BEHAVIORAL HEALTH OVERSIGHT COMMISSION
June 20, 2008

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The Behavioral Health Oversight Commission met on Friday, June 20, 2008, in Room 1402 of the State Capitol, Lincoln, Nebraska, for the purpose of holding a public hearing. Members present: Jim Jensen, Chairperson; Mario Scalora, Vice Chairperson; Gordon Adams; Mary Angus; Brad Bigelow; Susan Boust; Carole Boye; Topher Hansen; Linda Jensen; J. Rock Johnson; Senator Joel Johnson; Doris Karloff; Bill Mizner; Cindy Scott; and Dan Wilson. Members Absent: Andrea Belgau; Shannon Engler; Ronald Klutman; Howard Olsen; Joe Patterson; Ellie Tompkins; and Karen Weston.

JIM JENSEN: Good morning, everyone. Thank you for attending the last meeting of the Behavioral Health Oversight Commission. We do have a few things before us, and so I think it would be very well if we could move forward and expedite our agenda. And the agenda is before you; are there any additions or corrections to that? I don't see any. It will stand approved as presented. Also, the minutes from May 20 were circulated. Any additions or corrections to those minutes? Seeing none, they will stand approved as presented. And now we're ready for the report from the Division of Behavioral Health, and Scot has got a few things that he has and also other individuals to present. Welcome.

SCOT ADAMS: Good morning.

JIM JENSEN: Good morning. By the way, before Scot settles in and gets ready, I do have a sheet that just came across the wire that the Senate and House negotiators have reached an agreement on the parity bill, which I think is going to be great. (Applause) And we've made copies and we'll hopefully get one to everyone. Great. Go ahead.

SCOT ADAMS: (Exhibit 1) Thank you very much and good morning. I very much

appreciate and look forward to the time today in conversation with you all. I have some remarks that I'd like to go through relatively rapidly. I think there are a couple of areas of focus that we'd like to put our attention onto, and I know that an important component of today's agenda is with regard to the development of your report, and so want to leave time for that. However, I also would like to draw attention to the fact of the cake over there, which is available. (Laugh) I wanted to bring that cake to help celebrate the elements of success that have occurred in behavioral health reform over the past four years, and it's just an offer of congratulations and thank you to all of you for your work in cooperation with the department and with the division, in particular, over the last several years. I think Nebraska is in a better place than we were before, and it's a moment to sort of say thank you for that, this being the last scheduled meeting that I'm aware of at this point in time. So with that, feel free to grab cake now or afterwards, and we can go from there. Dr. Scalora, you're sort of looking like you've got an itch. (Laugh)

MARIO SCALORA: It's the notion of feeding the lions before one goes to the Coliseum. (Laughter) I thank you for the cake, as do the other members, but my waistline, unfortunately, is already gaining just by thinking about it, so.

SCOT ADAMS: Well, be that as it may. Okey-dokey. Does everybody have a copy of the document, then? Okay. In one way or another, we can follow along, then, and go from there. Would like to...just a couple of opening remarks, talk a little bit about LB1083 and what we think focus has been recently, talk about the Office of Consumer Affairs, highlights of things recently, some of the future, and then any discussion that you may wish to have. LB1083, as you know, is fairly...was a paradigmatic change. It was an important, significant, substantial change in the state of Nebraska. In 1955 our reliance on regional center hospital care reached a peak high of 4,746 people. In the intervening years between then and now, a number of significant things have occurred in a number of ways. I have highlighted and identified a few of those, including recent efforts within government to try to improve and to reform behavioral health services in the state of Nebraska. I think that important to LB1083, there has been an intense focus in the last

several years with regard to three particular areas, and that has been the focus on regional centers and moving people from those hospital settings into community-based services. At times that has ebbed and flowed. There have been high points; there have been low points. But I think that by and large, there has been some successes; notably, the closure of 251 beds and the diversion of perhaps thousands of people over the course of the four-year time frame, from regional center care to community-based resources. A second intense focus, I think, of the past several years has been the bringing up of community-based services, and these have been identified in a number of different ways and have been at a number of different levels. Some have started and ended; some have more recently begun. There are yet others yet to come up, both in the near term and longer term. But I think that there has been great planning, great energy, positive motion with regard to the development of new, different, and improved services at the community level. And then I think there has been, especially in this last year, an intense focus on the money in terms of moving services out. And with regard to that, the original intent was, from then Governor Johanns, $25.8 million. As you know, we have talked about this previously. Whether that was right, wrong, or indifferent, that was the original statement of moving the in-patient operations to the community, and in fact, what we think has been delivered is $30 million over the course of the last several years. With regard to the Office of Consumer Affairs, I think there has been recent conversations and requests for information, all of which I want to thank the commission for, with regard to helping sort of organize and to demand greater accountability for. We have recently provided the oversight commission some responses to particular questions about things, and here really want to just highlight a few items, I think, of significance with regard to the Office of Consumer Affairs, which is an important component of LB1083. Consumer specialists are now embedded in the regions across the state. That didn't occur before LB1083. Their role and function, I think, is augmented by a group of consumers in each case, to help guide and inform the delivery of services, the planning of services, the development of services, and how consumers are treated. I expect that that will continue to grow and flourish as a permanent fixture within regional government and regional service delivery. Consumers have been supported with

dollars, originally from about $150,000 to about $522,000 in the '07 fiscal year, and I think among the more notable elements, in the current year's contract we have really for the first time some increasing expectations of accountability for consumer specialists with regard to their work, their outcomes, their activities to promote consumer-driven services and to promote consumer involvement at all levels of the regional side of things. So I think there has been some significant development in regard to that. Last year in September we had some conversation with regard to consumer involvement and progress in recovery, in particular. And we spoke about and ended that presentation with a quote from a person who had been at the regional center and was about to begin college. This person has been living in the community at the Heather and had some bumps in the road but is continuing to pursue her love of writing, with support, and also is employed. And so moving from regional center to the college experience to pursuing her love of her life, in terms of her passion, I think is an evidence of some important kinds of things. Today her statement talks about being, again, in society, and I think that this is an important element because it speaks to the role of ongoing support and the connectedness of people. And when we spoke with her, the element of the need for sort of an ongoing system of maintenance, if you will, and the human side of this really came through in this quote, and so we see this as an important opportunity and an important example of the potential and also of the difficulty in the human side of recovery. Another person, a woman again, has been at the Lincoln Regional Center and visits the Heather a couple days a week, and her attitude about facing life is what is significant here. She doesn't think of herself as living at the regional center; she speaks about being at the Heather, in the community. And across the street she yelled at Joel McCleary, the director of the Office of Consumer Affairs, and invited him over for a cup of coffee, to be able to be part of the club, if you will, that she was with, going to live her life. And together they had a moment of recovery together. So I think that there are some good things going on, and she really is part of the community. In general, you will be getting again, probably our traditional, our regular report with the numbers. Didn't provide it to you--sort of the same trendlines, the same data; they're all in the same category more or less, in terms of services. But I think that what is significant over the course of four

years is that EPCs are down, people are being diverted, more people are being served in the community. I think that we all are going to be experiencing these unusual challenges as we move forward into the next chapter of behavioral health reform. In particular, special populations, persons of cooccurring disorders, cooccurring conditions, are really very difficult and vexing for us. We have had people move to the community only to be referred back. We have had folks stay at regional centers, obtain employment in the community, obtain education in the community, but no provider willing to take them in the community for housing and for living arrangements. We have had people with particularly difficult conditions and unable to find a person or an organization willing to house the person in the community. Literally, the particular cases that I'm aware of probably number around 30 or so folks who have been very difficult in one way or another, that have come to our attention. I think there's another group of folks who are perhaps close to the edge in some cases and will need strong community support of services to continue on. I think these kinds of challenges are the kinds of challenges that, as we move forward into the next chapter, that we should all face with eagerness and excitement. I think that the opportunity of the recent infusion of funds into the community presents the resources necessary to meet those challenges well. Other highlights include sort of the summary of those services. It's a laundry list of things, but all of these have either been started or have expanded in some fashion as a result of behavioral health reform, in and of themselves. Those are an insignificant listing of particular services, sort of a bureaucratic mix, if you will, of stuff. What is important here is that they're in the community, that they are the result of, I think, local planning and efforts to help people to live their lives with dignity and with respect, and to gain the maximum potential for their lives that they can. And so these are important supports, if you will, for folks with some difficulties. I think some of the significance with regard to the last four years related to regional centers has been all adult services, all the adult beds at the Hastings Regional Center has closed. On the way to behavioral health reform a couple years ago, Norfolk Regional Center acquired a new mission as a result of legislative direction. We are intensely about the effort to try to integrate the Lincoln and Norfolk Regional Centers into an integrated whole within a

community-based environment. I think that's an important component. We have got to find a way to be able to not have an "us and them" situation, but rather a situation in which the regional centers operate within the context of a community-based environment. Nationally, and you'll hear more about this a little bit later, we have an extraordinarily low readmission rate of 180 days, and I think that's something to be proud of. I think that indicates both the quality of care at the regional centers in conjunction with community-based follow up that's necessary to maintain progress made. And so I think together this is an indicator, a benchmark, an outcome, if you will, of pretty significant success. And the variety of different treatment options has been also improved. I would like to invite Dr. Watanabe-Galloway to join me up here for this next section of the report. Many of you are aware that the division, along with the University of Nebraska and the Medical Center, has been at work on a really difficult project. For those of you not familiar with or don't delve with numbers much, this has been difficult to bring together different systems and databases into a coherent, consistent, reliable, and valid single data system, to be able to obtain the kinds of data that we're going to be able to provide today. And so there have been efforts along the way that have been checkered, if you will, in terms of the reporting, but we think we're on to something now. We're really very excited about this. I think this data also presents encouragement for behavioral health reform. I think it provides a clear pathway, perhaps, in some respects, for future work in the area of behavioral health, and so I'm excited to ask her to join me. Doctor?

JIM JENSEN: Doctor, before you do that, could we just ask if there are any questions on Scot's report, before we ask the doctor to come up? If there aren't any, we'll move right into that. Any questions on the presentation?

CAROLE BOYE: Just one...

SENATOR JENSEN: Oh, I'm sorry.

CAROLE BOYE: ...quick request, which is for this. Can we get it electronically, too. Could you send it?

SCOT ADAMS: Which one are you talking about?

CAROLE BOYE: Your report. Just this.

SCOT ADAMS: Oh, sure. Yeah.

CAROLE BOYE: Yeah. Can we...

SCOT ADAMS: The handout?

CAROLE BOYE: Yeah, the handout.

SCOT ADAMS: Yeah.

CAROLE BOYE: Just because it'll last longer on my computer than it will in my bag. Thank you.

JIM JENSEN: Is that available electronically, is what she's asking.

SCOT ADAMS: I'll take that as a compliment. You bet, we'll send it.

SUSAN BOUST: And I'm going to give a compliment on that, as well. I don't...as long as I've been doing this I don't believe I've ever seen documented the number of our high point at our regional centers. And maybe I just missed it someplace, but the history there is appreciated.

SCOT ADAMS: Great. Yeah. We have, by the way, with a couple of gaps, the census

going back for decades.

SUSAN BOUST: I've made myself a little note to see you.

MARY ANGUS: Scot, do you have an idea of what the census was in 1998 or 1999?

SCOT ADAMS: Yes, not off the top of my head.

MARY ANGUS: Okay, thanks.

SCOT ADAMS: And lots of requests coming at me. If you would send me a note, I'll respond to it. I'm not sure I'm going to be able to remember all of them from here, so please send me an e-mail about that.

JIM JENSEN: I think that number was between 550 and 600--close in there. Yeah, go ahead.

MARY ANGUS: Okay, thank you.

TOPHER HANSEN: When you talk about special populations--we're talking traumatic brain injury and DD, MI, substance, maybe--do you look at cooccurring of substance and mental health issues as a special population?

SCOT ADAMS: You know, Topher, I think Dr. Watanabe-Galloway's information will help clarify some of that. The answer is it can be, not necessarily in and of itself. It depends on the case. But I think she'll provide some systematic answer to your question.

TOPHER HANSEN: Okay.

SCOT ADAMS: Thank you.

JIM JENSEN: I don't see anything else. Thank you. Doctor, you want to come forward, please?

DR. WATANABE-GALLOWAY: Thank you for having me here today. My name is Shinobu Watanabe-Galloway. I'm faculty at UNMC, College of Public Health. So right now, according to the data we have for this project called Regional Center Follow-Up Discharge Services Project, at the end of the last quarter, we had 1,084 people in the follow-up system, meaning these people have been discharged from regional center, and that's the definition, entering the follow-up system. We capture the consumers who are discharged from specified behavioral health reform units of the regional center. And there were 28 people who entered, or those new consumers discharged from specified regional center units, so right now we have 1,112 people. So this graph shows the consumer movement, meaning the monthly entries to follow-up system. Again, this means the number of new consumers discharged from the specified regional center reform unit, so you can see the steady decrease over time, as expected. Okay, this table shows...so the first point I would make is, if you look at the right column, under State Population Distribution, that shows the percentage of people across different behavioral health region. So of course, as expected, Region V and VI, we have higher proportion than other regions, and if you compare those numbers to the next column, the Total, would be the regional center population distribution, roughly reflects how the state population is distributed, but there are some differences. One of the things we did for this quarter report is looking to cause of death for the consumers who deceased after the discharge from regional center. There were a total of 17 consumers whom we identified deceased after the discharge. We obtained death certificate information from the state and looked into the cause of death, and also age at death. So here's the information, female and male. Forty to 60 percent roughly reflects this population group. And age at death--average is 46.8. Nationally we know people with serious mental illness die much earlier than the general population, and that is a reflection here you are

seeing. And medical condition: So we have the information for 14 consumers to how they died, okay, according to the death certificate. And 64 percent of them died from medical conditions; accident, 21 percent, so that's only 3 persons; and suicide, 2 persons. And we looked into medical conditions a little bit more and found out these individuals died from pulmonary embolism, respiratory failure, sepsis, cancer, and other heart-related conditions. This shows different types of services consumers received after their discharge from the regional center. As you can see, most of the consumers received some type of services in the a community setting. So 84 percent received both mental health and nonmental health services. When I say nonmental health services, those include treatment for medical conditions and also social support.

MARIO SCALORA: Professor, would that also include substance abuse services, or would that be in a separate analysis?

DR. WATANABE-GALLOWAY: That would be part of the mental health.

MARIO SCALORA: Okay.

DR. WATANABE-GALLOWAY: Okay. The next figure shows the trend in sue of community mental health services, again after the discharge, how much of the services have been used. So this is a trend. And we noted, so if you can see...in July-September, 2007, there is a decline in...this is Magellan identified services. We are looking into the data to see what would be the factors that influenced this change. The next graph shows the use of Medicaid mental health or medical services in the community setting; again, the same population. There has been an increase, steady increase up to July-September, 2006, and it has been pretty stable. This is only for the Medicaid. Now the next slide shows readmission and mental health diagnosis. As you can see, many people, many consumers had the combination of serious mental illness, substance-related disorder, and personality disorder--that's the top one. If you look at the row across--this row--the total is 43 percent. We're looking to the number of

readmissions within each group. So most of the consumers did have serious mental illness or with other conditions. And this is just showing the same information in a graph. Again, the combination of serious mental illness, personality disorder, and substance abuse was the highest for all the groups. Now I'm going to talk briefly about consumers with criminal justice encounters. This year starting from the end of last year, we linked our data to state criminal justice system data, which contains information about the prison data. So we did not county level jail data, just to make it clear. So we know that 60 consumers had some kind of criminal justice encounter, because those are the people who were found in the state prison data system. And again, the most common combination of psychiatric disorders in this group was the same thing--SMI, substance abuse, and personality disorder. And there are other things we looked at for this group of people, but because of the time, I'm not going to go into the details.

MARIO SCALORA: Just to be clear, Professor, then what you're saying is, of the thousand or 1,100--I'm sorry I don't have the number in front of me--60 ended up in a state prison?

DR. WATANABE-GALLOWAY: Yes.

MARIO SCALORA: That doesn't include people who may have had other police contacts for misdemeanors, ended up in county jail, they have had charges dismissed or whatever. This is just people who were engaged in serious enough criminal behavior and were convicted and in a state prison, not necessarily probation or anything else.

DR. WATANABE-GALLOWAY: That is correct.

CAROLE BOYE: And it is after discharge from the regional center or prior to admission to the regional center.

DR. WATANABE-GALLOWAY: We are looking at them both, so prior and after.

CAROLE BOYE: So it could be either.

DR. WATANABE-GALLOWAY: Yes.

CAROLE BOYE: Okay.

DR. WATANABE-GALLOWAY: And we can tease out to see when these people had encounters, but we wanted to see what is the overlap between two systems. That's the reason we looked at before and after; and again, with this data system, we have the ability to see, you know, what are the activities before people were admitted to regional center. But again, it's just for the prison data.

MARIO SCALORA: So we don't know if some of these folks were EPC'd from the prison to the regional center. We can't tease that out with this at the moment, but it's possible this includes people who were in prison and then later sent to the regional center directly from prison because of a protective custody or something.

DR. WATANABE-GALLOWAY: We have some information.

MARIO SCALORA: But that number might include some of those people.

DR. WATANABE-GALLOWAY: Some of my...EPC only is not included in the 60 people, so again, 60 people are just those people who have been to the prison.

MARIO SCALORA: I meant they were EPC'd from the prison to the state hospital.

CAROLE BOYE: Or somehow else got there.

DR. WATANABE-GALLOWAY: Yeah.

MARIO SCALORA: Generally, they go uninvited. I mean, (laughter) they're not there voluntarily. That's been my experience.

MARY ANGUS: They go invited.

MARIO SCALORA: Yeah, they're...thank you for clarifying. I'm sorry. I had cut off Mary. I apologize.

MARY ANGUS: Actually, it's related to your question. Okay, so these are people who ended up in your follow-up study; is that correct?

DR. WATANABE-GALLOWAY: Um-hum.

MARY ANGUS: All right. So in that follow-up study, what you looked at was actually felonious behavior resulting in a conviction, but prior to or after?

DR. WATANABE-GALLOWAY: Um-hum.

MARY ANGUS: Okay.

CAROLE BOYE: I would think, even in recognition that this is the last meeting of this body--there's going to be a subsequent body--I would think that the important measure here, in terms of LB1083, is people who end up in prison after being discharged from the regional center.

MARY ANGUS: Right, right.

CAROLE BOYE: That is more...that would be the focus here of this group. That doesn't mean that there isn't....shouldn't be a system focus that says how much is there in

overlap, but I think that's an important distinction to make, from an outcome perspective.

DR. WATANABE-GALLOWAY: And we are able to do that, so.

CAROLE BOYE: Okay. Good.

LINDA JENSEN: Right, to see (inaudible) increase...

CAROLE BOYE: Decreased level--hopefully it's gone down.

LINDA JENSEN: Yeah, hopefully not an increase, but nationally the stats are showing increases, so we want to know where we're at.

MARIO SCALORA: Dr. Boust, I think you had your hand up first. Why don't we just go around the table?

SUSAN BOUST: Obviously, this is a section that has gotten a lot of people's attention, and I want to thank Shinobu for this excellent report. I mean, it feels like we really are seeing some of the outcomes from LB1083. I had the opportunity to do the numbers on this, and .5 percent of Nebraska's population is ending up as connected with our prison system during this period of time, while 5 percent of our people who are released from the regional center, either before or after, has some connection. So clearly there is a tremendous need to look at this data in more depth, and I believe Dr. Watanabe-Galloway has the intention of doing that.

JIM JENSEN: It establishes a benchmark anyway, I think, that we can move from. Yes, Topher?

TOPHER HANSEN: Also, and I totally believe in this information-driven approach to it. And what this screams at me is that the vast majority of people that we're seeing have a

combination of disorders that we as a state are not prepared to address, which is personality disorder included in their mental health diagnosis, which may be multiple, and substance use disorders, and those people are the ones, in fact, who are ending up in the prison system, which is a little more evidence that we probably don't know how to deal with them very well, in terms of addressing their issues. And the other thing that we find in doing our outcomes data, is that people might come to us and then actually be...before they came to us, they've had charges that were levied and pending. And so one of our highest admissions to higher levels of care--and we include jail as one of those--is to jail, but it's because that group, again, is not dealt with...have charges that come from their behaviors, and then they end up going to jail, which is not the place, because the jail is saying, we don't know what to do with them, we don't know how to treat them. So it really gives us a charge, in terms of what our system response needs to be, to address the greatest majority of people in our system, by far, not just a slight majority. Really the vast majority of people seem to have...that you're following have these particular characteristics, and so we need to...I think the charge becomes here's our data. Let's figure out how to respond to the data.

MARIO SCALORA: Carole, please?

CAROLE BOYE: I also don't want us or a system to overreact. You know, 60 people out of a thousand, you don't regear a whole system to the detriment of the 940 that have done just fine. Okay. At some point I want to go back to...four pages, or four slides, but I don't know that this is the time. Maybe we want to finish.

SCOT ADAMS: Why don't we let her finish?

JIM JENSEN: Carole, why don't we finish where we are?

CAROLE BOYE: Yeah. Okay, because I just have some questions on that.

MARIO SCALORA: As a follow-up point, I think the 60 number is actually low, because I think that number reflects people who may be EPC'd or put into a regional center, who either show suicidal behavior before they're convicted or right after. And while those are people in need of services, that's the tip of the iceberg for the folks Bill Mizner or I would deal with. The kind of folks I really worry about--and in fairness to the doctor here, because she wouldn't have had the data to analyze this--where we worry about this placement to the criminal justice are the people who border, that Topher mentioned, the folks who have maybe minor charges levied or who come into the forensics system, who've been in and out a lot, who maybe for lack of access to services could end up with less felonious behavior being charged against them; for example, a person who shows up in a forensic unit for competency services for a trespassing charge. The criminal behavior itself is minor, the amount of energy the police department had to engage in. And so for the follow-up members who are there...I think if there is access to that other type of criminal justice information, I think that could also be very interesting, because those are the folks who talk about, who really scream about whether availability of services is an issue, because many of those cases could be dealt with straightforward in our system versus a criminal justice system. And in many of those cases the charges ended up getting dropped or they're not going to end up in that 60, because they're not going to prison. But a substantial number of our consumers fall into that net, unfortunately, and one might speculate as to why. But I think those are actually a greater number. We just don't know from this how many that is, and so I share that as an exhortation to our future cohort. Bill, did you want to add something?

BILL MIZNER: The only thing I was going to say is that if there is any way that you could do a cross reference check with the NCJIS system that the Crime Commission operates, you might find some of those criminal history records, where they've had the contacts, that would be the lesser charges would not end up in prison (inaudible). That might be one resource, if you might be able to gain access to that.

DR. WATANABE-GALLOWAY: Yes. If we get the data, we'll be able to follow those

activities as well, yes. Currently, we do not have the access to that data.

MARIO SCALORA: That's an extremely difficult thing to do. Having done this kind of research with other populations, this is not an easy thing to do, to get access to, so I can appreciate the barriers. It will take significant handshaking and wringing and arm wrestling at the Dr. Adams' level, with the Crime Commission, who will say we can't use this database for research. So...

BILL MIZNER: Yeah. But I think that that would actually give you a clearer picture, and I will echo what Dr. Scalora said: The majority of our efforts and contacts are not with those individuals who we end up having in prison. The majority of our contacts are with relatively minor violators, who really, the bigger problem for us is trying to get them the assistance and the help that they need, not the relatively minor crime that they committed at the time.

MARIO SCALORA: Thank you. Doctor, please.

JIM JENSEN: Thank you. Go ahead.

DR. WATANABE-GALLOWAY: Okay. So I have a couple more slides. Well, I...okay. So you're probably familiar with Uniform Reporting System that each state does for the federal government. One of the performance indicators is readmission rate so we report this every year, and last year, first time UNMC did the analysis of this data as part of the contract. Yeah, so there is a standard way to calculate this readmission across the United States, so each state follows the guidelines to define the population and calculate readmission. So we did that, and the data also comes back from the feds. So we will be able to compare our numbers to other states and the average, the United States average. So that's what it says here, is in 2006, 180-day readmission rate was about 10 percent, a little above 10 percent, and we saw some decrease. So now, 2007, about 8 percent. And if you compare those rates to national average, we are clearly

lower. And again, I have to say that we follow what the guidelines are, and each state is supposed to follow the same guideline to calculate. So that's what the data say, and that's what the rates say here.

GORDON ADAMS: Could I ask, does that include in-patient, community-based admissions, or is it only regional centers?

DR. WATANABE-GALLOWAY: This is just the regional center population, okay?

JIM JENSEN: Yes, J.Rock?

J.ROCK JOHNSON: Yeah, I believe there's a typo at the last line, for the fiscal year,...

DR. WATANABE-GALLOWAY: Um-hum.

J.ROCK JOHNSON: ...that that should be 2006-2007?

DR. WATANABE-GALLOWAY: Okay, yes. That is typo. Thank you for pointing out.

J.ROCK JOHNSON: And the reason I point that out is to note that prior to the contract with you, the division had no capacity to measure the readmission rates. And my question then goes, do we have a commitment from the division that you will continue to contract with UNMC to not just do what is being done, but continue to refine or expand, or what changes need to be made to keep this one really clean and excellent data process we have going?

SCOT ADAMS: You know, there are two or three elements in your question. One is a commitment going forward, for at least some period of time. I don't know a) what restrictions or other directions will be given by the Unicameral with regard to funding such things, and so I can't commit beyond that. Secondly, let me assure you that we

find this of great interest and of great value, and so want to continue on in the near term, certainly, with regard to that. Thirdly, some of the data that you are hearing today is reported on an ongoing basis through the mental health block grant, as well, and so as long as those requirements are in place, which, it's the federal government, and so that's probably locked in stone for a long time. So those are different kinds of things. I think what you want to hear from me, J.Rock, is a commitment of interest in this area. Yes, we have that. Barring changes in the environment, we'll continue with this.

J.ROCK JOHNSON: Yes, because this is being funded with block grant funds. Some additional funds from the Legislature would certainly be helpful. I appreciate your commitment here--thank you--and Dr. Watanabe-Galloway's extraordinary time and effort. Thank you.

DR. WATANABE-GALLOWAY: So based on the data that I shared with you today, I have three points to make. Here are our recommendations. Again, this was shown, you know, one slide after another. The most common type of combination of diagnosis is serious mental illness, substance-related disorder, and personality disorder. So somebody already said that we need to look into this combination and see what needs to be done to improve the health status of these individuals and the outcomes. And in relation to cause of death, we have been also looking into medical conditions, not only mental health, and we found diabetes to be pretty high, obesity, hurt-related disorders. So we need to look at not just the mental illness, but the medical conditions, because if you are going to look into increased outcomes after the discharge from the regional center, we need to take care of the medical conditions of these individuals. And the third point is, we need to really...the data-driven, evidence-driven approach is necessary. So continuing this type of surveillance, monitoring, is essential in order for the planning and implementation of necessary activities.

JIM JENSEN: Thank you. Dr. Wilson.

DANIEL WILSON: I would just reiterate, you know, thanks for some very helpful, basic information, and the need to continue and expand that process within state government is very important. I'd also, if I could, ask a question about the slide, Trend in Use of Community Mental Health Services. In particular, as you mentioned, there appears to have been what I would call a dramatic fall off in Magellan, if I'm reading this correctly, Magellan-authorized services about a year ago. I'm just interested in...when I see graphs and lines sort of drop dramatically, I wonder whether there's some causal factor that might be at work. So I don't know if the commission shares my interest, but...

MARIO SCALORA: Also, hard to argue error when you have three points following that trend. It would be one thing (inaudible) of a data error, but if it's...

SUSAN BOUST: If I could just make sure that I'm reading this information correctly, in April and June of 2007, Magellan was authorizing somewhere between 200 and 250 consumers for services in the community. And in the quarter, July-September of 2007, they were authorizing about 100, and now they're authorizing about 50; am I reading that correctly?

DR. WATANABE-GALLOWAY: Yes. So I guess I would pose a question for you and other people who are familiar with services providers and...

SUSAN BOUST: I'm sorry. I would like to hear your comment.

GORDON ADAMS: This base is just this 1,100 patients discharged from the regional center.

DR. WATANABE-GALLOWAY: Um-hum. Yes.

GORDON ADAMS: This is not a snapshot of all community-based services.

SUSAN BOUST: I think that's an important point. These are people who have used our regional centers, and we're being authorized at the rate of about 250, and now we're being authorized at the rate of about 50.

GORDON ADAMS: There's an attrition rate for various reasons. There are some moved out of state. I mean, there's a lot of attrition in this that probably explains that gap.

SUSAN BOUST : I think it's a very important question.

CAROLE BOYE: I think it's a hugely important question, and do you have any insight as to what is going on here?

DR. WATANABE-GALLOWAY: Okay. The first point to make is, because this is a follow-up system, we are able to follow most of the people, unless they disappear completely, meaning physically move out of the state and getting the service in other states. Then we are not able to follow the activities of those people, because we simply do not have the data. But because we continue to get the data every month...so if somebody is getting any kind of service within the state, we are able to capture that. So...

CAROLE BOYE: So it's illogical to assume that 95 percent of the people that you were tracking has moved out of the state? I mean, something has happened here.

MARIO SCALORA: Well, it's two different behaviors being measured there. One is authorization; one is an identified service. Authorization is just speaking to...it's an authorization of payment or authorization of an approval, right, versus whether this approved service exists.

DANIEL WILSON: Perhaps everyone...many of these people miraculously got better in the summer of 2007.

CAROLE BOYE: Even though they're triple diagnosed. (Laugh)

MARY ANGUS: Let me also point out that in your own data, Slide 18, you only have 5.1 percent who have moved out of state. So I doubt very much that that could be a major factor in this.

TOPHER HANSEN: Could I? I have a clarifying question. When you say "authorization," does that mean "registration," too? Because sometimes you don't have to get a service authorized; they're just registered. So is that brought in, too, you know?

CAROLE BOYE: This is the Magellan database, so I don't think it matters.

TOPHER HANSEN: So assuming...if it's registration or authorizations, it's the whole database. But again, if somebody came into community support and then just disappeared, which happens, that even the case managers and so on can't find them, then that person would fall off the authorization list and fall off the data list. But they're still in the community not receiving services. So I guess the question is begged, what's happened to everybody?

SCOT ADAMS: Well, especially in light of the next line, where you see people in service.

TOPHER HANSEN: Right. That's confounding.

SCOT ADAMS: That's confounding.

CAROLE BOYE: To me, again from a system perspective, my question is, are we losing track? And I don't think we are, because of that data. What is of greater concern to me is when you see authorizations go down, and I mean we're even starting to see...again,

we're talking about the most serious people...the percentages show us these are people with the most serious and persistent mental illnesses and all those kinds of things--chronic illnesses, lifelong illnesses, highest users--I'm concerned more with the systemic implication here, that we may be seeing the system de-authorizing services, as opposed to a decrease in need of services. This may be the first indicator that we've gotten with something that you're hearing everywhere, quite frankly, which is that the system is starting to ratchet down again, in terms of services being authorized, services being provided. And that's really my...my real question is, what can you tell us about what the data is telling us about what is behind this? Because there are two totally different directions you can go with the interpretation of these slides.

SCOT ADAMS: At least two. There are more.

DR. WATANABE-GALLOWAY: So I might make some suggestions. Of course, when we see any kind of a change like this we want to know whether there is any kind of data system change. We say no. So, you know, we are looking at a list of potential factors that might have contributed, and it seems like there is no data system change. So at the behavioral health system level, if there was any change to cause this, you know, this trend, I need to talk to people who are familiar with the system, because this is what the data says. What we can do from our side is to look into individual consumers' level and see where the change happened. So for that reason, I'm asking you not to jump to any kind of conclusion until we investigate it further, okay? That's why we're doing this, is to catch the trend, the changing trend. But I cannot really make any conclusion or any suggestion right now, until we look at this data more carefully and talk to the individuals who are familiar with how the data get managed and how the services are authorized. So I need more time and information.

JIM JENSEN: Well I think, however, a call to Magellan would certainly find out. We've gone from 250, and we're still headed on. At 50, I wonder what perhaps April, May, and June...we might be down to zero if this rate is continuing the way it is. So I don't know

that we can wait a year to find out what is happening there. I think Dr. Wilson, and then Carole.

DANIEL WILSON: I certainly agree that the data should tell the story, and thoughtful analysis of that is important. As an clinician and an administrator, having worked in three states and two countries, I'm certainly familiar with the sometimes arbitrary nature of systems of authorization and the rapidity with which those can change, and not jumping to any conclusion, but beginning to formulate a hypothesis. (Laughter)

MARIO SCALORA: Hint, hint.

JIM JENSEN: Whatever that means. Yes, Carole.

CAROLE BOYE: Thank you, Dr. Wilson. (Laughter) I agree. I think there's lots of hypotheses out there, and I think my question is, yes, the data needs looked at. This is the last meeting of this oversight commission. Where do you go from here, in terms of that data collection? And again, Scot, I'm going to turn to you and say, what commitments will you make that this will be followed up with and reported out in what forum, so that the system as a whole can take in this data and utilize it, test some hypotheses, and utilize to the best interests with people that we're all trying to serve?

SCOT ADAMS: Same answer I gave when J.Rock asked the same question before, Carole. The additional part would be to simply say that Dr. Watanabe-Galloway should go where the data leads her nose.

CAROLE BOYE: Would the department...

SCOT ADAMS: And I would also say that I'm not aware of...

CAROLE BOYE: ...make this information available not only to the new advisory group,

but say, to the regional program administrators and let's have broad dissemination of that, on that quarterly basis, or however long it goes out?

SCOT ADAMS: Sure, yeah.

CAROLE BOYE: That would be very helpful.

SCOT ADAMS: You know, we purposely made this an element of public discussion because when this came up, and especially the anomaly between the actual utilization and the authorizations, that's what doesn't make sense. If this trend were also in the same way, then I'd be more inclined with Dr. Wilson's initial formulation of a hypothesis. But it just doesn't make sense at this point. You don't have...

DANIEL WILSON: Well, Scot, it can if multiple services with different sources of funding and authorization are being tabulated on the one hand, versus specific Magellan services on the other. I mean, people...but this is a very anomalous graph, and talking about...

SCOT ADAMS: Yeah, isn't it? Especially in conjunction with number 20.

DANIEL WILSON: With this population and the purpose of mental health reform, I think a very skeptical, critical eye is warranted at this point and needs to be followed up very carefully.

JIM JENSEN: Doctor?

MARIO SCALORA: Thank you, Dr. Adams, for sharing this data and your openness to discuss it. Is Magellan an administrative services organization, in contract with the state?

SCOT ADAMS: Yes.

MARIO SCALORA: Is that contract managed by you or Director Chaumont?

SCOT ADAMS: The...in July there is a renewal of the contract effective July 1. That contract has...was a single bid package,...

MARIO SCALORA: Right.

SCOT ADAMS: ...and there are three separate contracts. And so the Division of Behavioral Health will manage our side. The other divisions will manage their sides of the contract.

MARIO SCALORA: So theoretically, hypothetically speaking, if there were rather dramatic or arbitrary shifts in authorization behavior that were not in concordance with reasonable behavioral health reform policy, who would be, when the new contract is in effect, who would be responsible for making sure that one monitoring that and correcting that behavior, hypothetically, that were to occur?

SCOT ADAMS: I'll take responsibility for monitoring this data and moving forward with regard to that. It would be a...it's a single department. We work jointly and together, and it's like it's hard telling hypothetical situations what's involved. So I can't respond to that. But let me say, I'll be responsible for making sure that whatever anomalous data are at least clarified, understood, made public, and worked through. (Inaudible) Magellan issue.

MARIO SCALORA: And I respect your openness and transparency with that, and I think that's obviously straightforward. My worry as a citizen, professional, and such is, given how big the agency is, and while you may have the right data and the right intention, if someone else is responsible or if there's such a diffusion of responsibility and there are

different people involved, I guess whose foot is going to kick butt in the end is going to be the question. And even though you may have the right information and intention, if someone else is responsible or...I guess it would be interesting to know who manages that in the end. And I realize you can't...there may be some things you can't assert unless it happens.

SCOT ADAMS: Yeah. Well, the department internally has agreed that while there's three separate contracts to assure greater accountability for the pieces of information and performance that we wanted, division by division, we have also assembled sort of the review team that will be done jointly and together for issues like this and other issues, where there's commonality of interest and overlap of impact.

JIM JENSEN: Yes, Topher.

TOPHER HANSEN: I also again appreciate this information. I think this is the first time I've ever seen outcome information in the course of our looking at behavioral health reform. And the inputs that we've looked at thus far are all good and well, but inputs aren't outcomes. And you really don't know where you're going as a system unless you're looking at your outcomes, because that tells you really what the product of your effort has been about, and whether what you're trying to achieve is, in fact, achieved. I think this tells us some important information that begs a hundred other questions that we ought to follow. And the dollars and the number of services and the number of people utilizing those services are all good and well, but that really doesn't tell us the effectiveness of the system and what we need to fine-tune and direct our efforts toward. This, I think, is some of the most important information I've seen in the course of this behavioral health reform. This tells me more about where we need to point as a state than I've seen in all the prior meetings, I think, and I hope that we go toward that and start making our decisions based on this kind of information, rather than the dollars or...the budget is always laced in, but it really needs to follow, not drive. And I think this kind of information really puts us in that direction. So I would encourage you to also

follow this up, to continue asking these questions and work as a team with the network providers who are doing a great job in trying to fine-tune their own systems. This will help a tremendous amount, this kind of information.

JIM JENSEN: Thank you. Any other comments? Yes, Dr. Boust.

SUSAN BOUST: I also want to follow on Topher's comments. Dr. Watanabe-Galloway, I know this is not your first time of presenting to us, and I do know how difficult this has been. I want to thank you for your persistence in getting us excellent information, and Scot, for supporting having this be presented. Thank you.

JIM JENSEN: Thank you, Doctor. Scot, is there anything more, then, on your report?

SCOT ADAMS: Brief...a couple of comments. I apologize for the length, but it was a great conversation. When I spoke with Senator Jensen about this, we had talked about the possibility of 20 minutes involved in that, but I'm glad of the great interest in this. Let me be brief and very summary in my remaining remarks. There is...in your packets you have a brief comment or two with regard to the ten original work groups that were formed in the wake of LB1083. There has been, I think, progress in many of those, not in others. And rather than take time here, unless any of you have questions, I think we will move through that.

DANIEL WILSON: Scot?

SCOT ADAMS: Yes, sir.

DANIEL WILSON: Sorry. The second point on this slide...the previous slide.

SCOT ADAMS: Your favorite?

DANIEL WILSON: No, but an important part of the original conceptualization. Any sense of the status of this presently and for the future?

SCOT ADAMS: You know, this was of course an element of some concern in the original conceptualization, and I am aware that there was encouragement by the academic institutions to develop the original white paper. There was consternation among some groups about funding for this component, coming from behavioral health reform dollars, and I think a decision reached that reform dollars from regional center operations would not go into academic supports. I am not aware of any current initiatives to fund this at this time from any front. I think there have been prior conversations. I've not been privy to those, and so I really don't have much to say about this, other than to say I am not aware of efforts at this time for funding in this direction. There could be; I'm not denying that that could be the case, but they've been outside my realm.

DANIEL WILSON: So HHS presently is unaware of any prospects for this developing further?

SCOT ADAMS: That would be correct.

DANIEL WILSON: Wow!

SCOT ADAMS: I want to draw your attention to, I think, what is another success with regard to the reform effort, and that is the Nebraska housing-related assistance effort which came in about a year after LB1083, and just a quick summary of number of people served in housing-related assistance. Again, this is a program that was introduced; it provided for an additional tax on the transfer of real estate within the state of Nebraska. Generated, I believe, originally $1.6 million; current funding for that is estimated in the $2.6 million. That was an increase of about $600,000 in the current fiscal year, and that will be the budget for the next fiscal year. That really is intended

to...since it's drawn upon the actual transfer of real estate--housing sales go up and down--and so we're trying to manage that in such a way to be able to maintain a consistent flow of revenue in a way that can absorb the downturns in economic activity but can remain with a consistent level, so that folks aren't thrown out of homes, to be able to sustain that. So we think this is a very important and positive element of behavioral health reform. Supportive employment also is an element that I want to draw your attention to, and while it has been relatively small, we have a start. And I think this will be an encouraging and ongoing important dimension for recovery for persons to live as independently as possible going on into the future. Finally, a couple of points. I know that some people have rejected the metaphor of closure of the chapter of LB1083 in the ongoing book of behavioral health reform, and that's fine. I think it's still a useful metaphor in a number of ways. It just seems that we have, at this point in time, had intense focus on downsizing the regional centers, upgrading community-based services, and the effort to try to move folks there. I think we're at a point of renewed energy. We have a new opportunity for strategic vision with the work of the new commission. I think a perhaps slightly broader focus that has been in the recent past, still focused on the goals and the elements of LB1083. We're certainly not rejecting those; that's part of what we're going to be about. And as you saw today, we have the opportunity for some data now to help inform decisions, rather than somebody's best guess as to what ought to be. And so I think that it is, in many ways, a new chapter. In particular, would like to announce the Governor's appointments to the new Behavioral Health Oversight Commission, effective July 1. As you are aware, the legislation was quite prescriptive in terms of persons who could represent particular slots, and so there was not a lot of wiggle room, if you will, in terms of opportunity for broad-based perspective. On the left-hand side of this slide you see the particular legislative mandates with regard to who could come from where. Mr. Patterson is a member currently of this Behavioral Health Oversight Commission and so represents continuity of thinking from what is to what will be. Mr. Egley is an attorney in Madison County and chairs the Board of Mental Health up there. TyLynne Bauer is the representative from the Norfolk Regional Center; she serves as the facility operating officer there and has brought great fresh, new energy, I

think, to Norfolk. Bill Gibson is the CEO of the regional centers and will represent the Lincoln Regional Centers. Three regional behavioral health administrators have agreed to participate with this, from Regions VI, III, and II. Three providers were to be selected the different Congressional districts from across the state of Nebraska, and you see those three persons. Again, Dr. Bigelow represents a current member, down the road from me here, with the current commission. J. Rock, as a consumer, has agreed to continue on in this role, and Rhonda Hawks as agreed to participate, a consumer advocate from the Omaha area who has been helpful recently with the Lasting Hope Recovery Center and its development there. We think that the constrictions of the legislation and the desire to balance current expertise in moving forward, along with fresh faces, if you will, results in, we think, a very good group of people that we're excited to work with. So bottom line, I want to say again, thank you for your work. I know at times over the course of the last four years it has been arm wrestling and perhaps contentious at times. I haven't attended most of these meetings, frankly. But in the last year I hope that there has been increasing spirit of cooperation and reaction. I hope that we've been able to move forward with you and with the state overall, in terms of behavioral health reform. I look forward to the future. I hope that you will continue to provide us all input--ideas, concerns, questions, challenges--so we can make Nebraska one of the best states possible. And I really am serious about the cake. I hope you grab a piece of cake on your way. So thank you very much for your attention.

JIM JENSEN: Thank you, Scot. Any questions? Yes, Topher.

TOPHER HANSEN: On the new oversight commission, they meet more than quarterly?

SCOT ADAMS: Much of that is to be determined, but I believe the legislation spoke to quarterly meetings, so it would be at least that frequently.

TOPHER HANSEN: And are there goals that HHS has to propose to the group to try and achieve in the next year?

SCOT ADAMS: We believe that at its first meeting on July 24 at 1:30, that we will have greater definition of that. But the short version is that they're charged with developing the strategic vision for behavioral health in the state of Nebraska.

TOPHER HANSEN: Okay.

JIM JENSEN: Yes, Dr. Wilson.

DANIEL WILSON: Scot, I would just like to thank you for your very circumspect professional, open approach to your job and the work of the commission. I think it's had a positive impact on things. Since you've joined it's been very helpful.

SCOT ADAMS: Thank you, sir. There was one other tidbit, if you will, that I neglected to mention that I think is important, in sight of Dr. Watanabe-Galloway's data. The state of Nebraska is involved in joint planning with other elements of the Department of Corrections, Probation, and others, with regard to justice behavioral health services. We received a grant in the current year and had some planning initially last December, and we're seeking a second follow-up grant in that area. So that will remain...my point being that that will remain, we hope, with additional resources, an important priority for the division. Again, thank you.

JIM JENSEN: (Exhibit 2) Thank you. That will conclude the report on the Behavioral Health Commission. The next item, Item 5, is the discussion of the final report. I'd like to just give you a little bit of comment on the final report and its presentation. And then also I'd like to set, perhaps, some of the guidelines on how we might proceed from here. First of all, does everyone have a copy of the final report? We did e-mail one out. If you don't have one, we can supply you with one. And I appreciate what Scot Adams presented. And also, I didn't have when I came up with this report Dr. Watanabe-Galloway's report, but it is interesting how many of the things collaborate

within this report. And as you all know, I probably...with the passage of LB692 in 2001 that began, perhaps, the behavioral health reform, where we took the tobacco money and started parceling that out with a large share going for mental health. And it was...prior to that time we really had a dismal behavioral health system in this state, and I'm so pleased at the progress that has been made. While I'm talking about LB692 I do have a lot of concern, however, in that we have a number of senators who are coming on who don't know anything about the Tobacco Settlement dollars, that is coming in, and that if left alone, those dollars would supply into the next certainly generations, dollars for health and behavioral health. We're one of the few states that took all of those dollars and put them into our health system. But I think we have people without any constitutional background or legislative history that I'm afraid, in the future years, are going to start raiding those dollars for other items, and that's just the nature of the beast, I guess, that will happen. But it does concern me. The final report started out with an introduction and purpose, and as introducer of LB1083, I certainly have a history of where that came from. We went then from the...and by the way, the last several meetings I did mention that we were going to do a final report. I asked that if you had any information, if you had any desires, if you had any thoughts about what should go into that report, that you would submit them to either the office of the Health Committee or myself. And I have received and did receive phone calls, personal meetings, and information that was brought into this report. And I think it is a time to celebrate, when you start at, first of all, the purpose and then the accomplishments and the progress that has been made, it is truly, truly, I think, rewarding to see how the mental health reform has proceeded. And then the findings and recommendations; again, these came from individuals that did make presentations and gave me information and many of the...some of the language actually came from those individuals. So that's where we are. And with this final report that would go to the Exec Board and to the Governor, and as we all know, and from my past of being a state senator, many things come across your desk. Some things you act on and some things you do not. And so even though this report goes to that Exec Board, certainly they may do with whatever they want with it. But I did feel that after four years, that a report be made, and maybe it's also

something that the new commission can also use and look back on. Now what I'd like to do, and because of the time, is take comments for about ten minutes, before any motions are made. Then if there are motions that are made, that we allow ten minutes of discussion and then either take an up or down vote on those. I think that is one way to proceed, and if I don't see any objection, we will do that. Like I said, I hope all of you have had the opportunity to read through it. I take full responsibility for the report; again, using the information that came from many, many people. I would also hope that we don't get caught up on "wordsmithing" and so on that can sometimes happen. So with that, I'll just open it up for any discussion, if there is any, and if not, why, we then can proceed on any motions that anyone might have. So any discussion on the report itself? Yes.

SHANNON ENGLER: Senator, I just want to say that as I read through this, I think it's very thoughtfully...or constructed in a thoughtful manner. It's reasonably complete. We could all probably add 27 different things, but I would support it in its current state at this point in time. So that's (inaudible).

GORDON ADAMS: I can't support Recommendation No. 8, indicating that there be no more psychiatric patients transferred to the Norfolk Regional Center. I think that history has shown that it was necessary to transfer those patients. The alternative we saw in the city of York was that a patient waited 90 days in the county jail to be admitted, and he had a psychiatric condition. And the solution that was implemented was to transfer some patients to Norfolk Regional Center, and I think that I will not support Recommendation No. 8.

JIM JENSEN: Thank you. Any other comments?

LINDA JENSEN: (Exhibit 3) We do have...the consumer and family members of the commission prepared a...kind of an addition to No. 1 and a little editing. And I will just pass that to you at this time. Basically we definitely support the draft as it's written,

including all of the recommendations. No. 1 was just...they were basically enhancements that we are suggesting, and I think we can live with the report the way it is. It just...we always like to increase the amount of consumer family inclusion language and to encourage that emphasis as much as possible. J.Rock, do you have anything you wanted to say about...

J.ROCK JOHNSON: Yeah. I think that that was well put. We've suggested some additions to Recommendation No. 1, and that has to do with consumer involvement, and revisions of the accomplishments in No. 7, which is the Office of Consumer Affairs, and No. 8, in the peer support services, to make them more consistent with our factual experience here. And the folks I've talked with have no objections.

LINDA JENSEN: We definitely want to congratulate the efforts that have been made for peer support services and just encourage those to go forward. I think that's one big thing we just really want to see that continue to go forward and be accountable.

JIM JENSEN: Mario.

MARIO SCALORA: Carole, do you have a reaction to that?

CAROLE BOYE: Yeah, I just...some clarification. I haven't had a chance to like really read it a little bit ahead of time here.

JIM JENSEN: Now are we talking about...

CAROLE BOYE: I'm talking about what Linda just handed out.

JIM JENSEN: Okay. It's my understanding that's going to come in the form of a motion; is that correct, or will it?

CAROLE BOYE: Sure, we can do it that way.

JIM JENSEN: Well, I mean, I would ask that we would talk...have general discussion, and then we'd...

CAROLE BOYE: General discussion first, and then...okay.

_____: And then we would do more specific, okay.

JIM JENSEN: And maybe we're at that point.

CAROLE BOYE: I'll withhold my specific question, then.

JIM JENSEN: All right. Mario, did you have something?

MARIO SCALORA: Just a couple points. First, Senator, thank you and whoever helped you pull this together. This is outstanding work, sir, and other words of praise for you are forthcoming. But you did a heck of a job. On the sex offender issue, more just a point of clarification and education. While the numbers look scary and we do need to evaluate whether we could do this better and there are probably some things we should be doing better, that number doesn't reflect other types of services they do that keep the recidivism rates down. They offer some other community...out-patient services and things that influence a larger number of persons but would not be considered as part of the per-bed cost. So you...the numbers may be slightly misleading in terms of numbers of people they deal with that keep the recidivism rates down, which I don't work directly at that service, but I'm very familiar with it--did some outcome assessment, looking at that service. And they do a really good job keeping recidivism low, especially in light of national statistics in that area. So I guess what I'm saying is: I agree with what you are saying. We need to look at this in depth, and I think an in-depth study will consider that. I just want you to consider the numbers within a greater context. Another question I

have, and I don't know whether we...I throw this as a question to my colleagues: Given Dr. Watanabe-Galloway's issues she raised about the overlap with the criminal justice system and how important it is to look at that as an outcome, do we need a specific recommendation to follow up on that? And I throw that out as a question. That's the only issue.

CAROLE BOYE: Yeah. I wrote a note of saying I'd like to add a...consider adding a recommendation at this point that the data be, you know, made available broadly, quarterly, and I'm not sure what that is. And then I backed off of that, after what Shannon said, which is I could come up with 20 other things, as well, of wanting to do this. I too want to thank you, Senator, because I don't where you start and stop on this. But I think it broadly reflective of the celebration of the accomplishments that needs to take place, as well as the sense that I certainly have and think that this commission has tried, especially over the last few meetings, to convey a sense of, our work is not done. LB1083 is not done; reform is not done. Here are some very specific major areas to take next steps in, and it's that flavor in here that I appreciate.

JIM JENSEN: Yes. Topher.

TOPHER HANSEN: Reiteration of some of those. As I look through this, I guess my reflections are, again, what Carole said--where do you start and stop? It's a huge bit of history to try and grab onto in a single report. But the thing that I guess I'm struck with is it's a good dissenting opinion, and so maybe it (inaudible) and be the next area. (Laughter) And the reason I say that is because you capture the thrust of what we all intended to go forward with but gives shape to what didn't happen, and the lack of completion of some of the deliverables that were promised at the outset, and that really are the mission, I think is important. And we have to keep our eye on the ball, of what the mission of this was about. The other thing, too, that I really appreciate here: Providers across the state will tell you that what is required of them and what they all set out to achieve anyway is to hit the standards of excellence, to really be at the standards

that achieve excellence to provide the highest quality of care for the consumers. And what this report asks of the state is to hit that same level, to meet the accreditation-type standards of accountability, and information driven, and transparency, and inclusion in planning, and issues like that, and to have it be a quality improvement process all the time. And as I said earlier today, having the kind of outcome data--not input data, which doesn't tell us how people are doing or how our system is doing--but outcome data which tells us about really how we are doing in our efforts, that kind of drive, I think, and that kind of charge is captured in this by the recommendations and by the reflection on what has happened. So again, not only nice job on this and thank you, but I think this is indicative of your commitment and involvement to this whole issue, and I do appreciate that.

JIM JENSEN: All right, thank you. Anything else? Dr. Wilson.

DANIEL WILSON: I guess I'd just concur. I think it's an excellent summary of the overall situation we're in presently, and looking back as well as forward. It seems to me it should be agreeable to most of the commission members, if some minor changes that we might come up with along the way. I would also suggest perhaps adding, if we could, some codicil or appendix that specifies what was not complete in LB1083, the deliverables in particular.

JIM JENSEN: Thank you.

DANIEL WILSON: But I think it's an excellent summary.

JIM JENSEN: You know, in looking back and we so often don't do that, at the deliverables, and not only that--this is four years. But really almost the first year was all spent on coming up with that program and those deliverables. And I know as introducer of the bill, I was really anxious to get into providing service, not just talking about how we were going to do it. But since we've done that, and then go back and look and see

what has been accomplished, and then yes, what didn't get there, for whatever reason. And I'll tell you, the department has got so many things. Do they need to do more? Yeah. How do we do that? I don't know. But anyway, any other comments? If not, I think we're ready to go ahead and move, and since Linda, either you or J.Rock, why don't you present what your requests are, and then we can take action on that.

J.ROCK JOHNSON: Our request would be that Recommendation No. 1 include the items that we have suggested be added, and that's just a suggestion.

MARIO SCALORA: Are you wanting to frame that as a formal motion?

J.ROCK JOHNSON: What I'm wanting...in two parts, frame the formal motion as replacing, in the accomplishment sections, No. 7, Creation of an Office of Consumer Affairs with our revision. Shall I read that revision? I believe everyone has a copy, but.

JIM JENSEN: Well, let's just...is there any comments on the revision? I think, Carole, you had something.

J.ROCK JOHNSON: We're on No. 7.

CAROLE BOYE: We're on No. 7. So for purposes of us moving forward here, that was a motion to replace No. 7 in the accomplishments in its entirety with this one?

J.ROCK JOHNSON: Yes.

CAROLE BOYE: If you made that motion, I'll second that, for purposes of discussion.

J.ROCK JOHNSON: Thank you.

CAROLE BOYE: And then I have question.

JIM JENSEN: Okay. Fine. Now we're open for discussion.

CAROLE BOYE: In terms of the question, is the only change that was made in that what I see italicized, that say "consumer positions created"? Or is that...that's the substance, as I'm trying to quickly compare and contrast this. The Office of Consumer...no.

SUSAN BOUST: I have a question because I am just to the end of comparing mine, and consumers have comprised an integral part of the membership of the oversight commission and advance principles and practices of inclusion in all aspects of the reform effort as envisioned by the statute. Do you want that language removed?

J.ROCK JOHNSON: We should like that language to appear possibly at the end of the introduction. It's very nice to have that acknowledgement, but to have that placed in that particular position doesn't seem consistent with the relationships.

JIM JENSEN: Dr. Wilson?

DANIEL WILSON: I'm very supportive of these changes. I would suggest that they be combined into a single recommendation and included somewhere in the report, perhaps under No. 1. But I'm confused about the idea of this proposal, J.Rock, for No. 7 on the Office of Consumer Affairs. And we're talking about replacing Recommendation No. 7, which is about recommending that the regional centers remain accredited, in my copy.

CAROLE BOYE: No. Seven and eight is actually accomplishments on page 4.

DANIEL WILSON: Oh, I see. So it's not a recommendation.

MARIO SCALORA: No.

DANIEL WILSON: Okay, thank you. All is clear.

CAROLE BOYE: I think that we have to deal with the accomplishments separate from the recommendations, would be my goal. I...again, for purposes of discussion and maybe calling the question here, I see No. 7...I have no objection to No. 7 and No. 8. I think it says, you know,...conceptually it's consistent with what Senator Jensen had included in the report. There are some words missing here, and I defer (machine malfunction)...of No. 7, current No. 7, remain there, because to me, it does add to the record that we have made strides, and I believe it belongs in the accomplishments, not in the preamble.

MARY ANGUS: I believe my...this was one of the things that I felt really strongly about it, and to include it under the Office of Consumer Affairs, I think, is erroneous. Our presence on this commission had nothing to do with the Office of Consumer Affairs being created.

J.ROCK JOHNSON: And in my marked-up copy where I put consumers every single place I could find to put it, which I am not bringing forward. (Laughter)

_____: Thank you. We want to be home before midnight.

J.ROCK JOHNSON: On page 2,...

_____: Of which document?

J.ROCK JOHNSON: ...on page 2 of the original introduction and purpose, four lines up, initial commission members were appointed by the Chair June, 2004, in order to meet the requests...we could add, consumers were active members of the commission and advocated for the principles and practices of inclusion in all aspects of reform.

DANIEL WILSON: I'm not following the citation, J.Rock. This is page 2 of the commission document?

J.ROCK JOHNSON: I'm sorry...of the final document. We were willing to let accolades for ourselves go by, by removing them from the Office of Consumer Affairs that we considered inappropriate. We have a suggestion, if it's considered important, of a sentence that could be added to the final report on page 2, toward the bottom. The sentence is, consumers were active members of the commission and advocated for the principles and practices of inclusion in all aspects of reform. It follows the sentence, the commission members were appointed. []

MARY ANGUS: Is that a motion?

MARIO SCALORA: So that's part of your motion, too?

J.ROCK JOHNSON: Yes. That was considered important.

MARY ANGUS: I would second that.

JIM JENSEN: Does a second...well, we have a motion before already. Now if you want to add that, and if the second would accept that,...

MARY ANGUS: Sure.

JIM JENSEN: ...I'll accept that also, okay?

MARIO SCALORA: Let's... []

J.ROCK JOHNSON: There's no discussion.

_____: I call the question. Can I do that?

CAROLE BOYE: Call the question. []

MARIO SCALORA: Yeah, let's move on.

JIM JENSEN: Yeah. We have a motion and a second.

CAROLE BOYE: I need my Robert's Rules; I don't know how this works.

JIM JENSEN: And Jeff, do you understand what we're doing? Oh. (Laughter)

_____: All right. Explain.

JIM JENSEN: No, no. I won't even ask for that.

SUSAN BOUST: No, I think before we vote it's important it's important we know what we're voting on.

CAROLE BOYE: We are moving the last sentence of the current No. 7 to...

JEFF SANTEMA: No, not specifically. That wording from the...the motion that I have is No. 7 in the accomplishments would be replaced by the language that you have in front of you, and then in the introduction section, at the point that J.Rock indicated, there would be a new sentence added there as J.Rock read. And J.Rock, if I could get the exact language from you. I have to make sure it gets...

CAROLE BOYE: I withdraw my second. I thought we were working on this language. If I haven't heard that that's a strong piece of...you know, that sentence being moved and us spending time to include that sentence is a strong piece of yours, so I withdraw my

second to your amended motion, and I'd like you to go back to your back to your original motion of No. 7 in its entirety, and I will second that, and then we'll clean...(inaudible).

J.ROCK JOHNSON: And I call the question, then.

JEFF SANTEMA: Just on Accomplishment No. 7 (inaudible)?

JIM JENSEN: All right, all right. All those in favor say aye. Opposed? All right.

J.ROCK JOHNSON: I would move the acceptance of No. 8 as we have revised it in the document that was distributed to you.

DANIEL WILSON: I will second that.

JIM JENSEN: We have a motion and a second on that. Discussion. Any discussion?

_____: Hang on just a second.

TOPHER HANSEN: I'm preparing (inaudible). I'm sorry.

JIM JENSEN: Any other discussion? All those in favor say aye. Opposed? Any other motions?

J.ROCK JOHNSON: The last motion is to add the sentence, "Consumers were active members of the commission and advocated for the principles and practices of inclusion in all aspects of reform"...

JIM JENSEN: That's on page 2?

J.ROCK JOHNSON: That's on page 2, to appear after the sentence that begins "Initial

commission members were appointed."

TOPHER HANSEN: Second.

JIM JENSEN: Motion seconded. Any discussion? All in favor say aye.

J.ROCK JOHNSON: Thank you so much.

JIM JENSEN: That concludes...

MARIO SCALORA: Did you want to add the recommendations? You want to do that right while you're here?

J.ROCK JOHNSON: Oh, sure.

MARIO SCALORA: Since we're in the parking lot, let's (inaudible). (Laughter)

J.ROCK JOHNSON: Yes. I move the acceptance of the recommendations as written and distributed to you, be included.

JIM JENSEN: Is there a second to that one?

MARY ANGUS: Second.

JIM JENSEN: We have a motion and a second to replace Recommendation 1 with the recommendation as presented by commission member, J.Rock Johnson. Yes, Carole?

CAROLE BOYE: For purposes of discussion, as I'm reading this, the whole syntax changes, okay? I don't disagree with anything that's in this recommendation. But what is of concern to me is that the audience of this report, as I understand it, are senators.

JIM JENSEN: That's correct.

CAROLE BOYE: There is a lot of philosophy and process in this recommendation, not as measurable action steps. I think that tends to water down its impact to our intended readers and makes it more difficult to measure whether or not the recommendation has, in fact, been implemented. So I would just ask the authors to consider that and see if there is any way to streamline it in a way that it's clear as to what are the actions steps that are being recommended here.

JIM JENSEN: And I'll just echo that as a former senator who had voluminous paper before them every day, and boy, the shorter you can keep it, the better chance you have of somebody reading it.

CAROLE BOYE: I think it will be more effective. What's the bottom line? I just think it would be more effective.

J.ROCK JOHNSON: And since we don't have the luxury of doing a rewrite, I will note that there are many aspects in here regarding outcome measures and so forth. There was nothing in the original that was any different than what has not already not been being done, such as expand, continue, provide. So I think that there are action steps that are included in here and that we as advocates would point to these different items. I recognize it's not in the best format, but it certainly gives us much more, in terms of action and very reasonable expectations.

TOPHER HANSEN: But if it's the difference between...for the statute and an annotated statute, that there is...that the bullet points and that sort of explanation and justification for it, and I think that gets too much. It just overloads, in my mind. I don't disagree with what I'm reading. It's just, in a final report of this sort, I just see what's written as carrying out the message in a concise way, which I think is of value.

CAROLE BOYE: I'm going to take just a quick shot at this, and I know time that if we can't reach agreement, then we'll take a vote. And again, this is...my intention here to make this more effective in terms of communicating. And I'm just starting from the bottom. I would eliminate "i" in its entirely, because it's needed...this is needed, but there's not a tangible action step to it. On "h" I would eliminate the first sentence and say, you know, "The commission...it would read, then, "The commission recommends comprehensive training and integrative treatment approaches must be provided." That's where I'm trying to just make this a bit more clear in what we're doing. "g" is fine. It's an action word. It's "provide funding and training necessary." "f" "Continue to measure and demonstrate." "e" provide for consumer. I don't have any recommendations for that. I don't know how you develop meaningful and good faith mechanisms for creating individual recovery plans, but it does say "develop." That one doesn't bother me as much, "and create additional." Okay, I would stop "c" at "Identify and incorporate existing 'real world' opportunities, and create the additional opportunities for consumer voice that are required for this mandate." Because now we're explaining it, in terms of "No government employed..." So I would delete the second and third sentences of "c". Fund the increase...I would delete the first sentence of "a". So Jeff, here I'm going to try...now I'll try to go front ways, okay?

J.ROCK JOHNSON: Senator Jensen, I would, if I may...this is prefaced with suggested approaches, and these are all approaches. These are philosophical, if you will. But they are nothing more than bringing these ideas and thoughts to the division as suggested approaches that they can consider, reject, work with. But that's what they are. They're not statements of fact.

JIM JENSEN: J.Rock, you are one of the new members of the new committee. Could these be taken up there, or do you want these to go in this report to the senators?

J.ROCK JOHNSON: Given whatever concerns or deficits that are perceived to be here,

I do think, frankly, that it's critical that this do go forward. And we can deal with some of these concerns there.

JIM JENSEN: Do you have any...do you buy into Carole's comments, or you would rather stay where you are?

J.ROCK JOHNSON: I understand her point of view. I don't have the capacity now to sit and cross and...

JIM JENSEN: All right. Dr. Wilson?

DANIEL WILSON: Given a number of consumers on the commission and beyond, apparently, have given quite a bit of thought to this, and with our time frame and this being our last meeting, I would recommend that we accept it as written in the final report, as a change. That's my story and I'm sticking with it. (Laughter)

JIM JENSEN: Susan, and then we are going to take a vote. Oh, excuse me. Did I miss somebody? Shannon, I'm sorry.

SHANNON ENGLER: I just wanted to comment. I believe that the original recommendations are fine. I think that...again, like everyone else, I don't disagree with these items, except there are a couple of them that are very pointed and that I think could be misunderstood and...for instance, comprehensive training and integrated treatment approaches must be provided to all members of treatment teams, including peers. That really extends beyond just the statement about peers and consumers. That's prescriptive about clinicians, so I can't...I would prefer to support the original recommendations and not list it.

JIM JENSEN: Susan, and then we will...

SUSAN BOUST: And with great reluctance I also am speaking against this motion. It is not that I disagree, again, with the words there. But I think this is a report for the entire commission, and there are certainly issues in here we have discussed, but I don't believe adequately to have them included as recommendations at this time, although I think all of the recommendations listed currently or the discussion that Carole brought forward, which is "wordsmithing," which I think we agreed not to do...it's a difficult position to be in, because I certainly am not speaking against consumer inclusion at all. I am saying, however, that as a report of the final commission, I think that there are things in here that I disagree with that require extensive discussion, and I think we touched on them earlier but never got to them. I think they need to be included in the new commission, but I don't want to go on record as a commission with these are my words, and yet I understand that the consumers also have to be allowed to say, these are the words we want. So I don't...but I don't know what else to do except to oppose the notion as it stands.

MARY ANGUS: I personally...perhaps this would be helpful, at least in part. If "i" were begun with the words "provide oversight by consumers." I'm not going to try to reword it altogether right now. I do feel like we have discussed these issues as a commission, and so other than having a separate report, which I think would be...I may be willing to do that, but I think as a commission,...

_____: In four days?

MARY ANGUS: In four days I could not do that. However, as a commission, for it to be split off is inappropriate.

SUSAN BOUST: I'm not disagreeing.

JIM JENSEN: We'll stop discussion.

CAROLE BOYE: I have one question.

JIM JENSEN: Yes.

CAROLE BOYE: Which is, this revised language, as I understand it, you are seeing as builds upon...is better language, broader language than the original Recommendation 1.

J.ROCK JOHNSON: Yes.

CAROLE BOYE: Is there anything in Recommendation 1, as it stands in the report, that...I understand you think it could be better or it should be broader, but is there anything that you disagree with in the original Recommendation No. 1 or objective?

J.ROCK JOHNSON: Recommendation No. 1, those were worked into. Everything that's in Recommendation No. 1 is included in here. It was simply that Recommendation No. 1 is simplistic, has no specific outcomes, does not provide us with the ability to go forward.

SUSAN BOUST: I know you want to vote on this, but if I might ask for permission for one more statement. I believe that this issue may be our most time-consuming issue, and I believe that it's extremely important that we not put ourselves in a position where the consumers and family members on the conference feel like there's a vote like this, without them having adequate voice. And I don't want to be put in the position where there's lack of clarity on why I'm voting the way I'm voting. And I don't know what else to say, except it feels like this is a very important issue that we should not rush through.

MARIO SCALORA: May I suggest a strategy? Maybe part of this is figuring out how workable or not workable this is. I understand the gravity of concerns from both sides. We could quickly poll if people had any objections to the specific aspects of this. I heard objections to sections "h" and "i". Are there other objections?

SUSAN BOUST: I object to the final part of section "c", and I think that will be a big issue for discussion. And I do agree, it has been raised, but I don't believe the commission has taken a position (inaudible).

CAROLE BOYE: Could we actually parse this, in terms of section by section...yes, include; no, not include?

MARIO SCALORA: I guess I'm trying to fine out how practically workable this is in a reasonable time frame, and if we find that most of it is objectionable, then we have a problem.

CAROLE BOYE: Maybe without discussion.

MARIO SCALORA: Right.

CAROLE BOYE: I would make a motion...here's a trial motion, okay, in terms of trying to parse this, that we adopt, section by section, the preample to Recommendation 1, and "a", the first sentence ending at the period, developed. That's my motion.

SUSAN BOUST: We have a motion on the floor.

CAROLE BOYE: Do we have a motion on the floor? Okay, never mind. I forgot that.

JIM JENSEN: Well, I'd like to go back to where Mario was, and if you've got any more comments.

MARIO SCALORA: I guess I just need to know how much is unworkable in the eyes of people, and how much is...you know, where the level of disagreement is. And for example, Carole, you raised a question about section "a", the last part, because you're

thinking it may water it down. Is there other objection to "a"? Let's go to "b".

TOPHER HANSEN: "a" in the proposal? So what is...I mean, I don't know "publicly take a position that new treatment approaches and attitudes have developed." What does that involved, and what does that...how, you know...if I were HHS and Scot, is the issue a news release or what? Do you understand? In terms of being a measurable task and what we need to do further. I don't disagree with the concept, but in terms of what this report is about, it's sort of editorialized and annotated in a way that's going to be hard to carry out as a report. And so, my...the fact that there's no objection to the content of the original recommendation, but this is just expanded upon, I think, says to me we have the core right here that actionable. And so to publicly take comment...you know, if that got thrown into my arena, I'm not sure what I would...what do I need to do with that? So I do have some objection to that.

J.ROCK JOHNSON: Again, that's why it's a suggested approach. That's the...all these are.

JIM JENSEN: Let's try this. Would you accept removing the first sentence on "a"?

LINDA JENSEN: Removing the first sentence.

J.ROCK JOHNSON: I think Mario was actually processing this, so.

CAROLE BOYE: I think you have one person who said, I have no problem...my suggestions, the wordsmith, would be give us the second sentence. You're saying the first sentence.

MARIO SCALORA: We've got problems all over the place.

CAROLE BOYE: So I think the answer to your question, Mario, is no.

MARIO SCALORA: Got you. Let me brainstorm another solution here, because I see some well-written recommendations already proposed, and I see a significant group of our colleagues saying this is good, but we think more needs to be said. And I don't want to ignore what they want to say here, and I think that voice has to be heard. Another option may be, thinking out loud and perhaps a friendly amendment, is not to change the recommendations but note in the recommendation, there is an annotation to be provided, and we use the term annotation to further elaborate what we think is important here and throw that in, or throw in that language. Now if there's still concern about the language, that doesn't work.

CAROLE BOYE: The problem is, is there's been some objection to some of the specific (inaudible).

SHANNON ENGLER: I would still be opposed to what I stated earlier.

MARIO SCALORA: Okay, got you.

JIM JENSEN: If we would vote on accepting Recommendation 1 as presented, move on through the rest of them, come back and add to that, either in what you said, to annotate or whatever, would that be acceptable? I'm asking the consumers.

DANIEL WILSON: We have a motion on the floor or not?

JIM JENSEN: We do.

MARIO SCALORA: Let's deal with the motion on the floor and figure out what we do next, I guess is the bottom line.

JIM JENSEN: All right. We have a motion on the floor.

J.ROCK JOHNSON: The motion on the floor is to accept these as published.

JIM JENSEN: To replace the Recommendation 1 with the one presented by J.Rock.

DANIEL WILSON: Senator, you were sort of saying that we'll do something...we could do something differently after dealing with this motion, or not?

JIM JENSEN: Well, I was saying that, but we do have a motion on the floor, and...

MARIO SCALORA: We may have options afterwards.

GORDON ADAMS: Call the question.

JIM JENSEN: All right. The question has been called for. All those in favor of replacing Recommendation 1 with the recommendation that was presented by the consumer group, raise their right hand.

JEFF SANTEMA: Seven hands.

JIM JENSEN: Those opposed, raise their right hand.

JEFF SANTEMA: Five.

MARIO SCALORA: We have abstentions?

JEFF SANTEMA: Two abstentions. (Inaudible)

MARIO SCALORA: So what was the vote, Jeff? I'm sorry.

JEFF SANTEMA: Seven, yes; five, no, on the motion.

MARIO SCALORA: So the motion dies?

JIM JENSEN: No, no. The motion passes.

MARIO SCALORA: The motion passes.

JEFF SANTEMA: Of those present and voting, (inaudible) majority of (inaudible) majority vote required of the entire commission. Is a majority vote of the entire commission required, is my question? There aren't...I think Bob (inaudible).

JIM JENSEN: We'll go by majority vote. Any other motions, going down two, three, four, five, six, and seven? I don't see any. I think we can take up...Dr. Adams, you would...well, go ahead.

GORDON ADAMS: For the reason I stated, I could not support this recommendation. I just...I think it's interfering (inaudible) HHS department.

SUSAN BOUST: Where are we?

DANIEL WILSON: Senator, I would move that the report, as amended, be accepted.

J.ROCK JOHNSON: Second.

MARIO SCALORA: I'm confused what just happened here, and I know that's not a new state for me, but (laughter) I heard Dr. Adams getting ready to make a motion, and then another one jumped in. Is that what I heard?

DANIEL WILSON: Well, I thought...I'm sorry. I thought Dr. Adams was saying that he

couldn't support a particular recommendation as a point of discussion.

MARIO SCALORA: Right.

DANIEL WILSON: But if...

GORDON ADAMS: You're saying you're not supporting my position.

DANIEL WILSON: Well, no, I'm sorry. I misunderstood what was happening. Dr. Adams, my apologies. I thought you were in a discussion mode, not a motion mode, but...

GORDON ADAMS: I would just make a motion to eliminate Recommendation No. 8.

JIM JENSEN: Is there a second?

MARIO SCALORA: I'll offer a second for purpose of discussion. We have now two motions on the table.

JIM JENSEN: No.

JEFF SANTEMA: There was no second.

MARIO SCALORA: There wasn't a second? I'm sorry, I thought there was.

J.ROCK JOHNSON: There was.

_____: There was a second.

_____: Did you withdraw your motion?

DANIEL WILSON: Yeah, I thought I did. I will.

MARIO SCALORA: I'm sorry.

JIM JENSEN: All right. We have a motion from Dr. Adams to remove Recommendation 8. And we have a motion; do we have a second?

MARIO SCALORA: I offered a second.

JIM JENSEN: We do have a second.

MARIO SCALORA: Yes.

JIM JENSEN: Discussion.

J.ROCK JOHNSON: Call the question.

TOPHER HANSEN: Could we have a little more time? (Laughter)

J.ROCK JOHNSON: I withdraw calling the question.

TOPHER HANSEN: By the way, just if we're on Robert's Rules of Order, just so you know, when you call the question, that requires a second and a vote before you move on. It's not just a matter of ending it. But...so the...I guess my concern here is that we keep our mission focus again, and that the idea is to develop the Lincoln Regional Center as the behavioral health location and not diffuse that and start to have creep, if you will, back to the old system. And I think that use of Norfolk in that way starts to blur that boundary and create problems, system problems down the road. And then what it demands of the system is to develop resources at the Lincoln Regional Center to cope with the demand of the state. So I support Recommendation 8.

JIM JENSEN: You support Recommendation 8.

TOPHER HANSEN: As it stands.

JIM JENSEN: Yes, Dr. Boust.

SUSAN BOUST: And I'm also going to speak against the motion, but primarily because of Recommendation 9, which is, I think...these two need to be very much considered together. This isn't failing...I think the commission is not failing to recognize the recent crisis and need to move people out of Lincoln Regional Center back into Norfolk to decompress the system as (inaudible) to deal with the critical criminal justice and mental health issues. But at the...and I think we've seen this at the...the original intention of LB1083 was to move those services into community, and I think 16-bed, locked residential, longer-term care is a better way to address this. Now this is the same kind of issue, I believe, that I was being critical of the previous change, of saying, you know, is this a thing that we've adequately discussed in here? I believe this commission has adequately discussed, do we want our long-term secure services at three state hospitals spread across the state in institutions, or are we looking for a different system of care that really meets the needs? And I believe that we've had that discussion. But I don't believe that we can just act on Recommendation 8 without looking at Recommendation 9, which says build a 16-bed facility in Norfolk and another one someplace else in the state, to start to deal with these issues, to get some (inaudible), to move away from the institutional kind of situation, where we really do have a (inaudible) maintaining that recovery focus, and where you're not putting some of our most vulnerable people in an environment where the great focus is going to be on sex offenders. So I'm speaking against the motion.

MARIO SCALORA: I guess I would...while I agree with the practice that we need to use more focus strictly for sex offender treatment--and I think at the moment they're able to

segregate mental health and sex offender treatment there, because I realize how contentious an issue that is, and appropriately so--I'm a little concerned about, even though this doesn't have the force of any authority, the notion of immediate cessation, when they're trying to integrate regional centers and manage this. This is a very complicated and difficult business. I don't think we should recommend to the Unicameral tying the hands of people while they're trying to get there. And so I guess I have the concern about the use of the word "immediate" in that respect, and tying hands. Frankly, this is...we're going to have some fits and starts. I also agree that we shouldn't throw the gates open and move Norfolk to where it was, and I'm not supporting that. I guess I don't recommend we tie the hands of people trying to get where we think they're going, and so that's where I'm coming from in that respect, and I think some flexibility is in order. So I...ultimately we should cease doing it. I think "immediately" ties hands and puts us in a very awkward spot, when we have other legal requirements that the regional centers meet as we're building these other services. So that would be my concern as we do this, so.

SUSAN BOUST: So is that for or against the motion?

MARIO SCALORA: I would be in favor of Dr. Adams' motion, based on how it would tie the hands of folks trying to run the regional centers at the moment, as we move toward what you're saying.

JIM JENSEN: Dr. Wilson.

DANIEL WILSON: Having actually run a state hospital system that made some of these transitions, there are times when it is actually helpful to have external pressure to do certain things that are uncomfortable to do, number one. Number two, Mario, this isn't...even if...this is our recommendation. It will forwarded to the Unicameral and others. I'm not aware that they're going to immediately enact any laws to do this. (Laughter) If they do enact a law, it will be a year or so from now, and I think Dr. Boust's

comments about the continuing development of alternative Medicaid-based services is salient, and this recommendation is very straightforward and sensible, in my view.

JIM JENSEN: We'll take one more comment, and...

CAROLE BOYE: I too would speak against the motion. The moving of patients from Lincoln to Norfolk was presented to us by the department as a temporary, we have a situation we need to deal with it, but a temporary solution to an immediate issue. We have been told by the department that it is not their intent to continue that, so I don't see this as being anything contrary to what the department has already said. That was a temporary thing and it's intended to stop. Recommendation 8, I totally agree with and support the comments, Dr. Boust, that you made, that 8 and 9, you can't accomplish anything till you start looking at Number 9 and what replaces it. But I particularly think that Recommendation 8 goes back to the essence of LB1083 and the purposes which are clearly cited in the introduction here.

GORDON ADAMS: Just an anecdotal thing. When I'm hearing from personnel at the Norfolk Regional Center, they have repeatedly dismissed patients to other facilities and had them come right back, because they couldn't be handled at any other facility. And so it's a necessary thing we've got there, and to just say, oh, just eliminate it, that puts some people out in the street, and that's been a concern of mine forever. Putting them in the street is not a solution; it does not help anybody's mental health to be denied treatment and kicked out.

JIM JENSEN: Any other discussion? Yes, Shannon.

SHANNON ENGLER: Senator, I would just say that in light of the fact that we seem to have continuing decreasing number of beds at LRC, and Dr. Boust mentioned No. 9, we don't have those two 16-bed facilities open, I'm not aware of any other immediate alternatives that have been produced to deal with the situation (inaudible). I think that

Dr. Adams' recommendation is reasonable.

JIM JENSEN: I'll take...Dr. Wilson, you'll be the last comment.

DANIEL WILSON: Well again, the recommendation gives the state and the regions a year to implement this, assuming it's enacted or endorsed as written. This is our recommendation, that over the next year--this could be our recommendation--that over the next year, with a time line, LB1083 is further implemented in an important way, and I think it deserves the support of the commission.

JIM JENSEN: Okay. I'll call for a vote. The recommendation from Dr. Adams was to remove Recommendation No. 8. All those in favor raise their right hand. Those opposed raise their right hand.

JEFF SANTEMA: Four, yes; nine, no.

JIM JENSEN: Recommendation 8 stands. Any comments on 9?

CAROLE BOYE: Senator, I move the adoption of all the remaining recommendations, as presented.

TOPHER HANSEN: Second.

J.ROCK JOHNSON: Call the question.

JIM JENSEN: Do we have a motion and a second? Any discussion?

JEFF SANTEMA: Who is the second?

MARIO SCALORA: Would that preclude any other additional recommendations?

JIM JENSEN: No, no.

MARIO SCALORA: That would not?

JIM JENSEN: No.

MARIO SCALORA: I just was curious.

JIM JENSEN: All those in favor say aye. Opposed?

GORDON ADAMS: Nay.

JIM JENSEN: Now, any other recommendations that anyone would like to make to the report?

DANIEL WILSON: Senator, I'm not certain it's yet a recommendation, but I think it would be helpful to hear from other members of the commission if anyone shares my concern that this commission ending, and with the follow-up commission constructed as it is, if there may be a narrowing of the representation and expertise and other important factors in the new commission, even if the intent is to broaden the vision and the work range of the new commission. It strikes me as anomalous as compared to other states in their approach to inclusion of stakeholders in the very important ongoing work of behavioral health reform. And maybe I'm the only member of the orchestra out of rhythm, but I'm concerned about that. And if true, there will be a reduction in influence and input to the state in the future. I don't know if a recommendation could be formed from that, but I'd actually invite some comments from colleagues.

JIM JENSEN: Yes, Mary.

MARY ANGUS: Dr. Wilson, you are certainly not alone. If I'm the only one that joins you in that concern, I'll be surprised, but I share that concern.

JIM JENSEN: Topher?

TOPHER HANSEN: I agree. I'm concerned about the manner in which this was approached. I know a number of the people...most of the people that are on the new oversight commission, and they are smart people who are dedicated and have experience, several of whom have either sat here in these meetings or sat in the gallery. But one year and four meetings or possibly more is not commensurate with the task, I fear, and that it takes continuity. And it took us awhile to gel as a group and get our information, even though we are all experienced in many ways in this area. I fear that it will be a difficult task and possibly one that can't be achieved well in that period of time. And the other thing that I think is just my own dismay is that this action was taken that the continuity and the experience of this group was not used to form the strategic vision when the experience is here, and that the issue was the delegation of powers and the constitutionality of our group. And to me, it's tremendously ironic that the Legislature defeated its own super vision of the executive branch, even though easy steps could have been taken to not...or to reduce the delegation issue and just have it be a balance of power. To move it under the executive branch loses the balance and is really defeating the whole purpose of the statement that Dr. Wilson brought up about the watchful eye of the citizen. So I object to what has happened. I have not been in favor of it. I think it's the wrong solution, but I certainly encourage the group that follows us to move forward with vigilance and carry out a strategic vision that will benefit the state.

JIM JENSEN: Okay. I might mention that there are two interim studies, LR337 and LR338, to kind of look at this, and that might be our time to really make our voice known on that.

DANIEL WILSON: I guess I wonder whether our report should comment on the

succession or remain silent about it. It's presently silent. I think it's an important issue.

MARY ANGUS: If I may?

JIM JENSEN: Yes.

MARY ANGUS: I would, although this wasn't necessarily written as a recommendation and I have just jotted things down here...I understand that the composition of that commission is under the Legislature and would not be necessarily up to new commission to change. However, I guess I would recommend that the new oversight commission...well, without knowing how it would go into the Legislature...the new oversight commission enlarge the number and composition of the membership to include at least two consumers, two family members, and then whatever else or whomever else this commission might suggest. If it needs to be reworded so that the recommendation would be that the commission go to the Legislature to change that composition, I would be open to that rewording.

_____: That's statutory.

MARY ANGUS: Then it would be to encourage them to go to the Legislature?

_____: I think...

MARY ANGUS: Well first, do I have a second on that, so we...

LINDA JENSEN: I'll second.

JIM JENSEN: All right. Then we're open for discussion. Carole, you had...

CAROLE BOYE: What we're doing is, in my opinion, something like that, a) it requires a

statutory change, okay. And we can get into a debate as to what the composition is, but I think there's two issues with the new commission; one is its composition, but the second is its very structure.

_____: Um-hum.

CAROLE BOYE: And I think there's varying opinions. I mean, I could certainly support what you're saying, Mary. I think there's various ways to try to increase the representation on that. I think structural issues, however, for me are of more significance, because if we don't address the structural issues, then it doesn't matter who's on that group. It doesn't make much difference. To me the structural issue here is that this is now, in essence, an advisory group to HHS.

MARY ANGUS: Right.

CAROLE BOYE: And Scot so nicely alluded to, at times this has not been nonadversarial. You know, it has felt adversarial, okay? The question is in my mind, is when it gets to the point again, on that kind of an issue, on that kind of a give-and-take. As an advisory committee to HHS, what is the department's response to that? My hope is that it's no different than it has been to this commission, which ultimately, you know, the Legislature could demand, or the Chair of the Health and Human Services Committee could demand something. But there is no safeguard for that, and I think that's the underlying concern here, is that there could be as much vigilance, there can be as much give and take, there can be as much discussion, and hopefully, as much input in any number of ways. It's what happens when there is disagreement, which has occurred at times here?

MARY ANGUS: My thinking on that, Carole, is that that's another recommendation. I would totally agree with what you're saying. I don't know if we can...

CAROLE BOYE: I don't know what to recommend, though. That's the problem.

MARY ANGUS: Well, yeah, exactly.

DANIEL WILSON: Senator?

JIM JENSEN: Yes.

DANIEL WILSON: These are very helpful comments, and I think Topher's statement I would reiterate. The people involved in the new commission, the ones I know, are very substantial and will contribute. The structural issues are important. The lack of comprehensive stakeholder involvement is my main concern, along with the fact that it sort of is involuting into state government, in a sense, the executive branch. But as a practical matter, the composition can't really be changed by statute before this commission is over,...

MARY ANGUS: Right, right.

DANIEL WILSON: ...so I guess I wouldn't recommend a Pyrrhic victory, even if we could have one. (Laughter)

MARY ANGUS: Good point.

JIM JENSEN: Susan.

SUSAN BOUST: I agree with all of those things, including, you know, the composition and the structure. It seems that we're back to where we were when LB1083 was starting, which is that the important thing isn't who's sitting around the table at the commission, but the citizens of the state of Nebraska's awareness of behavioral health issues--where we are and where we still need to go. And so for me the important

recommendation is...I do believe that it is important that this commission report recognize that we didn't feel that our work was done, and maybe even a statement that this is, to some extent, a minority opinion to HHS about our readiness to celebrate and be completed. And whether that goes in the front or the back or is an addendum, I don't know. But for me personally, I think what's important to me as we move forward, is that I feel some "assurity" that I'm going to be able to stay connected to the decisions that are being made, and informed about the choices that are being made. I see the folks who have sat and listened as public commentators, and I'll be out there now, and I don't know that we've done a good job of moving beyond ourselves and getting information out to people. And I'm hoping that the next commission does a better job, and I guess I would like a recommendation to say that that commission be much more public than maybe even we have been.

CAROLE BOYE: Okay.

MARY ANGUS: Could we maybe just vote on the first recommendation? Because I want to get to that one; I like that one.

DANIEL WILSON: You might withdraw it, Mary, based on the fact that it's...

MARY ANGUS: I will withdraw.

JIM JENSEN: Motion is withdrawn.

SUSAN BOUST: So I'm going to move a recommendation that we include at the Senator's, trusting your "wordsmithing," that there be an inclusion in the initial part of the document that indicates that we did not feel that we were done and makes reference to the importance of the structure of this commission and the oversight, and that we include in a final recommendation that as the new commission moves forward, that there be much more inclusion of information out to the community, and a better way

than people sitting through the entire meeting voiceless and waiting for three minutes to take in input from the outside. Survey (inaudible).

JIM JENSEN: You got that, Jeff?

JEFF SANTEMA: So including at the beginning is a statement that the commission's work is not done, the importance of the new commission,...

SUSAN BOUST: And that the commission's work is not done, and that we believe that the structure of this commission under the Legislature was an important piece, at least at the time that we were doing our work.

JEFF SANTEMA: And that the new commission be much more...

CAROLE BOYE: That would be a recommendation, now.

SUSAN BOUST: (Inaudible) this would be a recommendation.

JEFF SANTEMA: As a part of your motion?

SUSAN BOUST: This is a part of my motion, two things that we added. []

JEFF SANTEMA: And a new recommendation that the newly formed commission be more, you said inclusive of information to the community, or...

SUSAN BOUST: Public.

MARY ANGUS: Or public.

SUSAN BOUST: Interested parties.

CAROLE BOYE: A friendly amendment or two? Again, I'm into action words. That's what I think recommendations should have; you know, that the new commission publicly disseminate agendas, reports, data, on a regular basis. You know, and I know we're not in the discussion part, but I take note that this stuff is no longer on the Web site. That makes it harder for people...

MARY ANGUS: Do we need a second or a third second or a fourth, because I'd like to do that. (Laugh)

CAROLE BOUST: Well, I (inaudible) suggest a language (inaudible).

SUSAN BOUST: I take that friendly amendment, that it be in measurable and action words, and in addition to Carole's friendly amendment, that the Web site, you know, be active and take information from people.

MARY ANGUS: Right, right.

DANIEL WILSON: If we're entertaining friendly amendments, Dr. Boust,...

SUSAN BOUST: Jeff is writing, so...

JIM JENSEN: Yeah, he hasn't stopped writing, so just...

SUSAN BOUST: He's being real friendly at the moment.

DANIEL WILSON: I would like to suggest that we point out, politely and thoughtfully, that the new commission has a great deal of quality people on it, but that there is some risk of it having a rather narrow focus. I don't know quite how to phrase it, but I think if we don't point that out, they may not appreciate what...and that they don't know what

they don't know. And being a more narrowly drawn commission, more formally structured and placed under the executive branch, there are significant potential issues with that. So Dr. Boust?

CAROLE BOYE: So are you suggesting a friendly addition...

MARY ANGUS: To the friendly amendment. (Laugh)

CAROLE BOYE: ...that is yet another recommendation? I'm almost hearing another recommendation that the Legislature review the composition and the structure, and...

DANIEL WILSON: To broaden stakeholder involvement.

CAROLE BOYE: Broaden the stakeholder?

DANIEL WILSON: Yeah, that's fine.

CAROLE BOYE: Yet another recommendation.

LINDA JENSEN: And there will be a review with this legislative...with an interim study, or not?

JIM JENSEN: Well, the interim study is a public period where you can make comments, but...

DANIEL WILSON: Senator, that is to...part of the idea is to figure out what to do after next year. I mean, this new commission, the life span of it is to be...

JEFF SANTEMA: Just a year.

TOPHER HANSEN: (Inaudible.)

DANIEL WILSON: So do we have any comments about what...any recommendations about what happens thereafter, as a commission?

JEFF SANTEMA: Excuse me, Dr. Wilson. As I understand the motion now, it would be, if I...

DANIEL WILSON: We don't have Dr. Boust here to accept the friendly amendments.

J.ROCK JOHNSON: She left her (inaudible) with me and said, I support whatever. (Laughter)

MARY ANGUS: That's a formal support.

JEFF SANTEMA: The motion would be to include reference at the beginning of the final report that this commission's work is not done, that its original organization under the Legislature was appropriate, and stressing the importance of the new commission and its work. Then a new recommendation that is related to the new commission, a new recommendation related to the new commission. And then there have been a number of things suggested as to what that new recommendation ought to say about the new commission, that it have action words related to that the new commission publicly disseminate information and reports data on a regular basis, interactive Web site for the public. There is some risk that the new commission will have a more narrow focus, the concern about stakeholder involvement. The broad part of the motion seems to be for a recommendation to be added to the report about the new commission, and there are a number of things that have been suggested to say about that. Would you like...and I...

MARIO SCALORA: May I suggest we don't have a motion but a word salad, and perhaps we need to...

CAROLE BOYE: Start over again?

MARIO SCALORA: Let's just...

TOPHER HANSEN: And bifurcate. We need to...I think if...we have two issues; we have a compound question.

SUSAN BOUST: I remove my motion.

DANIEL WILSON: Senator, I might offer to the group that we consider a recommendation to the Legislature that they create a subsequent oversight commission to follow up on the new commission, that addresses some of the structural issues and the representation issues involved. In other words, what happens 2009 and onward. Should we maybe focus on that, rather than trying to fix or tweak the new commission, which we really won't be able to do anyway?

JIM JENSEN: And are we talking about a Recommendation 16?

DANIEL WILSON: I believe so.

JIM JENSEN: Okay.

MARY ANGUS: I would second that.

MARIO SCALORA: So something along the lines of, this current commission, before its sunset, found great value in its legislative oversight within its current structure and would encourage the future Legislature to look at alternatives that would incorporate that in the near future, or something?

JIM JENSEN: That's good.

DANIEL WILSON: I think actually, maybe just recommending that behavioral health reform will continue. It has benefited from oversight, particularly oversight that is not...

MARY ANGUS: Legislative.

DANIEL WILSON: Legislative oversight, and broad stakeholder involvement, putting it in a positive sense, and that we would recommend the constitution of an ongoing commission for 2009 and beyond.

TOPHER HANSEN: July 1, 2009.

DANIEL WILSON: Something.

JIM JENSEN: Do we have something that we can vote on? (Laughter)

JEFF SANTEMA: If...I don't feel comfortable with the exact wording, but if you are comfortable with the motion incorporating the principles that you'd like to cover and you'd like to entrust the drafting of it to Senator Jensen, (audible) something like that. And the idea is that the commission wants the Legislature to consider a subsequent oversight of behavioral health reform after the new commission sunsets in 2009. And that's the broad principle that you're...

DANIEL WILSON: But it includes the reference to particular structural issues, legislative oversight, and broadening stakeholder involvement.

MARIO SCALORA: Including broader legislative oversight and stakeholder involvement.

JEFF SANTEMA: And I have those two now. So legislative oversight and broad

stakeholder involvement. I have those two.

CAROLE BOYE: And that's a motion for a specific recommendation?

DANIEL WILSON: Correct.

JIM JENSEN: Yes.

CAROLE BOYE: A finding that this structure has been useful and specific recommendation that the Legislature provide some ongoing mechanism.

DANIEL WILSON: Right, and that behavioral health itself needs benefits from this sort of broad oversight, and we would recommend for the future, for the foreseeable future, really, that something be done.

TOPHER HANSEN: And I think what you just said is important, that there's a pair here.

CAROLE BOYE: There's a finding and a recommendation.

TOPHER HANSEN: There's a finding and a recommendation. And the finding is our unanimous view that this legislative oversight process is valuable and important in the continuation of the behavioral health reform, and our recommendation about July 1, 2009, to have that structure continue with broad stakeholder involvement.

CAROLE BOYE: Yeah, that's your motion, right?

MARY ANGUS: It isn't (inaudible).

JEFF SANTEMA: So the motion (inaudible) of the recommendation to (inaudible)? That's Dr. Wilson's motion?

DANIEL WILSON: Yes, I move that the illustrious Mr. Santema and the wise and wisdomed Senator...

JIM JENSEN: Does everybody understand what we're saying?

JEFF SANTEMA: Is there a second?

J.ROCK JOHNSON: I would second and offer a friendly amendment to stakeholder involvement and level of...composition, including people with lived experience in and with the publicly funded system. What I'm trying, obviously, to get at is that we have more people who can speak from their experience, and that it be experience in the public sector, which isn't to say that it's not helpful.

MARY ANGUS: J.Rock, would that be part of...like a definition of stakeholder?

DANIEL WILSON: It should be, and I would favor just a crisp observation and recommendation that the Legislature address this for the future, J.Rock. And at least in my view, stakeholders' involvement is a very broad term, and I think that, as it's used around the country, would certainly involve consumer input and lived experience.

JIM JENSEN: Should by chance the Legislature accept that recommendation, there's going to be another bill and a public hearing.

MARY ANGUS: Right.

CAROLE BOYE: Right, right. At the risk of offending our parliamentarian here, can I call the question?

TOPHER HANSEN: Aye.

JIM JENSEN: All those in favor,...or any other discussion? All those in favor?

_____: No, (inaudible).

J.ROCK JOHNSON: My discussion is that we're not the stakeholder, we're the stake.

SUSAN BOUST: The question is, calling the question.

J.ROCK JOHNSON: The question in calling the question is that I wanted to say that I don't think that reflects an important principle. And since we've moved on,...

CAROLE BOYE: We are deferring to Jeff and to Senator Jensen to draft this. I absolutely trust that they understand your point and all of our points, that when we say "stakeholder," number one on that list are people who experience (inaudible). And that...if that's not clear, then I think you've just an exclamation point on it.

J.ROCK JOHNSON: What wasn't clear to me was that we were voting on the concept of, in an incorporation of these, rather than specific language. So now that I understand that, certainly let's go forward.

JIM JENSEN: I think we got that. All right.

MARIO SCALORA: So we have a...

JIM JENSEN: Shannon.

SHANNON ENGLER: I just had a question. Okay, so...

SUSAN BOUST: Question is called and seconded.

MARY ANGUS: We should vote.

SHANNON ENGLER: I know. I need to get an answer to a question to understand, for the discussion component, right?

JIM JENSEN: Right.

SHANNON ENGLER: Okay. We're dissolved because of...what was it? The separation of powers act. Now we're saying...what I'm hearing is, is we're asking for a new commission to be formed which is essentially the same thing. This is going to be worded in such a way that we're not going to be abridging any laws that we're aware of, since I can't read this thing in front of me? Does that make sense to everybody? I mean, we're asking to put the same thing back in place that...

MARY ANGUS: Yeah, I don't think we're talking about anything illegal.

SHANNON ENGLER: Okay. []

DANIEL WILSON: Yeah, but getting the ball through the wicket, I think, is up to...

SHANNON ENGLER: Yes, so thank you.

MARY ANGUS: And if I may clarify, we are being dissolved because of the sunset of the original LB1083. It was the bill that moved that forward.

JIM JENSEN: I'm going to call for a vote. All those in favor say aye. Opposed? Motion passed. Any other recommendations? Any other business?

MARIO SCALORA: Senator, I think we can't end without recognizing publicly your very

determined and dogged efforts on behalf of LB1083 and seeing this all through, both as a senator and as a private citizen, and I think many people owe you a great deal of gratitude that words could not adequately reflect. And I think I speak for many of us, that we wanted to publicly recognize that as one of our final acts as a "sunsetting" commission. And thank you, in addition to many of the other people who did this, but you deserve great credit for your dogged and tireless effort in this regard. So just wanted to express our gratitude. (Applause)

JIM JENSEN: Thank you. Thank you very much. I wouldn't have wanted to do it any other way. We're ready for public comment.

J.ROCK JOHNSON: May I, sir...

JIM JENSEN: Yes. I'm sorry.

J.ROCK JOHNSON: As a person...I see that Dr. Bigelow has left and therefore will not be making any statement about moving forward to the next oversight commission. I wanted to point out that it stated specifically here, strategic visioning.

_____: Presentation (inaudible).

J. ROCK JOHNSON: From the presentation, yes. I don't know if that goes as far as the action words that Carole might want to see there. It doesn't quite, for me. But I do know that the division has talked about developing a strategic plan in the next six to nine months. In April there was an expectation that information would be out by the end of May and that there are core documents that would be involved that wouldn't be changed. And I look forward to the interface of the planning process, where we have an opportunity to do planning in more publicly inclusive way than we have before, and certainly the new mission, strategic visioning I see is only the tip of the pyramid. But it's the tip that's got the eye on it, as in the dollar bills. And I also believe that I will be able

to call upon any of the members of the commission for your assistance and hope that you will be able to be of help in this matter. Thank you.

JIM JENSEN: Now any other public comment. John, and then Jonah.

JOHN PINKERTON: I didn't realize we'd have another meeting before our NAMI walk tomorrow at 8:00 at Elmwood Park. Anybody who...everybody is invited and we're still taking contributions, and we've raised over $100,000, thanks to a lot of people, CNA industries especially. Kim Foundation really helped and Alegent and a lot of people really helped out on that. But this is money that's going to go for services for disabled people that we didn't have to tax people for. So there is money out there that doesn't have to come from the taxpayer. Thank you.

JIM JENSEN: Thank you very much. I think that's just outstanding, I really do. Jonah.

JONAH DEEPE: I would like to speak to you as a private citizen, taking off my other hat that you may know me as. I would really like to thank this commission for all the hard work you've done and the dedication you've had to LB1083, and I would hope that you would look at the work you've done as really being completion of the first leg on the journey to behavioral health reform in this state, because I think when we say we're closing the chapter, it seems kind of final. And I think it's really appropriate that we celebrate the progress that has been made and also voice the concerns that we have regarding what still remains to be done. And some of you have heard me speak before. I'd like to remind you that LB1083 did include children, but children kind of got left behind in LB1083 efforts and this commission's effort. And to me, just as I sit here thinking of closing the chapter, to me it (inaudible) me that will close the door on children, and I hope not. I hope that the new commission will open that door and look at children's services, and yes, I know that there are other efforts going on in this state regarding children's services, but I do feel that they should have been addressed as the whole picture of behavioral health reform, because children do grow up and they do

become the adults that you're talking about. So thank you, and I hope that we all will see the next leg on this journey be very successful.

JIM JENSEN: Thank you. Anyone else? Yes.

DIANA WAGGONER: I'm Diana Waggoner with the Kim Foundation and I would just like to, on behalf of the Kim Foundation, thank each and every one of you for the work you have done these past years. Your leadership, your strength, your vision, your compassion have inspired an incredible amount of people across the state. You know, from where the Kim Foundation sits, we see the stigma component and we seen the public education component, and you people have given so much towards breaking one stigmas and making mental illnesses what they are--illnesses that we need to treat and understand the symptoms, the same as we do for other illnesses. And I think, Jeff, you have been one of the unsung heroes. I know how much you have put into this of your own weekends and your own evenings, and I do thank you for that. Senator Jensen, you have inspired all of us with your vision to just continue and make this right. So thanks to each of you for being very the special person that you are.

JIM JENSEN: Thank you.

C.J. JOHNSON: I made a big mistake. I just got back from vacation and instead of taking my electronic Sudoku puzzle, I only found a calculator in there, so I've been crunching numbers now. No. (Laughter) I'm speaking before the commission. I appreciate the fact that this is the last meeting of this particular group; however, I also see a continuation with the new group coming in. So I really debated on whether I wanted to come up here and speak, because we're all saying how wonderful everybody has been, and you have. It's been a marvelous setting to come and present views. It's provided an opportunity for us to have a voice, and you know how critical that is in any discussion. I just wanted to...I'm just going to do this quickly. This is regarding a concern that I needed to express here, so that...as it carries over. There has been some

discussion over the last couple months with the regional administrators regarding the bed capacity at the Lincoln Regional Center for psychiatric patients. As you know, that bed capacity was set at 100 over the last couple of years, and it has been discussed with us that maybe it should move to 90, and the reason behind that was because if you really look at the average over the last year or two, the average is right around 90. And I can concur with that, because at any given time you may have several individuals who actually cannot be in a double room with a roommate, if you will, but were required to be by themselves. And that's true. In fact, I went back the last six months, and the average has been about 91.25 beds have been occupied at any given time, and the average has been about 6.5 individuals have required a "single" room at any given time. The problem that I'm having right now is, the regional administrators, this was discussed with the regional administrators by the division, and we indicated that we did not feel that it would be a good idea to move from 100 to 90 beds, okay? To me, the theory behind that would be somebody telling me that I only needed a 15-gallon tank in my car, even though I had a 20-gallon tank, simply because every time I filled it up I only put in 15 gallons. So I went back and crunched the numbers, and what appears to be happening is that despite the fact that we did not want to move to 90, it appears that that has become a practice. Prior to May 1 of 2008, the average, as I said, was 91.25 individuals in there at any time, and 6.5 individuals needing double beds. Since May 1, that average has gone to 87.87 individuals in the LRC beds, even though the number of people who require double beds has not changed the average. Now what that has done, on a quick hiccup, is...we went back and looked. Our average admissions per month in emergency protective custody is 57. However in May, we only had 41 admissions. So one would think we wouldn't have had any impact if, you know, there was some reality here. But the reality is, is we had an 85 percent increase in our post-commitment days in one month, even though we had only 41 admissions, compared to our average of 57, okay? The emergency system is extremely fragile, and when I say fragile, a hiccup here, a hiccup there, just dominoes everything else. And I'm just pointing this out, that conceptually, one could argue that yeah, the average has only been around 90 beds. But that's because we've had 100 beds to work with, and to

conceptually move it down to 90 beds means, on average, we're only going to have 80 beds to work with. And in one month, by that practice of going from 91.25 beds down to 87.87 beds, for us had an 85 percent increase in our post-commitment days, despite a significant in admissions. So I just want to point that out, that I'm concerned that there's an unagreed-upon change of going from 100 beds down to 90, and you know, I just needed to put that on record as indicating that, so.

CAROLE BOYE: Repeat your time frame again. What's your date?

C.J. JOHNSON: Prior to May 1 of 2008, the average was 91.25, but that...and I want to say, that's only going back to December 1, 2007. So the reality is, if you go back further, that number is actually going to go up, if you look at it, so.

CAROLE BOYE: How does...

TOPHER HANSEN: And then that month that you saw the spike is what month?

C.J. JOHNSON: May of 2008.

TOPHER HANSEN: Okay.

C.J. JOHNSON: So there was basically a four-person decrease from above 90, below 90, and it had an 85 percent increase in post-commitment days. And I'm very concerned...

CAROLE BOYE: We're done. You really do know that this commission is done. (Laughter)

C.J. JOHNSON: No, I know that. But I needed to put it on record, because there's another commission starting, and it's...and the reason I'm saying this is, if this is any

indication...last year before the bed allocation piece kicked in at those 100 beds, we had the highest number of post-commitment days, and we had the most number of law enforcement, hospitals, and everybody else screaming about how beds were backing up in the system. And I'm simply pointing out that if this trend would continue, in another month or so that screaming is going to begin again, if we're trying to limit the number of bed capacity at the Lincoln Regional Center, based on the current system as it is developed. That's all I'm saying.

CAROLE BOYE: C.J., I of course have to move beyond what it's impact is on Region V. What I'm trying to figure out, and maybe, Scot, you can answer this, is this same thing going on while we're moving folks to Norfolk, because we don't have enough room, or that they're sitting in jails, that we had to open up...so are we retrenching in Lincoln, at the same time that we're saying we have a crisis of people sitting in jail, so we have to reopen and move people into Norfolk? Is that connected, or are those two different issues? And then I'm going to say again, we're done. (Laughter) But that's a question I guess I have for you and for Scot and for the system, of how does all that work together?

MARIO SCALORA: As someone who deals with people who are in the jails and having to deal with folks who come into the higher security side, part of the problem is we're having folks who are being transferred to more secure beds who can't move back out, and we have a backing up in the system, so to speak, in terms of bed availability or moving people...

CAROLE BOYE: That's different than the 90 beds he's...90 to 100 beds he's (inaudible).

MARIO SCALORA: Not necessarily, because they go back and forth, and some of these folks are not folks who move back out in the community very easily, and so part of what is going on is we have some folks...I don't know what the length-of-stay data is, but part of the issue is that bed availability is being more challenged because of higher

lengths of stay for certain groups of people.

CAROLE BOYE: So I think my simple question is, is there an inconsistency between an increase in post-commitment days, retrenching of beds?

MARIO SCALORA: Has this been asked and answered? Yes.

CAROLE BOYE: And us having to use Norfolk. Is there an inconsistency with that?

MARIO SCALORA: It seems as if there are places in the system that are backed up, and if you want to call it an inconsistency, yes.

JIM JENSEN: Dr. Wilson.

DANIEL WILSON: I would reiterate Carole's reminder that we are done. And I appreciate your fine-grained, important comments, C.J. As it relates to this commission, I think Recommendation 5 that has been passed is pertinent, not in the next couple of months, but that long-term, Region V and its relationship to the state hospital system is different than the other parts of the state and needs...you know, should be changed, with appropriate money to make those changes.

C.J. JOHNSON: I agree. My only comment to that is, is the reason I came forward is, what I have found out over the last year, is because of that connectedness we have to the Lincoln Regional Center, and our data, ability to monitor (inaudible), that we can spot a hiccup quicker than other parts of the state can, because...

DANIEL WILSON: I hope you're not the canary in the coal mine.

C.J. JOHNSON: No. Well...and I just felt the need that if the practice is moved from 100 beds down to 90 beds without an agreed-upon relation to the system, and that's the

practice, that will change your bed capacity. If you take admissions based on a 90-bed capacity versus 100-bed, that will change. That's just...

CAROLE BOYE: Well, someone just said we have ten more days to solve this problem. (Laughter)

SUSAN BOUST: So I don't want this to take long, but I am just confused and maybe I missed part of what you were saying. You do not know that there has been a change from 100 to 90. You expect it, based on what you are seeing in your emergency services.

C.J. JOHNSON: Well, no. We...there was a discussion with the regional administrators presenting several options, one of those being 90 beds, okay, which we said, no, we want to keep it at...think of it as 100 beds.

SUSAN BOUST: I understand that. So my question is, do you have any hard data, other than your hiccups, saying that it is now 90 beds.

C.J. JOHNSON: I have...well, the data is that the average at the Lincoln Regional Center has gone before 90, and it's not because there haven't been people sitting in crisis centers and hospitals that need to get into the regional center. So it's a practice.

SUSAN BOUST: Thank you very much.

SHANNON ENGLER: The actual average daily census?

C.J. JOHNSON: Yes.

SUSAN BOUST: Thank you. Thank you.

JIM JENSEN: Is the savings, going from 100 beds to 90 beds, being passed on to the community?

C.J. JOHNSON: That was something we asked at that time; if we did agree to function that way, would that money transfer to the community, and we were told no, which then simply implies that the average per bed goes up, so.

JIM JENSEN: All right. Any other public comment? Scot, you got a...

SCOT ADAMS: If I might, Carole invoked my comment on that. Three or four points: One, no decision has been made with that. C.J. is right with regard to a discussion was held, and four or five options were made. The reason for that is really twofold. Reduced density improves safety. Secondly, when we went to 100-bed plan a few years back, regions started moving people back to the community. That's when the waiting list to get into the regional center started to happen. LB1083 does not identify regional centers by name. It says reduce them. We think we're very consistent here, and so the idea has not been implemented. There is discussion. The reason they are not safety is because you don't translate number of beds, you translate staff costs into savings to the community. Secondly, his major point I agree fully with. He's had somebody in the crisis center, which might be his blip, by the day, for about 60 days, trying to get in. That will cause your blip right there, because you didn't identify the (inaudible) involved with it. We have a person at a hospital in the regional center today, having been there for 80 days, and the reason they want to transfer to the regional center is because we just can't get them better here, and the region doesn't have a place to put them. So maybe they ought to go to the regional center. We think that's wrong. But I'm fearful that there is a growing backlash of consumers coming back into regional center pressure, so I'm very concerned about this issue, and it's coming from all over. So the balance in the services and the interaction of the regional centers into an integrated whole within a community-based system is what we're about. And look forward to the support of many people to achieve that. Thank you.

JIM JENSEN: Okay. Thanks, Scot. Any other public comment? If not, I just want to say it's been a great pleasure for me to work with all of you and to get to know you, and I just wish you well in the future. And I don't know about you, but I'll never lose my passion for mental health, and I hope you don't, either. With that, we're adjourned.

TOPHER HANSEN: Could we give a round of applause for our backbone of behavioral health? (Applause)