Children's Behavioral Health Oversight Committee
November 16, 2010

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The Children's Behavioral Health Oversight Committee met at 9:30 a.m. on Tuesday, November 16, 2010, in Room 1507 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing. Senators present: Kathy Campbell, Chairperson; Annette Dubas, Vice Chairperson; Bill Avery; Colby Coash; Tom Hansen; and Amanda McGill. Senators absent: Gwen Howard, Jeremy Nordquist, and Pete Pirsch.

SENATOR CAMPBELL: (Recorder malfunction)...didn't know each other before but you get to know each other and there's a lot of conversation. So we're pleased to welcome you to the LB603 Oversight Committee. Today is a day I've sort of been looking forward to in the sense that we're going to hear from all of the components of LB603, except for Senator Nordquist who...his component, of course, put in money into the process. But otherwise, we will hear from all of the components today as well as we will be receiving a report from Ms. Hornby on the evaluation, which, hopefully, will tie some ends. In several questions from my colleagues who are on the committee, we will probably have a meeting in...or in sometime in December and I'm going to try to dovetail it with any other meetings that they might have, but it will be an Executive Session for us to discuss all of the information that we have gotten, any recommendations that my colleagues want to make as we go forward into the next year. I've also been asked when this committee sunsets. It sunsets at the end of 2012. So we have additional work to do depending upon what happens with the budget. And so that's partly why we'll need an Executive Session to talk to my colleagues about how they want to proceed. But beyond that, we certainly will keep you all posted. I want to particularly thank Claudia Lindley, who is the clerk today, who is my LA in the office, who keeps everybody apprised on the e-mail. If you're not on Claudia's list, make sure that you get on Claudia's list. And with that, we'll start by the introductions. And again, I'm Kathy Campbell, a senator from District 25, and we'll go all the way to my right.

SENATOR COASH: Colby Coash, District 27, right here in Lincoln.

SENATOR McGILL: Amanda McGill, District 26, from northeast Lincoln.

SENATOR HANSEN: I'm Tom Hansen, District 42, which is Lincoln County and North Platte.

SENATOR DUBAS: Annette Dubas, District 34, Fullerton, Central City, Aurora, Grand Island.

SENATOR CAMPBELL: Senator Avery will be in and out, and the senators will be leaving because some of them have committee hearings and so people will be coming and going. I just want to make one other personal comment before we start out, and you all need to know that Senator Hansen has a new knee and so he's going to be even faster and light on his feet. (Laughter) So we're very delighted that he is here after his knee surgery. With that, we'll start with the agenda as printed and first here from the Behavioral Health Education Center of Nebraska, and Director Broust (phonetic) is here. Am I'm saying that correctly?

SUSAN BOUST: Boust.

SENATOR CAMPBELL: Boust.

SUSAN BOUST: Good German name.

SENATOR CAMPBELL: Yes. Welcome back.

SUSAN BOUST: (Exhibits 1, 2 and 3) Thank you. Yes, my name is Susan Boust, B-o-u-s-t, and I am the medical director for the Behavioral Health Center of Nebraska. Thank you for including me on this agenda for LB603. I know that much of your focus

will be on other services, but the Behavioral Health Education Center was part of this bill and I'm pleased to have an opportunity to give you a report. I've given you three handouts. One is the three-page update report and this has the most detail in it, and this report is written so that each of the seven strategies from our strategic plan list the language straight out of LB603, the language out of our strategic plan, and then the accomplishments or plans that we have done following each of those strategies. So there are five strategies that are based strictly on the legislation and we continue to do a crosswalk so that we're always sure that we're following what it is the Legislature had requested us to do. I've also given you a one-page time line and this is a very confusing document when you first look at it. But you can see up there in the legend on the right-hand upper corner, those are our seven strategies straight out of the legislation that we will have rural sites, that we will increase the use of telehealth, that we will have interprofessional learning collaboratives or curriculum development, that we will fund residents and students, that we'll do a work force analysis, and we'll have networks and administration to support the strategic plan. So this is this year's time line and you can see we've been very busy. And then the final handout I've given you, and would like to leave with anybody in the audience who is interested, is about a collaboration with a national training program to do training for Nebraska's primary care prescribers, family practice doctors, pediatricians, APRNs, and physician's assistants to do assessing and managing mental health problems in children and adolescents. And that will be a program that we've funded and will put on for those people April 8 through 10 of 2011 in Kearney. And then it will have a six-month follow-up so that these people really gain expertise and comfort in providing care to children and adolescents. So my quick report, there is no health without mental health. I think I'm speaking to the choir here. That is the watchword from the World Health Organization and we know that that's true. BHECN was created by the Legislature to support the recruitment, retention, and increased capacity of the behavioral health work force. Our strategic plan has been discussed with partners around the state, and the plan has done an excellent job of following the outline written in LB603. The current strategic plan is being reviewed in preparation for our advisory council meeting on December 16, 2010, and that includes

the leaders in academia, in community services, some community philanthropists, and government. BHECN continues to look for opportunities to partner with and include consumer voice in the planning process and we are contracting with NAMI and working with the state Office of Consumer Affairs, and all of our projects require consumers present during the planning and implementation. I got an e-mail from Jonah Deppe yesterday that said, just back from national NAMI, their goal: Children and adults with mental illness receive the right care at the right time and in the right place to experience lives of resiliency, recovery, and inclusion. Sounds like a great goal for us too. October 29, 2010, we had their second Behavioral Health Information Technology summit. About 85 people came together to look at how we will maximize the use of technology to make the services accessible around the state, and to identify any barriers and have a plan to deal with those barriers. We will also do distance education, distance supervision, and distance research. And we're changing our terminology now to virtual, so that it feels more like wherever you are, you're getting the same thing you would if you were face to face. A full report of that will be available on our Web site by December 15, 2010. We have training in interprofessional environment starting at Lasting Hope Recovery Center and Community Alliance. Those are all interprofessional, so it's psychiatry, pharmacy, nurse practitioners, PAs, and consumer support is also being trained in both those locations. We have an open house for BHECN Lasting Hope Center on December 8. I hope all of you got an invitation to that and will come see what we've been doing. We have completed contracts with two of our regional sites in Kearney and Scottsbluff and those collaboratives are working on getting their own needs identified and there's more information in the full report. Discussions are underway to digitally connect Creighton UNMC Department of Psychiatry, College of Nursing, University of Nebraska at Lincoln in Psychology so that we start to get some of those higher level licenses training together so they can work better together. We have a REACH Institute for training in primary care, as I've said, in April 8 to 10 and hope that everybody in this room will help identify the primary care doctors out there who you think would be good candidates for this. We can only train 20. Curriculum development is underway with Dr. Jim Wilson, Teri Gabel, two psychopharmacologists, and Dr. Arthur Lew, a child psychiatrist, and

including some consumers, and to develop a curriculum on depression for primary care providers in the state. This initial module will be in available in the spring of 2000. We've also participated in the development of the state strategic plan for behavioral health work force development to meet the needs of people with co-occurring disorders, and that was an HHS-led initiative. With behavioral health telehealth service delivery, we'll be starting to deliver psychiatry services to the Norfolk area sometime yet this fall. And I guess my only closing statement is the plan for the Behavioral Health Education Center of Nebraska was a four-year plan ramp up. We, right now, feel that we're pretty solid where we are on our funding, but in order to increase the residents to two per year over eight years and increase those rural training sites from the two we have right now to the six we had envisioned, it would take the finishing of the budget, which I don't think anybody is saying probably there's likely to be an increase this year. So we feel like we can stabilize and do what we're doing, but we may have to come back and talk with you about, you know, we can do one a year for the residents not two a year based on the current funding. Questions?

SENATOR CAMPBELL: Questions from the senators? Director Boust, I just wanted to elaborate a little bit on the fact that the Legislature also has had another committee working this summer on trying to anticipate what will happen with national healthcare.

SUSAN BOUST: Uh-huh.

SENATOR CAMPBELL: And we have heard from a number of people and one of the recommendations that we will be making to our colleagues is a reemphasis on work force development. That has really surfaced as one of the linchpins for what we need to do to be ready. So all of the efforts that you are doing really lead into that.

SUSAN BOUST: Absolutely.

SENATOR CAMPBELL: Thank you very much. You're sort of under the radar but we

need to get more people to hear about your program. But it will become vital that we spend some time talking to you when we get ready for that.

SUSAN BOUST: We will be glad to help.

SENATOR CAMPBELL: Good. Good. Any other questions or comments? Thank you very much for coming today. Our next information for the committee is on postadoption, postguardianship services. Jessyca, Jessyca Vandercoy, who is the director of Right Turn, good morning. How are you?

JESSYCA VANDERCOY: I'm great. How are you?

SENATOR CAMPBELL: Very good. Very good.

JESSYCA VANDERCOY: (Exhibit 4) Glad to be here and give you an update on how the program has developed and the success we've had in serving families. I'd like to begin, I noticed on the agenda that...just to clarify, there is...Right Turn is a collaboration between Nebraska Children's Home Society and Lutheran Family Services. And I mention it more than just for giving credit where credit is due, but between the two agencies there's over 200 years of adoption experience. Both Lutheran Family Services and Nebraska Children's Home have been in the business, I guess, of adoption for many, many years, which is, I believe, is one of the reasons why this program has been so successful. So I have prepared a little bit of a handout just to give you an update. Feel free to ask questions. I'm not quite sure...I think all the information is interesting so if there's something else that you'd like to know, please ask or feel free to interrupt me. Wanted to review at the beginning the core service components which are really taken out of what all of you had wanted in a contractor to provide the service, which were the six core services, which are case management, which is the bulk of our service, but also assisting the families in locating respite, providing a peer mentor support, developing and connecting families with adoption competent mental health providers throughout the

state, training and education opportunities, and then the support group component. And what's neat about that is it's a real true wraparound idea that we are going to touch families on lots of different levels and meet them where they're at, and we're able to do that with those six core services. So under each core service I've listed an update on where we're at. Case management, we've had 339 referrals; 272 or 80 percent of those have been of eligible families. There is a portion of families or callers that are not eligible for Right Turn because they have, perhaps, adopted a child that was not in foster care prior to, or that the family's adoption or guardianship was finalized by a lead agency. Lead agencies, as you know, are required to provide that year of aftercare and so those families are not eligible for Right Turn until 12 months postfinalization. So we do have some of those families calling. I'm proud to report that we are responding to those families and making sure that all families are connected to adoption competent service providers in our community, even when they're not eligible for Right Turn, because it's important. Six percent of families served in case management needed significant more time than the 90 days. I think that's interesting to note because we're limited to serving families for 90 days in that case management component. There are families that have come to us that...the issues that are threatening the stability of their home or of their parenting commitment need an additional 90 days. We've...that's low, I think, as 6 percent, but duly noted that there are families that could benefit from more than 90 days. Wanted to talk briefly, because I think you'll hear about it later in the annual report provided by the evaluators, but there's...our case management service follows the best practice in both postadoption but also in the area of family-centered practice and consumer-driven programs, which I think is really important to note because I believe it's part of the success of this program. The family...we meet the family where the family is at and the family lets us know what's going to help them restabilize and make things better for everyone in the family. But permanency support specialists who work with the families, most one on one, do have quite a bit of training in the area of that best practice as well as adoption competency. And then they come to the position with several years' experience. We have actually two permanency support specialists who...one in Norfolk and one in North Platte that have over 25 years'

experience working with families, birth families, children in the area of adoption. So that's really something to celebrate because you can't create that through education, but their experience is great. So that case management component, to break it down just a little bit on what we're doing, case management defined is probably a little bit different for everybody. Case management in Right Turn means that beyond education and support, we're actually providing some level of intervention. We have crisis intervention, which is those families that call and say, please come out here right now, I can't move forward in my parenting commitment until something gets resolved, or I need a service, or I need to learn how to maneuver through this behavioral health system so that I can be a better parent and provide for my child and address his or her mental health needs. So on top of sort of that advocacy component and service and referral, which is maybe more a typical definition of case management, we're also providing some independent living skills for teens that are aging out of the system that really need help in doing that. We're able to provide tutoring. We have...we follow a plan. It's a Wellness Recovery Action Plan, which was authored by Mary Ellen Copeland, a really, really neat model in serving families...or serving individuals, both adults and children, and learning new coping skills, particularly in the area of mental health, identifying triggers, identifying coping skills, figuring out a way to manage these mental health systems which are often really difficult for parents to manage. So that's one, been one of the great things we've been able to provide individually for children. Behavioral management, helping families if it's a behavioral chart maybe that we're putting up in the house, some of those just real small things, but having someone come in who's got the training and the knowledge and the willingness to help has really made a difference. Parent coach and establishing healthy relationships with birth families is another area that we get a lot of requests for. Children, you'll see later in the report that the biggest group of kids that are the eligible child that we serve is right in that 13- and 14-year-old range. We've had at that age...those of you who are parents know that all of a sudden you're separating from your parents, you're learning some independent, you're trying to figure out who you are. And for kids who are adopted, that's a real interesting age because what...you're not looking at people who look like you. You want to know where you came from and have

those questions. And so that's often where a lot of our parents are seeing some difficulty in parenting and not being able to answer, maybe, some of the questions their kids have. So building that relationship between birth family and adoptive parents or legal guardians has been really important. So the next piece in assisting and locating respite care providers, this has been interesting. I think when we began this there were lots of belief, and I think I had the belief, too, that respite was really going to be something that needed to be big and really widely available. And I do think that there is definite benefit in respite for families. But what we've noticed is that families typically have not taken advantage of our ability to help out financially or locating respite providers once they're engaged in our service. It is...families continue to kind of use it as that crisis service that it's Friday night, I'm not sure that I can make it through the weekend, someone may get hurt so we need to separate. And I don't have teenagers, but I know that even the best of families may get to that place because I was probably one of those teens. (Laughter) So I think it's important to note that once families are engaged in our service, we're connecting them with informal supports, they have someone to call, they believe that there is hope on the other side of the day that respite isn't as much of a need for those families. The peer mentoring support piece has been critical to our success because Nebraska Foster and Adoptive Parent Association has really expanded their ability to match parents who are going through tough times with parents who have already gone through those tough times and come out on the other end okay. So a good portion, 65 percent of the families we serve in Right Turn case management, also are using peer mentor support. So that has been a really great service for our families. On the next page, the mental health provider referrals, this has...it's been interesting how it shaped up. We are always networking with mental health providers and hoping that we are finding and locating people who have adoption knowledge who we coin as adoption competent mental health providers, because it's important that families who are needing assistance or their children are needing mental health providers, that they're going to someone who has this knowledge. They're going to someone who can intertwine the issues of identity and intimacy and shame and guilt and all these things that come with all adoptions, regardless of how it goes, is that they're intertwining that into their

treatment. That's the way it's going to be the most successful, that's the way it's going to be more quickly resolved, if that makes sense. We do have families that match up with maybe a mental health provider that doesn't have that experience and spend two or three years in counseling or in therapy sessions. We all have, maybe, an opinion on that. But for families it's very frustrating to be attending a weekly therapy session each week for several years and not see the progress that you believe your child should be having. So one of our visions for Right Turn, which is not written into the contract but is something that we are committed to trying to create, is a...to provide mental health providers with an adoption competency training so that throughout the state we have mental health providers that can serve any corner of Nebraska with that adoption knowledge. Because that's the best way to get treatment results quickly and resolve what's going on in the family, which ultimately stabilizes a parent's commitment to the child and parenting. Everybody good? Okay. (Laughter) Training and education opportunities, we have...if you've ever had a chance to look at our Web site, we have a phenomenal community calendar that any time we have opportunity to post anyone's training, whether it's from webinars to minigroups to conferences, trainings, they're on that calendar. We're always connecting families to educational opportunities because we do believe that that's part of a parent contributing to their child to being able to better address their needs is through education. We're also planning a conference for next year for families in the area of adoption as well as for mental health providers. So we're highly committed to being able to educate families and service providers to be better at managing the adoption specific needs of children. One of the things that has come out of this that is part of a gap and barrier to service is the lack of adoption competent mental health practitioners across the state. We really do have a shortage and not just in the western part of the state but in Omaha and Lincoln, as well as mental health providers who really have the experience and the knowledge to resolve what's going on for this child or the family. So we're really hopeful that before all of this is through that we'll have a way of training mental health providers to be better. Support groups, we have a Right Turn support group that occurs in Omaha and Lincoln right now that is specifically run by Right Turn. We have...it's sort of three components--a piece for

children who are adopted, teens who are adopted, as well as parents--and then we always provide childcare and dinner in cooperation with Nebraska Foster and Adoptive Parent Association, the PASE group, and ourselves. There are 21 support groups in the area of adoption that occur each month. So that's really phenomenal. So our work really is to connect families, making sure that everyone who will listen knows that these support groups are occurring. Those are also on our community calendar so if you'd like to take a look or if someone calls and wants to benefit from that type of support, it's always on our calendar. So the next...there's a graph for the referrals for January through October. As you can see, we really spiked at the beginning and have leveled off. Still accepting, you know, 20 to 25 new families a month involving several children or children beyond that 25 families. We've served over 500 children in the 227 families we've served. So although the numbers are less than maybe what was projected, I think because we're a new program and the word is getting out, that those numbers will increase. And if they don't, each day we're serving a really important family that may or may not be able to keep their parenting commitment, and we're having a really good success with that. So if there's questions later on that, I'd like to talk more about that, if there are questions in relationship to the numbers being maybe less than what was anticipated. Age and gender, the eligible child, you can see it's really split between males and females, basically 50 percent on average throughout the entire ten months of the program. And then families being served throughout the state, 38 percent of the families that we are serving are in the Omaha, or surrounding area; 21 percent in Lincoln. The 13 percent of out-of-state, really those numbers come from the beginning of the program. January, February, and March we had over 20 families that lived outside the state of Nebraska but had adopted children who had been state wards of Nebraska. That has been really slowed down. This last month we've only had two or three families that come from another state. So the percentage is high, although we've definitely seen a decrease in that over the last ten months. So reasons for referral, you can see that 82 percent of the families report aggression or out-of-control behavior as the reason for their call. Families call and say, I'm not quite sure what to do. Fifty-five percent of families report mental health is the reason for their call. That's typically

families who know that their child has a mental health diagnosis, they have been in mental health treatment or want to be connected to mental health treatment, and they're not really quite sure where to go, is usually the demeanor of that call. Forty-four percent of families report school issues or school problems is the reason for their call. And then, interestingly, but probably not surprising, 70 percent of families report their child is currently receiving mental health services or has a history of mental health treatment. It is...most of the children that we serve have a...have had mental health services or treatment. That's because we have to remember who we're serving. We're serving families who have adopted children who have been abused or neglected and been in foster care. And with that comes a whole set of issues, whole series of possible traumas that now an adoptive family has taken on in a permanency role or to provide for that child for the rest of their life. So it's a big undertaking, so I don't know that any of us are surprised that all of those...that the children that we're serving have mental health issues. Thirty percent of Right Turn families are parenting a child that fall in the reactive attachment spectrum. This was sort of initial data. I believe that at the end of this 18 months we'll find that that's actually higher. Families come and are not sure if their child falls on that spectrum. The interesting thing about a child being diagnosed on the reactive attachment spectrum is that having reactive attachment issues are preventable. The reason children have difficulty attaching to adults and/or making relationships is because they've had broken relationships and attachments previously. And that's evidenced of what happens to kids in foster care, what happens to kids when they've been abused or neglected by the people that were supposed to protect them the most. So this is, I believe, is a low estimate, but the good news is that it is preventable. When we do foster care and we do adoption, ahead of time, right, we will have less children who are having difficulties making relationships. Thirty percent of Right Turn families are reporting that they have...that their children that they've adopted or become legal guardians for have had pre- or postnatal drug exposure or fetal alcohol syndrome. And 15 percent of Right Turn families are parenting a child with a mood disorder. So interesting information, and I think it brings light to the condition and the fragileness of the children that are being parented by these families who really need the support of

Right Turn. And the success we've had, I think, is...I will highlight later and why I think we've had the success we've had, even when there's such predominate mental health issues with each family that they're coping with. So the program outcomes that we've had, and these were set out prior to us being involved, but I believe these were all of your wishes for the outcome of the program. Number one, the families formed by adoption or guardianship will remain intact. And I'm really proud to report that 1 percent or less than 1 percent, it's been 2 families of 227 families, who have dissolved their parenting commitment and adoption or guardianship, which is they have said, I no longer want to be tied to this child, to be a part of their treatment. The child has...in these two families have returned to foster care. What makes that number more significant is that nationally a state dissolution rate can range anywhere from 3 percent to 15 to 17 percent. So if we were to take that low number in Nebraska, which about on average 300 kids being adopted a year and you take that 3 percent of numbers and you're looking at 12, let's say 12 kids or 12 families that have ended their parenting commitment, in ten months we've had 2 of 227. So I think it's important to note because we've had great success. We've kept families together when, without this program, that number is significantly higher, and just not in Nebraska, nationally that's what's happening. Families have an increased ability to identify community resources and establish informal supports. This is one of the things we do best. We have over 1,100 in the first ten months of service referrals to community supports, to informal supports, to formal supports, to programs. These families are being connected to places they never knew existed. So that's...we've gotten really skilled at finding things that maybe no one knew about. And one of the best calls is when a family does call in and says, I've tried everything, and you're on the phone with that family, and ten things pop into your head that said, you know what, you haven't tried this or this isn't, you know...and that's not necessarily the conversation but it's sort of in my back pocket in saying, we're really going to be able to do something because this family hasn't tried these other community supports or asking these families or connecting with these informal supports. Parents have an increased understanding of their child's needs and their ability to meet them. We have a Right Turn assessment that we do pre- and post-, and then the evaluators

had also reported through their survey that 92 percent of families are reporting they can better meet their child's needs after working with Right Turn, which I think is phenomenal. Again on the second one or the next one, parents have a better understanding of adoption issues and how to address issues as their child age, we are working on this every day. It's one of the most important issues to me that when a family leaves our program, I want them to know that the ages and stages of adoption and how to best meet their child's needs because that child was adopted. And that's a knowledge challenge, that's a training opportunity that we're looking at every day. So 80 percent of families are reporting they have a better understanding. And then lastly, the program outcome that was put was identifying barriers and service gaps of systems and establish responsible solutions. I have...on the next page we'll talk about what the gaps and barriers of the system. I did not propose any responsible solutions in this report but if any of you would like to talk to me, I do have some ideas, so...

SENATOR CAMPBELL: Are there any questions before we go on to the final that you want to ask Jessyca? Do we have any data ahead of time before the program started of what the rate was for the dissolving of an adoption? Your statistic of, you know, only two families, I mean, which is remarkable, do we have any idea what that figure might have been prior to this?

JESSYCA VANDERCOY: We do not. Foster Care Review Board is, it's kind of their area of interest and I know they have been looking into finding out what Nebraska's statistic is.

SENATOR CAMPBELL: Okay.

JESSYCA VANDERCOY: It's not something that's readily given often or that is often talked about. And that's nationally, that's not just Nebraska. So that range, that 3 percent to 17 percent nationally, there's a whole bunch of things that influence that from turnover in case management to the amount of time that a family spends in matching

with the child. There's lot of things that go into that.

SENATOR CAMPBELL: Okay.

JESSYCA VANDERCOY: So I don't know what it is for Nebraska, but I know ours is definitely very low, so...

SENATOR CAMPBELL: Okay. Any other questions?

SENATOR McGILL: I have, I guess, a couple of maybe broad questions in just looking for your personal input on, you know, how do we better prepare parents for adoption. Is the state doing a well-enough job because it sounds like a lot of them need guidance? Is there something we should be doing on the other end of things or, as you said, to prevent reactive attachment, you know, disorders? What could we be doing to lessen that number earlier on in the process?

JESSYCA VANDERCOY: Uh-huh. Well, fewer placements, children moving is an issue. I will speak to preadoptive services because that's what I feel like is...impacts our program the most. When adoption is done well prior to, the crisis and chaos in postadoption is going to be less. So when families feel well-trained, when families have all the information in a disclosure format of what they're taking on for the next 19 years or 13 years, depending on how old that child is, they're going to be better prepared. Having the knowledge of how parenting a child who is adopted, may not be as it was parenting a child who was not adopted. So let's say you're a family that's...your children are adult now and you decide that you're working in foster care and there's a child you've fallen in love with and want to adopt, and you're going to raise them the same way that you did your 26-year-old who is very successful, and that's not always the same. We know as parents that we adjust our parenting based on our child's individual needs. If you don't have the knowledge to know how to do that in the specialty area, then sometimes we don't do that well in doing it. So training and preparedness of those

adoptive families is really very, very important and we'd like to see on the front end of preparing those families. How to navigate that relationship with birth families is something that we see a lot with families. What does openness look like? And there...many people don't know that there is a continuum of openness. That openness isn't, you have to have my daughter's birth parents over for dinner every Friday night. That's one end of openness. And so families, to give them permission to do what's comfortable to be able to have those conversations is important. So I would say preparedness, as well as spending some significant time in matching children with parents. I'm an adoptive parent and knowing other adoptive parents, adoption in itself for a parent can be a very spiritual time for someone, that they see a child, they've parented a child, and they say, that child is mine, I am somehow connected to that child. Unfortunately, it doesn't happen with every case but when we look and put resources and efforts into matching so that that child gets the best match of a parent and vise versa, you're going to have better success. And I don't know where the state is on that time that's there, the preparedness and all that. I do know that we can always ask for better.

SENATOR McGILL: I know it seems like with a foster care family, you mentioned how they bounce around a lot and it hurts their ability to attach.

JESSYCA VANDERCOY: Uh-huh.

SENATOR McGILL: And it seems like even at that level, more time should be spent in trying to match them with parents that suit their needs and beliefs and etcetera.

JESSYCA VANDERCOY: Right. One of the great things that happens in Nebraska that I didn't know until I was actually working in this program was that Nebraska is...and I'm not going to remember the statistic exactly, but it is...Nebraska's foster parents are three times more likely to be the adoptive parent. So nationally it's somewhere...6 percent of foster parents become that child's adoptive parent; in Nebraska it's like 25 percent. So

what you have in Nebraska is foster parents that are really committing to children long term and other states don't have that. That's something that's very unique to Nebraska that you have foster parents that are committing to permanency in the area of adoption, which is great. It means you have committed, loving foster parents.

SENATOR CAMPBELL: Senator Dubas.

SENATOR DUBAS: Thank you, Senator Campbell. I'd like to kind of continue on the same vein that Senator McGill brought up and you've talked a lot about the importance of having mental health professionals being adequately trained to deal with families who are going through adoptions. And you referenced a lot about the adults in it, but you haven't touched too much yet on the kids. And are our mental health providers prepared to deal with the issues that these children are dealing with? I think many of us who are not professionals in this area think you've removed a child from a very traumatic situation and put them in a healthier environment so that should be good for them. But we have not recognized, good, bad, or otherwise, there still is that attachment or that relationship with the dysfunctional family. How is it that we need to make sure...you said you're doing some training programs for mental health professionals. Are the schools that are training these professionals training them to deal with the types of issues that these children are dealing with?

JESSYCA VANDERCOY: No. Adoption is a "eensy-beansy" part of mental health. It is, you know, it's nationally 2 percent of the general population is adopted. It's a very small area of specialty, but worth looking at that those families are or those providers are aware of that there are different issues that come along with this. I think one of the things that can help with that, too, is that to make sure that on that front end when there's budget cuts that's coming and there's less training money maybe that's available, that we don't look at cutting that training to families. And I'm not sure if it's on the table or how it's happened, but it could be an area that really needs to be around.

SENATOR DUBAS: I'm a part of your advisory board and this really caught my attention when I attended my first meeting with you and not recognizing fully the fact that these children have to have some type of closure with their biological family. As traumatic as it may have been, that's still that connection and so I don't think we can underestimate the importance of recognizing these children. We may be treating symptoms without fully recognizing where those symptoms come from.

JESSYCA VANDERCOY: Uh-huh.

SENATOR DUBAS: And so, you know, I appreciate your comments about if we're going to make cuts, making sure we aren't making sure cuts...you know, the whole goal of the department is to make sure we have less out-of-home placements, and I don't want us to be so focused on that number that we aren't doing the types of things that we need to make sure that those kids don't get kicked back into the system if we haven't put the proper supports in place. I know you also touched on the peer support and just how important that is to the whole adoption scenario because those parents have been there, done that,...

JESSYCA VANDERCOY: Uh-huh.

SENATOR DUBAS: ...and understand it more than any of the rest of us can. So I guess I just want to give you this opportunity to reemphasize the fact, the importance of...the types of issues that these children are dealing with may appear very similar to what other children are dealing with as far as mental health and behavioral issues, but we have to recognize the trauma that they have experienced and I think the treatment needs to come from that perspective. Would I be correct?

JESSYCA VANDERCOY: Uh-huh. And I'll...because I have the utmost faith in all of you, this is normally a conversation I'd have with another mental health provider, but I'm going to...I know you'll get this. That we have a family that we are...they're serving in a

smaller town in western Nebraska. And this is to give you an example of what can happen when a mental health provider is not well-trained that actually additional damage can be caused. And this is...there's countless of these examples. So this child is actually a child that is in their second adoption due to safe haven and there's a mental health provider that's involved. The parent that has adopted this child, that was left at a safe site, is having lots and lots of behavioral issues with this child. This child, obviously, has been significantly traumatized from before the first adoption, has lost their second family. There was a recommendation made by the mental health provider who is, I believe, is trying to do what she believes is best. But because there is a lack of knowledge, it's actually potentially causing more damage. So this child is...the parent has put this child on a strict behavioral plan and in that, when this child was left at the safe site there was a box of pictures left by that first family of her history, of who she was at age 7, at age 8, at age 9, which is all things that we all like to go back and look at. The recommendation from the mental health provider was, use those pictures as a reward for this child. If she's not well-behaved, she doesn't get to have access to her pictures. So I believe that this mental health provider is probably a wonderful person but she doesn't know what she's doing. So we have lots and lots of those examples of how you can retraumatize someone by not providing competent mental health service.

SENATOR DUBAS: Thank you very much.

SENATOR CAMPBELL: Other questions or comments from the senators? Okay. Jessyca, any last comments you want to make?

JESSYCA VANDERCOY: Are you shutting me up? (Laughter)

SENATOR CAMPBELL: No, but I mean, you are at the last two pages. I am assuming you are going to cover them.

JESSYCA VANDERCOY: Yes, yes, yes. These are actually two of my favorite pages of

the entire report so I don't...(laughter)

SENATOR CAMPBELL: I would never think of not covering those two pages.

JESSYCA VANDERCOY: So in the initial contract that we had, one of our outcomes is to identify gaps in and barriers of service. Last time I was here I had two pages of lots and lots of things that families were coming to us with. We've cleaned up that process and I'd like to preface that probably none of those gaps and barriers in services that are difficult for families to get have gone away from that report that I gave last quarter. But in the interest of time and really being able to focus on major themes that we're seeing, I've shortened that list. The first one we've talked about. Families are not prepared to address the special needs of the children that they're adopting. The second we've talked about is that there is an insufficient number of mental health providers throughout the state that are able to address these issues. The third being that there's an insufficient number of community-based services throughout the state. This is something that's been talked about for months that that level be, and that example just doesn't exist in people's communities and so families are left with two extremes, either parenting a child at home that is aggressive or dangerous, or having them inpatient. We really need to be able to provide that middle level service to keep kids at home. Distance and specialty services are a problem throughout the state. Families not having current mental health diagnoses that are able to get them into the treatment that they need, this has been an ongoing issue where we'll have mental health providers who have worked with the family maybe six months, have made a recommendation of what they believe is in the best interest in a level of treatment, and then insurance being different in how to match those systems up so that we're all speaking the same language. So that me, as a mental health provider, when I say my recommendation is this child be in a treatment group home, that the insurance and their diagnostic criteria and all of that matches so that we move forward and there's not a fight in between on who is right or how we do it. Six and seven, I think this is something to definitely discuss. So a child...one of the issues that I know, Senator Campbell, you've asked very

directly, is the child welfare system and the behavioral health system overlapping in that are families being forced to make their children a state ward or put in the care and custody of the state of Nebraska to be able to access behavioral health services. And in fact, have given some examples on six, divided them into two, individual family services and mental health services that may not be available to a child who is not a state ward, which is important to note. So six, a child who is the legal custody of the state of Nebraska has access to individual and family services that are not available to children who are in their home and in the care and custody of their parents. Some of those examples are electronic monitoring, intensive family preservation, group home level of care, and family support services. That goes back to our insufficient number of community-based services. If I'm a parent and I know that I could really use some family support in my home, I'm not able to access that service. It's not covered by anybody's insurance and, in fact, is then expensive for the family. So accessibility is that I am not able to afford it even though it would be assisting me in keeping my child in my home and being a better parent. Number seven, in the same area, is that a child who's in the legal custody of the state of Nebraska has access to mental health services that may not be available to a child who is in the care and custody of their parent. I do have several examples of where this has happened with Right Turn families where families are unable to access the recommended level of treatment while maintaining care and custody of their child. We've had children who...although their families are intact, because the family is involved in their treatment and wants that child to return home, but have chosen to turn over their custody of their child to the state of Nebraska to be able to get treatment, which is upsetting in lots of ways if you can imagine as a parent to say, I love my child so much I want to get my child the mental health treatment they need, I am going to give over really not only custody and care but control over my child so that my child can have the treatment that they need. And then lastly, which is...I have a couple of family scenarios, but a child who has a mental health diagnosis and a developmental disability diagnosis can often be refused by both systems. We have a family in Omaha...this happened about a month ago. A mother called in. She was describing her 15-year-old son as being actively psychotic. He was threatening himself

and threatening a baby in their home, was homicidal. She had...this was now her fourth or fifth call to the police to try to get him inpatient to be assessed because she was afraid of him. She was afraid for his safety as well. The child has several diagnoses. He was adopted by this mother when he was 2 and he's now 15, and he had early onset signs of schizophrenia, mood disorder, ADHD. He also had an IQ of about 65. So what was happening was his mental health providers, his therapist, his psychologist, his psychiatrist were recommending this child needs to be in a treatment group home or inpatient to be able to address his needs and make sure that he wasn't going to hurt someone else or hurt himself. And what ended up happening was, the behavioral health system said, you know what, his IQ is low, this is a developmental disability's responsibility because he falls in there. Developmental disability said, he's too mentally ill for us to treat in developmental disability services. So that child actually ended up in inpatient in Lincoln at BryanLGH and then, against the mother's will but out of necessity, the child was made a state ward and is now being treated. But I suppose that some of that treatment is coming from child welfare funds. So just to give you an example of what does happen when there are kids that have both of those diagnoses. And it really, if you think about, it's really silly to think that a child who has a low IQ, who has been traumatized and abused and neglected and has all these other things that's gone on in their life, that they wouldn't also have mental health issues. So, hopefully, our system will...as we improve, will be able to serve those families. Lastly is the financial report, which kind of gives you what our actual expenses have been. The thing I'd like to highlight the most on this is that the case rate, which is our all-inclusive rate, that includes all costs to serving families for 90 days. So that means all indirect and direct costs related to serving a family is about $3,100 per family, which I'm not a businesswoman but I know that that's actually a phenomenal rate in being able to serve a family for 90 days at about $3,000 including all of our overhead costs, all of our ability to have a licensed clinician social worker triage, and be available to families, which we're able to provide. And then to be able to provide all those case management components with the success we've had I think is definitely something to highlight. If you have additional questions on the financial piece, I'd be willing to answer any questions

you might have but that's about what I have.

SENATOR CAMPBELL: Any questions? Thank you very much.

JESSYCA VANDERCOY: You're welcome.

SENATOR CAMPBELL: A very thorough report and I didn't short you the time this time we started with you because last time you sort of had the end.

JESSYCA VANDERCOY: Well, when we're talking Right Turn, you can always count...I could talk your ear off all day, so... (Laughter)

SENATOR CAMPBELL: It's okay, we kind of expect you to do that. (Laughter) Thanks. Our next report is on the Children and Family Helpline and the Navigator Program and Shellie Gomes is going to talk us through this. Did I say the name right, Shellie?

SHELLIE GOMES: Gomes, yes, that correct. Thank you.

SENATOR CAMPBELL: I was sort of eavesdropping when you were talking to Claudia. Welcome back.

SHELLIE GOMES: (Exhibit 5) Good morning. Thank you for the opportunity. I appreciate it. I think everyone has...I kind of just went through PowerPoint versions somewhat but we'll just talk through it, if that's okay. So if you all have the PowerPoint in front of you, it's the easiest way to start. All right. Well, I think if you turn right away to that first graph in the first slide, that's almost the best way to start and kind of introduce where we've come from January to where we are through September and now well into October and November for the program. But if you take a look at that first graph, you'll see several different lines. The blue line is going to be kind of those inbound documented calls, so we have seen a nice growth as we've expected. We knew we

were going to start kind of slow with marketing. We didn't really know what to expect and we're going to work our way forward, a big marketing push a couple of times throughout the year and see what we've done. So you can see that the number of calls have continued to increase over the past several months. Looking at the yellow bars, the unique families that we've served, so we know there's always going to be those families that we've talked to at one month and they're going to call us back and check in. So documented calls is kind of a difficult measure to look because we expect that call...or that number to really increase over time. But looking at the number of unique families, I think we take a lot of pride in knowing that those unique families, those new people calling us for the first time each month, and we've seen that continue to grow through the first nine months that we've been working. In addition to that, those family navigator cases have continued to increase. So those might be families that we call and we talk to once and give them some information and they say, gosh, I'm going to give it a try on my own, I'm going to make some phone calls, I'm going to see what I can do. But then they might call us back a month or two later and say we haven't made a lot of headway on our own, tell me again about that family navigator person, who are they and what can they do to help me? And then they're more open to that as an option kind of going forward. So we see that family navigator cases have continued to increase over time. I think an important part to note at this point when we're looking at volume and we're looking at the number of calls and the number of families that we're serving is back when this RFP was created the department was tasked with looking at the events of safe haven, looking at kind of the severity of the issues that were highlighted at that time. We know they looked at other hot lines and help lines across the country and kind of put out a number as to what to expect from phone calls, what kind of volume was this help line going to see. And it was really, in many ways, kind of a guess. We wanted to make sure that there were enough funds available to serve all the families that may need it, but we didn't really know what that number was. And so going through the time, we look, we see these numbers, we see that we've created a pretty solid baseline. And we think we've had a good consistent measure of calls to show us about what we're going to expect month to month. So with that in mind, I think it's important to point out

that since the help line began in January, our expenditures have matched our volume. Our expenditures haven't matched our budget. We haven't spent every penny that we've been allowed. They really match what our volume is and we've been able to have some good conversations with the department and get to a point where we can balance the budget with the department and allocate funds differently, return some funds knowing that this is a substantial amount of money for us to go forward and continue to serve the numbers that we're doing. So that, I think, is an important piece to hit on. When you look at the next page, it just kind of breaks down some of those call volumes. We talk about documented calls and different types of calls and I don't want to go too much into all the numbers today because I think there's other things that we can talk through. But just seeing that standard inbound call, those are the main calls we get. Those are the calls that we typically say are...there's a presenting problem, there's some precipitating event that caused that family to call the help line. So they're calling not only for some assistance and some support but also to get additional information and resources as to how to move forward with their child. In addition to that, that bottom graph shows the outbound follow-up calls and we really think this is a valuable part of our service that we've been kind of able to add over time. It wasn't necessarily built into the program, but it's something that we've been able to say, let's do this, let's put this in place, what families will allow us to call them back. So they're going to call us, we're going to touch base. Can we call you back in two to three days to see how things are going? We know often that families are calling us in a point of crisis and the information we're giving them maybe isn't everything they need or they're not absorbing all that information. But we're able to call them back within a couple of days and do some follow-up, maybe do some more education, and provide some other options to them at that point.

SENATOR HANSEN: Shellie, can I ask a question?

SHELLIE GOMES: Yeah.

SENATOR CAMPBELL: Sure, absolutely.

SENATOR HANSEN: On the map of Nebraska in the different regions there, it looks like after you leave the Grand Island area and head west that either there's a lot less problems or lot less served or underserved population. Which do you think it is?

SHELLIE GOMES: You know what, we've looked at that as well, and we've done some different marketing strategies in different areas of the state. We've tried to do kind of marketing per region, which we think are ways that are more effective. We've had our navigators get out in those areas and really go kind of town to town and community to community to spread the word about the help line, wondering if that's a more valuable approach, getting the information about the help line into the hands of those people who when a family is struggling maybe they're more likely to touch base with. So that's been kind of a more personalized approach in some of those smaller communities. We've been able to do, obviously, the radio and the TV kind of statewide for marketing as well. And I think it's kind of a time will tell sort of thing. I don't know...I don't believe we've reached every family out there in need, but I know that we're dealing with a different population, and, you know, that might be more of an area where word of mouth and developing the trust and understanding of what a help line or a service like this can provide really comes into play, so...

SENATOR HANSEN: Thank you.

SHELLIE GOMES: Yeah. The next page that you'll see is the top ten kind of child issues reported. And these, of course, are very common with what Jessyca reported and I think we see consistency in many programs. The majority of the time parents are calling, they're reporting an out-of-control child or a child who is not following the rules and expectations within the home. But I also think it's important to note that it's not always just the identified child that is causing concerns in the family. We have to be very open in gathering good information about the other stressors that those families are

experiencing because we all know that one stressor builds to another and continues to build. And so, yes, we see those significant issues in the child but that's not the only stressors going on in that family. It's not the one child that's acting out that's causing the problem. It's a bigger issue and we'll kind of touch on that a little bit more as we move on. The next graph is not January to September, rather it's just for these...kind of this Quarter 3, or what we call our third quarter of operation, so July through September. And during that time we changed the way we were documenting referrals that were provided to families. We took a look at and wanted to be able to document what services or what referrals are the families requesting, and what services or referrals are our counselors on the phone suggesting. Are they coming...you know, being able to talk through with that family to determine what might be most appropriate? And we run into a bit of a challenge with that because we...and many times we're going to know, for example, if we've gathered some information about a family, we're going to know in what they're telling us that they're not likely in a position where their child is going to qualify for residential treatment, although that might be what they're requesting. They're calling us specifically saying, I would like the name of residential facilities across the state of Nebraska and my child needs to live there instead of at home. And it is a challenge for our folks who are on the phone with them knowing, gosh, if those were the only referrals I've provided this family, I'm going to send them down three dead-end roads and they're not likely going to get anything out of this. And so we have those discussions on the phone. Yes, there are going to be those families who only want what they're asking for. And we're going to go ahead and give that to them, but we're going to let them know, please call us back if you don't get what you're looking for. There's also those families who are requesting something, but we're able to talk with them and explain to them that that might not be a service that your family is able to receive or access at this point, so let's look at some others. And so we're really trying to tease those two apart and be able to document what families are calling and asking for, and what we're recommending. So you can see those kind of broken out at that point. Some of them that are noteworthy, and again, this reiterates the point a little bit looking at referral types, that it's not just the identified child. Sometimes the referrals are for bigger

family needs as well. So it's not just the mental health services or a placement for their child. It's the basic needs, it's some of the housing, it's some of those other things that are causing stress for that family as well. Any questions on that? There's a lot of numbers on that page, I know.

SENATOR CAMPBELL: Just to note then on the third where it's an evaluation or assessment, not very many parents think that that's what they're asking for but you're certainly suggesting that in a lot of cases.

SHELLIE GOMES: Yeah, and that would be one of those where we're gathering...that might be the parent who is calling kind of in crisis at that moment: My child can't live here anymore, it's an unsafe situation. And we're asking questions about, does your child have a mental health diagnosis? Have they had any previous mental health interventions? And if we're hearing, no, there's not a mental health diagnosis and, no, we haven't done anything before, of course, we want to get them to the path where they start down the right road so we're going to make, you know, help them make the connections with those early level services of getting that initial evaluation and information.

SENATOR McGILL: I have a quick question.

SHELLIE GOMES: Uh-huh.

SENATOR McGILL: Are most of the calls...I mean, I'm assuming most of the calls are about violent, aggressive behavior. But are you also getting any calls from parents who are concerned about their kids in depression on the other end of it?

SHELLIE GOMES: Absolutely. And what has been interesting lately, the new commercials have been running for the last few months.

SENATOR McGILL: I love those commercials, by the way.

SHELLIE GOMES: And it is amazing to hear how often we hear the words, my daughter said the same things they said on the commercial.

SENATOR McGILL: Yeah.

SHELLIE GOMES: We're hearing a lot of parents repeat that exact information. She did write a note and that's exactly what it said. What do I do? I didn't realize...you know, it didn't strike me until I made the connection between my child saying that and what I saw in that commercial of yours. So we are seeing some of the depression as well. And I would say that we've seen that more often in parents who are also then reporting their child doesn't want to go to school. And we are able to link some of those, you know, different behaviors or different presenting problems to help that family do some problem solving or get some other additional services into place.

SENATOR McGILL: Good.

SHELLIE GOMES: Yep.

SENATOR CAMPBELL: Yeah, the new commercial is much better I think.

SENATOR McGILL: Love them, yeah.

SHELLIE GOMES: Good. I think it catches people's attention a little bit more. It kind of truly highlights the problem, so yeah. The next page just looks at demographics over the first nine months. And again, it kind of matches with what Jessyca was saying. We have our age brackets broken out a little bit differently, but you definitely see the most significant age of children where we're receiving phone calls is in between that 13 to 16 age group. The majority of the phone calls are parents calling about their male child.

There's not too big of a discrepancy, 57 percent versus 43 between males and females, but a little bit higher on the male side. And then we do have 4 percent of the callers are under the age of 18, so we do have some kids themselves utilizing the help line and making that initial phone call, asking some questions, and gathering some information about, you know, I've been feeling this or this is going on in my house, I don't know what to do, I don't know what to say to my parents. Some of those kind of calls are what we're getting from the younger kids calling themselves. Yep. You'll see that 81 percent of the callers were female, 74 percent of them identified themselves as parents so we're looking primarily at...when we start connecting all of those dots, female callers calling on behalf of more often their male children. And a separate piece of information that I left off of there is 41 percent of the families calling report that they're a single-parent household, so another significant piece of information there. The next graph just talks a little bit about those families who are referred or offered family navigation services. So if you look over Quarters 1, 2 and 3, you'll see the number of unique families in that first graph that were served or that contacted the help line per each quarter. And then the number of families who were offered family navigation services, and we know this is a voluntary service. The counselors are gathering some information, doing kind of some screening to determine if it might be a family who is appropriate for family navigation or who would benefit from that additional support and assistance. And then the next bar over is those families who accepted the service. And it is important to note, as I mentioned earlier, there are some families or callers who maybe won't accept family navigation the first time they call but they'll follow up, or we'll do a follow-up call with them, and they'll be a little bit more open to it at that point. And then just kind of...as a repeat of that next graph looking at the number of family navigator referrals across the state, it definitely matches that of the documented calls that we looked at a little bit earlier. And the total listed on there would be the January through September and then the Quarter 3 is going to represent just the July, August, and September numbers. I'll skip ahead just a little bit to talk about some marketing. The first marketing slide identifies just kind of an overview of the marketing that occurred since January. We know Quarter 1 was going to be kind of our slower ramp up. It wasn't until late February,

March that we really started pushing the television and the radio and getting word out there a little more about the help line. It was near the end of the second quarter, beginning of the third quarter where we changed the marketing. That's where the new commercials went into place and definitely saw an increase in volume at that time. I think the commercials, both on the radio and on the television, got people's attention a little bit more and really...we've heard people report more often, yeah, you know, I didn't even know about this until I saw that commercial, it really caught my eye, it stuck out in my head, I was hoping I would see it again. And then in addition, we just know that the momentum builds up. You might need to hear something one or two times before you make the connection of, gosh, that might be something I can call. And then you might need to hear it a couple more times before you actually make that phone call or a situation presents itself where you really are pushed to do so. During the third quarter was when we saw that biggest increase in call volume and family navigator referrals. We saw the highest numbers of unique families that we touched base with and some of the tactics outside of TV and radio and some of those basic consistent marketing strategies was...we did a Clear Channel radio kind of a Nebraska Family Helpline day within Omaha and several of the Omaha radio stations that we know really had a large outreach to folks across that Omaha and somewhat Lincoln area. And we did see phone calls definitely increase over that time. We also participated with the State Fair, being out there the entire nine days of the State Fair talking to people, having opportunities to really connect with people and talk about what the help line is, where it came from, how it's evolved, and really what it's in place to do. And then as I mentioned, we've done kind of our grass-roots effort in the Region 3 areas, getting out there and having navigators just making connections with people in communities, getting materials to schools, law enforcement agencies, community centers, those people in the communities where families would turn if they were in need.

SENATOR AVERY: May I ask a quick question?

SENATOR CAMPBELL: Oh, absolutely, Senator Avery.

SENATOR AVERY: What do these marketing activities cost?

SHELLIE GOMES: I did not bring the marketing numbers in front of me. I know that we would have those and it's certainly something I can make available to you but I don't have it all in front of me today. I apologize.

SENATOR AVERY: But a lot of this is free marketing, free access to radio, TV, public service announcements?

SHELLIE GOMES: Within the Nebraska Family Helpline and family navigation services' budget were built in dollars for budgeting and for marketing the service itself. That was actually a part of the budget.

SENATOR CAMPBELL: We paid for some.

SHELLIE GOMES: Yeah.

SENATOR AVERY: Yeah. I would suspect...it would be nice to know what that is because the money spent on that is money not spent on service.

SHELLIE GOMES: True. Absolutely. Yeah. All right. And the next couple of slides are just going to look at some preliminary data trends and then kind of next steps going forward. Looking at the preliminary data trends, you can see those first bullets are from the third quarter. Third quarter, 25 percent of the callers who contacted the help line reported that their child did have a mental health diagnosis. Now, mind you, that's self-report data. It's not us seeing, you know, any official paperwork but that would be a self-report. Most commonly reported was ADD or ADHD. And then of that same 755 unique families from Quarter 3, 40 percent of those reported that their child had undergone at least one form of a mental health service, whether that be a counseling,

some sort of medication, something of that sort. So it's important to note that some of the callers who were contacting the help line have accessed services before and what we're running into or seeing as a barrier is maybe it wasn't the most appropriate service at the appropriate time or they weren't finding the outcomes they expected from those services that they were able to access, so which is now prompting their calls. Callers often report having limited success with previous community-based outpatient. We know that that's not always the most appropriate or the best intervention for that age group and when you're looking at the primary age group of 14- to 16-year-olds where parents are calling, if you have a defiant or out-of-control 14- to 16-year-old, the odds of them cooperating in a therapy session are pretty limited. And so we're finding families who are saying, I've tried counseling, I've tried therapy, it doesn't work, now I need something else; don't give me another counseling referral, there's no way I could get him or her in the car and get them there, when they got there they were completely defiant, they refused to cooperate. And what that leads us to is families are saying, I haven't had success with those, my only other option is a residential placement; they can't live in my house anymore, this isn't working, I don't know what else to do. And so that's where we see that increased number of families calling and they're asking about respite services or they're asking about residential placement. And we know the additional issues that come into play when a family is asking for their child to be moved out of their home, even on a short-term basis with respite. The families are often calling us and contacting the help line in crisis and they're requesting that their child be removed from the home. And at that point, if the child is able to go to a formal respite placement for a few days, what we find is the family kind of takes a big sigh of relief. It feels a little bit more calm in the house. The other children in the home maybe get the attention that they need. And the thought of bringing that child who is acting out back into the home really kind of makes everyone cringe and now we have a family who is resistant or hesitant to bringing their child back in the home. So, ultimately, that brings us to, what can we do to serve this family and provide them with what they need as a unit without removing that child from the home, and not only focusing on the child's needs but also focusing on the entire family's needs as well, which we've identified. Of

course there's stressors involved with that. So with that I did a little bit a kind of research on my own, pulled up from the database at Boys Town, that Boys Town as an organization will serve approximately 600 families within their in-home, within their own homes with in-home family services this year. And I pulled from that data the top ten problems that those families working with in-home family services listed at intake and compared it with the stressors that families are identifying when they're contacting the help line, and I was able to identify that seven of the ten stressors that help line families reported matched up with those that families working with in-home family services are demonstrating as well. And I know that's kind of a rough connection to make, but it was kind of laying the foundation of we're seeing common stressors, we're seeing some of those common behaviors between the child's behaviors themselves and the family stressors. And those are those same things, looking at supervision and discipline in the home, relationships with the children, looking for some of those basic needs, the housing, the food, issues with substance abuse or access to services. And so I think it begins to paint the picture for you that this isn't about an identified child who the parent is calling the help line on behalf of, but a greater issue that both the family and the child themselves are looking for some services or some needs that are potentially out there. And I would think that our family navigators report that same thing. Our family navigators are often going into those homes and they're hearing families say, I don't know what to do, can you help me? And our navigators are fantastic at connecting people with the resources they're looking for. They're great at finding informal supports, they're great at getting good things in place, but their role isn't the immediate change that that family might need. The change where the family is contacting the help line in crisis and they're saying, yeah, that will be great for a week from now when I can get that initial evaluation or next week when I can attend that support group, but what do I do right here, right now? How do we get through the next week? How do we get through the next few days? So that is, I think, a piece that is definitely missing within the services that are being provided and it kind of pairs with what Jessyca was saying, that in-home or that intensive family preservation type service is not available to the average family who is going to be calling the help line or seeking out some of these resources.

Any questions on that? All right. And then the next page, just additional kind of data trends and I touched on a significant number of those: parents often requesting out-of-home placement before maybe fully exhausting less-restrictive interventions, parents also making the request for residential when maybe a short-term intervention in a respite facility would have been an option. And we go back and forth because we know the challenges that respite provides. And I touched on those a little bit, but we also know that there are times where there's a wait to get into those other services, or a wait in order to really get the ball rolling for what that child or that family may potentially need. And what do you do in the meantime? What happens in that middle amount of time for those families and where does that support or some of that skill building come in that both the child themselves and the parent could benefit from? All right. And then next steps, one of the additional things that we identified on the help line side was that we lose the ability to track some of those families who don't access family navigation services, who strictly work with the help line. And so we decided that within that help line program we'd like to expand it a little bit and we've started talking with families and requesting permission to contact them 60 days after their initial help line call. And, of course, that family is able to call back at any time for an additional support or guidance that they may need but we also wanted to be able to track those families who, when they've contacted us, and we've given them some referrals. Maybe they've called us from Chadron, Nebraska, and we've been able to provide them with a couple suggestions for referrals. And we might not ever hear from them again if we don't do a follow-up call or they don't contact us back, so we lose the ability to find out were those resources appropriate for you or were you able to access those. So we have implemented a 60-day follow-up survey with those families who just contact the help line, those who are not working with family navigators, to try to follow up and get some of that additional information from those families. And we've just started making those follow-up calls this week, so we're hoping to get some good information from those families as to what they've been able to gain access to or what changes have occurred within their families. And I guess I kind of wrap it up with we're on pace to receive about 3,500 calls for the year. That will put us at nearly 500 family navigator referrals, and

we'll have the help line and family navigation services would be in contact with a little over 2,500 families. And so to be able to take a step back and maybe it's not the numbers that were initially projected, but to know that 2,500 families across the state had someone to call, had someone to talk to, and got some information that they needed during a difficult time, you have to be able to appreciate that.

SENATOR CAMPBELL: Questions?

SENATOR McGILL: Well, just the general question of...I know this has been...these services have been put on the possible chopping block. You know, they have been listed as things to cut. Tell me what your reaction is to that and the impact on families?

SHELLIE GOMES: My...I guess my initial reaction would be, where would those 2,500 families turn to? Who would they call and would there be other options out there? And we know full well that that 2,500 isn't everyone across the state that's in need. And I guess that's the first thing that comes to mind. Who would they call, where would they turn, or how would they get the ball rolling to make some positive changes for their family if this wasn't an option?

SENATOR CAMPBELL: So at this point what you're saying is that we're still missing that immediate...an immediate step for that family, somewhat like the in-home and safety and child welfare. I mean, do you know what...

SHELLIE GOMES: Right. Uh-huh.

SENATOR CAMPBELL: ...where someone goes in and it's intensive 24-hours or...

SHELLIE GOMES: Yeah.

SENATOR McGILL: I think it's the same thing, isn't it?

SHELLIE GOMES: It is.

SENATOR CAMPBELL: But, I...

SHELLIE GOMES: It really is and I think it's...yeah, because we know it's a bigger, it's not the identified child, it's the family as a whole. We know there are some things that the parents could do differently or could, you know, learn, or implement into their home that is going to impact that child's behavior. And I also think those in-home people have the ability to motivate the kids that they're working with and it's not the parent trying to get the child in the car to get to the therapist's office.

SENATOR CAMPBELL: But sometimes in the in-home and safety, that part is coming from a report of child abuse and neglect, whereas the emphasis here might have to be on the mental health for the child, a mental health counselor that would go into...a very well-trained mental health counselor. So we're still missing that component, but it's how do you identify those families that need that. Without the help line, you probably can't.

SENATOR McGILL: And who can you talk in starting a business for providers (laugh) (inaudible) to do specifically that.

SENATOR CAMPBELL: Yeah, exactly. That's a tough...it's tough, but...

SHELLIE GOMES: Yeah. Well, and I think we have providers across the state who are doing in-home services and,...

SENATOR CAMPBELL: Yes.

SHELLIE GOMES: ...you know, the in-home can be potentially separated from those mental health services in that when the family is receiving help as a whole and the child

is then buying into the fact that the parents are also making some changes, and the overall stress and environment in the home is improving, then you might be more likely to get that child to engage in the additional services they might need. But initially what we're hearing is, it's a complete battle between parents and children and the child is not going to cooperate. And so nothing occurs and things just kind of continue to fester and eventually get worse.

SENATOR CAMPBELL: Isn't it Region 6 that took their money from the professional partners and did a mobile team? Is anybody nodding? Is that correct?

SHELLIE GOMES: I do have a mobile crisis response, yep.

SENATOR CAMPBELL: And I know that they felt really positive about that. So we may want to follow up, perhaps with Director Adams, and get some information on that.

SHELLIE GOMES: Yep. And we've actually had some good conversations with Region 6 seeing how we can link that with the help line and identify some of those families that when they contact the help line that we could maybe fit them into, that would be a service they would benefit from and we've had those conversations occurring over the last few months.

SENATOR CAMPBELL: Because I tend to believe, from Senator Hansen's question, that it is an underserved population, not necessarily...I think the population is out there.

SHELLIE GOMES: Oh, absolutely.

SENATOR CAMPBELL: I don't think the calls probably reflect the number of families that need help, but it would be wise. Maybe we can follow up and do some work on that. Any other questions that the senators have for Shellie? Thank you very much.

SHELLIE GOMES: Thank you.

SENATOR CAMPBELL: We'll move to our last report for the morning and that is Ms. Hornby who is here on the evaluation. And you have under all your papers, there is an evaluators' report which is in the...

HELAINE HORNBY: Do you want to take a stretch break while I set up?

SENATOR CAMPBELL: Sure. We can take a 5-minute stretch break, absolutely.

BREAK

SENATOR CAMPBELL: Hello. Hello. Hello out there. Would you all take your chairs and we will start in with the last piece of our reports this morning. We can have somebody be the Sergeant at Arms for that corner over there maybe.

SENATOR McGILL: That's the rowdy corner.

SENATOR CAMPBELL: It's the rowdy corner, I guess so. All right. I do want to say that I much appreciate all of the agencies who...are under contract, who brought the reports today, and I think we all recognize the dedication you have to children and families and trying to create a better situation for them, so thank you. Miss Hornsby (sic), how are you this morning?

HELAINE HORNBY: Hornby. Good.

SENATOR CAMPBELL: Hornby.

HELAINE HORNBY: Yeah.

SENATOR CAMPBELL: Hornby.

HELAINE HORNBY: Yeah. It's okay.

SENATOR CAMPBELL: I'm just going to let you go ahead and go through your report.

HELAINE HORNBY: Okay. Great.

SENATOR CAMPBELL: Then we'll go to questions.

HELAINE HORNBY: (Exhibit 6) Thank you. Thank you, everyone, for having me here today. I think you can tell from listening to Jessyca and Shellie that you have really excellent leaders that you've hired to lead these new initiatives. I can't imagine people who have really been more dedicated to what they're doing, them and the agencies behind them and their staff. We set up an advisory committee for our evaluation. We meet here quarterly with them, which includes both the agency directors and the staff, as well as parents, Voices for Children, the Kim Foundation, people in the community, Magellan, so we actually have a chance to work with folks on a quarterly basis to share our findings. And that's been very helpful to get feedback as we go along and they're just excellent people. In doing the evaluation we do many kinds of activities to collect our information. And just as an example, for the help line and also for the access line for Right Turn, we actually listened to telephone call of the families calling in. We listened to 50 to 100 calls each quarter. We actually get the calls, listen to them and have a sheet where we record the information about what was addressed and what the attitude of the callers were and so forth. We interview both the staff and the managers, and, more importantly, we talk to the parents themselves at random. We come here every few months and we actually speak to families who are getting the service. And we also have a family satisfaction survey, so every family that finishes the service gets a chance to respond directly back to us. It doesn't go through the agency. They give them the questionnaire, but the responses come to us. So we can get a lot of impartial

information from families. And also the programs keep a database where their counselors and permanency specialists record information in the field for everything that they do, their case plans and so forth. So we actually get an extract of all that data and review it. So we have about as much information as we can from what the programs are doing from multiple sources. I want to address six questions today. And some of it, particularly the first two, go a little quicker because it goes over some of the information that have already been presented by the two people. Are the programs generating sufficient business? Are they reaching the target audience? What are the families actually requesting when they turn to these programs for services and what are they receiving? And I think the questions you are probably most interested in are 4, 5, and 6, which are: What are the service barriers and gaps? Who are the families that have persistent concerns, some of these more difficult families that both Shellie and Jessyca alluded to? And what are the results of the services? Of course, feel free to interrupt me at any time. So the first question, are the programs generating sufficient business, this has been addressed by both Jessyca and Shellie in their remarks. For the help line and family navigator, they've served close to 2,000...the help line has served close to 2,000 families, individual families with over...they're getting close to 3,000 calls that they've handled. And Shellie has gone over this in quite a bit of detail. So the major thing I would like to say is that their volume is rising. You've heard about their PR, the efforts, and those efforts are, indeed, generating a lot of volume. So this particular chart shows the first, second and third quarter and you can see their standard inbound calls, their information referral calls, and their follow up calls are all increasing as time goes on. So that shows that the word is getting out and families are, in fact, using it to a greater degree. Shellie also alluded to the fact that the original expectation in the request for proposals was that something like 90,000 families in the state of Nebraska have children with a behavioral health concern and perhaps 2 percent a month would be reaching out. This was based on national data. They just kind of tried to estimate; they had to do something to estimate what the volume would be to know how much...for you to know how much to fund these services. And so it's less than they originally thought because it was just pretty much a guess based on some other national data. So the call

volume is less than expectation and Shellie addressed how they're not just (inaudible) using their entire budget on the help line for that reason. But we have seen, in our evaluation, that there's a benefit to the lower call volume. And what is that benefit? The help line staff themselves are providing a lot of services to families who never need anything more than the help line. They're able to spend more time serving the families, because they have a little more time, perhaps, than anticipated. You can see here the average length of the call...of all calls is 20 minutes. The standard calls where they're really gathering all the information about the behavioral health concerns of the family is over at least a half hour. And the information calls where they're just more or an I/R and are 13 minutes. We have even documented some calls that were a whole hour long. And this level of intensity of services we found has enabled the family just to stop right there. They got what they needed from the help line. The counselor took the amount of time that was necessary to address their concern on the phone. And they didn't need to go on to family navigator or something else. So that has been a real benefit to that. The number of referrals are up. The number of follow-up calls are up. And by that, I mean that the follow-up calls go in both directions. The counselors call the families--Shellie alluded to this--to follow up with them afterwards to say, did you...were we able to help you? Did you get what you needed from us? Is there anything more we can do? Sometimes those follow-up calls generate, actually, well, as a matter of fact, I really do need more and I'm ready now to enroll in the family navigator services. They remind them in the follow-ups that that service is available. And sometimes people come in, not in the first call but in the follow-up call. The other follow-up calls go in the other direction where the families call back and said, you told me this last week or two weeks ago, now I've solved that, but I need this or whatever. So they're really developing a relationship with the families just through the help line through these calls in the amount of time they're spending. And the families cite emotional support from just this help line service. They say things like: I know now I can do...a family might...we heard them on the phone say something like now I know I'm doing everything I can; I might not be the perfect family but through this interaction I know that I'm doing what I can; or just talking to you makes me feel better as a parent, that type of thing. So it's been really pretty impressive

what they've been able to do through the help line itself as a service unto itself. So yeah, the net effect is the service, the help line service unto itself, not merely a gateway to family navigator, although we do see that 20 to 30 percent do go on to actually enroll in the family navigator service after the help line. As far as Right Turn, they've handled over 500 calls; they've served over 300 families. When a call comes in, even if a family may not be specifically eligible for the service, and you know there is some very specific criteria about the child having been adopted through the state from...and not necessarily within the last year because they turned to the other agency who did the original adoption, nonetheless, Jessyca, personally, and one other person who works with her, talks to just about every family to see what she can do to help, even if they don't actually enroll in the Right Turn service. So they've served over 300 families through these follow-up calls and they've provided the case management to over 200 families. Those are the ones that actually enrolled in Right Turn and they track for three months. That's the case management service, the standard time is three months. So their weekly referrals are leveling off at about 25. This just shows some...the calls received so it's got to be...start with a call, then you get a referral to Right Turn, and then you actually open the case management service. So let's say in Right Turn does the call volume match the expectation? We started to delve further into what can we actually expect? And Jessyca mentioned this a little bit in her remarks too. We look back between 2002 and 2009; you had over 3,000 children who were adopted through the state, through the foster care system. That averages about 350 to 450 children a year. And of those, who is like your potential pool of people, because a lot of people come back years after the adoption actually occurred. It's not just...it happened two years ago, a lot come back as teenagers and so forth. So 172 adopted families have been served, plus 42 guardianship families out of this whole pool of potentially 3,000. The critical question here though is this question of adoption disruption and adoption dissolution, which Senator Campbell, I believe, raised the question of do we know how many would have dissolved without this service. As Jessyca mentioned, there is no actual target figure of how many dissolutions you could expect, but the research generally shows that about 3 percent of the children who are adopted don't last between 12, 18 months, 24 months,

so that would be about 12 children a year who you would expect to, actually, dissolve...where their adoptions would dissolve. Here you're serving over 172...well, actually, you're serving, yeah, that 175 families thus far. The year isn't even over yet. So if you're hitting those people, those really high-risk, high-need people, you are addressing a target population, if that makes sense. Of course your target group spreads out over all the years, not just the kids who were adopted last year. But that was a little clumsy, but I think you see what I mean about how many people are potentially eligible and what the worst case scenario is a dissolution of the adoption. As far as the question, do we know how many would have dissolved without it, besides going to national statistics, we have actually met with the N-FOCUS staff last week trying to get an extract of N-FOCUS data, which is their case management system in the foster care program. The only way you can tell if an adoption has dissolved is if a child who comes into foster care shows that their legal status or their origin was from a previously adoptive family. They don't...you have to kind of do that research to look in. It's not obvious; because a child just comes into foster care, their family could be anyone. So you have to track it, vis-a-vis, what was...are they from an adoptive family? So we're going to try to do that. The N-FOCUS data we're going to get is like ten years' worth of data. And so we're going to actually try to do that match, including children in foster care, not just children in adoption. We're going to try to tease out what that rate would have been...or what it has been in the last ten years up to now. This I don't expect you to read, but it's in your handout in case you're interested in this question of adoption dissolutions and what the research studies. It's very interesting that there is no one person or one study that has actually pinpointed the dissolution rate. But these different references, if you want to look more into it, shows some people 3 percent, some people 4 percent, and so forth. So the net effect is that Right Turn does appear to be generating sufficient business in relation to the number of children available for adoption...not available, the number of children who have been adopted, and the number, potentially, who could have problems with adoption. Either program is reaching their target audience. Here is this table. By the way, tell me if I'm going too fast, because I said I wanted to kind of go through the early part quicker.

SENATOR CAMPBELL: You're fine.

HELAINE HORNBY: This just shows a little comparison of the gender, the age, and the race of who the two programs are serving. There's no particular reason to compare them, but I just wanted to...I thought you might be interested in the target population. And family navigator is actually serving more males than Right Turn is. Right Turn is about fifty-fifty, whereas family navigator, the target children, about 60 percent are males in that program. As far as the age, family navigator is also serving the slightly older population, like two-thirds are over the age of 13, whereas Right Turn, half of them are over the age of 13 which means more are under the age of 13. So kids are coming in a little younger into that program. And on African-American, the percent of children adopted in Nebraska who are African-American is 18 percent. The percent that they are serving who are African-American is 30 percent. And by the way, the percent in your population overall is 5 percent. So there are more children being adopted who are African-American than are represented in the population. And then there are more that are showing up for Right Turn than are being adopted. So that's just something to...for like cultural competency. If there are any issues in making sure our programs are targeting this particular ethnic group, we need to be sure that they are. The families with the mental health diagnosis, both Jessyca and Shellie reported on this earlier. These are the ones who come in, I say self-report, because they are coming in...as people are coming into these two programs, even on the phone, they're being questioned: Do you have a diagnosis? Have you already received treatment? And about a quarter of the help line folks, maybe a little higher, are saying, yes, I already have a diagnosis. But, of course, two-thirds, and probably higher, of the Right Turn kids already have a mental health diagnosis which stands to reason because they've been through the foster care system. In looking at the comparison between the types of diagnoses in these two programs, attention deficient disorder and hyperactivity is higher among the Right Turn than the family navigator. That's the one that you see most frequently. Again, Jessyca reported on this a few minutes ago. It's probably about an hour or two ago by now. The

fetal alcohol syndrome you would expect to see in Right Turn because these are children who are...who have been adopted more than, you know, we're not seeing that right off in family navigator. But that creates its own special problems for children who are in that system, in the, you know, the postadoption system who have those problems, bipolar and oppositional defiant disorder. So those are some of the kinds of conditions; among the kids who have a diagnosis, these are the kinds of conditions that you're seeing. And when we talk of mental health services and the need and so forth, you know, it just stands to reason that parents aren't going to know how to handle these conditions without assistance themselves. So when we talk about in-home services and involving the families, the families need help, especially the ADHD and the oppositional defiant. You can't just treat the child; you've got to give the families help in how to deal with those behaviors if they want to stay in the home. The third question: What are families requesting and receiving? I believe Shellie probably had this in one of her slides, because I was just listening. The family navigator, now I'm moving from the help line, which is the telephone calls, to the ones who actually enroll in the Family Navigator Program. This bigger graph shows three things. One is...the whole big bar is whether a service was recommended or referred. Within that big bar there's three breakdowns: one is whether it was actually used by the parent, one is whether it was not used, and one is unknown. So this is a little bit tricky because we're talking about human behavior and we're talking about databases and people out in the field spread all over the state of Nebraska. But basically we are asking people to try to capture, people being the...probably a lot of the people you see behind you who are working on these programs, to actually capture in their database systems, did you refer a family to a service and what happened. And we have provided categories about what happened to both...we've worked with both agencies to try to categorize what happened, not just what happened but why, why if they didn't get a service, and so we can give you better information over time as to what was recommended and did they actually get it and why did they get it or not get it. And so the blue shows that they followed up and know that that service was actually used. Outpatient mental health was the one that was most used. It was also the one most recommended and the most unknown, which means

they don't know yet in the database whether the family actually used it. It hasn't been captured yet. What's interesting here though is that the outpatient mental health is the most used and recommended, but that if you look at parent monitoring, the parent mentoring rather, and child/youth mentoring--see those little 11, 12; and family support services, 11; and other home-based services, 15; these are nonmental health services in the traditional way that we think about family support, parent mentoring, so that a lot of the service use in the reality that...the services that are being used are a lot of the family-oriented services that you're hoping for in the first place by establishing these programs, if that makes sense. One of the things we're just starting to do is to analyze Magellan referrals. As you know, one of the major reasons for establishing these programs that you had was to link families to existing services in the community. You saw these programs as a way to work with families and to make these links. So one of the things we're trying to find out is, is that really happening? Are they linking families to services in the community? And Magellan, as you know, captures...well, registers all Children's Behavioral Health services. They have a system for registering what services are gotten from the Children's Behavioral Health system, as well as from Medicaid. By children's behavioral health, I mean the funds that is being funded through that system, the programs being funded through that system. And so the Family Navigator Program has been asked to register the families in Magellan who are getting family navigator service so we can...not we but so the whole system can track what's actually happening with those families getting these services. So to make a long story short, child Professional Partners has this huge big bar. Child Professional Partners so far...there aren't that many families who have wanted to be registered in the Magellan system. For those that have, this is the service that is getting...they're getting more frequently than any other service. And this service is not a Medicaid service. It's a service that's set up by Children's Behavioral Health that's basically a gateway to other services, just like family navigator is a gateway to other services, but you don't need a mental health diagnosis for the first 90 days to get into that service. And they hook you up with other services. So over time we'll be tracking this a little more. Senator Campbell, do you have a question?

SENATOR CAMPBELL: No. So when they go to the Professional Partners, they've had some...they may not have a mental health diagnosis by then?

HELAINE HORNBY: No. They don't have to have one to get in to that...

SENATOR CAMPBELL: Into the child Professional Partners?

HELAINE HORNBY: Correct.

_____: Yes, they do.

HELAINE HORNBY: They do?

_____: Yes.

_____: Yes, they do.

SENATOR CAMPBELL: A voice out of the audience.

HELAINE HORNBY: Okay. I thought last week you said that they had 90 days.

_____: (Inaudible) 90 days.

_____: (Inaudible) ninety days, right.

HELAINE HORNBY: Ninety days. They don't have to have it for...they have 90 days to get it (inaudible), yeah, right. You can't continue with them if they don't get it within the 90 days.

SENATOR CAMPBELL: Okay. Senators, have any questions about that? Okay.

HELAINE HORNBY: Is there more murmuring in the background that we need to address or we're okay? On Right Turn, this is the same kind of graph that we had for family navigator as to what services are being used. And we only have about a quarter, you know, three months of data about this right now. But you can see that parent education and support, the red is receiving. The parent education and support is the one that they're receiving the most and using. And mental health, again, is not quite as great so that the nontherapeutic supports and the parent education support, those are the kinds of things that family really...families want, need and are using through Right Turn. Okay, the fourth question: What are the service barriers and gaps? Okay, this looks a little alarming so I need to explain it. I mentioned to you that we worked with these two programs to create categories to capture why parents are using or not using the referrals that are being made. And so every time they do a case plan with the family and identify a service need, then the people follow up with the family to see if they got it and why they got it and why they didn't. And then we have these little ways to record what the answer is: family did not follow through; family found an alternative; the location was too far away; the person did not qualify for the service; the child refused; capacity or wait time; the family changed its mind; or the cost or funding. I'm reading that to you just because those are like the biggest reasons why families did not follow up on a referral. Now the family not following through...so these reasons can be thought of as family reasons and provider reasons. Things like capacity or wait time, the services are too far away, those have to do with the availability of services. The family reasons have to do with the family. Sometimes, quite often, the programs will refer three or four different...the same like three or four mental health services to one family. And the family not following through could be for all four services...all four mental health services but for different reasons. One could be the...they might have different reasons for different providers that they didn't go to. So this very long bar on family not following through, there is a lot of that, but a lot of times it's because there's multiple referrals to the same type of thing like mental health. As we get into this more, we're going to be

able to match the reason for not using service with the type of service. Right now we have many types of services and many reasons, so it's...we don't have enough numbers to actually do that cross tabulation to see, well, when it's this type of service, that's the reason; if it's another type of service, that's the reason that they're not actually getting the service. Make sense?

SENATOR CAMPBELL: Senator Hansen.

SENATOR HANSEN: I have a question.

HELAINE HORNBY: Yep.

SENATOR HANSEN: The second bar that said the family found alternative,...

HELAINE HORNBY: Uh-huh.

SENATOR HANSEN: ...is that alternative out of the system, out of what's organized? Would it be other family members, church?

HELAINE HORNBY: It could be that. I don't know specifically what it is. It is just sort of what something was...how it was coded in there, their own database, like the family navigator database. But they found another way to address the issue without using the specific referral that was made.

SENATOR HANSEN: Well, those issues that are attended in a different way, will those be counted as success? Or would it be counted as a family didn't follow through?

HELAINE HORNBY: Oh, I...yeah. No. I think it is a success. And family not following through, it sounds a little negative, but I think we do have to really understand, you know, whether it's really that it was too far away or there was some other reason. But I

think it is a success if they can find an alternative. That's what we want is to empower families to find what they need.

SENATOR HANSEN: Yeah. Right. Thank you.

HELAINE HORNBY: Yep. We tried to do something that was a little funny here because we had a hypothesis. And the funny thing we tried to do is to compare how happy people were with the service by whether they had a...whether they're eligible for Medicaid or whether they had private insurance. Because I think one of the kind of hypothesis is that the problem is that the service isn't available or you're not eligible or you can't pay for it. And so we were trying to kind of tease out, through our family satisfaction surveys. When people respond to these surveys and we asked them about it, we just tried to see whether there was a difference in the people that had Medicaid and how they felt about the service--by the service, I mean the overall Right Turn, family navigator--or whether they had private insurance. So this particular graph, family navigator process area is higher for people with Medicaid. What this means is that we asked the family members through these surveys: Did you get as much help as you needed from a service provider? This is after the service was done. These are people who closed their case with family navigator. Did you know how to access the service better? Did you know what services were available? Did the family navigator understand your issues as a family? Were you treated with respect? This particular list of these, what I call process measures, because it is sort of the processes of accessing services, knowing what was available, people with Medicaid had a higher percent of families who had Medicaid who were happier with all these processes. Now you see that the answers range from 71 percent to 100 percent, so everyone who responded was pretty happy. I mean, the lowest was 71 percent. But the lowest even here was some kind of interesting, got as much help as needed from the service provider, the service provider here is not family navigator. It is the community-based service provider because there is another question specifically about family navigator. So actually in this whole realm, people with Medicaid tended to be happier with all these things, but the least happy was

about the actual getting help from the service providers in the community. So one quarter of the people were not satisfied with that. This graph shows the people with private insurance and which things were they happier with. And the people with private insurance got as much help as they needed from the family navigator, that was slightly higher. They thought that the service built on their family strengths were slightly higher and the length of time available from the family navigator, because they're supposed to give their service over about a six-week period. I think that's it, right? They were a little more happy. So you don't have to draw too many conclusions because we only have about 30 surveys back from the parents. But we just wanted to try to see whether there is any difference between those two groups. Does that make sense to you? On the Right Turn we see something similar to the family navigator as far as the reasons for not using the service referrals. Again, the family declining for one reason or another was still the most prevalent. The distance, the capacity/wait time, service specialty not available, those are there, and the agency refused is second highest. So it is something that we're starting to track here and I think we need to do a little more work in figuring out why the families are declining these services and how does that relate to what we just said, which is that they weren't that happy with the services they were getting from service providers outside of Right Turn. The service gaps and barriers for Right Turn, Jessyca has started to talk about these and we certainly see it in reading the case records, talking to families. And this first one, the intensive family preservation and other home-based services, I'm going to get into that a little more in a few minutes. You have already started the discussion of that this morning and I'll talk about that a little more. The practitioners adequately trained to deal with complex adoption issues, Jessyca mentioned that, that she can speak more eloquently than I can about what special adoption issues means and what does it take. So we'll just underscore that need. And this one, the perception of need to give up custody to access residential care, I say the perception of need, parents perceive the need that they have to actually give up their custody to access residential care and I believe that is actually true that certain services, like treatment group homes, you're seeing in Right Turn that families are actually turning children...essentially putting them back in foster care. They have not

terminated the parental rights, but they're going back into foster care to get some of these services because that's the only way they can access it. And if...there's one or two things that, you know, that I want you to come away with...from...so far what we've...we're learning so far, but one of them is that I think I'm pretty sure this is wrong, that it should be this way, and I want to try to find out how some other states are handling it. But children who are former wards of the state are a very defined population. You're talking about approximately 400 children a year who are adopted from the state. And it seems like that defined group should be able to access the same thing after they leave a program as they did when they were in it from a treatment perspective. So I mean I know there's huge cost concerns about opening up services to large, large groups of people. But I think this is a very defined group of people. Those kids have been adopted right from your foster care system so that you need to look at...whether the eligibility for these services can be...they are already Medicaid-eligible, but the slots, the provider slots aren't being open to the kids who are adopted. This is probably too many bars to deal with so I'm going...I'll just tell you that we also looked at this question of Medicaid and whether people are happy...with Medicaid are more happy or people with private insurance on Right Turn. And all these ones, people with Medicaid are more happy; the number of contacts; timely services; understood our issues. And the areas people with private insurance that...where they were more happy than the Medicaid people was none. But...so that's just saying that the people with Medicaid seem to be more happy with some of these processes that are going on from these programs. Okay. So what are some of the concerns? The negative responses about service providers, not Right Turn or family navigator, but I already mentioned that about a quarter of the families don't...or are complaining about the provider...the services that they're getting. There is persistent eligibility complaints. The families requiring to surrender custody to receive certain services, which I just mentioned to you. In fact, 9 of 212 Right Turn families, including...have had to surrender custody, including 5 with a dependency filings, which means that they went back...that the child went back into foster care but they didn't surrender custody. They didn't have termination of parental rights, excuse me. But they had to go back into the system to get the service.

That's the group that I'm really concerned about. And the staff knowledge, about what...how to access services if they're not actually...if they have private insurance, how can they actually access these services? And I know that they're trying to be creative in telling families like to look at the employee assistance programs and other things that families might be eligible to get service from their employer, mental health services for their children from other sources than what they might ordinarily think of, such as private insurance. So the net effect of what I've talked about so far is that both the family navigator and Right Turn get most families what they want. They're satisfying most families. They make a lot of referrals to mental health services, but the families tend to use the nonprofessional support services more often than the mental health services. And while 80 percent of the families are very highly satisfied with the services, it's probably still a concern with 10 to 20 percent of the families have some concerns with what is available. So who are the families with the concerns? This is where we want to try to actually drill down to the populations being served here and understand them better. So we created this little, kind of schematic diagram, a way to think about what we're doing here. And this triangle, it is almost like the Maslow's needs, some of you might remember if you went to social work school or whatever. You have a broad group of people who have less needs and you have a small group of people who have greater needs. You have a large group of people who need, on the bottom, reassurance and emotional support about what they're doing as parents and how to handle their situation. And for those people, as I describe the help line and what Jessyca does when sometimes they call her from the access line, that phone call can be...serve their need. That's what...they got what they need. You go one step up and you have families who need something more, like service referrals, and both the help line and the Right Turn are telling families who to call, what to do, and that satisfies their need. In the follow-up calls they find, yes, that did it for me; great, I got what I needed. Then you have the next group up of families who need fairly short-term case management and support, and both the family navigator and the Right Turn are designed for that. They go in, they work with the families to see what their strengths are, what their stressors are, why did they come to us for help, you know, what do you need. They give them...oh, it's later than I

thought. They give them concrete things that they can do, and in 60 to 90 days that solves their problem. They might have to come back six months later for something little, but basically that short-term support is what they needed and they got it. You've got a smaller group who need longer-term support. And they can get all those things below and things like child Professional Partners, respite care, other mental health. Those are designed to give those families the longer-term support. Then you have this top of the triangle, the apex, families who need something not readily available, and those are the 10...maybe 10 percent of the families who need something that really isn't available. So it's just interesting to think about what you're doing here because you are addressing the need of the majority of people, but through these services there is still something that's missing. So the different sides of the equation here are, what services are available? Who will pay for them? Who is eligible to receive them? So what are the available services? Who will actually pay? And who is eligible to receive them? This...let's see, how much time; ten minutes, nine minutes?

SENATOR CAMPBELL: We'll finish your report. Trust me.

HELAINE HORNBY: (Exhibits 7, 8) Yeah. Okay. You might have some hungry people here, but I know you'll stay. Right now we're talking, primarily, about service availability. That's what we're all struggling with here. So one of the things we started to do is to delve more deeply into what are the services that are actually available. And you have, as any state does, you have services that are paid for by Medicaid, your services that are paid for by Children's Behavioral Health itself, and then you have services that are in the private market. And here I'm talking about this high-end group with the top 10 percent who aren't being adequately served now. In your packet I've given you two sheets of paper that's beyond the actual PowerPoint. Right now the Children's Behavioral Health is putting about $10 million into mental health services in the community. These are the services that generally is like 200 percent of the poverty. These are not Medicaid. They are the services that are...that you have established, and probably some federal funding, for the families who are not qualifying for the Medicaid,

but they still have, usually, income requirements that are usually around 200 percent of the poverty level. So these two sheets...is starting to say, well, what are the services that are available through the Children's Behavioral Health system, per se, versus through Medicaid providers and through private insurance? And these are the kinds of services that are funded and the little...this with the check marks shows what regions are available. We started to interview the regional directors of these programs, because you have these behavioral health regions that administer these services to find out things like how do you decide what services should be contracted for in your region. And we're getting different answers. We've interviewed about half of them, so maybe when I come back again, I'll give you a report after we interview all six regional behavioral health directors. But you can see that from this graph, and this drills down a little more, that there are certain things like child Professional Partners, outpatient mental health therapy, and outpatient substance abuse that is available in all the regions. Now as you know, just because it is available, it doesn't mean that's necessarily close by. But at least it is present in all the regions. You have other things that are available in some places and not in others. The bottom one has a little red circle...or square around it, home-based MST, that means home-based multisystemic therapy. That's one of those home-based services that Shellie and Jessyca are referring to where it is something more than outpatient counseling and less than residential treatment. Now this service is available in the state more than just this one region, Region 3. This is...Mid-Plains is your provider. It is available a little bit more than that, but not necessarily through Children's Behavioral Health funding. You have, let's see, in Lincoln, well, both, so both Grand Island and Lincoln, both Region 3...and Region 5 does have it, but it is not paid for by Children's Behavioral Health but you can get it through Professional Partners. And in Omaha you have something a little bit like it called FFT. It's functional family therapy. That's a similar service; it is available through OMNI, which is a private provider. So what I'm trying to say is that there is this high-end group that is not being adequately served. And I think what we need to do is look at the current services and funding that is available and is there anything...any adjustments that need to be made before...and I'm not suggesting any of these other things should

be taken away, but let's just also see what's here. Is there anything that can be done to beef up these services? And this little graph, or whatever you call it, we've done research before on what are these home-based services that we're talking about. And these are four models: functional family therapy; multidimensional treatment foster care, which is really for children in foster care, although one of your questions was how do we prepare kids coming out of foster care so they don't get into these situations because a lot of times the foster parents do adopt. I think it is higher than maybe Jessyca suggested, as far as nationally how many foster parents adopt the children. The multisystematic therapy and the multidimensional family therapy, these are some of the model in-home services that...across the top--Blueprints for Violence, Title V, dah, dah, dah--these are different groups that have substantiated these particular models as being effective primarily for teenagers in the kinds of services that we're talking about that don't exist for this top 10 percent. So, that's what I think we need to be thinking about more as the time goes forward as to what the gap is, even though they're serving 90 percent of the people really well now. And this is what I see as the gap. So, and then over time who will pay and who is eligible are kind of the other factors, being what is the service, who will pay and who is eligible to get it, whether you need a mental health diagnosis or not to get it. But these high-end service, chances are you should...you do and you should need it to get it, because these are pretty intense services. I had one little image that is...since this is such a serious topic, but this is a little bit more lighthearted. Do any of you ever watch Super Nanny on television? The role of the super nanny is to go into the home and to give the parents the tools and techniques that they need to help with their child's behaviors, which are really usually very, very severely poor behaviors. She works with younger children than we do. But when you think about these in-home services, that's sort of what came to mind to me, that you can't just send a child off to a counseling session and expect them to get better by themselves, even if the counselor knows adoption, if it is an adoption issue. Very often there is other things going on in the family and these models go into the home and work with the families and really give them tools to work on the behaviors of their children so...a little bit like that show but not really. But it is the only thing I could think of that

might be close. All right. Finally the last part--the results of the services. These are from our family satisfaction survey, the family navigator outcomes, 88 percent of the families are better able to navigate the mental health system with Medicaid. And they are...100 percent who have Medicaid are more confident in their abilities as parents. This is after the service is over and still we did this little thing about the private insurance versus the Medicaid. Other outcomes with family navigator: They're better able to make informed decisions, we have 75 to 80 percent. They're home situation is more stable. They feel more supported by other families. This is a little bit lower. It's probably maybe not as...one that's quite as much emphasis on. For Right Turn, 100 percent of the Medicaid families feel more confident in their abilities to help their child; 87 percent of those with private insurance. They have better understanding of adoption issues; a better understanding of the child's diagnosis. This is actually one of the lower ones where 50 percent of the Medicaid families and 80 percent of the private insurance feel like they have better understanding of really what is going on with their child and what the diagnosis is. But you can see that all of these are from like 60 to over 90 percent where there is improvement as a result of these services. So the net effect is that people with Medicaid are happier with the processes, whereas people with private insurance are happier with the outcome, but I don't know exactly why. The processes, I mean, like, they understood my issues, they work with my strengths, and kind of all that. But we're going to be looking at this more and more. And with the N-FOCUS data and the Magellan data we're going to be able to come back in the future, I hope, and tell you more about did the children return to foster care, how does it compare to children who didn't get these services to start with.

SENATOR CAMPBELL: Made the comment to Senator McGill during the break that at the last meeting, or meeting maybe prior to that, when the Magellan people were here, they talked about alternative services that they see paid for by Medicaid in some other states.

HELAINE HORNBY: Uh-huh.

SENATOR CAMPBELL: And I thought that was very fascinating that they were...and willing to talk to providers. So we may want to follow up, given what we've heard from you today, and then go back and talk to them, Magellan people, because they were very interested in some alternatives than just residential treatment.

HELAINE HORNBY: Oh yes, right, I think that, generally, I don't think residential is a long-term answer.

SENATOR CAMPBELL: You see the long-term answer as that intensive family...

HELAINE HORNBY: I see it more working with the family and getting the child stable in their own home and getting the parents...helping the parents know how to deal with that child over time. And residential, almost by definition, you don't do stuff much with the families because they're not in the home.

SENATOR CAMPBELL: Right. Right. Questions from the senators? I very much enjoyed your report today and we're glad to have you here with us.

HELAINE HORNBY: Oh good. Thank you. Thanks.

SENATOR CAMPBELL: We will keep you all posted as to what the next step is. The committee will meet in Executive Session probably early in December to kind of reflect on all the information that we've had and we'll be glad to follow up on any questions that the senators have. Let our office know and we'll do that. Otherwise we are adjourned.