

State Advisory Committee on Mental Health Services
November 4, 2010 – 9:00 a.m. to 4:00 p.m.
Country Inn & Suites – 5353 No. 27th St. Lincoln, NE
DRAFT MINUTES

Mental Health Committee Members Present (19):

Beth Baxter, Roxie Cillessen, Pat Compton, Cheryl Crouse, Sharon Dalrymple, Bev Ferguson, Scot Ford, Dwain Fowler, Melanie Lantis, Kathy Lewis, Dave Lund, Vicki Maca, Colleen Manthei, Ed Matney, Jerry McCallum, Mark Schultz, Joel Schneider, Diana Waggoner, Cameron White

Mental Health Committee Members Absent (4):

Adria Bace, Jette Hogenmiller, Kasey Moyer, Pat Talbott

DHHS Staff Present:

Scot Adams, Alexandra Castillo, Maya Chilese, Carol Coussons de Reyes, Sheri Dawson, Jim Harvey, Nancy Heller, Ashley Nielson, Blaine Shaffer

Speakers and Guests Present:

Corey Brockway, Charles Coley, Alan Green, James Russell, Dennis Vollmer, Denise Bulling
Present via Webinar – John Bekins, Ann Ebsen, Jay Jackson, Janet Johnson

I. Call to Order

Meeting was called to order at 9:00 a.m. Roll call was conducted and determined a quorum was met.

II. Approval of Minutes and Agenda

✓ Motion was made by Pat Compton and seconded by Scot Ford to approve the August 12, 2010 Minutes and approve the November 4, 2010 Agenda. Voice vote was unanimous and motion carried.

III. Strategic Planning - Via Webinar

Director Scot Adams mentioned the Strategic Plan is not finalized and DBH welcomes feedback specifically on the appendices. Should there be more or less? The deadline for feedback is November 30, 2010. Director Adams reviewed the webinar presentation. The web page address is: http://www.dhhs.ne.gov/Behavioral_Health/. The goal is to have the Strategic Plan finalized by Dec 30. Director Adams mentioned the health care reform has changed forever. The great emphasis is on integration of behavioral health within primary health and to have the primary physician and physician specialist take the lead on health care.

Committee comment to the Strategic Plan were:

- Data collection seems to be the main source. Can other data system be looked at? Response: Yes, the priority is to have effective systems and look at other sources for data
- Data is very important, the collection of data processing styles are ways to a story to explain the data.
- Housing concerns for population of sex offenders
- Definition of sex offender determines what happens and how the sex offender is handled
- There is a lot of fear to follow the law with primary care involvement. Need to educate Legislature
- State prison numbers are high and treatment is hard to get for everyone
- There is a movement to hold sex offenders accountable
- The Appendices are great. Good involvement of the consumers, likes the holistic and spiritual effect
- Has a good feeling, it will be successful
- Wonderful assessments for children are done by primary physicians but not covered by insurance; how long can we ask providers to provide care without adequate reimbursement?
- There are 330 meds being tested but only a small % for substance abuse
- Need to partnership with schools

IV. Public Comment Review

Alan Green - Executive Director of the Nebraska Mental Health Association

Thanked and acknowledge the Strategic Plan has good steps. Mr. Green mentioned two concerns; 1) what is done with the strategic planning after the document is published. Definition needed: what does wellness & recovery mean? 2) Communication brings better outcomes. Need to put a "voice" on data to measure quality of life, such as do individuals move in with their families?; do they get a job?

V. BH Division Reports

Independent Peer Review - Dennis Vollmer

Attachment 1

Dennis Vollmer reviewed the NABHO Peer Review summary. 19 Peer Reviewers were trained, and included a new focus on Trauma Informed Care. Six facilities were reviewed: Human Services in Alliance, Good Will Industries in Grand Island, Mary Lanning in Hastings, Heartland Counseling in O'Neill, Lancaster County Mental Health Center in Lincoln, and Nova in Omaha. The Peer Review is intense and takes a full day. The Peer Review standards and scores are listed in the handout. The NABHO final report will be submitted to the Division. A Committee member suggested that consumers be involved in the longitudinal effects and follow-up to review findings.

Suicide Prevention Report - Maya Chilese

Attachment 2

Maya Chilese provided a condensed overview on Nebraska Youth Suicide Prevention. The hand out includes training activities of QPR Gatekeeper Training, and Assess and Managing Suicide Risk which is a pilot training. Ms. Chilese mentioned there is military outreach available, which is staffed under Inter Church Ministries. The local mini suicide grants are up to \$5000 and are required to report back on data. Ms. Chilese directed the committee to the DBH website for a link for individuals to create their personal story. For promotional activities check the website <http://youthsuicideprevention.nebraska.edu/>

Help Line/Family Navigator - Maya Chilese

Attachment 3

Maya Chilese reviewed and distributed the Nebraska Family Helpline, Family Navigator Fiscal Year 2010 Evaluation Report. The target population is parents. When receiving calls there are questions to determine why are the parents calling for this incident and try to get information regarding a diagnosis or related information to pass calls. The difficulty is getting enough information to get them what they want or what they need such as getting medication. One committee member reported that some parents say they will not call due to the DHHS logo because they lack trust and feel their benefits could be hampered.

Ms. Chilese stated the navigator is like a family organization or a family peer support. The trends are toward Para-Professional support. A large variety of calls are received and the navigator needs to know what services are available. Another benefit is the out bound calls such as, can I call you back in few days to see how things are going.

Committee members stated the Evaluation Report is easy to read, it is positive but there are not enough providers.

SOAR (Social Security Benefits) - Charles Coley

Attachment 4

Charles Coley is with the Nebraska Homeless Assistance Program and Division of Children and Family Services. Mr. Coley reviewed the handout, SOAR: A Tool To Reduce and Prevent Homelessness.

For more information visit the SOAR website: www.prainc.com/soar

- State PATH programs have been known to fund SOAR programs
- Nebraska became an Official SOAR State in June 2010
- There are two SOAR programs in Nebraska; Lincoln's CenterPointe and Omaha's Community Alliance
- Can SOAR fit in a neighbor housing? Yes start with Community Alliance
- A SOAR 2 day training would be beneficial to Lincoln Indian Center
- SOAR trainers need to be in the field
- Community Alliance
- SOAR training information will be sent to Jim Harvey to share with the committee.

Mental Health Implementation Report- Sheri Dawson

Attachment 5

Sheri Dawson reviewed the State Implementation Report, Summary of Adult and Youth Indicators and FRAMEWORK. Ms. Dawson reported there are 39 Performance Indicators the Division must adhere to. The use of the indicators are to improve quality of services. The implementation of the plan is a requirement. If the Division fails to achieve its targets and implement the plan, the federal government can deduct 10% of the Mental Health Block Grant funds awarded to DHHS. The target indication set by the Division was conservative so targets were achieved, but DBH needs to set targets higher in the future to challenge the quality of services. Ms. Dawson indicated that with an improved data system, the Division is able to establish better benchmarks for measurement.

Ms. Dawson also reported on the Quality Improvement Consumer Surveys. The Division is reviewing the practice and process of surveys because the Division learned consumers are being asked to participate in 119 different versions of surveys across the State. The surveys are all being reviewed and the plan is to develop a standard survey to be used by many groups and organizations.

Committee Comments

- Families of youth would like the youth to be able to complete a survey not the adult/caregiver for the youth
- Need to increase the response rate of the consumers
- In order to get a higher number of participants, could peers be trained and utilized (contracted) to conduct the survey in person? Each agency could have a defined sample and use a standardized tool to be submitted to DBH?
- We need to set the targets for response rates and positive responses at a benchmark level and not be conservative even though there is some risk of losing Block Grant dollars

Jim Harvey stated the Committee's comments are listed in the Mental Health Block Grant (MHBG). Bev as Chairperson of the Mental Health Committee prepares a summarized letter that is included in the MHBG. The complete narrative will be reviewed at the February 2011 meeting. The Committee's time and efforts that go into the preparation of the MHBG is important and greatly appreciated.

Comments:

- Due to the report that MH Consumers die 25 years prior to non-MH people, the basics of life need to be worked on such as housing, supported employment, quality eating, quality meds and physical activity
- There needs to be a similar housing method but with different approaches when working with many populations.
- DBH needs to have a firm target and meet it.

Special Initiative Employment Development Application

Attachment 6

Jim Harvey reviewed the application as an employment opportunity for people with mental health and/or substance abuse disorders. The grant amount average is \$103,000 and will be provided to 9 states. The Project needs to be complete in 90 months. The submission of the proposal is November 19, 2010. DBH is asking for committee comments on Nebraska making application. Mr. Harvey explain the concerns involved are; the short deadline, the shortage of staff, research possible services and the need to complete the project in 90 months

Comments:

- Should show strengths and weakness in Nebraska Supported Employment.
- Supported Employment encourages fidelity monitoring.
- Good relationship with Vocational Rehabilitation.
- Improve on the ground/level providers.
- ACT needs a strong Supported Employment component.
- Education of employers needs improvement.
- Opportunity to integrate Supported Employment and ACT.
- Supported Employment fits with other BH goals and is consistent with Strategic Plan.
- This will give the provider the tools they need and will benefit the consumer.

Motion was made by Ed Matney and seconded by Diana Waggoner to recommend the Division to further explore this special-initiative opportunity to determine what direction to pursue, and based on findings along with the leadership of the Mental Health Advisory Committee, take action as deemed appropriate. Voice vote was unanimous and motion carried.

Election of Officers

Jim Harvey reviewed the By-Laws and read the duty descriptions of the officers. The committee members agreed to retain the officers currently in place, but want to expand the duties of the Secretary to include the review of the meeting minutes prior to the approval at the next meeting.

Motion was made by Jerry McCallum and seconded by Dave Lund to retain all three individuals in their current offices. Voice vote was unanimous and motion carried.

Motion was made by Vicki Maca and seconded by Scot Ford to amend the By-Laws to include the expansion of duties of the Secretary to include the review of meeting minutes prior to the approval at the next meeting. Voice vote was unanimous and motion carried.

VI. Public Comment

Alan Green, Executive Director of the Nebraska Mental Health Association.

- Encourages the Division to pursue the Supported Employment Special Initiative Grant.
- Challenge is how to integrate and train individuals on the model.
- An education component is needed for teams to work together.
- MHA is setting up a meeting with ACT Team to establish a mechanism to work together.

VII. Recommendation/Agenda Items for Next Meeting:

- Division to continue pursuing the direction of recovery-centered, consumer-centered services.
- Division to pursue Prevention in partnership with other agencies.
- Youth MH Services be very active in pursuing referral and delivery systems since privatization of services has failed.
- Continue to set standards high with MHBG.
- DBH needs to continue to explore the gaps individuals fall through, explore, identify and close gaps.
- DBH continue integration of Behavioral Health and Corrections – appreciate those efforts
- It takes a community effort to change and address needs.
- DBH is acknowledging the broken pieces and trying to make changes.
- Concern about lack of transportation/access to services, lack of providers, psychotherapy services.
- There continues to be gaps in the system—some individual's income level too high to be eligible for services.
- Thank you for continuing consumer focus.
- Veterans slip through the gaps and Veterans are not aware that they are eligible for services.
- DHHS is a large department and is important to continue collaboration between the Divisions of Behavioral Health and Children and Family Services.
- In the midst of progress we can't grow satisfied with services, but must continue to be aware of additional gaps to pursue.
- The Mental Health Block Grant reviewers are impressed with the involvement and knowledge level of the MH Committee in the Block Grant Application review

Agenda

In-Depth Technical Assistance – Roxie Cillessen / Vicki Maca / Ed Matney

Strategic Planning – progress update

Keya House Update – Alan Green

Consumer Survey – Paula Hartig

Update on Supported Employment – Jim Harvey

Region Presentation - Region 6

By-Laws Updated.

Update Committee on outcome of the Special Initiative Grant Application

VIII. Plus/Delta:

- The column was not blocking committee members.
- good conversation

IX. Adjournment & Next Meeting

Meeting adjourned at 4:00 pm

The next meeting date is: Thursday, February 3, 2011 at Country Inn and Suites.

Prepared by: Alexandra Castillo, Staff Assistant

Approved by _____

Federal Resource Manager
Division of Behavioral Health

Date _____

1-14-11 ac



NABHO Peer Review Summary

November 4, 2010

Overview

- 6 Peer Reviews were conducted in 2010
- Agencies selected were obtained from a list of eligible programs provided by the Department of Health and Human Services
- Programs were selected by NABHO representing a geographical and categorical cross section of services

The Agencies

- 2 programs receiving substance abuse block grant funding
- 1 program receiving women's set aside funding
- 1 program receiving mental health block grant funding
- 1 program that did not receive federal funding

Peer Review

- Program/Clinical Standards
 - Client Rights
 - Program Structure
 - Assessment
 - Service Planning
 - Continuing Care Planning
 - Documentation
 - Program Evaluation

Peer Review

- Administrative Standards
 - Organizational Leadership
 - Fiscal Administration
 - Strategic Planning
 - Health and Safety
 - Information Management
 - Human Resource Management
 - Quality Improvement

Peer Review

- 2 reviewers
- 1 day review
- 1 reviewer focuses on Program Standards
- 1 reviewer focuses on Administrative Standards
- At the end of the day preliminary findings are discussed
- Strengths and areas for improvement are highlighted
- A final report is sent to the program for their review

Scoring

- Commendation 255-360
- Strong Program 175-254
- Program in need of
consultation/assistance < 174

* All 6 programs scored above 255

Peer Review Trends

- Trauma informed care was a consistent area in need for improvement. Various levels of expertise and implementation noted.
- Overall lack of inclusion of patients, past clients, and consumers in strategic planning and governance.
- Establishing a methodology and process to measure meaningful outcomes.

Nebraska Youth Suicide PREVENTION

Garret Lee Smith Grant Activity Report – October 2010

Project Management Team: Meets monthly with Federal Partners and Stakeholders to provide focus, problem-solve, and integrate additional elements of the plan.

Promotional Activities: A website(<http://youthsuicideprevention.nebraska.edu/>) serves as a central place for suicide prevention activities and calendar; Veterans brochure was developed and distributed; Promotional materials for distribution at teen events have been purchased; Lt. Governor Proclamation 9/8/10 for suicide prevention month; Outreach activities for military and military families are underway; Means Restriction promotional materials were presented to the State Trauma Board and are now being distributed to Emergency Rooms across the state; Professional Partner Programs are screening all youth for suicide;

Training Activities

Locations	Audiences	Activities
<p>QPR GATEKEEPER TRAINING - All six of the Behavioral Health Regions have had QPR Gatekeeper training events ,and several additional events are planned To date over 500 people have completed QPR pre-post tests</p>	<p>community groups, nursing , College/University faculty, staff and students, Aging Partners, Health Department stakeholders, community coalitions, Urban Indian Center, hospital staff, LOSS team; Family Organizations Law Enforcement; military; behavioral health professionals</p>	<ul style="list-style-type: none"> • 35 QPR Gatekeeper Trainings have been completed • 1 Gatekeeper training has been completed through UN-K Community Cares Model • 7 additional Gatekeeper events are planned through October 1, 2010 - schools and Clergy
<p>ASSESSING AND MANAGING SUICIDE RISK (AMSR) – Pilot training has taken place in Lincoln – statewide training is planned in 2011</p>	<p>Addictions/Gambling /Mental health practitioners</p>	<p>4 Nebraska trainers were certified August 35-27 in Omaha to provide AMSR sponsored by SPRC. Nebraska, Iowa, Missouri, and New Hampshire partnered to offer the Training of Trainers</p>

Grants: \$90,000 has been distributed to Behavioral Health Regions to support suicide screening activities. \$74,000 will be distributed to local grantees after Round 3 of grants to fund suicide prevention activities (December 2010). *Local Grantees* include: Grand Island Public Schools on behalf of Hall County Suicide Prevention Coalition, Panhandle Public Health District, Norfolk Area Ministerial Association, The Indian Center (Lancaster County), South Heartland District Health Department; FamiliesCARE, Kearney; Norfolk Community Health Center; Winnebago Counseling Center.

Evaluation: Reporting protocols are carried out in conjunction with the Federal evaluation requirements; Evaluation reports will be available on the website soon.

Grant Continuation: Year 2 of the GLS grant has been awarded.



**Nebraska Family Helpline,
Family Navigator and
Right Turn Post Adoption/
Post Guardianship Services**

FISCAL YEAR 2010 EVALUATION REPORT
JANUARY 1, 2010 – JUNE 30, 2010



Produced by
Hornby Zeller Associates, Inc.
September 2010

Contents

Programs and Providers: Overview	1
Evaluation Questions and Methodology	6
Clients and Services	11
Fidelity: Compliance with Requirements	16
Effectiveness: Service Referral and Provision	21
Outcomes: Benefits to the Clients	29
Summary of Findings and Recommendations	37

**For questions about this report please contact:
Helaine Hornby
Hornby Zeller Associates, Inc.
373 Broadway
South Portland, ME 04106
hhornby@hornbyzeller.com**



Programs and Providers: Overview

ORIGINS OF THE INITIATIVES

In 2007, the State legislature established the Children's Behavioral Health Task Force to provide a new strategic direction for addressing the behavioral health needs of children, adolescents and their families. The intent of LB 542 (2007) was to create a parallel level of emphasis on children and adolescents that LB 1083 (2004) provided for adults and to oversee implementation of the children's behavioral health plan.

In response to the Task Force's recommendations the Nebraska Department of Health and Human Services issued, in 2008, *Creating Change and Hope for Nebraska's Children, Youth and Families*, which articulated a vision for changing the behavioral health system. It shifted the paradigm from restrictive services and out-of-home care towards community-based services with a focus on prevention and early intervention. The goal was "to provide the right service, in the right amount, in the right location, for the right length of time, at an affordable, sustainable cost."¹

In 2009, the Nebraska Legislature followed up by passing LB603, authorizing the creation of a Children's Behavioral Health Help Line (later named the Nebraska Family Helpline), Family Navigator Services and Post-adoption/Post Guardianship Services (later named Right Turn) as defined in the Children and Family Behavioral Health Support Act. The three programs all are intended to provide empathetic support to families in meeting the needs of their children who may be experiencing behavioral or emotional problems; they generally focus on helping families to clarify their concerns, identify their strengths and needs, and develop plans to address the needs. Staff also provide referrals to community-based services and informal supports and sometimes shepherd families through the process of accessing services. A further goal of Right Turn is to prevent the dissolution of adoptions and guardianship situations by ensuring that the adoptive parents and other caregivers have adequate support to deal with the special issues they face. Focusing its efforts on subsidized adoptions and guardianships of children who had been in DHHS custody, the program also offers families case management and peer support services. Each of the initiatives employs system of care principles meaning they are family-driven and community-based, emphasizing the least restrictive types of services.

This report constitutes the first fiscal year report by the evaluation contractor of the three programs, Hornby Zeller Associates, Inc. While it is preliminary in nature, covering the first six months of the programs' operations, the report lays out the framework for the evaluation and provides initial observations and recommendations.

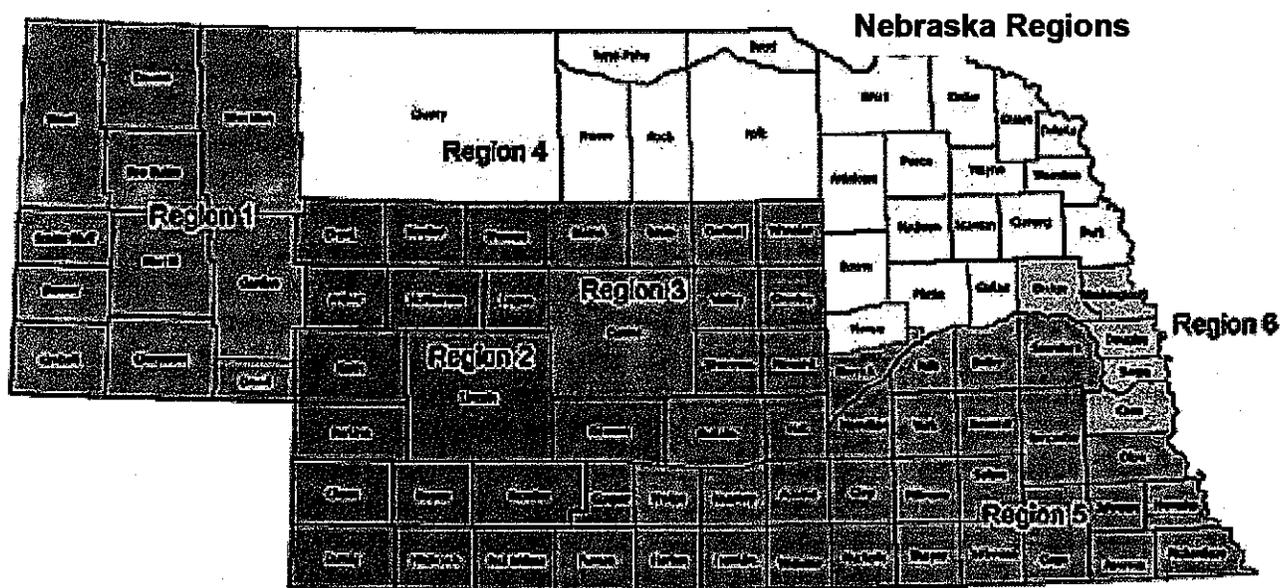
¹ Nebraska DHHS, "Creating Change and Providing Hope for Nebraska's Children, Adolescents and Their Families," January 4, 2008.

PROGRAM AND ORGANIZATIONAL STRUCTURES

Organizational Auspices

All three programs are administered by the Nebraska Department of Health and Human Services through contracts with community providers. They were launched on January 1, 2010 for an initial 18-month period. Both the Nebraska Family Helpline and the Family Navigator contracts are housed at Boys Town, with the former serving as the referral source for the latter. While Boys Town operates the Helpline itself, it subcontracts the Family Navigator program to three agencies which combined provide statewide service coverage:

- the Nebraska Chapter of the National Alliance on Mental Illness (NAMI), serving Regions 1 through 4;
- the Healthy Families Project, serving Region 5; and
- the Nebraska Family Support Network, serving Region 6.



Monthly management team meetings among the Boys Town Contract Manager, the Family Navigator Project Coordinator and each of the Executive Directors of the subcontracting agencies are designed to ensure that the program operates as intended.

Right Turn, the name given to the Post Adoption/Post Guardianship program, was initiated by Lutheran Family Services (LFS), a licensed child placing agency, in conjunction with its subcontractors, Nebraska Children's Home Society (NCHS), Nebraska Foster and Adoptive Parent Association (NFAPA) and KVC Behavioral Healthcare (KVC). LFS and NCHS formed a limited liability company to operate Right Turn, which serves as the primary contractor and employs the Program Director. Other

staff are employees of the respective agencies. NCHS recruits, trains and supervises staff responsible for case management, support groups, educational classes and other services. NFAPA recruits and trains staff responsible for mentoring, support groups, and respite. KVC operates the Access Line which takes the initial calls from families and then refers them to Right Turn's case management arm. Unlike the Nebraska Family Helpline, the call center operates as part of the overall Right Turn program, rather than as a separate program.

Staffing

By the end of the first calendar quarter of the project, Boys Town had hired staff for all key positions at both the Nebraska Family Helpline and Family Navigator. In addition to the Program Manager at Boys Town who oversees both the Helpline and Family Navigator, there is a Family Navigator Project Coordinator who provides oversight, supervision and coordination across all the partnering organizations. Each subcontractor organization then provides daily supervision and oversight to the Family Navigators through the Executive Director and Team Leader.

The Family Navigator program experienced some staffing challenges during initial implementation, most notably in the rural regions (1, 2, and 4) where NAMI found the hiring of qualified staff more difficult than it had initially anticipated. To address this issue, during the second quarter NAMI implemented an "on-call" model. Family Navigators in the rural regions receive a small hourly stipend every day in addition to an hourly rate plus travel expenses when working with a family. In the other regions, most Family Navigators are part-time on this project with many holding dual roles within their organization.

All the Family Navigators have some experience with the mental health system either as support providers, parents/family members of a consumer, or both. However, some come with extensive experience in the peer mentoring field, while others were entering a completely new area professionally. All Family Navigators receive intense training on the various service systems, providers, program requirements, and the Family Navigator database which they use to keep track of the work they are doing. Family Navigators must complete 40 hours of job-specific training within the first year. Moreover, each subcontractor engages in clinical supervision meetings two times per month with the Boys Town Program Manager (a licensed mental health professional) to discuss difficult cases, review proper case note documentation and learn different approaches to working with and engaging families. Staff also convene monthly for a web-based meeting with all Family Navigators. In addition, the Family Navigator Project Coordinator holds meetings with the Team Leaders to deal with process issues such as communication, reporting, documentation and other procedures.

By the end of its first half year of operation, Right Turn employed, over and above the Program Director, eight Permanency Support Specialists and two supervisors. Because some of the Specialists were part-time, the ten staff represented six and one-half full-time equivalent employees. Currently, there are employees in the Panhandle, Grand Island, North Platte, Lincoln and Omaha. In Omaha, a supervisor was hired for the three

Permanency Support Specialists in that office. This supervisor also does the clinical intakes for the program.

Facing issues similar to those NAMI discovered with hiring Family Navigators, during the first calendar quarter of operation Right Turn employed "on call" or "coverage" employees who filled in the gaps in regions when cases arose where there were no Right Turn employees. Right Turn decided, however, that this was not a satisfactory solution because the on call employees were not as dedicated to the program. Many, for instance, did not wish to participate in training. In lieu of using on call personnel, the Right Turn board decided that everyone employed by the program should have a secondary role at his or her respective agency, so that Right Turn's program needs would always be met and all staff would produce sufficient billable hours.

Among the eight Permanency Support Specialists the styles and approaches vary somewhat. Some assume more of an advocacy role, such as going with the parents to school meetings to advocate for their position. Others use more of an empowerment approach. In this mode the Specialist has the parent assume more responsibility. Some give "homework" and have the families practice. Others act more like counselors or try to facilitate conversation. At the present time, at least, there is no single model imposed by the program.

Supervision and Quality Assurance

In addition to the Program Manager at Boys Town who oversees both the Helpline and Family Navigator, there are two Helpline Supervisors and a Family Navigator Project Coordinator who provide oversight, supervision and coordination. Each subcontractor organization then provides daily supervision and oversight to the Family Navigators through the Executive Director and Team Leader. Moreover, Boys Town employs a Data Analyst/Quality Assurance staff person to focus on both programs and to review and analyze data extracted from its database.

The Boys Town Program Manager and Project Coordinator both conduct case reviews in order to provide quality control and oversight of both documentation and service delivery. In addition, as mentioned above, the Family Navigator Project Coordinator holds Team Leader meetings to deal with process issues such as communication, reporting, documentation and other procedures.

At Right Turn the Program Director reviews every intake so missing information is addressed right away. A Continuous Quality Improvement (CQI) group has been formed which includes the hired CQI staff person, the Program Director, Board Members and staff from the Access Line, Right Turn and NFAPA. This group conducts a monthly review of reports, a web forum and, when feasible, quarterly meetings in person. They also conduct quarterly reviews of the NFAPA peer mentor files. In addition, supervisors call families to spot check their satisfaction with the program's services.

Evaluation Questions and Methodology

In creating the three programs to help families deal better with their children's mental and behavioral health issues, the legislature asked DHHS to evaluate the implementation and impact of each of them. Specifically, evaluators were asked to address three types of questions: questions about fidelity, questions about effectiveness and questions about client outcomes. Fidelity questions address the issue of whether the programs are operating as originally intended. While DHHS articulated some of the requirements of the programs in the original requests for proposals, the organizations chosen during the competitive bid process also articulated how they intended to provide the required services which were incorporated in their contracts. Fidelity questions, then, must relate both to DHHS requirements and the providers' own designs.

Effectiveness questions relate to the degree to which the programs are successful at supporting families and connecting them with the services they need. There are obvious complexities in measuring effectiveness. One is defining "need." While many families often approach the programs with requests for specific services, solving the problem the family faces may be done as well or better through a menu of different services, some of which the family may not have considered. Quite often these may be less intensive services. Professional judgment has to play some role in the definition of need, although parental perceptions of need must also be taken into account if families are actually to use the services or view them as helpful. A second is defining "connecting." In some cases it may mean providing accurate and timely information; in others it may mean more support in actually accessing a service.

Effectiveness and, in particular, the definition of need will also have a connection to client outcomes. For all of the programs the most important outcome is maintaining family integrity. In general, the family remains intact where the behavioral or emotional concerns have been alleviated or are being addressed appropriately. For that to occur, however, there must be some level of success in defusing the crises which cause families to request services in the first place.

The following pages outline the specific questions this evaluation uses to answer the questions about fidelity, effectiveness and client outcomes, divided by the three programs under review.

FIDELITY QUESTIONS

Nebraska Family Helpline

1. Are Helpline staff afforded training and supervision by currently licensed behavioral health professionals?
2. Do Helpline staff:
 - a. identify high risk and crisis situations?

Right Turn staff also review intakes from the Access Line for quality assurance purposes, identifying and correcting any missing or inaccurate information. During the second quarter the program initiated a peer record review process for the cases accepted into the program. All current and closed cases are being reviewed through the peer review process.

Advertising

One of the crucial issues for both Boys Town and Right Turn has been letting the public know that the new services are available. Boys Town implemented a major marketing campaign at the end of March, 2010, which included television advertising, radio spots and newspaper advertisements. It also launched a Helpline website which provides more information to the public as well as the opportunity for visitors to submit questions to Helpline staff via email. In addition, the agency distributes marketing materials to emergency rooms and service providers, as well as at conferences (e.g., statewide school nurses' association annual meeting).

With a more limited population, Right Turn has taken a different approach to advertising, engaging in more networking opportunities to spread the word about the program as well as by using direct mail. Right Turn staff speak at various community events and with other providers, such as social workers and clinicians, to promote the program. Right Turn also reports that it is reaching out to the juvenile court system in an effort to divert parents who approach the court with the thought of relinquishing their children.

Right Turn also does quarterly mailings to those on the State mailing list who have finalized adoptions or guardianships and who may qualify for Right Turn's program. These mailings have focused on the availability of crisis response services, although during the third quarter the program intends to change the emphasis, focusing more on the availability of supportive and preventive services, instead. The program estimates that 50 percent of the people on the mailing list are eligible for the services Right Turn offers but approximately ten percent of the addresses are inaccurate or incomplete. To remedy this situation Right Turn is exploring with DHHS the possibility of: 1) placing an insert offering Right Turn services and information into the subsidy stub that post-adoption families receive; and 2) gaining access to the Nebraska Family On-line Client User System (N-FOCUS) to help determine which families are eligible for Right Turn services.

- b. make appropriate referrals to Family Navigator and Right Turn Services?
- c. identify and recommend other appropriate services/hotlines as needed?

Family Navigator

- 1. Are the Family Navigators trained peer support specialists with personal experience as a family member of a youth with a severe emotional disorder?
- 2. In what percent of cases:
 - a. is the first contact made within 24 hours?
 - b. is the first meeting held within 72 hours?
 - c. does service to the family last no longer than 45 to 60 days?
 - d. does the family receive no more than eight contact hours during the service period?
- 3. Do Family Navigators serve approximately 360 families per month?
- 4. Is the caseload per Family Navigator between 1:10 and 1:15?

Right Turn (Post Adoption/Post Guardianship)

- 1. What percent of calls are on hold or in cue for longer than 100 seconds?
- 2. What percent of calls are abandoned?
- 3. In what percent of cases:
 - a. is the first contact within 24 hours?
 - b. is the first meeting within 72 hours?
 - c. does service to the family last no longer than 90 days?

EFFECTIVENESS QUESTIONS

Nebraska Family Helpline

- 1. What percent of calls do not result in a service recommendation because there was no known appropriate service?
- 2. What percent of callers follow through on one or more Helpline service recommendations?²

Family Navigator

- 1. Do Family Navigators identify the youth's and family's strengths and needs including mental health needs?
- 2. Do the service plans match the strengths and needs identified including behavioral health services?

² While Helpline staff cannot control the consumer's behavior, it is important to track the degree to which the recommendations are actually used, even as a quality improvement measure.

3. Do the Family Navigators effectively assist families in obtaining the help they need, particularly from the behavioral health system?

Right Turn (Post Adoption/Post Guardianship)

1. Do the Permanency Support Specialists identify the youth's and family's strengths and needs?
2. Do the service plans match the strengths and needs identified?
3. Do the Permanency Support Specialists effectively assist consumers in obtaining the services they need?

CLIENT OUTCOME QUESTIONS³

Nebraska Family Helpline

1. Do parents believe they were recommended the appropriate service?
2. Do families use the Helpline again within the following six months?

Family Navigator

1. Do families believe they better able to navigate the behavioral health system as a result of the Family Navigator?
2. Do families feel better able to cope with their home situations?
3. Are families able to meet the child's needs within their home?
4. Do families experience a system-related event, e.g., youth's arrest, school suspension, removal from home, within six months of the service due to the same or similar circumstances?

Right Turn (Post Adoption/Post Guardianship)

1. In what percent of the families receiving services does the adoption or guardianship remain intact compared to those not receiving services?
2. What percent of children whose families received services re-enter foster care compared to those who did not?
3. Do the families receiving the service feel more competent to seek and receive help in the future?
4. Do families experience a system-related event, e.g., youth's arrest, school suspension, removal from home, within six months of the service due to the same or similar circumstances?

³ Some of these questions will require the cooperation of other service systems to access comparative data.

EVALUATION METHODS

Hornby Zeller Associates, Inc. (HZA), the program evaluator, is answering the research questions through the collection and analysis of both quantitative and qualitative data. The primary sources of quantitative data are the tracking systems the service providers created for their own utilization. The tracking system used by Boys Town went into operation on January 1, 2010. It begins with the Helpline call and follows the family through to the completion of its service with the Family Navigator program. Examples of the information collected include:

- whether the call represents an emergency,
- whether a referral is made to either Family Navigator or Right Turn,
- the caller's emotional state at the beginning and end of the call,
- risk factors affecting the child and family,
- start and end dates of Family Navigator services,
- referrals made by the Family Navigator and
- dates and kinds of activities the Family Navigator conducts for each family.

For Right Turn the tracking system was effectuated in the second month of the project although services themselves were launched earlier. Unlike the Helpline and Family Navigator Request for Proposals (RFPs), the Right Turn RFP did not conceptualize the initial call as a service itself whereby service information would be provided by the call taker. Therefore Right Turn's database does not contain information about each call received. Instead, Right Turn's subcontractor for its Access Line, KVC, collects some basic information on each call. The Right Turn component is a relatively small proportion of KVC's operation and any information about the details of the calls coming into KVC is available only through that organization. The Right Turn tracking system, therefore, does not begin to provide information on clients until the family is enrolled in Right Turn's case management services.

Both organizations provide HZA with periodic extracts of the data from these tracking systems. Analysis of that information provides the basis for most of the straightforward, factual information about the programs in this evaluation report.

A second source of both quantitative and qualitative information is HZA's own process of listening to Helpline and Access Line calls and recording information into its own database. During the six-month period January through June 2010, HZA listened to 208 Helpline calls⁴ and 18 Access Line calls. The smaller number of Access Line calls reflects HZA's difficulty in obtaining those recordings and reflect two weeks of calls from each quarter.

A third, smaller source of quantitative information involves the written case records each program maintains. On a quarterly basis HZA selects a small sample of cases and reads

⁴ The calls reviewed by HZA consisted of 135 standard inbound or high risk calls, 15 inbound follow-up calls, 24 outbound follow-up calls, 21 information and referral calls and 13 calls which were out of scope, hang ups or wrong numbers.

the records to collect those elements of the case records which are not captured in the electronic tracking systems. Primarily, this involves narrative portions of the service plans and case notes. Some of this information is categorized and quantified after the fact and some of it is used to illustrate specific points about one or the other program, often points which are raised in other forums.

A fourth source also contains both quantitative and qualitative information. This is the parent survey which is offered to every family that completes either the Family Navigator or the Right Turn program. HZA developed the instrument but it is distributed by the programs for reasons of confidentiality. Completed instruments are sent by the family to HZA directly in a pre-paid business reply envelope. Many of the questions ask for "yes/no" answers about what families had wanted to get out of the program and what they actually got, while others are presented as Likert scales, asking the families to "strongly agree," "agree," "disagree" or "strongly disagree" with each of a series of statements. Other parts of the surveys provide room for the respondents to provide narrative responses on specific issues or on their experiences overall.

Finally, qualitative information comes from interviews HZA conducts on a quarterly basis with program administrators, program staff and families currently receiving services. In part, the interviews provide HZA a means of keeping track of changes in the providers' processes, and in part they provide an ongoing record of the impressions both staff and families have of the successes and failures of the programs.

Interviews with the program administrators also provide HZA with information from some of the providers' own quality assurance results. For instance, the Helpline makes a large number of follow-up calls to families to measure their satisfaction with the Helpline service and, in some instances, to provide additional assistance linking families to services. These calls provide an additional source of consumer feedback, and one that is not covered by the surveys to clients of Family Navigator or Right Turn.

HZA also plans to obtain "system" data as the project progresses. It has already received a test file from Magellan to determine what Medicaid-authorized publicly-funded behavioral health services were received before, during and after Family Navigator services were provided. HZA also hopes to be able to track child welfare and juvenile justice data to answer the system-related outcome questions posed above.

This first semi-annual evaluation report starts with a brief description of the clients and services in the next chapter. It then provides a very early stage assessment of each of the programs in terms of fidelity, effectiveness and client outcomes. The report also points to questions which cannot yet be answered but which will be explored in later reports. The recommendations found in the last chapter are, therefore, both tentative and partial.

Clients and Services

CALLERS

During the first half year of operation, the Nebraska Family Helpline handled nearly 1,500 documented calls.⁵ The vast majority of these calls were either standard inbound calls, i.e., calls in which a family was seeking referral to appropriate services (869), or information and referral calls (301). The 869 standard inbound calls represented 828 families, some of whom called the Helpline more than once. In addition, 281 families called for information and referral. Standard inbound calls lasted on average 33

minutes, while information and referral calls consumed only 11.5 minutes on average. One can gain an insight into the Helpline process by noting that calls resulting in a referral to Family Navigator took nearly twice as long as standard calls, 62.5 minutes. Those referrals seem to be made when the family's situation is more complex and the Helpline cannot solve the issue through telephone support and service recommendations.

Call volume increased during the second quarter but continued to lag behind the initial projection of 60 calls per day. By the end of the second quarter, there had been a high of 19 inbound calls (including standard inbound calls, information and referrals and high risk calls)⁶ answered in one day and a low of zero calls received, with the average being eight calls per day.

Call Types	Number
Standard Inbound Call	869
Information and Referral	301
Inbound Follow Up	272
High Risk	15
Positive Consumer	4
TOTAL Documented Calls	1,461

Legend: Call Types	
Standard Inbound Call	A call that usually results from a precipitating event regarding an individual under the age of 19 in which intervention strategies, resources, and/or parental support are provided.
Information	A call in which someone is looking for a specifically identified resource or information regarding behavioral or mental health issues or Helpline services.
Inbound Follow Up	A consumer/family call to the Helpline to provide or obtain information following a previous call.
High Risk	A call that results in immediate Helpline intervention such as contacting child protective services, the police, fire department, or other emergency personnel. Such calls could be precipitated by violence in the home or the risk of suicide as examples.
Positive Consumer	A call specifically to give positive feedback to the Helpline for the assistance provided on a previous call.

⁵ "Documented calls" excludes hang-ups/wrong numbers (27), inappropriate use of the service (6) and outbound follow-up calls (352).

⁶ Inbound follow-up calls and positive consumer calls were excluded from the calculation of daily average number of calls received.

The Helpline made 249 direct referrals to Family Navigator services. These referrals occurred during standard inbound calls, inbound follow-up calls (which are consumer initiated) or outbound follow-up calls (which are Helpline initiated). The 249 referrals represent 30 percent of the families who first contacted the Nebraska Family Helpline during the initial six months of the project, excluding those who called only for information and referral. The initial projection for the number of families to be referred to Family Navigator was 20 percent, so the actual referrals exceeded expectations on a percentage basis although not on an absolute basis since call volume was below projections.

Right Turn's Access Line received 389 calls in the first six months. Most of the eligible callers were referred to Right Turn; those who were not referred wanted and received information only. Several of the ineligible families were also assisted, either by a referral to the Helpline or to the Right Turn Director for other types of post adoptive support and referrals.

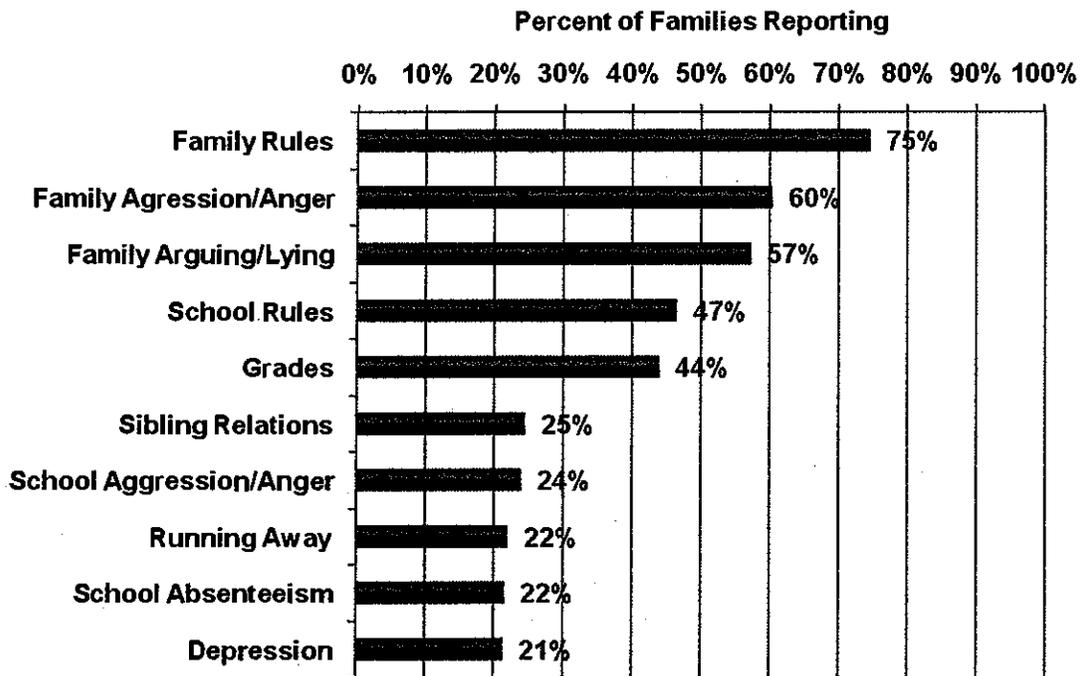
Call Types	Number
TOTAL Calls	389
Ineligible	184
Eligible	205
Referred to Right Turn	194
Accepted Services	154

The majority of calls to the Helpline were placed by women (80 percent), and the median age was 40 years old. The children about whom they were calling tended to be older, with 70 percent over the age of 13, and male (55%).

Right Turn's Access Line does not provide demographic information on callers. Among those referred to Right Turn, 81 percent were women and they tended to be older, with an average age of 50. Just over half (54%) were concerned about a male child, but the ages of the children were somewhat different than among those calling the Helpline, with only 55 percent seeking help for a child over the age of 13.

Callers to the Helpline usually cited multiple reasons for their calls. As illustrated in Figure 1, the most frequent reasons cited by families had to do with family relationship issues, including children not following rules, aggression and anger, and arguing and lying. These were the same issues reported among families who were referred to Family Navigator services, although the rates of incidence were much higher. For example, while 75 percent of all Helpline callers cited the child not following rules as a challenge, 91 percent of families referred to Family Navigator reported this as a reason for calling. This finding holds true for all the reasons included in Figure 1 below.

Figure 1
Top 10 Reasons for Calling Helpline



Legend: Reasons for Calling Helpline	
Family Rules	The identified youth does not follow or agree with the rules (e.g., curfew, bedtime, use of technology, chores) that have been given to them.
Family Aggression/Anger	The identified youth behaves in a belligerent, destructive, forceful or violent way which could result in bodily harm to another family member.
Family Arguing/Lying	The identified youth speaks disrespectfully persistently to an authority figure.
School Rules	The identified youth has in the past, or continues to have conflict with an authority figure at school such as a teacher, counselor, coach, or principal.
Grades	The identified youth is not performing to the academic standards the guardian feels he or she is capable of.
School Aggression/Anger	The identified youth behaves in a belligerent, destructive, forceful or violent way at school which could result in bodily harm to another student, or staff member.
School Absenteeism	The child frequently fails to attend school.
Sibling relations	Siblings in the home have verbal and/or physical altercations or fail to interact with each other in a healthy manner.
Running away	The identified youth has left the home of his or her parent or legal guardian without permission and her whereabouts is unknown.
Depression	The identified youth has described feeling sad, hopeless, worthless, or pessimistic; or the caller feels that the identified child is demonstrating what he or she has identified as signs of depression.

For the Right Turn Access Line the reasons for calling are sorted into fewer categories, but the general tendency is for there to be more mental health concerns than strictly behavioral concerns. The most frequently mentioned issues include:

- mental health concerns (53 percent),
- out of control behaviors (46 percent),
- school problems (45 percent),
- aggressive behaviors (38 percent) and
- running away (18 percent).

PEOPLE SERVED

Of the 249 families referred by the Helpline to the Family Navigator program, 182 accepted the referral and enrolled in Family Navigator. Table 3 shows the number of families served by Family Navigator during each of the first six months of the program. Across the first six months of the Family Navigator program the average number of families served per month was 64. There was, however, a steady increase during the first five months, with only 15 families served during January of 2010 and 107 during May. The June figure was 106, suggesting that the trend is flattening out and that about 100 families can be expected to be served every month. Despite the increases, this is well short of the originally projected 360, reflecting the lower than expected call volume to the Helpline. One should also note that because of the frequent openings and closing of cases there will only be, given current trends, about 75 cases open on any given day.

	January	February	March	April	May	June
Opened	15	21	22	48	43	33
Closed	2	12	14	14	34	33
Open at End	13	22	30	64	73	73

There were differences in gender but not age between the population calling the Helpline and the population ultimately accepting Family Navigator services. While the children about whom parents called were somewhat more likely to be boys (55 percent), the families accepting Family Navigator were slightly more likely to be concerned about a girl (51 percent). However, the youth whose families got Family Navigator services were about the same age as those about whom families called with 70 percent of the former and 69 percent of the latter being 13 or older.

Racial demographics are not collected for Helpline calls but are collected when a family enrolls in the Family Navigator program. In the first six months, the majority of children in families referred to the Family Navigator program were White (68%), followed by African American (18%), two or more races (7%) and Hispanic/Latino (4%). When compared to

statewide population estimates, this reflects an over-representation of African Americans (who constitute 5% of the population statewide).

Among Right Turn's Access Line's 389 calls, 205 or 53 percent involved families eligible for Right Turn services. Among these, 154 accepted Right Turn case management services. Table 4 shows the flow of cases into and out of the Right Turn program during the first six months of the year.

	January	February	March	April	May	June
Opened	51	30	14	22	22	15
Closed	3	13	6	33	31	13
Open at End	48	65	73	66	62	62

The Right Turn program grew fairly quickly to a reasonably stable level, and it has maintained that level, because after the first two months case the number of case openings and case closings has not differed much.

Consistent with the proportion of boys who are the reasons families call the Access Line, 54 percent of the target children in Right Turn cases are also male. Teenagers are represented among Right Turn's case management population somewhat more frequently than they are among the population about whom families call. Roughly half of the target children are 13 or older. Among the children for whom the race is recorded (about three quarters), White children represent 61 percent and African or African American children 27 percent, Hispanic 9 percent and Native American 3 percent.

Fidelity: Compliance with Program Requirements

NEBRASKA FAMILY HELPLINE

While Helpline staff are not themselves required to be licensed, the model requires that they be trained and supervised by licensed behavioral health specialists, which is the case here. In the course of their work, they are charged with identifying crisis situations; making referrals to Family Navigator and Right Turn when appropriate and recommending other services appropriate to the caller's situation.

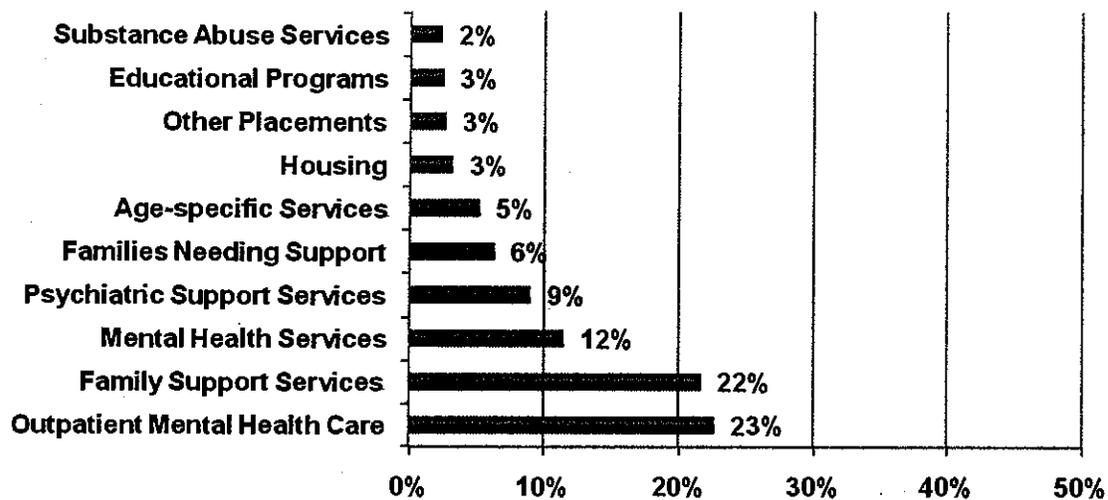
Among the 869 standard inbound calls to the Helpline, counselors identified crisis situations in 435 cases, almost exactly half of the calls. HZA's review of 208 calls verified that the counselors were making appropriate determinations about whether the family was in crisis. In fact, in only one of these calls did the reviewer find that the counselor treated the caller as if she was overreacting.

The appropriateness of the Helpline's referrals to Family Navigator can only be judged on a case specific basis.⁷ However, just under three-quarters (74%) of all families referred to Family Navigator by the Helpline accepted the referral, which suggests that the referrals are generally appropriate.

When the Helpline does not refer the case to Family Navigator, it frequently recommends other services to the caller. In fact, the Helpline made at least 1492 service recommendations to callers during the first six months of the project. This does not represent, however, the same number of families or even the same number of discrete services, because in many cases multiple recommendations are made to the same caller, presumably to ensure that the caller has a range of options from which to choose. The number of families involved is not known at this time, because tracking of this information did not begin until well into the second quarter and then it was recorded and calculated manually rather than being included in the database tracking of Helpline activity. Helpline staff reported that recommended services included everything from counseling to mental health evaluations to substance abuse services to education classes and summer camps. Figure 2 shows the most frequent service recommendations made by the Helpline.

⁷ Referrals to Right Turn are rare, although they do occur. About 2.5 percent of all standard calls to the Helpline were referred to Right Turn's Access Line.

Figure 2
Top 10 Most Frequent Recommendations Made by Helpline



Helpline staff report that the need for immediate respite placement in a crisis situation was consistently expressed by callers and unable to be met by the Helpline. For example, there are only a handful of respite providers in Omaha and callers report waiting lists for most of them. However, while still acknowledging callers' expressed requests (such as residential placements or respite), counselors often explored informal and other supports for families by asking what could help over the next few days while other services could be arranged or accessed.

FAMILY NAVIGATOR

The fundamental intent of Family Navigator is "to assist the family in navigating the current community based behavioral health system, helping the youth and family understand their options and make informed decisions, provide information and support, and promote a productive partnership between the youth and family and their choice of professional services." The Family Navigator program is designed to do this through peer support and referrals to both formal and informal supports and services. Contact is to be made with the family within 24 hours to 72 hours of the initial phone call and a first face-to-face meeting is to occur within 72 hours. Moreover, the services are supposed to last no more than 60 days and generally are to involve no more than eight hours of contact. Navigators are not supposed to have to handle more than ten to 15 cases at one time, with the original projection for total caseloads being 360 per month.

When asked about past experience with mental health, most of the staff reported they had some degree of personal history with someone with mental health issues. One supervisor said that her son has an IEP and she also has a brother who was mentally ill as a child and was made a ward of the State when he was younger. Most Family Navigators had previous work-related experience with youth who have mental health issues. One worked for the National Alliance for Families with Mental Illness and another

stated she worked 17 years in childcare where she often cared for children with mental health related problems.

For slightly more than 80 percent of the referrals to Family Navigator, the Navigator made first contact by phone with families within 24 hours. The average length of time between referral and first contact was just under 18 hours. The RFP and Boys Town proposal requires contact within 24 to 72 hours and while the RFP does not specify the type of contact, Boys Town's proposal stipulates face-to-face.

However, the first face-to-face meeting with families occurred within the required 72 hours in only one-third of the cases. The low percentage seems to be a function of the fact that about one-half of the cases show no face-to-face contacts at all. Whether this is because the Navigators do not enter the information into the tracking system or because they conduct all their work with some families over the phone is not known, but Boys Town did say in its proposal that it would conduct at least one face-to-face meeting within 72 hours.

According to Family Navigators, finding an appropriate time within a family's busy schedule is the primary challenge they encounter when arranging the first face to face meeting. When scheduling issues do arise, Family Navigators try to maintain telephone contact with families to keep them engaged.

According to the initial Request for Proposals the Family Navigator service is projected to last for 45 to 60 days and encompass approximately eight contact hours between the Family Navigator and the family. Families responding to the surveys generally thought that the Navigators were available to them for an appropriate amount of time, with only two of the 14 respondents disagreeing. Moreover, most staff felt that on average 45 to 60 days is an appropriate amount of time. Staff also reported, however, that there are exceptions, and one family HZA interviewed said that its case had been open for about four months, while the Family Navigator tried to help get the family a slot in Boys Town. Those who do need more than the allotted timeframe have to re-refer themselves to the program, calling the Helpline again.

Among those families whose cases have closed to Family Navigator, the average length of time is 45 days. Sixty-two percent of the cases closed within the first 45 days, while 73 percent closed within 60 days. Because the program is still relatively new and some of the families seen as needing longer term services may still be open, later calculations of this measure may provide very different answers.

When asked whether they felt eight hours on average was enough time to work with families as specified in the DHHS contract, family responses were overwhelmingly positive while the Navigator and supervisor responses were mixed. Only one family believed it did not get enough contact. Staff, on the other hand, reported that it depended on the unique situation presented by the family. In many cases, families called the Helpline about a "target" child, but may actually have had more than one child with special needs. As those needs came to light, the workload sometimes tripled. The average time

Navigators spend with families is slightly over three hours, and just under nine percent of the cases exceed the eight-hour limit.

The lower than expected number of cases is making itself felt in the workloads of individual Navigators. Family Navigators are not supposed to handle more than 15 cases at one time. During the interviews one supervisor reported that typically a Navigator only has three to four cases at a time, but that she had seen one with seven. There does not appear to be any danger of exceeding the workload limit in the foreseeable future.

RIGHT TURN (POST ADOPTION/POST GUARDIANSHIP)

The Access Line is supposed to keep callers on hold or in the cue for no more than 100 seconds and to have no more than five percent of the calls abandoned. Once a case has been referred to Right Turn and has been deemed eligible, the first face-to-face contact is to be made within 72 hours and service is to continue no longer than 90 days.

No calls experienced a hold time of longer than 100 seconds and the average hold time was less than nine seconds in both quarters, thus complying with the performance standard.

Right Turn's contract stipulates a call abandonment rate⁸ of no more than 5 percent. With only five calls abandoned out of 238 overall, this objective was met in the first quarter (2% abandonment rate), but exceeded during the second quarter where 6.7 percent of the calls were abandoned. However, no calls were abandoned during the month of June, the last month for which this measure was tested. In total, this comes out to an overall abandonment rate of 3.9 percent for the first six months (15 out of 386 calls), thus meeting the standard.

Unfortunately, it is not possible to determine, from the data supplied by Right Turn to the evaluation project, whether face-to-face contacts are being made within 72 hours. Neither the date the call was received at the Access Line nor the date the Access Line made the referral to Right Turn is included in the database.

Both staff and parents have seen the 90-day service limit as both a motivator and a potential issue. Some have expressed real support for the limit because it makes people work efficiently and many have said it is sufficient to do what needs to be done, with some families needing far less time. However, some staff have asked for a policy or statement about the potential circumstances for extending a case beyond 90 days or re-opening one. Moreover, this was one of the areas in which families registered dissatisfaction with the program. Six of the 23 respondents to the parent survey disagreed that the length of time the program was available to them was about right. The issue was clearly one of duration, since only one of these respondents thought that the number of contacts made was insufficient while case management was being provided.

⁸ An abandoned call is one not answered within 5 rings or 15 seconds.

Some staff thought that more flexibility in the timeframe or extending the timeframe would be beneficial. For example, one Permanency Support Specialist pointed out that some families call the Access Line in May, needing help right away, but they also want help advocating for their child at school. Because the 90-day period will be over before the child goes back to school, the family has to re-refer in order to get assistance from Right Turn when school resumes in the fall. It would be easier if the Permanency Support Specialist could leave the case open past the 90 days, with minimal contact, so that the family does not have to re-refer at the start of the school year.

FIDELITY SUMMARY

All three programs examined here appear to be conforming generally to the specified models. They provide short term assistance to families in crisis because of their children, helping them to find the appropriate services to allow the family to function normally and preferably without having one or more of the children placed out of the home.

The largest fidelity issue may be with the timeliness of the first meeting with families in the Family Navigator program. If the findings here are not simply a function of poor data entry, some families are not receiving face-to-face assistance from the Navigators at all, while others have their first meeting more than three days after their initial call. Given that two-thirds of the families in the program are noted as being in a crisis situation, more timely and more personal responses would seem appropriate.

Both Family Navigator and Right Turn also question the appropriateness of the time limits as an absolute rule for all families (45 to 60 days for Family Navigator, 90 days for Right Turn). While most of the families involved in either program seem to find the service delivery timeframe to be sufficient, some reported needing help for a longer period. In Lincoln, many families seem to be referred to the provider's peer mentoring program at the conclusion of Family Navigator, which performs basically the same functions as Family Navigator but which does not operate with the same time limit. Allowing the programs more flexibility in terms of the overall duration of the service would be a major departure from the original design of the model, but one that is being urged by staff of both the Family Navigator and Right Turn programs.

The only other large deviation from the original design does not involve an issue of fidelity to the model but relates rather to size. While the Helpline originally projected receiving 60 calls per day, it actually receives only a small fraction of that number, with no calls at all on some days. A major marketing effort increased activity for about six weeks, but then the numbers fell back to their previous levels. To this point the result of the reduced volume seems to be that the Helpline staff are able to provide more assistance than they had originally anticipated, and that adds a new feature to the model. To the extent that it is successful in helping families through their crises, it provides an even less intensive means of doing so.

Effectiveness: Service Referral and Provision

NEBRASKA FAMILY HELPLINE

According to the RFP, the primary aim of this service is "to reduce the crisis state of the caller from the presenting level at start of call, identify immediate safety concerns, and provide recommendations and/or referrals for an appropriate course of action." For the Helpline effectiveness entails in large measure making appropriate service recommendations to families and helping them diffuse the problem situations which prompted the call. In some cases that will result in a recommendation to Family Navigator, but for most callers other kinds of service recommendations are sufficient. The Helpline is effective to the extent that it results in effective management of the call, providing accurate referral information and working with the caller to establish a future plan of action based on resources in the community. It cannot be effective if its staff know of no services that are both appropriate and available.

During interviews Helpline staff reported that the services they recommend include everything from counseling to mental health evaluations to substance abuse services to education classes and summer camps. While among the 117 inbound calls reviewed by HZA for the first six months of the project there were 24 in which the caller was given no service recommendations, the reason did not appear to be a lack of available services. Several of these calls were repeat calls in which the caller did not expect to get referrals. One caller even acknowledged that she used the Helpline as part of her support network. Several other callers had legal questions, usually having to do with custody of children, rather than service needs.

During the second quarter of the project, the Helpline made several changes to both the questions staff asked and the data collected. First, the Helpline placed greater emphasis on exploring mental health needs and concerns. Counselors were made more aware of mental health issues and now routinely ask callers whether there has been a mental health evaluation or diagnosis. For families who report a mental health history, the call screens can now capture the specific diagnosis and interventions that have been tried in the past, as well as the outcomes of those interventions. Counselors are also recording the information in a quantifiable manner, rather than in call notes where the information is difficult to extract.

Using the initial data from the new procedures, the Helpline reported that 23 percent of callers indicated that their child had a mental health diagnosis. The most frequently cited diagnosis was Attention Deficit Hyperactivity Disorder (ADHD) (40 percent), followed by bipolar disorder (14 percent), oppositional defiant disorder (11 percent), depression (11 percent) and reactive attachment disorder (4 percent). Moreover, according to Helpline records, 47 percent of those indicating that their child had a mental health diagnosis reported that the child had previously undergone some form of mental health treatment, usually some form of outpatient therapy.

In addition, the Helpline began collecting more detailed information about the service recommendations made by the Helpline. Specifically, a new set of service categories was employed and counselors distinguished between the services that the callers requested and the services the Helpline recommended. Boys Town collected the data manually and conducted an analysis for the families who made a specific service request during their Helpline call (40 percent of all families). Preliminary results show that counselors provided suggestions for more services than the callers requested, with information on 483 services provided compared to only 251 services requested (see Table 5 below). Moreover, families made 137 requests for referrals to mental health services whereas counselors made 225 recommendations for those services. Notably, referral information for residential treatment was the most often requested (81 times, or 59 percent of all mental health service requests), whereas information for community based outpatient services were the most often provided (108, or 48 percent of all suggested services). Residential treatment suggestions were provided 47 times (21 percent of all mental health service recommendations made).

Table 5
Requested and Suggested Service Types

	Requested	Requested (%)	Suggested	Suggested (%)
Mental Health	137	55%	225	47%
Parent Education and Support	55	22%	112	23%
Legal Services	17	7%	56	12%
Child Development and Support	14	6%	37	8%
Substance Abuse	8	3%	25	5%
Education	1	0%	12	2%
Basic Needs	4	2%	3	1%
Health Care	2	1%	2	0%
Benefits	13	5%	11	2%
Total	251	100%	483	100%

FAMILY NAVIGATOR

For Family Navigator services to be effective, the Navigators must identify the families' strengths and needs, match the service plans to those strengths and needs and assist the family in identifying the appropriate services and navigating through the system to connect to those services. To measure the degree to which these standards are met, HZA reviewed 66 Family Navigator case records, 50 of which included service plans. The plans outline family objectives, strengths, stressors and strategies to help them meet their objectives. All the family plans included both strengths and stressors in the families, and all but three included achievable objectives for the family and Family Navigator to

accomplish. In two of the three cases without objectives, the space was simply blank, while the other one indicated that the family made too much money to qualify for help.

When categorized into themes, the most frequently cited family strengths were their love and commitment for one another and their willingness to seek help. The most frequent family stressors were the children's aggressive, violent or destructive behaviors and the parents' inability to cope with those behaviors. Objectives in the plans cover a wide range of issues, including referrals to therapy, psychiatric evaluations, mentoring, support groups, and afterschool/summer programs. Twenty-seven of the 50 plans included at least one objective involving mental health services.

The case plans also exhibited strong internal logic, meaning that the strategies directly built on strengths and addressed the identified needs. An example of a Family Plan, including objectives, strengths, stressors and strategies is included in Table 6.

Table 6 Sample Family Plans			
Objectives	Strengths	Stressors	Strategies
Parent will have access to resources for mentoring programs.	Parent spends a lot of time with family and believes in family time.	Child's father coming in and out of life.	FN will research and deliver Parent resources on local mentoring programs.
Parent will have access to resources for afterschool and summer programs.	Parent is willing to seek services.	Child becoming physically abusive toward Parent.	FN will research and deliver Parent resources for after school and summer programs.
Parent will have access to resources for psychologists.	Parent is committed to children.	Child being disrespectful to family after getting off the phone with dad.	FN will research and deliver Parent resources for local psychologist.
Parent will have access to resources for in home and out of home therapy.			FN will bring Parent a list of in-home and out-of-home therapists.

While many families did connect to services through Family Navigator, often by a referral to Professional Partners, Family Navigators and families consistently reported significant challenges to accessing short-term respite, in-home support services for mental health, counseling for children, and support groups for parents of children with severe mental/behavioral needs. They identified three barriers to obtaining the services to which the Navigators referred the families: distance (or travel time), eligibility criteria and waiting lists.

The first of these, distance or travel time, can be viewed either as a service gap (meaning a service does not exist) or as a service barrier (meaning an existing service cannot be accessed), and occurs primarily in the rural areas of the State. Psychiatrists, day treatment and therapy are often not available in many of the rural areas, meaning that

families must drive to Lincoln or Omaha, or even to South Dakota or Colorado, to obtain services. Multisystemic Therapy (MST) is not available outside of Lincoln, Kearney and Grand Island, while Functional Family Therapy (FFT) is available only in Omaha. This is noteworthy in that these intensive community-based services are intended to replace or mitigate the need for residential placement. In some instances, Family Navigators have encountered scenarios in which the only available provider was too far away and no one could provide transport (for example, a family in Omaha who found the only open respite placement in Grand Island).

The eligibility issue may involve either eligibility for public programs, such as Medicaid, or private insurance, when the insurance does not cover the specific service to which a family is referred or the provider does not accept the insurance the family has. Some publicly-funded behavioral health services (provided through the Regional Behavioral Health Authorities) do not require Medicaid eligibility although there are still income guidelines. Forty-seven percent of families served by Family Navigator do not have Medicaid. In those cases, Navigators report that families struggle to pay for services when private insurance does not cover many mental health services and/or the out-of-pocket expenses are too high. One family reported that it took a month to get approved through private insurance for an updated psychological evaluation. By the time it was scheduled, their 45 days with the Family Navigator were nearly gone.

When the eligibility issue involves public programs, the issue is often the family's income, as with the parent who wrote on the consumer survey:

We needed behavioral help to prevent our child from having to be placed outside the home. We have been trying to get MST services...for 3 months... [S]ervices are being denied to our family because we do not qualify for Medicaid. We were assigned a Family Cares person and a Professional Partner who were unable to help me get MST or any other help in the home.

In other cases the barrier involves getting a formal diagnosis or a referral from another provider. One parent reported, "When I called them directly...I was informed that they will only speak to you if you have been referred by a therapist or a place like Boys Town." Other families reported that if the child is too aggressive, the programs refuse to take him or her. In one case, a family reported that it was denied respite because the child's diagnosis was too severe. Another cited a scenario where the child refused to cooperate when it tried to obtain a formal diagnosis and so some services could not be accessed.

The third major barrier is waiting lists. Even when families meet all the criteria, they report that they may have to wait months for an open appointment – longer than the time allowed for the Family Navigator program. Families get discouraged because they are doing nothing to make changes but waiting to receive needed services. One family wrote: "She did put me in contact with some resources, but none had room for me or my daughter. She checked back with me several times, but we weren't really able to come up with a viable plan for my child." Another stated, "I still would like help with my son...we are waiting for Region 3 at this point."

On the parent satisfaction survey, 12 out of 14 respondents (86%) reported that the Family Navigator helped connect them with services they were seeking. However, five out of 14 families (or just over one third) reported that there were still services that they wanted but could not get. These included residential treatment, respite, counseling and MST specifically. Four of these families indicated that the services they wanted were not covered by their regular insurance and that they were not eligible for Medicaid. However, it is unknown whether these families went through the Medicaid and/or Kids Connection application process, or if they simply made that determination based on publicly available income guidelines. Certain respite and in-home supports are reportedly available for families without regard to income who are involved with Child Protective Services (CPS), but that is because the State has a different set of responsibilities for the children in those families.

RIGHT TURN (POST ADOPTION/POST GUARDIANSHIP)

The effectiveness measures for Right Turn are the same as those for Family Navigator. In other words, the Permanency Support Specialists must identify the family's strengths and needs, develop plans to match those strengths and needs and help families actually obtain the services called for in those plans.

The most frequent strengths identified in the case plans include the love and commitment of the family to the child, the support that the families have from outside family and friends and the openness of family is seek help. In the parent satisfaction survey, 19 out of 20 parents agreed with the statement that the Specialist helped the family use and build on its strengths; this was consistent with the proportion of case plans in which strengths were identified. Families recognize and acknowledge the process of building on strengths. Some of the most prevalent problems identified in the case plans were the child's aggression and educational or vocational issues but even these were identified in less than 20 percent of the cases.

According to the monthly reports issued by Right Turn, families are provided many services directly, such as case management, and are referred to numerous other services. Table 7 shows the services provided to families and those to which they are referred during the most recent three months of the project. The Permanency Support Specialists themselves provide case management so every enrolled family receives that service.

**Table 7
Number of Services/Referrals Provided**

	April	May	June
Total Families Served	100	91	74
Short-term Respite	15	16	5
Mentoring	62	50	41
Education Referrals	32	12	28
Support Referrals	9	146	19
Referrals for Service	209	126	96

Both families and staff report that many services are not available to families, particularly those living in rural areas of Nebraska and especially those in the Panhandle (Region 1). Indeed, in the responses to the parent satisfaction survey HZA conducts at the end of the service, only 13 out of 20 respondents answered "yes" to the question about whether they got the services they were seeking. The services which both staff and families report are unavailable include respite, counseling, and residential placements. Families living in rural areas have to drive several hours to access services such as counseling.

Table 8 below summarizes additional service gaps identified by Right Turn staff, rather than families. These are services where staff who are helping a family have not been able to find something that meets the family's needs. Of note are services for second generational parents whose needs often differ from those of birth parents, services for teenagers who have issues with "sexual inappropriateness" or acting out, services for those with Asperger's Syndrome, inpatient mental health services and in-home services aimed at family preservation. Finding practitioners who are familiar with and trained to work with children who have been adopted was also a need identified across locations.

**Table 8
Service Gaps by Area Identified by Staff**

Omaha	Grand Island, Alliance, Lincoln	Statewide
Programs for teenagers with "sexual inappropriateness"	Services for children with autism, particularly Asperger's Syndrome	Practitioners adequately trained to work with adopted children with complex mental health needs
Inpatient psychiatric hospitals	Services tailored to "grandparents"	Services for children with developmental disabilities
Intensive family preservation services		Adequately trained mentors

The two major barriers reported by the Right Turn staff and families, when services do exist, involved authorizations and waiting lists. These were the same across all locations.

If the family has Medicaid coverage,⁹ it can usually access something, but due to availability this may not be what families feel are the most appropriate services. For example, as described above, a child might be approved for therapy but not with a therapist who specializes in attachment disorders. In two cases, families expressed to the evaluators that they had to "fight" the authorization system to obtain what they needed (in one case the family succeeded in obtaining residential services, in another it was not able to obtain a psychiatric evaluation and eventually reversed the guardianship). On the other hand, staff also reported that families often struggle to distinguish behavioral issues from mental health issues. Children presenting behavioral health issues cannot be authorized for mental health services if they do not meet the clinical guidelines.

Families and Permanency Support Specialists reported that often all of the services needed for Right Turn families exist, but there are not enough providers, which results in long waiting lists, particularly for respite care. This poses a particular problem for many of the families who work with Right Turn because they are often in a state of crisis when they contact the program and cannot wait weeks or months to access services. Similarly, it was reported that some hospitals or other residential settings discharge children to the home with referrals for services, but that children cannot access the services upon discharge due to the waiting lists. That leaves the children in the home with no formal supports or services in place.

EFFECTIVENESS SUMMARY

The majority of the families who approach the Helpline, Family Navigator or Right Turn, appear to get connected to services which are satisfactory to them. Although it is a bit early in the life of the project to be sure, reading the satisfaction surveys tends to give the impression that the families who *do not* get connected are most likely to be those who have already been seeking services for some period of time, without success. This would make sense, because one of the key components of the service is knowledge, and the families who have already been searching for services know what exists and often know the barriers, as well.

Staff at both Family Navigator and Right Turn, as well as the families they serve, identify both gaps in the services available and barriers to obtaining those services. Mental health services, respite and mentoring seem to be in short supply in many parts of Nebraska so that families are not always able to obtain the specific service most appropriate to their needs without traveling long distances.

Both staff and families also report issues with waiting lists. Because the services, when they exist, are in short supply, they may not be able to take a family, even a family in crisis, right away. For the services for which this is a large issue, the need is not for the development of new services, but rather for the expansion of the services which already exist.

⁹ Children receiving federal adoption subsidy, which is a condition of Right Turn, should all be eligible for Title XIX Medicaid by federal law, at least to supplement whatever a family's own insurance does not cover.

Because all families receiving Right Turn case management should be eligible for Medicaid for their adopted children, that program does not face the income barrier that challenges some of the families working with Family Navigator. For the latter it is not sufficient that they are aware of the services which exist; they must also know the eligibility criteria, as well as any exceptions to the normal rules. For instance, Intensive Care Management (ICM) may be available to children under the age of 12 who have had at least one inpatient admission. Moreover, some families may qualify for Kids Connection (Nebraska's State Children's Health Insurance Program funding) even if they already have some type of health insurance. Neither the interviews nor the case readings have indicated the extent to which Family Navigators have attempted to help families maneuver through the barriers they encounter, or even whether, when those barriers involve income eligibility, they are sufficiently familiar with the income criteria, the steps that families must take to obtain eligibility determinations for these services or the alternative services which may be available which do not involve the same restrictions. For some of the families this more extensive help may be necessary.

That applies to both programs in relation to non-financial criteria for service admission. At this point it is not clear to what extent the Family Navigators and Permanency Support Specialists are addressing these barriers by walking families through the steps they need to take, e.g., getting a psychiatric evaluation or a referral from another provider, but their effectiveness will be hampered if they are not doing so.

Outcomes: Benefits to the Clients

The most appropriate measures of client outcomes are those which examine whether the benefits of the intervention endure for some period beyond the end of service delivery. Naturally, providers hope that clients benefit in measurable ways while they are receiving services, but unless the intent is that everyone who ever experiences a crisis should receive services indefinitely, those benefits have to persist well after the service provider is out of the picture.

At the end of the first six months of projects such as those being evaluated here, too little time has elapsed for those kinds of outcomes to be measured. What are available, however, are the clients' impressions of and reactions to the impact of the services they did or continue to receive. At this early stage of the process, this is probably the best indicator of what is likely to be found later. For all three services, therefore, this chapter will focus on the various sources of feedback received from the clients.

NEBRASKA FAMILY HELPLINE

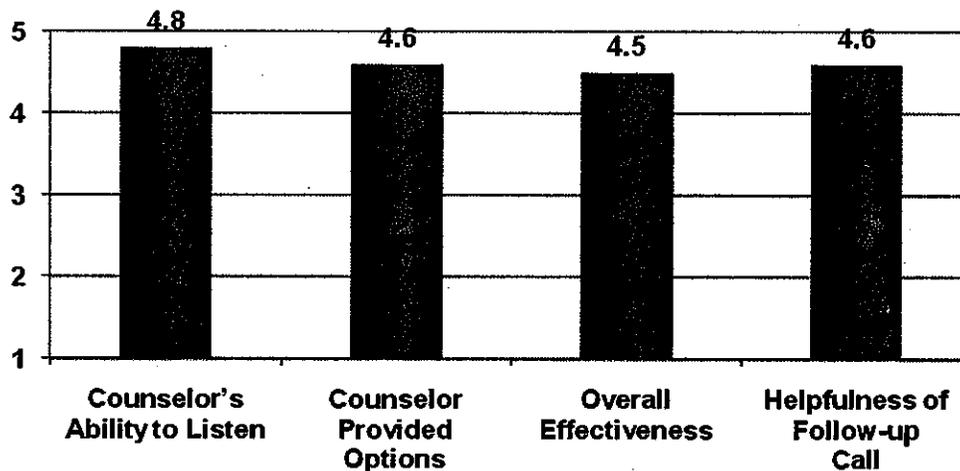
For those calling into the Helpline, the major question which can be answered at this point is whether the family thought it received information on an appropriate service. Based on its review of 135 standard Helpline and high-risk calls to the Helpline, HZA found that although callers often expressed frustration early in the call about the lack of services available to them, they nonetheless appeared satisfied at the conclusion of the Helpline call, in large part due to the moral support offered by counselors but also due to the many service suggestions provided (1,822 over the first six months). Typical of the statements callers made at the end of the calls are the following.

- "I'm calmer now. You have no idea what you've done for me."
- "You've given me so much courage, and a wealth of information."
- "Do you know, I feel better just for talking to you!"

In addition, 50 percent of families who received a follow-up call reported that their situation had improved, and callers indicated that the Helpline was indeed helpful; on a scale of one to five (with five being most helpful), the average consumer rating was 4.3.

Boys Town has instituted a new automated telephone survey that is offered to Helpline callers at the conclusion of the call. Based on 60 responses, callers rated the Helpline on a scale of one to five with five being "excellent." Overall, callers appeared satisfied, as illustrated in Figure 3.

Figure 3
Average Caller Ratings of Helpline



HZA's review of inbound calls corroborates these findings. HZA found that counselors continue to offer moral support to callers by listening to their situations and offering a number of options that range from service referrals to coping skills to parenting techniques. Even when counselors could not address callers' needs or questions directly, they still provided guidance to the best of their abilities. For example, in one case the caller had a specific legal question that the counselor could not address, but she referred the caller to some resources appropriate for answering that type of question.

HZA overwhelmingly found counselors were professional with callers, kept the conversations focused and provided accurate information and advice to the best of their abilities. Of those reviewed, HZA determined that 92 percent of callers were satisfied with the Helpline. Many callers were grateful to have a list of referrals and one was clearly relieved to have an idea of what to do by the conclusion of the call. Another caller stated that she knew the Helpline probably could not help her but she called just to get the chance to talk to someone about the issues she was having with her family. Another stated that it was very helpful to hear the counselor explain how to deal with her daughter's behaviors in simple words. One caller was frustrated because she had called before and was referred to a service but was put on a waiting list. The counselor worked with her to provide other options for the caller to explore in the interim.

In those few cases where the caller was not satisfied, it appeared that the caller was not open to the suggestions being made by the counselor. For example, in one case, the caller rejected all referrals and did not seem willing to work with the counselor from the start. In another, the caller seemed too negative to accept any suggestions.

FAMILY NAVIGATOR

For the Family Navigator program, there are two sources of client feedback: interviews conducted on-site with family members receiving services at that time and a survey of

family members who had completed services. During the first six months of the program, HZA interviewed eight families, while 14 returned completed surveys. The information gleaned from these sources will provide a preliminary exploration of three of the expected outcomes expected of the Family Navigator program, namely, whether children in these families entered care, whether families felt better able to navigate the behavioral health system and whether they were better able to cope with their situations.

In both the surveys and the interviews, families were overwhelmingly positive when asked for broad reactions about their experience. People were impressed that the Navigators call back to check on them and are accessible to talk to them just to touch base. As one parent stated, often "...it is enough just knowing that [Navigator]...hasn't forgotten me." Additional comments include the following.

- "It is nice to know that I have this resource that I didn't know I needed."
- "[Family Navigator] is a gift from God. [Family Navigator] calls, checks up on me, helps me sort it all out, and we have a chuckle."
- "I have tools! I have helpers!"
- "Before, I was like, 'what do I need to do to get [child] into Boys Town?' But this [Family Navigator program] is something new to me, and it is such a help to have a second hand."
- "I feel more confident about parenting."

Among the 14 families responding to the survey questions, the responses were similar. Fourteen reported that the services were timely, 12 that the length of time the Navigator was available to the family was about right, 13 that the number of contacts was about right, 12 that the Family Navigator treated them with respect and 13 that the Navigator demonstrated sensitivity to their cultural and religious beliefs.

All those reactions represent process related reactions, i.e., the families liked having the Family Navigators' assistance. The families' reports about the substantive changes were nearly as positive, with a couple of exceptions. This is demonstrated below.

Table 9		
Proportion of Families Who Agree/Strongly Agree		
Statement	Agree	Total
I feel more confident about my abilities to help my child.	12	14
I have a better idea of how to get help.	13	14
Our family is better able to navigate the behavioral health system.	12	14
I feel more supported by other families.	7	11
I feel that I am better able to make informed decisions.	10	13
Our home situation is more stable.	8	11

The last three lie clearly outside the range of the other responses. Since two of the families did not answer the final question at all and another said it was "not applicable," either stability may not have been an issue or perhaps some of the families are not yet

sure whether their situations are stable. Similarly, two families did not feel that being supported by other families was applicable to them and one skipped that question, suggesting that linking families to peer supports may not always be the most appropriate service.

However those answers are to be interpreted, there were a few families who were unhappy with either the process or the outcome, or both, of their Family Navigator experience. Three of the 14 responding families reported that they did not think the Family Navigator understood their issues and did not believe the Navigator "shared helpful experiences with the mental health system." These were not a homogeneous group, either in terms of the issues that brought them to the program or in terms of what they wanted from it.

The least frustrated of the three families reported wanting help to have its child get passing grades, behave and follow rules. Even so, this family disagreed that the length of time the Navigator was available was right, that the number of contacts was right, or that the Navigator treated the family with respect, understood its issues or built on its strengths. On the other hand, this family reported getting the services it wanted and seemed to have responded negatively because the Family Navigator did not answer phone calls.

The other two families started from polar opposite positions. One was looking for a residential placement for its child, the only family among the 14 for whom this was true. The other was trying to get Multisystemic Therapy (MST) and respite to avoid a placement of the child. The first family complained that the Navigator had not experienced the kinds of issues it was dealing with, did not understand residential admissions criteria and referred the family to service providers who were full. The other respondent had been and continued to be denied MST because the family was not eligible for Medicaid. While many of the responses from this family about the Family Navigator were negative, the major frustration seemed to be with the system: "What system? There are no services. Other than to know now that I'm not missing out on anything because there is nothing." The family expects to have to place the child out of the home.

Despite these cases, most families reported that Navigators offer services, information, and parenting approaches consistent with what parents believe the family needs. They particularly appreciated that the Family Navigators listened to their story first and got their opinions, rather than telling them what was wrong and what they had to do. "She came and talked to me, and asked me what the problem was. She got my opinions of what was going on."

Families also reported that having someone to help them organize themselves and manage service contacts and appointments was extremely helpful. They felt that the planning and goal setting process made obtaining services seem more manageable, and ensured that "things do not get out of control." One family member reported that linking the action steps to the family goals reminded her of why she was doing these things and

helped keep the whole family focused on what they wanted to achieve. Another stated it was a relief to have the Navigator help track and document everything that they were working on so it could be presented to the school and be available in the event of a possible CPS investigation due to the child's continued truancy.

While many more responses are needed to get a good measure of the actual impact of the Family Navigator program, the range of responses suggest that there may be at least two different populations receiving these services. One population seems to present issues which can be handled through some standard service provision, along with some support and encouragement. The other has issues which are more serious perhaps because the issues themselves are more serious but perhaps also because the services needed to address those issues are less accessible. They may not exist at all or they may have very restrictive eligibility requirements or they may be in such short supply that waiting lists are too long for families in crisis.

Whether there are two populations or not, as the evaluation proceeds HZA will pay attention not just to whether the majority of the families receive what they need but also to what happens to those who do not, and what the barriers were. In addition, more concrete information should become available about whether families were able to weather their crises and stay together or whether a failure to get timely services typically results in a separation of the child from the family through some form of placement.

RIGHT TURN (POST ADOPTION/POST GUARDIANSHIP)

The same types of information are available for Right Turn's programs as for Family Navigator, parent interviews and surveys. Although the program is smaller, there were slightly more responses, nine families interviewed rather than eight and 24 family surveys returned compared to 14 from Family Navigator.

As with the outcome analysis for Family Navigator, not enough time has passed to be able to calculate any kind of success rate on the ultimate question the evaluation will need to answer: How many families remain intact because of Right Turn? With that caveat, there are two questions the evaluation can begin to address at this point: whether the families feel more competent to seek and receive help in the future and what percent of the children whose families receive services entered care or had their adoptions/guardianships dissolved almost immediately?

The "almost immediately" is not part of the original research question, but it does get revealed in some of the interviews and surveys HZA conducted. How well it predicts the longer term impact of the program is a question that will need to be addressed later. In other words, one should be neither too pessimistic if a substantial percentage of families almost immediately placed their children nor too optimistic if very few did so. Families in which this occurred right at the start may have been beyond the capacity of any program to help, or they may represent the proverbial tip of the iceberg. Only further follow-up will tell the difference.

As was the case with Family Navigator, families are extremely pleased with Right Turn. As one stated, "It was a healthy and reviving experience." Families appreciated the many instances where Specialists accompanied them to school meetings and advocated for the children in school. This was perceived as particularly helpful by parents. One parent called her Specialist a "go getter" who was "not afraid to ruffle some feathers." The parent said, "She fights for me." Specialists also help empower families by giving them ways to understand their children's behaviors and how to respond to them. One family noted, "She gave me an evaluation booklet...that helped put my daughter's behaviors into groupings. She is helping me develop behavioral charts to use at home."

Several families were also very pleasantly surprised that the Specialists were concerned about the parents' needs and understood their need for support. Many had experienced the opposite in prior encounters with providers. As one family stated, "Just knowing that she understands what our family is going through and wants sincerely to help is a wonderful feeling." Those who accepted a mentor were also finding it helpful. One said, for example, "I can go to my family and they tell me I haven't done enough, but my peer mentor is non-judgmental."

Survey responses were generally just as positive as the reactions given in the interviews. Of the 24 parents who completed services and returned their anonymous surveys, the following table shows the proportion who agreed or strongly agreed with a series of outcome statements.

Table 10
Proportion of Families Who Agree/Strongly Agree (N = 24)

Statement	Agree	Total
I feel more confident in my abilities to help my child.	19	21
I feel my child or family is safer.	19	21
I have more informal support.	18	21
I have a better understanding of my child's needs.	16	18
I have better parenting skills.	15	17
I have a better idea of where to get help.	16	19
I feel our family can remain intact without placing my child somewhere else.	14	17
I have a better understanding of adoption issues.	10	13
I have a better understanding of my child's diagnosis.	10	15

As with the Family Navigator program, there were some dissenting voices among these generally positive reactions. There was a difference, however. The negative comments seemed to have much less to do with Right Turn and more with the service system to which the Specialists tried to refer families. For instance, no one reported that the Specialist did not understand the family's issues, only one family said that the Specialist did not treat the family with respect or know what services were available and only two reported that the Specialist did not know how to access services.

Where the answers were more frequently negative was in relation to the services. Eight of 22 respondents said that the Specialist had not helped them get connected with the service providers they were seeking, six of 23 disagreed that the length of time the Specialist was available to the family was about right and seven of 22 disagreed that they got as much help from the service providers as they needed. The only one of these over which the program really might be said to have some level of control is the one about connecting the family to the service provider it wanted.

Perhaps the most extreme situation in which a family felt Right Turn had done everything it could but that the service system had failed is reflected in the following responses to a series of the survey's questions. The following three statements are from a single family.

Right Turn Specialist gave every effort but we could not get child admitted without a full psych eval, and Magellan would not cover it. Plus the child was uncooperative toward that goal.

The major roadblock was twofold - finding a psychiatric professional willing to work when Magellan would be paying the bill, and getting Magellan to approve the evaluation. Eventually we ran out of time.

Unfortunately, we had to reverse the guardianship.

A second case which resulted in placement of a youth was reported by parents in the following way.

Medicaid was refusing service and was looking at the bottom line and not the safety risk of our child to himself and other family members...we finally persisted and got him into residential with the help of his psychiatrist. Medicaid did not help our son at all. The system is reactive, not proactive.

As with Family Navigator, the interview and survey responses suggest a wide range of levels of seriousness in the issues families bring to Right Turn. The extent to which all of those levels can be addressed will be dependent not only on the program but also on the larger service system on which it depends.

OUTCOME SUMMARY

Less can be concluded about the programs' success on outcomes than is true with either fidelity or effectiveness. To the extent that consumer reactions reflect actual results, all of the programs appear to be highly successful. Even when no service referrals are made, families seem grateful for the chance to talk about their issues with someone who is sympathetic.

What needs to be watched during the remaining months of the project are not only the actual results, but also the group of families who do not share the majority's view. As

suggested above, some of these may be families in such crisis that no program could help them effectively. Others may have been seeking services for their children for substantial amounts of time and either be aware that there is nothing appropriate for them or face access barriers neither they nor the Navigators and Specialists can overcome. By studying what happens to these families, the evaluation can help define the population for which these programs can be effective.

Summary of Findings and Recommendations

The Nebraska Family Helpline, Family Navigator and Right Turn programs all represent experiments. In the face of complaints about a lack of mental health services for troubled youth, the State's first step was to establish programs which would assist families in finding the services and supports which do exist in a highly supportive family-friendly context. In other words, the first hypothesis to be tested was: to what extent is the problem primarily one of knowledge of the available services and support in connecting to those services?

Each of the programs was established with certain parameters. The Helpline was designed as an initial screening process in which it was expected that 80 percent of the cases could be handled during the phone call, while 20 percent would need to be referred to Family Navigator. The latter program was defined as a short-term planning and referral service for families, most of whose families were expected to have children with mental health issues. The program was designed to be limited in both duration (45 – 60 days) and intensity (eight hours of contact). Right Turn was designed to deal with adoption and guardianship issues, specifically for families whose children had previously been State wards and who were now receiving subsidies for the support of those children, but probably few if any other services. Its duration was also limited, like that of Family Navigator, but to 90 days.

Perhaps the largest surprise, given the initial expectations of the programs, has been the low number of consumers asking for help. While the initial Request for Proposals, based on national averages, projected that the Helpline should expect to receive an average of 60 calls per day, it has never received more than one-third of that and averages only five. As a result, despite the fact that the Helpline refers 30 percent of its callers to Family Navigator rather than the projected 20 percent, the latter's caseload is also below expectations. If one measures the size of the problem not in terms of the seriousness of the problems some families face but rather in terms of the number of families affected, it appears to be smaller than anticipated.

There may also be an issue hidden within the difference between 20 percent and 30 percent of the Helpline's referrals going to Family Navigator. If the Helpline counselors are unable to resolve as many of the service needs of the families as had been expected, despite having more time to spend with each family, then perhaps a higher proportion need the hands on support provided by Family Navigator or perhaps the barriers to accessing services are greater than knowing what is appropriate or where they are. Certainly, the Family Navigators and Permanency Support Specialists appear to believe this to be true, and some of the families echo their sentiments.

To find out whether that is the case, and ultimately to determine whether these kinds of navigating and case management services can make a substantial difference in the accessibility of mental health services, more work will need to be done. To ensure a

complete test of the model, HZA makes the following suggestions for the remaining months of the project.

Recommendation 1: The Family Navigator and Right Turn programs should ensure there is an emphasis on helping families actually get connected to services, walking them through all of the necessary steps, including those involving other agencies and providers.

While Family Navigators and Permanency Support Specialists will not be able to connect families to services which are either non-existent or too far away from where the families live, they may be able to help overcome some of the eligibility barriers. For those that are income related, this may mean a greater awareness of the Medicaid rules, including all of the exceptions and special conditions which might make a family eligible, or greater awareness of the State-funded behavioral health programs whose income guidelines are more generous. In those instances where the issue is either private insurance coverage or clinical or programmatic conditions, the Navigator or Specialist may need to help parents figure out what all the steps are and even to help them take those steps; they should record the efforts and results to help document service gaps and barriers.

Recommendation 2: To make it possible for Navigators and Specialists to complete the process of connecting as many families as possible to the services they need, DHHS should consider altering the time limit for the most difficult cases.

No group thought that the time limits on services are inappropriate for the majority of families, but both families and staff thought that for some families the limits prevent some from completing the connections to services. Exceptions might be made on a case-by-case basis or a rule could be created that specify the conditions under which longer services are permitted. If no cases are permitted to receive navigation and case management services longer, however, both staff and families are likely to conclude that the barriers to access are more difficult than they are.

SOAR: A Tool To Reduce and Prevent Homelessness

Charles Coley
Nebraska Homeless Assistance Program (NHAP)
Division of Children and Family Services
DHHS

SSI and SSDI: The Basics

- SSI: Supplemental Security Income; federal benefit rate is \$674 per month in 2009; provides Medicaid in most states
- SSDI: Social Security Disability Insurance; amount of benefit dependent on earnings put into SSA system; Medicare provided after two years of eligibility in **most** instances
- The disability determination process for both programs is the same; when one applies for SSI, they are reviewed by SSA for their eligibility for SSDI as well

Why is Access to SSI and SSDI So Important to Individuals?

- SSI/SSDI can provide access to:
 - **Housing**
 - Income
 - Health insurance
- Preventing or ending homelessness
- And promoting **recovery!**

Why Is Access to SSI and SSDI Important for States and Localities?

- Homeless people are frequent users of expensive uncompensated health care
- Providers can recoup cost of uncompensated health care from Medicaid for up to 3 months retroactive to date of SSI eligibility
- States that fund health care for low income and/or disabled persons can save state dollars once Medicaid is approved
- States and localities can recoup from SSA the cost of public assistance provided during SSI/SSDI determination period
- SSI, SSDI and Medicaid bring federal dollars into states, localities and community programs

The Problem: Why SOAR is Needed

- Only about 10-15 percent of homeless adults who apply are typically approved on initial application
- Only about 37 percent of **all** applicants are typically approved on application
- Appeals take an average of 2 years and many potentially eligible people give up and do not appeal

What We Know Is Possible...

Approval rates of 65-95%
on initial application

SOAR Technical Assistance Initiative

- **SOAR** stands for SSI/SSDI Outreach, Access and Recovery
- Sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA); **No direct funding provided to States or localities**
- Helps States and communities increase access to SSI/SSDI through:
 - Collaboration and strategic planning
 - Training
 - Technical assistance

Uses SAMHSA's *Stepping Stones to Recovery* Training Curriculum

- Based on success of University of Maryland Medical System Baltimore SSI Outreach Project
- Achieved success rate on application of 96% for those deemed likely eligible
- Comprehensive approach to individual's needs with income as the "hook"
- Engagement, relationship, and assessment are integral parts of project and curriculum

37 States Participate in SOAR

- Alabama
- Alaska
- Arizona
- Colorado
- Connecticut
- DC
- Delaware
- Florida
- Georgia
- Hawaii
- Indiana
- Kentucky
- Louisiana
- Maryland
- Massachusetts
- Michigan
- Minnesota
- Montana
- Nevada
- New York
- New Hampshire
- New Jersey
- North Carolina
- Ohio
- Oklahoma
- Oregon
- Pennsylvania
- Rhode Island
- Tennessee
- Texas
- Utah
- Virginia
- Washington
- West Virginia
- **Nebraska, Iowa, Kansas**

NEW Data from SOAR States

- As of August 2009, **71 percent** of the 4,386 persons assisted in 32 states were approved for SSI in **89 days** on average
- In 2009 alone, SOAR-assisted SSI recipients will bring \$25.4 million into the state and local economies of these 32 states

Approval Rates Are Highest...

- In places where more SOAR critical components are able to be implemented

Successful Models: Nashville

- Nashville's 10-year plan funds 3 positions in community mental health center
- 94 percent of first 158 applications approved in average of 70 days
- Works closely with medical records staff of local primary care clinics and hospitals
- Outreach ensures contact with applicants
- Treatment provided in agency where SSI project is housed

Successful Models: Utah

- SOAR based in Department of Workforce Services (public assistance agency)
- Rolled out in Salt Lake City initially; rest of state started in September 2008
- Recovered \$2 million in state general assistance funds from SSA in Salt Lake City alone
- Has done 662 applications with 82% approved in 122 days

Successful Models: Portland, OR

- Strongly linked to provision of housing
- Approval rate of 88% on 82 applications in average of 49 days
- \$300,000 of past medical bills became reimbursable through retro Medicaid for 12 applicants
- Funding from local hospital, foundation, City of Portland and Portland Housing Authority

Successful Models: Philadelphia

- State contracted with Homeless Advocacy Project (HAP), a program of attorneys and paralegals
- Two SOAR trainers at HAP:
 - Train community social workers to do applications
 - Perform quality review for all applications
 - Track outcomes
- 98% of first 96 applications approved in 30 days

Successful Models: Collaborations with Corrections

- SSI applications done prior to release from **Sing Sing prison** by a community services agency in NYC
- Same staff who does applications follow folks in community and access housing for them
- 89% of 100 pre-release SSI applications approved in 59 days on average
- SOAR in **Miami jail diversion** program; 77% of 146 applications approved in 70 days

How Is This Model Different?

- **Case managers** actively assist applicants and develop evidence
- Focuses on the initial application – **“Get it right the first time!”**
- **Avoids appeals and consultative exams** whenever possible
- **Focuses on documenting the disability**

Successful Models: Staffing Incorporates...

- Serving as appointed representatives and doing outreach
- Ensuring collection of all medical information
- Collaboration with community medical providers
- Writing medical summary reports
- Ongoing communication/collaboration with SSA & DDS
- Conducting evaluations as needed
- **Tracking outcomes**

How Have States and Communities Funded SOAR Efforts?

- State or local plans to address homelessness (TN, PA, MN)
- Collaborations with hospitals (KY, RI, TN, GA, OR)
- **State PATH programs (MI, GA, AL, VA, WI, NC)**
- Foundations, United Way and other non-governmental funders (OR, RI, Palm Beach, FL; CA)
- Applying for VISTA or Americorp volunteers (TN, MI, NC)
- State or county general assistance programs (UT, NY, WA, FL, MN)
- Working with corrections on re-entry (NY, MI, Miami, Contra Costa, CA)
- **Using outcomes to argue for additional resources (UT, PA, KY, TN)**
- Partnering with schools of Social Work for internships (MI)
- Asking state medical association for retired physicians to do pro bono assessments (WV)

Nebraska: Official SOAR State

- In June 2010, Nebraska was named an “Official SOAR State”
- This designation came from Policy Research Associates (PRA), the Federal entity implementing SOAR nationally
- PRA receives SAHMSA funding for its SOAR work
- SOAR Nebraska Forum held September 10th (*Director Adams, thank you!*)
- Strong collaboration between BH and CFS
- **Why NHAP:** Housing and benefits acquisition linked

Official SOAR State: What It Means

- Nebraska receives Federal technical assistance for SOAR implementation
- **SOAR=Data+Training**
- Via designation as an Official SOAR State, local SOAR efforts will be strengthened and case management trainings will be conducted statewide

SOAR Trainings

- Training materials free of charge to Nebraska (*no small thing*)
- Trainings only conducted by SOAR-certified trainers (several NE trainers at present)
- SOAR training in Omaha next Monday/Tuesday; SOAR training in Lincoln February 2011; greater NE trainings upcoming
- SOAR State Committee formed

SOAR NE: Where we're at now

- In late 2008, two locally grant-funded SOAR initiatives began: Lincoln's **CenterPointe** and Omaha's **Community Alliance**
- These two programs have been active participants within their respective BH regions and Continuum of Care regions
- Success of these two programs=**NE as Official SOAR State**
- Without these two programs, there is no SOAR Nebraska

CenterPointe: SOAR Lincoln

- 57 Approved
- 9 approved on appeal
- 72 applications
- 48 approved upon first application
- Allowance rate (% approved): 67% initial app, 79% including reconsideration
- Average time for decision – 73 days
- Funding through June 30, 2012

Community Alliance: SOAR Omaha

- Total # applications: 109
- Total # decisions: 91
- Total # approved (on initial application only): 57 initial apps, 66 initial and reconsideration
- Allowance rate (% approved): 63% initial app, 73% on reconsideration
- Average Time to decision (in days: day the full application is done, inclusive of the disability report – to our receiving): 99.7 days
- Funding through June 30, 2011

Where do we go from here?

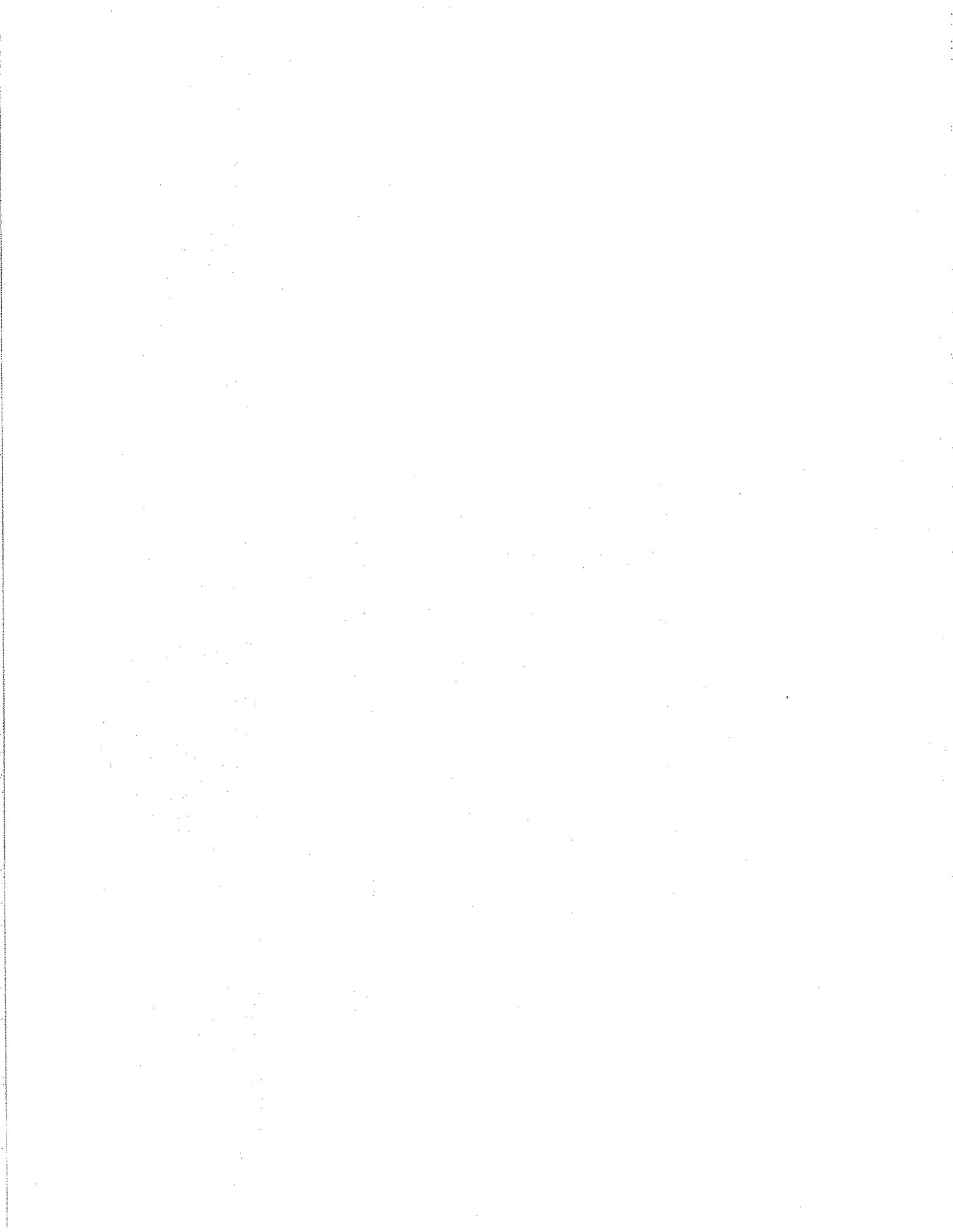
- **More SOAR statewide trainings:** get this best practices model out in the field!
- **Collect data:** data submitted via NHAP will reflect reality and success of SOAR NE
- **Ensure support for current two SOAR projects:** CenterPointe and Community Alliance (*don't reinvent the wheel*)
- **Continue BH/CFS collaboration**

For More Information...

Visit the SOAR website at www.prainc.com/soar

Or contact:

Charles Coley
NE SOAR State Team Lead
(402) 471-9200
charles.coley@nebraska.gov



State Implementation Report CMHS Block Grant 2010

Summary of Adult and Youth Indicators

Framework

- The indicators in this 2010 report were developed by the DBH MHBG Federal Aide Administrator.
- The indicators discussed with my last visit to the council will be on the FY2011 report.
- Data sources primarily DBH Annual Consumer Survey, Magellan/DBH Data System, or DBH stand alone systems (housing, PPP, etc.)

MHBG Indicators

- There are 21 Adult indicators
- There are 18 Youth indicators
- States are required to develop a goal and target for each indicator each year
- Targets for this report were developed by the DBH Committee of One – moving forward this is incorporated into the QI infrastructure

2010 Overview Adult Indictors

- 12 of 21 indicators achieved the target
- 4 of 21 indicators did not achieve the target
- 5 of 21 indicators were marked Not Applicable

2010 Adult - Achieved Targets

- *Reduce utilization of Psychiatric Inpatient Beds, 30 day readmission rate to State Hospitals (page 42)*

– Target = 3%

– Achieved = 2.67%

2010 Adult – Achieved Targets

- *Reduce utilization of Psychiatric Inpatient Beds, 180 day readmission rate to State Hospitals (page 43)*

- Target = 7%

- Achieved = 5.33%

2010 Adult – Achieved Targets

- *Numbers of persons served in Supported Housing (page 46)*
 – Target = 700 **Achieved = 8⁴32**
- *Number of persons in Supported Employment (page 48)*
 – Target = 400 **Achieved = 686**
- *Number of persons served in ACT (page 49)*
 – Target = 250 **Achieved = 278**

2010 Adult – Indicators Not Achieved

- Access to services (page 40)
- Persons served (page 64)
- Services to Rural Population (page 68)
- Count of EBP implemented in NE (page 44)

Primary reason for 3 of 4 is the data system clean up project. Counts were artificially elevated in previous years and lowered the number reported in 2010.

The count of EBP's needs to be clarified and cleaned up.

2010 Adult – Indicators Not Applicable

- Persons served in family psycho education (page 50)
- Persons served in Illness Self Management Programs (page 52)
- Increase or retention in persons employment (page 56)
- Decrease in criminal justice involvement (page 57)
- Increase in stability of housing (page 59)

2010 Overview Youth Indicators

- 10 of 18 indicators achieved the target
- 1 of 18 indicators did not achieve the target
- 7 of 18 indicators were marked Not Applicable

2010 Youth – Indicators Achieved

- *Client Perception of Care – Percent of persons responding positively about outcomes (page 81)*

Target = 55.50

Achieved = 62.72

- *Client Perception of Care - Increased Social Supports/Social Connectedness percentage (page 85)*

Target = 80

Achieved = 85.78

2010 Youth – Indicators Achieved

- *Client Perception of Care – Percent of persons reporting improved level of functioning (page 86)*

Target = 59

Achieved = 64.04

2010 Youth – Indicators Not Achieved

- *Number of children participating in the PPP (page 87)*

– Target = 415

Achieved = 345

Primary reason for not achieving the target was the data system clean up project. Counts were artificially artificially elevated in previous years and lowered the number reported in 2010.

Recent work with the data team

2010 Youth – Indicators Not Applicable

- Numbers of EBP (page 76)
- Children with SED receiving Therapeutic Foster Care (page 78)
- Children with SED receiving FFT (page 80)
- Children Return to/Stay in School (page 82)
- Decrease in CJ involvement (page 83)
- Increase stability in housing (page 84)
- Children enrolled in ICCU (page 93)

Praise for Achievements

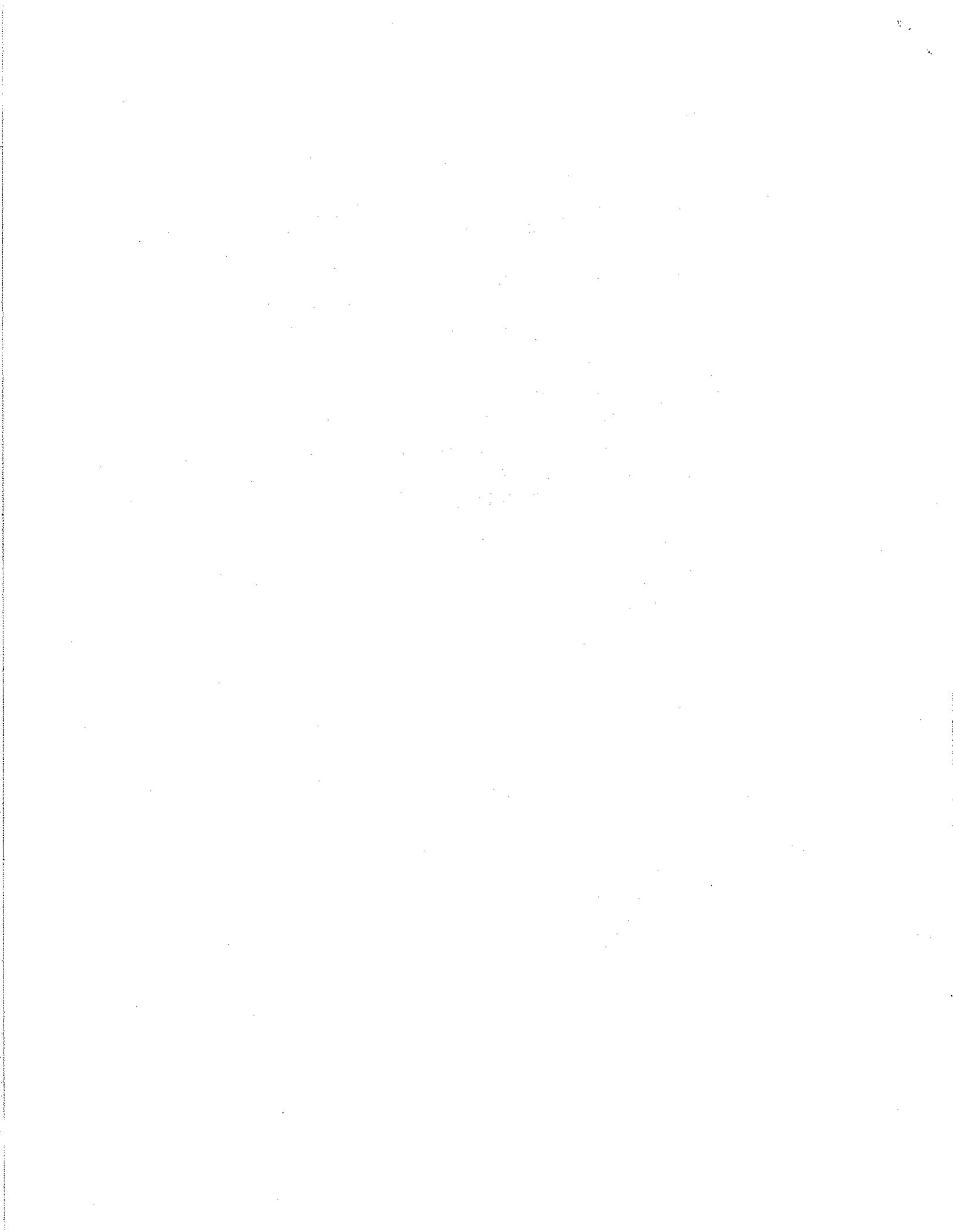
- Excellent work is occurring in the service system to promote consumer recovery and improve outcomes.
- We are developing a culture that is data-driven and believes in the value of quality improvement and involves consumers.
- Many individuals provided leadership at a variety of levels to make a difference in the lives of consumers we serve
- DBH re-organized and is integrating the talents of the data team with a variety of workgroups and processes

Opportunities for Improvement

- Indicator and target development will be integrated into the current QI and DBH data team infrastructure
- Continue efforts with data system cleaning and education on processes (MQIT)
- SQIT Quality Initiative for the Consumer Survey
 - Improve the survey process, methodology and target increase in both adult and child response rates
 - Review the survey results and identify strategies for improving outcomes and other scales

Opportunities for Improvement

- Clarifying specific EBP for youth and adult populations in Nebraska in the MHBG to clean up reporting and achievement parameters;
 - Work on Medication Management EBP
- Do we agree Nebraska would like to increase the number of individuals receiving services as an EBP? If so, need to develop ongoing process for implementation and the monitoring of EBP fidelity



**Special Initiative for State Mental Health Authorities
(SMHAs) to Address the Impact of the Economic
Downturn through Employment Development
*APPLICATION***

(Proposals Due to NASMHPD by November 19, 2010)

Introduction

In an effort to assist states in planning and implementing activities to foster increased employment opportunities for people with mental health and/or substance abuse disorders, the Substance Abuse and Mental Health Services Administration (SAMHSA) and its Center for Mental Health Services (CMHS) created the "Special Initiative for State Mental Health Authorities (SMHAs) to Address the Impact of the Economic Downturn through Employment Development." This project will provide, on a competitive basis, modest funding awards to States, the District of Columbia, and the Territories. For FY 2011, CMHS will award grants averaging \$103,000 to nine (9) states or territories. In addition, each grantee will receive two (2) consultant technical assistance visits coordinated and paid through NASMHPD's portion of the project.

These flexible employment funds will be used to identify, adopt, and strengthen employment and activities that can be implemented in the State, either through a new initiative or expansion of one already underway, and can focus on any portion of a state system which is working to improve or create employment opportunities to those served in a public mental health system.

Applications will be judged on the following criteria:

- Demonstrating ongoing significant collaborative efforts with SSAs;
- Identifying and adopting best/evidenced-based practices in order to maintain and/or enhance supported employment programs which will increase employment opportunities for people with mental illness and substance abuse disorders;
- Maintaining program integrity through multi-agency collaboration and by engaging performance management tools;
- Identifying appropriate performance measures and anticipating and reporting on plan outcomes and;
- Involving consumers and families in the development and implementation of the initiative.

Consideration will also be given to proposals that:

- Incorporate realistic timeframes, concrete activities, and measurable outcomes for the proposed initiative;
- Identify other state resources and infrastructure which can leverage these award funds for the proposed initiative; and
- Identify a quality experience and track record of the proposed state-level Project Coordinator.

States should choose an initiative which will best use these federal investment dollars to assist their overall employment efforts and outcomes. Examples of potential initiatives include conducting a state needs assessment, forming a Mental Health Employers Consortium to work with businesses that pledge to hire mental health consumers, strengthening peer support programs by establishing Medicaid reimbursement or expanding to incorporate whole health components, creating a formal interagency group with representatives of mental health, substance abuse, vocational rehabilitation, and workforce development to develop joint programs and projects, or supporting a pilot One-Stop Career Center to enhance blended or braided funds to support cross-system efforts. *When choosing your proposed initiative, please keep in mind the SMHAs requirement for measurable outcomes and the short period of time from proposal to implementation to reporting of initiative outcomes.*

SMHAs Timeline

- *November 19, 2010* - By 5:00pm EST, all proposals are due to NASMHPD. Please see submission details below.
- *Mid-December 2010* – Employment awardees are selected and announced by CMHS.
- *Late-December 2010 – January 2011* - Subcontracts are initiated, finalized, and signed.
- *September 15, 2011* – All projects will be completed and final reports submitted to NASMHPD.
- *September 29, 2011* – NASMHPD submits comprehensive final report to CMHS.

Proposal Requirements

I. Initiative Description and Projected Budget

In three (3) pages or less, please describe your proposed initiative, how it would fit into your state's larger employment goals, how it would improve your mental health system and/or other systems, and specifically the activities you would fund using your subcontract, if awarded. Make sure to identify the following items:

- Other agencies or organizations which will be collaborating with you;
- Other resources and infrastructure, in-kind, as well as financial, which you may use to leverage these award funds;
- Consumer involvement in the planning and if appropriate the implementation of the initiative;
- Specific measurable outcomes you plan to achieve with this initiative; and
- Sustainability plans after the funding is exhausted.

NOTE: As many of you know, the federal government prohibits spending technical assistance grant funds on food, beverages, and purchasing of equipment such as computers or other infrastructure/administrative items. There are also spending limits on certain items, such as a \$1,000 per ticket cap on air travel. Please feel free to call with any questions pertaining to items that you may or may not include in your proposal.

II. Initiative Timeline

In one page or less, please outline projected timeframes for your initiative. From implementation in December 2010 to a final report in September 2011, chart the projected path of your project and tie those timeframes to your projected measurable outcomes.

III. Initiative Coordinator

Designate an individual within your State office of mental health to be the coordinator and contact person for your Employment initiative. This person will be the main contact person with NASMHPD and CMHS, and will need to have the ability to negotiate and oversee deliverables for this project. Please include their contact information within your proposed submission.

IV. Fixed-Priced Subcontract

In one page or less, please describe your state or department's contracting process. Each Employment awardee will be expected to quickly (within 4-6 weeks) approve and sign a fixed price subcontract with NASMHPD, outlining the work and outcomes each state will accomplish and produce under this technical assistance project. Deliverables under this subcontract include monthly written and oral status reports and a written final report. Given the short timeframe of this project, from award to final report, please outline how your contracting process will not hamper your ability to deliver your proposed outcomes in a timely manner. A sample subcontract, similar to the one that we will be asking you to oversee for approval and signature, is attached to this email.

Submission of Proposal

By 5:00pm EST of November 19, 2010, all proposals are due electronically or via certified mail to David Miller, NASMHPD Project Director. The proposal needs to be sent by, or on behalf of, the State Mental Health Commissioner/Director, with the acknowledgement that the proposal has his or her approval. Mr. Miller's contact information is as follows:

David W. Miller
Project Director
NASMHPD
66 Canal Center Plaza, Suite 302
Alexandria, VA 22314
(703) 682-5194
david.miller@nasmhpd.org