since the Family Navigators provider has changed, it is perhaps more important than ever that counselors do screening rather than just noting information volunteered by callers.

Third area of program evaluation: Outcomes: Benefits to the Clients. HZA asked whether families think they are receiving information about an appropriate service. Based on its review of 63 standard inbound calls in the sixth quarter, HZA found that “most callers for whom a judgment could be made appeared satisfied at the conclusion.”

HZA also reviewed counselors' ratings of calls for three groups of callers: those referred to Family Navigator, those referred to another service, and those who received emotional support (callers who were not seeking service referrals). Of the three groups, callers who were ultimately referred to Family Navigator were much more angry (86%), helpless (95%) and confused (98%) at the beginning of the call than callers in the other groups. By the end of the call, however, all three groups' ratings were similar – anger persisted in only 13% or less, 15% or less were rated as helpless, and 18% or less were rated as confused.

HZA reviewed only a “handful” (16) of follow-up calls in the sixth quarter. Most callers' perceptions of the Helpline itself were positive; they said they'd been treated professionally and with respect. However, callers' perceptions of services were not uniform. Some felt services were appropriate and helpful; some felt some services were appropriate; a couple felt some of the referrals were not appropriate; some said no services had yet begun. More than a third said they'd had a negative event since calling the Helpline. Three callers said their situation had improved.

Note: The Helpline's review of FY2011 information shows that 35% of callers who participated in follow-up calls reported improved family situations since the initial call. That result was “in line with findings for the sixth quarter.” The Helpline also performed follow-up calls to gauge effectiveness and provided an automated phone survey. Results are summarized above under Helpline activities.

Family Navigator

Background of the Family Navigator Program

Boys Town operated the Family Navigator program for the first contract period (18 months, which ended June 30, 2011). Boys Town worked in partnership with Healthy Families Project, NAMI Nebraska and the Nebraska Family Support Network to offer the Family Navigator Service. In July 2011, the Nebraska Federation of Families for Children's Mental Health began operating the program.

Purposes of the Family Navigator Program

The Family Navigator program is intended to (1) connect families seeking children's behavioral health services to other families and individuals who can provide peer support and (2) connect families to existing services, including the identification of community-based services.

Funding

FY09-10: \$ 611,984
FY10-11: \$1,056,047
FY11-12: \$ 866,047
FY12-13: \$ 866,047

Due to lower than anticipated use, funds for the Family Navigator program were reduced in FY12 and FY13 by \$190,000 from \$1,056,047 to \$866,047.

Summary of 2011 Family Navigator Activity – Boys Town

Program Marketing

Boys Town advertised Family Navigator

- in newspapers, on radio, cable TV, and network TV
- in *Omaha Family* and *Family Spectrum* magazines, the Lincoln Public Schools newsletter, and in programs of the statewide Nebraska School Activities Association.
- on its website, which the provider monitors for numbers of visitors, unique visitors, total page views, how traffic arrived at the site (which keywords were searched, which sites referred traffic) and other data.

Acceptance Rate of Services Offered

Family Navigator services were offered to

- 686 families, of which
 - 67% (460) accepted services.

Timeliness of Contact and Time Spent Assisting Families

- Navigators made first contact with families an average of 14.4 hours after families accepted the service.
- First meetings were held an average of 5.7 days after families accepted service.
- Cases were open, on average, 62.4 days.
- Taking all the cases in FY2011 and all the navigator-family contact hours, the average number of contact hours per case was 5.7.

Cases by Behavioral Health Region

- 54% - Region 6 (Dodge, Washington, Douglas, Sarpy, and Cass counties)
- 22% - Region 5 (southeast Nebraska)
- 12% - Region 3 (central Nebraska)
- 8% - Region 4 (north central and northeastern Nebraska)

- 2% - Region 2 (west central and southwestern Nebraska)
- 2% - Region 1 (Panhandle)

Family Navigator cases occurred in 56 (60%) of Nebraska's 93 counties.

Child Demographics

- Children age 13 to 16 were those most often served
- Average age for service was 13
- Of all children receiving services,
 - 66% were white
 - 14% were African-American
 - This is “significantly higher” than the state's proportion of African-Americans in the general population.
 - This reflects previous quarters' demographics.
 - 9% were Latino
 - 8% were two or more races

Child Insurance Coverage

- 70% Medicaid/Kids Connection
- 23% private insurance
- 6% no insurance
- 0% private insurance without mental health coverage
- 0% other

Pilot Program for In-Home Family Services

- Boys Town is compiling and comparing data regarding the need for in-home services and has begun a pilot program.
- In-home services are often requested but rarely available so families who are not involved in the Department of Health and Human Services' child welfare system.
- Information on the pilot program is contained in the *Nebraska Family Helpline & Family Navigator Services Annual Report: FY2011*, Boys Town, August 25, 2011.

Summary of 2011 Family Navigator Activity – Nebraska Federation of Families for Children's Mental Health

The Nebraska Federation of Families for Children's Mental Health began its contract for Family Navigator services July 1, 2011. The federation's approach is to integrate Family Navigator services with family peer support and child welfare advocacy.

The goals of this approach are to

- use similar standards for all programs, including policies and procedures;
- tie in data collection and analysis to measure across systems and time;

- use a peer model to measure longer term success through specific outcomes; and
- allow continuity for families through connection to a support network.

The following information is for the period July 1 through September 30, 2011.

- Total families served: 266
 - Families referred from the Helpline: 104
 - Families transitioned from the “Families Mentoring Families” contract: 120
 - Families referred from Peer Support: 39
- Age groups represented in referrals
 - 17% were age 16
 - 12% were age 14
 - 9% were age 15
- 1% of the total families served became involved with the child welfare system after referral to the program.
- The federation's summary of activities states that the overall number of Family Navigator referrals increased by 50% from July to the end of September 2011.

In its first quarter of providing Family Navigator services, the federation's administrative activity included

- acquisition of a data management system
- implementation of a work plan, including quality assurance
- use of evidence-based promising practices, such as
 - a wellness recovery action plan
 - a caregiver strain questionnaire
 - a suicidal behaviors questionnaire screening tool

For additional information, see *A Snapshot: Family Navigation and Family Peer Support Services, Quarter 1 (July 1 – September 30, 2011)*. Nebraska Federation of Families for Children's Mental Health.

Evaluation of the Family Navigator Program

LB 603 requires Family Navigator to be evaluated. Section 7 of the legislation states that the evaluation “shall include, but not be limited to, an assessment of the quality of the interactions with the program and the effectiveness of the program as perceived by the family, whether the family followed through with the referral recommendations, the availability and accessibility of services, the waiting time for services, and cost and distance factors.”

The Legislature has appropriated a total of \$450,000 in General Funds over FY10, FY11, and FY12 for evaluation of the Helpline, Family Navigator, and Right Turn programs. Funding for

evaluation is discontinued in FY13. Hornby Zeller Associates, Inc. (“HZA”) received the contract for evaluation of Family Navigator and reported its findings in its *Fourth Quarterly Evaluation Report (FY2010-2011) April 1, 2011 – June 30, 2011*. (Boys Town was the contractor when HZA evaluated Family Navigator, so the report does not apply to the Federation of Families for Children's Mental Health.) The report evaluated three areas of performance.

First area of program evaluation: Fidelity: Compliance with Program Requirements.

Boys Town's contract called for contact with the referred family within 24 to 72 hours of the initial Helpline call, and the first face-to-face meeting to occur within 72 hours. Services were to last no more than 60 days per family and involve no more than eight hours of navigator-family contact. Finally, navigators were to help youth and families create a safety plan.

Contact rates remained stable from the third quarter through the sixth. In that quarter, 90% of first contact occurred within 24 hours of the initial Helpline call, and almost one-quarter of cases had contact within four hours. HZA found, however, concerns about other target goals for services.

For instance, HZA found that timeliness of the first face-to-face meeting with the family regressed in the sixth quarter. In addition, in every quarter, more than one-fourth of referred families had no face-to-face contact at all. Some cases lasted more than the 45 to 60 days called for, and navigators spent fewer than the target eight hours in contact with families. HZA notes that these figures may be attributed to the loss of staff once it became clear that another provider would be given the contract in the next contracting period. HZA also notes that of the two cases that went over the eight hour limit on total contact hours, both were closed within nine contact hours; and both involved children between ages 14 and 17 – consistent with the previous quarter's findings that the average time spent on a case is higher for cases involving children in this age group.

Safety plan completion and documentation improved in the sixth quarter, but previous quarters showed that the plans were not being done in a large proportion of cases. In the fifth quarter, for example, 16% of cases had a safety plan. HZA's review of 37 cases in the sixth quarter showed that 23 (62%) had a safety plan. HZA noted that the provider increased emphasis on safety plans in the sixth quarter, and supervisors increased efforts to ensure the plans were completed and documented.

Second area of program evaluation: Effectiveness: Service Referral and Provision.

HZA appears to have evaluated client satisfaction with services by reviewing 62 cases in the sixth quarter, determining why services were not used, and noting how many cases had plans. In the sixth quarter, 37 had plans. The remaining cases were either closed by the family before face-to-face meeting, had no records available, or had not yet responded to the navigator. **By far the plans' most common strategies related to getting mental health services (87%).**

HZA reported notable satisfaction differences between those families with Medicaid and those with private insurance as illustrated below:

- “The Family Navigator shared helpful experiences with the mental health system.”
81% of private insurance clients agreed; 95% of Medicaid clients agreed.
- “We got as much help as we needed from the service providers.”
77% of private insurance clients agreed; 90% of Medicaid clients agreed.
- “The Family Navigator knew how to access services.”
83% of private insurance clients agreed; 95% of Medicaid clients agreed.
- “The Family Navigator knew what was available.”
83% of private insurance clients agreed; 95% of Medicaid clients agreed.
- “We got as much help as we needed from the Family Navigator.”
85% of private insurance clients agreed; 91% of Medicaid clients agreed.

Third area of program evaluation: Outcomes: Benefits to the Clients.

In the sixth quarter, HZA reviewed family plans, family survey responses, and family interviews to see how clients rated their experiences with Family Navigators and with referred services. Scores were generally higher than in previous quarters.

Right Turn

Background of the Right Turn Program

Right Turn has been operated by Lutheran Family Services through a contract with the State of Nebraska since the program's inception. KVC Behavioral Health operates the Right Turn access line and reports data from the access line quarterly.

Purposes of the Right Turn Program

Right Turn is intended to offer case management services to families who have adopted or become guardians of children who were previously wards of the State of Nebraska. DHHS is responsible for notifying adoptive parents and guardians that case management services are available on a voluntary basis. Notification is to be made in writing at the time of finalization of the adoption agreement or completion of the guardianship and each six months thereafter until dissolution of the adoption, termination of the guardianship, or the former state ward attains nineteen years of age, whichever is earlier.

Funding

FY09-10:	\$1,198,800
FY10-11:	\$2,027,970
FY11-12:	\$2,027,000
FY12-13:	\$2,027,000

Summary of 2011 Right Turn Activity

The following is taken from KVC Behavioral Health quarterly data reports, January through September 2011.

As in other programs reviewed in this report, **children's mental health is a significant issue among children in families referred to Right Turn.** The program's intake process reveals that, **of parents who know of a child's mental health diagnosis,**

60% said their children were not receiving mental health services at intake in the first quarter of calendar year 2011.

63% said their children were not receiving mental health services at intake in the second quarter of calendar year 2011, and

52% said their children were not receiving mental health services at intake in the third quarter of calendar year 2011.

Issues for referral included (from most common to least common)

- mental health
- out of control behaviors
- requesting resources / information
- requesting support
- aggressive behaviors
- respite
- academic concerns
- running away
- school refusal

In administrative activity, Right Turn received updated lists of adoptive/guardianship families from DHHS in October 2011. This information is crucial to notifying families that services are available and will help Right Turn carry out its responsibility to notify (a statutory responsibility of DHHS which Right Turn has assumed through its contract with the state).

Evaluation of the Right Turn Program

LB 603 requires post-adoption and post-guardianship case management services to be evaluated. Section 8 of the legislation states the evaluation “shall include, but not be limited to, the number and percentage of persons receiving such services and the degree of problem resolution reported by families receiving such services.”

The Legislature has appropriated a total of \$450,000 in General Funds over FY10, FY11, and FY12 for evaluation of the Helpline, Family Navigator, and Right Turn programs. Funding for evaluation is discontinued in FY13. Hornby Zeller Associates, Inc. (“HZA”) received the contract for evaluation of Right Turn and reported its findings in its *Fourth Quarterly Evaluation Report (FY2010-2011) April 1, 2011 – June 30, 2011*. The report evaluated three areas of performance.

First area of program evaluation: Fidelity: Compliance with Program Requirements.

HZA reports that based on access line operation statistics, the contract standard of having no callers on hold or in the cue for more than 100 seconds is being met in all cases. Average hold times continued to decrease during the sixth quarter. The percentage of abandoned calls has fallen consistently since the fourth quarter, with the sixth quarter report showing only 1.9% lost. This is “well within the established standard.” As to rate of contact, HZA reports that “Compared to all cases to date, the rate of contact within 24 hours is 90% for all cases and the rate of face-to-face contact within 72 hours is 48% for all cases.” As to the 90-day time frame for case closure, in the sixth quarter, 37% closed within 90 days and 87% closed within 95 days.

Second area of program evaluation: Effectiveness: Service Referral and Provision.

HZA states that “While the number of surveys received from families who have completed Right Turn services is relatively small, a total of 52 through the end of the sixth quarter, most people generally reported getting what they wanted. However, 28% indicated that there were still services they wanted but could not get,” most often citing respite care and residential care. Others cited approval through Magellan was a barrier. Still, HZA states that “Overwhelmingly, families continue to appear satisfied with Right Turn” based on family surveys. However, a fourth of families said they did not get as much help as they needed from the service providers to whom they were referred by Right Turn. “This percentage has remained relatively unchanged throughout the project.”

Interestingly, when measuring satisfaction based on type of insurance – Medicaid or private – HZA found that Medicaid families were less likely to be positive than were families with private insurance. This is the opposite of how private insurance and Medicaid clients rated services in the Family Navigator evaluation. (In the Family Navigator evaluation, private insurance families had high positives, but their positives were not as high as those of the Medicaid families.)

Third area of program evaluation: Outcomes: Benefits to the Clients.

HZA found that clients continued to agree that Right Turn specialists were sensitive to consumers' culture and religious beliefs, and that the specialists spoke in ways the clients could understand. More than 90% of clients felt that they were treated with respect; that they received Right Turn services timely; that specialists understood issues and helped with building on strengths; that the number of contacts was amount right; and that specialists knew of available services. Greatest dissatisfaction was not with Right Turn but with service providers. For more discussion of additional satisfaction measures, see HZA's *Fourth Quarterly Evaluation Report (FY2010-2011) April 1, 2011 – June 30, 2011*.

Family Navigator and Right Turn - Evaluators' Recommendations

Hornby Zeller found that, in the first eighteen months of their operation, Family Navigator and Right Turn program providers noted gaps in Nebraska's network of available services. Program operators arrived independently at the same conclusion: “a proportion of families need more

intensive services than Family Navigator and Right turn themselves were designed to provide.” HZA made the following recommendations to address service gaps:

- Explore why so many referrals to Family Navigator itself are turned down by family members.
- Expand the availability of intensive, in-home support services and waive financial eligibility requirements for these and other services available from the regional behavioral health authorities for children with diagnoses of serious emotional disturbance who are at risk of residential placement. (Ten to twenty percent of families served by Family Navigator and Right Turn either require services for their children that are more intensive than what is currently available without placing a child in residential treatment, or do not qualify due to income guidelines.)
 - Expand the availability of intensive, in-home support services.
 - Develop or sponsor clinical training programs.
 - Develop new ways to fund these services for parents who are not income-eligible but whose children require the service to avoid state wardship and residential treatment.
- Provide Right Turn with access to the adoption subsidy mailing list for its direct mail marketing. *Note:* On November 3, 2011, DHHS reported to Senator Kathy Campbell that the department would provide Right Turn with an updated list by the end of the week; that the department had identified the problem and put in place a process to address it; and that the department will continue to work collaboratively with Right Turn to provide addresses for all families eligible for Right Turn.
- Build on the expertise of Right Turn staff to provide follow-up services to families who need continuing support.

Appendix A of Hornby Zeller's final evaluation report provides information on evidence-based intensive in-home services. The appendix describes five in-home service programs by purpose, target population, services provided, and delivery modes. For more information, see *Nebraska Family Helpline, Family Navigator and Right Turn Post Adoption/Post Guardianship Services Final Evaluation Report, January 1, 2010 – June 30, 2011*. Hornby Zeller Associates, Inc. October 2011.

Behavioral Health Education

Background

LB 603 states the Legislature finds that “there are insufficient behavioral health professionals in the Nebraska behavioral workforce and further that there are insufficient behavioral health

professionals trained in evidence-based practice. This workforce shortage leads to inadequate accessibility and response to the behavioral health needs of Nebraskans of all ages: children, adolescents and adults. These shortages have led to well-documented problems of consumers waiting for long periods of time in inappropriate settings because appropriate placement and care is not available. As a result, mentally-ill patients end up in hospital emergency rooms which are the most expensive level of care or are incarcerated and do not receive adequate care, if any . . .” In response to these findings, LB 603 created The Behavioral Health Education Center (“BHECN”) beginning July 1, 2009, to be administered by the University of Nebraska Medical Center.

Purpose

The BHECN is intended to address the competent workforce shortage to meet Nebraskans' behavioral health needs.

Funding

FY09-10: \$1,385,160

FY10-11: \$1,563,993

These are the only appropriations made to the BHECN. Future appropriations will be necessary to continue the work to address the shortage of a competent workforce to meet Nebraska children's behavioral health needs.

Summary of Activities

Following are some of the accomplishments of the BHECN since it began in July 2009.

- Funding of medical residents
 - 6 additional rural psychiatry residents 2010-11
 - 15 graduate students 2010-11
 - 60 students funded in 2010-11

- Training of professionals
 - 7 inter-professional training sites statewide
 - UNMC, UNL, UNO, UNK, Chadron State College, Doane College, Lasting Hope Recovery Center in Omaha
 - 356 professionals trained in telehealth techniques
 - 734 professionals logged 180 continued education hours
 - 27 trainees, interns and post-doctoral fellows embedded in 27 hospitals and clinics statewide.

- Learning Collaborative Partnerships Established
 - UNMC, UNO, UNL, UNK, Chadron State College, Doane College, UNMC/Creighton Psychiatry/College of Nursing, Munroe-Meyer Institute/Lasting Hope Recovery Center/Alegent Health, NOW, Resource for Advancing Children's

Health Institute (“REACH”), Rural Health Education Network (“RHEN”), National Alliance for the Mentally Ill (“NAMI”), Community Alliance

- Behavioral Health Site Development
 - 3 developed, active sites in Scottsbluff, Kearney, and Omaha
 - 6 statewide site visits with 115 community participants
- Collaboration with rural outreach behavioral health training programs at UNMC, UNO, UNK, UNL
- Pilot program on shared supervision of psychiatry and psychiatric nurse practitioner in rural locations.
- Integrated Rural Behavioral Pediatric Internship Training Program
 - Only 20% of licensed psychologists practice outside of Omaha and Lincoln
 - Designed to integrate pediatric behavioral providers into primary medical practices across the state.
 - Designed to attract, recruit, train, place, and retain doctoral level psychologists, counselors, social workers, and marriage and family therapists in primary care practices in Nebraska.
 - Funding included federal grant and the AmeriCorps program; the Munroe-Meyer Institute at UNMC collaborated with the BHECN to set up this program.

For a complete report of the BHECN's activities, accomplishments, and plans, see the center's *2009-11 Legislative Report*, December 1, 2011.

PROGRAMS EXPANDED BY LB 603: FUNDING AND SUMMARIES OF ACTIVITIES

Medical Assistance (Medicaid)

Funding

In FY10, almost \$2.2 million in General Funds and \$7.9 million in total funds were provided to the Children's Health Insurance Program (“CHIP”) to increase eligibility from 185% of the poverty level to 200%. Implementation began September 1, 2009. In the first two months following the increase in eligibility, the largest percentage enrollment increases occurred; enrollment grew by 3% each month during those two months. Since then the growth has continued, but at a slower rate. Enrollment grew by 3.782 or 15.8% from August 2009 to July 2010. In the prior fiscal year the increase was 1.2%.

Funding is no longer tracked for the expansion from 185% to 200%; it is blended in with the overall budget projection for the CHIP.

Behavioral Health Regions Professional Partners and Pilot Programs

Funding

FY2009-10: \$ 500,000
FY2010-11: \$1,000,000
FY2011-12: \$1,000,000
FY2012-13: \$1,000,000

Region 1 (Nebraska Panhandle) in 2010 used LB 603 funds to try to help two groups who have historically been missed by local services: Youth displaying developmental trauma disorder, and youth who had not responded to multiple services. The committee did not receive an update from Region 1 for this report.

Region 2 (central south-western Nebraska) in FY2011 served 14 individual youth for 75 units with the LB 603 dollars which for Region 2 Human Services totaled \$60,050. It has long been a goal of the Region 2 board to continue increasing access to its youth care program (Professional Partner) so the LB 603 funds were invaluable. Toward the end of the previous fiscal year Region 2 was able to move more funding into that category so that the region provided an additional 40 units.

Region 2 uses its youth care wrap around program helping youth with behavioral health disorders to stay out of the child welfare system or to provide support when they are no longer in that system to prevent further disruption in their lives. Region 2 reports that outcomes show good results in keeping youth in home and in school.

Region 3 (central and south-central Nebraska) in 2011 expended \$134,220 from state-appropriated LB 603 funds to serve 43 children and adolescents through two programs. The Transition Age Supported Employment (“TASE”) Program expended \$37,727 and the Professional Partner Program (“PPP”) expended \$96,493. Region 3 also expended \$20,742 in county matching funds to serve LB 603 youth in the PPP, bringing the total Region 3 expenditures for LB 603 youth to \$154,962.

The TASE Program began in October 2010 and serves youth who are within at least two years of high school graduation. This program is part of a partnership among Goodwill Industries of Greater Nebraska, Grand Island Public Schools, Vocational Rehabilitation, and the Region 3 PPP, which allows the LB 603 funds to leverage additional system resources to serve youth. Fifteen youth participated in the TASE Program and received job skills instruction, benefits planning, job development and placement, job coaching, and employment related independent living skills.

Region 3 used some LB 603 funds to target a specific high-risk population of youth and to serve them in a more intensive case coordination style than is traditionally used in the PPP. Region 3 used one specific Professional Partner to work with children between the ages of 0 to 18 who were (1) referred to the program, often by the Division of Children and Family Services, county

attorneys, or the Nebraska Family Helpline, and were (2) determined to be at imminent risk of becoming wards of the state due to unmet behavioral health needs. The goals include reducing safety and risk factors, making immediate service referrals, establishing a strong family support system, and (5) keeping the youth out of the child welfare system.

Region 3 tracks data monthly for the PPP to identify improvements and areas of need. Upon entering the program the overall average Child and Adolescent Functioning and Assessment Scale (“CAFAS”) score was 104.6 (moderate to severe impairment). At the time of discharge the average CAFAS score was 50.

In 2011, LB 603 funds supported services for 28 children and youth in Region 3. Twenty-two children and youths were discharged from the PPP in 2011. The average length of stay was 111.09 days (range was 24 days to 229 days). 27.3% of youth graduated after completing the Individualized Support Plan goals, but another 27.3% left because the family passively refused services. 13.6% left because they became state wards.

Region 4 (north and northeastern Nebraska) During FY11 all of the LB 603 funds allocated to the Professional Partner Program (\$96,493.00) were drawn down. With the increased funding, PPP was able to serve an additional 19 youth ages 6 to 17 through the Traditional Professional Partner Program.

The purpose of the Region 4 Professional Partner Program is to provide wrap-around services, which access and coordinate community resources in order to maximize the functioning of the severely emotionally disturbed child and family within the home and community. Services are initially intensive, goal-oriented, based on family strengths and needs, and directed toward restoring and/or stabilizing the family unit and supporting health and well-being.

The Professional Partner Program assists families who have a child with severe emotional disturbance in accessing services for the family without having to give up their child as a ward of the state, or go into undue debt. The PPP model is needs-driven and based on the strengths of the child and family. The parents are an integral part of the team and act as equal partners because the program's premise is that parents know their children best.

Risk factors for the child included: Previous psychiatric hospitalization, sexual abuse, runaway, suicide attempts, substance abuse.

Risk factors for families included: Domestic violence, history of mental illness, psychiatric hospitalization of parent, criminal history, substance abuse (family member), substance abuse (parent).

Presenting problems included: non-compliance, hyperactive-impulsive, poor peer interaction, academic problems, poor self-esteem, physical aggression, attentional difficulties, extreme verbal abuse, police contact, alcohol/substance abuse.

The average score on the CAFAS at intake was 132.5 and the discharge CAFAS was 65 – clinically significant change. Average length of stay was 11.88 months. 58% of youth were male and 42% were female.

Referral sources: school-based services: 5; Professional Partner: 3; family member: 2; county attorney: 2; DHHS: 1; mental health therapist: 1; Nebraska Family Navigator: 1; Norfolk Middle School: 1; Parent-to-Parent Network: 1; psychologist: 1; state probation, Norfolk: 1.

The remaining LB 603 funds (\$27,285.00) allocated to other children services such as Mental Health and Substance Abuse Outpatient, Assessments, and Intensive Outpatient Substance Abuse were not used. These funds are planned to go to the Professional Partner Program during FY12 to increase capacity.

Region 5 Systems (Southeast Nebraska) uses LB 603 funds in its Prevention Professional Partners Program (“PPP”) and Linking Individuals/Families in Need of Community Supports (“LINCS”).

The PPP program provides intensive case management to bring together community resources. A PPP Partner is assigned to work with a family for 90 days to create an individualized plan with the family. This is a voluntary program. Eligibility for the PPP program includes youth who are: referred to LINCS by county attorney; referred to PPP from the Health Families Project Family Navigator Program; between ages 7-19 at high risk of juvenile justice involvement; diagnosed with a mental illness under the current edition of the Diagnostic and Statistical Manual (DSM), American Psychiatric Association; residing in the designated 16 counties of southeast Nebraska; not a ward of the state at time of referral.

There were eight referrals to the PPP Program in the quarter comprised of July-September 2011. Six enrolled. The total number of families served was nine, with three having been enrolled in the previous quarter.

The average intake Child and Adolescent Functional Assessment Scale (CAFAS) score at intake was 86.67, which indicates additional services beyond outpatient care. The three youth who were discharged during the quarter displayed an average decrease in total CAFAS score of 13.3. Though this is not clinically significant change, the sample size is small.

The LINCS process is offered in collaboration with the Lancaster County Attorney's Office, Lancaster County Human Services Federation, Lancaster Youth Assessment Center, and the Child Guidance Center. LINCS offers assessments, services, and supports to families that have acknowledged a need for assistance with their children who are demonstrating difficulties in their homes, schools, and communities.

This voluntary process also responds to youth with serious/complex needs who are at risk of a juvenile court filing and becoming state wards. LINCS applies the wraparound approach, including prevention, intervention, and coordination designed to address behavioral health needs

of youth and their families. The primary goal of LINCS is to reduce formal juvenile justice involvement while generating community support.

Eligibility for the LINCS process includes youth who are: referred by the Lancaster County Attorney or Youth Assessment center; referred from Healthy Families Project Family Navigator Program; between ages 7-19; at risk for substance abuse; diagnosed with a mental illness under current edition of the Diagnostic and Statistical Manual (DSM), American Psychiatric Association.

There were 27 referrals to LINCS in the quarter comprised of July-September 2011. Of these, 64% were referred to community resources and supports, 12% did not respond to attempts to contact them, 12% completed a family and youth assessment, 9% were referred to the PPP Program, and 3% had juvenile justice involvement.

Region 6 Behavioral Healthcare (Dodge, Washington, Douglas, Sarpy, and Cass counties) used LB 603 funds to support its Mobile Crisis Response and Rapid Response Professional Partners programs.

The Rapid Response program provides short-term (90 days) services for severely emotionally disturbed youth ages 0-19 to achieve stability, improved functioning, and reduce risk of involvement with juvenile justice. Referrals to the program come from the county attorneys' offices; thus far, referrals have come from four of the five counties in the region.

Rapid Response is voluntary, in-home, for families not currently involved with a Health and Human Services case manager. A Professional Partner meets with the family one to two times a week to coordinate services and put formal and informal supports in place. Partners update the county attorneys on families' involvement and progress, and notify them of case dispositions and recommendations. Families discharged from the program may be referred to the traditional Professional Partners Program.

The Rapid Response Program began in January 2010 with one case manager and by August 2010 had four full-time positions. Referrals consistently increased and by June 30, 2011 there had been 211 referrals which resulted in 114 intakes and 102 youth admitted to the program. The most significant factors in the increase were collaborations with the Douglas County Truancy Coalition and the Juvenile Assessment Center.

Region 6 Behavioral Healthcare found that its initial expectations for behavior improvement in a short term were not realistic, and so has adjusted its targets relating to Ohio Scales and CAFAS scores for the next fiscal year.

However, the program did succeed in getting families engaged in community resources, and in keeping youth out of the juvenile court system. Sixty-three percent of youth in the program avoided involvement with the courts. This is lower than the 80% goal but the data are limited at this point. It may be that additional data will show a higher percentage of avoidance.

The Children's Mobile Crisis Response program (“MCR”) is intended to resolve immediate behavioral health crises within the least restrictive environment, and help with planning and resource linkage. LB 603 funds allowed the original MCR program to serve youth as well as adults in mental health crises.

Originally the MCR was designed to be activated by law enforcement officers; in 2011 Region 6 facilitated linkage with the Nebraska Family Helpline so that staff there would make direct referrals to the MCR. In FY2010, the Helpline made 15 referrals to the MCR. This collaboration has been positive and Region 6 is discussing it with its sister regions for possible development in other parts of the state. In FY2011, 74 youth were served through MCR. Of the 74, six needed hospitalization, one required detoxification services, and for 67, the crisis was resolved with less restrictive assistance.

Resources

A Snapshot: Family Navigation and Family Peer Support Services, Quarter 1 (July 1 – September 30, 2011). Nebraska Federation of Families for Children's Mental Health. November 2011.

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