[LR295]

The Committee on Judiciary met at 9:00 a.m. on Friday, October 9, 2015, in Room 1113 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LR295. Senators present: Les Seiler, Chairperson; Laura Ebke; Bob Krist; Adam Morfeld; and Matt Williams. Senators absent: Colby Coash, Vice Chairperson; Ernie Chambers; and Patty Pansing Brooks.

SENATOR SEILER: It's a little past the bewitching hour, but we were waiting for a quorum. We now have a quorum. Just in housekeeping, we have some senators in the back that I don't see. I think Senator Campbell stepped out. [LR295]

SENATOR WILLIAMS: No, she's there. [LR295]

SENATOR SEILER: Senator Kolterman is back over there. And John McCollister was here a second ago and he has left. But there will be senators popping in and out during the hearing so--there's one (laughter)--so they are interested in this program also. The senators will introduce themselves from starting at the right. [LR295]

SENATOR BOLZ: Good morning. Senator Kate Bolz, District 29, south-central Lincoln. [LR295]

SENATOR WILLIAMS: Senator Matt Williams from Gothenburg, District 36. [LR295]

SENATOR SEILER: Les Seiler, Chairman of the Judiciary Committee, from District 33. [LR295]

SENATOR SCHUMACHER: Paul Schumacher, District 22. [LR295]

SENATOR EBKE: Laura Ebke, District 32, from Crete. [LR295]

SENATOR SEILER: Oliver. [LR295]

OLIVER VANDERVOORT: Oliver VanDervoort, the committee clerk. [LR295]

SENATOR SEILER: Diane. [LR295]

DIANE AMDOR: Diane Amdor, committee counsel. [LR295]

SENATOR SEILER: Okay. Did I miss any senators that are hiding back there? Okay. Thank you. We will be on the time clock in front of you. It's a five-minute presentation. At the end of one...or when you have one minute left the yellow light will come on. And when the red light comes on, we appreciate it if you would stop your testimony and allow the senators to ask you questions. Many times, if you're right in the middle of an important point, the senators will ask you to go ahead and complete your point. And that doesn't count against your time. So we want to get a good, fair hearing on this. We think it's a very important subject. And if you have...are going to testify, please get one of the testifier's information sheets. Get it filled out. Give it to Oliver. If you have documentation that you want to present, give it to Oliver before you start your testimony. Senator Mello has arrived, so we're ready to go. Senator Bolz, would you introduce LR295. [LR295]

SENATOR BOLZ: Good morning. I'm glad to be here today to discuss LR295, an interim study to examine the intersection between behavioral health and public safety. This study has three main areas. The first is addressing the pressures related to behavioral health that have an impact on our corrections system. The second is identifying ways to support community-based behavioral health services in order to better serve individuals and protect the public safety. And third, identifying cost-effective front-end options and alternatives to prevent high-cost, long-term incarceration of individuals with mental illness. As members of the LR34 Special Investigative Committee on Corrections, we've all heard about the concerns related to behavioral health within the corrections system. Our estimates vary, but the data provided estimates that between 30 and 40 percent of incarcerated individuals in Nebraska have a severe mental illness, and over 80 percent experience some form of mental illness while incarcerated. It is important to note that progress is being made. Important changes have been made by the Legislature, have been made as a result of this committee, and have been made by the Department of Correctional Services related to solitary confinement, staffing, programming, and reentry. I also want to be clear that

people nationwide and in Nebraska live with mental illness and contribute to society. They are our friends and neighbors. There is a broader context of mental health and mental illness across the state, but today's interim study focuses specifically on those with severe mental illness or mental illness that might lead to criminal behavior. The fact is that our correctional facilities remain significantly over capacity and many behavioral health providers in the community continue to have waiting lists. So people struggling with mental illness in the community may not get the services they need, and those exiting the incarceration system and reentering society also struggle. Today's interim study asserts that it is time to address the supply side of our overcapacity issue, to think about a more strategic way to both address our public safety and public health concerns related to mental and behavioral health in the state. Let me give you a quick statistic. A short-term residential treatment program for an individual with mental illness can cost between $5,000 and $6,000 a year. And while that's a significant cost, it's also significantly less than the cost of incarcerating an individual for a year. The cost of incarcerating an individual in Nebraska on average is over $35,000 a year. History is also important here. Nationally, moves from institutional care to a focus on community-based services have been topics of conversation for decades, and in the early 2000 Nebraska passed LB1083, which was the final and most significant step in moving the state from an institutional approach to providing mental and behavioral health services to a community-based approach. Many institutions closed and those dollars were diverted to community-based services through mental health regions across the state. So in terms of mental and behavioral health, our state's approach is community based--in other words, providing services to individuals in the least restrictive setting possible within the community. What that looks like varies depending on the individual. It may be counseling or residential treatment. And in cases where health and safety are risks, individuals still are served in a residential setting at the Lincoln Regional Center. So some of the challenges I have identified in this community-based approach are: (1) serving the highest need individuals can be challenging in terms of providing the right types of services and enough funding for those types of services; (2) the highest need individuals when not served in the community at times end up in the judicial system; and (3) upon exit from the judicial system, the highest need individuals need more transition support to prevent recidivism. You'll hear today about a variety of challenges and gaps and exceptional efforts and services provided across the state. This is a broad-reaching interim study and is intended to begin the dialogue about how we can move forward on some important changes that are needed to protect the public safety and improve our

public health. But I want to conclude by offering some of my observations and conclusions after studying these issues in my office over the summer. First, in order to fulfill our commitment to the community-based approach, we must assess our current status and develop and support appropriate community alternatives to avoid institutionalization and incarceration, as well as relieving the suffering of those in our community who have mental illness. Second, in order to fulfill this commitment to community and protect public and personal safety, we must develop policies and services that respond to needs that cannot be sustained by market forces, such as treatment options for low-income and homeless individuals. Third, high-need individuals must be served by working across silos. In many cases there's an intersection of behavioral health, developmental disability, intersection with the courts. Those folks need a comprehensive approach. Nebraska may want to consider developing a systems-of-care approach for adult services, as we have already done with children's behavioral health services. And last but not least, I want to say that Nebraska has bright spots and smart, strategic initiatives that we can build on: jail diversion programs, crisis response programs, early episode psychosis response. There are a variety of efforts that can help us both prevent and ameliorate behavioral and mental health needs. Mental health courts are also a topic of conversation that will be brought up today and can be a part of the solution. So I appreciate your participation and engagement in this interim study and I look forward to the testimony of all the folks who have decided to come to participate today. [LR295]

SENATOR SEILER: Any questions? Thank you for the introduction. Just to clarify a little bit, the gentleman that came in and sat down in Patty Pansing Brooks's is Senator Bill Kintner from the eastern part of the state. He's...what is that, District 3? [LR295]

SENATOR KINTNER: Two. [LR295]

SENATOR SEILER: Two, okay. [LR295]

SENATOR KINTNER: Close enough. [LR295]

SENATOR SEILER: And then Senator Bob Krist has arrived, so we have a full contingent of senators now. And I'm going to call witnesses in the order in which they were given to me. So

the first witness, Jan Riedman, director of outreach ministry, would you please come forward? Please state your full name and spell your last name. [LR295]

JAN RIEDMAN: (Exhibit 4) My name is Janice Reidman, R-i-e-d-m-a-n. [LR295]

SENATOR SEILER: Okay. Would you have a seat and pull the mike up close to you so that you can amplify. And more especially, we don't care if the people in the back can hear it. [LR295]

JAN RIEDMAN: Okay. [LR295]

SENATOR SEILER: But the people that transcribe it needs to hear it. [LR295]

JAN RIEDMAN: Thank you. [LR295]

SENATOR SEILER: Thank you. You may begin. [LR295]

JAN RIEDMAN: Good morning. My name is Jan Riedman. I thank you for this opportunity to speak regarding behavioral health and mental health services, particularly with those within with corrections system, which is where I have the most contact. I'm the director for outreach ministries at Our Saviour's Lutheran Church in Lincoln. One of the ministries I facilitate is the FEAST prison ministry. Every Sunday for the past 11 years we have gone to CCCL--Community Corrections Center of Lincoln--to pick up between 25 and 45 men and women who we call partners, not inmates but partners. Over a four-hour period they attend services; they are provided a meal; they participate in small groups, Bible studies, reentry planning, writing groups, discussion groups. They have the opportunity to give back to the community by doing service projects. A recent example is the men and women built picnic tables for neighborhood schools to use in their courtyards. The overall goal of this ministry is really to provide a support community where they can establish themselves and participate in positive activities and when they are released they feel comfortable coming back knowing they have someplace to go. On any given Sunday I spend the majority of my time in conversation with partners who are struggling with various personal issues. I have some experience as a drug and alcohol treatment provider so I can somewhat navigate those short and sometimes intense conversations. However, they're time

limited and not always productive. Men and women come to prison with a diminished sense of self and poor decision-making skills. While in prison the majority cannot access mental health services unless they have severe and persistent diagnosed mental illness. For those who do not meet that criteria, they live with the issues that brought them to prison in addition to those that they encounter while in prison. One of the most devastating experiences for them that I can attest to is losing a parent or a partner or some family member while they are in prison. If they happen to be at the Community Corrections Center, they may attend that funeral if they find...if it's in Lancaster County, if they find somebody to give them a ride, those kinds of things. But those are things that they end up bearing by themselves during the time that they're incarcerated. So they walk back to the community with compounded issues and few resources. I can appreciate also the efforts that have been made by Corrections to provide advances and ways to reach the men and women, particularly the moral reconation therapy, in addition to the reentry...the addition of reentry specialists, both which work primarily in groups. So individual help is sometimes necessary because they're not going to address those personal issues with people they live with every day. Brief therapy sessions to talk about grief issues and family would be beneficial for the folks that I work with. For most at CCCL, this might be accomplished by an opportunity to work with master-level psychologists or students at the university that would just involve contracting drivers and getting them to the places that they need. That way, if higher level of treatment is needed, you know, those students can evaluate and make referrals. For those who come to CCCL with major diagnosis, they have a consistent or once-a-month contact with a psychiatrist or psychologist within the secure facilities. At CCCL what the inmates tell me they have: their ten-minute appointment that they have. Once they reach that level of incarceration, it's just for medication management only. So for someone who has bipolar disorder or other major mental health issues, that's not adequate. Few have taken the responsibility to find programming and counseling for themselves. Some of the programming is required by parole but not provided by Corrections, so it ends up costing them, you know, upwards of $1,000 at times. And for those still struggling when they get out, there are places that I can make referrals to but most of those places are also overwhelmed with phone calls. So I guess just in conclusion I think leaving prison with the unresolved emotional pain that they came in with is really leaving prison vulnerable. So thank you. [LR295]

SENATOR SEILER: Questions? Senator Krist. [LR295]

SENATOR KRIST: Jan, thanks for coming and thanks for your work. I guess I have two questions for you. You've been around the system for awhile. [LR295]

JAN RIEDMAN: Um-hum. [LR295]

SENATOR KRIST: Do you remember when the behavioral health hospitals and systems were stronger than they were right now in interfacing with the system itself? [LR295]

JAN RIEDMAN: I remember that time. I didn't have a lot to do with that or wasn't involved at that time. [LR295]

SENATOR KRIST: Okay, then I'll save my question for somebody else. I would assume that you would like to go back to some of the strengths within the behavioral health system that we had prior to what we have right now. [LR295]

JAN RIEDMAN: I believe some of those. I also am a strong believer in the community-based systems where there is peer support for folks. That seems to be one of the things that's working well. [LR295]

SENATOR KRIST: Well, when we--and I use the word because I am part of a legislative process in the government right now--but they and we together, when we destroyed the behavioral health system we should have shifted some of it, as you say, to the local communities and having that mentorship. The other question is, do...is it too early to tell yet? But we put the Medicaid suspension in place last year so that when...people who leave incarceration can immediately be put back on the drugs that they need to sustain. And the thought is that they would be less likely to recidivate if they continue to be on the medication. Have you seen any result out of that at all yet? [LR295]

JAN RIEDMAN: I think it's still an individual thing for the partners that are...the inmates that are coming out. When they come out, and kind of being overwhelmed with many things, one of the first questions I get from them is, where do I go to get my prescriptions, where do I go to get medications? So those things are in place. It's just kind of helping them navigate where to go.

And they do come out with two weeks' worth of medication, so they do need to get to a physician and get that scrip, you know, in that two-week time. And sometimes that is delayed. It's not that it's not there for them. It's just that...one of those hurdles that they have to kind of...one other thing that they have to do when they get out. A gentleman I had this...within the last couple weeks came out with 15 medications, and getting him to someplace and having them, you know, review his medications, it happened to be the City Mission clinic, which is a great addition for them. So he was. It was a matter of getting him there. [LR295]

SENATOR KRIST: Okay. Thank you very much. Thanks for your work. [LR295]

SENATOR SEILER: Senator, hold it. You're not a member of the two committees, so you can't question. Sorry. Any other questions? Thank you. [LR295]

JAN RIEDMAN: Thank you. [LR295]

SENATOR SEILER: Alan Green. [LR295]

ALAN GREEN: Good morning. My name is Alan Green, A-l-a-n G-r-e-e-n, and I am the executive director of the Mental Health Association of Nebraska. First I want to thank you for the opportunity to talk today. But also I want to say that my laptop passed away sometime during the night and, along with it, my testimony that was prepared, so I'm operating off notes so please bear with me. What I would like to talk about is our organization and our...and the programs that we are already providing in this area. MHA is the only, as far as I know, the only behavioral health provider that is peer run, meaning that all staff self-identify as living with behavioral health issues. And the majority of my board also self-identify as living with behavioral health issues. MHA has been providing education and advocacy for over 15 years and direct services for over eight years. Our services are primarily focused in the 16 counties, southeast counties of Nebraska. And that includes supported employment, crisis diversion, and outreach activities. What I would like to...and in February we also received one of the reentry grants that allowed us to expand our programs and open one of our crisis respite houses targeting specifically people transitioning out of the state correctional system. Our respite houses are the ones that have had significant impact. Keya House, which opened about five years ago, is open to anybody, any

adult that needs respite, needs a chance to get away, visit with trained peers 24 hours a day. They can stay up to five days for free. That program in the time that it's been operating has...our estimate is that it's exceeded $4 million in helping to divert over $4 million worth of higher level care by keeping people in the community and keeping them employed and connected with their families. Our supported employment program provides...it helps people find competitive employment in the community, meaning it's employment that anybody can apply for that pays at least minimum wage. And in the...in 2012 I asked my program coordinator to give me an estimate of the earnings made or earned during the year by program participants, and it exceeded $400,000. So not only are these programs helping to help people become economically self-sufficient, they're getting off benefits, they're paying taxes, they're actually paying into the system instead of out of the system. I mentioned our reentry program. Out of that it helped us...oh, it doubled the size of our supported employment program so we have staff that are targeting specifically people coming out of the state correctional system. And we also have the ability...we have what's called a Level 3 CWIC benefits specialist, so we can do complete benefit specialist programming for participants that come into the building in addition to the SOAR applications, which is the expedited enrollment in Social Security for folks that are eligible. Honu House (sic) was the new respite house that came out of the corrections grant. It opened the end...the last week of June and has been full ever since. And what's different between it and Keya is that people can stay up to 90 days. We do it in 30-day blocks. We review after 30 days to see their progress, whether this is effective, if there are other things that we can do. We have not had anybody stay longer than 30 days. We've been very successful in working with landlords and helping to get arrangements and follow-up services so that they can move into their own apartments. In addition to the employment and the respite programs we have, we also have a very effective program with the Lincoln Police Department and where...when officers find somebody in the community, come across somebody in the community that is in distress but does not meet the level of need to trigger the emergency protective custody, officers e-mail us and we go out within 24 hours with trained peers to find out, try to engage, try to find out what they need, and then divert them from further contact from law enforcement and the rest of the system. This program has been very, very significant. We're close to 300 different officers have participated in this program. That's pretty much, you know, again, operating off of notes. And I seem I'm on the red light, so there's not much left. Again, the programs have been very, very effective. And peer support, if you're not familiar, is not a clinical service. We do not monitor

meds. We do not provide formal counseling. We just do peer support. We treat people like they're adults. They have a relationship with their prescriber. They know what they need to be doing. We focus on helping them get the skills they need to self-monitor their issues, put their own strategies in place so that they can address those issues. [LR295]

SENATOR SEILER: I'm going to ask you to stop. [LR295]

ALAN GREEN: You bet. Thank you. [LR295]

SENATOR SEILER: Questions? Bob. [LR295]

SENATOR KRIST: How many houses did you say you had? [LR295]

ALAN GREEN: We have two now. [LR295]

SENATOR KRIST: Two, and where are they? [LR295]

ALAN GREEN: Both in Lincoln. [LR295]

SENATOR KRIST: Okay. Thank you. [LR295]

SENATOR SEILER: Any other questions? Thank you very much for your testimony. [LR295]

ALAN GREEN: Thank you. [LR295]

SENATOR SEILER: Mary Barry from St. Monica's. [LR295]

MARY BARRY-MAGSAMEN: Good morning. [LR295]

SENATOR SEILER: Good morning. [LR295]

MARY BARRY-MAGSAMEN: (Exhibit 5) My name is Mary Barry-Magsamen, M-a-r-y B-a-r-r-y, hyphen, M-a-g-s-a-m-e-n. Thank you for having me this morning and thank you, Senator Bolz, for inviting me. I'm the executive director of St. Monica's Behavioral Health Services here in Lincoln, Nebraska. We've been around for 51 years and I've been with the agency for 18-plus years. I started at a very young age. St. Monica's has had I think--hopefully many of you know--lots of success over the years. And I think a lot of that is due to our focus on serving a specific population: women and their children. And I would be remiss if I didn't take this opportunity to, as Senator Bolz pointed out, point out some highlights. We do have some gems in our state, and I think programs like St. Monica's are one of those, including Alan's programs as well, but, for example, a program called Project Mother and Child here in Lincoln where women can keep their children with them while they're in residential treatment which, if you try to think about that choice, if you do residential treatment and you have a six-month-old, that's a tough choice. So we have unique programs like that in our state but we have very few. There are three programs like Project Mother and Child in the state of Nebraska. Our program serves eight families at a time. The length of stay is generally four to six months. Do the math. We're not serving a huge number of families in those programs in any given year based on capacity. But our outcomes are really quite incredible. If you look at national treatment complete rates, they tend to run around 40 percent roughly. That can fluctuate. In '14-15, our completion rate for Project Mother and Child was 69 percent. It's been higher than that in other years, so I would argue that there are programs that are very much worth funding. And many of the women who come to us come to us via corrections in some way or another. For years we have worked closely with innovative programs like Adult Drug Court in Lancaster County, family drug court in Lancaster County. We work with probation currently, State Probation system. We have a contract with federal pretrial. So there are programs like St. Monica's that are very familiar with working with the criminal justice population and with those programs and those entities, and we'd like to see more of those. So we're actually very excited at the prospect of...at looking at that. I included some statistics here. I won't go through now. And you probably read many of those that come from places like the National Association of Drug Court Professionals that speak to individuals that you're thinking about and considering. St. Monica's receives letters literally weekly, and I can say that because they often come to me from women who are in the correctional system either in the county jail or in the York facility. And they're handwritten and they address it to the executive director because they don't know who else to write it to and they're saying, can I have a

spot, I'm out in six months, two months, three weeks, I've been on your wait list, can you please help me get a spot, because while they're incarcerated they are not getting the treatment they need to address the behavioral health issues. And they know that and they're trying very hard to get into a spot like a program like St. Monica's. If I had to sum up what I hope you would consider as you look at this complex issue is two things, and that is rates and capacity. And you have probably heard this before but I'll say it again: Our behavioral health system is underfunded both in terms of the rates we're paid...they're not adequate, they don't keep up with our costs. I spoke with our regional finance person before my testimony. We looked at the past nine to ten years. We've had rate increases two of those years. As a provider who sits down with my board every year, our increases, our costs increase generally at least 3 percent, sometimes more. And so every year that margin gets slimmer and slimmer and it's far more difficult. I have some very talented community leaders on my board and every year they look at me when we do this budget and say, I don't know how we're going to do this, I don't know how the state expects us to keep this up, it's...you're not funded adequately. So I would ask you to think about both rates as well as increasing capacity. If we can't address the needs that we have currently and you're looking to serve more individuals in the behavioral health world instead of incarcerating them, we have to address those two pieces or we're a sinking ship, I'm afraid. And then I think just one last point...oh. [LR295]

SENATOR SEILER: No, go ahead and finish your last point. [LR295]

MARY BARRY-MAGSAMEN: ...is I really appreciate looking at the creative models, looking at the silos and those funding sources and saying we don't have to do this so separately. We can combine child welfare, behavioral health, probation, Medicaid. You can combine all those things if you choose to be creative and fund us much smarter. [LR295]

SENATOR SEILER: Thank you. Questions? Senator. [LR295]

SENATOR BOLZ: Thanks for being here. I appreciate your testimony. Would you just elaborate a little bit more on your waiting lists, the pressure of those waiting lists. Are those folks who are court ordered? If you just provide me a little more detail... [LR295]

MARY BARRY-MAGSAMEN: You bet. I checked before I printed this off. We have I think 51 women on our waiting list today. I think 42 of those have some involvement with the criminal justice system. We are required because of our federal funding, funnels through the state, to prioritize. There are some priorities like IV/pregnant drug users, for example. So we're forced within that wait list to serve those priorities. And that is, in addition to just not having the capacity, that also creates an additional burden. We're choosing to bump women over others. If you are a chronic alcoholic, which I would say from our experience is deadly for women, you will get bumped over and over again because there are so many women who are IV meth drug users and/or pregnant. And so, for example, we have chronic alcoholic women who never get into services because they are continually bumped by the federal priorities we face. So they are...they're referred from probation, from judges, from attorneys, family members themselves. There's really no limit to who refers the women. But the wait list is a huge struggle for us. [LR295]

SENATOR BOLZ: Thank you. [LR295]

MARY BARRY-MAGSAMEN: Um-hum. [LR295]

SENATOR SEILER: Further questions? Senator Schumacher. [LR295]

SENATOR SCHUMACHER: Thank you for your testimony. I've roughed it out and it looks like you serve somewhere around 25 families a year? [LR295]

MARY BARRY-MAGSAMEN: Um-hum, tops. [LR295]

SENATOR SCHUMACHER: Okay. And you mentioned that the system is underfunded as to rates and as to capacity. Any guesstimate or have you heard any guesstimate as to what it would take in revenue to properly address this problem? [LR295]

MARY BARRY-MAGSAMEN: I think that exists but I couldn't tell you that this morning. I'd suspect we have some folks in this room that might be able to tell us that. But for our system I don't have that number in front of me. [LR295]

SENATOR SCHUMACHER: Thank you. [LR295]

MARY BARRY-MAGSAMEN: Um-hum. [LR295]

SENATOR SEILER: Further questions? Thank you very much for your testimony. [LR295]

MARY BARRY-MAGSAMEN: Thank you. [LR295]

SENATOR SEILER: Elizabeth Lay, deputy county attorney, Platte County. Good morning. [LR295]

ELIZABETH LAY: Good morning. My name is Elizabeth Lay, L-a-y, and I am a deputy county attorney from Platte County, Nebraska. And I can tell you now that my testimony is going to be different than what you've heard so far. But that's why we're here, right, to get more information on the behavioral health unit...the behavioral health system here in Nebraska. I have three things that I'd like to talk with you about today. And I'm going to try to not get to talking so fast that you can't understand, but all three are very important. The first problem that I see as the county attorney or as a deputy county attorney is that out in the rural areas our regions have contracted with private hospitals to take our EPC individuals, our mentally ill individuals, whether voluntary or EPC. But we're moving into a point where our private hospitals won't take those people. Even though they've contracted with our regions to take those people, they won't. They cite government regulations as to why they can't take them--patient safety--but we have very assaultive, homicidal, suicidal individuals that they will not take and we don't have a place to go with them. So I can let you guess where we go with them. We go with them to jail because that's the only way that we can keep our communities safe. It's not that that's where we want to keep them, at least not in our office. Our goal is usually to move them out of the criminal system as quickly as possible and as soon as we find a place. But as we all know, it can take us four to eight months to find a place in the regional system for them to actually go. I think a lot of county attorneys get very distraught, very frustrated with that process and instead just go the criminal route and there you have more mentally ill prisoners. It's really frustrating when we can't get our private hospitals to treat our individuals. Second is a lack of local resources and a lack of resources in general. Our residential programs have an eight-month waiting list if you aren't

EPCed, and so if you are EPCed or you are under a Mental Health Board commitment, they have a four-month waiting list. Our private hospitals will then say that, we are not a long-term care facility and they will stabilize the patient, send them back out into the community and, before they reach their treatment, they are now back in front of us as a criminal once again. And people seem to be less likely to give them the benefit of the doubt once they're in front of us two or three or four times. And so with the lack of local resources that we have, the fact that they are at capacity, the ones that we do have, and underfunded, we absolutely cannot keep them out of the jail no matter how hard we try. Even though there are offices like mine out there that are trying very hard to keep them out of jail, we can't. The third thing I'd like to talk to you about is the Medicaid provider Magellan. Basically what we have is an agency making budget-driven decisions on treatment, what should be a treatment-based decision, and that's not happening in the right way. We have Medicaid saying, no, we won't pay for treatment, that doctors that have been caring for these people for years have said that they've needed and, therefore, the appeals process is so difficult that the service providers just decide not to go the appeals route which is unfortunate because then they're out, turned into the community, and then they reoffend because they didn't get the treatment that their doctors thought that they needed. We also have them making decisions that, because our state has contracted with them to not only be the Medicaid provider but to also be the provider for our regions money, that once they say no for Medicaid our region has to go back to them again to ask them to pay for something that they think is beneficial for that person to try to help them with their support. And then guess what? I can pretty much say that every time they're going to come back and say that, no, our regions can't pay for it either. And so we have this opportunity to pay for this care for people to try to keep them out of our prisons, but Medicaid is saying, no, we won't pay for it in Medicaid and we also won't pay for it and your regions can't pay for it and there's no way to pay for it. And so we're at our end of the rope. And I refuse to accept that because, if I accept that, then I'm part of the problem and I'm not willing to be part of the problem. So then that brings that case back to me in my office and I have to try to figure out how to keep that person in the regional center. And then that bill comes to my county and then I have to answer to my county board or to my county attorney or whoever it might be why we have a $100,000 bill for treatment when I'm just trying to do the right thing for that person and give them a chance to stay out of prison because that's where they always end up, right? Because we're not giving them a chance to succeed on the front end, we're putting them in prison on the back end and it's costing us all a lot of money. And just

one last point. I see I have the yellow light. I think all of this could be a conversation on prevention. What can we do in preventing this from happening? But I know that our region doesn't actually do any crisis prevention. They are very crisis driven. We have a very crisis-driven mental health system. Let's just put it that way. You know, we don't react to things or we're not proactive about things. We're very reactive. Our system is very reactive. And I think if we can move away from that and into a more proactive way of dealing with these people, then we would be better suited to keeping them out of our prisons in the long run, giving them an opportunity to lead a more productive life. [LR295]

SENATOR SEILER: Senator Krist. [LR295]

SENATOR KRIST: Take a deep breath. [LR295]

ELIZABETH LAY: I'm sorry (laughter). I had a lot to get out. I'm sorry. [LR295]

SENATOR KRIST: No, and I'm going to give you an opportunity to say some more. For the record, I know where you're at. But for the record, so everyone knows, what region are you/we talking about? [LR295]

ELIZABETH LAY: I am...Platte County is specifically in Region 4. [LR295]

SENATOR KRIST: Region 4. [LR295]

ELIZABETH LAY: I do think that I probably speak for most of our rural regions. [LR295]

SENATOR KRIST: I think you do. So let's talk about the third point first: Magellan. For the record, I think I'm the only member that has served on the Health and Human Services Committee in here and I can tell you for a fact Magellan doesn't do anything that the state of Nebraska doesn't tell them to do or supervise them doing. And there is a new contract being let on managed care services and Magellan will have to compete again for those contracts. So I invite anyone in here that has professional/legal opinions or experience with dealing with Magellan, in particular medical necessity, speak up, get to the Department of Health and Human

Services, and talk about it because the RFP, if it's not on the street right now, will be on the street. And it's going to be critical that we deal with that problem because medical necessity by itself is preventing some of the services that we need. In that same vein, you talked about preventative issues. I believe that if we do more in juvenile justice we will avert the adult criminal from evolving into where they are. Senator Mello, Senator Seiler, and I have been involved with, and Senator Schumacher, been involved in the special, and Senator Bolz, special investigative committees over the last few years. It's apparent to me that if you intervene with a child who is seven years old who manifests himself with those problems coming into school that at some point you are going to have some success in averting the recidivism of the juvenile and then creating a monster, if you will. Your experience is invaluable to solving this problem because you're seeing that revolving door. I've had juvenile court justices tell me that they have sent a child in the metropolitan area to Immanuel Hospital for services and for evaluation and, unbeknownst to him, they're out, because at the point when they are released they are deemed to be okay... [LR295]

ELIZABETH LAY: Stable. [LR295]

SENATOR KRIST: ...and then back in the courtroom, back in the courtroom, back in the courtroom four or five times. I'm working on a piece of legislation that will make it mandatory that when a judge sends somebody for an evaluation, that person has to come back to that courtroom to appear before him or her, before the judge, to try to close that revolving door, that loop that goes round and round. I really appreciate your words and I'd give you an opportunity to say anything else that you want to say. I just want you to know you and people like you have to be involved with this Magellan RFP in terms of putting input in because, again, Magellan as a service provider does nothing that the state of Nebraska doesn't tell them to do or supervise them doing. So the floor is yours again. [LR295]

ELIZABETH LAY: I would say in regards to the insurance problem that I see that we face is that the...I understand it's a profit-driven company. It is and that's just a reality that we have to face is our insurance...the insurance is a profit business or a profit-driven business. Where I get the angriest is when I see someone coming across my desk who needs the help. They've been in and out of the hospital many times. I really...I see it most with substance dependency. That is a part

of our Mental Health Commitment Act that you do put that in there. So I do feel like we have to address it under the Mental Health Board (sic) Commitment Act. Because it's in there, you saw value in that when you enacted that law. I see value in that because I do feel like people deserve the chance to get better. And with the insurance issue, I see it most in that realm, in that context of that substance dependency. When someone has been to treatment, they've been to treatment once or twice or maybe they haven't been to treatment yet and that can sometimes cause an issue, too, but they go into inpatient, into the hospital. They're EPCed. They're...they, you know, ingest some substance and then they become suicidal or homicidal or whatever it might be. And we put them into emergency protective custody. We get them to a hospital if we can find one that will take them. And then from there they decide they need residential treatment. And the insurance company comes back. They've never laid eyes on the person. They've never seen the person. They have a team of doctors that they contract with to make these decisions, which also causes a little bit of a conflict because then when you have a patient with that doctor they're a little concerned about going against them because they don't want to jeopardize their contract that they might have for these independent evaluations. But you have a team or a doctor somewhere who is basically deciding on treatment availability or treatment options for a person that they've never seen, that they've never laid eyes on, even though the person that is actively treating them says this is appropriate. And so what they say is, we don't feel he's appropriate for that level of care so we won't pay for that level of care, all we will pay for is this level of care. And it's usually outpatient. And I can tell you an example of a person who went in for that, had an alcohol dependency disorder, and Magellan wouldn't pay for his residential treatment. He left that night, got drunk, crashed his car. And guess where he is? He's in jail because that's what we had to do. And then when he got out of jail he was sober too long for us to put him in treatment, for me to go back again under the Commitment Act and try to get him some help now that he was sober and still asking for it. But he had been sober too long. He was sober too long. He had received no treatment but he was sober too long. In what universe does that make sense? It certainly doesn't in mine where I'm trying to keep people out of jail and I actively have an insurance company telling me that they would prefer them to go in the jail because then they don't see those costs on their bottom line. They see it on yours and that's acceptable, but the other way is not. And I just...I'm unwilling to accept that as a solution. [LR295]

SENATOR KRIST: Thank you, Elizabeth. Thanks for coming. And do get involved with that, if you would, please, because it's going to take professionals involved with that RFP process to change that culture. Thank you. [LR295]

SENATOR SEILER: Senator Williams. [LR295]

SENATOR WILLIAMS: Thank you. And thank you for your being here and your passion. Part of my legislative district is in Region 2 and the comments that you're making are very similar to the comments that I'm getting from the county attorney in Dawson County. [LR295]

ELIZABETH LAY: Um-hum. [LR295]

SENATOR WILLIAMS: One of the things that I would like to probe with you as a deputy county attorney is how well problem-solving courts, in particular drug court, has helped or not helped in these cases, and then your opinion on the possibility of expanding problem-solving courts beyond drug court to cover things like mental illness. [LR295]

ELIZABETH LAY: Well, I don't...my county particularly does not have drug court, and so I can't give you personal experience on that particular issue. However, I have spoken with the Dawson County Attorney and she seems to think that it is a very valuable and useful tool. But personally, we don't have any experience with that. I know that recently we have implemented an adult diversion program in Platte County where we can filter some of the cases that have some mental health components. We can filter through that adult diversion program to ensure that people are receiving the help that they need if they don't, in fact, meet that criteria for EPC. And I think diversion is a great program in which to do that if you can afford to put that into place, especially in smaller counties that don't see a lot of EPCs but do see a lot of mental health. And so that's extremely important. Another tool that we use in our office is that we have an attorney who is dedicated solely to mental health and that's myself. And so our county attorney diverts...he diverts cases, before they're even charged, to me to try to figure out if there's another avenue that I can take to put them in the realm of mental health as opposed to the realm of a criminal action. And sometimes we can, especially in those most dangerous of cases when someone is arrested for a very dangerous or in a dangerous type of crime--and, you know, we don't want to for a

second underestimate the criminal aspect of it either but we also want to make sure that we're taking into account the mental health aspects of it--and sometimes we can definitely see from the police reports and from witness accounts that the crime actually stemmed from the mental illness as opposed to just happening concurrently with it. And so it...there are things that we can do to try to better understand how to use the systems together to best, I guess, to best help treat people and to make sure that they don't reoffend. But as for your specific questions on drug court, I can't answer to that. I'm sure that it would be somewhat useful in that same capacity. [LR295]

SENATOR WILLIAMS: Thank you. [LR295]

SENATOR SEILER: Senator Schumacher. [LR295]

SENATOR SCHUMACHER: Harvard University uses with considerable success a thing called a case study. And you take a real-world situation and you look at it and you try to ascertain from it where the system works and where it doesn't work. In the cases that you've had and worked with, does any come to mind where it would highlight for us in a real-life way how the system works or doesn't work? [LR295]

ELIZABETH LAY: Absolutely. You know, I have one case in particular that I can briefly tell you about that encompasses everything that I think is wrong with our mental health and behavioral health system today. And it generally...what happened was we had a young man who was threatening, making threatening statements towards others. And the police was called. He was making threatening statements to a young child. The police were called. He was immediately arrested and jailed because that was the way that they knew that they could deescalate the situation as quickly as possible without having further information. The very next day the law enforcement officer sent through his reports. They came through to me. I started collecting collateral information because from the reports I could see that there was absolutely something else going on. I started collecting the collateral information that I needed, contacting the family to figure out what was going on. And the information that I gained, in addition to the fact that he already had a Mental Health Board Commitment in a different county, led me to believe that the criminal activity stemmed from the mental illness and that it wouldn’t be prudent to go forward in a criminal way. And so I decided at that point that we would try to move him into the mental

health realm. And I got into...in touch with the county attorney in the different county and he was willing to help and go forward with it. And I think it bears...I think it's important to say that this person had only just recently left a stint at the regional center and he had been discharged into independent community living. And so I tried to EPC him from our jail and guess what? No private hospital would take him. No private hospital that our region had contracted with would take him because they found his criminal charges too scary; his assaultive behavior was too concerning; and his homicidal ideations were very concerning to them. And they said, because of our government regulations with the way we have to regulate our hospital, they won't allow us or they...we can't take a person like that without putting our licensing in jeopardy; and so at this point we're going to say, no, we're going to refuse to take that, which is an interesting concept since they've contracted to do that for the region. They're supposed to take everyone and they're the appropriate and nearest medical facility. So, okay, fine, so we went on down the list and we tried a multitude of different private hospitals that all of them said no. So we finally came to the conclusion that our only hope was to commit him directly back to the regional center except for that there's no room there. There's no room in the regional center. If you're lucky it takes as little as four months, like it did in this situation. But if you're not lucky and it's not an absolute emergency, it takes as much as eight months to a year. And so in this particular situation, the gentleman sat in our jail for four months. Four months he sat in our jail awaiting mental health help and treatment, which is inhumane. That's inhumane. But he was current...I mean he was actively expressing homicidal ideations. He was actively expressing suicidal ideations. And to keep him safe and to keep our community safe there was no other option. So, you know, please, I invite you to ask me how that felt, because that was pretty horrible to know that I was...you know, that we were keeping someone in jail under a legitimate criminal charge but keeping someone in jail and just by default being forced into going the criminal route when we absolutely wanted to go a different route and keep this person out of prison. So he sat in our jail for four months and then he went to the regional center. And he was there and was receiving treatment and they deemed him, you know, ready for discharge and his treatment team decided he was ready for discharge. And they wanted to discharge him to secure residential because they tried a couple of times to discharge him to independent living and it didn't work. So we were going to try more support this time coming out of the regional system, more support, and do a secure residential type of facility, except for that Magellan said no. Their statement was that he was too dangerous to go to secure residential, that they would only authorize a release back to

the community for outpatient care. So, please, tell me how someone is too dangerous to remain locked up but not too dangerous to go back to independent living. Ridiculous! That is the most ridiculous thing I have ever read. So I called and I said I would like to know why, I'm challenging this, and if I can't get some information on this, then I'm going to have to challenge it in front of my Mental Health Board as well. And the reason was that they thought that he was too dangerous to be in close proximity with anyone, that they thought he was likely to offend if he were to go into secure residential treatment but not if he's to be out in the community. So, you know, we are...they're pretty much saying no. So we tried to do an appeal. We wanted to do an appeal of that and I encouraged the regional center to do so. They were very helpful and said, okay, that's what we'll do. They tried that. The Magellan still said no. So they went to the region and guess who gets to decide if the region gets to pay, because our region did decide that this person was appropriate for secure residential and...but guess who gets to decide the region pays? [LR295]

SENATOR KRIST: Magellan. [LR295]

ELIZABETH LAY: Magellan. And they said no. And I will tell you that their reasoning was, even though we have a lifelong history of mental illness, they determined, a doctor, a doctor somewhere determined, their team determined, even though they'd never set eyes on this person and only done doctor-to-doctor or peer-to-peer types of consultations, they decided that his problems were not mental illness in nature, they were behavioral, and that they were concerned about his criminal history and they didn't think it was a mental problem. So basically, just in case you don't understand that reference, what Magellan just told me to do was to put him in jail. That's what they just said to do. They said, release him to the community, let him reoffend again, and then he needs to go to jail. So that story, and we're still dealing with that right now, we're still trying to figure that out, so that story would tell you exactly why you have so many people with mental illness in your jails and why, even though there are people out there trying to stop it from happening, we're trying to get these people help, we're trying to give them a chance to succeed, we can't. At every--at every--every corner there is just a roadblock. At every...down the path you just can't move forward. And I'm going to say that most people--most people--would probably just quit because it's too hard. You know, county attorneys' offices that are small in rural areas, they don't have the manpower to dedicate to this type of thing. They don't have the manpower to

both prosecute crimes and do mental health. They don't have the manpower. You have part-time county attorneys that don't have the manpower. They just don't have the resources to keep pushing and to keep fighting. It shouldn't be that hard for them to avail themselves to the resources they need to help their community members, but we're making it impossible. [LR295]

SENATOR SEILER: Senator Krist. [LR295]

SENATOR KRIST: If you've notice some senators smiling at each other around the table it's not because we think it's funny. It's because this is so familiar. This is Mr. Nikko Jenkins, who I'm sure you know the name, was too dangerous to put in GP, in general population, so we released him into the community. [LR295]

ELIZABETH LAY: Right. [LR295]

SENATOR KRIST: Isn't it amazing? That's amazing to me. It was staggering when I heard it. Thanks for your testimony. [LR295]

SENATOR SEILER: Senator Schumacher. [LR295]

SENATOR SCHUMACHER: One of the reasons committees like this are convened is to hear about the problem. And we're supposed to figure out if there's a problem and, if there is, what we can do to solve it. From your perspective, what tools--and do you have any guesstimate of the number of people that would have to be involved, facilities have to be involved, money that would have to be involved--would you like to have at your disposal to do what in your opinion would be properly address these issues? [LR295]

ELIZABETH LAY: Well, to a certain extent, yes, I can answer that question. If I was shooting just pie-in-the-sky dreams of what I would think our mental health or our behavioral health system would look like, I would say you have to start with prevention. You have to be in the community letting people know, if there is a problem, this is what you do, because if you are only reacting to crisis, if you're only always reacting to crisis, then all you're ever going to have is crisis; all you're ever going to have is chaos. You have to react. You have to be proactive and

act on things before they get to that point. And so, you know, dealing with the law enforcement officers that are the first responders, because that's who you have as your first responders, you have a law enforcement officer, so you try very hard to get as much training as they can possibly get in this type of activity. But let's be honest, our rural areas don't have the manpower to send people to week-long trainings on how to be a better assessor of a mental health situation. So they do the best that they can and they're the first responders and they have...you know, they're spending 16-18 hours with these people because throughout the entire process they're taking them to the hospital, they're taking them to a hospital, they have to be medically cleared, but then that hospital won't take them or they're taking them to detox. And by the time they get to detox and they're checked out, the detox center won't take them. And then they come back. And by the time they get back, the guy is sober and they just take him home because there was nothing else to do with him. So there is an absolute and definite lack of resources. So I would say the first thing we have to have is more prevention and more resources. And it would be nice if we had, you know, some sort of uniformed way or uniform system for our regions so that we have more of an idea of how something is going to work in another region because right now all of our regions have similar problems but not the same one and that's because they always...they all work differently because you've given them all this money but you really haven't put any strings attached to it or you really haven't told them this it the way we think it's best to utilize it. So, therefore, the prevention dollars, that varies from region to region. But I know in our region, I think the majority of it, if not all of it, is spent in alcohol education and tobacco education. None of it is spent in your community library doing depression screens. It should. It should be. We used to do that, you know, but that funding was pulled. And so now we don't have the ability to be in our community. And if those people aren't out in the community, then other people don't know where to go when they have a problem. And I can tell you that when I have a family member calling me about a situation because one of their children has been EPCed or someone has been EPCed, the first thing is, I'm so glad to talk to you because I knew something was wrong but I didn't know where to go--I didn't know where to go. And that is because our mental health system is so fragmented and you have so many people doing it so many different ways that there is no uniformity. And there is no way for a regular person who knows that their son is spending a lot of time in their room and he hasn't been acting like his regular self and you notice that there are more pills in his bottle than there should be but you can't really get him to do anything because he's 19 years old.. It would be great if that person knew that there was a center

somewhere, kind of a like a center for survivors or, you know, a domestic violence type center that accepts everyone and gives them a way to get out of their trigger place. It accepts them and gives them a place to get out of that situation where they're overwhelmed. It could be a place like that where you could have a place where people can go to get information so that if they know something is wrong they have a place to say, what can I do about it, because your first level of defense in this shouldn't be your law enforcement officers. It should be your moms and your dads and your neighbors. That's who it should be. Those are the people that we're talking about. And if you don't have prevention in place and you don't...and those people don't know where they're at or where to go or how to get that information, then all of a sudden you've lost that. You've lost their ability to help you regulate that crisis before it gets to the level where you have Nikko Jenkins or where you have a Von Maur shooting or where you have an Oregon shooting. I mean I can bet, I would be willing to bet any of you all of those parents knew something was wrong, that they were either too afraid of the stigma to say something about it or they don't know where to go. They feel lost themselves. How do we stop that? And stop that and I can guarantee that you'll see a long-term effect of the level of EPCs and the number of EPCs going down because people will know where to go. So have a center. Have a Keya House. Someone was here talking about the Keya House where it's a respite center where people can go and get out of their trigger system or their trigger...out of their trigger environment to just deescalate. And they do and it's a wonderful program. So why don't we have more of those? We certainly don't have any of those in rural Nebraska. And so, you know, to answer your question...and I apologize for being so wordy. But to answer your question, we have...the only thing that we can do to make this better is understand that mental health is a problem and stop trying to make it not one, stop trying to say, well, we've given it a little bit of money and this is what we're going to do with it, or we shut down the regional systems and we can't backtrack. Yes, you can. You don't have to reopen them up again and you don't have to stick people there and have them mistreated. That's not what I'm a proponent of. But you need to understand that from where you were there and where you are here, where's the middle ground? Why can't we utilize the community resources but give more space at the regional center? They're not mutually exclusive. They can operate together and that's what we need. We need a community who is working together to help treat this problem. It's not one you're going to solve because mental illness is chronic. It's a lifelong problem and the sooner we all realize that, the better off we'll be. So we need to work together. We need to open up more space at the regional center and we need to make sure that if our

private hospitals can't accept people, that there is a place for those people to go that's not jail. We don't have that cohesion and that's what we need. [LR295]

SENATOR SEILER: Senator Mello. [LR295]

SENATOR MELLO: Thank you, Chairman Seiler. And thank you, Elizabeth, for your testimony this morning. I have a little...kind of a series of questions possibly and it will kind of depend on a couple of answers you give, I think, at the beginning. Everyone we've heard from this morning has reiterated the point of needing more resources or more funding in the behavioral health system. Can you share with us a little bit on maybe your understanding in dealing with individuals who are coming through the county attorney's office in regards to their personal situation in regards to whether or not they have health insurance, their private health insurance that may be covering some of their services? Or are you seeing a number of people who just don't have health insurance and then we put them through some of the systems that you talked earlier about? [LR295]

ELIZABETH LAY: Most of the people that I see coming through in the mental health realm in our office are Medicaid. So most of the people that we see coming through are Medicaid patients. If they don't have Medicaid then, more often than not, they have veterans' benefits or no benefits at all. And so, you know, with that, you know, most of the people that we see are Medicaid, VA benefits, or no benefits at all. [LR295]

SENATOR MELLO: Give us a little bit, maybe a better understanding of what you mean by no benefits though. So they have no health insurance? [LR295]

ELIZABETH LAY: No health, none, no health insurance whatsoever, no... [LR295]

SENATOR MELLO: So they're coming to you... [LR295]

ELIZABETH LAY: ...unemployed, no health insurance, no way to pay for much of anything. [LR295]

SENATOR MELLO: And for that population that is not currently on Medicaid or is not eligible for their veteran benefits which could take them possibly to a veterans' hospital, essentially you're directing them. More than anything else they're going to either the...going through the regions and going through a provider that then the regions would pay for that care essentially? Is that kind of the process in regards to how things work? [LR295]

ELIZABETH LAY: Pretty much. You do have some instances where someone comes through our system with no benefits. But when they move into the system, the social workers and the support network there help them try to get those benefits, whatever they might qualify for. So it's not that they'll always remain without benefits. But at the moment that they're coming through my office they generally, you know, may not have those benefits or may have, you know, like I said, Medicaid. But once they're into the system, that support network is there to help them gain that while they're in the system. Of course, that support network drops off then once they get out and a lot of them lose it again. So sometimes I'll see people come through with no insurance. They'll get insurance and they'll keep that insurance while they're within the support network of that commitment. But as soon as I terminate the commitment and they come back through three months later, they have no benefits once again. And so it's a...it can be a cycle. [LR295]

SENATOR MELLO: Okay. All right. Thank you. [LR295]

SENATOR SEILER: Anything further? Okay. Senator Paul (Schumacher). [LR295]

SENATOR SCHUMACHER: Just one question. Part of the problem you described was the...you've got a problem case. It's beyond the prevention case. You've got somebody who is...who the police have brought in and you've got a real issue on your hands and the hospitals that are contracted with say, no, we can't take him, won't take him. How...what do we need to do to establish a place within reasonable distance, and what do you think is reasonable distance, for you to then put those people for immediate triage and then ultimately disperse to a proper treatment? Do we need a facility like that? What do you need to have a place to put these people besides jail? [LR295]

ELIZABETH LAY: Honestly, I feel as though...that the only way you're going to solve that problem is by opening up more beds in the regional center and dedicating a certain number of beds to those types of individuals because I can tell you from experience that it won't matter if you have a person in Scottsbluff. If they're a violent, mentally ill person that no hospital will take, those law enforcement officers will happily take them to Lincoln just to know that they have a place for those people to go or, in the alternative, Hastings, if you opened up a portion of the regional center to house those types of individuals that...I don't think that there's any way that you're going to be able to fix that problem except for that because to ask a private hospital to put their staff at risk and their licensing at risk is to a certain extent unreasonable. They have other things to think about other than their just mental health patients. They have other people that they treat. And when, you know, and when the board gets wind, the hospital board gets wind that the mental health is causing these problems, then they start saying, well, let's just close it down completely. And we don't want to lose those resources completely. So why not just take that monkey off their back, don't make them make that decision, and put them in the regional center where they can get the type of treatment that they need to stabilize? We can do...I am in Platte County. I'm in a rural community. And I can tell you that I'm certain that our officers would be willing to help us with the transport to get them back for commitment and then back to Lincoln again. I think as long as law enforcement knows that they're not going to show up on someone's doorstep and be turned away and then not know what to do with this individual or, worse, have to put them in jail even though they really don't want to, I think they're willing to go a little further to make sure that that person is safe and that their community is safe because, let's just face it, our number-one concern is keeping people alive and keeping our community safe from danger. And so I think that there...we're all willing to make those sacrifices. We just need the place to take them. And from my viewpoint sitting in the county attorney's office, the only way I see that you're going to solve that problem and not have anyone complain about it is make more room for these people in the regional center. It's there. You shut half of it down! Just make more room for them there. And you don't have to open up all of them again and you don't have to put people there who don't deserve to be there because that's not what we're trying to do. But we are trying to make sure that there's a safe place for these people to go. We want them to stay alive. We want them to come back out and be productive members of society and live a life and have a family. And we can't do that if the room isn't there to treat them. So just, like I said, there's no way,

there's no reason that we can't coexist. Open up more space. Give us more space for the treatment that we need. [LR295]

SENATOR SCHUMACHER: Thank you. [LR295]

SENATOR SEILER: I want to make sure she's not a paid advertisement for my architectural drawings that are already on the board, including for a 200-bed facility just like you're talking about. But I want to go back and ask you some questions about...I think you hinted at that your alternative, if you don't have a place to go with an EPC, is to charge them criminal to take them off the street because... [LR295]

ELIZABETH LAY: It's an option. [LR295]

SENATOR SEILER: ...isn't the law under EPC that you can't put them in a jail, they have to go to a Corrections-run...the state Corrections-run facility? [LR295]

ELIZABETH LAY: The law states that once a person is EPCed, or put/placed into emergency protective custody, they are to immediately to be taken from jail. They cannot be housed in a jail facility. They cannot be housed in a correctional facility. They must be only housed and taken to the nearest and appropriate and available medical facility. We all know that our jail is not a medical facility. The corrections office, D&E, is not a medical facility and, therefore, once we place someone into emergency protective custody they absolutely cannot...can no longer be held in our jail. They cannot be taken to jail. So then we get into a song and dance of sorts because we have a person who has committed a crime but we also know that that crime was most likely committed due to mental illness. And you want...the law enforcement officers want to do the right thing and they want to get that person help. But if they're assaultive in any way, whether verbally or physically, you do not have a private hospital that will take them, and the only other thing is to charge them with a crime because how do you keep them alive? Now that's our bottom line is, how do we keep them alive to get the treatment that they need? How do we keep their family members alive? How do we make sure that our community is safe? And how do we make sure that they are safe from themselves? We have to make sure that they're watched 24 hours a

day. We have to make sure that they're in an appropriate environment. And jail is absolutely inappropriate, but it's less appropriate than telling them good luck. [LR295]

SENATOR SEILER: And after about two or three times through the system they start getting longer sentences by the judge... [LR295]

ELIZABETH LAY: They do and, you know,...they do. [LR295]

SENATOR SEILER: ...and they fill up our penitentiaries. [LR295]

ELIZABETH LAY: They do. [LR295]

SENATOR SEILER: And we get overcrowded. [LR295]

ELIZABETH LAY: They do because if you have, you know, if you have a county attorney's office that doesn't have the resources to dedicate to mental health, then what you end up with is a default to criminal because that's what we do. We prosecute criminals. That's what our office is intended to do. And if you make it too hard, if the system is too hard to break through or let's say you get to the end of the line and they say, we're not paying for it, we're not doing anything, there's nothing else we can do, well, what are we supposed to do? We have to still somehow keep them safe and we still have to somehow keep our communities safe and they still have to answer for their crimes to a certain extent. And so you end up with a person getting no mental health help in our jail. They get out with no treatment. They come back and they get picked up for something the same or more serious and they get more time. And then, three, four, five times down the road, they're in your penitentiary and they have no mental health help. And they probably have no hope of recovering because you've waited too long to give them the help that they need because we all know that the experts will testify that the longer you go without mental health treatment the less likely it is that your brain will recover full capacity. [LR295]

SENATOR SEILER: I want to thank you for your testimony today. Any other questions? Thank you very much. [LR295]

ELIZABETH LAY: Thank you for listening. [LR295]

SENATOR SEILER: Beth Baxter from--the regional administrator--Region 3. [LR295]

BETH BAXTER: Well, good morning. [LR295]

SENATOR SEILER: Good morning. [LR295]

BETH BAXTER: (Exhibit 6) Good morning, Chairman Seiler and members of the Judiciary Committee. My name is Beth Baxter, spelled B-e-t-h, last name B-a-x-t-e-r, and I serve as the administrator for Region 3 Behavioral Health Services, which is a rural behavioral health region in Nebraska. And I'm here on behalf of the Nebraska Association of Behavioral Health Administrators who is...consists of all six of the administrators across the state. In preparing to testify today I provided you with information as how each of our regions respond to the population that we've been discussing this morning. I'd like to help put this into perspective by sharing that in 2014 the Nebraska behavioral health system served a total of 31,861 persons of which 10,681, or a little over 33 percent, were involved in the justice system. Of the justice system involved individuals, 438 were under the age of 18 and 10,243 were 18 years and older. First of all, I'd like to just begin by sharing some information regarding juvenile behavioral health. I'd like to address the area of crime prevention and share about a program that's been around since 1995 that serves children who have significant behavioral health needs and their families. These professional partner programs serve children from a very young age through adulthood. They have significant mental health issues and the program works to keep them out of the juvenile justice system, the child welfare system. And the vast majority of these youth and young adults remain in their home, their school, and their community with little or no encounters with law enforcement and the courts. Youth who are involved in probation are served in the professional partner program with considerable success in preventing further penetration into the systems. Regions 5 and 6 have implemented specialized justice wraparound programs in Douglas, Sarpy, and Lancaster Counties. Beginning next month, Regions 5 and 6 will be screening youth in probation who have been determined to have a behavioral health need and will be referred to independent evaluator associations and in order to increase timely access to evaluations and provide consistent recommendations for their care. When addressing youth

behavioral health needs, as Senator Bolz mentioned earlier, it really is important to take a system-of-care approach. Children come into the system not with just one issue. They often have conflicts at home, conflicts in the community. They may be failing school. Their families may not know where to turn to so they seek out the child welfare system to address these issues or the child may be simply being served by their primary care physician in an effort to address their behavioral health needs. Across the region...across the state, the regions have been working with law enforcement, probation, schools, county attorneys, and behavioral health providers in an effort to reduce the number of youth who are going to detention centers. Often these youth present in crisis and to address this the regions have expanded their crisis response programs to serve juveniles. I'd now like to talk just a little bit about the adult system. I think information has been cited, statistics about the vast majority of individuals who are in jail at the local level who have behavioral health issues. A report in the early 2000 put that estimate at 64 percent. I bet that percentage has increased over the years. This is a significant and staggering issue and it must be addressed at the local level. In several areas across the state providers have...provide services directly to inmates while they're in jail. This is done through jail diversion programs, psychotherapy, medication management, and peer support services. Case management and system coordination efforts also help to transition that individual out into the community. Regions have worked to improve access to medication and medication management. However, the shortage of psychiatric prescribers across Nebraska contributes to wait lists and delays in access to medication. Another barrier is the cost of medications whereby people can't afford to purchase their medications. Additionally, I've personally had providers and consumers alike tell me of instances where Magellan or other third-party payers will not authorize the use of a prescribed drug until a lower level, less expensive drug is tried first. We often call that failing up. Telehealh is used to improve medication management and has been expanded across the state. I'd like to address and share with you some of the areas that we believe can provide some short-term fixes, as well as long-term fixes to the system. It's been identified before that we need really a three-legged system response that should include prevention, supervision, and treatment options. We believe that improved communication between the regions and the correctional system can improve that transition into the community. Second, we believe that there are...we certainly have to identify ways that people again get access to the most effective drugs that are available to them. We need to expand training on mental health and psychological trauma into the larger correctional system. A longer-term fix would be that: to utilize the intercept model or some other

type of evidence-proven model for comprehensive planning and system enhancements. We need prompt access to treatment, opportunities for diversion, timely movement through the criminal justice system, and linkage to community resources. I see that my time is up and I would be happy to answer any questions. [LR295]

SENATOR SEILER: Senator Krist. [LR295]

SENATOR KRIST: Nice to see you again, Beth. [LR295]

BETH BAXTER: Thank you. [LR295]

SENATOR KRIST: We've had several discussions about the failing up process. So you make the point about the declination of services or of drugs because of Magellan, and I would invite the regions as well to become involved with the RFP process for the managed care across the state. Is there anybody here from Magellan? Imagine that. I would invite you as well as regions to become involved with that because so many times we hear...and I see Senator Campbell is in the audience too. So many times we hear that medical necessity stands in the way and/or other providers stand in the way. You've heard, you know, Elizabeth's testimony. So please, please, get involved with that RFP process. Who better than the regions to understand how the declination of services and/or drugs is affecting the individual? Thanks for coming. [LR295]

SENATOR SEILER: Senator Mello. [LR295]

SENATOR MELLO: Thank you, Chairman Seiler, and thank you, Beth, for your testimony and for some of the recommendations. I assumed when I saw your...I asked if there was...who else was testifying and I saw someone from the regions. I would expect that we would talk a little bit about funding. And as you've heard from some of the other testifiers this morning, the discussion about the need for more resources within the behavioral health system is fairly apparent from everyone who has testified. And the question you heard me ask the deputy county attorney from Platte County I was...wanted to save a little bit of it for you in the sense of giving us as a select investigative committee that encompasses Judiciary Committee as well, a little bit more background in regards to who is paying right now for a lot of our behavioral health services in

the state. I think in the sense of realizing, hearing from her, and you can probably share a little bit more maybe background understanding in regards to what...the clientele that currently is coming through our criminal justice system, whether through the counties and/or through the state. Are those individuals coming in with private insurance and essentially their private insurance is denying these behavioral mental health services? Are they coming in, as we heard? Are they current Medicaid recipients, those who may be aged, blind, and disabled or a mother with a child or the individual is coming in with no health insurance, which then leaves us to figure out how we're going to pay for their healthcare moving forward? [LR295]

BETH BAXTER: Well, often people who come into the public behavioral health system really have very limited or little benefits. They're uninsured often; they are underinsured. Probably the percentage of individuals with...and that the regions serve is probably an estimate of 60 to 75 percent of those individuals have an income of probably $20,000 or less. One of the challenges that face the individuals that we serve--I mean even with the expansion of the Affordable Care Act--is that they really...their income is so low. They're too poor to qualify for benefits and those entitlements that would assist them in providing insurance. So the folks that we see really do not have another type of payer source. [LR295]

SENATOR MELLO: So that...just so I can understand it and kind of walk through a scenario here, so a large portion of the people who are going...Nebraskans who are going through our public health system, which, by the way, is almost 100 percent funded with General Funds, if I'm not mistaken, through behavioral health aid, so give or take the $75 million we put into the public behavioral health system is mostly...is all General Funds. Seventy percent, let's just take that number, are individuals coming into that system with no health insurance. If the state was able to develop some kind of way to be able to provide some kind of health insurance of that population, what would that do to the behavioral health system as we know it in regards to being able to provide some kind of other financing or payment mechanism in regards to covering their mental health and behavioral health needs. What would that do to the system as we know it right now? [LR295]

BETH BAXTER: Well, I think it would absolutely shore up the system in terms of we rely on networks of behavioral health providers, and those providers are small organizations and some

are larger organizations. So when they have the opportunity to have maybe multiple areas/ sources of revenue, that only shores up their ability to be viable and continue to serve people in the public and the private system. [LR295]

SENATOR MELLO: Okay. So the takeaway as much as anything else--and I know we're talking about individuals who are coming through a county jail, as we heard, possibly a regional center, state correctional facility--if there's a way for us in theory to find a way or a payment mechanism or financing mechanism through some kind of health insurance concept or program, that in theory could help shore up our entire behavioral health system outside of the population that we're talking specifically today that falls in that category but...or those individuals going through our criminal justice system. [LR295]

BETH BAXTER: Absolutely. [LR295]

SENATOR MELLO: Okay. Thank you. [LR295]

SENATOR SEILER: Any further questions? Senator Bolz. [LR295]

SENATOR BOLZ: Thank you. Two questions, one kind of building on what Senator Mello was talking about, we have multiple funding streams, probably a complex network of funding streams that serve the whole population of individuals with mental and behavioral health needs. One of the things that I'm hearing you say pretty clearly is that a more comprehensive approach to systems planning could really add value in terms of rebalancing our systems to make sure that the most cost-effective services are the ones that we're investing in when- and however possible. Is that fair to say? [LR295]

BETH BAXTER: Yes. [LR295]

SENATOR BOLZ: Is that the heart of your point? [LR295]

BETH BAXTER: Um-hum. [LR295]

SENATOR BOLZ: Okay. I just wanted to kind of reiterate it because I think we need creative solutions and one of the solutions is thinking about how we use the dollars that we already have more effective. [LR295]

BETH BAXTER: And if you think about individuals who are in the justice system, I mean they come into that system from various angles, from various sources. And so if we look at a model that can intercept them at wherever they are coming in, whether that's the community level, we can prevent that as the deputy county attorney shared with us. We can identify some of those issues in school. We can identify them in the community. Our law enforcement officers can identify those early. So if we can intercept that individual early in that process, we're going to prevent a lot of additional behaviors. If the person is in the system then we need to ensure that they have treatment, that we can intercept those behavioral health needs that they have at the time that they're incarcerated and serving out a sentence for some criminal behavior. And then we intercept that person when they're on their way out of the criminal justice system by ensuring that they're linked to their community, that their community is ready to serve them, and that their family and their support system is there and shored up as well. [LR295]

SENATOR BOLZ: And I'm not putting words in your mouth. This is a comment from me. But I think one of the challenges or one of the places that we need to think through our strategies is the regional approach to mental and behavioral health, that local flexibility really adds value and really allows you to respond to the needs in your own communities. At the same time, my commentary is that there may be additional work for us to do on the state level to have a more strategic investment in the goals that we want to see come out of mental and behavioral health funding. One final thing, I just thought it would be helpful and useful to have you, if you would, elaborate on your point about individuals no longer meeting clinical criteria who still have court-ordered treatment. Could you just speak a little bit more about what the needs and challenges you see in that area are. [LR295]

BETH BAXTER: And I think it's been talked about and there's been some pretty significant and graphic examples shared today. But an individual may be court ordered into a treatment program when they don't meet the clinical criteria to be there. They may be under a mental health board commitment and they may attend and participate in that treatment program and then, at some

point, considered that they're ready for release into the community or were going...they fulfilled the terms of that commitment. The individual then may still need some kind of support within the community. If that legal hold hasn't been dropped then there's still a responsibility that we have at either the regional level, you know, in partnership with counties to ensure that that person has access to treatment. But it does create some challenges in ensuring that that person does fulfill that commitment order or they do fulfill those terms within treatment. And when Magellan or some other entity says, no, you no longer meet criteria, that's when the community has to be pretty creative in problem solving in how to meet those needs. [LR295]

SENATOR BOLZ: Thank you. Thank you, Beth. [LR295]

SENATOR SEILER: Senator Krist. [LR295]

SENATOR KRIST: Just one follow up and this is just for the record. On our fiduciary responsibility on that side of the equation, when you contract with the private hospitals is there a retainer involved or is it a pay-as-you-go basis? [LR295]

BETH BAXTER: For us, it's a pay as you go. We pay a fee-for-service mechanism. We do also...individually we have supported the hospitals when they have taken individuals who have a history of aggression and violence. When they've taken individuals from the jail who have been EPCed from the jail, we will provide financial support to provide one-on-one supervision or to bring, you know, a Corrections officer into the facility. So we can utilize some flexibility to support that individual and ensure that the staff are safe. [LR295]

SENATOR KRIST: And then we've heard several times that it is the federal regulation and licensure for the hospitals that's creating a roadblock for them to take people within the facility. Is that true, is that 100 percent? Is there any workaround there, or can we approach that as a potential problem to be solved? [LR295]

BETH BAXTER: You know, I have not experienced that with the hospitals that we contract with. I mean, you know, we live in those communities, so we work with them every day. We have staff who...for example, with Richard Young Behavioral Health Center in Kearney we have a staff

member who goes to that hospital on a daily basis to meet with consumers who are in crisis and working to get them back out into the community. We sit down with the hospital to problem solve. And as I said, there are times when we can provide kind of flexible resources to bring in additional security. But you know, it's true that we do have people with behavioral health needs who place people at risk. And we've experienced in our hospital staff being hurt. And that's extremely unfortunate. So we really try to figure out how we can supervise and support that hospital in doing it. [LR295]

SENATOR KRIST: I'm not suggesting that we need to bring together all of the functions in the regions. But is this in particular a function that the state could help in terms of a standardization of potentially providing security in those places. I mean is this something that needs to stay regional, or can the state help in terms of providing a secure environment within the facility? [LR295]

BETH BAXTER: Well, it's a local problem. [LR295]

SENATOR KRIST: Okay. [LR295]

BETH BAXTER: I mean it truly is. I think how the state supports and addresses those kinds of issues is allowing the regions to have some flexibility and to be creative with funding to...you know, for those in...I think we all understand that there are individuals who complicate the system. There are individuals that, you know, I scratch my head about in terms of how are we going to serve. Yesterday I had a call from a county...one of our board members, a county commissioner. They were concerned about an individual that we had problem solved about previously who has behavioral health issues but who is violent, who has hurt their parents physically. And that's where the individual is getting ready to be released. So obviously there's concern about what are we going to do to ensure that person has their behavioral health needs and ensure that the community is safe. So we are challenged by individuals who have extreme needs within our system. [LR295]

SENATOR KRIST: Are you saying that we are hampering your ability to be flexible and think outside the box in some way? [LR295]

BETH BAXTER: Sometimes. [LR295]

SENATOR KRIST: That's something we probably should know. Thank you. [LR295]

SENATOR SEILER: Senator Schumacher. [LR295]

SENATOR SCHUMACHER: Thank you, Senator Seiler, and thank you for your testimony. I guess I'm a little confused on the issue of when...particularly in rural areas, this may not be the case in Omaha and Lincoln but it should be if it's the case in rural areas. The present mental health system, taking somebody to a hospital that they've contracted with. And they don't really have any alternative but to contract with hospitals because they don't have any facilities of their own. And then the hospital is saying, look, we can't accept that person because our license isn't of sufficient scope to deal forcibly with a person to restrain somebody, to do this so, gosh, sorry about that. Take us...take them someplace else. And supposedly that's due to some licensing which supposedly is somehow related to somebody's regulation and the only somebody it could be would be the federal government or the state government. So what...and you indicated that it's a local problem. So I guess I'm not clear on what do we have to do to address the issue if we have a facility out there who could conceivably handle the situation saying, hey, you know, the regulation is not permitting us. If that's a state regulation, what is it? Which one do we need to address? If it's a federal one, is there some waiver program, some appeal process, some special license that you can get because you're in a rural area, something, because that doesn't sound, that turning them away and letting the hospital out a contractual obligation doesn't sound reasonable. [LR295]

BETH BAXTER: You know, I don't know honestly the specific issues and situations. I'm not familiar with the regulations that would prohibit a hospital from taking individuals who are violent. I'm certainly going to check into that and make sure that we have an ability to support hospitals who feel that way. I think any time that we can take a look at regulations it's helpful to do so. It's helpful to look at how regulations may...how federal and state regulations make it more difficult for providers to provide services. Some hospitals may interpret things differently. I just really...I have not experienced that issue with the hospitals that we contract with. Now there are times when we get an individual who is under protective custody in one of our local hospitals

and they cry for help. They ask us to intervene and this individual is too violent to serve. And we've been able to utilize the beds that are allocated to us at the Lincoln Regional Center to get that person there. We do that very carefully. We consider that because we have nine beds at the Lincoln Regional Center. That's the amount that we have access to. So we want to make sure that we're utilizing those beds for the individuals who need that level of care and can benefit from it. [LR295]

SENATOR SEILER: And...excuse me, go ahead. [LR295]

SENATOR SCHUMACHER: Just one follow up on that, hearing about the Lincoln Regional Center, that apparently is a principal facility of last resort outside of the criminal system? [LR295]

BETH BAXTER: It is for Region III. [LR295]

SENATOR SCHUMACHER: Okay. [LR295]

BETH BAXTER: That's the way we... [LR295]

SENATOR SCHUMACHER: And we've heard about beds in the regions. How many beds are there; how are they allocated; how does somebody in Scottsbluff get a bed; what happens when their beds are full? I mean what's the process? I've heard stories that there's...at midnight, county attorneys are calling back and forth trying to barter for beds with another county. How does that work? [LR295]

BETH BAXTER: Well, I can address the 90 beds that are the general mental health population. And those are the beds that the regions are allowed to utilize for, you know, spatial circumstances and individuals that need them. Those beds basically are allocated based on our population. And Region V utilizes the Lincoln Regional Center as their acute psychiatric hospital because they don't have access to those types of resources through a community-based hospital. But basically those 90 beds are apportioned out based on the region's population. Now we have nine beds that are allocated to us. We generally have six of those beds that are full. So we have

beds that another region can utilize. And the regions work together very closely with the Division of Behavioral Health in managing those beds and helping other regions get access to them. So I imagine there's some bartering going on at times. [LR295]

SENATOR SCHUMACHER: But should that bartering be occurring at midnight? I mean do we have a problem there? I mean if there's beds available, somehow there should be a mechanism for plugging into them without trying to figure out whether you've got somebody who's picked up off the street by the police and needing to be parked someplace because the local hospital says no can do because of regulation, which may or not be there. [LR295]

BETH BAXTER: I think it's unfortunate when that bartering happens at midnight. [LR295]

SENATOR SCHUMACHER: How would you...if it's crisis bartering that is driving this, why isn't there a mechanism to avoid that? [LR295]

BETH BAXTER: How we would handle that in Region III, and we've experienced that, our emergency system specialist, her role is to help coordinate the emergency psych system within the 22 counties of our region. She has a cell phone that she is available 24/7. And so...you know, most of our county attorneys are familiar with her. They know her. They trust her. And they will call her at midnight if they're experiencing some issues where she can help problem solve that area and try to get access and open up access either at a local facility or at the Regional Center. [LR295]

SENATOR SCHUMACHER: I guess this may be a dumb question, but one of the things about term limits is you don't know the reasons for things. Why do we even have regions? Why don't we have a centrally administered operation? [LR295]

BETH BAXTER: Well, I believe we have regions with the intent to decentralize operations to get services, behavioral health services out closer to where people live. I see the regions as a mechanism, too, for counties and the state to partner, for the counties to leverage resources, provide human resources but also leverage financial resources to take care of people who live in communities. Behavioral health issues, like many issues, are local. And it takes a local response

to address those. It takes a local response to support the work force, to know the people who are in the community, and to respond to providers and the challenges that they have. So I think the very nature of the behavioral health regions is to decentralize the provision of behavioral health care. [LR295]

SENATOR SCHUMACHER: But then isn't control of the regions centered into DHHS, one of the offices down there? I mean isn't that the ultimate authority as the regions have evolved, from like 1990 when they were converted from kind of local entities to state entities? I mean who is the official in charge? [LR295]

BETH BAXTER: We, the regions, contract with the Division of Behavioral Health. And the Division of Behavioral Health is one of the divisions within the Department of Health and Human Services. The Division of Behavioral Health is the state authority on behavioral health. They work with the regions, and as I say, we have a contractual relationship with the Division of Behavioral Health. The Nebraska Behavioral Health Services Act identifies how the system works. It identifies that counties have responsibility; county commissioners, elected officials make up the governing boards of the six behavioral health regions. But we do contract with the Department of Health and Human Services. [LR295]

SENATOR SCHUMACHER: I've had one county board member tell me that there's more discussions at this--at least in one region--of gravel prices than there is of mental health issues at the regional board meeting and that...if these county board members have no mental health experience, are supposed to run these shows and somehow that's all under the supervision of the head of Division of Mental Health, it doesn't seem like it could work very well. [LR295]

BETH BAXTER: You know, I think it's similar to the Legislature. You have responsibilities around a variety of issues. We have a Health and Human Services Committee who has responsibility for health issues, for behavioral health issues. They may not be experts. You may not be experts on a particular issue or subject, but you have access to people who are experts. That is the way I see the regional governing boards operate. They have the statutory responsibility for behavioral health services to people who meet criteria, but they have staff who are experts at carrying that out. [LR295]

SENATOR SCHUMACHER: How is the amount of money that a county contributes to this determined? I mean is this...is it apportioned by the board of this organization or is it just free-will offerings or how is it done? [LR295]

BETH BAXTER: Well, we don't pass the hat, no. There's statutory language that identifies how that county matches. And basically it comes down to, for every $7.50 of state general funds, the counties contribute $1. Now there are dollars when we did go through behavioral health reform. And there was $30 million that came out of the regional centers to community-based services. We did, the counties did get exempt of matching those dollars. But any new state general funds, the counties are under that match obligation. [LR295]

SENATOR SCHUMACHER: Thank you. [LR295]

SENATOR SEILER: Any further questions? Thank you very much for your testimony. [LR295]

BETH BAXTER: Thank you. [LR295]

SENATOR SEILER: Marshall Lux, the Ombudsman for the state of Nebraska. [LR295]

MARSHALL LUX: (Exhibit 7) My name is Marshall Lux, M-a-r-s-h-a-l-l, last name Lux, L-u-x. I am the Ombudsman for the state of Nebraska and I wanted to take just a few moments today to speak to the committee about three big words that kind of summarize what you've been hearing here this morning. And the three big words are deinstitutionalization, reinstitutionalization, and transinstitutionalization. And of course you're all familiar with the deinstitutionalization part. That goes back to 2004 and LB1083, which closed many beds in our regional centers and moved mental health to the communities and to private providers. I'm not here to pass judgment on LB1083 today, but it is the starting point for what I want to really talk about, which is the other two big words. Reinstitutionalization is something I'm sure you're all familiar with already. By deinstitutionalizing our mental health population, what we have done as a consequence is reinstitutionalized many of them in our prisons and our jails. It is estimated nationally that about 15 percent of the people in our prisons and our jails have a serious mental illness. So this makes the Nebraska Department of Corrections the place where the majority of our mentally ill,

seriously mentally ill are institutionalized. And their only competitor for that title would probably be the Douglas County Jail. So one thing that we have to be concerned about and that you should be concerned about as the Legislature is what's going on in those facilities, especially the state facilities and whether they are adequately meeting the needs of the mentally ill who are incarcerated there. In the past I would have told you that the mentally ill in our state's prisons are going largely untreated, but that's changed in the last five years with the opening of a dedicated mental health unit at Lincoln Correctional Center. However, there is...I think it is right to ask whether the Department of Corrections is truly meeting the needs of all of its seriously mentally ill inmates or whether the department needs more in the way of resources to help these troubled people. And I suspect that the answer is that they do need more resources. That's reinstitutionalization. I think you're all familiar with that. The other big word is transinstitutionalization and we've heard quite a bit about that this morning in the testimony before myself. I strongly believe that the state's mental health system needs to do a better job in terms of providing mental health treatment to the most chronically mentally ill individuals in our environment, some of whom are potentially very dangerous; and in most cases, or at least many, these are adolescents. There are some in our state who are seriously mentally ill and also seriously dangerous but who simply have no place to go insofar as Nebraska's community-based providers are concerned. And you've heard about that phenomenon today as well. These are the most difficult cases and few private providers are willing to take these cases on. And so the actual result of the deinstitutionalization movement in these cases has been to transinstitutionalize these people, move them from place to place to different programs where they don't get the treatment that they need. About a month ago I sent a memo and I had it distributed to you about the case of Cody Riddle, a young man here in Lincoln who was arrested and charged with the rape of an 8-year-old girl. His case is a case of transinstitutionalization. If you read the news report that's in that memo you'll find that this young man was made a state ward in 2009, he then was sent to the Boys and Girls Home in South Sioux City, returned to his parents, sent to the Lancaster County Youth Detention Center, went to YRTC, then went to Epworth Village in York, and finally back to YRTC where he timed out of the system. The news story relates how Cody's father wrote a letter to Cody's probation officer at one point pleading for help. He said that his son was a ticking time bomb and that he had threatened physical harm to his parents and that both parents were afraid. Quote, I fear for the safety of my family and of society, that he could cause harm to all, the father said; I love my son so much and feel that I am

abandoning him, but he needs professional help that I am unable to provide. And of course the truth is that Cody Riddle never got that help. That's transinstitutionalization. It means that the system isn't meeting some of its most important needs on its most important cases. And I would like to see something done about that. And I think that the answer is to pick up on a word that...a term that Senator Schumacher used; we need to have a placement of last resort for these people. And that's going to have to be the state and it's going to have to be probably beds in our Regional Center, of which we do not have enough. [LR295]

SENATOR SEILER: Senator Williams. [LR295]

SENATOR WILLIAMS: Thank you. Marshall, in Senator Bolz's introduction, she talked about four different points and I'd like to focus on the first and the last one that she talked about. The first one was the basic question and it's not at the end, where do we go with the last resort? But where do we go on the front end? How do we avoid incarceration with these mental health situations to start with? And then her last point was exploring diversion programs and others which may be a source of avoiding incarceration to start with. What comments or thoughts would you have on ways that we could structure a system that helped avoid incarceration of mentally ill people to start with? [LR295]

MARSHALL LUX: That’s the big question. That’s the question I'm bringing... [LR295]

SENATOR WILLIAMS: That's why I asked. [LR295]

MARSHALL LUX: ...I'm bringing to you. And what you will find...young Cody Riddle's is hardly unique. What you're going to find is that we have these difficult cases--Nikko Jenkins was one of them--where we can identify fairly early in their life these deeply troubled adolescent young people. But what the system doesn't do is have anything for them when what we're talking about is the system that is community based and provided by private providers. It's understandable but when you bring these individuals to these programs, they quickly decide that this is not a person that they can serve--just too troubled, too much potential for violence. And so they're handed back to the state and the state then has to find someplace else for them. And this case of Cody Riddle is a pretty good example of all of the difference places that...where these

kids bounce around from program to program. I'm afraid that unless we come up with some other way of doing...of providing the services in the community that we're just not going to solve the program through privatization and community-based services. So I think that the right answer is that we need that placement of last resort. And I think that that needs to be the state in some way. Now please recall that we had at one point in time an adolescent unit out at the Lincoln Regional Center. It was closed six or seven years ago, something like that. If you talk to people who were around that program, you will hear some negative things about it and how it was run. I don't challenge that, but it seems to me that when you have a program that has problems that you can usually fix those problems by changing leadership and by probably adequately resourcing it. So one of the things that I would suggest looking at is reestablishing an adolescent unit at the Regional Center to undo what was done all those years back. [LR295]

SENATOR WILLIAMS: Again, it seems like we're focusing and it certainly needs focus on the last resort kind of thing, and again I'm interested in probing into the front end of this with cases that may not be a last resort. But right now I think your number was 15 percent of the people in the Corrections system have mental health issues. Earlier in a testifier that number was 40 percent. So it's a number... [LR295]

MARSHALL LUX: It jumps. [LR295]

SENATOR WILLIAMS: ...and I don't care what the number is. [LR295]

MARSHALL LUX: Right. [LR295]

SENATOR WILLIAMS: But is there a way...we've had what appears to be great success with the drug court concept in our state. And under current legislation, I think it's available that the Supreme Court could make a decision to expand problem-solving courts to other areas than just drug court. What would be your thoughts of the success that we might expect if we were into a system where we had mental health courts along with drug courts? [LR295]

MARSHALL LUX: I like the idea of mental health courts. I think that that is a direction that the state should move into. There will be problems. Some of these same problems will emerge

because you have to have a program for the patient. And that's what I'm seeing doesn't exist. But I certainly think that that is a very good approach and I would encourage the Legislature to facilitate that if it's possible. [LR295]

SENATOR WILLIAMS: And the final question, back to Senator Bolz's fourth point about diversion programs, do you have an opinion on diversion programs as they're used in mental health? I know that's part of what drug court does, in a sense, is a diversion program. [LR295]

MARSHALL LUX: I could pretend that I do, Senator, but I don't. [LR295]

SENATOR WILLIAMS: Okay. [LR295]

MARSHALL LUX: It's not my area. I'm interested in state government and state agencies. And those kinds of things are beyond my level of expertise. [LR295]

SENATOR WILLIAMS: Thank you. [LR295]

SENATOR SEILER: Senator Krist. [LR295]

SENATOR KRIST: Marshall, thanks for coming. We have had many conversations on preventative medicine and the final resort. And I don't know that you can separate the two in terms of concept when you have a child manifest the kind of behavior that we saw in several cases and we don't take action and we allow that to happen over a period of time. We've witnessed what does happen. So intervention, prevention, what I'm concerned about is your last point which is we continue to shuffle people around and hide the fact that we cannot do anything for them in reality. [LR295]

MARSHALL LUX: Right. [LR295]

SENATOR KRIST: So it would seem to me that a concept I discussed earlier, I don't know if you were here, when you leave the courtroom and are assigned to either an evaluation or sentenced to some kind of treatment program, we have to close the loop. You have to come back I think to

that jurisdiction and say I've either completed or I haven't completed. So there's a lot of things that we have done within the Judiciary, our committee, and the judges have done in terms of trying to make sure that the loop is closed, and we'll probably do more. But the reality is that a judge, a defense attorney, and a prosecutor have to have an alternative to keeping someone confined in a jail. I mean during the privatization botched effort when we were all over the state looking at it, I was looking at it, I was looking at a 7- or 10-year-old I think, 10-year-old in a full-size orange jumpsuit incarcerated in a Scottsbluff jail because there was no place else to put them. [LR295]

MARSHALL LUX: That's right. [LR295]

SENATOR KRIST: So give me a sense, I guess, give us a sense, we don't want to go back to where we were. I don't think that's the place we want to be in terms of institutionalization. But give us a sense in terms of overall. How many beds do we need to reinstate at the Regional Center...regional centers or how much brick and mortar is out there that can be used at this point where we can solve the problem of the capacity, because we know we have a problem with the number of psychiatrists in the state and we're dealing with that on a different level. We know we have injected psychiatry as a science and a medical science into the Department of Corrections with the changes that we've made. So I think we're moving down that track, but we have to have the capacity to bring these people back. Can you talk to that for a minute? [LR295]

MARSHALL LUX: I can talk a little bit about it. I don't...I can't tell you how many...I can't answer the "how many beds do we need" question. What I can tell you...and again we're talking now about people who have not been convicted of a crime. So these are just the civil cases. I can tell you that it's my understanding that we have 85 beds at the Lincoln Regional Center that are dedicated to the treatment of sex offenders. [LR295]

SENATOR KRIST: You said 85? [LR295]

MARSHALL LUX: 85. [LR295]

SENATOR KRIST: Okay. [LR295]

MARSHALL LUX: And it's my understanding--this is something that I've heard and it probably deserves checking--but it's my understanding that there is capacity for more people to be moved to the Norfolk Regional Center, which as you know is dedicated to the treatment of sex offenders. So what you could do, as an example, is take, for instance, 50 of the sex offenders from the Lincoln Regional Center and move them to Norfolk where there would have to be money spent for staffing and so forth and then open up space at the Lincoln Regional Center for whatever needs there might be for the cases that we're talking about. I'm not positive that that's the case, but this is my understanding. [LR295]

SENATOR KRIST: Well, if there's a surplus of beds in one space and a need for a reallocation and prioritization of beds at another place, that makes an infinite amount of sense. I will say though on the record that I've looked into the Norfolk and the Lincoln centers in terms of sex offenders because of a constituent issue that I've had. And I think there's a lot of room there for us to look at our sex offender therapies and treatment and what's going on because... [LR295]

MARSHALL LUX: Yes, it's... [LR295]

SENATOR KRIST: ...they're so different that before I throw somebody from Lincoln, which is I'm hearing or I know, unsubstantiated, is a much better program than the undocumented scientific thing that's going on in Norfolk. So that's another issue all by itself. [LR295]

MARSHALL LUX: Right. It is, yes. [LR295]

SENATOR KRIST: But reallocating the beds and prioritizing, reprioritizing where they are is an excellent suggestion. [LR295]

MARSHALL LUX: Right. And I again...and this has come out from other testimony as well, the thing we need to remember about, especially these early cases, these young cases, this sort of...the Cody Riddle kind of phenomena, the thing we have to remember is, and you've been told this already, the default is to simply not provide real treatment to these people and simply wait for them to commit a crime. And then when they commit a crime, we send them into our correctional system where I...frankly, they have a fairly good chance of getting access to some

mental health treatment. And that's just the way the system is working now in these cases. And of course, the problem with that is that there is a victim when a crime is committed. That doesn't seem like...that does not seem to me like the way we want the system to work. [LR295]

SENATOR KRIST: No, and on that point, this is a whole different subject but it's the same philosophical move. Let's just take the kid out of the home and make him a foster kid because we can use this money to take care of him. My god, I mean that's how we got so many foster kids. And we blamed it on a lot of things, but in reality it was money. Let's just take them out of the home. Thanks, Marshall. Thanks for what you do. [LR295]

MARSHALL LUX: You're welcome. [LR295]

SENATOR SEILER: Any further questions? I just have one. As I look at this program, it looks to me like we have an opportunity from the testimony to jump in ahead of the program before we get to criminal law and work with the EPCs and then getting them stabilized, getting them back to community under supervision into community resources. That would relieve a lot of the mental health people that we're seeing in our prisons. [LR295]

MARSHALL LUX: Yes, it would. [LR295]

SENATOR SEILER: It would help...would you agree with that philosophy? [LR295]

MARSHALL LUX: I would absolutely agree with that, yes. [LR295]

SENATOR SEILER: Thank you. I have nothing further. [LR295]

MARSHALL LUX: Thank you. [LR295]

SENATOR SEILER: (Exhibits 1, 2, and 8) Okay, at this time I would introduce the testimony of Thomas K. Casady, director of public safety for the city of Lincoln; and also for Rodney Schindler who is an inmate at CCC-L. And those letters will be accepted into the testimony, also all the written material presented. Is Shannon Engler or a representative of that person here? I

didn't see any written testimony from that particular person. It's coming? Okay. We'll include that in the written testimony. Okay, we have testimony also from the Nebraska Hospital Association written by Bruce Rieker and Elisabeth Hurst, and that will be included. I would normally say we're closed with the invitation. Is there anyone else, Senator Bolz? This is your hearing. Okay. Then I'll declare the Judiciary Committee closed...if you want to close your hearing. [LR295]

SENATOR BOLZ: Thank you for your time and attention this morning. Very briefly I want to articulate what I hear and what I think could be a continuum of steps forward. And these are my thoughts and ideas about the areas that we could work on and think about together. I think first, we should start where we are and think about funding oversight and requirements as we're currently spending dollars specifically as it relates to the regions and how we could better leverage those state dollars, and to Senator Mello's point, to consider alternative funding streams. Second, I think that the point that Beth Baxter made from the regions about strategic planning and rebalancing to the most cost-effective services is really important and a good strategy for us to think about. The third is that there are best practices and you heard about some of those best practices today ranging from family therapy to early intervention to medication management to mental health courts to diversion and respite. I think that strategic planning should lead us to those best practices and we should think about how we can build on those bright spots. The fourth piece is probably the most challenging in my mind and that is addressing what Senator Krist has addressed in his questioning which is the revolving door. How do we make sure that we are finding places for the people that need a place to get help and therapy? And that is a difficult intersection of our managed care providers, our community-based providers, our hospital providers, and the Lincoln Regional Center. But that's really essential work in my opinion. And last but not least, the conversation that we've all had about the adequacy of the Lincoln Regional Center, the availability of beds, and making sure that that facility of last resort meets the needs of the state and it is serving its purpose in protecting public safety. And to reiterate my goals in this interim study, public safety is the first goal. That is essential and that is part of our responsibility. Financial stewardship is a part of this conversation too. If we can keep individuals out of a $35,000 a year institutional setting, we should do that. And last but not least, this is a conversation about public health and humane treatment of our neighbors and our community members who are struggling with mental illness. So I appreciate your engagement. Happy to have any further dialogue and I look forward to continuing to work on these issues. [LR295]

SENATOR SEILER: Any questions? Thank you very much, Senator Bolz. This meeting is adjourned. [LR295]