[LR338]

The Committee on Health and Human Services and the Committee on Appropriations met at 9:00 a.m. on Thursday, November 6, 2008, in Room 1510 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LR338. Senators present: Tim Gay; Dave Pankonin; John Nelson; Arnie Stuthman; John Harms; and Tony Fulton. Also present: John Synowiecki; Tom Hansen; Danielle Nantkes; and Joel Johnson. []

SENATOR GAY: We'll get started, everyone checking in, and thanks for coming today to LR338--Senator Johnson, it's an interim study to conduct research and develop recommendations relating to the implementation of the Nebraska Behavioral Health Services Act. This is a joint with the Appropriations Committee so we welcome them, and it's great to have them here since they're such a crucial aspect of whatever we do needs to be funded. But we'll start off--there's plenty of people here to talk today. I'm going to turn this over to Senator Johnson, who has been a leader on that, and this is his resolution so I want to turn it over to Senator Johnson right now. [LR338]

SENATOR JOHNSON: Thank you. Senator Gay, one of the things that we might do is to formally start this by instead of we going through and introducing people, let's just go around the room and, Senator Synowiecki, would you like to start and say who you are and who you represent and so on and then we'll just go around the room. [LR338]

SENATOR SYNOWIECKI: Well, thank you. I'm John Synowiecki, District 7. [LR338]

JOHN NELSON: Thank you, Senator. I'm John Nelson, District 6, central Omaha. [LR338]

SENATOR HARMS: John Harms, 48th District, the Scottsbluff area. [LR338]

SENATOR FULTON: Tony Fulton, District 29, south central, southeastern Lincoln. [LR338]

JEFF SANTEMA: Jeff Santema, legal counsel to Health and Human Services Committee. [LR338]

SENATOR GAY: Tim Gay, Senator, District 14,, Papillion-La Vista. [LR338]

SENATOR PANKONIN: Good morning. Dave Pankonin, District 2, which is Cass, southern part of Sarpy, and Nebraska City area. [LR338]

SENATOR STUTHMAN: Arnie Stuthman, District 22, from Platte Center. [LR338]

SENATOR JOHNSON: [LR338]

SENATOR JOHNSON: And Joel Johnson, District 37, Kearney and Kearney County. [LR338]

SENATOR NANTKES: Good morning. My name is Danielle Nantkes, and I represent north Lincoln, "Fighting" 46th Legislative District. [LR338]

ERIN MACK: I'm Erin Mack, the committee clerk. [LR338]

SENATOR JOHNSON: And I thought we had another person representing the Appropriations Committee here as well, but I don't see--oh, there you are. Why don't you stand up and introduce yourself. [LR338]

SANDY SOSTAD: I'm Sandy Sostad (inaudible). [LR338]

SENATOR JOHNSON: And in the audience I see Senator Tom Hansen as well who is a

member of the Health and Human Services Committee. Tom, you want to stand? [LR338]

SENATOR HANSEN: District 42, Lincoln County. [LR338]

SENATOR GAY: All right. Go ahead, Senator Johnson. [LR338]

SENATOR JOHNSON: Senator Gay and members of both committees, for the record I'm Senator Joel Johnson, J-o-e-l Johnson, J-o-h-n-s-o-n, representing the 37th Legislative District. I'm here this morning to introduce LR338. This is an interim study to conduct research and develop recommendations relating to the implementation of the Nebraska Behavioral Health Services Act. This is done with both of the members of the Health and Human Services Committee and the Appropriations Committee. Colleagues, for the record let me start with this. I introduced this resolution for three primary reasons. First, to educate members of the Legislature about the contents of the Nebraska Behavioral Health Services Act and its implementation. This is LB1083 and it was originally passed in 2004 as the vehicle to bring about substantial reform of the state's behavioral health system. The initiation of term limits has severely affected the Legislature's institutional memory with respect to this piece of legislation. You are some of the people who at least have some memory of this taking place. Secondly, I would introduce this resolution to provide general orientation to the behavioral health policy and how Nebraska compares with other states on a variety of these issues. You will hear from Dr. Noel Mazade tomorrow morning on this topic particularly, as a nationally known person. Thirdly, I introduced the resolution to identify and discuss various future challenges that still remain and to develop necessary and appropriate legislation for the next session of the Legislature so that we make sure that we continue to move behavioral health reform forward in this great state. I have provided you with some background information to begin this full day and a half of hearings. The hearings have been arranged by topic with consumers and family members being given the "final word" tomorrow morning. This is only appropriate because LB1083 was drafted and

passed with consumers as its primary focus. I want to thank you in advance for serving on this committee. You will be the ones who help lead the ongoing discussion on these issues with your colleagues in the upcoming session of the Legislature. I want to highlight one issue that is particularly important to me personally and that is in the area of health work force development. Recent hearings by the Developmental Disabilities Special Investigative Committee under LR283 and the recent national attention being given Nebraska's safe haven law have once again highlighted the pressing needs that many individuals and families have and the need for a trained and available and available work force, including peers with real-life experience and a variety of other people and organizations to help them. This I see is a critical need and I want to emphasize the importance of doing all we can in partnership with individuals and communities to see that services are available for those that need them. We have seen encouraging progress in the last four years of LB1083 in making the transition from an institutional-based system to a more community-based and recovery-oriented system. Reorganization of HHS and I personally believe in the quality of personnel within this organization have made it so that we are making substantial progress, but we must continue to move forward with our discussions over the next day and a half. Look forward to the testimony provided by some great people over the next day and a half and would thank you personally at this time for your interest and concern regarding this. I think it would be inappropriate to go into a discussion of questions of me at this time. Let's hear from the people that have knowledge and expertise about what we're talking about. Senator Gay. [LR338]

SENATOR GAY: Thank you, Senator Johnson. Thank you very much, Senator Johnson. I agree--there's a lot of topics to be covered here today, and we have a lot of people who would like to inform us as senators what's going on. Of course, we can ask questions. You all got a copy of a time line. This is a guideline we're going to try to follow. You know how that goes. But if we need any follow up, Jeff and Sandy, I'm sure we can get all the information we need. But I think today is a good time we're going to start out with Scot Adams is going to give us an overview. But today just for everybody's

knowledge, I guess, you have a copy of the agenda. I know some people will come up as panels, some as individuals, but we'll try to listen to you as much as we can and then we'll ask some questions at the end when you're done. We don't want to rush anybody, but there's a lot to be covered here in a day and a half. So that's kind of the plan and we'll see how it goes from there. So we'll start off with Scot Adams and welcome, Scot. [LR338]

SCOT ADAMS: (Exhibit 1) Thank you very much and good morning. This is an important time, and I'm happy to be here to be part of this. Reform across the country has been going on for some time, and today's effort recognizes Nebraska's efforts in that regard. I think there is some good news and some challenges left to attend to, as Senator Johnson said. Here are some packets. Thank you, sir. My name is Scot Adams, S-c-o-t A-d-a-m-s, director of the Division of Behavioral Health in the Department of Health and Human Services. I am here to testify about the implementation of LB1083, the Nebraska Behavioral Health Services Act, which went into effect on July 1 of 2004. There we go with that. You know, there's a great slide behind this screen. Very good, thank you, appreciate it. Thank you, Jeff, I appreciate the technical assistance on that. My presentation will identify progress in the last four years, identify challenges that the state faces, and identify integrating themes. In 2003, former Senator Jim Jensen, with the endorsement and support of then Governor Mike Johanns, championed LB724 which served as the blueprint for LB1083 and created conversations statewide that focused on changing the behavioral health system. On July 1, 2004, LB1083 went into effect. This would be in the fiscal year '04-05. This is significant because some of the information you'll be seeing over the course of the next day and a half relates to the '04-05 fiscal year. Dr. Mazade's materials, for instance, tomorrow will reflect '05 data in many cases. And so early on into the transformation process it's important to keep that in mind. This legislation focused on providing behavioral health services in the community as opposed to regional center hospitals. There was agreement that some people might still need regional level services, but that most people can be successfully treated in a community closer to their friends, family,

and other natural supports. I would like to share some of the significant progress that has resulted from the LB1083 chapter of the behavioral health reform. And let me begin with the reorganization of the department. Senator Johnson referred to the reorganization of the Department of Health and Human Services that created greater accountability, accessibility, and access to services. This describes the Division of Behavioral Health and how we have come along. One point that I would highlight on this slide is to say that Dan Powers is the acting director of the office of consumer affairs. We are in the midst of a process that is chaired by Diana Wagner (phonetic) from The Kim Foundation and which has representatives from the consumer organizations to review all of the applications to come for this office. Their task is to give me three recommendations, hopefully before year's end, from which then I will make a selection for the office of consumer affairs administrator. Consumers are very involved in this process. Perhaps the most important success of behavioral health reform is the rise in the number of people served in the community and the corresponding reduction in the number of beds needed at the regional center hospitals. This slide shows the total numbers of people in blue served--adult admissions at regional centers from calendar year '03 on through today. You can see with the blues in fact all of them a declining number over time. This is an important slide and I think a landmark slide, if you will, in the sense of being able to identify the moment in time when Nebraska now in its regional center hospitals serves more sex offenders than we do mental health patients. That occurred in April of this year, and that trend continues to grow as the populations of mental health patients at the regional centers decline. Since July of '04, there's been a 30 percent increase in the number of people receiving behavioral health services in the community. More than 9,000 new consumers have received services. There has been a 47 percent increase in admissions to identified community services and 251 beds have been closed at regional center hospitals, including all of the adult services at the Hastings Regional Center and all but 30 beds at the Norfolk Regional Center. Sixteen adolescent mental health beds were also closed at Hastings. And as of 2008, the regional centers serve more sex offenders than mental health patients. Since 2004, approximately $30 million in ongoing operational funding has been moved from regional

centers to the community, mostly through the behavioral health regions, though not exclusively. A total of $167 million is spent on behavioral health funds in a year's time in the state of Nebraska. The final $3.5 million was moved permanently from the Norfolk Regional Center operations to community-based services in fiscal year '07-08. On May 28 of 2008, this current year, $17 million for community-based services was distributed to the regions. This included about $8 million in one-time money. One-time money was generated by the department requesting the reappropriation of funds that had not been used in the community in prior fiscal years. The Legislature, in an unusual move, but recognizing the significance of the moment, reappropriated unused funds rather than keeping those as is more typical of the process. We have now really completed the fiscal intent of LB1083. This slide demonstrates a couple of important items. It sort of shows the flow of the monies to the communities over time as regional center services were discontinued and allocations of funds made to the community-based services. Here we have a slide that demonstrates the appropriation at the beginning of behavioral health reform to the regions and the current fiscal year allocation appropriation contractual arrangements with the regions. I would like to draw your attention to that other category because it sort of stands out because there's no 2004 number there. That is significant and is composed really of two numbers--$8.8 million of Medicaid matching funds is included in the $15 million. As you know, part of LB1083's intent, purpose, hope, desire was to be able to attract federal fund participation in the delivery of behavioral health services. The Division of Behavioral Health, in its General Fund appropriation, matches those funds. In 2004, that was spread among the contracts to the regions and really was a negligible sum. In 2009, we have fiscal year 2009, we have identified that as an $8.8 million component that is just matched at the level of the state. Secondly, there is about $6.5 million targeted for the Lasting Hope Recovery Center in Omaha, a 64-bed hospital. That is a direct contract between the state and Lasting Hope Recovery Center, does not go through Region 6 at the present time, though our plan is that that will become a regional allocation in the next fiscal year. Because it did not go to Region 6, it was a state contract, we stuck it in this category of other so those are the large components of that. This slide I think is also a significant slide and shows the

distribution of approximately $168 million of funding that goes to behavioral health and where it goes. If you look at the top, you have the Lincoln Regional Center and Hastings in the sort of brownish-beigeish color. And next to it is the Norfolk Regional Center which is funded by 1199 sources. Together, that forms about 38 percent of the distribution. The rest of the blue can be understood as community-based services. And the blue I have divided into two segments of this pie. One, the speckled blue is the amount of contracts to regions in the current fiscal year. And the other community aid then includes things like the...what I just mentioned with regard to the Lasting Hope contract and the Medicaid match and other items like our direct contracts with tribes, which are, of course, their own communities. And so all of the blue represents the community-based aid, and that is almost 61 percent of total dollars available to the Division of Behavioral Health going to community-based services. I should also note that about 1.3 percent was that little pink thing at the top and that's the administrative side for community services in the Division of Behavioral Health. So about 1.3 percent goes to administration at the state level of $168 million. I'm also proud of the significant decrease in people placed in emergency protective custody across the state. It has been a significant decline and the 63 percent reduction in the number of people in voluntarily committed to regional center care. That's a significant change. It reflects on the human side the paradigm shift that the dollars represented in going from regional center care to community-based care. I will now more rapidly identify some other significant accomplishments of behavioral health reform. We have created or enhanced a wide variety of community services, including but not limited to community support, day rehab, psychiatric residential rehabilitation, transitional residential care, short-term residential, emergency community support, subacute services, intensive community services, and medication management. In your packets you have long sheets of paper, legal-size sheets of paper, that identify the provider, a contact name, and by region so that you can look at your area and see who the providers of services are in your area. We also have sort of a summary sheet if you want a cheat sheet in terms of what's available. This sheet by region identifies the services in your area so that you will be able to look at the types and nature and extent of the services in your area and also

inclusive of the exact and specific providers of that care. There has been raised more than $28 million from the private sector as part of the public-private partnership formed to advance the goals of LB1083. This is not an insignificant moment. There has been more than $28 million of private money that has gone into the behavioral health system in the state of Nebraska. The largest portion of that has been from the Lasting Hope Recovery Center where Rhonda Hawks (phonetic) and Ken Stinson (phonetic) were instrumental in raising about $24 million. But other hospitals have stepped forward to make infrastructure improvements in terms of facilities and other services to be able to move forward behavioral health reform. That's an extraordinary number in my opinion. We've also created the office of consumer affairs. We have created paid consumer positions within each behavioral health region, expanded consumer participation at all levels of planning and delivery of service; lowered the admission rate to 7.5 percent to regional centers compared to a national average of 19.9 percent. Let me say that one again. That also is significant. The readmission rate--that is somebody who has gone through treatment at a regional center, left and come back--the readmission rate is 7.5 percent in Nebraska compared to a national rate of 19.9 percent. That is a strong indicator in my mind not only of the care and quality of services at the Lincoln Regional Center in particular, but also the interface with the community-based providers. And so the ability to hand off and to transfer patients back to home communities seems to be working well, knock on wood. We have assisted 717 people with serious mental illness with $2.1 million in state housing assistance in fiscal year 2008. We've encouraged peer support services across the state. I will share some other divisional accomplishments as well. We have successfully managed a tribal mental health and substance abuse program in the four tribes of the state; successfully managed the Gambling Assistance Program through direct contracts with providers across the state and with assistance from those persons who eventuated in LB1058 earlier this year; established the Office of Children's Behavioral Health; and produced the Children's Behavioral Health Implementation Plan in cooperation with other Department of Health and Human Services divisions as a result of LB542, sponsored originally by Senator Synowiecki. We have established Trauma Informed Nebraska, and we have improved safety at the

regional centers through training and security upgrades such that the trend lines in security and incidences of abuse and harm have declined steadily over the last three years. This summarizes some of the points that I have made in that regard. Recently, I announced the end of the LB1083 chapter of behavioral health reform because of several significant elements. All of the money identified by law and process, about $30 million, has been moved from the regional center operations into community services. The money was provided to the regions on May 28, 2008, as reflected in current contracts with the regions in this current fiscal year. The original Behavioral Health Oversight Commission was sunset this summer in accord with LB1083, and new challenges are emerging that need a fresh focus, new ideas, and renewed energy. LB1083 behavioral health reform itself has ended, but reform continues to be an ongoing, evolving story, just as it has been throughout our history, beginning two years before we were a state. Two years before we were a state, we dealt with persons with mental health illnesses, we worked with the state of Iowa for provision of those services, and unfortunately we kept many of those people in jail. Our beginning planning was directed that far back so the evolution of behavioral health as an ongoing concern I think will continue. However, we have met the structural and financial requirements set forth in LB1083. We are building on LB1083's accomplishments and moving forward to a new chapter for behavioral health reform using these new dollars in the community. Nebraska's challenges can be divided into two categories: special populations and systems considerations. These challenges will occur within a framework that no new state resources will be assumed and within the theme of integration of where we have been and where we have come from. Some of the challenges that we face are these: forensic psychiatric services at the regional centers, coordinating emergency access, and fully integrating mental health and substance abuse services within a behavioral health context. If you will, the intent and purpose of this slide is to be able to show that the integration is a very important element. Earlier I mentioned the very low rate of readmission. That's good news, but we can do still better in terms of the coordination and utilization, both on the incoming side of things and on the exiting side of people leaving regional centers. It should be used, I think, as a system to be able to focus on

those most in need and the vast bulk of persons in need of behavioral health services ought to be served in the community. I'd like to draw your attention to four specific groups: those in the emergency system; people who have dual diagnoses such as developmental disabilities as well as a mental illness; transitional age youth between the ages of 18 and 22 who may have received treatment services as a child and may no longer be covered by Medicaid as they grow up; youth with juvenile court involvement; or youth whose parental insurance no longer covers them and whose mental illness still needs treatment; and people who are or may become involved in the criminal justice system. One of the things I think that scares me perhaps most is that as we decrease the size of regional center capacity and services that they might be shifted over to the criminal justice system. We have to be vigilant that that does not happen. There continue to be significant system changes to the state in providing services. Currently, the regions have the money and the state provides oversight. The state needs to be able to more directly ensure that state and federal funds are utilized to address consumers for whom the state is responsible. Now that $30 million from adult inpatient services at Hastings and Norfolk Regional Centers has been distributed to the community, we must have increased collaboration between local management and central control. There are very different LB1083 implementation strategies and services among the six regions. The documentation in those legal-size sheets will show you the differences of what services are available from region to region and how that works. The testimony by the regional administrators after me I think will provide additional commentary in that regard. But at times, this is uneven and fragmented. A recent example involves patients from the Omaha area that have been placed in the Region 3 resource and questions about who ought to pay for those services has arisen. Secondly, LB1083 encourages the treatment of the person with behavioral health disorders to be served closely to their home and clearly not in the regional center. In fact, that is the definition in LB1083 about community-based services, not in the regional center and so that's an important consideration. The role of regional center hospitals is one that focuses on the forensic patient, the sex offender, and the violent patient who cannot be cared for locally. State statute 83-338 sets out these priorities for the regional

centers. The strongest, clearest step to be taken to improve the system of care and to help resolve the issues around specific populations is full-risk managed care. There are several reasons why this is so. According to the Substance Abuse and Mental Health Services Administration of the federal government, managed care improves access to services. Secondly, managed care can better integrate behavioral health services with primary care, which is a growing area of one to link the mental health with primary care and be able to take and attend to services all at the same time. Having a single payor not only simplifies the administrative aspect for everyone, but ensures that fee for payment is maximized and that the federal participation is maximized, while reducing administrative redundancy. And finally, managed care allows greater flexibility in the development and deployment of consumer-based, consumer-driven services across the state. Nationally, managed care is regarded as an important set of tools that can increase access, provide for more uniform quality, provide uniform data, and improve efficiencies. The goal is to improve access by unifying the system, improve placements of people moving from regional centers, save some money, and improve individual outcomes among the various regions of the state. Only three states across the country do not currently have managed care as part of their involvement. Let me be very clear. We intend to have many discussions with our stakeholders and partners before implementation of managed care targeted for 2011. I'm going to touch very briefly on children's mental health. LB1083 did not distinguish between adult and child services, but the past four years has focused mostly on adult mental healthcare since the funds and patients were from regional centers that served mostly adults. Governor Heineman identified integration of children's behavioral health as one of his top ten priorities for the newly restructured Department of Health and Human Services in 2007. LB542 also became law in 2007, and it challenged the state to focus attention onto children's behavioral health. The department's Divisions of Behavioral Health, Medicaid and Long-Term Care, and Children and Family Services are collaborating around this important issue. The department issued a children's behavioral health plan in January of 2008, which is up on our web site, that is clear, bold, and provides direction and time lines. Elements of that plan are being implemented and the results are being seen. For

example, the overall number of state wards is down by about 1,000, and significantly fewer children are being served outside of the state of Nebraska. I urge your support for a new chemical dependency treatment and secure care facility for youth from the Kearney YRTC. This is in the proposed capital expenditure plan the Governor has submitted. These collocated facilities will improve outcomes for youth who will need them. I believe all of the challenges revolve around the integration of mental health, substance abuse, and gambling disorders. LB1083 specifically includes mental health concerns, substance abuse, and gambling disorders. However, behavioral health reform efforts of the past several years have focused almost exclusively on mental health reform and for good reason. Even though people with substance abuse disorders outnumber people with mental illnesses in our prisons and in the general population. In fact, research reports that somewhere between 40 and 80 percent of people experience both mental illness and addictions disorders. Currently, there are several reasons for this lack of integration. Some believe that substance abuse has received sufficient attention over the years. Others believe that while the wording of LB1083 was about behavioral health the conversation at the time focused on closing regional centers and developing mental health services in the community. Substance abuse and gambling disorders were rarely mentioned during that debate and discussion, and the bifurcated system of regions and the state adds further complexity to the whole topic. It's really time to consider where the behavioral health system should now focus. The Governor's call to the new Behavioral Health Oversight Commission to develop a strategic vision for this next chapter of behavioral health reform is apt, timely, and proper. I hope that that group will soon turn its attention in that direction. The state itself is sponsoring a planning event on November 20 to assist in this process of developing a strategic vision. To achieve some of the continued behavioral health reform challenges within existing resources, I propose some of the following...I propose all of the following: the "planful" implementation of at-risk managed care to unify the system and standardize recovery principles; more communication involving all of the stakeholders; regular meetings with consumers, providers, and others will be important as well as an annual conference. A new web site to be in operation in February will also be helpful in this

regard. Operate a new chemical dependency secure unit for adolescents; agreement on clear system-level outcomes so we're all headed in the same direction; implementation of the children's behavioral health plan; increased consumer participation and involvement at all levels of the system; and provide peer consumer training to help more effectively allow consumers to participate in the system; an integration of our language, efforts and understanding of behavioral health disorders so we talk to one another straightforwardly and clearly. I will turn your attention to the theme I noted early on--integration. Integration is the important element that I think will mark this next chapter of behavioral health reform. We need integration of addiction and mental health services. We need a common vision of recovery for people affected by the behavioral health disorders. We need professionals who are trained in multiple methodologies who understand addictions and mental illness, the biological as well as the psychosocial. Our vision is a behavioral health system of many parts that expects the same things we expect of consumers--an honest, future-focused, collaborative willingness to change with a keen focus on measurable outcomes. We can work together to build a Nebraska that encourages her residents with behavioral health disorders to embrace recovery fully and be an integrated member of the communities in which they live. I'd like to turn your attention to the packets again, just to go through that a little bit. You have not only my testimony and the slides that have been shown up there, but these documents again summarize the services in your particular part of the state, one by one. Those are the colored ones. And then as you get into the more boring, mundane, and tedious documents, these show the actual providers who are probably calling you to meet with you to talk about rates or some kind of aspect of the system. So you have a contact person as well as the type of services that those providers deliver in your home communities. I'd very much appreciate your attention, not only to my testimony at this moment, to your work and attention to the issues of behavioral health overall. As Senator Johnson mentioned early on, we have a number of issues facing us that seem to all touch on, in one way or another, behavioral health. And so it's an exciting time and it's a challenging time. And I thank you for your attention and would be happy to respond to any questions you may have. [LR338]

SENATOR GAY: All right. Thank you, Scot. Let's see if we have any questions. Senator Harms. [LR338]

SENATOR HARMS: Thank you, Senator Gay. Scot, a number of questions I'd like to ask if you've just got a few moments. Let's talk of the budget, start with the budget first. This is to be implemented in, what, 2011, the changes? [LR338]

SCOT ADAMS: Our intention, our plan is to develop and implement full-risk managed care in 2011. [LR338]

SENATOR HARMS: And so what's the increase in the actual cost... [LR338]

SCOT ADAMS: The increase in the actual... [LR338]

SENATOR HARMS: ...to implement what you would like to implement, make all the changes you want to make? What kind of impact does that have on our budget? Because it gets down to the end, it always gets down to the bottom line. So I just want to know up front what you're thinking this budget cost increase is going to be. [LR338]

SCOT ADAMS: Yeah. We are working with the assumption that we will work with existing resources. [LR338]

SENATOR HARMS: Okay. Community-based services programs, okay, your intent, of course, is LB1083 is to move as many people from regional centers to community-based programs. [LR338]

SCOT ADAMS: Yes, sir. [LR338]

SENATOR HARMS: The concern that I have for you and for this great state is do we

actually have enough trained personnel and enough services to truly provide appropriate community-based programs? [LR338]

SCOT ADAMS: The answer to that question is best I think addressed within context. And first of all, I would have two or three points that I would like to make about that. Nationally, there is a shortage of psychiatry and psychiatrists in almost every state. In the state of Nebraska, something on the order of 85 out of the state's 93 counties have an identified shortage of psychiatrists. In something like 13 to 14 counties across the state we have no behavioral health professional in there. Point two, I think you will hear later today about thoughts and ideas with regard to the work force issue and things that can be done. The item that I would like to suggest that Senator Johnson and I have talked a little bit about is that I think the biggest bang for the buck can be developed, if you will, by training people who are in a solid program of recovery in a consumer-based, consumer-led, peer-to-peer set of services. [LR338]

SENATOR HARMS: Do you believe that having that type of shortage and not having appropriate trained personnel, regardless of whether you go peer-to-peer or however you do, you really don't have the formal training now that you probably need, the basic underlying training, are we going to put our clients we have in these regional centers and community-based programs at risk? [LR338]

SCOT ADAMS: Safety is a paramount value of the system throughout and we believe in the notion of recovery that is real, possible, tangible. People who have come through the kinds of tortures, if you will, that's probably too strong a word but prevails in the upset and the horrible experience of a behavioral health disorder are typically folks who are, research indicates, above-average intelligence, oftentimes more creative, more flexible, better employees on the backside of things in many ways. So I think this is a resource that has to be molded, trained, nurtured, encouraged. But...and, of course, as that moves forward the issue of safety in context and appropriate services. But already today we are involving across the state in mobile crisis teams consumers so that they

will go out with law enforcement during times of a mental health or a psychiatric crisis and oftentimes a EPC is able to be averted or diverted as a result of being able to talk person to person within that moment when people are there in crisis. [LR338]

SENATOR HARMS: The problem I have and a concern that I have is that the further you leave urban America and the further you go into rural America the greater the issue is, the greater the problem is. And how are you going to counter that because you're just not going to have the people there? Yet we need the kinds of services that are available. How are you going to deal with that? And on top of that, what criteria are you going to use for evaluation so we can be assured that we don't end up with another Beatrice or we don't end up with another issue where people are just not dealing with this structure, putting people into an environment where you maybe don't have the services available that are, in fact, limited services I'm not sure is wise? And that's why I'm asking this question. [LR338]

SCOT ADAMS: Um-hum, yeah. In addition to what I have said about consumer-led services and the development of other services, I think the idea of telehealth offers an opportunity to provide through the telehealth network that Nebraska is a leader in opportunity and access to some of the higher-end professionalized services. And so that represents yet another one. If your concern is with regard to the need for ongoing regional center levels of care, let me assure you that the regional center is intended to stay there. I don't think it's going to be going away. But I do think that our opportunity to have that be used at an appropriate level for the most dangerous and violent clients is its proper role moving forward. [LR338]

SENATOR HARMS: Are we, and I'm just going to have to be real direct with this question, don't take it wrong, but are we just moving clients from the regional centers to become more cost-effective? Or are we making those movements so that we believe the bottom line is not an issue here, but we believe that they would be better served in a community-based program? [LR338]

SCOT ADAMS: Yeah. I think absolutely this is not about the fiscal side of things in regard to that because the evidence will show the increasing appropriations each and every year, increasing federal fund participation every year since the beginning of behavioral health reform so it's not the money side. It is, it truly is the right thing to do because folks can, in fact, be treated in communities successfully every day. I see it every day in terms of folks who have been there. Let me also add another component to...as response to your question and that is there are people who are at the Norfolk Regional Center in that 30-bed unit who have been there for more than four years, meaning before the beginning of behavioral health reform. So we have not willy-nilly just sent people to the regions. Each person has been carefully considered. Regions have been brought in, highly created folks. A great clinical review has been involved with the review of each and every individual, not unit by unit, not clump by clump, but person by person. And so some have not come to the community yet because the community has not been able to find a way to be able to manage the person successfully and safely in the community. They remain at the regional center today. And so I think that's further evidence that we have not just moved people to the community for either cost reasons or do it because it was the fad of the day. [LR338]

SENATOR HARMS: Well, one final question, Scot, and thank you for your kindness in answering these questions. Managed care and the evaluation of managed care, what criteria, what tools are you going to have established that we can look at that you're going to tell us that you can manage this system that we know that it's not being done properly or it is being done properly? Because the bottom line comes to the evaluation and to meeting the criteria that you have established. So what tools are you putting together or what tools do you have put together in regard to this evaluation because I think that's critical? Because when it comes to the end, that's the very question that those of us who sit around here are going to have to ask. [LR338]

SCOT ADAMS: Yeah. A great question and I'm really glad that you raised it. I would

offer you a couple of points in response to that. First of all, this document which is available from Sampson represents a...that document represents a study by the federal government of 15 years, 1990-2005, of managed care implementation across the country, summarizes the ups, the downs, the ins, the outs. And so we have that basis of information available as well as updated information. Secondly, we have contracted with a company by the name of Milliman who specializes in at-risk managed care. They're an actuarial firm out of Colorado that does this work. And the exact purpose of the contract is to help us to know what we need to know. So we're not going to a managed care firm or company. We are simply preparing ourselves for that conversation so we will have clear, specific, and enumerated answers to the questions and concerns that you have. [LR338]

SENATOR HARMS: I'd like to add one other question. When that's done and you have reached an agreement about what this evaluation tool is, would you share this with the legislative body? Because I think that that's really critical and we need to have a better understanding of how it's going to be evaluated. And then also, how you will then evaluate other third-party agreements or contracts because I believe the third-party contracts, at least for some of the things that I've had a chance to review, are not very clean and very clear in the state and we leave ourselves at risk. And so I just want to make sure that when we move in this direction that this time we put everything into place before we shift those gears and that we have the evaluation tools established, and with third-party contracts we know that somebody is going to evaluate those third-party contracts so that we have a feeling that we are moving in the right direction. It all boils down to evaluation. These are great and I think it will be great for the clients that you want to serve, but it comes down to management and evaluation of those services. And are you going to have that established and are we going to be guaranteed that this is established? [LR338]

SCOT ADAMS: I fully agree with your call for openness and transparency in the process. And in my testimony I indicated that we will be having many conversations with

stakeholders and others involved in the system. Clearly, the Unicameral has to be one of those groups that are kept informed all along the way. Governor Heineman has been clear with those of us working at the director level in the Department of Health and Human Services that transparency and accessibility and access are key values for this administration. And so we will be part of that and reporting on that as we move forward. [LR338]

SENATOR HARMS: Thank you. [LR338]

SCOT ADAMS: Thank you, sir. [LR338]

SENATOR GAY: Thank you. Scot, that is an important document I think that we should have a copy of if that's the direction you're heading. I think we should be obviously well-informed. If you could get, and I hate to kill that many trees, it looks pretty...I think if you could get those to these members to look at it would be pretty important. [LR338]

SCOT ADAMS: Be happy to do that or we'll give you the web site address as well... [LR338]

SENATOR GAY: Yeah, or either way. [LR338]

SCOT ADAMS: ...because it's right out there on the web with Sampson. [LR338]

SENATOR GAY: But if...and I know that's down the road but I think we should be informed of that. And then we've got some more questions. Senator Pankonin. [LR338]

SENATOR PANKONIN: My question, Scot, is a little bit in answer to Senator Harms's or to follow up to some of his questions. And we're going to get into the topic of mental health workers, and I think there's a definite shortage in west of the metro areas, but there's a shortage probably in the metro areas as well. I think you would agree. And I do

think, for example, what community alliance has done, along with peer to peer, and I think we're going to have to be innovative, not only from a cost standpoint, but just from an innovation standpoint because a lot of these workers it's going to be just to say we're going to have all of a sudden a pool of workers all through the state I think is going to be very difficult. So I think we are going to have to look at whatever works and what can be effective, and I think that one does have great potential because a lot of those folks familiar with the program there who have gone through these difficulties can be valuable to new clients that are having these conditions. And so I think there's promise for that. [LR338]

SCOT ADAMS: Yes, sir. [LR338]

SENATOR PANKONIN: But I think overall is our committee, the Health and Human Services side, has heard, you know, a general shortage of healthcare workers is an issue that our state is going to face, our country is going to face partly depending on what the federal policy is with a change of administration and those sort of things. So that will be an ongoing discussion. I know we're going to discuss it more over this period. But I think we will have to be very innovative. And to think that we're going to have the mental health workers as much as we would like is probably not practical, it's not...we need to work on that, no doubt, but we're going to have to look at all kinds of solutions for that problem. [LR338]

SCOT ADAMS: I really agree with that, and it is important to keep in mind the entire range of high-end specialty trained persons like advanced practice nursing who are specialists in behavioral health concerns, psychiatrists, psychologists, licensed mental health practitioners. We have licensed alcohol and drug abuse counselors in the state as well, and also including the peer and consumer cadre of people who are out there. It is a very different environment, and yet there are parallels to be learned from the addiction side. AA, NA, and others have been in existence for decades and have helped one another to achieve recovery. Now I'm not saying it is that simple. There are some

very particular kinds of situations on the mental health side of this that need attention--the training that Senator Harms spoke to and was concerned with. I share those and we have this week, actually tomorrow, we will submit an application for some funding to help with consumer training protocols and opportunities in the state. And so we are seeking to move ahead carefully with that to be able to help train that component of the total work force environment. [LR338]

SENATOR PANKONIN: Thank you. [LR338]

SENATOR GAY: All right. Senator Nantkes. [LR338]

SENATOR NANTKES: Hi, Scot. Thanks so much for all of this really incredible and good information. But I wanted to talk a little bit just about the interplay with behavioral health system, the child welfare system, and some of the clear manifestations thereof that we've seen with the recent safe haven situation and otherwise. You mentioned in your testimony that we're currently at about 1,000 or so state wards. Is that right? [LR338]

SCOT ADAMS: No. What I intended to say if I did not is that we are down about 1,000 from our peak number of wards. We have about 6,400 wards in the state of Nebraska. [LR338]

SENATOR NANTKES: Okay, all right, and that was my question. If you could just provide a brief historical context maybe for the committee and the audience about where we are in terms of where we've been, in terms of the number of state wards that we have, kind of where we are today and where we're headed down the road, and just what considerations we need to keep in mind with how we categorize some of those youth and family in need as we look at some broader issues. [LR338]

SCOT ADAMS: Let me do a disclaimer because I suspect my colleague, Todd Landry,

is jumping up and down in his office at this moment. But let me perhaps just sketch a couple of high-level things that I think I'm familiar with. The high number of state wards occurred I believe several years ago at this point at about 7,800 or so. We're around 6,600, 6,700 at this point in time. If we were normal, if we were average with the other states, we'd be somewhere between 4,500 and 5,000 in terms of that. Second point would be that about 70 percent of those children are served in out-of-home care. Our goal is, as stated in the children's behavioral health plan, is to reverse that statistic to have about 70 percent served in their homes, meaning that the delivery of services needs to be very different. Rather than going to someplace and dropping a person off, services would come to a home or that there would be clinic-based services but we would retain the strength of the family and the bonds that exist between the family, caregiver, and the child. And so that would probably be my response. I (inaudible). [LR338]

SENATOR NANTKES: No, that's very helpful, that's very helpful and I'm sorry it's better answered by Todd. And then just one quick follow-up question. You mentioned there were still a few youth being treated in out-of-state programs. And can you talk about roughly how many there are in those out-of-state programs and why they're in those out-of-state programs? I'm just not familiar with that dynamic. [LR338]

SCOT ADAMS: Yes. First of all, I'd be happy to get that. We get a monthly report. Senator Synowiecki actually was instrumental in developing the interest and the energy to report on this monthly, and so we have that and I will get that to you. In general, I believe the high was reached about two years ago when there were nearly 80 young people served in services outside the state of Nebraska. As I recall the last time, that number was in the mid twenties. The types of child who leave the state, and I should also note that this is after a rather exhaustive search for a provider instate who is willing to work with the child and with the family, only at that point then is a decision made to seek outside of the state resources. But it has come down dramatically. But some of the reasons for that include fire setters, sexual involvements that are dangerous to others in

a residential setting for whom a provider may not feel comfortable in putting other residents at risk. And those are the two major categories for most of the people who are out of state. [LR338]

SENATOR NANTKES: Okay, great, thanks. [LR338]

SENATOR GAY: Scot, you answered the placement question fairly well I think. I know you...but it is important. They do work closely with Children and Family Services so it's not like their department is completely separate. They are talking back and forth and we discussed that last week during our hearings when we talked about priorities and things like that. So it is involved, not as much as Todd so, but continue to do that because a lot of times those issues, behavioral health issues, are going to bigger family issues. So I know you're working hard to do that so. [LR338]

SCOT ADAMS: And again just to maybe give a little more detail about that, the Division of Behavioral Health, the Division of Medicaid and Long-Term Care, and the Division of Children and Family Services have work groups in place on particular issues. Implementation of the children's behavioral health plan is an example. The work around involvement with Magellan and data gathering is another example. And so not only do we meet as directors to talk about that, but we have staff assigned to work together as well. [LR338]

SENATOR GAY: Senator Stuthman. [LR338]

SENATOR STUTHMAN: Thank you, Senator Gay. Thank you, Mr. Adams. I have one question about the services that were provide, you know, at a regional center, and I was very supportive of LB1083. We have moved the money from the regional centers to the community-based center setting. Are we able to provide enough services in the community-based setting to make sure that the providers are funded at a reasonable rate? Or are we going to be starving them out by not having enough money to provide

good services at the community-based setting? [LR338]

SCOT ADAMS: Yeah. There are a couple of ways of looking at that. The original promise of LB1083 was to move all of the money in the operations of inpatient services only to the community. That number was $25.8 million. As you heard in my testimony, we have moved more than that--roughly $30 million. The difference was that while the conversation at the time focused in on inpatient services, other services at the regional center also have either declined or been transferred. Examples include the Hastings Regional Center had an ACT team, assertive community treatment, team which is composed of a team of professionals that actually go to people rather than waiting to come to the office. It's an assertive outreach to people with serious mental illness. In addition, there were outpatient services at both Norfolk and the Hastings Regional Center. Those have closed. Those funds also now have moved to the community, thus bringing us up to about $30 million rather than the original promise of $25 million. So we've exceeded the original target is my point with regard to that. Is there enough money? Boy, you know, that's a question for better minds than me. I suspect you're going to hear a lot of testimony today that suggests that that's not the case. I think that it is always a question of the context in the environment in which we work and live. There's $168 million going to behavioral health services in Nebraska. It strikes me as a big number, might be one of being able to be the greatest efficiency, maximum bang for the buck, if you will, making sure that everything is used as effectively and efficiently as possible. And so those are questions that I think that as we move toward the managed care environment that we'll be able to obtain some greater efficiencies in that regard. [LR338]

SENATOR STUTHMAN: Okay. Thank you. One other question I have is in one of your slides you had $2.25 million for behavioral health administration over the community-based service portion of it. What does that really entail? What do they do? [LR338]

SCOT ADAMS: Okay. That side of the pie chart, the pink side, is headed by Vicki Maca. Maybe it's appropriate that it was pink. Vicki is the administrator for the community-based services and so part of what her unit does is to contract with the regions in the development and oversight of those contracts in the regions. She also receives the gambling assistance program and monitors the particular contracts with gambling providers across the state. We have contracts directly with the Native American tribal nations, and so we monitor those and ensure compliance with the terms of that. We also involved in things like Synar compliance. Synar was a congressman in the United States Congress who wanted to make sure that tobacco did not get into the hands of young people. So there's a national program where we receive funds and do checks to make sure that retail agents do not sell tobacco to young people. We have also the mental health and substance abuse block grant funds from the federal government that have particular levels of compliance. We also with the regions contract for services for the housing assistance program that I mentioned in my testimony that 717 people would be served in supported housing. And we review those contracts and share with the regions the compliance standards that the housing is safe and reliable and that kind of thing. So there's a whole host of things that that section of the Division of Behavioral Health does. Those are maybe seven or eight of those things that we do with that money. [LR338]

SENATOR STUTHMAN: But this has been an administration that's been in existence. It's not been formed just because of moving the people from the regional center to community-based. [LR338]

SCOT ADAMS: That's correct. Before LB1083, its title was, I believe, the Division on Alcoholism, Drug Abuse, and Gambling or other addictions, something like that. LB1083 reformed it, but it existed ahead of time. Way, way back when I got into this field in '76, there was a division of drug abuse and a division of alcoholism, interestingly known as DOA, always had fun with that. But over the years, and it has gone at least that far back in terms of a state resource known as the single state authority to be able to interact

with the federal government on these kinds of issues. [LR338]

SENATOR STUTHMAN: Okay, thank you, because that clears it up with me because I was under the impression that it was just because we had moved the people out of the regional centers to community-based programs that there was a new administration started, but that's not true. [LR338]

SCOT ADAMS: No, sir. No, sir. [LR338]

SENATOR STUTHMAN: Okay, thank you. [LR338]

SENATOR GAY: We'll go with Senator Fulton, then Senator Synowiecki. We'll go till about 10:20, 10:25. [LR338]

SENATOR FULTON: Thanks, Senator. Senator Stuthman very joyfully asked one of the questions I was going to ask. Autism, how does autism fit within this behavioral health model? Does it now and how will it in the future? [LR338]

SCOT ADAMS: Autism, of course, was the subject of the Unicameral last session and services are being developed within the Division of Medicaid and Long-Term Care and has not been a primary focus of attention within the Division of Behavioral Health. [LR338]

SENATOR FULTON: Is there potential...does the potential exist that there is presently overlap between what has been misdiagnosed or maybe not recognized? [LR338]

SCOT ADAMS: You know, there is potential I think, especially on a clinical level, that that kind of misunderstanding can happen. In an individual practitioner's office, it's always difficult to ascertain with great certainty if it's this particular category versus that particular category. One of the unfortunate elements of government is we have to sort of

build stuff in programs and sometimes have walls and barriers. As much as possible, we work together to communicate about that at an administrative level. There will always be, I think, the tension around individual diagnostic interpretation at the moment of clinical impact with a family and its particular clinician. It's best addressed, in my opinion, in a team effort so that there's multiple eyes and perspectives looking at that kind of thing to ensure that they're getting the right services and the right amount at the right time. [LR338]

SENATOR FULTON: And last question here is, might be a deeper question but it's something that needs to be asked, what I'm hearing, what I'm seeing, and I guess what I'm perceiving here is that presently we may well be underfunded with respect to funding community-based care. That's what it seemed like in the last budget cycle, and I don't know that we've caught up yet. So would that...is that accurate? Will there be those who say that we're underfunded with regard to our present structure? [LR338]

SCOT ADAMS: I think there will be those that will say that. I'm not ready to commit to that statement today. [LR338]

SENATOR FULTON: We have a shortage of behavioral health professionals, what I'm hearing. Therefore, if we are somehow able to add more behavioral health professionals, I assume that that is not structured into our present budget policy. So, number one, we're underfunded. We'll need more money. Number two, we're going to be needing more professionals within the industry which will necessitate more money. Number three, I'm hearing that we have...the number of patients is increasing also, which means we'll need more money. So we're trying to get a handle on how much more money. I guess the question I have is do we...is there a root cost analysis that's done? Are we having an increase in need for funding on behalf of society to deal with behavioral health because there are more people with behavioral issues? Or is it the case that we are just better able to identify those who have always had behavioral health issues? [LR338]

SCOT ADAMS: Well, you know, I think there's a mixed answer with that. And again, I would just like to point out that you drew a second conclusion as you were going through that, Senator, about underfunded system. And I just want to reiterate I'm not ready to go to that at this point in time. But, you know, in the sense I think the recent safe haven moment in time sort of highlights this. I think there have been a number of folks who have wanted to say that all of those cases are behavioral health issues, in part because we don't quite understand how else to understand this. And no one really had a sense that they would be of this nature. If you look at the nature of the cases in the safe haven moment, it reflects to me more of a scattergram than a regression line in terms of causality. You have some people who were clearly in a moment of grief in their own personal life. That's sort of a momentary kind of thing that can need some particular help. You have situations where there were clearly behavioral health disorders and in process of receiving services for those already. You had...and sometimes that was the child, sometimes that was the adult. There seems to be very little that at present sort of ties all of the cases together in a causal manner which linked them where there would be an easy answer. I understand that there is a hearing coming up on this at a later point. I know that my colleague will be developing further information with regard to safe haven and the data and what the data seem to indicate in that regard. My point at this point, however, is simply to say...is to urge some caution about drawing conclusion and rushing to solutions from a scattergram of situations as opposed to A plus B plus C equals the solution. I'm not sure we're there. I don't know that the cases that we're seeing there lead to any single solution that will fix it. I don't think it's that easy. [LR338]

SENATOR GAY: Thanks. Senator Synowiecki. [LR338]

SENATOR SYNOWIECKI: Thank you, Dr. Adams, appreciate your comprehensive testimony. I looked over the Behavioral Health Oversight Commission, the legislative branch oversight commission that was previously impaneled, and I was reviewing the

recommendations. A couple of them caught my eye. And one of their findings caught my eye. And one of their findings was that the cost of providing sex offender treatment at the Norfolk Regional Center was excessive when compared to other states, and they went on to provide some examples that the cost in neighboring states, Kansas and Iowa, the cost was $69,000 to $70,000 respectively for those states. And the cost for delivering these services at the Norfolk Regional Center at the maximum number of patients, which would have been 120 beds, was $114,000 a bed. And at its current census, which at the time this report was compiled, was 87 that would have brought us to a per year patient average in excess of $157,000. Is the department developing, pursuant to this recommendation from the Oversight Commission, are you guys developing any strategies relative to that, what would appear to be some excessive cost factors? [LR338]

SCOT ADAMS: A couple of points, and I'm glad that you raised that, Senator Synowiecki. One, the topic of sex offender treatment is a relatively new topic on the national scene. As you know, 2007 I believe was the year in which LB1199 was passed and gave particular attention to the idea of treatment after incarceration for sex offending crimes. My point is that the data recorded is really very scattered across the country in terms of what's included in that. For instance, in the Kansas example, they have a cost factor that is perhaps not even built into that, and that is that the threshold for someone to leave in Kansas from a confined, locked facility is that there is zero chance of reoffense. Since 1997, there has been one person released in Kansas once convicted of a sex offense. One might consider that a lifetime cost of that kind of treatment in relationship to such a conversation as this. They also recently constructed a $55 million new facility for behavioral health. But in emptying the old hospital, that is where the sex offenders have gone into in Larned, Kansas. I have gone to visit that facility, and it's a very impressive facility, but it's in the middle of Kansas, just a "scootch" down south and west from the center of Kansas. And they have corrections as well as other facilities on campus there. My point being that I would draw...I would be cautious in drawing any firm conclusions from the data on sex offenders because of the

enormity of the difference of understanding of what's meant by that term. Secondly, more on point to your question, and that is that we see a continuing growth in the number of sex offenders into the department's custody by virtue of LB1199. We anticipate roughly a couple of dozen per year come in. Some will leave, but that's about the rate at which that happened. The regional numbers which were given to the Unicameral for sex offenders in the LB1199 legislation were pretty much on target. We're close to the original estimates and intend to continue to work with both Norfolk and the Lincoln Regional Centers in an integrated fashion so that one complements the other on regard to sex offender treatment as well as with community providers. [LR338]

SENATOR SYNOWIECKI: I appreciate that answer. I don't think that the commission was at the point to draw conclusions. What their recommendation was, was that some kind of independent audit or independent assessment be done. Is the department looking at doing anything along the lines of the recommendation? [LR338]

SCOT ADAMS: We have not begun that specific work on that. [LR338]

SENATOR SYNOWIECKI: And along those lines, another recommendation from the Oversight Commission was kind of the commingling of the mental health patients that are under LB1083 commitments with the LB, as you know, LB1199 which I think passed in 2006, develop a separate and distinct...a commitment procedure for sex offenders. And one of the recommendations, and it speaks to, I think, the quality of care, perceived quality of care at the Norfolk Regional Center, is that those two different patient bases should not be commingled in a treatment environment. And the recommendation was that those committed under LB1083 not go to the...very specifically should not go to the Norfolk Regional Center, which is our state's response to the sex offender prevalence. Can you kind of speak to that and that recommendation? [LR338]

SCOT ADAMS: You bet. There are four physical units in operation at the Norfolk Regional Center composed of 30 beds each. And so you can sort of visualize two floors,

east and west, 30 beds each. There are 120-bed capacity, funded capacity currently at the Norfolk Regional Center. Three of those units are for sex offenders and one is reserved for committed mental health persons. Now our goal is to move those folks into the community from the mental health side in LB1083 commitments as rapidly as can happen. As I mentioned earlier, I think in response to a question, some of those people have been there for more than four years, and community resources have been unable to accept them for one reason or another. They're not people with easy maladies to be able to adjust to in a community setting, at least that's been the case so far. But I want to assure you that we agree that the sex offenders ought not to be involved or mingled with mental health side. We keep them separate by virtue of feeding, by virtue of line of sight, and all of those kinds of things. So they operate as distinct units that do not intermingle. [LR338]

SENATOR SYNOWIECKI: The report...thank you, Dr. Adams. The report spoke to a relatively recent phenomenon that was going on where there was a shift of patients from the Lincoln Regional Center, mental health patients, LB1083 patients, to the Norfolk Regional Center. And that kind of, I think, caught the commission's eye, and they wrote specifically about that shift which was recently done evidently toward publication of the report. And I could kind of, you know, sympathize with particularly consumers' families that have very deliberate or mental health issues and not sex offender issues and having them participate in a treatment environment that has sex offenders that are committed under LB1199. So I understand and can appreciate that we've had patients at the Norfolk Regional Center that are long-term patients, and we're having great difficulty finding a community-based setting for those patients. But the shifting of patients from the Lincoln Regional Center to that environment is what I think the task force is particularly concerned. [LR338]

SCOT ADAMS: A couple of items in response. Again, I would reiterate that the environment that the treatment goes on in with regard to the mental health unit is separate, distinct, and different from the sex offender environment--treatment,

(inaudible), techniques, and expertise. So it really is separate. Secondly, with regard to the fact that there were some people who were moved to Norfolk Regional Center was really in response to earlier this year you may recall that there was some notoriety and some media attention around the fact that there had been a build up of people in jails waiting to be ordered into the Lincoln Regional Center for treatment. We were faced with a situation where we had to accommodate court orders and not to have people wait in jail. One of our slides identified the forensic population as a particular challenge and issue that needs to be addressed and resolved. In order to help people leave the jail setting because we felt that that was not a good place for a person who is mentally ill at all costs, and so to be able to accommodate that we did move some people from the Region 6 and Region 4 area up to the Norfolk Regional Center. Let me assure you, though, that the ongoing coming of persons with...who will be committed under LB1199 sex offense kinds of concerns aligns us with the goal of moving all mental health patients out of Norfolk at some point in time. For now, those beds are needed in the mental health capacity. But at some point those folks need to move to the community, that unit transitioned into a sex offender unit. When that will happen I'm not sure. I'm sure it will not take longer than three years. We suspect it will be in the one- to two-year range, in large part depends on how communities are able to accept these people who are on the mental health side back into the communities. We're not holding onto them for any particular reason. [LR338]

SENATOR GAY: Thanks, Scot. All right, with that, thank you very much. I know you covered a lot of issues and we're going to get a little more in-depth and appreciate the questions here. Thank you very much, Scot. [LR338]

SCOT ADAMS: Thank you very much. [LR338]

SENATOR GAY: We are going to move on to regional behavioral health authorities that are here, some of the regional directors are here. Whoever wants to...I don't know how many of you are going to come up, but come on up and...thank you for coming. Let's go

to about five till, then we'll take about a ten-minute break or so, just so we keep it moving. Go ahead and introduce yourself and...C.J. [LR338]

C.J. JOHNSON: Thank you for allowing us to speak with you this morning. My name is C.J. Johnson, that's J-o-h-n-s-o-n. I'm the regional administrator at the Region 5 Systems. Region 5 covers 16 counties in southeast Nebraska. [LR338]

PATTY JURJEVICH: Good morning. I'm Patty Jurjevich, J-u-r-j-e-v-i-c-h, regional administrator with Region 6 Behavioral Health Care--Cass, Dodge, Douglas, Sarpy, and Washington Counties in eastern Nebraska. [LR338]

BETH BAXTER: (Exhibit 2) Good morning. My name is Beth Baxter, B-e-t-h B-a-x-t-e-r, and I'm the regional administrator for Region 3 Behavioral Health Services which covers 22 counties in central and south central Nebraska. I'm going to start off this morning. We really appreciate the opportunity to be here and to be part of this discussion today. We've developed some booklets for you that hopefully will provide some information about the regional behavioral health authority system and each of the six regional behavioral health authorities across the state. I'm going to start out by giving you just a brief overview of the regions. The regional behavioral health system was enacted in 1974 through the Nebraska Comprehensive Community Mental Health Services Act and then with revised responsibilities and authority in 2004 under LB1083, the Nebraska Behavioral Health Services Act. And this act is designed to create and sustain a community-based behavioral health system. As you know, Nebraska is divided into six behavioral health regions. I believe there's a map of those regions that lists the counties (inaudible). They're each responsible for the provision, oversight, coordination, and management of the behavioral health services within a geographic area. The regional behavioral health system really provides the avenue of local participation in the development, delivery, management, and oversight of needed services and supports across the entire state. The regions facilitate behavioral health services on both an individual and community level by being close to the point of service delivery and having

daily contact with those we serve, the providers that we work with, and our key stakeholders which include consumers, education, children and family service providers, law enforcement, county attorneys, community leaders. And we do this to access...assess the needs and to look at issues and the resources that are both impacting our communities and collectively (inaudible) region and our state. I believe the effectiveness of the regions over the years has really been in our ability to represent (inaudible). This effectiveness has been enhanced through the partnerships that we forge with our consumers, with network providers, with Health and Human Services, and (inaudible). I think the region of behavioral health authority system provides for a flexible system that can meet those unique needs across our state. The regions are governed by a regional governing board that consists of elected officials, either county commissioners or supervisors. We cover a specific geographical area. We contract with the Department of Health and Human Services Division of Behavioral Health for state and federal dollars, and then counties provide what we call county match dollars based upon a statutory formula. Regional governing boards are assisted by regional behavioral health advisor committees. These committees include consumers, at least 50 percent or more need to be consumers, family members of consumers, (inaudible) elected officials, interested individuals, and providers as well. And the behavioral health advisory committee does just that. It acts in an advisory role to the regional governing board (inaudible). The regions utilize state, federal, and county funds to manage a network of behavioral health providers; ensure the provision of mental health and substance abuse services, rehabilitation and support, and prevention services. Dr. Adams alluded to (inaudible) a potential bifurcated system (inaudible). I think we've worked really hard to integrate services--mental health and substance abuse services, integrate adult services across various stakeholders, and worked with children and family service providers in education efforts to integrate services. We facilitate system coordination efforts. It truly is a system. We come at it in a systemic manner. We do this through coordinating our emergency psychiatric services, children's system of care, adult behavioral health services, housing and rental assistance program, consumer and family advocacy and inclusion, and our prevention services. In your packet in the

booklet there's also (inaudible) three of them that are missing. (Inaudible) and then some information along (inaudible). If you happen to get one of (inaudible) that does not include these pieces of information, please let me know and I will (inaudible). [LR338]

PATTY JURJEVICH: Okay. I want to just take a couple of minutes and provide some brief background and context within which we begin the behavioral health reform effort. And just from my perspective I want to say how extraordinary and historic, I think, this process was in the behavioral health system for our citizens. And also a note that this planning process, when we began this in 2004, was really designed around serving hundreds of people statewide. And as we saw in Scott's presentation, over 9,000 people have been served. So I think when you think about efficiencies, I think that's an important point to keep in mind. Three priorities were identified in the initial planning under LB1083 and behavioral health reform. One called replacement, which essentially means that services and supports would be developed or expanded to serve persons in their communities who previously would have been committed to a regional center. Secondly, discharge ready, which essentially is again services and supports being developed or expanded so that individuals who were currently in a regional center might transition back to their home communities. And the third area was emergency system development, which the intent there was to upgrade the emergency psychiatric system to more adequately meet the needs of persons who might be in crisis in their community. I think one of the things that is important not in that list of top three priorities but is significant in the work that we're doing and continue to do is the role of consumers and their family members and their inclusion in helping us shape what we do and how we do it and the decision-making around that and the role of peer specialists and peer provider services in our systems and the inclusion of the recovery philosophy in the services and supports that we provide. [LR338]

C.J. JOHNSON: I want to start off with earlier comment that was presented that at-risk managed care is going to be looked at over the next (inaudible) behavioral health system. And the regional behavioral health authorities look forward to those open

conversations around that. They can look at how in fact that will affect behavioral health provisions throughout the state. And one of the big reasons is we talk about a unified system. And the regions themselves were developed to do something other than just look at the state as a whole but to actually look at the local areas and the unique components that are in relation to that. And I think as you...and each of you know that as you look around the state and you look at the various regions, they are very diverse in relation to their population, very diverse in relation to issues such as travel, availability of professionals, sometimes just the specific local needs. For example, just yesterday I met with two representatives out of Lincoln and a specific representative from the Asian Center. I'm looking at how to address the needs of women who attend the Asian Center who basically are scared, if you will, to seek behavioral health services. And we had to discuss with St. Monica's, who provides gender-specific treatment, what we can do to establish a liaison between St. Monica's and the Asian Center. These are the kind of things that on a regular basis the regions have to look at what's the local need, what's the almost sometimes right there need, two blocks away need. And as we move along, one of the things that we need to be very conscience of is that we don't lose that, because if we do and whether you're in a rural area or a metro area one of the things that we don't want to lose is that uniqueness that (inaudible) for each other. With that in your packets, as was said, if you look through that you'll actually see that the development over the last four years of behavioral health reform does look different in each region. For example, Region 5, again (inaudible) example, is as we develop behavioral health reform we do not receive money up front as the other regions who actually purchase psychiatric care in their community. The original plan was that we would continue to use Lincoln Regional Center as our psychiatric (inaudible) of care. That meant that we had to develop a system that looked differently than some of the other regions in relation to addressing and fulfilling that goal. It doesn't meant that one region is better than the other. It doesn't meant that one region's services are better than the other. It just simply means that sometimes the systems look differently, as the geographic area or the population. Again, we don't want to lose that focus because it's just very critical to Nebraska as a whole to really kind of look at those unique areas. And

as Beth pointed out, because of the governance structure that is set up we do have local elected officials, that's in our governing boards. And our Behavioral Health Advisory Committees are made up of a variety of representatives from the local area who understand the local issues (inaudible) behavioral health needs and provide that guidance not only to us as administrators but also to that governing board. Anyway, I just want to talk about the uniqueness of each of the regions. The other thing that I...I'm going to speak to a critical issue that comes up time and time again and that is that the regional behavioral health authorities in some of the regions actually provide direct services. This is going to be probably a discussion that will continue on as long as there is regional behavioral health authorities because I think regional minds would disagree about should they provide services or should they not provide services. LB1083 did lay out under what conditions that a region could subsequently provide direct services. I will point out that again Region 5 provides...when you look at all the regions, Region 5 provides the least number of actual direct services. In fact, the only direct services that we do provide are the Family and Youth Investment Program, which is for children (inaudible) families. Also, the Integrated Care Coordination Unit which is a contract directly with the state. The other regions, though, have at times had to use their administrative abilities or their management abilities (inaudible) services. A lot of times that is simply because in those areas there was not a willing provider to provide those services or because of the type of service that was coming up it was very difficult for a provider to maybe go with the up-front costs or the managerial pieces. In fact, in Region 5 itself there's been a couple of times where we've actually had to start the service and hand that off, eventually, to another service provider simply because of the management costs and startup costs to get that started. With that, I'll...we're going to move into some gaps. And Mrs...Patty is going to start with those. [LR338]

PATTY JURJEVICH: Okay. As I spoke earlier about those priority areas that we started in behavioral health reform, much of that directed our time and attention and dollars towards creating services and supports to bring folks back out of the regional center as well as to create some community alternatives so that folks didn't have to go to a

regional center. And so particularly in Region 6, I believe, that when we talk about gaps in our current system we are now turning our attention towards what I commonly refer to as kind of the front end of the system, although it makes the system sound linear, which it isn't. But it really is around what kinds of activities can we develop and services that will help prevent a crisis or create something that will develop an early intervention so that perhaps an EPC situation can be avoided. Perhaps an acute hospitalization might be avoided. So I think what...we look forward to that opportunity to be able to put some effort into that part of our system. [LR338]

BETH BAXTER: And one of the other areas that I'll address (inaudible) is both the opportunities and the challenges that (inaudible) funding (inaudible). (Inaudible) talk about (inaudible) distribution of funds through (inaudible) and the lack (inaudible). And those are a great opportunity for us to have an infusion of funds into the behavioral (inaudible) community. It provides seed money to maybe look at a variety of gaps within (inaudible). But the challenge is how do we sustain those services, how do we sustain those (inaudible). So it's a process that the regions (inaudible) developed (inaudible), have received considerable input and feedback from our stakeholders (inaudible) going about the process (inaudible). And so one of the areas that we look forward to is expanding the provider (inaudible). While that can (inaudible) help us address our (inaudible) situation (inaudible) and the challenges (inaudible). (Inaudible) providers have come into our (inaudible). (Inaudible). Again, it's a wonderful opportunity for us but also creates (inaudible). [LR338]

C.J. JOHNSON: One of your areas which we've all been talking about throughout the state is in relation to children's (inaudible). I spent three decades working with children in a variety of capacities (inaudible) during that time, including an 11-year stint with the state of Nebraska, out at NCCY. People used to know that as Whitehall, whatever it was. (Inaudible) a psychiatric hospital's private practice, etcetera. And one of the things that I think we really need to look at in relation to the gaps is that of the public behavioral health system in relation to children's services. (Inaudible) very small amount

of money, if you compare statewide with the child welfare dollars, if you look at Medicaid dollars and then if you look at public behavioral health, there's only a little required $5 million that is actually contributed towards public behavioral health for children's services. (Inaudible) remainder of that is associated with child welfare in some capacity. And what we need to...what we really need to look at is people will argue about do parents really have to give their children up as state wards to receive services. But the reality is if you look at the adult public behavioral health services, individuals who are underinsured or do not have any other kind of insurance of any kind or support are able to access services, if they have no ability to pay they still are able to access the services. This is not an accurate statement when it comes to (inaudible) services. And if you do not have some kind of coverage, there is very, very limited services available out there that parents can access and which they don't need some kind of financial support to do that. The other thing that we need to take a look at is in LB1083, even though we talked about the end of the chapter, LB1083 still is in play. And it does say in there that cost-effective behavioral health services, including but not limited to services that are efficiently managed and supported with appropriate planning information, and here's the key, the services that emphasize prevention, early detection and early intervention. It really stresses the fact that in LB1083 we should take a look at early detection and early intervention, which speaks to our children and youth in our system. And that kind of moves us, as we talk about those gaps and potential future legislative issues that we think we think need to be considered. The first is, and again I want to cite LB1083. It does say, "Encourage and facilitate the statewide development and provision of an appropriate array of community-based behavior health services and continuum of care for both children and adults in the integration and coordination of such services with primary healthcare services." And I emphasize that, that even though the majority of (inaudible) and the funding which move from the regional centers into the community is focused on adult services, which because the intention was those adults were moving into the communities, (inaudible) there still was an emphasis in LB1083, or it states that there should be a service array for children within our state. It also goes on to say that there is a need to integrate all behavioral health funding. And I emphasize all behavioral

health funding within the Nebraska Health and Human Services System and allocate such funding to support the consumer and his or her plan of treatment. And the reason I stress that is a couple of things that were discussed this morning in relation to children as we move forward. I don't need to remind a lot of you because you heard me rant about this a year ago and two years ago when I was concerned that through the development of the Integrated Care Coordination Units that there was established cost savings in an agreement with the previous administration that any cost savings that occurred between the development of that program and the regions, that subsequent cost savings would be utilized to bring up and develop behavioral health services for children and families in our state. At that time there was $6.2 million that was available within the region. The region (inaudible) on a number of occasions made proposals to start up those behavioral health services. And then subsequently two years ago, we were told that because they were appropriated to child welfare that we as regions would not be able to start those behavioral health services up and that funding was withdrawn to the state and was not, as far as I know, was not used as it says in LB1083 to support additional community services based on that funding. With that, there continues to be some question in relation to funding (inaudible) As to the 16 beds that were reduced at the Hastings Regional Center, again I would propose that there may need to be some consideration as to was the funding that was being used for those adolescent beds, was that shifted to the community to develop additional behavioral health services for children and families, as it says in LB1083. If not, I think that needs to be (inaudible). And then finally, in relation to the children services it's great news that our state is actually reducing the number of state wards by (inaudible). That is actually great news. As was pointed out, we were almost 3,000 state wards above the population ratios of any other state. However, I do have a concern. During the discussions that we've reduced the number of state wards by 1,000-plus, what I haven't heard in this discussion is how is the amount of money that's been saved by not having to purchase services for those state wards, how is that savings, that cost savings associated with the reduced number of state wards, how is that being shifted within the Department of Health and Human Services into the public behavioral health side to bring up additional

services in our communities for children and families. Because the reduction of 1,000 state wards is a significant cost savings in relation to the provision of services for those state wards. And I would ask that there be some serious consideration that as the state ward numbers reduce that the savings from child welfare simply doesn't fall into our cash reserves, but actually does follow what LB1083 says, and that it goes to be used for the additional development of behavioral health services in our community. [LR338]

SENATOR GAY: All right. Thanks. Let me check and get (inaudible). You got something (inaudible)? [LR338]

BETH BAXTER: Just very briefly, I think Senator Stuthman raised the concern around do we have adequate rates for behavioral health services in our community. And as we talk about potential legislative consideration (inaudible). (Inaudible) just want to remind us all again that the rates that we pay our providers to provide services to our citizens are extremely important in shoring up our system and maintaining community-based services that have been developed. (Inaudible) just, I want you just all to think about, you know, those necessary rate increases that we need on an annual basis. And understand that fair rates equals access to services and (inaudible). [LR338]

SENATOR GAY: Okay. With that, just looking at the clock, if this is okay with the committee, what I wanted to do is we all know how to contact our regional people here. If you want, let's talk to them. They gave us a good presentation of where they're at so not ask questions right now, but you know you can get these answers from them if you ask. What I'd like to do is take a ten minute break. Meet back here about 11:05 because we're going to go into 30 minutes on the State Advisory Committee wants to speak. And then we've got a good presentation as well on the workforce issues, and that's going to go for a whole hour, to 12:30. So you'd get an hour lunch and I want to kind of stick the...so let's meet back here at about five after 11:00. Thanks. [LR338]

BREAK [LR338]

SENATOR GAY: All right. If we can get started again, we're going to try to round up people. I could be the only one here. All right, if I can get you to grab a seat, I'd appreciate it. We're going to get started. All right, we'll get started again. And I know (inaudible) the State Advisory Committee is going to speak. And, I think, daylight savings time screwed up our watches here. (Laughter) Anyway, we'll get started. Go ahead, Sherrie, if you want to introduce yourself. [LR338]

SHERRIE GEIER: (Exhibit 3) Good morning. My name is Sherrie, S-h-e-r-r-i-e, Geier, G-e-i-e-r. I was a staff members with the Gamblers Assistance Program and I have served on the state committee since 2001. I was the chair for five years and now I'm the vice chair, mentoring the new chair. I will use several different terms today to refer to gambling, and I'm not doing that because I'm indecisive or I want to confuse you, but rather the terms have changed as the field and treatment of gambling has grown and evolved the terminology has changed. And I use the words that I do simply because they're the words that currently exist in statute. In the packets that I...that Erin handed out to you, the first page of the packet, after the title page, provides you an administrative and legislative landmark time line so that you can see at a glance how...what has happened administratively... [LR338]

_____: Excuse me. Could you use the microphone (inaudible). (Inaudible) can't hear (inaudible) very well. Thank you. [LR338]

SHERRIE GEIER: Is that better? [LR338]

_____: Yes. [LR338]

SHERRIE GEIER: Okay. You can see at a glance what has happened administratively and legislatively with this program since the state lottery was passed. The state lottery was passed in 1992 in response to a popular vote. And action by the Legislature and

the citizens who voted for the lottery did so, in part, because they were assured that education, environment and most recently the State Fair may benefit from the profits of the lottery. But they also were very concerned about providing treatment for individuals for whom problem gambling is an addictive disorder. The Gamblers Assistance Program, the Compulsive Gamblers Assistance Fund and the first Advisory Commission on Compulsive Gambling were all created through the passage of the State Lottery Act. The Gamblers Assistance Program and the fund were originally administered by the Department of Revenue, but they were transferred to the Department of Public Institutions in 1995. When Public Institutions merged with four other state agencies in '97 they were transferred to the Department of Health and Human Services where they currently reside in the Division of Behavioral Health. When the Behavioral Health Reform Act was passed, in 2004, the original Advisory Commission on Compulsive Gambling was eliminated and was replaced by the State Advisory Committee on Problem Gambling and Addiction Services and that was a component of a larger entity called the state Behavioral Health Council. And the Mental Health Advisory Committee, the Substance Abuse Advisory Committee and the Gambling Advisory Committee were all attached to this overarching Behavioral Health Council. Members of each committee also served on the Behavioral Health Council, and I was one of those members who did so. In 2005, LB551 was passed and it required that at least three members of each committee who are appointed to serve on these be consumers of the services. Right now we are required to have three but we currently have five and they're very helpful to us in decision-making. This year the passage of LB1058, the State Committee on Problem Gambling underwent its third and, hopefully, final change in its name and purpose. In accordance with legislative intent that the Compulsive Gamblers Assistance Fund be used primarily for counseling and treatment services of problem gamblers and their families, the committee is responsible for developing and recommending to the Division of Behavioral Health guidelines and standards for the distribution of monies from the Compulsive Gamblers Assistance Fund. The committee also develops recommendations for evaluation of services, prevention plans, public awareness and education activities and training of counselors. The committee, contrary to some public

belief, does not take a policy position on the issue of gambling; that's not our way. The Gamblers Assistance Program is an administrative entity that combines a public health model with advice from the Problem Gambling Committee, expertise from certified treatment counselors and recovering gamblers or consumers, as they are often known, to reduce the impact of problem gambling on all Nebraskans. The services that the Gambling Assistance Program provides are all let based upon competitively awarded contracts. We focus first and foremost on treatment services. There are six agency and nine private providers that currently hold treatment contracts in the state of Nebraska. The analysis that we have indicates that people who receive both individual and group treatment are more likely to complete treatment. And even though it may cost more to do both group and individual treatment, the costs, in our opinion, are worth it because they are more apt to recover and maintain their recovery status. Nebraska, in 1999, became the first state to certify gambling counselors. The Gamblers Assistance Program oversees the certification process for the counselors. And the certification process used by the GAP is modeled after the state of Nebraska's licensure process for substance abuse counselors. Last year, the Gamblers Assistance Program initiated a licensing process for gambling counselors. The 407 Review Process is currently underway, and the goal is that Nebraska will be the first state in the nation to have licensed counselors and that the process will be completed by 2010. We promote access to problem gambling services through a statewide 24-hour-a-day, 7-days-a-week crisis line that is staffed by trained volunteers. In 2007, the help line received approximately 2,000 calls per month. One of the most important initiatives that we're focusing right now is on prevention. We have learned, through self-reporting in the Nebraska Risk and Protective Factor Student Survey, that 66 percent of underage youth report gambling illegally for money. The average onset of gambling among youth is age ten. The surveys have included gambling questions in 2003, 2005 and now 2007. And what we found was that there was an increased amount of self-reporting of this type of gambling activity between the 2003 survey and the 2005 survey. As a result of the concern about problem gambling starting among youth and the fact that we feel that with our limited resources we can perhaps make the greatest impact on youth, we have

focused prevention activities on youth and their families. And we currently have contracts awarded in Lancaster, Garfield, Loup and Wheeler counties to do prevention activities that focus on youth and their families. The last thing that I really want to mention is the Compulsive Gamblers Assistance Fund. This fund has never received a General Fund appropriation from the state of Nebraska, nor has it received federal funds. There are no federal funds, so far, for gambling as there are for substance abuse and mental health treatment. There is hope that there will eventually be federal funds. SAMSA is attempting to encourage this. With the current economic problems that the nation is facing it's unlikely to happen anytime soon. With the passage of the lottery, 1 percent of 25 percent of the lottery's profits are allocated to the Gamblers Assistance Fund, that is approximately $250,000 a year but it fluctuates. In 1996, the Legislature appropriated an additional $250,000 a year from the Charitable Gaming Operations Fund and included intent language in an appropriations bill to increase the appropriation in future years if the need arose. In 2000, the Legislature increased annual funding from the lottery to a fixed initial amount of $500,000 plus the original 1 percent of 25 percent of the lottery profits. But at the same time it reduced the Charitable Gaming amount from $250,000 to $50,000. The current annual funding from these two sources is about $850,000, but it goes up and down based upon whether the lottery is being played a lot or not. In 2005, the Legislature passed a bill to appropriate $250,000 a year for each of two years from the Healthcare Cash Fund. The Department of Health and Human Services included this same amount of funding in 2007 biennial budget request. And the department is expected to make the same request in 2009. In 2006, LB1039 provided 5 percent of the lottery's annual marketing budget to be directed specifically at providing educational public awareness messages for Nebraskans about responsible gambling as well as the existence of treatment services. And I've provided you with some handouts or some breakdowns of the spending by category and by activity. And I also provided for you some general information, background about problem gambling, about the interchange in use of language and what it means to be a problem gambler versus a pathological gambler, and to talk a little bit about how it's going to change with the next addition of the diagnostic and statistical manual. Right now it's categorized and thought

of as an impulse control disorder, but with the next edition of the DSM it's expected to be categorized as an addiction. And with that, I'll let you review the materials I've provided. If you have any questions, I'd be happy to answer them. [LR338]

SENATOR GAY: All right, thank you. Are you the only speaker? [LR338]

SHERRIE GEIER: Yes. [LR338]

SENATOR GAY: Okay. All right. Any questions? Senator Stuthman. [LR338]

SENATOR STUTHMAN: Thank you, Senator Gay. The one question that I have is the fact that when you talked on the prevention... [LR338]

SHERRIE GEIER: Um-hum. [LR338]

SENATOR STUTHMAN: ...part of it, the youth prevention, and we've got programs in Lancaster, Garfield, Loop and Wheeler Counties. [LR338]

SHERRIE GEIER: Um-hum. [LR338]

SENATOR STUTHMAN: Are these programs that they apply for a grant... [LR338]

SHERRIE GEIER: Yes. [LR338]

SENATOR STUTHMAN: ...and they have them in the school system? Is that what it is? [LR338]

SHERRIE GEIER: They are operated, one, the Lincoln one is operated through the Lancaster County Substance Abuse Coalition. The one in...the other three counties was applied for and awarded to a coalition that was formed out of the SICA program that is a

federally funded program that puts alcohol prevention dollars, federal dollars into coalitions throughout the state. They applied for and were granted that. We are going to renew the competitive awarding process again next year. So it may change. If we have more money, we might add more but this is what we could do with the funding that we had. [LR338]

SENATOR STUTHMAN: Are there more gamblers and more addictions in certain parts of the state than other parts of the state? I mean, I look at Wheeler County as, you know, a fairly sparsely populated area. Are there, you know, 25 percent of them have addictions up in that area or it's just...this is just a program to try to teach the kids? [LR338]

SHERRIE GEIER: And it's aimed at children and their families, so we don't know the statistics. The answer to your question, I think, is we don't know for sure that there are currently active problem gamblers in greater or lesser degrees in that area. But this is aimed at, hopefully, preventing, delivering a message to youth and their families about the fact that this, for some people, is more than a source of entertainment. It becomes a problem. So it wasn't awarded based upon the knowledge that there are more gamblers in that area. [LR338]

SENATOR STUTHMAN: It's just to provide information to the youth, hopefully, to keep them out of gambling the rest of their lives. [LR338]

SHERRIE GEIER: Um-hum, yes. Ideally, if we had the funds to do it we would be providing this message. And we do it through public awareness messages. All of the counselors who serve all parts of the state through agencies and private provider contracts also receive monies in their contracts to do community outreach messages. [LR338]

SENATOR STUTHMAN: Okay. [LR338]

SHERRIE GEIER: So all communities have the ability to have this information but this is a concentrated effort. And based upon the data that we collect from this, we may decide to move it, we may decide to expand it, we may decide, if we have additional revenue to work with, we will add another program. We just have to see what the money allows and what the data evaluation shows. [LR338]

SENATOR STUTHMAN: Okay, thank you. [LR338]

SENATOR GAY: Senator Hansen. [LR338]

SENATOR HANSEN: Thank you, Senator Gay. Sherrie, it's somewhat bothering to have adults be addicted to gambling. But when you talk about kids being addicted to gambling ten years old or even younger, what type of gambling are you talking about? Is it more than bingo or...what... [LR338]

SHERRIE GEIER: Try internet gambling. [LR338]

SENATOR HANSEN: Internet. [LR338]

SHERRIE GEIER: They can do it from home, they're using parent's credit cards. Parents are buying lottery tickets for children as gifts. Are you aware of high schools that want to prevent alcohol abuse on prom night that switch to casino nights? It's sports betting, it's a whole variety of activities. They're playing poker, Texas hold 'em, they're playing poker for pennies in bathrooms, on playgrounds. So...and we don't know that these children are going to grow up to become compulsive or problem gamblers, but when they start this young, right now we've got an adult population that didn't grow up necessarily with casino type gambling, except perhaps in Las Vegas and then ultimately in Atlantic City. And you have to get on...you have to make a conscience effort to travel and budget money to go to someplace to play a game. That's not true for the kids these

days, they can play it from home, they can play it in their rooms. [LR338]

SENATOR HANSEN: Thank you. [LR338]

SENATOR GAY: All right. Any other questions? Senator Pankonin. [LR338]

SENATOR PANKONIN: Thank you, Senator Gay. Sherrie, on page 2 you've got that there were 432 consumers were served during the 2007 fiscal year. And it may be in here. That number, is it going down, going up, pretty constant, do you know? [LR338]

SHERRIE GEIER: It fluctuates, but I would say if you look at it in the big picture it's going up. The bill that was passed in 2005, that gave us the original appropriation from the Healthcare Cash Fund, was largely driven by the fact that the number of persons who needed to be served was growing to the point where the providers either had to turn people away and/or they were providing pro bono counseling. And we felt that that was not fair, wasn't realistic. And so the Healthcare Cash Funds were used to reimburse some of that. And now...and the legislative intent in LB1058, that was passed this year, makes it very clear that even if we have to do away with all of the other services, the first thing we have to provide is treatment. [LR338]

SENATOR GAY: All right. Senator Harms. [LR338]

SENATOR HARMS: Thank you very much, Senator Gay. The information that you gave us on clinical treatment, talk about the cost, around $3,300, and then you indicate that between 14,000 to 21,000 people potentially could be pathological gamblers. [LR338]

SHERRIE GEIER: Um-hum. [LR338]

SENATOR HARMS: How do you determine that? [LR338]

SHERRIE GEIER: That is based upon a national study. [LR338]

SENATOR HARMS: Okay, so that's...but this is talking about Nebraska. [LR338]

SHERRIE GEIER: It's extrapolated from... [LR338]

SENATOR HARMS: But how do they determine that we would have that potential number of gamblers with that kind of problem? [LR338]

SHERRIE GEIER: Based upon the statistics that have been gathered statewide and ruralwide. McGill University does an enormous amount of research, both in Canada, but in this country as well. And it's based upon a couple of decades now of compiling data. [LR338]

SENATOR HARMS: Okay. In regard to treatment is there any evaluation done that you track in regard to the clients that come in, you need to have what the results are and whether to go back to gambling or not, it's kind of like being an alcoholic, you're addicted to this whole thing. And if they don't stay in a program they're pretty much going to probably be back where they are after a period of time. What's being done here and what's the data show? You might have mentioned that and I might have missed it. I would apologize. But what is the data that shows us how successful we are at the front end of dealing with these clients? [LR338]

SHERRIE GEIER: Right now we are in the process of funding a fairly comprehensive evaluation process that is trying to be a little bit more precise than we've been able to be in the past. The evaluation is the data is collected and housed in Magellan, the Magellan System that, I think, members of this committee are familiar... [LR338]

SENATOR HARMS: So we don't really know yet at this point how we're doing in regard to that, is that what you're saying? [LR338]

SHERRIE GEIER: We know based upon the counsellors reports about who is returning, who is repeating. When we ask them to self-report, afterwards if we ask them to continue to communicate with us how they're doing, we can only depend upon them, we can't require them to do it. Some people do. They're asked afterwards to keep in touch and report back, they're contacted. But it's up to them whether or not they report back. We know if they require or they return, they have a crisis and they ask for treatment again. We also have the data that's in Magellan that's being evaluated by the Nebraska Public...UNL Public Policy Center right now. [LR338]

SENATOR HARMS: So when will you have that data available to where we could actually look at how well we do? [LR338]

SHERRIE GEIER: We hope that by next year, we have a committee meeting on 21st of this month, and we're going to get an update from both Magellan and the Public Policy Center about where they are and the time line for this. The Magellan System has had some technical problems that have prevented data from being entered. And if data can't be entered for a period of time then the Public Policy Center can't crunch the numbers, so to speak. So we hope we're going to get a report on the 21st of this month about where we are in the progress of both data entry...collection entry and then analysis. [LR338]

SENATOR HARMS: Do you know when you look at a client or look at a client to see (inaudible) do individual and group therapy with them, which is the most successful. [LR338]

SHERRIE GEIER: They need both. [LR338]

SENATOR HARMS: Use them both? [LR338]

SHERRIE GEIER: Um-hum, if at all possible because the evidence does show that if they participate in both they are more likely to finish treatment and more likely to maintain their recovery. [LR338]

SENATOR HARMS: So what's the length of the program and time that they have in individual therapy or group therapy? How long does it take for us to go or what's the length? [LR338]

SHERRIE GEIER: That also depends on the individual client. I don't pretend to be one of the counselors. But the counselors report to us that some people it takes a few months, some people it takes several years. [LR338]

SENATOR HARMS: So this $3,300 goes a long ways, doesn't it? [LR338]

SHERRIE GEIER: And that's an average. [LR338]

SENATOR HARMS: An average? [LR338]

SHERRIE GEIER: Yeah. So for some people who require less time the cost, obviously, is lower, and for some people who need more long-term care and counseling it's higher. And it's just like any other form of treatment, the cost vary depending upon the individual need. [LR338]

SENATOR HARMS: Thank you. [LR338]

SENATOR GAY: Thank you. Well, thank you for your service on the Advisory Committee, as well. And thank you for coming today, appreciate the information you gave us. [LR338]

SHERRIE GEIER: (Inaudible). [LR338]

SENATOR GAY: All right. Move on to Behavioral Health Workforce issues. And I know... [LR338]

BEV FERGUSON: Wait. [LR338]

SENATOR GAY: Oh, I'm sorry. Go ahead, quickly. [LR338]

BEV FERGUSON: I'm Bev Ferguson, B-e-v F-e-r-g-u-s-o-n, and I'm here today as the chair of the State Advisory Committee for Mental Health Services. I have served on this committee since its implementation in 2004. I've been chair of this committee for the last two years. And I was appointed to this committee because of my personal experiences in seeking appropriate services for children with mental health and behavioral health issues, children, adolescents, transitional ageing youth and adults. I've been at this for a long time. My children are now adults. I'm a parent of three biological children, in addition to that I have three adopted children, one foster child and am now raising two grandchildren for the last decade. So I've had some experiences that are real life in trying to obtain services for children all the way through the system until they're adults. And I've looked forward to this opportunity to be on a committee where I have an avenue to give input so maybe some positive experiences can come out of those personal experiences. And I'm not alone in my personal experiences or my experiences trying to get people services with mental health no matter what age they are. Our committee is comprised of people, both professionally and personally, that have spent a lot of years trying to seek services for people with mental illness whether they're children or adults. Our committee is comprised of 23 people. And I'll just read for you what the composition of our committee is. It's composed of 1 regional governing board member, 1 regional administrator, 12 consumers of behavioral health services or their family members, 2 providers of behavioral health services, 2 representatives from the state Department of Education including 1 representative from the Division of Vocational Rehab of the state Department of Education, 3 representatives from the Department of

Health and Human Services representing mental health, social services, Medicaid, and 1 representative from the Nebraska Commission on Law Enforcement and Criminal Justice, and 1 representative from housing...the housing office and Community of Rural Development Division and Department of Economic Development. During the last four years, this committee has developed into a very collaborative and cohesive unit. As you can see, this is a very diverse group. For this committee to be effective it was imperative that everyone was on the same page and talking the language with one common goal. Once this occurred, the committee embraced its role and developed a passion to be a vital component in mental health reform. The committee meets once quarterly for at least seven hours. These meetings are very well planned and organized. And the committee spends time gathering and reviewing information on proposed changes to existing services or the development of new services and provides feedback on the possible implication of those proposals. In an effort to do this and have a real understanding of what's going on through the whole state the committee asks each regional administrator to come to our meeting and give us a report on what was going on in their regions and what mental health reform looked like in their regions and, graciously, each one has done that. And what we learned as a committee from that and what was apparent to us and what we discussed was how different services looked in every area of the state, but how necessary it was for services to be able to be delivered in a flexible manner with flexible funding to suit the area of the state because the state is, as you all know, very diverse in its needs. And what works in one location may not work in another location. The committee makes recommendations at each meeting or submits questions to the division for more information or for documentation on something. Or just some examples of those is we suggested an ad hoc committee be formed to address the needs of the elderly individuals with mental illness. We've made some requests of the division to check on how to reduce the Medicare drug costs to people. The committee has asked the division for a chart and an explanation of funding sources and the percentage of each and for reports on the extent of family and consumer participation in this process. And the committee has also had very many animated discussions on various topics and barriers that have a profound affect on

individuals with mental illness. Just some of those topics, and you've heard a lot of these discussed here today: The relinquishment of parental rights in order to access services for children with severe emotional disorders; we have several people that serve on this committee that has had to go through that process; accessible services and supports for families; educational and training for law enforcement officers; emergency protective custody procedures; barriers to people with (inaudible) to employment; system disincentives for people with mental illness to be employed; supportive employment; barriers to education; the challenges and the need of collaboration between children's residential treatment and public schools; barriers to affordable and accessible housing for those with low and extremely low income; cultural barriers in providing and receiving services; Medicaid; services for transitionally aged children; veterans services for the returning veteran and their families; suicide prevention; the mortality rate for individuals with mental illness; ways to disseminate information regarding available services to people who need the services; the Mental Health Block Grant; and gaps in services. In addition to addressing the reform issues, this committee reviews and evaluates and gives feedback on the Nebraska application for Community Mental Health Services Block Grant. This was taking a great deal of our committee time. So in response to our concerns about that and being able to still review the grant, the division did get the committee access to a Web site that we can go on doing the writing of the grant and post comments on anything that's posted in that grant. In retrospect, our committee believes that the Legislature showed great foresight in establishing the State Advisory Committee on Mental Health Services. Overall, the division has been prudent in their use of this committee to fine-tune proposed changes prior, hopefully prior to their implementation. This has enhanced the chances of success in having effective reform effort. And as a committee, we look forward to continuing this collaborative effort to ensure that the Nebraska citizens have access to quality mental health services. [LR338]

SENATOR GAY: All right. Thank you. Just one thing I want to do is if we keep the questions quick, and what I want to do is make you an offer. We have four returning

members of the Health Committee, and sometime bring them together and get some more information from you, if that would be okay, as we come back in January. [LR338]

BEV FERGUSON: Yes. [LR338]

SENATOR GAY: Answer a few quick questions here today, but I want to stay on track. And this is my fault,... [LR338]

BEV FERGUSON: That's fine. [LR338]

SENATOR GAY: I didn't know how long we were going to take here. But if that would be okay, just a few quick ones from Senator Harms and then we'll have Senator Nelson. [LR338]

SENATOR HARMS: Thank you, Senator Gay. There's nothing quick with me. (Laughter) Sorry about that. [LR338]

SENATOR GAY: Is that one questions? (Laugh) [LR338]

SENATOR HARMS: You know, I'm not a troublemaker. I'll go quick. When you look at the organization, the new structure that's coming in, the barriers that you've just listed to me are pretty breathtaking barriers. Is this going to address this issue? And secondly, will this reorganization actually give us better community-based services or not? And third, is the funding appropriate? I put you on a spot, I didn't want to do that. [LR338]

BEV FERGUSON: I'm going to speak as a parent to this and my experience on being the end of those services that is trying to access those and the barriers that have faced my children as they've grown into adulthood. And these are huge and overwhelming problems. And we can't let ourselves think that, you know, we're going to solve all of this immediately. But I think what we really need to be attuned to is, as you hear reports

from different groups and you hear numbers of children, as an example I'll use this one just because I know more about this one, children leaving the status of state ward and that those numbers have been reduced, which is great. You know, the state doesn't make a great parent. But I would just would encourage you to ask that second question, you know. Those children aren't state wards anymore but where do they go. And you know, they still have the same problems. And maybe those problems have been increased or changed or added to because of the move. And are those services going to be accessible to them now because they are not state wards and their funding mechanism isn't there to fund those services. Those are questions I would always ask as you're being presented data. And as success stories what are the further implications of reducing this number? That's great. But if that causes 14 more implications over here that aren't so great, you know, we have to look at the whole picture and not just a part of the picture. [LR338]

SENATOR HARMS: My concern still is that I haven't heard anything yet that is going to resolve this in my mind at this point. (Inaudible) moving (inaudible) adults or children into a community-based program that I don't think is adequate nor is it funded adequate nor it will be supervised adequate nor will we have the appropriate services, I am concerned about that aspect of it. What are your thoughts? Is that something that I should be concerned about or we should be concerned about? What are your views about that? [LR338]

BEV FERGUSON: I think for children in our state we have had so few services, community-based or otherwise, that I just think we need to look seriously at what we do. There is nobody that wants reform more than I do. I can tell you this system has been a nightmare. So that's the role I see a lot of our committee playing as the people who have had to go through those barriers and had to walk through those doors and sometimes knock those doors down, then when programs and things get brought before us we're very...we are a very vocal group to the division. And we do bring forth barriers that we see. And it has appeared to us that on many occasions they have listened to us

[LR338]

SENATOR HARMS: Well, I know the system is a nightmare because I have had the fortunate opportunity to talk to a number of parents. And I worry a little bit about (inaudible) you talk about flexibility and funding and flexibility because each of the districts varies, the regions you might serve are different and that's absolutely correct. The concern that I have is the further we go into rural America the less opportunity we have of serving children with appropriate help or adults or whoever it might be, we just don't have that service available. And putting them in a community-based program without appropriate funding, without the appropriate services, I just believe very strongly we're going to put people at risk. And then, in fact, we put these people in a community-based program that's not established well, doesn't have the services, and if we think we're going to train people who don't have an educational background to do this, I'm sorry folks, we're just a nightmare waiting to happen here. It's an accident waiting to occur. Am I just out in left field with these views or...(inaudible) again. I don't mean to do that. [LR338]

BEV FERGUSON: (Laugh) I have a couple of insights on that. [LR338]

SENATOR GAY: Can I stop you there because that's a perfect segue, actually, into the next topic we're going to discuss about training and workforce development and the...if that's okay. [LR338]

BEV FERGUSON: That's fine. [LR338]

SENATOR GAY: Because we do need to move on. And, John, do you have a quick one? [LR338]

SENATOR NELSON: I'll just...I'll pass, I'll ask (inaudible) later. [LR338]

SENATOR GAY: Okay, thank you. And not that...and I really do want you to come back and...in front of the...there's four members here that will be returning. We'd love to hear more of what you're doing in a nonrushed basis, you know, at a breakfast meeting or over a lunch or something like that. So let's get together and do that. All right, thank you very much. [LR338]

BEV FERGUSON: Okay, thank you. [LR338]

SENATOR GAY: Thank you. Okay, we will go to the workforce issue. And while they're getting ready, I did want to say earlier, I know we were introducing senators, I see Senator Jim Jensen is here. And I know he got a lot of this started, all of it. And there are a lot of great things that have happened because of your efforts. Thank you for being here. I know you have a lot of information on this issue and you've been a good help to a lot of people, so thanks for being here, Jim. Go ahead. [LR338]

RHONDA HAWKS: (Exhibit 4) Thank you very much. Senators, my name is Rhonda Hawks, spelled H-a-w-k-s. I am president of The Hawks Foundation. Thank you for allowing me the opportunity today to provide an outside view of behavioral health. I applaud Senator Johnson for allowing us the opportunity to update you and for his unwavering support. Like almost everyone here today and like many who became passionately involved in this issue, I know someone who has struggled with behavioral health issues. My father was diagnosed with schizophrenia in his early twenties. He suffered from the effects of the disease all his adult life, including the desire to self-medicate with alcohol in a desperate attempt to find any way to get some kind of relief from the disease. He battled numerous side effects from a myriad of psychotropic drugs and isolation from friends and family who did not understand the behavior prompted by the disease. I'm a strong believer in behavioral health reform. I believe in treating patients or consumers in their home territory, close to family and other support systems and believe in early access to medical professionals and medicine to avoid a psychiatric crisis, which not only avoids the trauma for the patient and their family but

also avoids an expensive, high-end level of care. Because of reform, we are serving many more people in our communities. We saw them in a slide by Scot today. We ask for your patience as we sort through the services that are necessary and the most effective in each region and how best to deploy the financial resources moving from the state regional centers to the region. I'm here representing a private sector partner who has worked hard to promote a strong public/private partnership that helped make Lasting Hope Recovery Center in Omaha a reality and provide financial assistance to agencies providing behavioral health outpatient services in Region 6 as well. A fundraising team made up of Ken Stinson, chairman of Peter Kiewit Sons'; my husband, Howard Hawks, founder and chairman of Tenaska; and me raised about $25 million in private sector donations to renovate, furnish and provide startup expenses for Lasting Hope Recovery Center, a 64-bed psychiatric hospital in Omaha. The private funding was for capital expenditures and was predicated on the state's promise to provide an agreed upon amount of operational funding to make the project break even on an operating basis. Continuation of this funding is critical to Lasting Hope's financial success. In addition to the numerous private donors, the public/private partnership for Lasting Hope includes many organizations: Alegent Health, who manages, operates and licensed the hospital; the Nebraska Medical Center and Alegent who provide backstops, financial backstops for the hospital; and, of course, the funding by the state of Nebraska is critical. Region 6, community-based agencies, consumers, law enforcement, the local universities including UNMC, Creighton and UNO and private psychiatrists have lent support not only to Lasting Hope but behavioral services in Region 6 as well. Lasting Hope opened in April 2008 and ramped up operation slowly until late August 2008 when all 64 beds were opened. Alegent has battled recruitment of both psychiatrists and nursing staff. They have been recruiting for well over one year to a brand new, state of the art psychiatric hospital in an urban area and have had little success in attracting psychiatrists due to a nationwide shortage. We need five psychiatrists to complete our compliment of psychiatrists. We now have three on staff full time. We hired our medical director who is retired military and has family ties to the area. One of the doctors is a UNMC...is a graduate of UNMC's psychiatry program. The

other doctor is a graduate of Creighton's psychiatry program. We have one locum tenens who is a doctor hired on a temporary basis through an agency which is an increased expense to the hospital and it's only, again I emphasize, on a temporary basis. To help assist for weekend and evening coverage, UNMC doctors and other Alegent system physicians have graciously agreed to pitch in so that we can serve the patients at Lasting Hope. Lasting Hope is recruiting nursing staff from around the United States. Lasting Hope is part of the Alegent system, and Alegent currently has 41 nursing vacancies throughout its systems. Vacancies cause nurses on staff to work longer and increased hours and leads to fatigue and burnout. And the same thing happens to the psychiatrists as well. As you can see, the behavioral health workforce shortage is very real. I'm currently serving as chair of the new Behavioral Health Oversight Commission. In addition to tackling the question of how the regional centers should be used, we are addressing the workforce shortage issue in Nebraska as well. Today, I have two experts with me who have worked tirelessly on a plan to increase the number of psychiatric residents who train in Nebraska, utilize telehealth across the state of Nebraska, and build a new multidisciplinary training model to improve the quality of behavioral healthcare in the state. These experts are Dr. Steve Wengel, Chair of the Department of Psychiatry for the University of Nebraska Medical Center, and Dr. Susan Boust, Associate Professor with the University of Nebraska Medical Center, Department of Psychiatry. Thank you very much for the opportunity to share this information with you today. I'll be glad to answer any questions I can. And then I'd like to turn it over to Dr. Wengel and Dr. Boust to talk about the things that I mentioned before. [LR338]

SENATOR GAY: Okay. Rhonda, are they going to...are you going to go give your presentation? [LR338]

RHONDA HAWKS: Yes. [LR338]

SENATOR GAY: Let's do that, and then we'll hold the questions till the end, if that's okay. [LR338]

RHONDA HAWKS: Perfect. Yeah, that would be great. [LR338]

SENATOR GAY: And then Dr. Boust, are you going to speaking? You want to edge to a microphone or...there you go. Okay, go ahead. [LR338]

STEVE WENGEL: (Exhibit 5) Good morning. I'm Dr. Steve Wengel, and that's spelled W-e-n-g-e-l. As Mrs. Hawks mentioned, I'm the Chairman of the Department of Psychiatry at the University of Nebraska Medical Center. And want to thank all of you again for this opportunity to talk about an issue that's very dear to my heart and I think a pressing and critical issue for the citizens of Nebraska. We have a brief presentation on a proposal. And you have copies of all of our slides, I believe, in front of you. And the upshot of what we're going to be saying in the next few minutes is that we propose to create an innovative, recovery-focused education and training center for the purpose of developing a competent, interdisciplinary behavioral health workforce to serve the people of Nebraska. That's really the punch line, if you will, of this presentation. I wanted to start with that up front. I'll explain what we mean by these various terms here. I probably don't have to say this but I will anyway. I think most people recognize that behavioral health issues are widespread, they effect virtually every family in this state and in this country. Everyone knows someone, whether it's a loved one or a friend, with mental health or behavioral health issues. Some conservative estimates are that at least 24 percent of the population will suffer from a significant behavioral health issue in any given year. I would like to also briefly define what I mean by behavioral health. The older term was mental health issues or mental health. And behavioral health is a bigger umbrella, it's mental health issues plus substance abuse. So if one suffers from either or both of those things we refer to that as behavioral health. So again, these are very common problems that have devastating effects. Really, when you think about it what other (inaudible) illnesses have such impact on people in terms of lost wages, high healthcare costs, human suffering, even law enforcement costs. The next slide demonstrates or describes the problem again. As you've heard, the mental health

reform process is in full swing and many successes have been accomplished. But there is still work to be done. We still lack trained professionals in all of our communities. And the other issue is that, historically, our training has used old models that really have not kept pace with developments in the behavioral health field. And in particular, we train within our disciplines rather than training together. So, for example, medical students train with medical students, nursing students train with nursing students and so on. And yet, after we get out of training, particularly if we work in an inpatient setting or a community mental health center we need to work together as a team, but we don't really have that training as the system has not really supported that. A quick reminder on a section of LB1083 which describes the need to promote activities in research and education to improve the quality, underlying quality, quality of behavioral health services, the recruitment and retention, and I'd like to verbally underline recruitment and retention of behavioral health professionals and the availability, and underlining availability, in rural health services. With the shift of services from institutions back to the community, again a move that I fully supported and think it's timely, we have got to support those communities. Communities are facing tremendous need with very limited resources to meet those needs. Even with exceptional public/private partnerships, such as Lasting Hope, the need is still overwhelming and behavioral health issues then spill over into other areas, including the school system and law enforcement. As my colleague, Dr. Boust informs me, the largest public mental health, or let me just back up. The largest psychiatric hospitals in this country are penal systems, in LA and in other parts of the country. So we've done great work with reform. Behavioral health reform has done many, many positive things and there is much cause for celebration, but there is still unfinished business. This is my last slide before I turn over the microphone to Dr. Boust here. But we're making a case, basically, that now that clinical services have been moved to the communities, and that was the initial focus of the reform efforts, appropriately, is to move the clinical services away from the big institutions and back to the communities. Now it's time, I think, to move to education (inaudible) effort. We've changed the location of care and we're also changing the philosophy of care to keep up with modern times and research into better ways to treat people with behavioral health

problems. As you see listed here, community-based care, interdisciplinary, (inaudible) right from the git-go work together where nursing students, and medical students, and pharmacy students, and social work students, and a variety of others train together so we learn how to work together, we learn how to use each other's strengths. Consumer-oriented, this is really a very big (inaudible) change, I think, in behavioral health treatment involving consumers as peers, as part of the treatment, very, very powerful assistance to the treatment process. Then recovery focused--we don't have time, the hour is short I realize. But recovery is a model. It's not just a word but it's a whole new model and philosophy of care and treatment for people with behavioral health issues, which largely revolves around hope. Just to give you a very quick sense of some of the...the magnitude of the changes, when I was in residency 20 years ago if a person...if one of our patients or consumers was diagnosed with schizophrenia conventional wisdom, at the time, was that at least two-thirds of them would probably have a poor outcome, a poor prognosis. They would be very unlikely to hold down a job, would be unlikely to be able to, say, complete a college degree, unlikely to sustain personal relationships and things like that. There was not a lot of room for hope back then. We've had advances in treatment, but we also now need to advance the way we work with consumers so that we can instill hope and help them to lead meaningful, productive lives because they can. It involves a new training method and new modality of training that is not really in practice right now. And the last phrase is evidence-based. This needs to be data-driven and it is. We need to look at what others have done before us, what works and what doesn't work. And we need to constantly evaluate what we're going to be delivering, too, to make sure that we're doing the right things at the right times. So the bottom line really is we believe that this requires a statewide change (inaudible) model (inaudible). And with that, I'm going to ask Dr. Boust to (inaudible). [LR338]

SUSAN BOUST: My name is Susan Boust, B-o-u-s-t, and I work for Dr. Wengel. And I've spent my career working with people with serious and persistent mental illness. We have been working on a proposal for this since LB1083 passed. And the proposal I'm

talking about is based on statewide work with input from lots of academic institutions, consumers and the state through the Academic Support Workgroup. What the proposal is, is a center which is a small number of people and then a virtual center, a lot more using the faculty of all of our academic institutions, consumers, people from agencies to actually bring this change of curriculum to the professionals in the state of Nebraska. Besides the center, there are sites that would be in the rest of the state. So the center would increase the number of trained practitioners, at least one special focus will be on increasing the psychiatrists that are needing this. As a national shortage our proposal would increase the number by 25 percent. And this has a significant expense--psychiatry residents, any physician in training during their residency is the only professional who is...or generally the only professional who is getting a salary during the time that they are training, psychologists may also, some social workers. So we have a proposal to increase the number of psychiatry residents and to improve recruitment and retention of providers, particularly in rural areas. We want to make better use of telehealth. Telehealth works very well for psychiatry. As a matter of fact, the state of Nebraska was one of the pioneers in this, back in the sixties. And then we want to improve the preparation of the behavioral health workforce, and this would include development of interdisciplinary educational tools, putting together a grant process where we would write a curriculum that would be available on the internet, could go into the school of social work, could be developed for special...for people who are already in training on what is recovery; how do you work better with cooccurring disorders. This involves all stakeholders in rewriting the curriculum that we're teaching our practitioners. Dissemination of these materials, both through current educational schools, through certificate programs, through statewide in-service training and then finally development of one interdisciplinary site where, as Dr. Wengel talked about, we actually have nursing students, medical students, residents in psychiatry and psychology and working all together under expert leadership to deliver care at the same time, that they learn how to work as a team while retaining their own professional identity. I did want to mention the Statewide Secure Information Network. Nebraska is blessed to have so much connectivity between our hospitals. We have one of the faculty

in the Department of Psychiatry who provides care to, how many nursing homes? [LR338]

STEVE WENGEL: Approximately 20. [LR338]

SUSAN BOUST: ...20 nursing homes in rural areas where, instead of that person needing to be put in a car and brought to Omaha to see their geriatric psychiatrist, they can go to their local hospital and sit in a room and have their psychiatric visit over telehealth. This network is available. It's tremendously underused. And I have worked for years to try and get more telehealth going. It is difficult. The equipment is there. It's ready to go, but you have to train the practitioners, you have to coordinate things. There has got to be somebody on both ends. Only one end gets paid. So there are some hurdles to jump. But this is a tremendous opportunity for us to better deliver services in rural areas. I said there were two parts of the proposal--the center and the sites. And the sites are less developed than the center because the sites must be developed with local input. What is needed for providers in Scottsbluff and North Platte is different than what's needed in Grand Island and Nebraska City. So we would propose to model this after the very successful Rural health Education Network which already is a great pipeline to get students from rural areas into medical school, to have the sites developed with partners, including the Behavioral Health Regions, the Rural Health Commission, the area health education networks, local folks who know what their provider shortages are and what they're needing out there and what their resources are to do more local training. You have to always consider this accreditation issue. You can't just train someone and then not have them be able to graduate from school or not have that school be able to retain its accreditation. So this really has to be a partnership between the academic institutions and the people who are actually needing the providers at the local areas. We would propose that two sites would be developed each year over three years, for a total six sites, and that the sites would be developed using a tool of local agreements so that it would be clear what each site is getting, what they're providing and what the...how the collaboration would work for that area. We believe that

it's the leveraging of existing resources that we have to do and it has to be targeted. We already have people training social workers, training psychiatrists, training nurses. And we propose to use those same people, but get it more targeted for the folks who would use high-end services. Many people go into our schools hoping to be a counselor and wanting to hang up their own shingle and do marriage and family counseling. And not that that's not greatly needed, but that's a different training than you want people to have if they're going to come out and work with people with schizophrenia who need assistance in maintaining their independent housing and managing their budget and learning how to reestablish their life in the community. So we believe that integration of resources is a key. We believe that it's important to involve all stakeholders across the board and that a very small investment would lead to a much greater gain in the providers that we have in this state. The resources and partners we propose to bring in, and have already done some work with is: consumers, family, Creighton University, University of Nebraska campuses, UNL, UNO, UNK, UNMC, Lasting Hope Recovery Center, as our interdisciplinary training site, community colleges, which do a lot of training for folks who are staying in the more local area and doing a lot of behavioral health work without a masters degree, that we believe that we can provide them better resources to do that work better. They also do a lot of the training for substance abuse providers in community colleges. And then community-based providers, because we know that our academic institutions are not putting out the finished product that our community providers want to hire. Dr. Wengel will finish. [LR338]

STEVE WENGEL: So to wrap up then what we're...this proposal (inaudible) these outcomes. (Inaudible). We would see this as improving rural recruitment and retention of providers across the board of all disciplines. (Inaudible) would provide an increased number of psychiatry residents, 5 percent, it would improve statewide access to high quality care through telemedicine, and then also to improve the quality of behavioral health training because of the issues of teaching people or training people in a multidisciplinary setting, where people work together from the various disciplines and also to provide ongoing support to those clinicians when they do get out to the state by

linking them together into sort of a virtual faculty, as Susan had said. I know this is a very broad overview. And we haven't been very specific because (inaudible), but I wanted to just paint that picture for you. Of course, we are more than happy to answer questions now or in the future. You have our contact information there (inaudible) slide set, too. If there are questions or comments that remain after this session we, of course, stand ready to (inaudible). [LR338]

SENATOR GAY: All right. Senator Nelson. [LR338]

SENATOR NELSON: Would the center possibly be located at the Sorrell facility there in Omaha? Could it accommodate that? Would that be a logical place for the center? And then how long do you envision that this would take to get set up and become productive? [LR338]

SUSAN BOUST: We would expect that within the first year that we can put out ten modules by using a process of this granting mechanism where we can pull together three, five, eight people to work on what is our module for recovery going to be. That includes a social worker, a psychiatrist, a consumer, a family member, and then that module could quickly get into...back into the School of Social Work, the Department of Psychiatry, all of those places. So we believe that the curriculum development can happen pretty rapidly and have probably 50 modules within the first four years of the proposal, and we would expect those modules to be able to be delivered in person via Internet in written format. I mean, our intention would be to make this as accessible to the providers for their training as we want the services to be accessible to the consumers. The plan right now, actually there is some annex space in Lasting Hope Recovery that is not part of the service delivery and for a very minimal amount of money, I think $5 a square foot, we could house the initial part of the center. And we're only envisioning like three to five people being the center, who work for the center. The rest of the people continue to have their job where they are and develop things virtually. So...and we are connected by telehealth through this way, although I would expect we

would deliver some things in the Sorrell Center as well. [LR338]

RHONDA HAWKS: One...and just in addition to that, when we built Lasting Hope out, we have 20,000 square feet in an annex that's to the north. We finished all that space in anticipation of others using it. One of those we were hopeful would be an education component. The Salvation Army has a small office there, as done Lutheran Family Service, as does NAMI, and we're renting that space back to those agencies at basically a break-even on the heating and cooling costs. [LR338]

SENATOR NELSON: Thank you. [LR338]

RHONDA HAWKS: Uh-huh. Sure. [LR338]

SENATOR GAY: Senator Fulton. [LR338]

SENATOR FULTON: Thank you for being here. Thank you for the help from the private sector. [LR338]

SUSAN BOUST: You're welcome. [LR338]

SENATOR FULTON: This is how we...it's how we best address problems, in my opinion. How does...so I've heard this proposal. How...is there some specificity that you can provide as to how government cooperates collaboratively with what's going on presently? [LR338]

SUSAN BOUST: Um...(laughter) either one. [LR338]

STEVE WENGEL: Well, I'll take... [LR338]

SUSAN BOUST: Yeah. [LR338]

STEVE WENGEL: ...a crack at it and hopefully Susan can add more words of wisdom here. But one thing we didn't say is that in the spirit of the public-private collaboration that's already taken place at Lasting Hope, we believe that if we have a steady amount of state support, we can leverage that and then eventually get additional federal grant funds and a variety of other grant monies to do bigger and better things on top of this. Really feel like we need the infrastructure, I think, to get the thing off the ground. We need this core group of people, as Susan said, this three to five people that really this is their full-time job, is linking providers of the state together (inaudible) developing these new learning materials that don't exist, incidentally, which is why we have to develop them ourselves, you know, developing teaching materials that revolve around disciplines working together, working with patients or consumers that have combined problems with mental illness and substance abuse. Because most of our training has been siloed--you either deal with the substance abuse problem, you have special training in that, or you deal with the mental health problem because you have training in that. But we don't do a good job of training people to do both. So really, the initial focus is, again, to develop those materials and disseminate them so that our providers in communities are up to speed with that, but with the understanding that once we can show some success with that, that we really anticipate considerable other support down the road from other entities. [LR338]

SUSAN BOUST: I guess I agree with all of that. We really believe that this educational piece is the final piece of LB1083 and we knew that we needed to do this. We're asking out providers to do a very different thing than they were trained for and we have to beef up the education to let them do that well. We believe some basic infrastructure from the state is necessary to get this off the ground, but we think that this will eventually infiltrate into lots of other areas back into the schools who are already doing this work. We would plan a three- to four-year ramp up; as the sites, we plan to develop two a year, so over three years we would have six. We think that covers each of the behavioral health regions. The residents themselves we would plan on increasing by two a year because

the infrastructure in the residency training program requires some ramp up. You can't just all of a sudden put eight extra residents in there. So it does have some ramp up over three to four years. [LR338]

RHONDA HAWKS: And one additional thing is I think it's very difficult to go to the private sector and get operating dollars year after year. When we raised money for Lasting Hope, one of the things that we said to private donors is we'll raise the capital from the private sector. We'll build the building. We'll put the initial program in place. We'll cover startup costs for salaries before we get going. But from year to year it's very difficult to sustain that on an operational basis, so Dr. Boust and Dr. Wengel have worked on a budget, and they like to say they've applied a machete to it, and it's still in draft form. But we've worked it down, down, down so that we can not compromise quality but get programs in place to start this. [LR338]

SENATOR GAY: Other questions? Senator Synowiecki. [LR338]

SENATOR SYNOWIECKI: Thank you for your testimony. Thank you for being here. [LR338]

SUSAN BOUST: Thank you. [LR338]

SENATOR SYNOWIECKI: Dr. Wengel kind of hit something that struck me as I was sitting here. During my legislative career I've put in a few bills to try to address this, and this is the silo impact of practitioners. And as one who brought bills to the Legislature to try to look at scope of practice and perhaps an expansion and to try to more collaboratively deal with these sorts of issues, what happens, I found out, is suddenly you get involved in these turf battles over scope of practice. And is part of your mission here, are you going to convene the disciplines so we can get beyond some of this, what I would characterize as turf battles and scope of practice battles? Is that part of...is that part of your mission? [LR338]

STEVE WENGEL: I think that's an excellent question. It's not an overt part of the mission but it really is in there when you think about it, because...first of all, let me say I have personally observed some of those turf battles myself and there are, you know, like a lot of these things, there are legitimate points kind of buried in a lot of rhetoric and emotion. People get very emotional when they feel like their turf is being invaded. And you know the funny thing about it, and it's not funny actually at all, is there's way too much work to go around. This is not...this is not the sort of thing we should be spending our time and energy on because it's not as if any one profession or discipline is going to not be needed. We have so much work to be done. There's so much...so many people with mental illness do not get treatment. Some estimates are only 50 percent even seek treatment. So anyway, we need to get beyond that. And to try to answer your question, part of this development of new materials--we call it curricula but that's where, you know, we're academicians, we have our own language--but developing learning materials and interdisciplinary training. Much of it, as Susan said, is virtual, you know, teleconferencing and, you know, doing things...having people that "disincites" doing things, you know, over the Internet or whatever. But part of it really is the value of bring people together in one room and we propose that these people that are writing all these new materials--who will come, by definition, they will come from different disciplines--to bring them together every three months and bring them together in the same room and, you know, compare successes and find out where the challenges are and really help...which I really think, even though that's not a manifest, you know, goal here, it really is something that I think will happen. When people start working together and realizing what each other have to contribute, we can get beyond, I think, a fair amount of that. [LR338]

SENATOR GAY: Any other questions for these? Senator Stuthman. [LR338]

SENATOR STUTHMAN: Thank you, Senator Gay. Rhonda, I would just like to ask you questions as far as your initial statement in there, the state's promise to provide an

agreed amount of dollars. Have you seen one penny? [LR338]

RHONDA HAWKS: Yes. Yes, we have. (Laugh) [LR338]

SENATOR STUTHMAN: Okay. So they... [LR338]

RHONDA HAWKS: ...and we're counting on that coming in. (Laugh) [LR338]

SENATOR STUTHMAN: Right. Right. So... [LR338]

RHONDA HAWKS: We're keeping a close eye on that. [LR338]

SENATOR STUTHMAN: But that has...it has happened then already. [LR338]

RHONDA HAWKS: Right. [LR338]

SENATOR STUTHMAN: It has happened. [LR338]

RHONDA HAWKS: Yes. We're working very closely with Scot Adams and the division. [LR338]

SENATOR STUTHMAN: Okay. The other question that I have, and being a parent and a grandparent and...do you see the behavioral health, the issues with children, because of the family environment, more than hereditary? Or could we be doing something, you know, early intervention with families and activities or something like that, that could avoid this behavioral health problem at a teenage time or later age? [LR338]

RHONDA HAWKS: I'm way out of my depth on that one. (Laugh) We have...we've concentrated on adult behavioral health with everything that we've participated in at Lasting Hope and also in the service end of it, and I feel like I've gone to college on the

adult end, and I know there's a huge problem on the children's end and Dr. Wengel and Dr. Boust perhaps could address that. [LR338]

STEVE WENGEL: Right, and I'm second to Rhonda in terms of being out of my depth. I'm a geriatric psychiatrist. I see people over 65, so...but in reality, the focus of this really is adults with behavioral health issues. But in reality, as these materials get developed, as Susan said, part of the...part of this is we have to have accountability built in and it's built in right up front that we have to survey the regions and not just the regions but even the individual providers of the community health agency, what do you need most. We can't do everything for everybody ever, and certainly not right off the bat, but we need to figure out what the most pressing issues are. I think there is certainly a role and there needs to be a role to have some child and adolescent issues kind of addressed up front. I would tell you I have a very active child and adolescent division in my department and they're doing some really creative things, certainly locally in the Omaha area, with the Building Bright Futures Program and so forth to try to address the mental health needs there, and I think that will be another resource, once they kind of work out the kinks in Omaha, that we can hopefully export to the rest of the state too. And the last thing I'd say, and again this is just something I heard literally yesterday from a colleague of ours that is a child psychiatrist, that some data that's come out of that area, Building Bright Futures, is that for every dollar spent early on you save two dollars in other healthcare costs, law enforcement costs, school costs down the road. So in addition to obviously reducing the tremendous burden of human suffering, it even makes economic sense. [LR338]

SENATOR GAY: All right. I think there are two other groups that might want to talk on this. Does anyone else want to talk on the work force issue? Please raise your hand. Okay. I still want to keep going because I do (inaudible) another 15 minutes. Thank you very much for your testimony and your presentation. [LR338]

SUSAN BOUST: Uh-huh. Thank you. [LR338]

SENATOR GAY: If you want to come forward and... [LR338]

REBECCA SCHROEDER: Hello. [LR338]

SENATOR GAY: Hello. [LR338]

REBECCA SCHROEDER: I know it's getting close to lunchtime... [LR338]

SENATOR GAY: No, that's all right. [LR338]

REBECCA SCHROEDER: ...so I will try to be brief. [LR338]

SENATOR GAY: We won't starve to death. [LR338]

REBECCA SCHROEDER: (Exhibit 6) My name is Rebecca Schroeder, S-c-h-r-o-e-d-e-r, and I'm a licensed psychologist from Curtis, Nebraska, and I am the rural mental health professional representative on the Rural Health Advisory Commission. Today I am here to provide testimony on behalf of the Rural Health Commission. The purpose and duties of the Rural Health Advisory Commission are defined in the Rural Health Systems and Professional Incentive Act. The purpose of the commission is to advise the Legislature, the Governor, University of Nebraska, Department of Health and Human Service Division of Public Health on rural health issues. One of our specific duties is to award student loans to certain graduate-level health professionals and students, and loan repayment to certain licensed health professionals. The mental health professions include psychiatrists; psychiatric advanced registered nurse practitioners, which is a mouthful; licensed mental health practitioners, which from here on I will just call LMHPs; and psychologists. These are all eligible for one or both of our rural incentive programs. Today, most of what I will be saying is focusing on the LMHPs, but I also want to mention that one thing that has come to the

attention of the commission is very similar reimbursement issues for the psychiatric advanced registered nurse practitioners. LMHPs, psychologists and psychiatrists have all been eligible for the loan repayment program since it was first funded in 1994. It was not until 2004, though, that graduate-level mental health students, as defined by students working toward becoming LMHP or a doctoral level psychologist, were added to the student loan program. In the last four years we have awarded 15 student loans to master's level students and four to doctoral level students. As of August of this year we have four LMHP students now currently in practice and receiving forgiveness for their student loans. The rest of the mental health student loan recipients are still in training, either in school or working on their licensure hours. This legislation that added students that was passed in 2004 was based on the need for mental health professionals in rural areas. The scope of practice was used to determine which groups of mental health professionals would be eligible. Unfortunately, it was later learned that Medicare and Medicaid do not reimburse LMHPs unless they are supervised by a psychiatrist or a psychologist. This means that rural master's mental health student loan recipients, who are required, by the way, to accept Medicaid patients, do not get reimbursed for these visits unless they have developed the appropriate supervision contracts. In rural Nebraska right now there is definitely a shortage of people being able to supervise the LMHPs. Other issues concerning mental health care have also been brought to the attention of the commission. In April of 2008 the commission sent a letter to Dr. Scot Adams, director of the Division of Behavioral Health. In that letter, Roger Wells, the Rural Health Advisory Commission chair, requested that the Division of Behavioral Health and Medicaid consider expanding the definition of the provider panel under the administrative services only, the ASO, contract, and expanding it to include LMHPs and psychiatric nurse practitioners who could be supervised by doctorate level health professionals other than a psychologist or a psychiatrist. In his letter, Mr. Wells stated, "While the quality of standard needs to be maintained, the ASO contract needs to take into consideration the providers available to rural areas which may be different than providers available to urban areas." The Rural Health Advisory Commission received a response from Vivianne Chaumont, director, DHHS Division of Medicaid and Long Term

Care. Ms. Chaumont confirmed that Medicaid regulations currently require LMHPs and psychiatric advanced practice registered nurses be supervised by a psychiatrist or a psychologist when the clinician applies for Medicaid enrollment for mental health or substance abuse services. We realize that Medicaid is now in the process of updating regulations to allow licensed independent mental health practitioners to practice without supervision. However, this licensing process generally requires several years of supervised practice before the LMHP may apply for license and requires that the supervisor sign an affidavit approving the application. This process does not help the rural student loan LMHPs who are required to practice in rural areas and see Medicaid patients. Most recently the commission has learned that the new 2008 ASO agreement for mental health services for Medicaid recipients no longer reimburses for services provided by provisionally licensed mental health practitioners. This agreement has a huge impact on rural health, as many agencies rely on provisionally approved providers to help sustain their training programs. This lack of reimbursement may endanger some training sites and may result in fewer providers being placed in shortage areas. The Rural Health Advisory Commission is willing to work with the Legislature, the Department of Health and Human Services, the University of Nebraska, as well as any professional associations impacted by these issues. Providers are needed in order to have community-based behavioral services. At the present time there is a shortage of providers in rural Nebraska and a disconnect between the rural incentive programs and Medicaid reimbursement. Thank you for your time and I would be happy to answer any questions that you may have. [LR338]

SENATOR GAY: Thank you. Any questions? I don't see any right now, but thanks for this information though. []

REBECCA SCHROEDER: All right. Thank you. [LR338]

SENATOR GAY: Thank you. [LR338]

JULIA HOUFEK: (Exhibit 7) Thank you for the opportunity to speak to you today. I'm going to speak about psychiatric mental health nursing work force. I'm Dr. Julia Houfek, spelled H-o-u-f-e-k. I coordinate the graduate psychiatric mental health specialty area at UNMC College of Nursing. Today I am also representing the Nebraska Chapter of the American Psychiatric Nurses Association. Our program at the College of Nursing educates advanced practice mental health nurses. Over the past ten years we have graduated over 75 advanced practice psychiatric mental health nurses. Most of our graduates are licensed in Nebraska as psychiatric nurse practitioners or clinical nurse specialists, and we hold various full-time positions in advanced practice nurse...in the advanced practice work force in Nebraska. However, there's a critical need to continue to educate additional advanced practice psychiatric mental health nurses, particularly psychiatric nurse practitioners, for at least three reasons. The movement to provide more tertiary services to seriously mentally ill patients in their communities emphasizes the need to increase the number of behavioral health practitioners in numerous smaller communities throughout Nebraska. I think that's been well established here today. Also, there's a great need to increase the primary and secondary mental health services to our communities as they face stressors related to our economy, aging, and the complexities of modern life. Psychiatric nurse practitioners can provide needed mental health services in rural areas which have critical shortages of qualified behavioral health specialists. National data show that 13 percent of all advanced practice psychiatric mental health nurses live in the rural area, compared to 7 percent of psychiatrists. We believe that providing programs that allow students to stay in their communities increases the likelihood that they will practice there. And then third, Nebraska's psychiatric mental health advanced practice nurses reflect the national average age of our specialty group--these are our current practitioners--which is about 51 years, give or take 10 years. Thus, we have a great need to replenish our aging work force. At the College of Nursing we are striving to educate quality psychiatric nurse practitioners in the following ways. The college is currently developing a federal Division of Nursing grant proposal to increase our capacity to offer our programs across our 500-mile campus without requiring students in rural areas to attend classes at one of our four

campuses, and that is in Omaha, Lincoln, Kearney, and Scottsbluff. Our current practice now is that the student needs to be able to come to one of those campuses. And we continue to offer a program that allows our students to be dually prepared as both psychiatric NPs and a family nurse practitioner, and this is quite attractive to different agencies or hospitals throughout rural Nebraska to have the nurse certified in both specialties. And this program was initially established through a federal Division of Nursing grant at the College of Nursing and our commitment to the federal government was to continue this program, which we have done. As the Legislature considers options to address the behavioral health work force shortage, I request that you and your colleagues grant maximum flexibility to psychiatric nurse practitioners to practice in rural areas. And thank you for your willingness to tackle this difficult issue. [LR338]

SENATOR GAY: Thank you. Do you have a copy you want to hand to the committee members? [LR338]

JULIA HOUFEK: Yes. [LR338]

SENATOR GAY: We'll get somebody to make copies and distribute them. Senator, do you have a question? [LR338]

SENATOR STUTHMAN: I'll wait. [LR338]

SENATOR GAY: Okay. Thanks. All right. Thank you. And anyway, they'll make copies and we'll get them. Thank you. [LR338]

ROBYN HENDERSON: Thank you for the opportunity to provide some comments. My name is Robyn Henderson, R-o-b-y-n H-e-n-d-e-r-s-o-n. I'm director of the Southeast Nebraska Area Health Education Center and I'm representing all five of the area health education centers today on our behalf. I wasn't really sure whether I was going to try and testify today. My intent was more to maybe react or provide some feedback or

additional information on areas that had already been touched on, and to that degree my comments will be very short, I promise you. I know I'm between you and lunch. I was pleased to see the production...or the presentation by the UNMC folks talking about the develop center and I was pleased to see that AHECs had been included in a part of their structure. When they talked about being able to ramp up the program, the AHECs are already in place. Our infrastructure is already in place. We can start working immediately on behavioral health work force development issues. The center proposal is more kind of a top-down proposal, working from the Med Center in developing more psychiatry residents and, therefore, hopefully more providers in rural areas. We work from the bottom up. We start working with students as early as elementary grades and help build their awareness about healthcare careers that are available. And as they progress through their high school and into their college years, we develop progressively more detailed and more in-depth programs for those students to help them further explore the options that they have. One of the problems that we have with mental health or behavioral health is the lack of opportunities for job shadowing, and job shadowing is one of the...a very important tool for students to have an opportunity to do, and help them develop interest in a career they would like to explore and go into, and it also helps students realize that that's not the career they want to go into, and we consider that a success as well. And part of the job shadowing problem is the increased privacy around behavioral health patient-client relationship and that kind of thing. I'm hoping that perhaps the center would be an avenue that we could set up some possible job shadowing opportunities for these high school and college-age students that really want to go into mental health and behavioral health but really don't know for sure what to expect on a day-to-day basis or as a career...as their career in this field. The other thing I would say is that the AHECs are already in the communities. We serve all 93 counties of Nebraska. Southeast Nebraska serves 17 counties in southeast Nebraska. We're in place. We've got the relationships already. We work with people that would need to be involved in this and I just...I'm hoping that you will see what an integral part of this the AHECs can portray. And, as I said, we're already in place. Our infrastructure has been built. We're ready to dive into this with both feet and just trying to figure out

how we can do that. So I'm pleased to see that there's a focus method on this and, again, I just...I hope that you will understand and support the inclusion of the AHEC program as behavioral health work force continues to be an issue. And I'd be happy to take other questions or meet with the committees separately. [LR338]

SENATOR GAY: All right. Senator Stuthman. [LR338]

SENATOR STUTHMAN: Thank you, Senator Gay. Robyn, since it's a real problem with the job shadowing,... [LR338]

ROBYN HENDERSON: Uh-huh. [LR338]

SENATOR STUTHMAN: ...have you got any type of solution that we could help you with or the federal government or the U.S....? [LR338]

ROBYN HENDERSON: We're trying to figure that out, Senator Stuthman, and thank you for that question. When we have talked with the providers, a lot of them say, you know, we'd like to do that but we just can't because of patient privacy issues, and we understand that. Basically what that would mean would be the patient, or if it's a group therapy session the group, would need to give permission to allow a student in, and I think that we all know that that would be...that that's hard to do when you're talking especially with high school students. A lot of the providers will work with and allow job shadowing with students who are working on their master's in...for social work they're at the master's level or the Ph.D. level students in psychology, but we need to figure out how we can work at a different level and create some kind of opportunity to get students experience in the mental health field. That's just so important to students as they make their decisions. [LR338]

SENATOR STUTHMAN: I really think that's very true because, you know, they need to see, you know, what they will be working with and develop an interest or lack of an

interest so they may say,... [LR338]

ROBYN HENDERSON: Uh-huh. [LR338]

SENATOR STUTHMAN: ...I've been interested but since I went through it, you know, this week or this month,... [LR338]

ROBYN HENDERSON: Uh-huh. [LR338]

SENATOR STUTHMAN: ...I have no interest whatsoever. So I think that it'd be very beneficial and I think we should try to figure something out. [LR338]

ROBYN HENDERSON: Well, I'm afraid that we're going to lose some students that have that initial interest in psychiatry or psychology or other behavioral health fields because of that lack of closeness or opportunity to see that. Specifically, I know there's a young student at Wesleyan that is a psychology major and really is interested in going into psychology, becoming a provider, and hopefully work in a rural community, but she's not having...she's not finding the opportunity that she would like for more career exploration and more of that in-depth work, so I'm afraid that we could, therefore, lose that student to some other field in psychology and not necessarily as a provider. [LR338]

SENATOR STUTHMAN: Okay. Thank you, Robyn. [LR338]

SENATOR GAY: Any other questions? Thanks, Robyn. [LR338]

ROBYN HENDERSON: Thank you. [LR338]

SENATOR GAY: Appreciate it. All right, anyone else? That's it. Let's...appreciate everyone's patience. And 1:30, I think is...we're going to come back and discuss some

more. [LR338]

SENATOR STUTHMAN: Pizza deliver. [LR338]

SENATOR GAY: Yeah, Senator Stuthman has that. Thank you. [LR338]

BREAK []

SENATOR GAY: I'm sure others will be joining us and we've got some people here to talk about what we're doing for sex offenders and how the state is dealing with the issue of the sex offenders. So we'll start, if you can introduce yourselves and (inaudible) on. [LR338]

MARK WEILAGE: Okay. Just introductions first and then... [LR338]

SENATOR GAY: Yeah, let's do introductions first for Erin. [LR338]

MARK WEILAGE: Okay. All right. Dr. Mark Weilage. I'm the assistant behavioral health administrator for mental health at the Nebraska Department of Correctional Services. It's spelled W-e-i-l-a-g-e. [LR338]

SHANNON BLACK: Dr. Shannon Black. I'm a clinical psychologist with the Lincoln Regional Center, Department of Health and Human Services, Sex Offender Services Program. Black, B-l-a-c-k. [LR338]

DEAN SETTLE: I'm Dean Settle. I'm the director of the Community Mental Health Center here in Lancaster County and with me is Dr. Mary Paine, and Dr. Paine heads up our sex offender treatment program at the community. It's a community-based treatment program called STOP, and we'll talk more about that later. My last name is S-e-t-t-l-e. And, Dr. Paine. [LR338]

MARY PAINE: P-a-i-n-e. [LR338]

SENATOR GAY: All right. All right, go ahead, whoever wants to start. [LR338]

SHANNON BLACK: I guess I've been drafted to go first. [LR338]

SENATOR GAY: All right. [LR338]

SHANNON BLACK: (Exhibit 8) I do have copies of my testimony. [LR338]

SENATOR GAY: She could make... [LR338]

SHANNON BLACK: Okay. My name is, as I said, is Dr. Shannon Black. I am the clinical psychologist with the Lincoln Regional Center, Sex Offender Services Program. Since the enactment of Nebraska Revised Statute Section 83-174, formerly known as LB1199, the Department of Health and Human Services Norfolk Regional Center, NRC, has received 44 patients identified as dangerous sex offenders. The majority of those have been from Douglas and Lincoln Counties, 16 and 7 respectively. This does not include sex offenders admitted to the Lincoln Regional Center, LRC, under Nebraska Revised Statute 29-2928 related to convicted sex offenders or committed individuals who have a history of sexually assaultive behavior without conviction or committed prior to the enactment of LB1199. As of October 31, 2008, the NRC had 59 sex offenders in treatment under some type of commitment order proceeding; that is, 30 dangerous sex offenders and 29 that do not meet the statutory definition of "dangerous sex offender," or who were committed prior to the enactment of that statute. As of that same date the Lincoln Regional Center had a total of 78 sex offenders in programming. These numbers do include two women at the Lincoln Regional Center. The treatment program is based on the philosophy that: deviant sexual behavior is learned behavior; treatment requires learning adaptive and responsible social and sexual behavior; new thinking and

behaviors substitute harmful behavior that leads to sexual offenses. The program involves three phases that utilize cognitive behavioral therapy to address thinking and behavior. The program provides structure and supervision for a strong therapeutic community that involves patients holding each other accountable in pro-social ways. Patients are involved in 20 to 30 hours of programming per week with extensive focus on relapse prevention. In each phase, patients are evaluated to determine individual treatment needs. Patient progress is evaluated utilizing multidisciplinary treatment planning every two months. Offenders who fall under the convicted sex offender, or CSO, statutes are evaluated--and this actually says within six months prior to the end of their sentence but they actually can be evaluated any time after being admitted to the Nebraska Department of Correctional Services--to determine the appropriateness of transferring those individuals from the Nebraska Department of Correctional Services to the Lincoln Regional Center Sex Offender Services for programming. A person may be paroled to the Lincoln Regional Center to continue treatment, be referred to the county attorney for possible commitment as a dangerous sex offender or as a mentally ill and dangerous person, depending on the circumstances, or released from incarceration without further involvement with the Department of Health and Human Services. For those committed as dangerous sex offenders, Phase I begins upon admission to the Norfolk Regional Center. The goals of Phase I are to orient patients to the treatment process, begin working with patients to accept full responsibility for their sex offending/sexually deviant behaviors, teach patients to give and receive feedback and utilize coping skills, build motivation to change behaviors with intensive treatment in Phase II. Based on a multidisciplinary staffing review of progress and patient goal accomplishment, a recommendation for transfer to Phase II may be initiated. Patients are then transferred to the Lincoln Regional Center, Forensic Mental Health Services, for Phase II. In this phase the focus is on helping patients gain awareness of cognitive distortions, gain understanding of the precursors to sexual assault and develop relapse prevention skills, as well as gaining understanding of the impact of their sexually assaultive behaviors on victims and families, and reduce deviant sexual arousals and fantasies. Once patients reach the treatment goals identified in Phase II of the program,

the multidisciplinary team will conduct a staffing to determine appropriateness for Phase III. This phase is preparation for the patient's eventual release to a less-restrictive environment, as is appropriate for the individual needs of each patient. The goals of Phase III is for patients to apply the concepts and skill learned in Phase II with staff monitoring, gradual reintegration into the community as a safe and productive member of society, and to develop a long-term plan of aftercare support to maintain change and minimize the risk of reoffense. This gradual transition is closely monitored by staff at the Lincoln Regional Center in conjunction with employers, parole officers, members of the patient's support network, etcetera, so that any needs for additional treatment interventions can be implemented before the patient is released into the community. Patients must participate in the following core groups during treatment: orientation group, individual therapy, sex offender therapy, relapse preventions I and II, community living skills, patient hour, and arousal reconditioning. Depending on individual characteristics, patients will be assigned to one or more of the following psycho-educational groups: substance abuse education, human sexuality, assertiveness training, anger management, victimization group, victim empathy group, grief group, healthy relations group. Prior to releasing a patient, a risk assessment and staff evaluation are completed to identify risk factors and needs of the patient. The assigned social worker will assist the patient in making appropriate living, employment, and continued therapy arrangements. The appropriate mental health board is sent a recommendation for outpatient commitment. The mental health board has the authority to amend the commitment order based upon those recommendations. If the person is placed under an outpatient commitment, the Department of Health and Human Services no longer has custody or oversight of that patient. An offender's risk of reoffense can be mitigated or aggravated by various factors. When evaluating risk, one must consider both static factors, those factors that are historical and unchanging, such as offender age, previous sexual assault convictions or charges, other criminal history, previous violations of supervision, and victim selection. One must also consider dynamic factors that may change over time, such as substance abuse issues, anger management and coping skills, and intimacy deficits. There are some community factors that may also

decrease risk, such as social support, continued mental health treatment, and supervision. There is no assessment procedure that allows one to predict who will or will not reoffend. We can only identify those people who have more risk factors in common with sex offenders who have reoffended. One of the most frequently asked questions is whether or not treatment works. Research indicates that 25 years ago 75 percent of sex offenders reoffended within the first 5 years of release. In the 1980s, cognitive behavioral treatment with a relapse prevention component was introduced. Currently the reoffense rates range from 13 to 15 percent in programs using the model of treatment at the regional centers. Thank you for your time, and I can answer question as you may have them. [LR338]

SENATOR GAY: Thank you. Let's do this. Let's have the presentations first and then questions that come to mind, we'll just kind of throw them back at you, okay? [LR338]

MARK WEILAGE: (Exhibit 9) All right. As I said, my name is Mark Weilage. I'm the assistant...can everybody hear me...the assistant behavioral health administrator for mental health at the Nebraska Department of Correctional Services. I'm in charge of all the mental health services in the agency, including sex offender treatment and sex offender evaluation services. I was asked to participate in the discussion today to provide information about the offenders that are currently committed to the Nebraska Department of Corrections for sex offenses and I was also asked to provide information regarding the relationship between the Department of Corrections and the Department of Health and Human Services. So I'll cover both those briefly. The Department of Correctional Services began communicating directly with Department of Health and Human Services once we began work on LB1199. So once we realized it was going to happen, we started our communication. Among the requirements, LB1199 obligates the department to perform mental health evaluations to determine if an individual meets the criteria established in the law for a dangerous sex offender status. Initially, the Department of Corrections met weekly with Health and Human Services to discuss LB1199 processes and issues that it raised for the two agencies...that were raised for

the agencies by this law. Now as the issues have kind of stabilized, we continue to meet at least bimonthly. We discuss issues related to communication about sex offender services for both sex offenders that both agencies deal with. Health and Human Services staff attended seminars conducted by...have attended seminars conducted by national presenters that the Department of Corrections have coordinated, and that's an ongoing thing, where one other thing I wanted to add was we're going to be doing a training in November that a number of Health and Human Services staff are going to be attending. Since the inception of LB1199, 411 sex offenders have discharged. The Department of Correctional Services has completed 229 dangerous sex offender evaluations: 64 individuals have been identified as dangerous sex offenders; currently 44 of those individuals were committed by the mental health board to inpatient treatment. Now we don't have complete information on the status of the remaining 20 offenders that were evaluated as dangerous sex offenders; however, based on the available information some have been committed to outpatient treatment, some were transferred to INS or the Bureau of Immigration and deported, some are pending, and some have discharge directly without a specific commitment. Now projections for the next 32 months, which would take us kind of through the fiscal year ending June of 2011, are as follows. Now this is data that's based on current discharges and assumes that no additional sex offenders will be admitted and discharged during the 32 months. So we know how many sex offenders we have currently that will be discharged and the estimate is that there will be 366 discharges with no new admissions calculated in. It's estimated that we would complete approximately 205 new evaluations and, based on the prior 28 months of data, it's estimated that 59 would be classified as dangerous sex offenders and estimated that 40 would be committed to inpatient treatment at the regional center system. I appreciate the opportunity to come and share that information and I'll be happy to answer any questions. [LR338]

SENATOR GAY: Thanks, Mark. [LR338]

MARY PAINE: (Exhibit 10) If you have difficulty hearing me, please let me know. My

name is Dr. Mary Paine and I'm here to testify in regard to the management and treatment of sex offenders in our community. Unlike Dr. Black and Dr. Weilage, I am--and I'm not saying you're not treating them on the front line--I am treating them where they're actually in a position where they have a very real possibility of offending, and the risk is substantially higher. Lancaster County has become a magnet for individuals who are convicted and registered as sex offenders, due in part to the Lincoln Regional Center's program and correctional facilities in our community. An urban setting affords greater anonymity, more jobs and housing in a service rich community such as Lancaster County. With that acknowledged, most of the individuals who I work with are poor and have difficulty providing for their basic needs, and are unable to pay for sex offender and other mental health treatment needs. The purpose of this presentation is to continue concerns that were first introduced to the Unicameral last year by Senator Carol Hudkins in LB1168, which spoke to the need for funding of community-based treatment and management of sex offenders in the community. Second, the bill spoke to manpower issues, the critical need for attracting qualified professionals to work with this special population, and third, providing professionals choosing to work with this population ample opportunity and assistance to receive the training and professional supervision while working with sex offenders in the community. While it's important that professionals treating sex offenders receive specialized training to work with this population, it's of paramount importance for those treating sex offenders in the community setting where there are increased opportunities to reoffend. An integral part of managing sex offenders in the community is a collaborative, interdisciplinary approach among probation, parole, treatment providers, and the county attorneys, among others. These are skills new to many therapists. This regards a high level of interacting with county attorneys, managing risk, understanding how people move through the correctional system and the laws that are governing them. Last, it is important that individuals have an awareness of local resources, community programs, and employment opportunities in order to engage sex offenders in rehabilitation and recovery, and to ensure that the individual becomes productive and does not reoffend. As you all know, committee members, the vast majority of sex offenders in Nebraska

are not in institutional settings but, rather, live in the community. In the community setting, it's critical that they be able to implement the management and treatment insights imparted to them at the Lincoln and Norfolk Regional Centers and in the various correction programs serving sex offenders. That's a key important part of our treatment program at the community mental health center. I don't have specific numbers on the number of individuals in our program who have been previously treated either at the Lincoln Regional Center or Norfolk within Corrections, but it's a substantial number. We have individuals come into our program who have never received sex offender treatment, or who have received some sex offender treatment and not completed it, or individuals who have completed the programs that you were just having described to you a moment ago. Even for the individuals who have successfully completed intensive sex offender treatment within the Department of Corrections or the regional centers, it's very, very important to make sure that when they come out into the community that they're able to generalize that knowledge and apply it, and that they actually have the willingness to do the things that they need to do to manage their risk levels while they are placed in the community. The mission of the STOP program, which I supervise at the Community Mental Health Center of Lancaster County, is to promote community safety by providing sex offender specific therapy to adult men and women who have committed a sexual offense. This is being accomplished through group and individual therapy in a variety of continuations of the same types of elements of treatment that they receive at the regional center in Corrections. Education of support persons involved with the offenders is also provided to increase risk management. We're currently serving over 60 individuals with the recent two-year SAMSA Grant, and should eventually serve as many as 80. By the end of this year it's noted there will be approximately 500 registered sex offenders residing in Lancaster County and 2,800 statewide. These figures pertain only to those offenders on the registry, so obviously the actual number of offenders in our communities across our state is much higher than this. Ensuring there are affordable programs to treat them, programs staffed by professionals with the specialized training and experience necessary to assess and manage the risk that they pose on an ongoing basis is critical. Thank you. Be happy to

answer questions. [LR338]

SENATOR GAY: All right, thank you all. Questions from the committee? Senator Stuthman. [LR338]

SENATOR STUTHMAN: Thank you, Senator Gay. Dr. Paine, you had mentioned when these...when these sex offenders are serving their time and then you mentioned, you know, after they get released, you know, they got to have employment and a job and stuff like that. Is there anything that they can do while they're incarcerated that, you know, as far as employment or a job or some job training, or do they just sit there and look at the walls? [LR338]

MARY PAINE: They actually do in two places. Those coming out of the Lincoln Regional Center oftentimes have been in the transition program there, which is somewhat equivalent to community corrections in that they're placed in a community setting and they go out and they work in the community and they return back to those settings. [LR338]

SENATOR STUTHMAN: As a work release... [LR338]

MARY PAINE: Yes. [LR338]

SENATOR STUTHMAN: ...person. [LR338]

MARY PAINE: Yes. [LR338]

SENATOR STUTHMAN: So... [LR338]

MARY PAINE: But that's not true for all of them coming out. [LR338]

SENATOR STUTHMAN: I mean that's a real concern of mine. You know, say they get...maybe they have two to five years, or five years of incarceration and there's five years of their life where they're doing absolutely nothing and thinking. Maybe they're going to class or something like that, but when they get out in the real world, you know, they should be productive. Why can't we do something while they're in as an inmate to teach them a skill or get them to do something or package bolts or something during that 8-hour day when they're there that 24 hours, something to occupy their mind? [LR338]

MARK WEILAGE: Well, actually, there's a lot of opportunities for them to learn different types of trades. There's Correctional Industries that woodworking, other types of trades that they can develop, work on while they're incarcerated. Everybody has an opportunity to have some sort of job, even if it's janitorial work, in the institution. The reality is not all sex offenders have that problem in terms of job skill deficits. Some would be difficulty finding employers willing to employ them. So it's kind of a combination of both and one of the things that our staff have been working on is identifying employers that are willing to have sex offenders work there. I know they've identified some in Omaha, some in Lincoln that are more likely to be accepting and willing to work with a convicted sex offender when they get out. We're also moving towards getting more people, if they get through treatment in Corrections, to work release so that they can, while they're still incarcerated, get out, find a job, start working. [LR338]

MARY PAINE: In that same...on that same note, I agree with Dr. Weilage that oftentimes...I have people who are highly educated. I have one individual who I work with who has an advanced accounting degree and is working for $10 an hour because he cannot use a computer. He had a child pornography offense. And oftentimes just people don't want to hire them because of the stigma and the risk that they feel it poses to their business. Going along with what Dr. Weilage said, I would also say that, as outpatient treatment providers, we far, far prefer that people come to us with still having some time to serve so that there are external controls. If they come to us and they don't

have, they're not on probation, they're not on parole and they're not on mental health board commitment, and they start to have difficulties, we have very little control. I'd far prefer to see them come up through community corrections or with some time still to serve so that we can be seeing how they're actually going to do in the community while there's still some ability to pull them back in if need be. [LR338]

SENATOR STUTHMAN: Okay. Thank you. [LR338]

SENATOR GAY: All right. Thank you. Senator Hansen. [LR338]

SENATOR HANSEN: Thank you, Senator Gay. Dr. Black, you said in your written testimony that it's gone down, since 25 years ago, 25 percent of those incarcerated are expected to become...it's gone down to 15 percent for the reoffenders, is that correct, on your last...? [LR338]

SHANNON BLACK: Well, 25 years ago 75 percent reoffended and now with the types of... [LR338]

SENATOR HANSEN: Oh, 75. [LR338]

SHANNON BLACK: ...with the types of treatment that are generally accepted for sex offenders--the cognitive behavioral therapies--the reoffense rates for the regional center patients has been between 13 and 15 percent. Nationally, it's anywhere from about 10 to 40 percent. [LR338]

SENATOR HANSEN: Okay. Thank you. And then on Dr. Paine's testimony, you said that there's 2,800, at least 2,800 registered sex offenders in the state. [LR338]

MARY PAINE: Correct. [LR338]

SENATOR HANSEN: So are we to assume that there will be...there could be up to 420 or 15 percent sexual offenses in Nebraska within the next five years or every year? I don't know how to...how am I supposed to interpret those figures? I'm a grandfather of three beautiful girls, little girls, naive little girls raised in western Nebraska, and if there's 420 of those people out there, sexual offenders, possibly to reoffend out of that population of 2,800, I think we need to do some more. I mean that's too many. [LR338]

MARY PAINE: Senator, I... [LR338]

SENATOR HANSEN: There should be...if you could get it to less than 1 percent I'll go along with that. (Laughter) [LR338]

MARY PAINE: I can fully appreciate your concerns. There are several things that I would say to that. That figure of 2,800 refers to the people who are registered. It doesn't include the people who are convicted sex offenders but have not been required to register. It doesn't include people who have come through, say, the Health and Human Services System. They've not been convicted but, rather, adjudicated in juvenile court. And that number does not include the people who have never been convicted or identified yet. So it's really far higher than that. And obviously I am a big treatment proponent. Let's identify where they're at and keep a watchful and well-informed eye on them. [LR338]

SENATOR HANSEN: And how do we do that? [LR338]

MARY PAINE: I think by being aware, in part, of what some of the actual research-based, shown techniques proven to have some efficacy to them as opposed to doing legislation, with respect to everybody who's in here, because this is an enormously difficult population to treat and highly emotionally charged issues. I think that we have to take care to put our monies and our resources where we actually have some research showing that these things are proven effective as opposed to what

simply makes us feel better but maybe does absolutely nothing to protect our children and our communities. [LR338]

SENATOR HANSEN: The State Patrol, the Troop D in North Platte, said that the sex offender registration is almost a joke in western Nebraska because if someone moves it's up to them to reregister, it's not the State Patrol to go out and find them and get them registered. And that was discouraging news, too, so... [LR338]

SENATOR GAY: Did you have something to add to the earlier question? [LR338]

DEAN SETTLE: Thank you, Senator Gay. As an administrator of a community-based community mental health center, we knew that our system always had served sex offenders. Out of 3,000 to 4,000 people that we see every year here in Lancaster County, there has always been sex offenders coming in for medications, for therapy, and so about a decade ago we decided that it made a lot of sense to make this a specific, dedicated program with trained professionals so that we know who they are, know where they are, and give them the tools to maintain a proper lifestyle and not to reoffend again. So in answer to your question, Senator Hansen, I think that the senators need to look very, very carefully at a separate funding stream to develop community-based treatment programs that can identify and give these people the skills they need to never reoffend again. It's a public safety issue, in my opinion, one that you can't avoid, one that we must take care of. LB1168, which Carol...Senator Carol Hudkins introduced last year, was going...we proposed no new money out of the state treasury but to divert some of the unexpended monies at Norfolk to try a pilot in the community to see if we could help get more people connected to community-based funding, very, very important in my opinion. The thing that Dr. Paine referred to, the people in the community also have to deal with where are they going to live and where are they going to work, so it's a management of sex offenders in our communities, not just treating them. [LR338]

SENATOR GAY: All right. Senator Synowiecki. [LR338]

SENATOR SYNOWIECKI: Thank you for all of your testimony. We created the LB1199 sex offender in response to (inaudible) problem and, if I remember correctly, essentially what that does is have a separate and distinct committal process, be done under LB1199. Now are you telling me then that if we have a committal under LB1199 and outpatient treatment or community-based treatment is what is recommended by the board, then LB1199 funds can't be used for that? Are they, LB1199 funds, used exclusively at the Norfolk Regional Center? [LR338]

DEAN SETTLE: That's correct, Senator. [LR338]

SENATOR SYNOWIECKI: And how is...I know we had some problems initially with county attorneys kind of reacting to LB1199 and the different method for commitment under that process. How is that going? [LR338]

DEAN SETTLE: What one...I need to clarify my previous statement. There was some additional monies set aside by the Unicameral for training within LB1199, training of correction, county attorneys. There were a variety of training dollars but there were no funds for the purchase of community-based treatment. And we know that out of that 2,800, probably 2,500 are living in the community and there's no ability to treat them in the community. [LR338]

SENATOR SYNOWIECKI: Okay. Let me...there were some members of the Legislature that were here when LB1199 passed who were very, very straightforward that Mental Health Services Commitment Act money should not be used for sex offenders. I think what I'm hearing here is that, in fact, we're probably using some mental health service delivery monies for sex offenders, particularly if you're confronted with the fact that LB1199 funds aren't used for community-based treatment at all. Where are these funds coming from then to help? Assuming that the offender or the patient, whatever it might

be, doesn't have the funds for the treatment, where are these funds coming from? [LR338]

DEAN SETTLE: We use a sliding fee scale for people, based on their income, to pay for therapy and to pay for treatment from Dr. Paine and her team of professionals. [LR338]

SENATOR SYNOWIECKI: Do you receive any funds through the regional behavioral health system? [LR338]

DEAN SETTLE: We do not. [LR338]

MARY PAINE: We also have a two-year SAMSA Grant, but that's only going to last a period. [LR338]

SENATOR SYNOWIECKI: Uh-huh. [LR338]

MARY PAINE: And that's very recent, obviously. [LR338]

DEAN SETTLE: It afforded us to double Dr. Paine's staff from two people to four people part-time. [LR338]

SENATOR SYNOWIECKI: The SAMSA Grant? [LR338]

DEAN SETTLE: Uh-huh. And to go from serving 40 people each week to 80 people each week. And we already know that by the end of December there will be 500 registered sex offenders living in this community. My board, the County Board of Lancaster County, are upset because 55 percent of them never came from this jurisdiction originally, so they've come here from other counties. They were discharged from Corrections or the Lincoln Regional Center and stayed. [LR338]

MARY PAINE: On an encouraging note to your question, Senator Hansen, I would estimate that approximately one-fourth of the patients currently being served in our program are there on a voluntary basis, after either they come to us asking for treatment, maybe they've been treated someplace else, they hear of the program, they want to continue with relapse prevention, or we have treated them and discharged them from their mental health board commitment and they elect to continue on their own, which is very encouraging. [LR338]

DEAN SETTLE: In a lot of the hearings regarding LB1083, there was many conversations about unbundling sex offender treatment and costs from mental health, and that needs to be looked at again and I think there are some real merits in keeping these funding streams separate for the separate populations and the separate and unique needs. [LR338]

SENATOR GAY: All right. All right. Well, thank you for your testimony. We're going to keep moving on. Thank you. [LR338]

MARY PAINE: Thank you. [LR338]

SENATOR GAY: Appreciate it. We've got on the agenda, we have the emergency systems issues at for about 45 minutes to an hour we wanted to talk about. I have down on our agenda that the Sheriffs Association would like to speak, Police Chiefs Association, emergency services providers, representatives from some mental health boards, and NACO as people here that want to talk. If there are others who want to talk on emergency issues, can you raise your hand right now? So those are others than I just spoke of? Okay. [LR338]

(MAN): I'm with the County Attorneys Association. [LR338]

SENATOR GAY: Okay. All right. So the plan is we got about an hour. If whoever wants

to come up, I have no particular order that we have. I guess the Sheriffs Association I named first, but whoever, if you want to start working your way up. Let's not try to be repetitive, I guess. If one of your colleagues or somebody brings up a topic, let's not rehash that, I guess. So new information would be helpful. After each person...well, how do we want to do this? Do you want to wait? We should ask the person that's testifying. If we have a question for you, we'll ask you and try to be succinct in your answers. We will take some time on this because it's an important issue. And then also, after that, then we'll take a break. After about an hour we'll take a break and then there's about an hour and a half we have scheduled for community-based services. So I assume there's a large interest. Who's interested in speaking on community-based services? Just one person? There's others coming up there, Kathy? Okay, so we'll take some time there too. But we do have some time. It's...we'll get going. So let's go with that and the first, come on up if you want to talk on emergency services. Bruce, go ahead. [LR338]

BRUCE BEINS: Thank you, Senators. My name is Bruce Beins, spelled B-e-i-n-s, and I'm a representative of the Nebraska Medical Services Association. I thought it was interesting that you...that it was put in the agenda as emergency systems issues and I know you're here talking about behavioral health, so I'll try to tie all this together because some of it does tie together very well. For those that aren't aware, emergency medical services in Nebraska is about 85 percent volunteer and that volunteer service covers about 95 percent of the geographical area of the state. The volunteer system itself has a lot of problems that some of you heard me testify before, again and again, mostly with manpower issues and the societal changes that are making it more difficult to keep that volunteer system going. With the advent of more community-based behavioral health services, it has put some burden over on the emergency medical services system. The EMS system a lot of times is the entry point, if not directly through a call to 911 but maybe through a transfer from a community-based system, to a hospital. The population probably has more health concerns than what you would say was average for people in Nebraska and that does put a burden over on the providers. Basic level providers in Nebraska are providing very little training in behavioral

emergencies as a whole. As a basic level EMT, they get about three hours, and that's very generic training and that is mostly on some of the issues that they may have come up or have arised with a patient that they're trying to treat in the ambulance. And also then the communications issues with some of these patients makes it also difficult with some of these providers. So even at the advanced level, the amount of training that they get is no more than six to eight hours of training on how to handle these patients. So it has caused somewhat of a burden and probably will continue to do so on a system that is already pretty much overtaxed on the manpower side of it. I mean the volunteers provide about $200 million worth of services to the public, unpaid. Training continues to be an issue. Emergency medical services does get an appropriation from the Legislature strictly for training new providers and, of course, at the time we asked for it, it immediately became not enough money because of an increase in tuition costs and books and so forth. So these providers do provide a lot for their communities and do so willingly. They need the tools to do that. And as more burdens are placed upon that system, it only makes some of the system issues more difficult--the recruitment, retention of people that want to do that in their communities. A lot of anecdotal evidence from places where there is some community-based services about a increase in call volume, some of these calls are during the daytime when their manpower shortages are at the worst, so that is an issue that will continue to be a problem. And then there's also some anecdotal evidence of patients that have been picked up and the difficulty in finding a place to take the patient, finding a hospital or some place that is willing and equipped to be able to handle that type of patient. And, of course, that takes the ambulance out of service until such time that that patient can be placed somewhere. So without getting on my soapbox about some of the other issues with emergency medical services, I would gladly answer any questions you guys have. [LR338]

SENATOR GAY: Thanks, Bruce. Any questions from the committee? Senator Hansen. [LR338]

SENATOR HANSEN: I have one quick question. [LR338]

BRUCE BEINS: Uh-huh. [LR338]

SENATOR HANSEN: On training EMTs in general, is there national standards and state standards to meet? [LR338]

BRUCE BEINS: Yes. The statutes actually say that we will train people to the DOT curriculum, Department of Transportation, United States Department of Transportation curriculum. That's one of our upcoming issues because that curriculum is going away so we will eventually have to get a statute change to change that. The new...what they will have new are called the educational guidelines and they will take basic training from about 130 hours to from 150 to 190 hours of training for a basic EMT. [LR338]

SENATOR HANSEN: And we can't get enough people at 150 hours. [LR338]

BRUCE BEINS: We have a really hard time at 130 to 150 to get people. [LR338]

SENATOR HANSEN: Do we need to rewrite our own state statutes and go away from the national standards? [LR338]

BRUCE BEINS: Well, the statutes will have to be rewritten one way or the other, because if they keep referring back to a DOT guideline that no longer exists,... [LR338]

SENATOR HANSEN: Okay. [LR338]

BRUCE BEINS: ...and I think that is in 2012, then we'll have to do something at that point. [LR338]

SENATOR HANSEN: Thank you. [LR338]

BRUCE BEINS: A whole nother discussion on whether we should go away from the state. [LR338]

SENATOR GAY: Yeah, it is. It is. And we will, I'm sure, discuss that this year. Bruce, I do have a question. Did you say six to eight hours are on training behavioral health issues? [LR338]

BRUCE BEINS: For paramedic level training. [LR338]

SENATOR GAY: Okay, for paramedic. Out of the 130 to 150, that's all it is? [LR338]

BRUCE BEINS: You know, the EMTs get 130 to 150 hours of training and they only get about 3 hours... [LR338]

SENATOR GAY: Okay. [LR338]

BRUCE BEINS: ...of behavioral emergencies. [LR338]

SENATOR GAY: Okay. [LR338]

BRUCE BEINS: And the paramedic level, that training is 600-and-some hours, depending on which college you go through. [LR338]

SENATOR GAY: So pretty minimal on... [LR338]

BRUCE BEINS: It's very, very generic, very minimal. [LR338]

SENATOR GAY: Okay. Thank you. Any other questions? I don't see any. Thanks, Bruce. [LR338]

BRUCE BEINS: Thank you. [LR338]

SENATOR GAY: Others, come on up. Leonard. [LR338]

LEONARD HOULOOSE: I'll get the ball rolling for law enforcement. Good afternoon, esteemed committee members. My name is Leonard Houloose and I'm the chief of police in Papillion, speaking on behalf of the Police Chiefs Association of Nebraska. If you ask virtually any Nebraska patrol officer, deputy or trooper their opinion of the adequacy of available emergency medical healthcare resources, I can almost guarantee that each would be able to provide numerous examples to cite how they believe the system is in some degree of meltdown. Whether because of the lack of available bed space, transportation issues, or because of restrictive placement facilities rules and regulations, almost no emergency protective custody situation flows smoothly. Often the majority of an officer's shift is consumed by a single EPC incident and in many cases, the law enforcement agency's obligations to the incident may last for several days. Each time we handle an EPC one, if not two, officers are removed from all other law enforcement duties. This means fewer officers are available to answer calls for service, perform preventative patrol, or conduct traffic enforcement efforts. In our agency, which is considered one of the larger municipal departments in the state of Nebraska, a normal patrol shift consists of six officers. One EPC may easily tie up 33 percent of my patrol force for hours, and the problem just keeps getting worse. In 2004, our department performed a total of 58 emergency committals. Year to date, we are well over 125. Although safe haven has received the bulk of recent publicity for putting strain on state resources, I believe that it pales in comparison to what we've been experiencing for years with emergency behavioral healthcare resources. In the Omaha metro area, the problem is exacerbated because of conflicting rules among care providers. For example, Immanuel is the only facility that will accept patients 17 years and under, Lasting Hope Recovery Center will only take patients 19 and older, and no one in the whole metro area will accept a patient that is 18 years old. Sarpy County committals are no longer accepted at Douglas County Hospital, and Lasting Hope is not

up to advertised capacity. Some facilities won't accept a patient if their blood alcohol content is too high; Campus Hope won't take them if their blood content is too low. Immanuel is the area's primary secure and appropriate and available medical facility as defined in Nebraska statute, however, in 2006 all metro law enforcement agencies and ambulance services were directed by the director of Immanuel emergency department to have psychiatric patients transported to the closest catchment facility, in other words, emergency room. For the majority of Sarpy and Cass Counties, that would be Midlands Hospital, which is in my jurisdiction, which is not considered an appropriate medical facility for psychiatric care. Therefore, any patient transported to Midlands must then be transported to another facility when and if bed space becomes available. The complexity of my agency's available processes and options is detailed in a nine-page department EPC policy which has undergone ten revisions in six years, primarily due to changing system requirements and resources. Whenever I get to feeling sorry for our situation in the metro, all I need to do is talk with my counterparts in other parts of the state. Departments with fewer patrol resources than ours may have to make three or more hourlong drives if a facility can be found that will take an EPC patient or, worse yet, they're required to take a patient to the nearest hospital, wait three or four days for them to become...to be deemed medically stable, then transport a handcuffed medical patient several hours to a follow-on facility. As your committee ponders recommendations relating to the implementation of the Nebraska Behavioral Health Services Act, I respectfully ask your consideration of the following. Number one, devote adequate resources to address the lack of bed space for mentally ill and dangerous persons, as defined in Nebraska statute. Whether these beds are continually unavailable because of clogs in the subacute or follow-on treatment phases is of no consequence to the patrol office that has no place to take an EPC patient. Number two, create at least one adequate, one-stop shop in every region which any and all EPC patients, regardless of age, the presence of intoxicants, drugs, etcetera, can be taken to by law enforcement for screening assessment and initial treatment. And number three, prohibit hospital-to-hospital transport by law enforcement. Any officer, deputy or trooper will attest that the last thing that any medically stable psychiatric patient needs is to be

handcuffed and transported in the back of a patrol car. Mental illness is not a criminal offense, nor should we treat it as such. I want to thank you very much for your time and attention regarding these emergency systems issues. [LR338]

SENATOR GAY: Thanks, Chief. Senator Stuthman. [LR338]

SENATOR STUTHMAN: Thank you, Senator Gay. Thank you for your testimony. [LR338]

LEONARD HOULOOSE: Yes, sir. [LR338]

SENATOR STUTHMAN: Has it gotten better in the last year or so of finding space for EPC individuals? [LR338]

LEONARD HOULOOSE: Well, sir, I can only speak for our experiences in the metro. In some ways it has but in other ways it has not. For instance, in the Omaha area we used to have the Spring Center as a one telephone number clearinghouse in which they would try to procure a bed throughout various places in the metro area. That has gone away now. In some respects, we are still able to call the...what we were told is the replacement, which is the Lasting Hope Recovery Center. However, we've experienced some frustrations with respect to getting any kind of assistance there. Ultimately, in many cases, at least in Sarpy County, what things regress into is we will try to...we will try to locate a bed somewhere in the Omaha metro and which officers will transport, but if the delay is too long in getting an answer or no answer is received at all or we're just simply told that there's no room at the inn, that's when the officers within Sarpy and Cass County will transport to Midlands Hospital, which has an emergency room, but obviously no meaningful treatment is done there. They're simply held until a bed becomes available. [LR338]

SENATOR STUTHMAN: Thank you. Are there going to be any other police chiefs

testifying? [LR338]

LEONARD HOULOOSE: Yes, sir,... [LR338]

SENATOR STUTHMAN: Okay. [LR338]

LEONARD HOULOOSE: ...and probably much more articulate than I, so... [LR338]

SENATOR STUTHMAN: Then I will refer a question later on to one of them. Thank you. [LR338]

SENATOR GAY: Hold on. Hold on. [LR338]

SENATOR FULTON: (Inaudible) wait too. [LR338]

SENATOR GAY: You sure? [LR338]

SENATOR PANKONIN: I just have a quick one. Chief, your testimony was compelling. You did a great job. What do you do with that 18-year-old? You told about the hole. I mean literally, what would you do? [LR338]

LEONARD HOULOOSE: Senator, a police chief should never lie (laughter), however, we will beg, borrow and steal (laugh)... [LR338]

SENATOR PANKONIN: That's what Senator Stuthman said. [LR338]

LEONARD HOULOOSE: We will do virtually anything we can, but most often in the cases that I'm aware of in Sarpy County what ultimately happens is they get brought to an emergency room at Midlands Hospital and they are basically dropped off there. What they are able to find for them after that, I believe there's a county attorneys

representative here, they may be able to tell you what they do with them. But in our situation there is at least a basic understanding of federal EMTALA law out there amongst law enforcement officers and they know that if they bring a patient into the emergency room that that patient cannot legally be turned away, if we understand it correctly. And therefore, it's always going to be probably our opinion that any emergency facility hospital is better, once again, than having them in the police station or in the back of a patrol car. [LR338]

SENATOR PANKONIN: Thank you. [LR338]

SENATOR GAY: And I've got a question for you real quick. Did...how many times...is there meetings going on to try amongst yourselves to say what's the best practice? And I, you know, we've talked on this and... [LR338]

LEONARD HOULOOSE: Yes, sir. [LR338]

SENATOR GAY: ...I've seen your report. Yeah, I mean do you guys talk? And give us a solution. [LR338]

LEONARD HOULOOSE: There are a number of regularly scheduled meetings on all levels at the basic patrol officer level, the actual front lines. They get together and hash out things on their level on a regular basis. I believe... [LR338]

SENATOR GAY: Amongst different forces, you mean? [LR338]

LEONARD HOULOOSE: Yes, representatives from Region 6, representatives from all the different police agencies and representatives from HHS, I believe, and many times some medical representatives from Alegent and/or Immanuel and/or the Douglas County Hospitals and really it's a pretty good turnout that we have at those meetings. None of these issues are new for most of us on the front lines. What appears to be new

is the sheer volume of activity that we've been seeing the increases over the past several years, and as the volume increases, the resources have not increased at the same rate and, therefore, the problem seems to get worse. [LR338]

SENATOR GAY: Yeah. And this is not excuses, but earlier this morning we ended before lunch and we talked about a work force shortage and this just compounds that situation. And I know everyone is kind of banging their head against the wall right now, but we at some point have to...and we have a good committee here, Appropriations and Health, and try to come up with a solution and that's what today...a lot of what we're talking about today is, to understand the problem. And we're hearing a lot of the problems, but also, as you have solutions out there, bring them forward as well and see if we can correct them. So... [LR338]

LEONARD HOULOOSE: Yes, sir. [LR338]

SENATOR GAY: ...thank you. [LR338]

LEONARD HOULOOSE: Yep. [LR338]

SENATOR GAY: Anyone else? [LR338]

LANCE WEBSTER: Members of the committee, thank you for hearing my testimony today. My name is Lance Webster. I'm the chief of police in the Wayne Police Department and I'm also here representing the Police Chiefs Association of Nebraska. These are very difficult issues that we face and there's not an easy answer to this question, but there are some things that I think your committee needs to be aware of. Transportation costs for the emergency protective custody cases are very onerous for small agencies such as mine. As Chief Houloose said, when someone from his agency is involved with an EPC, he loses 33 percent of his patrol staff. Oftentimes, I lose 100 percent. I have one person working. We have an EPC, even if we can take them to

Norfolk, which is our closest facility in Region 4, if they have bed space, I've lost an officer for three hours to three and a half hours, plus, I send a second officer because with mentally ill patients we want to transport with two people for safety. So now I've called somebody in, I'm paying overtime for him. Then I call a third person in to cover the shift, so I'm paying a lot of overtime plus transportation costs and the transportation costs become very critical for us because oftentimes Norfolk does not have room. It's been improved in the last probably six months, but we still have some issues. But we usually go to Kearney or to Lincoln to BryanLGH. Last year we were told to go to Scottsbluff and we just can't do that. I mean that's just horribly onerous for us. And if you take that in the context of we have a mentally ill patient who's a medical patient and he's handcuffed and placed in the back of a patrol car--I'm sure most of you have never been in handcuffs in the back of a patrol car, at least I would hope not--it's a very uncomfortable transportation situation. If we're taking somebody clear, literally, clear across the state of Nebraska, that's, you know, that's just cruel. And so those are issues that we have to work on. Whether we can use a transportation service to transport people if they need to go further than our region, that would be something I think that you should take a look at. But again, bed space is critical. We often have overflows. They've added bed space to the hospital in Norfolk which has been very helpful for us, but we're still faced with oftentimes trying to find bed space throughout Nebraska. And one of the things with our proximity to Sioux City, Iowa, we've done some checking and found oftentimes when there are no bed space available for...in Nebraska, they do have bed space available in Sioux City. But because the law doesn't allow us to transport over there, we can't do that. So as you look at some options and some different things, I would certainly encourage you to take a look at a contract with out-of-state resources to help alleviate some of the issues that we have here in Nebraska. Thank you. [LR338]

SENATOR GAY: Thank you. Any questions? Senator Fulton. [LR338]

SENATOR FULTON: These EPC episodes, do they tend to be...what necessitates law enforcement's involvement? Is it a disturbing the peace? It is public drunkenness? Is

it...help me understand what's... [LR338]

LANCE WEBSTER: For us, oftentimes we get a call from our hospital or we have a regional mental...community-based mental health treatment facility in Wayne and a lot of times the calls come from them. And Region 4, to their credit, have been very good in working with and trying to mitigate some of those issues to help us out because two years ago we were doing several transports and that's been dropped down considerably, but...or we'll just have a family member call and say, you know, my son is suicidal or something like that. Very seldom do we get an EPC out of a regular call for service. We're usually called to the event. [LR338]

SENATOR GAY: Senator Stuthman. [LR338]

SENATOR STUTHMAN: Thank you, Senator Gay. If you pick up or are called to a situation and you pick the person up and EPC them and he's from a different jurisdiction, who pays the cost of the "EPCing" that you're doing? [LR338]

LANCE WEBSTER: We do. [LR338]

SENATOR STUTHMAN: You do. [LR338]

LANCE WEBSTER: Yeah, the cost is to my agency. We do. Ultimately, when the person gets placed in a mental health facility, the county of origin will stand those costs. But the up-front initial costs come to my department. [LR338]

SENATOR STUTHMAN: And you're not reimbursed. [LR338]

LANCE WEBSTER: And we're not reimbursed for that, no, sir. [LR338]

SENATOR STUTHMAN: Okay. Thank you. [LR338]

SENATOR GAY: I've got a question for you. I know Chief Houloose and I had talked about the number of incidents in our community, but how many in yours? You said it ties up a lot of your resources, but how many annually, just ball park? [LR338]

LANCE WEBSTER: This year has been...we've been, actually, low. Last year I think we had 35 and this year we're sitting at about 12, so... [LR338]

SENATOR GAY: So it fluctuates, obviously. [LR338]

LANCE WEBSTER: Yeah, it does fluctuate. It's up and down. [LR338]

SENATOR GAY: What's the most you've had that you can remember? [LR338]

LANCE WEBSTER: 60. [LR338]

SENATOR GAY: Sixty in one year? [LR338]

LANCE WEBSTER: Uh-huh. [LR338]

SENATOR GAY: So that's a lot of money. Right. Thank you. Any other questions? Don't see any. Thank you. [LR338]

LANCE WEBSTER: Thank you. [LR338]

SENATOR GAY: Oh wait. Senator Nelson. [LR338]

LANCE WEBSTER: Oh, excuse me. [LR338]

SENATOR NELSON: Thank you for your testimony. Are you required to put these

people in handcuffs? Is that policy or what? [LR338]

LANCE WEBSTER: That's our policy if they're being transported. One of the reasons is the instability, potential instability of a mental health patient. The closer they get to a facility, they may get more aggressive. Again, we believe some of those things can be dealt with through transportation companies or even by ambulance. There's more humane ways, probably, to restrain someone for a long transport than handcuffs. [LR338]

SENATOR NELSON: That was my next question. Who else could do this transportation there besides law enforcement? What suggestions do you have? [LR338]

LANCE WEBSTER: They are medical patients. I see no problem with an ambulance transporting them. There may be some people in the emergency medical service that disagree with that, and I understand that. But again, we have transportation services that different sheriffs' offices use to transport prisoners across the country or across the state, I should say, and I don't know what their policies are relative to handcuffing and things like that, but they're in a van. They're in a much more comfortable setting. You know, we're pretty confined in our cars, at least for the prisoner. But then there's just the sheer stigma that, you know, I pull out of my police department with someone in handcuffs in the backseat and drive through town. Everybody can see that somebody is in the backseat of my car and no one makes a distinction for these individuals as are they criminal or are they someone that is a medical condition. They are assumed to be criminals, and I think that's an unfair stigma to place on somebody, especially in smaller communities. [LR338]

SENATOR GAY: Okay. All right, thank you. [LR338]

LANCE WEBSTER: Thank you very much. [LR338]

SENATOR GAY: Thanks. [LR338]

WILLIAM GUMM: Thank you, Mr. Chairman, members of the committee. My name is William Gumm. I'm the police chief at Columbus, Nebraska, and I don't want to belabor the point but I feel that these issues that...are important to repeat. The issue of bed space, the issue of transportation, the issue of intake rules and administrative rules on how to get these folks service are a detriment to providing the service to the citizens of our community. These people are medically ill and they need some assistance from our communities. To require us to transport by handcuff, to require us to wait hours at a time to get them service, to require us to transport to long distances to provide service is not an appropriate service that we should be providing for our citizens. Again, I don't want to belabor the point. Chief Houloose was very eloquent but I just want to repeat that it's an issue that is addressed by every policy, county sheriff and, in some instances, the State Patrol across the state. Emergency protective custody issues are time consuming, they're cost consuming, and I don't know that we're doing the right thing for our people. [LR338]

SENATOR GAY: Thanks, Bill. Senator Stuthman. [LR338]

SENATOR STUTHMAN: Thank you, Senator Gay. Chief Gumm, thanks for coming down today and testifying. And I know we've discussed this many times. Do you have any solution for, you know, yes, we need more beds, but is there some other place or some other thing that we could do that could accept these people that, you know, that you wouldn't have to travel a day? [LR338]

WILLIAM GUMM: I agree with...I think I agree with Chief Houloose's suggestion on a one-stop intake location. I'm not so sure that any hospital should be allowed to be...to intake these people, to medically stabilize them and to prepare them for transport by, again, as Chief Webster talked about, some other outfit other than police departments, some medical transportation company that would step and provide that service to these

folks. I think that these folks need to get into a medical facility as quickly as possible and most of us have close access to a 24-hour emergency room. And I know that's putting a burden on other people, but police are not trained to be...to provide this service. [LR338]

SENATOR STUTHMAN: In other words, if we could establish a one-stop, say in Columbus, like at the community hospital just for a short time, that they could be transported then by other than law enforcement. [LR338]

WILLIAM GUMM: I believe that that would work, Senator. [LR338]

SENATOR STUTHMAN: Okay. Thank you for that suggestion. [LR338]

WILLIAM GUMM: Thank you. [LR338]

SENATOR GAY: Senator Johnson. [LR338]

SENATOR JOHNSON: Yeah, thank you very much. Just one short question: Where are the police and sheriffs in general at...since you're using the first responders, or often are, how much training has there been for these two aspects? And I guess I'm asking the answer for both but... [LR338]

WILLIAM GUMM: And I'll be quite honest, I think it's very minimal. I think we're about up to eight hours at our training center on recognizing mental health conditions. [LR338]

SENATOR JOHNSON: That's when you go in to being a police officer or whatever. [LR338]

WILLIAM GUMM: When...as you are a recruit officer, a new deputy. [LR338]

SENATOR JOHNSON: Okay. [LR338]

WILLIAM GUMM: And I think most officers learn of this, more of this, through on-the-job experience with the persons in their community. There's not much follow-up training done, no, sir. [LR338]

SENATOR JOHNSON: Okay. Great. Thank you. [LR338]

SENATOR GAY: There's a federal grant we received, I think, the last hearing, a quarter of a million dollars for two years on training and that may help a little bit. But I think that's what we discussed last week, so there might be a little help out there but...on that end. [LR338]

WILLIAM GUMM: (Inaudible). []

SENATOR GAY: Okay. Any other questions? Don't see any. Thank you. [LR338]

WILLIAM GUMM: Thank you. [LR338]

SENATOR STUTHMAN: Thank you. [LR338]

SCOTT TINGELHOFF: Good afternoon, Mr. Chairman and senators. Thank you. My name is Scott Tingelhoff, Saunders County Attorney, on behalf of the County Attorneys Association. Most of the concerns I want to talk to you today are basically law enforcement concerns but they do pertain to the county attorneys' offices because I would guess that 75 percent of the issues that arise, our offices are contacted on how to appropriately deal with them. So we do spend a lot of time with the officers. Each situation is unique, but Saunders County is unique in the situation that we still are rural as far as budgets and funding. We have a lot of small town, two-person police departments, smaller sheriff's office. Budgets aren't huge so...but we are fortunate we are located close to Lincoln and Omaha for services. We very frequently have problems

with bed space. We just, in fact this week, encountered a situation where we had to stabilize an individual at an out-of-county facility. They contacted our dispatch and said, they're stabilized, they need to be taken into the Crisis Center, except we have no ability to hold them and they're walking out the door. They're 11th in line right now to get a bed. So we're a half hour to an hour away of getting to even be able to pick them up and they have to wait at least 11 people before them to even get into a facility. It is a huge concern from the law enforcement. The other concerns that I have heard today and I hear from our law enforcement everyday is they are not trained to...best to do the assessment of who's actually the danger to themselves or others. Ninety percent of our reports come from family members or friends, so they've taken all that information in and they're doing, you know, their best judgment of what they're getting from family members and friends, and past histories. We do have a lot of repeat offenders that come in. The thing that's concerning, after they do get placed into the Crisis Center, is it seems that they're back out in a day. We very rarely will actually have a mental health hearing, I'd say only 10 to 15 percent of the time. My concern is that due to lack of funding that decisions are being made to release them to create more bed space for the people coming in rather than treating them like we should, which in turn we see them a month or two later with the same problems. So I'd be welcome to answer any questions you may have. [LR338]

SENATOR GAY: Thanks, Scott. Any questions from the committee? Hey, just for the record, could you spell your last name for Erin? [LR338]

SCOTT TINGELHOFF: Yeah, Tingelhoff, T-i-n-g-e-l-h-o-f-f. [LR338]

SENATOR GAY: Doesn't look like there's any. Thank you. [LR338]

SCOTT TINGELHOFF: Great. Thank you. [LR338]

SENATOR GAY: Thanks. [LR338]

JIM PESCHONG: Mr. Chairman, members of the committee, my name is Jim Peschong. It's P-e-s-c-h-o-n-g. I'm the assistant chief of the Lincoln Police Department and here on behalf of the Police Officers' Association of Nebraska. The emergency system continues to suffer many of the same problems now as before behavioral health reform began several years ago. Although new issues rise to the surface from time to time, we experience unacceptable outcomes due to the same system weaknesses year after year: number one, crisis beds are unavailable to law enforcement. Under normal circumstances, we expect a person under EPC to stabilize quickly and move on to treatment within a few days. Cycling each emergency bed efficiently allows a small number of crisis beds, 15 in all of Region 5, to adequately serve law enforcement in 16 counties in southeast Nebraska. As the regional centers have closed, treatment has become unavailable and people become stuck in crisis beds when they are not in need of that level of care. The beds cannot cycle and become unavailable to law enforcement. This issue is measured in postcommitment days--the number of days a client spends in a crisis bed when he is ready to go into a treatment program. Postcommitment days have increased over the past two years. Each region has a designated facility which has been identified to receive persons placed into emergency protective custody by law enforcement. When these beds are full, officers and deputies are forced to find other secure beds which can be miles and miles away. Officers and deputies are kept from their other duties for hours at a time, incurring payment of overtime and stressing already low staffing levels. All acute beds for adolescents were removed from the system two years ago and have never been replaced. This creates a void in the system, as there are times when a secure bed is needed for a teenager who is experiencing a dangerous mental health crisis. Without the safe environment provided by the previously available beds, law enforcement has no where to place adolescents who need crisis stabilization at a highly secure level. Two, the division of developmental disabilities uses law enforcement as an emergency level of care. Service providers for people who are developmentally disabled, DD, have received brain injuries or suffer from organic brain disorders use law enforcement to access the behavioral

health emergency system for crisis care. Developmental disability providers continually call law enforcement to take custody of their clients when the client is experiencing a behavioral crisis. Providers expect the client to be taken into custody and be confined for some type of mandated treatment. In most cases, the client stays in a crisis bed for days or weeks until he returns to his normal program, to his, excuse me, original program. This lowers the numbers of crisis beds available to law enforcement even further. These situations create very problematic Fourth Amendment issues as well. Since his discharge from Beatrice State Developmental Center six months ago, one man place in Lincoln in a group home has generated nine police calls per service. In one case, he ran away from the residence, in another he tried to kill himself. Six of the remaining calls were mental investigations calls where the staff of the group home called the police to ask for assistance because the group home staff did not have the capacity to deal with the issues at hand. Many group homes in our city have similar situations. Group home staff depend on law enforcement to fulfill their responsibilities to their clients. The Developmental Disabilities Court-Ordered Custody Act was created so developmental disabilities clients could be treated at the proper level of care when in crisis. To our knowledge, this statute has never been used in order to assist a DD client in need. Rather, the DD system relies on the statutes created for the behavioral health system, meaning DD clients are sent to facilities created for people who suffer from mental illness, depression, anxiety, thought disorders. Three, new community programs offer no mobility between levels of care. The new community-based programs which have been developed to serve clients coming out of the regional centers have not been designed to allow clients to move within a spectrum of care. As our newly created, assertive, community treatment programs find their clients in minor legal trouble for some type of intermediate mental health crisis, we have found these programs have no emergency plan or respite care in place to successfully manage their clients' needs. Unfortunately, law enforcement is called to take custody of the client and either arrest the client for a minor crime or place the client into emergency protective custody when no other options are available. Five weeks ago the police were sent to the home of a women enrolled in one of the assertive community treatment programs. She suffers

from a thought disorder and was repeatedly calling 911 to ask for help. Officers called her care provider to ask that someone come and help her. The officers were informed that staff from the program could not come to the assistance and that the safest place for her to be placed was to be placed in jail. The only way the officers could stop the calls from coming in was to jail the woman for a misdemeanor offense. Many of these issues can be managed successfully. Providers from all systems of care will have to create programs which are designed for clients who need emergency services from time to time. Providers, consumers, and law enforcement can work together and increase the number of successful outcomes for the mentally ill who receive services from our community. Thank you. [LR338]

SENATOR GAY: Thanks, Jim. Any questions? I don't see any. Thanks. [LR338]

JIM PESCHONG: Okay, thank you. [LR338]

SENATOR GAY: Anyone else who would like to speak on this? [LR338]

ROBYN HENDERSON: If I may beg the committee's indulgence for just one moment, as I was listening to this testimony... [LR338]

SENATOR GAY: Robyn, can you state your name? [LR338]

ROBYN HENDERSON: Oh, I'm sorry. My name is Robyn Henderson, R-o-b-y-n H-e-n-d-e-r-s-o-n. The AHECs are ideally suited to provide some of the continuing education for police and emergency technicians that we've been talking about. We do continuing education for the healthcare providers on the medical side, but we could also do this and we can do it locally. We can do it within, in my areas of 17 counties, we could do 3 of those that cover all parts of our county and not require time for our providers, our police office officers and our EMTs to be away from their community. We have the flexibility that we can do it nights or weekends, again, because of the lack of

daytime support in the communities. So I just, again, I would offer that as another part of what we can do. We're very multifaceted in the role that we can play in the community though health education, through continuing education, and through other community regional planning issues. Thank you. [LR338]

SENATOR GAY: Thanks. Thanks, Robyn. Any questions? No. All right, anyone else? Well, let's take a 15-minute break, be back at 3:00 and we'll talk about community-based services. [LR338]

BREAK []

SENATOR GAY: Go ahead. We're here to finish up today on community-based services and we have about an hour and a half if we need it or we'll play that by ear, so let's...we don't need to rush through this because, as we know, we're hearing these very important issue of all...as it gets put together, and we're going that way, this is an important issue. So we'll take our time. We're going to start off, but we'll start off and then who wants who to speak. [LR338]

PATRICK CONNELL: Okay. [LR338]

SENATOR GAY: Who wants to speak on this today, this afternoon? And then if you change your mind...so we don't have too many, but if you'd want to come on up later, come on up. But we'll...Pat, go ahead and introduce...(Recorder Malfunction). [LR338]

PATRICK CONNELL: (Recorder malfunction) (Exhibit 11) I serve as the vice president of Behavioral Health Services at Boys Town and I'm here today as the chair of the Nebraska Behavioral Health Coalition. I'm kicking off the testimony from the consumer organization because I'm going to try to give you a view from about 5,000 feet up. The other people who will be testifying will be telling you about how this affects individual providers but I want to...I think it's important that you see the cause and effect and

copies of my testimony have been passed out. The purpose of our coalition is to promote access to mental health substance abuse treatment in child welfare services for all Nebraska citizens. The services that the coalition members provide include inpatient, partial hospitalization, residential treatment services, treatment group homes, substance abuse residential services, treatment foster care, various outpatient services, inhome family services, the child welfare services, other adult rehab services. The coalition providers receive payment or funding for patient services from a variety of payment sources. And I think that's important to differentiate because it will help explain some things later on. We receive payments from Medicare, Medicaid, insurance companies, the Nebraska Mental Health Regions, self pay, etcetera, some county funding too. The primary location of these treatment providers are in the areas surrounding Omaha and Lincoln, with a lesser number of providers located in the cities and towns along interstate I-80, as well as the Norfolk area, Beatrice, and...but a lot lesser so the farther the way you get away from the interstate. Over the years we have utilized the following simple model to illustrate the cause and effect of system change on behavioral services funded by the public sector. And the model is, adequate rates and funding equals adequate capacity, which equals access to mental health services or substance abuse services. We use this model today to illustrate the history and future of behavioral health services in Nebraska. But before proceeding, let me note that Nebraska is not alone in facing these challenges. I just came back from the National Council of Community Behavioral Healthcare organizations. We had 37 seat associations alike ourselves. We're all facing similar type challenges in our states. Some states are ahead of us, others are behind. Some states are facing greater challenges and others smaller challenges. Some states have made good decisions, some changes are unknown, and other states have made changes that have, frankly, been disastrous. But before beginning, the first thing we need to understand is, what is rate funding history in Nebraska? In the early 1990's, Nebraska Health and Human Services went through a series of actuarial driven cost studies. After each study, HHS determined that the rate was higher than they were willing to pay and therefore, they modified the assumptions and ran another version until they found the rates that would

meet their budget assumptions. It was kind of like, you know, the story of Goldilocks. You know, they just kept trying different bids until they found one that fit for them from a budget perspective. The new rates were used for the Nebraska Medicaid fee for service program. Now the fee for service program is when the state pays a provider for a specific service to, for a specific patient, for a specific day of service. At the same time they entered into a full capitation contract with a national behavioral health managed care contract, which frankly created a lot of chaos across Nebraska. Now capitation is a financial arrangement in which a state pays a managed care company a fixed fee for every patient in their care per month. In return, the managed care company provides for all of the patients' healthcare needs. Under capitation, the managed care company rather than the state are at financial risk, because if they lose money, if their total cost exceeds their fixed per-patient fees, they lose money, and therefore, they assume the risk. As such, managed care companies in theory have an incentive to minimize their patients' consumption of healthcare, but also have an incentive to make liberal use of preventative education and care to avoid, you know, having minor problems develop into crisis. The major problems that we saw that when we implemented this back in the mid '90s and, frankly, you know, I must be getting old because 13 years ago just seems like yesterday, there was huge problems that we had when we rolled out this program. The rates that were implemented were substantially below cost and therefore, services were closed or limited. Some providers would not accept Medicaid patients. A number of providers closed their doors and others closed selected offices. Some providers attempted to merge. Second, there was a substantial delay in payments to providers. It was not uncommon for providers in those early years to report payment delays of 180 days to 365 days. These providers did not have the financial reserves to continue paying their bills while waiting for Medicaid or the managed care company to reimburse service costs. Some providers again closed their doors, others left the state. Some providers choose to retire while others stop accepting Medicaid patients or even capping the number of Medicaid patients that they would accept. And all providers had to hire additional staff. And what these new staff did was, they did the functions of utilization review or the additional billing requirements that was required to do a

managed care billing. As a result of this additional cost, some providers again closed their doors, limited their services and limited the number of Medicaid clients they could serve. What we saw, this was a stairstep effect. It did not happen all at once over the first year. It happened over a three to four year period, as the costs did not keep up with the costs of actually...the reimbursement did not keep up with the cost of what those services were. As evident, things did not go well. Consumers could not access services in some parts of the states, other consumers had to travel long distances, and some were on long waiting lists. During these painful years, the managed care contractor was able to make a profit while restricting access to care. HHS then converted the fully capitated contract into an administrative service organization. And what an administrative service organization is, is a plan that where the state assumes medical expense...where, the state assumes the responsibility, the risk. They assume the medical risk liability. The managed care company provides administrative functions including claims adjudication, bill submissions and other services. States hope to achieve savings through outsourcing the administrative functions while retaining the financial benefits of good claims experience. So additionally, every year over the last 14 years, the behavioral health community has asked the Unicameral for a cost of living increase for provider funding and rates. Sometimes this occurred, and other times it did not. Yesterday I was reminded by a provider that we went through one dry spell where we did not get an increase in seven years. As per our previous testimony to the Health and Human Services committee last spring, the provider rates have not kept up with costs and they've not kept up with inflation. As a result, our current rates are now lower on a comparison basis to what they were set back in 1994 when they were set at below cost. Still there are HHS staff out there that believe that providers are generating a profit from Medicaid. The opposite is true. Providers have closed the doors, limited services or minimized losses from the Medicaid program. So the first part of this is rates and funding. Rates and funding affect capacity. Capacity is the number of providers out there, the number of beds they have available, the number of mental health professionals they have to see patients. As a response to the decline in available provider capacity, the mental health regions have been able to pick up a small amount

of capacity and keep some of the rural providers from closing their doors. There are some individuals in HHS that will argue that we have enough capacity in the current system, but they are simply looking at numbers without a proper analysis. Let me give one of many similar examples. According to the American Psychiatric Association there is a national shortage of child psychiatrists. Nebraska has a ratio of one psychiatrist per 52,000 individuals. Nationally, the ratio is one psychiatrist per 44,000 individuals, so the lower the number of population per psychiatrist, the greater the ability to access a psychiatrist. We're 15 percent below the national average on a professional area that has work force shortage. What is missing from the above analysis is, how many of the Nebraska child psychiatrists are available full-time to see patients? A more critical question is, how much of their practice are they willing to devote to seeing Medicaid patients? As earlier illustrated, Medicaid is paying less than cost, so there's a disincentive from serving Medicaid patients. Therefore, it is logical to assume that the real ratio is much worse. In reviewing this testimony with a member of the Nebraska Psychiatric Association, and the members of our coalition, by the way, is attached. It's the last page of our testimony. It's a diverse group of providers and consumer associations from around the state. This individual compared themselves to a plumber. Now, frankly, I don't know what the plumber's name was. It might have been Joe, (laughter) it might have been something else, but it was a plumber. And he said, a psychiatrist is paid on an hourly basis by Medicaid less than what you pay a plumber. The plumber gets paid after the visit. I've had plumbers out to my house recently and they take credit cards now and they take cash or check and they expect to get paid when they get done providing that service. The psychiatrist, on the other hand, has to complete various amounts of paperwork before his office staff can bill Medicaid. He may also have to participate in preauthorization, utilization review, and may have to answer many questions from the Medicaid staff before his claim gets processed. Sometimes a claim is lost and the staff has to rebill Medicaid. Sometimes later, which can run from weeks to months, his office receives payment from Medicaid. So with these disincentives, is it any surprise that behavioral health providers may have reservations about accepting more Medicaid patients? Which brings up the issue of access. And

again, still there are those in HHS that would still argue that they have more than enough providers to serve their patients and therefore, have adequate access to behavioral health services. If this is true, how do we explain that new patients may have to wait several weeks for an appointment? How do we explain the waiting list for numerous services? How do we explain the delay in transferring patient from one level of service to another? How long of a delay is acceptable and to whom? Over the last days, weeks, and years, the behavioral health community, along with consumers, law enforcement, educators, parents, judges, and advocates have shared countless stories about the difficulty in accessing behavioral health services. It is important to note that this lack of capacity affects both the public and privately funded system. A lot of the discussion today has driven around the public funded system. The privately funded system is that which is paid by your insurance companies, your employers insurance companies, HMOs, PPOs, that you may be a part of. I have to be frank with you that I do not go a month in my capacity at Boys Town where I do not get a call from one or two people that are associated with this branch of government, and the executive branch, that will say to me, I have an AIDS grandchild or I have...my mother-in-law is having problems and I called a psychiatrist or I called a mental health professional and they it's going to be weeks, it could be a long time. Is there anything you can do to help me get access to those services earlier? And so sometimes I pick up the phone and say, could you see a patient during your lunch hour or would you see this patient, you know, during the evening. It affects everybody. It does not only affect the patients that don't have money and the indigents, it affects everybody from the top on down as to the ability to access mental health services in Nebraska. So now that you understand the relationship between rates and funding to capacity, and how capacity affects access, the solution should be obvious. We need to adequately fund and provide rates to providers that will allow them to recover to their costs. This will help the manpower issue. We've had people that have left the state of Nebraska just simply because they couldn't make a living. We've had mental health professionals that have left the rural communities and come into the urban settings simply because they couldn't make a living in their home town. Second, we need to allow them to build or maintain capacity

based upon what the local community needs is. Oftentimes, we'll have a unit of government that's says, based on our understanding of a given problem, this is what we see...we had adequate access. But what they're doing is they're counting 100 percent of that individual's time or a 100 percent of those inpatient beds as being available to them when, in reality, they're not. They've got Medicaid patients in them, they've got insurance patients in them, they've got a variety of people, a variety of groups accessing those services. We need to be able to get a system designed and would get that with capacity that will allow people to access services without delay. And then the last thing is, is that, you know, as I said before, I'm getting old. We've been coming to the Legislature almost every year and tying up a lot of time talking about getting a CPI adjustment to behavorial health rates. We need to actually take the time, create a piece of legislation that adjusts the rates on a biannual basis so that it isn't a burden on the Legislature to argue about this every...or not argue about it, advocate for us, which we very much appreciate all your efforts in the past. But I think that will help us have more time available to address the other issues that we have within mental health. We'd like to thank the committee in scheduling this hearing. We have a lot of topics that we'd love to talk about, but we understand time is limited. We stand ready to assist the committee in improving the behavioral health system in Nebraska, and would be happy to answer any questions. [LR338]

SENATOR GAY: all right, thanks Pat. Senator Harms. [LR338]

SENATOR HARMS: Thank you, Senator Gay. You talked about the waiting list. What is your estimate of the waiting list we might have in Nebraska for services? [LR338]

PATRICK CONNELL: Well, it all depends upon the level of service and what part of the state. [LR338]

SENATOR HARMS: Can you help me? [LR338]

PATRICK CONNELL: Well, I'll give you an example. In children and adolescent services, which I have probably the greatness knowledge, and Topher has a lot more knowledge about what goes on in the adult world, right now the waiting list could be...a child psychiatrist, it's not unusual for a first time appointment to be six weeks out. [LR338]

SENATOR HARMS: What about the numbers? Do you have any idea about the numbers of people who are on that waiting list that need services across this great state? [LR338]

PATRICK CONNELL: No, but it has to be substantial. I mean, just from the perspective of it, it takes six to eight weeks to get on that list. That must mean that the numbers far exceeds the availability of services. [LR338]

SENATOR HARMS: And what would your solution be to that question? [LR338]

PATRICK CONNELL: Well, we're going to need to expand the work force. You know, we're...our work force is aging just like a lot of other work forces are, and we've got to get new bodies into those jobs. We need to be able to train them. We need to get psychiatrists, psychologists, mental health professionals, substance abuse counselors. We've got to figure out ways of drawing people into this profession and then providing them with a salary that they can earn that they can afford to live in an urban area or rural area. [LR338]

SENATOR HARMS: When you look at Nebraska in general, the further you go into rural America, the problems become much more difficult. [LR338]

PATRICK CONNELL: Absolutely. [LR338]

SENATOR HARMS: Because of the simple fact, as you were correct when you said,

that people are leaving, have been providers, because we haven't paid them appropriately, they can't stay in business. And so what we're seeing now where I live in rural Nebraska, great concern about having services available for people. So that leaves me to my next question then. What is a good...first of all, I need to tell you that I have some real concerns about community based programs. And I'm not convinced, in my mind, yet...I think they're important and we need to have them. And I don't know whether we have the right kind of community based program established in this great state, so. And I also think that the services that would be available are going to be more difficult for the rural (inaudible) the further west we go. So what would you tell me is a...just a good, what are the components of a good community based program? What are the components we need to have, and then what kind of an evaluation system should we have to be able to measure this to make sure that we are providing the services that are appropriate and that we are evaluating the providers? Because that seems to be somewhat of a problem in our system as I see it, so. [LR338]

PATRICK CONNELL: Well, one thing that is really necessary is a continuum of services. You have to be able to take care of that patient who is very acute and may need very intensive services for a couple of days, as well as have adequate number of services down at the other end of the continuum, which would be outpatient services. So you need to be able to have access to inpatient, residential treatment centers, rehab services, outpatient services, etcetera. Part of the way of evaluating whether or not the system is working well is looking at what is the...when a patient needs to move from one level of care to another level, is what kind of waiting time do they have to have before they can move. If you had some of the hospitals here, if you had Bryan, LGH, or Alegent here, they would tell you that they have a waiting list of people waiting to step down from one level of care to another. We also have the same thing from outpatients having, waiting to get into programs. [LR338]

SENATOR HARMS: Okay, looking at the shortage that we have in professional people and the shortage that we're going to continue to have as you mentioned earlier with

people coming my age and retiring, it's going to be more difficult then for us to provide quality community based programs if something is not done soon. And I guess my concern is that, are we placing children or adult clients into an environment that will be unsafe for them? Unsafe on the basis that, one, we have a shortage of professional people. We don't have psychiatrists, we don't have probably the social workers, we just don't have a system. What are your thoughts about that? [LR338]

PATRICK CONNELL: Well, that keeps me awake at night. [LR338]

SENATOR HARMS: And it really bothers me, that's why I'm asking the question. And I probably would not have been in tune with this until we went through the Beatrice issue. That opened my eyes on a lot of things. My question is completely different in how I think now. And so that's why I'm asking the question, because I believe that we're going to put people at risk, and I think that the state then walks away from that issue and says, you are the third party provider, you now have the problem. I don't think we've set up a program, so I'm just asking the question. [LR338]

PATRICK CONNELL: Well, that was a big issue back when we went to a fully capitated managed care contract. Because providers were saying at that point in time, hey, we have this particular patient that is exhibiting these following symptoms and they need to be at a higher level of care. And it was a fight on an ongoing basis to get them, to be able to achieve those levels of services. [LR338]

SENATOR HARMS: So the question I'm really asking, are we putting those people at risk? With the present structure we've got right now, and knowing what we all know, are we at risk here? [LR338]

PATRICK CONNELL: I think we are. [LR338]

SENATOR HARMS: I agree, thank you. Thank you. Mr. Chair. [LR338]

SENATOR GAY: One thing Senator Harms just seen in a prior hearing, and I'll get you the numbers, but I think the Department of Health and Human Services said, in five years 50 percent of their work force is ready, eligible to retire. So not only are we looking to outsource something, but our own internal sources. We may not have those people either, so just put to that in the back of your mind, not to scare you more, but it's a tough issue. Senator Pankonin. [LR338]

SENATOR PANKONIN: Thank you, Senator Gay. Patrick, we really appreciate you coming and told us well and your testimony is important. I've got a couple questions. First, I've got a comment though, I think it's good that we're having this resolution with the Appropriations Committee because Health and Human Services is always going to be sympathetic to (inaudible) we'll get the people the checkbook, so maybe that will help. You mentioned you went to a national conference and that some of the... you know, funding is always going to be a big part of this, but that you also looked at, heard about policies and procedures and methodology in other states. Some that was better, some that was worse, some that was disastrous, I think was your words. After being there and knowing where our system is, and not so much on the funding part of it, although that's obviously a huge piece of the puzzle, but just your general opinion about our system with all the weaknesses we have, but how would you rate it after going to this conference and hearing about other...the national picture? [LR338]

PATRICK CONNELL: Well, you know it's really kind of an interesting world that we have out there because what ends up happening is, we announce, a state will announce that we're going to be moving in this particular direction, it's a research evidence based program, and grand announcements occur when they start the program. And what happens is, and the greatest example out there is Tennacare. I don't know how many of you are familiar with that but that was the hottest thing since "sliced bread" as my grandmother would, used to say. I mean it was really going to change the way the healthcare was going to be delivered in this country and Tennessee got out there. And

Tennessee made some serious mistakes out there. They counted people that weren't committed to serving those kind of clients in their practice because Tennacare wasn't paying. Tennacare was delayed, they had problems with funding, etcetera. But what we don't hear is when states kind of just quietly move away from them. They don't call a press conference and say, we're going to terminate this program because it didn't work. And so when I go to these conferences, I hear these stories. I don't even want to talk about them out loud in case somebody in this room has...hey, that's a bright idea, that's a great idea. We ought to think about doing that in Nebraska. I don't know if that answers your question, but... [LR338]

SENATOR PANKONIN: Well, the question is, how do you rate our situation versus other states overall? [LR338]

PATRICK CONNELL: Oh, I think our system isn't broken. I think our system is underfunded. I mean, we have great providers out there. We have people that are doing wonderful jobs and Topher, you know, his testimony will address some of those things. I mean, we have a great overall system. It's just that we've been so seriously underfunded for years that it's a question of capacity which, we don't have sufficient capacity so we therefore, don't have access, or access is delayed. [LR338]

SENATOR PANKONIN: And wouldn't you agree though that funding, I mean, there's a political reality here of, in funding in that you have to have a buy-in from the Governor's side, the administration side, and the Legislature, obviously. [LR338]

PATRICK CONNELL: Absolutely. [LR338]

SENATOR PANKONIN: But then the public, you know, as a whole. So I think part of it is for all of us to better educate about the issue, the problems, as Senator Harms has brought up as well. If it is funding, then, you know, we have to sell that with all the competing interests and there's a lot of competing interests. [LR338]

PATRICK CONNELL: Right. But look at for instance heart problems. There's been some recent studies out that have identified that patients that are diagnosed with heart problems suffer from depression. Well, if I was diagnosed with a heart problem, I'd certainly would be depressed about that because I like to stay physically active. But there's a connection between the mind and the body, and so we really need to start looking at this from a unified approach. And I agree, we're going to have to sell this and whatever we can do to help sell it, we're here to do that. I mean, it's a national educational system that we have to go through. Mental health parity, who ten years ago, nobody would have said it would ever going to be passed in this country. Now it is. [LR338]

SENATOR PANKONIN: Yeah, takes time. Thank you. [LR338]

SENATOR GAY: Senator Nantkes. [LR338]

SENATOR NANTKES: Well actually I...thank you, Senator Gay. I wanted to kind of follow up along the lines of Senator Harms and Senator Pankonin's questions in regards to the practical and the philosophical in terms of funding for behavioral health issues and programs. And I don't want to preempt your testimony, Topher, (laughter) because it's always insightful, but if you have some ideas, please jump in or you can save it for your testimony. I know we've talked about this a little bit, but if you could talk about from a philosophical perspective what our general fund obligation should be in terms of taking care of the most vulnerable within our state, and then looking at the practical side of things, in particularly the historical context you provide saying that you come in for increases for over 14 years, then get them for maybe 7, you've seen incremental increases throughout that time. How can we get creative moving beyond the general fund in terms of some other revenue sources that we may or may not have available to us to carve out some dedicated revenue streams or otherwise? I know that there's been maybe some creative ideas that been looked at in the past but in order to address the

competing interests that are out there, I think we have to get creative. And I don't know if other states have some ideas in that regard or if there's a way that that would help to alleviate some of the political realities and pressures that do exist. And I know that's a lot of questions in a very short amount of time, so if you could just provide some general thoughts in terms of the practical and the philosophical, I think that would be helpful to me. [LR338]

TOPHER HANSEN: Uh, that's a giant question. I'm Topher Hansen and I'm executive director of CenterPointe here in Lincoln and also president of NABHO, statewide behavorial health organization trade group. And I think the philosophy, the underpinning philosophy of the whole thing is where you have to start. What's our presumption here? And in a little bit, I'll go into a little bit of that in my testimony. But that's where we have to start. So what are we assuming will happen as a group, as a state? And then, how are we going to meet that? So if what we assume is that people are going to be cared for, then our next step is, then we've go to figure out how we're going to fund what we're presuming here. So the first thing might be little pieces like the tax that we get from alcohol. Maybe that gets directed in a more specific way than what it's directed right now. That we can do simple things like that that might help fund our system in a more creative way. One of the things I've done, and I can speak from my experience, I'm not the grand wizard of the state budget so I don't know that I can offer a whole bunch of suggestions there. But let me give you a suggestion of what I've done. We, our behavioral health organization, we do mental health and substance treatment, we do housing. We got there because that's what clients told us they needed and so we started down that path to get what they need to get better. So we get funds from the city-county because they have to underwrite what funds we get from behavioral health funds. They aren't adequate to meet our costs. We have to, somehow, supplement so we get city-county money to help us out. We get Medicaid. We get a little bit of Medicare. We also have HUD housing, Housing and Urban Development, because we know that number one, our clients need a roof over their head, and number two is, HUD has a philosophy of how to pin it all together with services and housing to provide some

services. So we do that as well. Well, add it all up and I have a $6.1 million budget. Add it all up, last year before audit, our rough numbers, we made $89. And that's because our funding is way short on some fronts and others I can add the pieces together and I can make it all work. Now that has a multiple. It's not just that we're underfunded. When I get staff turnover because they're going to other places, because they can make more money in the insurance industry or with Magellan or other places, staff turnover kills me. I make a budget that assumes I have staff in place all the time, so when I lose staff I'm losing revenue. But more importantly, my list backs up and I have more people on the list. So there are things like that that you can get out and look around the horizon to say, what can we do? And we're I in charge, I'd somebody in Washington working with the Senators and the Congressmen saying, what can we do here to generate some additional revenue out of SAMHSA, our of NIDA, other federal pots, that might help us as a state think of some great ways to begin to address some of our funding issues, to address service issues, to address work force development issues, all those kinds of things. The federal government is interested in that stuff. We just need to get on our toes and go get it. And we have not been doing that over the course of time, a long time. So I think there are things you can do. We just have to go do them. The first thing, though, we have to decide is, what's our attitude on this? What is our philosophy as a state in caring for people? I think that's fundamental. That directs everything. If it's a cost based system, then that's how we'll direct our system. If it's a care based system, then that's how we'll direct our system. We need to make those decisions. And I think you all are the policy group. [LR338]

SENATOR GAY: Thanks, Topher. [LR338]

TOPHER HANSEN: Did I answer your question? [LR338]

SENATOR NANTKES: Thanks. No, that's helpful, thank you. [LR338]

SENATOR GAY: Topher, do you...are you going to have some more testimony? Okay,

why don't we do this, just time wise, and then, Joel, do you have one? [LR338]

SENATOR JOHNSON: Yeah. Is there enough knowledge base of the mental health parity bill that Congress did pass to know what effect it's going to have? [LR338]

PATRICK CONNELL: I don't think so, not yet. I mean, I think, it's a $64,000 question. We're all kind of waiting to see how this is going to roll out. What it's going to do to people's insurance, who's going to continue coverage, who's not, you know, etcetera. [LR338]

SENATOR JOHNSON: Okay. Thanks. [LR338]

SENATOR GAY: You going to summarize this? [LR338]

TOPHER HANSEN: I'm sorry? [LR338]

SENATOR GAY: Are you going to summarize this? (Laughter) [LR338]

TOPHER HANSEN: It will take me less time than his. [LR338]

SENATOR GAY: Well, I know there are others waiting... [LR338]

TOPHER HANSEN: Yeah, I'll... [LR338]

SENATOR GAY: ...now patiently, but, I mean, we don't want to rush through it, that's for sure, so go ahead. Let's do that and then open up some more questions and get some more testimony. [LR338]

TOPHER HANSEN : (Exhibit 12) I'll try and not touch on what I've touched on. What I do want to say is, I'm president of the Nebraska Association of Behavioral Health

Organizations, known as NABHO and our group consists of consumers, providers, and funding entities. We have members who deal with both mental illness and substance issues, either one or the other, and both at the same time. We are the front line of community based behavioral health services. Our planning and implementation bring the real world of experience of our consumer groups, the sophistication of our clinical and business practices, and a history of performance that brings a great quality to the lives of the people of Nebraska. Now a little bit to my point, Senator Nantkes, that you asked for. "He ain't heavy, he's my brother." That is the philosophy that Boys Town started with. And this famous quote inscribed in the walls of Boys Town, a NABHO member, is the point at which we must all find consensus. This statement speaks of our ethical duty to unconditionally care for the most needy among us. This policy must not only be evident in the mission statements of providers, but in the policy of the state and the practice of the Health and Human Services administration. We, as a state, have the ethical duty to care for those that are unable to care for themselves. It cannot be a conditional duty, but one as essential as the need to care for someone with a broken arm. And, it must be carried out so we are effective in our care and efficient with our tax dollars. LB1083 intended to move the care from the regional centers into the communities. We wanted a better quality of life for consumers. We want services closer in proximity to the consumer's home community, and better leveraging of our tax dollars by increased use of Medicaid, and a more efficient system of care. While we have brought more services to the communities and increased the number of people served and reduced the census at our regional centers, we still have wait lists. And I can talk a little bit about that later on. It takes six months to get into residential services at CenterPointe for adults. While we have increased the number that we serve in that program, the line remains the same. In the 15 years I've been at CenterPointe, I've never seen the line change about six months. And if it reduces, we shake the tree and it regenerates. Let me be very clear that we believe that Nebraska providers offer an effective, high quality system that is not broken. It is just not funded to meet the need. We must put a sharp pencil to the need for services in each region and begin to work toward that goal. It is likely to cost money, but all the evidence points to the fact that

providing treatment, rehabilitation and supportive services saves an exponential amount of money in the long run. Denying care, and I'm going to talk a little bit about cost shifting. Denying care, putting people in a lower level of care than what they need that results in their failure in that treatment, shifting responsibility from Medicaid or child welfare to behavioral health, is all a process of cost shifting that results in a better looking budget sheet and a worse system for consumers. It is a "pay me now and pay me later" approach to care. We all must remember that this is a life and death business that must be operated with the greatest effectiveness and the greatest efficiency. Effectiveness meaning, when they leave our doors, they have to be better down the road. And efficiencies meaning, we have to do this so we're not wasting dollars in providing services. One idea in behavioral health reform was that we can leverage state funds by establishing and growing Medicaid eligible services. If, however, we cut Medicaid, deny services, make inappropriate placements, cost shift, underfund what we simply...then what we do is simply put the burden on consumers, their families, the police that you heard talk earlier, our jails, the hospitals, detox centers, crisis centers, and so on. Each one of those organizations would get up here and tell you, if they haven't already, that underfunded system, behavioral health system, means a greater burden on them. The rate issue. If we look back in the mental health and substance rates and see how many increases occurred over the last two or three decades, you can see that there are, since 2003 there were more rate increases than in the two decades before. This Legislature and the Legislatures since about 2002 have been more consistently attentive to listening to behavioral health providers talk about what the funding system is and trying to give rate increases. Last year we got a 1.5 and 2 percent behavioral health Medicaid increases. My LES bill just went up 9 percent and is about to go up 4 percent more. So that tells you a little bit of a snapshot of the burden we're in. We're in the unamiable position of being told how much money we'll get, and how much money it will cost us, and don't get to direct our resources that way. How can we expect them to have a reasonable system of care under those circumstances? We know the medical CPI has grown almost 26 percent since 2003, but the rates have gone up about 9 percent. Our system has to catch up and keep pace with inflation and costs. Each

year behavioral health providers struggle against the administration for fair rate increases to be passed in the Legislature. We want what is fair and responsible, but don't believe it is something we should be in a constant struggle about. A healthy system needs a fair process to determine adequate rates for the services and adequate increases based on costs. We have had some disturbing snapshots in our system in the last weeks and months, Von Maur, safe haven drop-offs, Beatrice State Developmental Center. All these involve people who want help, who need help, but our state has failed to meet the call. These are consequences of not adequately funding a system to meet its mission. We cannot point at managers or supervisors or call the families irresponsible. We must take responsibility for these outcomes and make a plan to correct it. It starts at the top, at the legislative level, and the gubernatorial level. Transparency and collaboration. If we are to succeed in caring for those who need public services, we must collaborate. NABHO is such a collaboration. The Behavioral Health Coalition is such a collaboration. We desperately need the State Department of Health and Human Services to join us in that collaboration. Decisions on the future and implementation of the system of care needs to consult with...the state needs to consult with those that know the ground level best, but that is not what is happening. Critical decisions are made without advice or input from any of the providers. The relationship is much more adversarial. This is not how it is among providers or between providers and the regions, or between consumers and providers, but it is palpable with HHS. The state must develop a culture of transparency so decisions are discussed in advance, so funding is not shuffled around in a manner that nobody can find it. What are the goals and outcomes for the behavioral health functions in HHS and did we achieve them or fall short? If we don't have any, then how do we know whether we are doing harm or good? Work force. Attracting and retaining a professional work force is extremely difficult. Based on what we can afford, I pay masters level counselors with provisional licenses in two fields, a starting wage in the low '30s. I think that's too low. Compare that with the state pay scale and you will see it's lower than what the state believes as well. We must initiate a multifaceted approach to increasing the behavioral health work force in Nebraska. Don't put up unnecessary barriers like the restriction on supervising

provisionally licensed professionals. While quality supervision is critical, a more precision approach to this goal is demanded than the one initiated by HHS. We must provide incentives to draw people into the field, encourage educational institutions to offer the course work, and offer compensation packages that attract young students toward a career in the field. With our restrictions on places that can train and supervise provisionally licensed people, we are beginning to find all our slots for training full and have people waiting to get in. We may also lose people to other states who may have otherwise joined the profession in Nebraska. Why didn't we discuss this before the decision was made? The organizations across the state are committed to quality and would gladly collaborate on how to solve the problem. To conclude. The right treatment at the right time for the right person saves lives and money. We want the presumption of care to be our guiding policy. We want a process established under which provider rates can keep pace with our costs. We want collaboration, transparency, and accountability that will benefit the consumers. We want legislation that will establish an infrastructure that encourages educational institutions to offer behavioral health course work, and that encourages young students to engage in the profession. And we want the state as our partner, not our adversary. We have 1.7 million people in the state of Nebraska. We can do this. [LR338]

SENATOR GAY: Thanks, Topher. [LR338]

TOPHER HANSEN: Thank you. [LR338]

SENATOR GAY: Any questions? I don't see any right now. [LR338]

SENATOR PANKONIN: I've got one. [LR338]

SENATOR GAY: Oh, I'm sorry, Dave. Go ahead, Senator Pankonin. [LR338]

SENATOR PANKONIN: Topher, I appreciate your testimony. On your comments earlier,

I'm just on your second page after cost shifting, you talk about rates. I'm just curious about this and why whether this is anecdotal or based on your experience or based on other data, but you say here that there are more mental health and substance rates or issues apparently, more since 2003 than in the two decades before. So that's a 5 year period versus 20 years. [LR338]

TOPHER HANSEN: Uh-huh. [LR338]

SENATOR PANKONIN: I mean, do you think that's a true statement? [LR338]

TOPHER HANSEN: Yes. [LR338]

SENATOR PANKONIN: And why do you think that is happening? Why is that, in your opinion? [LR338]

TOPHER HANSEN: Well, I think the population that's being served...this still is an area that has a high amount of stigma and our line is that from here on up, it's your fault and from here on down, we're sorry to hear about it. That there's a lot of stigma that goes with brain disease, which is addiction and mental illness. And before behavioral health reform really started nationwide and in Nebraska, it really was an issue that got pushed down on the side and it was not a politically powerful group, it was not a politically present group, and as such, the rates didn't come frequently. [LR338]

SENATOR PANKONIN: So part of it is, that we're just acknowledging we've got those issues more... [LR338]

TOPHER HANSEN: Oh, I think so. [LR338]

SENATOR PANKONIN: ...as a society than the rate has jumped that much is probably...and your colleague is nodding, so I assume that's...Okay, thank you. [LR338]

TOPHER HANSEN: Yeah. I have a...if I can respond to your question, Senator Harms, about the wait list and, in particular, I mentioned that it was an average length of about six months for our long-term dual disorder program. Different programs have different wait lists, of course, levels of care in parts of the state. And I can tell you with our youth program, we don't have much of a wait list. There might be five kids on our wait list right now. But when I talk to people in the Lancaster County...oh, or I'm sorry the Douglas County attorney's office, the first thing they say to me, and this is the deputy county attorney, who I'd have no reason to believe that she would know about me, except the fact that they need treatment so bad she knows it. And she said, we need more of you. We have so many people who need your help and I don't know why they can't get in. The other odd circumstance I tell you is, that about 90 percent of the people sitting in our youth residential program, which is about 2 miles from here, and 90 percent of the kids are from Douglas County. And almost nobody is from Lancaster County. I have no idea why that is. It all comes funneled through Magellan and the need is there, the identified need is there. So we don't see the list in terms of our particular wait list, but we do see it when we talk to the judges, the jails, and the other providers who are saying, help, help, help, help, kind of thing. The adult system is much more crowded and harder to get into, generally speaking. [LR338]

SENATOR GAY: Thanks, Topher. Danielle. [LR338]

SENATOR NANTKES: Yeah, I just have a real quick follow up question, maybe they're best directed to the Medicaid Reform Council that was meeting next door earlier today. I don't know if they're still meeting, but we've seen some preliminary budget numbers in terms of the budget proposed by Health and Human Services for the upcoming budget cycle. Of course, those are just preliminary numbers but I think they provide some good discussion points. And one of the items that I'm particularly concerned about that I've seen is a limitation on the number of visits for outpatients, mental health services in particular, which seems to me would be at odds with the overall spirit and intent of

LB1083 and moving into outpatient and community based services. And I don't want to throw you too far off of your comfort level in terms of the reason you're here testifying today, but could you talk, maybe, just a little bit about the interplay that exists there? [LR338]

TOPHER HANSEN: And there is between the specific... [LR338]

SENATOR NANTKES: How it would affect the work that you do if, for example, Medicaid services would be arbitrarily limited to a certain amount of visits per year. [LR338]

TOPHER HANSEN: Uh-huh. [LR338]

SENATOR NANTKES: Trying to save bucks in the Medicaid budget, you know. [LR338]

TOPHER HANSEN: What I can say to that is that the 30-day treatment is not clinically driven. That was insurance driven. Twenty-one day treatment, insurance driven. Those things aren't clinically based. This goes back to the philosophy again. Do we have a cost based system of care? Do we have a system of care that presumes caring for the client first? The 52 sessions depends on who it is. For the average, we refer to them as, kind of, worried-well. People who were generally well but have some issue that comes up in their lives, 6 to 8 to 12 sessions might take care of that. For people who have severe persistent mental illness and addiction that sometimes, some people, not everybody, but some people need a longer term than that. I don't see it generally giving huge restrictions to what we're doing, but what I know is, the system has to be able to flex with the person because if you don't give them the care they need, then what happens. Then if they revert to a higher level of care like a jail, a hospital, and so on, crisis center, then you've just spent more money than you've saved. We just have to approach this in a smart manner and that to me is not the right way to go about it. The first in that budget list, the first priority for the contingent cuts, right, so the list of, if we

have to cut further, here's where we'll start, is provider rates. And that's obviously one of the big things we're talking about. Well, what HHS told us in the Behavorial Health Coalition is, we don't do rates. Don't talk to us about rates. We don't set the rates. The Legislature sets the rates. But then that's the first recommendation they bring for where to cut. So obviously, they do rates. We need to, again, start back at the beginning and say, what's our presumption here? And how are we going to carry this forward? And if what we say is care, and we know that's costly and we have to figure that out, we can do it. Providers do it every day. I don't have all the money in the world. I balance my budget. I don't go deep into debt. I don't ever borrow money except for a mortgage. I make it work. We just have to decide how we're going to do it. [LR338]

SENATOR GAY: All right. Thanks, John. Senator Synowiecki [LR338]

SENATOR SYNOWIECKI: First of all, Pat, I want to extend my congratulations, the Boys Town Cowboys... [LR338]

PATRICK CONNELL: Thank you. [LR338]

SENATOR SYNOWIECKI: ...impressive victory last night. (Laughter) [LR338]

PATRICK CONNELL: Thank you. [LR338]

SENATOR SYNOWIECKI: They're in the second round of the playoffs. But you spoke to the, like a CPI index associated with rates. I just caution to warn you that we already have some type of methodology, at least I'm told all the time methodology with developmental disability rates, but the Legislature has a history of just ignoring that. So I think it would still be down here if we pass some kind of CPI indexed rates, because one Legislature can't bind another Legislature, we're all to do appropriations. So just caution you that that would not be the answer to all the problems associated with rates. [LR338]

SENATOR GAY: All right. Do you have one? All right. Thank you guys for your time. [LR338]

TOPHER HANSEN: Thank you. [LR338]

SENATOR GAY: And we do have still...we're still going to spend more time so those of you who have been patiently waiting...Carole, come on up. We'll just keep moving forward, so. [LR338]

CAROLE BOYE: (Exhibit 13) I think you all need an hourly pay increase. (Laughter) Hi, my name is Carole Boye, I am the executive director of Community Alliance, which is a mental health rehab agency in, actually the largest community based rehab agency in the state of Nebraska, based in Omaha, Nebraska. If any of you are Mash fans, this is what's been going on with me back here. There's an old episode of Mash where Hawkeye takes a bet for 24 hours, he's not going to crack a wisecrack or a joke or say something and then at the end it all spews out. I have a list of comments I want to make. I do have some prepared testimony. But before I do that, I want to respond, I want to add, there is not anything that Pat or Topher said that I disagree with. There's some things I would like to amplify. And maybe I'll start from the bottom in terms of limitations on outpatient visits. I find it incredible that after decades of fighting to get parity in insurance, to get a federal law that says, we will not treat mental illnesses, brain disorders any different than physical disorders, which means that we can...what the federal law now says is, we cannot put limits, artificial limits on, you can only have ten of this, if it's not ten of this, surgical, you know, outpatient doctor to doctor mental health, that our Medicaid system on this historic event of passing parity, now wants to distinguish that you can only have 52 outpatient visits a year, if it's a mental illness as opposed to a physical illness. That is in absolute opposition to what we just accomplished on the federal level. It's discriminatory, it is not right. It is just not right. All right. Not that I feel strongly about that. (Laughter) Senator Harms, you asked what are

the components of a good community based system and program. Let me add, and to a couple of things that were said. I think we know what good components are. It is clearly, I think Pat said, it's a full continuum of services, the full range of services. The reason we have a wait list for residential services and we like to have residential services and always have wait lists. The reasons that we have back logs and crisis centers and in hospitals and all that, is because we don't have the next step down. Or we don't have enough of the next step down and we have got to be looking at a continuum of services. What is a good community based program? It also incorporates all the national best practices that we have. We have research based, evidence based practices which have been shown to be effective. We do not have that in our continuum of care. And the reason we don't have it in our continuum of care, is that our state system won't allow us to bring that in. It won't fund it. We can do it. Integrated community...dual diagnosis treatment, national best practice. We can't get that into our Medicaid program. Peer support services, emergency best practice. I heard earlier that there's some discussion on the state level that, well, maybe, that's not right for substance abuse but maybe it's okay for mental health. There's been lots of mixed messages. But data shows us, the research shows us, National Best Practices, we need a range of peer support services. And yet the history of our state is, not one service has been added to Medicaid, community based service has been added to Medicaid without the Legislature saying to Medicaid, thou shalt add it to our state plan. Assertive community treatment. The Legislature said, thou shalt add that to the state plan. That is a best practice that we have in our system. It took HHS and Medicaid five years after the Legislature said that, to actually add it, to start doing that. That ties into creative funding strategies. LB1083 tried to create a funded strategy. We were leaving money on the table. We were leaving federal, millions of dollars, federal Medicaid matched dollars, on the table, of services that we were in one way or another providing that we were spending 100 percent state funds for. And yet, if you look at LB1083, four years after the fact, we have added an array of services to our continuum of care, but we have added one service to our state Medicaid plan, one. One of the recommendations in my printed testimony here or prepared testimony, is to ask you as a Legislature to say once again, thou shalt add X,

Y and Z to the state Medicaid plan. You are...we are already providing it, you are already paying for it. Why not get that 59 cents, 60 cents on the dollar for folks. That's how we start leveraging some things. But I believe it is going to take, history has shown us, it's going to take you to do that. Because some how, some way, because we're trying to control Medicaid costs, it's become some kind of...another visual here, up on the stadium, every time you go to Nebraska football games, there's that little shell game that goes on. It's somehow, let's shift money here and shift money there and let's hide the actual costs. And we have to, we have to shine a light on this and we have to get going on that. Other components of a good community based system, by the way, accreditation, and outcome measures. Every mental health service that is funded, adult mental health services funded through the regional community based system, has to be accredited, nationally accredited. Every one of our regional centers has lost their accreditation at some point over the last four or five years. Several of them still don't have accreditation. That is, that is, a good quality measure to use. Those are national standards which also then overlays the need to have some measurable outcomes. I can you that the services that we provide, that anywhere from 85 to 90 percent of the people we serve, all with serious mental illnesses, all with histories of hospitalization, stay out of the hospital on a 12-month basis. Eighty-five to 90 percent every year, people don't even walk across the threshold of a hospital. What measures...what measures can our state funded system, can our regional center systems point to? Without accreditation, without outcomes, without quality improvement kinds of measures and those kinds of things, it's really hard to do a comparative type of analysis. One other comment I wanted to just make quickly is, Senator Pankonin, and you asked about...you know, Pat talked about good things, things that worked, things that didn't work, what are some of the disastrous kinds of practices out there. One thing I find that's really curious is that we're hearing more and more from HHS, and I think it might have even been said up front here this morning, that within two years we're going to go a fully capitated managed care system or...and, again, I don't know if it's been said publicly, it's certainly been said in a lot of meetings. There's also been lots of whispers about whether or not we really need regions versus, you know, state system and is that costly, and all those

kinds of things. I find it interesting that we are looking at going to a managed care system, fully capitated managed care system, while we see a lot of other states moving away from that. I mean, that's kind of an old way of trying to handle some of these issues. I find it curious that we talk about whether the regions and local control is really an effective and efficient way of doing things, when everything I'm reading is that at across the country people are trying to figure out how do we better utilize the counties. How do we organize counties into some kind of regional system so we have local control, local input, so we can deal with the difference between rural and urban, and all of those kinds of things. So one of the things in that too, is in my written testimony that I would ask you all to consider is before the administration decides that this is the way we're going to go, perhaps our policy making body could say, let's take a look at that. Let's do a study. Let's figure out, based upon what's going on in other parts of the country, rather than just moving forward on some of these things, when we know that there's evidence out there that some of these grand ideas just don't work. They're just not working in other states. Okay, Senator Gay, I promise you I'm not going to read all of this. And a lot of the things that...some of this is implied. What I've said already is also stated in different ways in here. I think what I really wanted to come here today and say, Community Alliance was and is a very, very strong supporter of LB1083, and of community based services. And the reason that we are such a strong supporter of that is because there are so many cost effectiveness, so many humane, so many legal reasons, that we need to continue on this track. Now HHS told us, I was also on the Oversight Commission, the legislative Oversight Commission for four years, and then in one of the last meetings we were told that we were going to close the chapter on LB1083. And if that means...does that mean that we're going to quit looking at transferring money from regional centers to the community. Okay, we've accomplished that. But what we've got to recognize is that LB1083 wasn't just about transferring $26 million to the community. It was about a different way of approaching, a smarter way, a more cost efficient way, certainly a more humane way, in a more outcome driven way, of dealing with our behavioral health services in this community. And we are continued to be supportive of that. So we can't close the door on the Behavioral Health Services

Act. Perhaps we can on, has money been transferred. But what does that mean? I think there's some things going on out there right now that really is of concern to us. And it starts with, Senator Synowiecki, you referred early...it was early this morning, to the Oversight Commission's final report. There are 15 recommendations in there. You asked questions on a couple of them and it sounds like that report is gathering dust somewhere within HHS. I would ask you, as our Legislature, and as a member of a group that reported to the Legislature, to once again look at that. There are 15 recommendations on there. We support that. Most of the community supports that. They're not adversarial. They are truly means of trying to move the system on. And those are very specific actions that this body could take to help us continue down the road. One of the things that we're starting to see happening now is, lots of talk again, we move $26 million to $30 million to the community. We're getting about $6 million, I think, more in additional Medicaid money. But again, a whole wealth of services that were developed under the auspices of reform are not within our Medicaid program, so we're still leaving money on the table. The other thing that we're starting to see in the name of cost containment of Medicaid, is we're starting to see a cost shifting take place, and that's really of concern. What's happening is that HHS is administratively allocating an increasing portion of dollars that the Legislature appropriated to behavioral health for distribution to the regions under what is that, program 38, I don't remember which program that is, 38, under program 38. And they're taking an increasing portion of that, which we can't really figure out what the numbers are, but we know more and more of that is going to the Medicaid division to be the state match for Medicaid paid behavorial health services. So what's happening is, we're taking that 40 cents over here that's supposed to go for nonmedicated eligible services to the region. We're seeing that, administratively transferred to the Medicaid division and that becomes the state match. So guess what, yes, we're lowering Medicaid costs, but we're not really. We're still paying those dollars and less people are being served. That started as a strategy a number of years ago to get some rehab services funded under the Medicaid program. But now the new subacute services are being paid. Additional services are being paid. What we would ask you as a Legislature to do, I, again, I would argue that we ought to

treat Behavioral Health Services like we do any other Medicaid physical service. Let's fund the Medicaid match straight up for behavioral health services. Let's prohibit the administrative cost shifting from one to the other. That is going to become a serious, serious problem. Wait lists are going to expand as more and more of those dollars are being transferred. We have several other and specific recommendations to ask of you. We would ask that before we move to a Medicaid capitated system and a full fee for service system, that we really take a step back, and that we have the involvement of community providers of consumers and of the Legislature before those decisions are made. The rest of this, I will defer at this point. [LR338]

SENATOR GAY: Thanks, Carole. Any questions from the committee? [LR338]

SENATOR PANKONIN: I just have one. [LR338]

SENATOR GAY: Senator Pankonin. [LR338]

SENATOR PANKONIN: Carole, roughly, just for the...for your organization being one of the larger ones or if it be larger, your budget just in rough numbers or percentages of what comes from private insurance and donations and just so people have a feel of how your organization is funded. [LR338]

CAROLE BOYE: We serve about 2,000 people a year in a range of longer term services. Our annual budget is about $10 million a year, probably $6 million of that is Medicaid or Medicaid driven. Another $2 million or so is non-Medicaid regionally driven, and then we do a lot of housing so there's a lot of rents involved. We get virtually no insurance services because the longer term, kind of, services support rehab community based services, insurance companies do not pay for. So this parity act will not impact upon the array of rehabilitation and support services. It will impact more upon doctor services and counseling services, if you will, outpatient. [LR338]

SENATOR PANKONIN: You've had an impressive coalition or folks in the Omaha area that have been very supportive, but...and what percentage, does that money go to more facilities and whatever private donations? [LR338]

CAROLE BOYE: The private donations, there was about $24 million, $25 million raised. All of that went to capital, to Community Alliance was a part of that. It helped us get a larger day rehabilitation program and to get some apartments for folks. [LR338]

SENATOR PANKONIN: So most of that money goes to... [LR338]

CAROLE BOYE: It all went to... [LR338]

SENATOR PANKONIN: ...to facilities and things like that. Not necessarily operations. [LR338]

CAROLE BOYE: To facilities. The private sector is, in Omaha, is incredibly generous but every private funder says to you, we do not want to get into ongoing operation costs. Or as one person told me just a couple of weeks ago, you know what, I've always wanted, you know, my family, it was a family foundation, I've always wanted my parents money to be the icing on the cake. I never wanted it to be the cake, which probably a pretty good way of looking at it. [LR338]

SENATOR PANKONIN: Thank you. [LR338]

SENATOR GAY: Thanks, Carole. Any other questions? And, thank you, Carole. [LR338]

CAROLE BOYE: It occurs to me that I probably showed my age referring to Mash. I'm going to have to update my analogies. (Laughter) [LR338]

SENATOR FULTON: No, no, I'm a fan. I remember the episode. [LR338]

CAROLE BOYE: Thank you all. [LR338]

SENATOR GAY: All right, next. [LR338]

MARIAM GARUBA: (Exhibit 14) Good afternoon, members of the committee, my name is Mariam, M-a-r-i-a -m as in Mary, last name is G-a-r-u-b, as in boy, -a. I'm a third-year psychiatry resident with UNMC in Creighton and I'm a representative of the Nebraska Psych Society. I represent the residency program with the Nebraska Psych Society, so I'm speaking on behalf of the Nebraska Psych Society today. So we are pleased to have this opportunity to speak with you and to comment on the implementation of the Behavioral Health Services Act. First, we do recognize the extensive work that has been done by the Division of Behavorial Health and the regions to improve the care of persons with mental illness and substance abuse problems. Particularly, we're grateful for the Lasting Hope Recovery Center, especially the residents, I can speak on behalf of them. But the opening of this facility has improved mental health care access to the community and particularly, because of the emergency service that it provides and the community outreach programs that it provides. So in light of that, I'll just mention some of the concerns that we have or the issues that we have. The first one is, as you've heard today, obviously, there is a critical shortage of psychiatrists in the state of Nebraska and it's true in all areas of the state, but particularly in the rural areas. And I happen to moonlight in Norfolk, so I experience this almost on a weekly or bimonthly basis. Members of the Nebraska Psych Society would be willing to collaborate with the Rural Health Commission academic health centers in the state, to assist in ways to plan how we can recruit more psychiatrists, more residents, and mental health practitioners to help in this area. The second issue is the paucity of critical access beds for patients whose level of dangerousness can't be met with routine medical care. This includes patients who typically have a history of mental illness and dangerousness that's attributed to their mental illness and not of criminal history. An example would be, a

patient who has been determined by the county attorney to be dangerous but cannot have access to a bed simply because there's no way to pick them up and there's no bed available. So this patient is out wandering the streets, is potentially dangerous to the society, but we can't get them in for care. A second example would be, patients who cannot get access to a regional center or a security building bed for them for their care or their help and oftentimes they end up being incarcerated because of their mental illness. And I think they touched on this earlier, especially. Again, the NPS would be glad to work with the state and regional centers on the triage of dangerous patients. Third, patients with severe mental illness, they have to have access to LB95 if they have been committed and in a regional center. However, there are many patients who have not been committed, are not dangerous, and are not under a board of mental health, who we see in the clinic who do not have access to medications, who oftentimes we provide medications for through samples. And it would be our pleasure to work with the state to find solutions for this issue as well. Number four, patients who are incarcerated, like I mentioned before, oftentimes due to mental illness, may face limited access to care in the criminal system itself, and this is more in the jails and in the prison system, I believe. Concomitantly, us doctors in the community do not have access or don't receive notification when they're discharged about their need for care. And so we can't provide the standard quality of care for these patients and we would be certainly willing again to address or assist in addressing solutions to this problem. And number five, which is pretty important, as the Behavioral Health Services Act focuses mostly on adults, but I think at this point it's incumbent upon us in the adult system to better address the needs of the older youth, which, I think, was brought up as well before who were transitioning into the adult system. Because this kind of tends to be a confusing or gray area, and it's true for youth in the residential treatment centers and the juvenile justice system. So once again, we would be willing to help in assisting coordinating solutions or providing a way to enhance continued care for these individuals. So I'd like to thank you for this opportunity to be heard. And again, we represent psychiatrists of the state of Nebraska and we look forward to working with you to improve the health and well-being of all citizens. [LR338]

SENATOR GAY: All right. Thank you. Senator Hansen. [LR338]

SENATOR HANSEN: Mariam, thank you for being here today. How many classmates do you have in psychiatry? From Creighton. [LR338]

MARIAM GARUBA: From Creighton, in my class there were 3 out of 118 graduates. As far as the residency training program, we have 30 residents that service Omaha. [LR338]

SENATOR HANSEN: I think that you're a great example of the psychiatry of college, I mean, part of the college in Creighton. And I think that you would be the best recruiter to go back to your younger classmates and say, you know, psychiatry would be a good field for you to get into, so. [LR338]

MARIAM GARUBA: Yeah, and we actually are going to meet tomorrow to try to recruit some students from Nebraska. (Laughter) [LR338]

SENATOR HANSEN: Good. Good. [LR338]

MARIAM GARUBA: We tend to have students that come weekly. I work at the VA, in a clinic, and every student that comes in, you know, once or twice a week, we talk to them about joining psychiatry, so we're working on it. We're definitely working on it. Sadly, a number of our residents are foreign. They come from, a lot of them from India or Pakistan, some from Africa, so. [LR338]

SENATOR GAY: Senator Pankonin. [LR338]

SENATOR PANKONIN: Kind of a follow up to Senator Hansen's comment, Mariam. We appreciate you coming and obviously your enthusiasm for your field and the work you're

already doing around the Omaha area but also Norfolk and stuff. It's appreciated. Where are you from? Are you from... [LR338]

MARIAM GARUBA: I'm from Nigeria, actually, so. (Laugh) [LR338]

SENATOR PANKONIN: Okay. [LR338]

MARIAM GARUBA: Yeah, my mother was a diplomat so that's how I ended up here, but just...yeah, I've lived here long enough where most people consider me to be American. (Laughter) [LR338]

SENATOR PANKONIN: Well, I appreciate your interest in the field, and... [LR338]

MIRIAM GARUBA: Thank you. [LR338]

SENATOR PANKONIN: ...and as Senator Hansen said, we need, obviously you've heard the testimony, we need a lot more people. You're a great ambassador. [LR338]

SENATOR GAY: Any other questions? Thank you very much. [LR338]

MARIAM GARUBA: Thank you. [LR338]

SENATOR GAY: Anyone else? [LR338]

KEVIN KAMINSKI: Good afternoon, senators, committee members, my name is Kevin Kaminski. I am the executive director of the Nebraska Counseling Association as well as a clinical director of a private practice in Omaha, Nebraska, and I'm here as a practitioner but also as the executive director. Part and partial of something that happened a year ago that piggybacks off the behavioral health reform bill was that independent mental health practitioners bill. That came about which allowed for

professional counselors, licensed social workers, as well as marriage and family therapists to practice independently. That has been one of the boons for our professions through behavioral health reform, and the fact that we can increase the level of access to care. That would be my executive director's statement as well as a private practitioner statement. The other statements that I have would be directly related to my clinical director duties as well as direct caregiver. And that is in Omaha, in Douglas County, we have within the last two to three months seen a decrease in our ability to provide services. We would be an overflow service provider for agencies within the Douglas County Region 6 area, service area. And in that time, just in the last three months, what we have come to find out is that we will no longer be able to provide those overflow services, especially for adults. We will be restricted to provide one service and that would be the initial diagnostic service. The region was not aware of this when we were told by Medicaid, the Department of Medicaid, and Health and Human Services, that we would no longer be able to perform these services. We had people within our service already that we will actually have to terminate, because we will not be able to get funds for their care. And I have two clients who fit into this dynamic that were referred to me by the Department of Health and Human Services caseworkers who, again, were not aware of these limitations for funding, and we're actually informed initially by our office and not by the state. And these two people that I have combined have been in my service for 17 months. They are special cases that are ongoing in court and need to be monitored by court order. But that court order is going to be overlooked and their services will be declined to me and to my psychiatrist that I work with directly. Another piece is that the adult services that we can provide as a private practice are now limited based on an accreditation issue. And we full, wholeheartedly, are in the process of gaining accreditation on a national and state level to perform services. However, that's a long, arduous task as well as the region has no more money. They will not...they aren't opening up a call for programs or a request for programs, because they have no more monies to offer, because of the other agencies in town. Yet there is an overflow. There is a number of individuals who don't get services or are on waiting lists that can go upwards of six weeks. We built out private practice based on one thing, and that was

access of care. We usually can get a client in within a two-week period. They can have a psychiatric evaluation, begin their medications, as well as begin individual and/or group therapy if that is what they need. Those are the concerns that also piggyback off of everything that anyone else has said prior to this point is the...our number one issue, as the Nebraska Counseling Association as well as our private practice, is that there is an access of care issue and it is being limited by the greater organization of the department. [LR338]

SENATOR GAY: Thanks, Kevin. Any questions? I don't see any. All right, thank you. Anyone else to...C.J. [LR338]

C.J. JOHNSON: Thank you again, and I'll be brief. Again, my name is C. J. Johnson, J-o-h-n-s-o-n. I'm the regional administrator of the Region V Systems. I felt somewhat compelled to come up at this, during the community providers discussion. I just want to share with you, and I know that you will be receiving other data, earlier you heard testimony about the emergency system from the law enforcement. And the reason I'm up here once again, and a couple of weeks ago I testified to this to the Health and Human Services Committee, is I can appreciate the experience that law enforcement experiences when they encounter somebody who is having acute mental health crisis, and the challenge, the emotional challenge that can put somebody through. But the reason I came up is, you heard data, specifically around the Lincoln area today, and I just want to tell you that the data you heard is just plain inaccurate. The reality is, as you heard earlier this morning from Scot Adams, the number of EPCs has significantly been reduced over the last several years. In Region V, law enforcement do not drive around with people in the back of their cars. They make a single phone call to a single place and they are directed as to which facility to take that person to, because we keep track of the open beds. The crisis center last year was only full 80 days out of 365. In fact, it's a 15 bed unit, its average daily census was 11.4 and many times when it was "full", that was only for about an hour or so. As far as processing, at the Lincoln Crisis Center it's an average of 30 minutes. When law enforcement shows up with somebody on an EPC,

it takes approximately 30 minutes for them to be processed. In fact, it probably takes longer for the law enforcement officer to fill out their paperwork than it does to process that person through the crisis center. The reason I bring all this up is, again, I can appreciate some of the concerns, because I do know there are times when there may be a single situation in which beds are full somewhere and law enforcement has to take a number of hours out of their system. But that's a transportation issue. And again, as I said a couple weeks ago, state law does not allow anybody else to transport somebody on an emergency protective custody hold other than law enforcement. So if it's a transportation issue, one of the things we have to address is changing the law that would allow for subcontracting to occur so that when somebody is identified under an emergency protective custody hold, that a contracted service could possibly do that transportation rather than law enforcement having to be taken out of their jurisdiction to move those people. The reason I'm bringing all this up, once again is, I would hate after all this time and the focus that we have spent on the emergency system over the last couple of years, and it really does run pretty efficiently if you really look at it, people are not just being thrown out of crisis centers to make beds. The reality is after, during an acute mental health crisis, most people stabilize within 72 hours. Those individuals that don't stabilize and are still deemed dangerous to themselves or others, then have to go before the mental health board. In fact, in our region, out of all the individuals that are placed in emergency protection custody hold, 64 percent of all those individuals are stabilized within three days, they're doing fine, they're able to return back to the place in which they had that issue, maybe with some supportive services. But they don't have to go before a mental health board. Eighty percent of all the people that are EPC'd in our region on an annual basis have never had an EPC before. In other words, they had a single acute episode and they will never have another acute episode again and end up in the crisis center. So the reason I'm bringing this up is, I would hate to have a crisis reaction to the crisis system, if you will, and cause us to have to go in and continue to throw money at the crisis system when you heard providers talk about the fact that at lower levels of care we have waiting lists, we have people waiting to receive services. That if they receive those services would definitely mitigate the fact that they would ever

have an acute mental health crisis and require that emergency system. And that's the reason I wanted to come up is just... we really need to take a look if there are some issues in the emergency system. Most of them, I believe, are easily done without building a lot more expensive beds, without doing a lot of expensive stuff that may be a policy here or a law here to allow people to do their work more effectively and efficiently, so that we can continue to take money that we have seen over the last several years and actually continue to increase the overall capacity at those other levels of services where people literally are sitting on waiting lists, and waiting sometimes for months to receive services. So with that I can answer any questions. [LR338]

SENATOR GAY: Thanks, C. J. Senator Nelson. [LR338]

SENATOR NELSON: Just for my own education, are these mental health crisis that could be stabilized within 72 hours, are a lot of them related to addiction, alcohol, meth, things of that sort, or is this strictly mental problems? [LR338]

C.J. JOHNSON: Well, in relation to our crisis center, of all them are in super intensive custody holds that do occur, approximately 55 percent of all those individuals not only have a mental health issue but they also have a substance abuse issue. Now whether that's related to meth or alcohol or whatever...so that speaks to, you know, earlier that the reality is about, I heard 40 to 80 percent of those individuals who struggle with a mental illness may also struggle with a substance abuse issue. And that's just a fact that goes along with it, so. Those in our...well, in any region, if somebody actually is under the influence and considered a danger at that point, they are placed on a civil protective custody hold, if they're a danger to themselves at that point, so, yeah. [LR338]

[]

SENATOR GAY: Senator Pankonin. [LR338]

SENATOR PANKONIN: C. J., I appreciate your testimony and obviously, it was at the meeting, the previous one, I wanted to just make it just real clear. You're recommendation would be if we changed state law so that folks in the protective custody situation can be transported by subcontractors, is that for the initial part of the episode or is that after they've gone to the crisis center or the hospital or whatever? Be specific, what are you recommending and why? []

C.J. JOHNSON: Well, right now my understanding of the state law is that somebody who is on an emergency protective custody hold has to be transported by law enforcement. That is both at the initial point of contact when they're being taken to, say, to our crisis center, but it is my understanding that also includes if they have to go before a mental health board, then law enforcement has to come up, take that person, take them back to the mental health board. If the mental health board at that point commits them, then they have to transport them to the point of commitment, especially if it's inpatient. And I think the whole transportation issue really needs to be looked at that would allow more flexibility around the various transportation points. []

SENATOR PANKONIN: Maybe not the initial, but subsequent or the whole thing? []

C.J. JOHNSON: Subsequent, but maybe even at the initial thing. I mean, as you heard today, you know, are there other ways to transport individuals who are having a mental health crisis other than cuffing them and putting them in the back of the car. There may be alternatives there. I do also want to point out though, that each of the regions have invested in developing crisis response teams that are available to law enforcement at the point of meeting somebody who is having that acute mental health crisis, and especially when law enforcement at that point determines, believes that person really doesn't have to be placed on emergency protective custody hold. Historically, especially in the rural areas, law enforcement, they have their own hands handcuffed, if you will, and what they would do in this situation, they'd go ahead and place that person on an emergency protective custody hold and get them to a hospital or a crisis center. In

Region V, since we've started our crisis teams out in the rural areas, we've actually seen a 50 percent reduction in emergency protective custody holds because those crisis teams go and work with that law enforcement officer as well as the other person, and that person never has to be placed in an emergency protective custody hold. And in conjunction with that, we've actually seen a 80 percent diversion rate with those contacts because law enforcement not only contacts adults who are having acute mental health crisis, but also children adolescents that get called on. So overall, we're seeing an 80 percent diversion rate from involuntary hospital care at the point of the law enforcement making those calls. And again, they call one number and somebody comes out to that point to help them out with that, so. []

SENATOR GAY: C. J., is that in every region has that going? []

C.J. JOHNSON: I can't speak...all the regions have crisis response teams involved. I can't speak to how the phone, you know, how the call situation works. All I can speak to is in Region V. At the point of an EPC, law enforcement makes one call so they know which facility to take that person to and they make one call if they want a crisis response team coming out and that's an 800 number under both circumstances for law enforcement, so. []

SENATOR GAY: Yeah, okay. Well, I'll check into the mobile crisis teams because we just had a conversation this morning on that. But I kind of...I'll find out if that's each region because that would help in some of the rural regions especially. But the question would be how far can they go? I mean, an emergency crisis team if you're four counties away, I mean, that would be hard to staff. []

C.J. JOHNSON: Well, we've actually got it set up... []

SENATOR GAY: You've got 16 counties? [LR338]

C. J. JOHNSON: ...in Region V, we have 16 counties, 15 of them are rural. And what we do is, we ensure that we have enough professionals on call that it's never more than an hour away. [LR338]

SENATOR GAY: Based out, all based out of Bryan, or...? []

C.J. JOHNSON: Oh, no. It could be out of Lincoln. It could be out of York, Beatrice. So we have enough people on call at any time that the minute law enforcement calls, that we'll have somebody there within an hour to help them, yeah. []

SENATOR GAY: 24/7, yeah. []

C.J. JOHNSON: Yeah, within an hour. 24/7, yeah. []

SENATOR GAY: Thanks. Any other questions for C. J.? I don't see any, thanks. []

C.J. JOHNSON: Thank you. I'm sorry to take up more of your time today. []

SENATOR GAY: No, that's all right. Anyone else? I'll wrap it up here, and, well, thank you everyone...oh, Senator Johnson. []

SENATOR JOHNSON: I just want to close by saying what a great day its been. So many good people that coming in and testifying and it might have been a long day but it's certainly been a great day. So thanks, everybody. []

SENATOR GAY: Yep, thanks everyone for their patience. Tomorrow at 9:00? All right, see you bright and early tomorrow. Thank you. []